THE HISTORY OF OBSTETRICS AND GYNAECOLOGY IN AUSTRALIA FROM 1950 TO 2010

Thesis submitted to the School of Humanities and Social Science, Faculty of Education and Arts, University of Newcastle, in fulfilment of the requirements for the degree of Doctor of Philosophy.

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DECLARATION

I hereby certify that this thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

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Alan Donald Hewson

May 2016

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ABSTRACT

This thesis provides an overview of obstetrics and gynaecology in Australia from 1950 to 2010. The author was an active member of the discipline over that timeframe and draws on his professional experience during the period under review as one of the tools to shape a historical analysis and interpretation of the complexities and significance of change. The care of women is seen as critical to the survival of humanity but many historians do not give this subject a high priority. This thesis seeks to remedy that deficiency by providing a detailed review of the discipline during the marked increase in knowledge in medicine after World War Two, which resulted in a dramatic improvement in safety for mothers and babies. It also includes a detailed outline of the life-saving advances in the discipline over the past 60 years.

The thesis also documents the impact of a rapidly changing Australian society on the discipline and its practitioners, by analysing the historical background of their education and training, and the necessary adjustments in mindset and practice of the older generations to the confronting social and cultural issues of the 1960s and beyond. Many of the controversies explored have a long history, and include the background of role delineation in the discipline, the increasing impact of legal issues, the feminist debate, the changing site of delivery, and interventions in obstetrics. But the growing awareness of ethical dilemmas, obligatory continuing professional development and bureaucratic intrusion into practice needed inclusion. A focus of the thesis is the manner in which all these issues affected the region where the author spent his practising life, illustrated by graphs, diagrams and private files acquired over that period. The thesis should be a valuable resource for historians and others interested in the medical care of women and their babies in Australia during the second half of the 20th Century.

KEY WORDS: Australia, obstetrics and gynaecology, second half of Twentieth Century, progress, education, overseas training, knowledge explosion, Australian College, obligatory education, cultural changes, permissive society, role delineation, home births, medicopolitical influences, litigation scandals, Hunter Valley, history, advances, continuing challenges.

INTRODUCTION

Women of all societies in their role as mothers form the central nucleus and backbone of the family. 'There is no temple holier than one's own mother'.

Tamil Poem [1]

The genesis of this thesis was the wish of the author to provide a memoir of sixty years of obstetric and gynaecological practice, covering the period of the most dramatic changes in this area of medicine in the last 200 years. Having been delivered by a home birth midwife in country New South Wales between the two World Wars in 1927, the author was one of that unique generation who grew up in the Great Depression, suffered all the infections of a non-vaccinated childhood, saw the members of his family enlist in the Second World War, and then became one of the early recipients of a Scholarship into Medicine in 1946. The Medical course for that generation was designed to prepare graduates for general practice, and having graduated with Honours in 1952, three further years of hospital training were spent preparing for that career, but the opening of opportunities for four years of specialist training led to a lifetime in obstetrics and gynaecology.

A passion for preserving records and documents over the next sixty years provided a valuable resource for more than a memoir, and as the author had a major involvement in most of the changes in the discipline from 1950 to 2010, it seemed logical to expand the horizon and prepare a thesis on the subject. Initial enrolment in a Masters Degree in history, and course work in the discipline, was followed in February 2014 with permission to upgrade to a PhD.

The obstetrics practised in Australia between the World Wars had changed little from that practised for the previous 150 years. The discoveries of Simpson, Semmelweis, Wendel Holmes and Lister in the second half of the 19th century had made little impact on the day to day care of women during pregnancy and in the care of women in general, and deaths in childbirth had remained between five and ten per

[1] Konrai Venthan, in T.B. Krishanaswami, *Ten Tamil Ethics*, (Madras: Salva Siddhanta Publishing Society, 1957), 19.

1000 even in the 1920s. During the latter half of the 20th century, childbirth deaths in Australia fell to five per 100,000, the most dramatic change in human history.

There were many reasons for this change, and this thesis has not only analysed the background to events, but also used original material to clarify the changes in the medical discipline itself which contributed to the change. The information explosion after World War Two and changes in education and teaching were important, and these are analysed in a historical context in the first chapter

However changes in the Australian community after World War Two, including major migration, the rapid expansion of an educated middle class, and the social and cultural developments from the 1960s, completely altered the environment in which obstetricians now practised, and this is addressed in the next chapter. Obstetricians were still mostly male, and had all trained and qualified in the United Kingdom as there was no Australian College before 1979, so came to specialist practice with an Anglicised mindset which made many of them ill-equipped to deal with a rapidly changing Australian society. Further, the very hierarchical Australian public hospital system, again inherited from its British forebears, was also undergoing marked changes, as the old Honorary system was unable to deal with new challenges. Nursing, especially midwifery, was also changing rapidly as nurse education moved out of the hospital system into Universities. Inevitably there were also potential conflicts between GP obstetricians of the old school, who saw obstetrics as an essential part of family practice, and the new breed of specialist obstetricians who went directly from hospital training into specialist practice.

All these changes led to a reassessment of role delineation in the care of women, especially during pregnancy, and the thesis devotes a special chapter to that subject. The place of delivery became a subject for major debate as birthing moved from the home to hospital and the home birth controversy is also discussed in that chapter. Another major issue was the problem of increasing intervention and medicalisation of childbirth led by the new generation of specialists, allegedly accompanied by a loss of the totality of care from the old family doctor. This in turn led to a change in medical education in a new generation of medical schools from the mid-1970s, prioritising communication skills and care of the whole person. This required separate discussion and analysis in the thesis.

The development of an Australian specialist College in 1979 deserved special discussion, including its 'world first' compulsory continuing education programme. The College became the national voice of obstetricians, necessitating the development of a large network of committees to negotiate with Government entities and other professional groups, particularly their midwifery colleagues.

Medico-political controversies became more prominent in the decades from 1970, and required discussion in a separate chapter, including an insider's view of the controversial 'Doctors' Dispute' of 1984, with the later development of a nationwide quality private hospital system, which also had implications for obstetric practice. The enormous impact of litigation on obstetric practice needed separate discussion, and the sequel of rapidly increasing bureaucratic control of the profession needed extensive analysis, again informed by prime source documents from the time. The related entity of damaging scandals affecting the profession also required analysis.

In spite of the problems and challenges outlined, the discipline was part of important advances and achievements over those decades. Australia's contribution to these is considerable and are outlined in a separate chapter. A chapter detailing changes in the discipline in the Hunter Valley of NSW over the sixty years is included to provide an insight into the way in which the geography, topography, and historical background of the region modified the national developments. The metamorphosis from an isolated colonial convict settlement to a world class obstetric centre deserved to be recorded for posterity.

The final chapter summarises the thesis, outlines the current challenges faced by the profession, and the opportunities for continuing research. There have been informative medical histories in the past, but a thesis providing a detailed study of a particular discipline and its responses to changing cultural and societal trends over a long period in one country is unique. Any one of the chapters could form the basis for further study, and should provide a sound basis for further research.

CHAPTER 1
THE EDUCATION OF DOCTORS IN AUSTRALIA: FROM GENERAL PRACTICE TO SPECIALISATION

It is that which we do know, which is the great hindrance to our learning that which we do not know.

Claude Bernard[1]

From small acorns mighty oaks grow.

Anon

This chapter provides an overview of the training of medical practitioners, including obstetricians, in colonial and post colonial Australia. The first section details this history up until World War Two (WW2). It emphasises the profound influence of the Northern Enlightenment and the contributions of Scottish trained doctors and academics, especially at the Medical School and Faculty of Sydney University, contrasted with that of Melbourne University which was more strongly influenced by English and Irish institutions in the early decades. These developments are set against the backdrop of the medical difficulties of the original European settlement. The education of doctors who were to care for women during pregnancy cannot be understood without an appreciation of the problems facing the whole medical profession. The second section's primary purpose is to explore the education and training of medical practitioners in Australia after 1955, particularly the education of obstetricians.

THE EDUCATION OF DOCTORS IN AUSTRALIA PRIOR TO 1955

The Crown supplied almost all medical care through the salaried Colonial Medical Service (CMS) in the penal colony of New South Wales (NSW) from colonisation in 1788. Colonial medical officers also pursued public health measures, applying quarantine to ships potentially carrying infections and providing vaccination against

[1] D. Berry Hart, "Obstetrics at the beginning of the Twentieth Century", *Journal of Obstetrics and Gynaecology of the British Empire* 1 (1902): 51-60.

smallpox.[2] Free settlers and convicts both benefitted, and this also occurred in South Australia later, settled without convicts in 1836.[3] These surgeons had the right of private practice, but William Bland became the first fulltime private practitioner in 1815, and contributed to the Royal Hospital for Women in Sydney. Most doctors were graduates from the United Kingdom (U.K) until the medical schools were established in Sydney, Melbourne and Adelaide in the 1880s.[4] The difficulties of the Colonial Surgeons were enormous, documented in the conflicts and rivalries of John White (1788-1795), William Balmain (1796-1805), Thomas Jamieson (1805-1811), D'Arcy Wentworth (1811-1819), James Bowman (1819-1836), and finally, John Thompson (1836-1848), when military rule ended.[5] The medical difficulties of the sailing ships on those voyages give an insight into medical practice between 1840 and 1860, as each ship had a surgeon on board. There was ignorance and neglect, outbreaks of epidemics, and as many as sixty deaths on one voyage, including deaths in childbirth.[6]

However, Edward Ford is less critical of the early doctors.[7] He states that the doctors:

> played an essential part in every phase of development, bearing in mind their limitations and training, and some had medical problems themselves. They went with early explorers to the bush, and shared the heartbreak of the colonists and were united in serving their profession.

They brought British medical practice to a vastly different environment with different patterns of disease.[8] The Australian colonies demanded well trained general

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[2] Milton J. Lewis, "Medicine in Colonial Australia, 1788-1900", *MJA* 201 (1) (7 July 2014), S5-S10.
[3] Lewis, "Medicine in Colonial Australia", S5.
[4] Ian Cope and William Garrett, *The Royal, A History of the Royal Hospital for Women 1820-1997*, (Sydney: The Royal Hospital for Women, 1997), 7.
[5] C.J. Cummins, "The Colonial Surgeons, A History of Medical Administration in NSW", New South Wales Government, http://www.health.nsw.gov.au/resources/aboutus/history/h-surgeons_pdf.asp, 14-23.
[6] Michael Cannon, *Perilous Voyages to the New Land*, (Mornington, Victoria: Australia Publishing Company, 1997), 151-163. See also Bill Barlow, *Voyage of the City of Brisbane, 1862* (2nd edition), (NSW: Southwood Press, 2001), 15-18.
[7] Edward Ford, *Bibliography of Australian Medicine 1790-1900*, (Sydney: Sydney University Press, 1976), introduction, xii- xv. See also J.H. Cumpston, *Health and Disease in Australia*, M.J. Lewis (ed.), (Canberra: Australian Government Printing office, 1989); A.V. Edgeloe, *The Medical School at the University of Adelaide*, (Adelaide: University of Adelaide Archives, 1991); K.F. Russell, *The Melbourne Medical School, 1862-1962*, (Melbourne: Melbourne University Press, 1977).
[8] Ford, *Bibliography*, Introduction, xiii.

practitioners, broad competence, and self-reliance, and the first medical courses in Australia were increased by one year to give extra training in medicine, surgery, and obstetrics. Ford comments that their brass plates always stated 'Physician and Surgeon' but should have added 'Obstetrician, Gynaecologist, and Anaesthetist'.[9]

The need for Australian medical schools was urgent, bearing in mind the enormous variability in training and background of the early British doctors. Their tortuous careers are exemplified by the eminent Arthur Renwick, who was born in Glasgow, grew up in Redfern, and took Arts at Sydney University, and then medicine in Edinburgh in 1861.[10] He was a prime example of that generation who were still going to Britain to study medicine. The strong links with the Edinburgh school deserves explanation as it continued from 1882 to 1956.[11]

Contributions of the Scots to Medicine 1750-1900

The Australia we know owes much to the generations of Scotsmen who made Australia their home in the early years of settlement, part of the Scottish Diaspora.[12] The rise of Calvinism in Scotland so that it dominated the national conscience and the central ethos of the nation produced dramatic changes in Scottish society. Calvinism taught piety, equality and that all people must embrace education so that they could read the Bible and learn God's will.[13] As a result, the Calvinists built churches and schools all over Scotland, and the Scots became the best educated nation in Europe in the 18th century, making enormous contributions to Science, engineering, literature, theology, and medicine: a period later called the Age of the Scottish Enlightenment (1730 -1790).[14] Thinkers such as David Hume and Alexander Carlyle were all centred in Edinburgh.[15]

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[9] Ford, *Bibliography,* Introduction, xiii.
[10] Cope and Garrett, *The Royal*, 7.
[11] Alan Hewson, "The Contributions of the Edinburgh medical School to the Sydney medical school", *University of Sydney Alumni magazine*, (January 2014).
[12] Arthur Herman, *The Scottish Enlightenment, the Scots Invention of the Modern World*, (London: Fourth Estate, 2001), 63. Hundreds of thousands left Scotland in the 16th, 17th, 18th and 19th centuries, recorded in detail in the *Official Histories of Scotland*.
[13] Herman, *Scottish Enlightenment*, 22.
[14] Magnus Magnusson, *Scotland, the Story of a Nation*, (London: Harper Collins Publishers, 2000), 642, quoting from David Daiches, Peter Jones and Jean Jones, *A Hotbed of Genius*, (Edinburgh: Edinburgh University Press, 1986).
[15] Herman, *Scottish Enlightenment*, 182.

Adverse social conditions caused whole communities in the Highlands and the Islands to leave during the 19th century to all corners of the globe, as well as across the border into England.[16] Wherever they went they took with them the Calvinist work ethic, education, a close social structure, respect for, but not subservience to, authority, and a strong religious faith. The time of the greatest emigration was from the 1840s to 1850s, and then in the 1880s, particularly relevant to this study. Two million Scots emigrated between 1820 and 1914.[17] Arguably the Scottish influence is still most evident in education and medicine in NSW. Scottish education had as its aim equality of opportunity and wide availability, based on the theological egalitarianism of the reformers, and the Scots brought with them these fundamental beliefs. Further, Scottish education was general and practical in its orientation which was just what the new colony needed.[18] The whole system of public primary, secondary and tertiary education, the curricula and even many academic titles in NSW was profoundly influenced by Scots, and this has survived until recent years.[19]

There were good reasons for the Scots making major contributions to medicine in Australia during that period. The Edinburgh medical school was recognised as one of the best in the western world.[20] The Northern Enlightenment had contributed to this pre-eminence, with authorities in anatomy, physiology, surgery, physic, and medical education as a whole being prominent. The Hunter Brothers, John (1728-1793) and William (1718-1783), are recognised as the founders of modern surgery and obstetrics respectively. William Hunter, with William Smellie (1697-1763), established the 'man midwife' role in the discipline in London, and was criticised by the midwives of the time.[21] There were other outstanding men, for example, Dr Thomas Young who, for twenty four years, instructed midwives for the first time in history. Then Professor Alexander Hamilton, followed by his son Professor James Hamilton in 1800, published textbooks, taught as well as examined, and succeeded in getting midwifery established as part of the examinations in

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[16] Herman "Light from the North: Scots, Liberals and Reform", *The Scottish Enlightenment*, 256.
[17] Christopher Harvie, *Scotland, a Short History,* (Oxford: Oxford University Press, 2002), 163.
[18] Malcolm D. Prentis, *The Scots in Australia,* (Sydney: Sydney University Press, 1983), 169.
[19] Prentis, *The Scots in Australia*, 176-193.
[20] F. Antill Pockley, "Reminiscences", in *The Centenary Book of the Sydney University Medical Society*, eds. Ann Sefton, Nicholas Cheng, Ian G. Thong, (Sydney: Hale & Iremonger, 1992), 45.
[21] Geoffrey Chamberlain, *From Witchcraft to Wisdom, William Hunter, 1718-1786, the Father of British Obstetrics*, (London: RCOG Press, 2007), 78-81. William Smellie was also a Scot from Lanark in Scotland. See Smellie *A Treatise on the Theory and Practice of Midwifery*, (London: Wilson, 1752).

medicine in 1824. Then came the most famous, James Young Simpson (1811-1870), the man who introduced chloroform and anaesthesia to the world of medicine.[22]

However other world leaders in medicine in Edinburgh made an indelible mark on history from the late 1750s, including Alexander Munro in anatomy from 1726, and later, an 'extra mural' world first training programme in anatomy and surgery flourished. With men like Bell, Liston, Syme, Wilkie and Fraser, and collaboration with the Royal College of Physicians in Edinburgh, the centre produced a comprehensive School of Medicine at the Royal Colleges, again unique. From 1859 a 'double licence' of the two Edinburgh Colleges was a registrable qualification.[23] Sir Joseph Lister, the pioneer of antiseptic Surgery, was born in Essex, trained in London, but moved to Scotland, becoming Professor of Surgery, first in Glasgow, then in Edinburgh, in 1869. He first used the Carbolic acid spray in his operating theatre in 1865 in Glasgow, which revolutionised surgery for all time.[24] This was the heritage in Scottish medicine which was to have a remarkable impact on Australian medicine. This influence was most obvious in the development of the Medical School at University of Sydney.

The Scots made enormous contributions to many fields at the University of Sydney but the Faculty of Medicine was the major beneficiary of imported Scots from the Northern Enlightenment.[25] The University of Sydney Medical School was begun by Professor Thomas Anderson Stuart in 1883.[26] He subsequently recruited a team of medical teachers, largely from Scotland, who set up training modelled on that which was 'the norm' in the medical schools of his native Scotland. The Faculty of

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[22] Michael J. O'Dowd and Elliott E. Philipp, "Simpson, James Young, [1811-1870]", in *The History of Obstetrics and Gynaecology*, (London: The Parthenon Publishing Group, 1994), 650.
[23] "Surgeons of Edinburgh", reprinted from *The Scottish Field*, (September, 1962), Fellows Reading Room, R.C.S. Edinburgh, (personal file, A.D.Hewson).
[24] John Walton, Paul Beeson, Ronald Bodley Scott, eds., *The Oxford Companion to Medicine Volume 1*, (Birmingham, Alabama: Gryphon Editions, 1988), 675.
[25] Clifford Turney, Ursula Bygott & Peter Chippendale, *Australia's First, A History of the University of Sydney, Volume 1, 1850-1939*, (Marrickville, Sydney: Hale & Ironmonger, 1991), 639.
[26] John Atherton Young and Nina Webb, "Anderson Stuart and the Medical School", (chapter 4), in *Centenary Book of the University of Sydney Faculty of Medicine*, eds. John Atherton Young, Nina Webb and Anne Jervie Sefton, (Sydney: Sydney University Press), 171. Born in Dumfries Scotland, he came from a comfortable middle class family, was educated at a private school, completed studies in chemistry, and then planned to study Medicine in Edinburgh. But initially he studied Greek, German, and French in Germany. He then began medicine, was a brilliant student, and graduated with First Class Honours. He began teaching Physiology, and later acquired an MD by thesis. He accepted the Professorship at Sydney at the age of 26, became the second Dean in 1883 and stayed for 40 years.

Medicine of Sydney University was established on 13th June 1856, but the medical school itself was not opened until 1883.[27]

The Development of the University of Sydney and the Medical School

While Sydney University antedated Melbourne University by five years, Melbourne's Medical School opened in 1863, twenty years earlier than Sydney.[28] Adelaide Medical school opened in 1885, but those in the rest of Australia were decades later.[29] This meant that Sydney and Melbourne, and to a lesser extent Adelaide, dominated the training of Australian doctors for those early decades.[30] The educational pattern for medicine in Sydney was determined quite early, with the incoming Head of the Faculty, Professor Anderson Stuart, having a classical education before moving to Medicine.[31] Beginning with one staff member, Anderson Stuart himself, and four male students in 1883, in a four room brick cottage, Anderson's drive, initiative, and vision within six years established a firm foundation for the Faculty both within the University and the outside world.

By 1893 there were almost 100 students, and 13 staff, and the Anderson Stuart building, still surviving, already had its major structure completed in 1889. The first year of the programme was spent in the Faculty of Arts, followed by four years of the traditional medical curriculum.[32] The profession in Sydney had the opportunity to observe the progress of current reform of medical education in England. Many of the practising doctors in the colony had come from Scotland and to a lesser extent from Ireland, so that the local profession was more accepting of the Edinburgh pattern that teaching and examining went together, different from the system in England, where the two functions were always separate. In fact, 48% of all graduates in NSW in 1885 had a degree (or licence) from Scotland, which made Anderson's task easier. There was also an absence of pre-existing medical corporations (Royal Colleges) in the

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[27] John Atherton Young et al., C*entenary Book*, 1.
[28] Jacqueline Healy, ed., *Strength of Mind, 125 Years of Women in Medicine*, (Melbourne: Medical History Museum, University of Melbourne, 2013), 7. See also Laurence Geffen, "A brief history of medical education and training in Australia", *MJA*, *MJA* Centenary, 1914-2014, 201 (1), S19.
[29] Queensland, 1936; Western Australia, 1957; Tasmania, 1965.
[30] The much smaller size of the Adelaide School and Faculty, and its distance from the major population centres on the eastern seaboard made this inevitable. Queensland, Western Australia and Tasmania came much later. See Milton J. Lewis, "Medicine in Colonial Australia 1788-1900", S5.
[31] Lewis notes that in the early 1880s, most colonial doctors were college licentiates. See Milton Lewis, "Medicine in Colonial Australia", S7. Only 37% of doctors in NSW had degrees.
[32] Webb and Young, "Anderson Stuart and the Medical School", *Centenary Book*, 179.

colony with vested interests to defend.[33] The fortuitous development of the Royal Prince Alfred Hospital on University of Sydney land at the same time facilitated a symbiotic relationship between the medical school and the hospital, which did not occur in England.[34]

Of the first twenty six teaching appointments made at the University of Sydney medical school before 1900, fifteen were Scottish, twelve of these from Edinburgh; two from Irish universities, three from England and one was local. Five had only medical licences (Scots and English). Of the first twenty two examiners appointed, twelve were Scots, three were English, and six had licences (English, Irish, and Scottish).[35] There was a preponderance of Scottish graduates in England also at that time, but the vested interests of English Corporations and Universities kept them out of senior positions. This was not so in the Colonies. The large number of Edinburgh born or trained appointees to the new school included such luminaries as Scot Skirving (1859-1956), who was a student at Edinburgh with Anderson Stuart.[36] Anderson Stuart appointed his own graduates after the school was established, and did his utmost to keep them in Australia.[37] Additionally, he appointed a local untrained boy of fifteen when the school opened to look after cadavers, who stayed for thirty three years.[38] His training took place on the job in a practical sense.

Anderson Stuart revolutionised teaching methods by reducing the number of lectures, and greatly increased practical training, following Scottish tradition. Space precludes expanding on other less important changes, but a review of that early teaching programme is instructive. The subjects taught were similar to those of the 1940s, and the number of hours of teaching lectures (950 hours per year) were almost identical to the hours of teaching as recorded in 1983.[39] The course lasted five years,

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[33] John Atherton Young, "Second Act, the Medical School, 1882-1889", (chapter 3), *The Centenary Book*, 102.
[34] J. Walker Smith, "Edinburgh and its Role in the Foundation of the Sydney Medical School", *Journal of the Royal College of Physicians, Edinburgh*, 36 (2006): 355-361.
[35] John Atherton Young, "Second Act, The Medical School", *The Centenary Book*, 105.
[36] John Atherton Young, "Second Act", *Centenary Book*, 108-162. Other Edinburgh teachers and lecturers are documented in the Centenary History, and include Sir Alexander MacCormack, Sir James Graham, Arthur Murray Oram, William Haswell, Thomas Storey Dixon, Alfred Roberts, Sir Henry MaClaurin, John Macfarlane, Donald MacEwan, Richard Jones, John Blair, Thomas Rowen and Chisholm Ross.
[37] John Atherton Young, "Second Act", C*entenary Book*, 137-163.
[38] Lise Mellor and Vanessa Witton, "The Prince of the Dissecting Room", *Radius*, 26, (July 2012).
[39] Ann Jervie Sefton, Nicholas Cheng, Ian Thong, eds., *The Centenary Book of the Sydney University Medical Society*, (Sydney: Hale and Iremonger, Southwood Press, 1992), 179.

but the failure rate was initially very high. For the first course with four students, none passed the finals, and only one eventually graduated. Stuart was determined to set and keep very high local academic standards, and later he wrote passionately about the advantages of medical students having an education in Australia, rather than going to the United Kingdom.[40] He set up a Medical Society, which he chaired, based on the Royal Medical Society of Edinburgh. [41] This had a broad academic remit covering intellectual and social objectives.[42]

There were important differences between the Medical Schools of the Universities of Sydney and Melbourne. The pattern of development of the first medical school at the University of Melbourne for example was more influenced by clinicians and training programmes from England and Ireland, even though it began at approximately the same time, but Edinburgh graduates were still prominent, as were Scottish benefactors.[43] The Development of Clinical Academic Chairs was relatively late. Sydney had the first Professorial chairs established in Medicine (Charles George Lambie, 1930) and Surgery (Harold Dew, 1930) and both men exercised enormous influence on teaching and training from then until they both retired in 1956. [44]

Charles Lambie (1890-1961) was affectionately known as the 'Wee Mon', and always remained true to his Scottish roots. At the time of Lambie's retirement, seven of the thirteen Professors of medicine in Australia had been his students.[45] Both Lambie and Sir Harold Dew were World War 1 veterans, and Lambie was decorated with the Military Cross during his war service. They were both excellent clinicians

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[40] Anderson Stuart, "The Advantages of a Colonial Medical Education for Colonial Youths", *Hermes, Journal of the University of Sydney Medical Society*, 1895, (Reprinted in *Radius*, March 2006).
[41] Sefton et al. *The Centenary Book of the Sydney University Medical Society*, 12.
[42] Sefton et al., *Centenary Book of the Sydney University Medical Society*, 45. Anderson Stuart's influence went even further beyond the topics covered in this thesis. For more see Alan Barcan, A *Short History of Education in New South Wales*, (Sydney: Martindale Press, 1965). Barcan showed a remarkable dominance of medical students when compared with those doing liberal studies, at the time. See also Steve Meacham, "Sydney's War, the Book of Remembrance", *Sydney Alumni Magazine*, (July 2014), 30-32. See also John Ramsland, "Sydney University Men and the Great War: John le Gay Brereton as Memorialist", (in press), *Education Research and Perspectives*, The University of Western Australia, (2015). The Memoirs of Frank Antill Pockley provide an insight into the trials of going back to the UK for more study with a 3-4 months voyage by sailing ship around Cape Horn.
[43] Prentis, *The Scots in Australia*, 187.
[44] Sir Harold Dew, a Melbourne graduate (1914), was a brilliant administrator as well as a highly regarded surgeon,took a leading role in the formation of the RACS,and was loved by students for his down to earth, modest manner and approachability. See Young, Sefton, Webb, *Centenary Book, Medicine*, 386.
[45]Kempson Maddox, "Charles George Lambie", *MJA*, (Dec 13th 1969), 1185.

with enormous clinical experience, who taught the prime importance of taking a detailed clinical history, carrying out a meticulous physical examination, and managing with the minimal special investigations available at the time. Both had a classical training. Lambie quoted from Latin and Greek literature in his lectures, was fluent in German, French, and Italian, translated the New Testament from the original Greek into English, was a serious student of music, and so Lambie in particular was very much in the Osler mould of 'a cultured medical gentleman'. Lambie's continuing Scottish influence on the Faculty was outlined in Kempson Maddox' article in the *MJA* in 1969. [46]

Furthermore Lambie's two volume work on *Clinical Diagnostic Methods*, co-authored with Jean Armitage (1946), was typical of the best scholarship of the time, and it demonstrates the vast gulf between the didactic clinical teaching methods of the old school, and what happened from the 1960s onwards. He wrote articles on a broad range of subjects, was an enormous inspiration to others, and a role model for generations of graduates of the Sydney school. Prof J. Witherington Stump, Professor of Histology and Embryology, also continued the Edinburgh tradition during the 1940s and 1950s. When Professor Ruthven Blackburn took the Professorial chair in Medicine in 1957, he for the first time asked that students should no longer stand as he entered the lecture theatre. This was the final curtain on a tradition going back seventy years and harbinger of the 1960s cultural shifts.

All these changes at the University of Sydney were still dominated by the influence of the General Medical Council of Great Britain (GMC) which remained a critical factor in education and training in Australia and the legal status of the medical schools, as detailed by Geffen.[47] The development of the new Australian schools was always predicated on them satisfying the requirements of the GMC, which ensured that they followed the United Kingdom pattern of secondary school entry on academic merit followed by preclinical, paraclinical, and clinical phases. The schools at Sydney, Melbourne, and Adelaide in the 1880s, followed by Queensland (1936), were all in this pattern, and the next group of universities with Medical Schools -

[46] Michael Bliss, *William Osler, A Life in Medicine*, (Oxford: Oxford University Press, 1999). William Osler (1849-1919) was one of the most admired physicians in the history of medicine, and influenced medicine in Canada, the United States, and Great Britain. He had professorships at McGill, Pennsylvania, Johns Hopkins and Oxford.

[47] Laurence Geffen, "A brief history of medical education and training in Australia", *MJA* 201 (2014), S219-222.

Western Australia, (1957), Monash (1961), NSW (1961), and Tasmania (1965) - were all basically traditional in philosophy.[48] Geffen argues that the philosophy of the GMC on undergraduate education was influenced by the ideas of Abraham Flexner from the United States of America (USA), who had advocated this two phase curriculum from the early 20th century following his review of medical schools in the United States and Canada.[49] It is accepted that this conformity to the GMC pattern of the United Kingdom was essential in the early decades to give the new Colonial schools appropriate international educational status. The changes after the 1960s will be addressed later.

The overall emphasis in the teaching programme in the years from 1883 until 1950 was to produce a competent general practitioner who would be able to deal with most of the clinical problems to be met in clinical practice in Australia, covering general medicine, surgery, obstetrics, and anaesthesia, and only needing to refer patients in most unusual situations. The post WW2 era with the information explosion so changed medical practice that the earlier medical education programmes had to change completely. This will be addressed in the next section, including its particular relevance to obstetrics and gynaecology.

There were some outstanding teachers and practitioners in that colonial and early post-colonial era, but there were ongoing problems in education and the actual practice of medicine. Some were a reflection of the difficult social problems of those decades but also there was a failure to utilise and implement available knowledge in the western world in the second half of the 19th Century. The variable, and often poor standard of practice after WW1, and during the Great Depression years from 1929, has been documented by Milton Lewis, E.S. Morris, Dame Constance D'Arcy and others. [50] The undergraduate education programmes of the time were falling short of what was required to enhance and expand education in the workplace setting. What was needed was for the profession itself to take the initiative to remedy this problem. It was in this time of turmoil that the medical specialties were born.

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[48] Geffen, *MJA*, 202.
[49] Abraham Flexner, *Medical Education, A comparative Study*, (New York: McMillan, 1925). See also Abraham Flexner, *Medical Education in the United States and Canada*, (Boston: The Carnegie Foundation, Merrymount Press, 1910).
[50] Milton J. Lewis, E.S. Morris, Constance Darcy, references regarding obstetrics in particular, see chapters 2 and 3.

The Development of Medical Specialties in Australia and New Zealand

The development of Medical Specialties in Australia and New Zealand was described by Storey recently.[51] Her paper outlined the sequence of events after World War One, when many surgeons came back from the war with enhanced practical experience and knowledge, particularly in surgery. As a result, the British Medical Association (BMA) in Australia created permanent Postgraduate Committees to provide education for retraining of ex-servicemen. By 1920 there was a general recognition of the haphazard nature of training and accreditation in many aspects of practice and it was also recognised that the traditional providers of education, the Universities, were not equipped to provide this postgraduate training. Initially the BMA, representing the practising profession, was believed to be more appropriate to improve and even regulate professional practice. This eventually led to the establishment of the Royal Australasian College of Surgeons (RACS) in 1927, to 'promote the art and science of surgery'. [52] This pioneering body began the task of specialist surgical training, establishing standards by examination, and ensuring ethical standards. There was initially some opposition from general practitioners as would be expected.[53]

There was also a change in the field of internal medicine after the First World War because of increasing knowledge in biochemistry and biophysical medicine, and improving methods of investigation. From 1930, a group of physicians from Sydney and Melbourne formed an Association of Physicians of Australasia, specifically to include New Zealand, which eventually led to the Royal Australasian College of Physicians (RACP) Incorporation in 1938, when it held its first examinations.[54] However, overseas training with membership of a British College remained a requirement for some years, and it was not until the 1970s that the College took over responsibility of accrediting training positions.[55] Only by 1951, when the colleges

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[51] Catherine Storey, "A Brief history of the specialties from Federation to the present", *MJA* 201, (7 July 2014), S26-S28.
[52] G.A. Syme, "The Aims and Objects of the College of Surgeons of Australia", *MJA* 1 (1928), 488-491.
[53] H.W. Armit, "Specialists and Specialities", *MJA* (1920), ii, 437-438.
[54] Charles G. McDonald, "Internal Medicine, its Development and Practice in Australia During Fifty Years", *MJA* 1 (1951), 1-5. See also, Ronald Winton, *Why the Pomegranate? A History of the Royal Australasian College of Physicians*, (Sydney: *RACP*, 1988).
[55] Necessary to confirm appropriate training had occurred.

had made a significant impact on postgraduate education, did the Universities relinquish their role in specialist training and qualification.[56]

This process facilitated the development and accreditation of specialist teachers in major hospitals, all working under the Honorary system, with appointment at a teaching public hospital becoming the aim of all doctors 'specialising'. During the 1950s subspecialties also began to emerge as discrete clinical units in the teaching hospitals.[57] This system changed after the Labor Government introduced Medibank, which metamorphosed in to Medicare in 1984, and a differential fee structure became institutionalised. In the early years the National Specialist Qualifications Advisory Committee (NASQAC) was the accrediting body for specialists, so the process remained under the control of the Colleges, but this was subsumed by the Australian Medical Council (AMC) in 2001. The development of an increasingly important private hospital system and subspecialties led to an exodus of some specialists to the private sector, so the central role of the public teaching hospital appointment became less dominant.

The overview by Storey does not emphasise the overriding impact of the two World Wars. War service is a characteristic of most of the senior medical staff during the years from 1914 to 1945. It also affected all faculties in World War Two. Over 4000 students and staff from Sydney University enlisted and 250 were killed.[58] The effect of war on all types of medical practice was a major confounder through this period, as it affected medical progress, the careers of leading teachers and students, the medical care of the community and the services provided by hospitals. While

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[56] There are parallels between this process in the other disciplines and the discipline of obstetrics and gynaecology. The timeframe of development of the other 14 Specialist Colleges is included in the Appendices.

[57] Storey, *MJA*, s27.

[58] The effect of WW1 on Sydney University was severe. See Golden Graduates Lecture, Michael Spence, Sydney University, 2014: "50 medical graduates and students died in World War One". War service was a characteristic of most of the senior medical staff during the years from 1914 to 1945. The loss of talented graduates and undergraduates during WW1 was tragic. See John Ramsland, "Sydney University Men and the Great War", (in press), *Education Research Perspectives*, University of Western Australia (2015), and also John Ramsland, "The Elite Education of Lieutenant Arthur Wheen, MM", *History of Education Review*, 44 (1), (2015): 85-98. At Royal Prince Albert Hospital (RPAH), William A. Bye, C.G. McDonald, Stan Goulston, Maurice Joseph, Vernon Barling, John Maxwell, Frank Mills, and John Leowenthal, (later knighted) George (later knighted) and Malcolm Stening, John Knox, and Sir Herbert Schlink from WW1 in gynaecology, were also ex-servicemen. All these men had years away from their special medical interests because of war service. War service affected all faculties in WW2. See *Australia's First, History of the University of Sydney volume 2, 1940-1990*, eds. W.J. Connell, G.E. Sherrington, B.H. Fletcher, C. Turney and U. Bygott, (Sydney: Hale and Iremonger, 1995), 8.

military service by the medical profession had positive aspects, the disruption of career paths, death or injury of key personnel during military service, pressures on those doing civilian work, and interruption of teaching and training, caused enormous problems for the medical workforce, and particularly those with positions on teaching hospital staffs. Those with new specialist positions before WW2, most of whom enlisted, were particularly disadvantaged. The development of education and training for obstetricians must be seen in this context.

MEDICAL EDUCATION AFTER 1955

The new era from 1955 was a reflection of the inevitable alterations brought on by a new generation of teachers, due to accession to positions of authority of teachers like Professor Ruthven Blackburn himself. He was a trained scientist clinician, with a background in research, and he focussed on the rapid advances in scientific knowledge after WW2, but he was just one of a growing cohort of likeminded leaders. Professor John Loewenthal (1914-1979), who succeeded Professor Harold Dew (1930-1957) in the Chair of Surgery in 1957, was an ex-serviceman, had a brilliant mind, encouraged research and led changes in thinking in surgery.[59] The drive towards Specialisations in Medicine was not limited to Australia. Indeed, Dr Alec Cooke, an Oxford physician, commented on the UK situation that he was 'looking forward to the Royal Colleges of Flat Feet and Halitosis'![60]

This pattern also occurred in the discipline of obstetrics and gynaecology. Large numbers of 'obstetricians', that is, GPs with a special interest in obstetrics, had enlisted in WW2, some individuals rising to the top of the military hierarchy, notably Dr F.A. Maguire, DSO, WW1, who was Director General of Medical Services (DMS) from 1941 to 1944, and Sir William Refshauge who succeeded him. [61] Many had distinguished war records, most served overseas, and a number have already been

[59] John Loewenthal was one of the post war ex-servicemen of Jewish background, on the staff of Royal Prince Alfred after the war. Other prominent Jewish doctors included Maurice Joseph, Stan Goulston M.C., Eric Goulston, Lyn Joseph, Joseph Steigrad, CBE, Victor Brand (from Victoria), as well as many killed in action. See Gerald Pynt, *Australian Jewrys Book of Honour, World War Two*, (South Australia: Griffin Press, 1973).
[60] Alec Cooke, *My First 75 Years of Medicine*, (London: Royal College of Physicians, 1994), 111.
[61] Dr F.A. Maguire was acting Professor of Anatomy at Sydney University 1921-1922.

mentioned.[62] But the downside of this was that during the time when they would normally be increasing their specific obstetric experience they were engaged in general medical work in the services.[63] So these teachers of obstetrics to the early post war undergraduates had enormous general medical experience, were great role models for that post war cohort, and exerted enormous influence on the next generation of doctors. But keeping up with the post war explosion of knowledge, and teaching these advances to the next generation, was a difficult task for all of them.[64]

The development of the Royal College of Obstetricians and Gynaecologists (RCOG) in Britain in 1929 had a profound effect on the emergence of the specialty in Australia, because it revolutionised not only the training of specialists but had a dominant effect on the actual staffing of the teaching hospitals, clearly seen in the changes over a short timeframe at particular hospitals. The British College of Obstetricians and Gynaecologists (BCOG, to become RCOG) had a difficult beginning, a story in need of more research. However, because there was significant jealousy and difficult egos involved, the original prime movers, William Blair–Bell (1871-1936) of Liverpool and William Fletcher Shaw (1878-1962) of Manchester, ensured that it was not 'London based' like the Colleges of Physicians and Surgeons.[65]

This was probably why it always had a more global outlook than the other two colleges, who were united in opposing its formation. A matter of public concern at that time was maternal mortality, which in the UK was still 4.3 deaths per 1000 births, virtually unchanged since the year 1800.[66] This enhanced public support for the establishment of the new College, to concentrate on improving standards in obstetrics. It was inaugurated in 1929, and initially Membership (MRCOG) and Fellowship (FRCOG) were determined by a grandfathering system (by invitation). This was followed later by a *viva voce* system for the MRCOG i.e. just an oral

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[62] For example, Malcolm Stening, gynaecologist at King George Vth Hospital, served in the British Navy, and there were several others.
[63] See also Janet McCalman, *Sex and Suffering: Women's Health and a Womens Hospital, the Royal Womens Hospital Melbourne, 1856-1996*, (Melbourne: Melbourne University Press, 1998), 147, 148.
[64] See James Le Fanu, *The Rise and Fall of Modern Medicine, definitive Moments of Modern Medicine*, (New York: Carrol and Graf, 2000), xvii.
[65] The Royal College of Physicians was founded in 1518, The Royal College of Surgeons of England in 1745 (as the Company of Surgeons). See Alec Cooke, *My First 75 Years in medicine, RCP, London*.
[66] O'Dowd and Phillip, *History of Obstetrics and Gynaecology*, (London: Parthenon Publishing, 1994), 186.

examination.[67] There was no requirement to have training in the basic sciences, nor extensive hospital experience. This changed in 1936, when a requirement to have appropriate hospital experience was made compulsory before sitting the examination. This was different to the two existing colleges, which allowed candidature before doing special hospital training. Then came the requirement to complete a case study book, with documented records of twenty obstetric and twenty gynaecological cases managed by the candidate, and two Commentaries on obstetric and gynaecologic subjects with a review of the literature, 'expressed in good English'. To this was added a written examination and a clinical examination. This continued until 1966, and was the format under which the great majority of the teaching hospital specialists in Australia from 1955 had progressed to their final positions as consultants, as the earlier generation moved to retirement.

The next change introduced was a separate 'Part 1' in the basic sciences, with a multiple choice paper plus a written paper, but the latter was subsequently ceased. The second part could only be attempted after at least three years in recognised posts, and an elective year was introduced.[68] It was not until the mid-1970s that the second part examination could be attempted in Australia. There was never any commitment to obligatory Continuing Medical Education which became a hall mark of the Australian College (founded in 1979).[69]

The formation of an Australian Regional Council in 1946 led to the official recognition of specific training posts.[70] This was a desirable move, but it meant that these were limited to the central teaching, university -affiliated hospitals in the capital cities. In practice, this lead to streaming into those posts of early postgraduates already in the central teaching hospital system, to the detriment of well qualified graduates working in other centres. The only hospital with an accredited post in obstetrics not part of this system was the Royal Hobart Hospital, which, although it had a well qualified staff in all disciplines, was not directly associated with a medical

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[67] John Peel, *William Blair- Bell, Father and Founder,* (London: Royal College of Obstetricians and Gynaecologists, 1986).
[68] Paul Barnett, *75 Years of the RCOG, 1929-2004,* Royal College of Obstetricians and Gynaecologists, London, 2004,14
[69] "Companies Act, 1961, Memorandum and Articles of Association of the Royal Australian College of Obstetricians and Gynaecologists", (Melbourne: RACOG, 1979).
[70] Ian A. McDonald, Ian Cope and Frank M.C. Forster, *Super Ardua, The Royal College of Obstetricians and Gynaecologists in Australia, 1929-1979,* (Melbourne: Australian Regional Council RCOG, 1981), 7

school. This meant that there was fierce competition for that one post from all over Australia, as the alternative was for any aspirant obstetrician to go to the UK and compete with local UK graduates.[71]

These years also witnessed changes in the makeup and classification of the teaching staff of the central obstetric teaching hospitals in Sydney from 1945 to 1960. A typical example is the history of the Royal Hospital for Women at Paddington (RHW) founded in 1820 and finally transferred to partnership with Prince Henry/Prince of Wales in 1997.[72] Up until 1940 the visiting obstetric staff were usually appointed as Honorary Surgeons, as the RCOG had yet to make an impact on the medical profession and specialist practice in Australia, even though it had been formed in 1929. According to the official records of the RCOG, there was only one member of the RCOG in Australia in 1940.[73] There is some doubt regarding that figure, as pointed out by the Australian obstetric historian, Dr Frank Forster in his overview of the growth of the RCOG in Australia.[74] He states that the total numbers of Fellows in Australia in 1938 was fourteen, with five in NSW, five in Victoria, and four in South Australia. Members in 1938 totalled sixty one, with thirty in NSW, twenty three in Victoria, one in Tasmania, three in South Australia and four in Western Australia. According to Forster the initial growth of the College was rapid, but WW2 caused a dramatic slowing of growth, as many potential trainees joined the services.

By 1947 the number of Fellows had increased to twenty eight, with eighty one members, five in Queensland, thirty nine in NSW, twenty five in Victoria, four in Tasmania, three in South Australia and five in Western Australia. According to the RCOG, the numbers had only increased to seventeen Fellows and sixty three members in 1945.[75] The dramatic increase in numbers in 1947, and the discrepancy,

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[71] Alan D. Hewson, author of this thesis, began his obstetric career in 1955, by being selected for that post (see abridged biography in appendix).

[72] Cope and Garrett, *The Royal*. Research at Crown Street Hospital in Sydney confirms that the teaching appointments system followed the same pattern before and after WW2. See Judith Godden, *History of Crown Street Hospital* (in press), which lists the whole staff at Crown Street Hospital pre and post World War Two, and highlights the explosion of higher degrees after 1950 (personal communication to the author).

[73] Archivist, the Royal College of Obstetricians and Gynaecologists, personal communication, February, 2013.

[74] Frank M.C. Forster (1923- 1995), *Progress in Obstetrics and Gynaecology in Australia*, (Sydney: John Sands, 1967), 82.

[75] The Archivist, RCOG, personal communication, February, 2013.

is probably related to the visit of Sir William Fletcher Shaw from the UK, with the first examination held in Australia in 1947, leading to a marked increase in numbers with the admission of new Fellows and Members during that year.[76] The first election of an Australian Regional Council was also held in that year. It is not clear from the records as to whether all of these obstetricians were actually practising and with hospital appointments. An important issue in the early development of the Royal College in the UK as an international organisation was clarified by a major statement by the second President, John Shields Fairbairn (1865-1944) in 1933, when he stated:

> Our branch of medicine is scarcely large enough to justify our existence unless our College embraces all Britain and its Dominions. The strength of the College must depend on its success first in appealing to and attracting all those practising obstetrics and gynaecology and fitted for its membership throughout the British Commonwealth: and next, to maintain their interest and obtaining their service for the objects for which the College was founded. Unlike the Royal Colleges of Physicians and Surgeons in London, Edinburgh, and Dublin, we are not of London, not of England, Scotland or Ireland, but of all of them, and our British people overseas.[77]

This Commonwealth concept is one reason why the link between Australian obstetricians and the British College was such a strong one, and why it took a comparatively long time for the impetus to form an Australian College to gather strength, which was not until 1979.[78]

The changes in the staffing of the Royal Hospital for Women (RHW) in Sydney were a typical example of a comparatively rapid change in a teaching faculty. In 1940 all of the staff at the RHW were reclassified as 'Honorary Obstetricians and Gynaecologists'.[79] Notably, only seven were appointed between 1930 and 1940 and continued on the establishment until well after WW2. There were virtually no new appointments during the succeeding ten years (1946 to 1957). Then there was a marked increase in specialist numbers when the new breed of specialists entered

[76] Forster, *Progress*, 78. This special examination was run to allow ex-servicemen to attempt the examination without the expense of travelling to the UK.
[77] RCOG Archives, 2013.
[78] RACOG, "Articles of Association", (Melbourne: RACOG, 1979).
[79] Cope and Garrett, *The Royal*, appendix 1, 163.

practice; those who had come through the newly established RCOG training programmes referred to earlier.[80] They were now to take over the teaching and training of both undergraduates and postgraduates from the 'old guard'. Similar changes occurred at the other major obstetric teaching hospitals in Sydney, the Crown St Women's Hospital (CSWH) and King George 5th (RPAH). In 1950 at CSWH, the senior consulting staff of four had not one person with the MRCOG qualification, all having an FRACS, the specialist qualification of the Royal Australasian College of Surgeons. There were 'Honoraries' with the MRCOG or FRCOG, the next layer in the hierarchy, and five Assistants with an MRCOG, but still one (Dr Alan Grant) without. The highly respected Superintendent, Dr Reginald Hamlin, who carried the major role of teaching and training, did not have an MRCOG.[81] That was the total of the senior obstetric staff.[82]

The following decade was to witness dramatic changes and by the 30 June 1959, the staffing situation was quite different. All the senior Honorary staff, Drs Chesterman, Stevenson, Bellingham, Grant and Devenish Meares, had either a Fellowship or Membership of the RCOG. The Assistant Honoraries, Drummond, McGarrity, Mackey, MacBeth, McGrath, and Relievers, McBride and Bowman, also had the MRCOG. Three of the Clinical Assistants out of seven already had the MRCOG, and in Gynaecology Assistants, four out of six had the MRCOG.[83]

The Knowledge Explosion from World War Two

James Le Fanu has described the explosion of medical knowledge during and after WW2, and listed the major events. Beginning with Penicillin in 1941, Cortisone in 1949, Streptomycin, Chlorpromazine and the revolution in Psychiatry in 1952, various new surgical options, for example for heart and kidney disease, the first test tube baby in 1978, and finally the discovery of Helicobacter in 1984.[84] A more

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[80] Cope and Garrett, *The Royal*, appendix 2, 172, 173.
[81] Dr Hamlin was the most influential of all those on the staff of CSWH, largely responsible for training ex-servicemen who wished to enter the world of obstetrics and gynaecology after the war. They were appointed for only one year, given intense practical experience, and were allowed to sit the MRCOG Examination under a special provision. See Catherine Hamlin, *The Hospital by the River*, (Oxford: Monarch Books, 2001).
[86] Judith Godden, *Crown Street: A History of Crown Street Womens Hospital, Sydney*, in press. Personal communication between Alan Hewson and Judith Godden, 2014. Appreciation is expressed for her permission to quote some data from her current research.
[83] Judith Godden, *History of the Crown Street Womens Hospital,* personal information from the author.
[84] Le Fanu, *The Rise And Fall.*

complete record of advances in obstetrics and gynaecology is provided in the Advances chapter. What le Fanu does not address is the more important accumulation of knowledge of the basic sciences after the war, which underpins the practice of medicine, in contra-distinction to the eye catching headlines he mentions. These changes in the basics of practice have been enormous, and have made it very difficult for doctors trained before the 1950s to keep up to date. Those charged with teaching had to absorb the explosion of new knowledge, and ensure that it was made available and usable in everyday medical practice, overall a Herculean task.[85]

Beginning in the early 1950s, there was a marked change in the textual material in obstetrics and gynaecology pouring onto the market, which had to be absorbed by both teachers and learners. The text books of previous generations were altering rapidly. For generations classic texts like F.J. Brownes' *Antenatal and Post Natal Care*; Williams' *Obstetrics*; Delee–Greenhill's *Principles and Practice of Obstetrics*; Bonney's *Gynaecological Surgery*; Novak's Text on *Gynaecology*; Wilfred Shaw's *Textbook of Gynaecology*; and finally *Diseases of Women by Ten Teachers,* had changed only slowly.[86] These were the texts still being used widely over the years from 1945-1955. A characteristic was that with few exceptions, one author tried to cover the whole field of the specialty. The mid-1950s, which this author recognises as an 'educational enlightenment' period, saw a marked change, as it became evident that it was impossible for one author to claim to provide information over the whole speciality. One of the classics used by Australian postgraduates, written by F.J. Browne, was republished with joint authorship in 1955, 'FJ' having invited his son, J.C. McClure Browne, now Professor at University College Hospital in London, to share authorship. But this was just the beginning.

The volume, *British Obstetric and Gynaecological Practice (*1955) was one of the first of the new format textual material. It was edited by Sir Eardley Holland and

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[85] Carl Wood and Simon Gordon, "Defining Moments in Medicine, Obstetrics and Gynaecology 1900-2000", *MJA* 174, (1 January 2001), 13-15.

[86] F.J. Browne, J.C. McClure Browne, *Postgraduate Obstetrics and Gynaecology* (2nd edition), (London: Butterworth and Co., 1955); F. Gary Cunningham, Kenneth Leveno, Steven Bloom, Catherine Spong and Jodie Dashe eds., *Williams Obstetrics* (22nd edition- now almost 100 years in publishing), (New York: McGraw Hill, 2014); De Lee Greenhill, *Principles and Practice of Obstetrics* (1st edition 1915, 10th edition 1951, still widely used after WW2), (Philadelphia: WB Saunders company, 1951); Victor Bonney, *A Textbook of Gynaecological Surgery*, (first published in 1911, 6th edition), (London: Cassell and Company, 1952); Frederick Roques, John Beattie, Joseph Wrigley, *Diseases of Women, By Ten Teachers* (first edition 1919), (London: Edward Arnold, 1953); Wilfred Shaw, *Textbook of Gynaecology* (first edition 1936, 4th edition), (London: J. and A. Churchill, 1945).

Dr Alex Bourne and broke new ground. The obstetric volume ran to 1166 pages, and the gynaecologic volume to 839 pages. The volume on obstetrics was written by thirty eight different authors, and the introduction says it all: 'In the space of less than a generation, the practice of obstetrics and the scientific principles on which it is based have altered and advanced to an extent almost unbelievable to the young graduate of today.'[87] This work paid tribute to the contributions of obstetricians from other countries around the world, again a forerunner of the world to come. The editor comments on 'the major contributions to our obstetric knowledge by discoveries in the basic sciences'. This volume for the first time 'recognises a marked change in the attitude to Caesarean section, emphasising its increasing safety with improved techniques, antibiotics and availability of blood transfusion, as well as other major changes'.

This is important, as the Caesarean section rate in many teaching hospitals in the previous decade was as low as 1.07%, with a very high rate of operative vaginal delivery and often considerable morbidity.[88] The section on gynaecology had twenty one contributors, again with a timely introductory comment by Professor Alex Bourne on the gradual incorporation of knowledge from the basic sciences, a closer relation with other branches of medicine, and a developing awareness of the fundamental part played by the mind and emotions as a cause of many of the complaints of women. A chapter was included on this subject for the first time.

In that decade another phenomenon appeared which facilitated the rapid expansion of knowledge, and placed enormous pressure on teachers to keep up to date. This change in knowledge base is obvious in comparing *Recent Advances in Obstetrics and Gynaecology* which in its 1926 first issue discussed 'rapid advances' including the view that antenatal care was recognised as important, describing it as the most important line of new thought in the discipline. The treatment of eclampsia, X-rays in gynaecology, and electro therapeutics and radium in malignancy were featured. The 8th edition, published in 1953, mentioned for the first time the breakthrough of the 'Pap smear'. These examples reinforce the snail's pace of progress prior to the 1950s when, in the USA in particular, many new publications

[87] Eardley Holland and Aleck Bourne, *British Obstetric and Gynaecological Practice* (2 volumes), (London: William Heinemann, 1955),vii.
[88] R.B.C. Stevenson, "The Medical and Clinical Report of the Womens Hospital Crown Street Sydney from 1st July 1953 to 30th June, 1954", *JOGBE,* (1955), 1025.

were launched, some as often as quarterly, addressing particular topics. *Clinical Obstetrics and Gynaecology* was launched in 1957 and published quarterly. *The Year Book of Obstetrics and Gynaecology*, published in the USA, had been on the scene since 1903 but its format of short summaries of new papers limited its usefulness.[89]

The Year Book was really the forerunner of the internet, publishing its summaries of major papers in each year, with distinguished editors like De Lee and Greenhill from Chicago. It now began to enlarge its editions. There was a rush of regularly published books of 'Updates' in obstetrics and gynaecology to help professionals cope with the information explosion after the war. These included *The Obstetrical and Gynaecological Survey* (USA) in 1945; *Clinical Obstetrics and Gynaecology* in 1957; *Ob/Gyn Digest* monthly from 1958; and *Modern Trends in Obstetrics* in 1953. *Obstetrics and Gynaecology Clinics of North America* began in 1973, and later *Progress in Obstetrics and Gynaecology* from London in 1981, began covering controversies in depth. Another, *Recent Advances in Obstetrics and Gynaecology*, began in 1953, then in 1955 a second series was published on different subjects by twenty seven authors. A later entry was *Contemporary Gynaecology*, authored by Geoffrey Chamberlain in 1983, a collection of articles from the *British Journal of Hospital Medicine*. Additionally, *Perinatal Mortality, the First Report of the British Perinatal Mortality Survey* in 1958 was a watershed moment, and led to statistically based analysis of perinatal problems across the whole of Britain, followed by *Perinatal Problems, the Second Report of the British Perinatal Mortality Survey* in 1963 demonstrating the value of having a National Health Service which provided massive data collection and analysis.[90] After the 1950s, textbooks proliferated. In Britain, authoritative works on special interests often drastically altered standard texts.[91] Again new texts aimed at the specific needs of trainee specialists appeared,

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[89] *Clinical Obstetrics and Gynaecology*, Hoeber Medical Division, Harper and Row, New York, from 1957.

[90] These volumes are discussed elsewhere in this thesis.

[91] Chassar Moir, *The Vesico Vaginal Fistula*, (London: Bailliere Tindall and Cox, 1961) was destined to become the classic text in Britain on this subject, distilling a lifetime's experience in managing this disorder. Ian Donald, *Practical Obstetric Problems* (first edition 1955, 4th edition), (London: Lloyd - Luke medical books, 1969). This work provides an honest opinion on many of the social problems of the time in the UK. His pioneering work on ultrasound is featured (928-944). Victor Bonney, *A Textbook of Gynaecological Surgery* (first published 1911, sixth edition), (London: Cassell and Co., 1952). Comyns Berkeley and Victor Bonney, A *Textbook of Gynaecological Surgery* (first edition), (London: Cassell and Co., 1942), later revised and re-edited by John Howkins and Sir John Stallworthy, as *Bonneys Gynaecological Surgery* (8th edition), (London: Bailliere Tindall, 1974). Victor Bonney, *The Technical Minutiae of extended Myomectomy and Ovarian Cystectomy* (1st

like T.L.T. Lewis' book *Progress in Clinical Obstetrics and Gynaecology*, first published in1956, specifically aimed at the needs of postgraduates attempting the MRCOG.[92] The same trend occurred in the USA.[93] A later innovation in the American literature was the publication of Reid's *Controversy in Obstetrics and Gynaecology* in 1983, which pulled together contrary opinions on contentious subjects authored by noted authorities, mostly from the USA. This book also became a part of most Australian obstetricians' libraries, and introduced the wealth of talent and expertise in the USA to this country.[94]

A rare few gynaecologists from other countries were recognised as worthy teachers by Australians in that era, when the dominance of the UK was gradually fading, one such being S. Joel Cohen, born in South Africa, who served in WW2 and later moved to Israel. Cohen's book on hysterectomy attracted worldwide attention, and his techniques were copied by others.[95] There were few formal Australian publications in obstetrics and gynaecology in those early years. F.A. Maguire's *Anatomy of the Female Pelvis* became a classic; Davies' text on *Gynaecology* in Sydney; and Johnstone's three volume *Lectures in Gynaecology* from Melbourne stood out. Bruce Mayes' *Textbook of Obstetrics* in 1946 was extremely useful for undergraduates going out to practice in the GP era of obstetrics, building on his monographs designed for returning servicemen wanting to do country general practice obstetrics.[96]

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edition), (London: Cassell and Co., 1946). See also Geoffrey Chamberlain and Victor Bonney, *The Gynaecological Surgeon of the Twentieth Century*, (London: Parthenon Publishing, 2000). G.W. Theobald, *The Pregnancy Toxaemias, or the Encymonic Atelositeses*, (London: Henry Kempton, 1955), offers an elegant discussion of the aetiology of toxaemia of pregnancy.

[92] T.L.T. Lewis, *Progress in Clinical Obstetrics and Gynaecology* (2nd edition, 1st edition 1956), (London: J. and A. Churchill, 1964).

[93] Edmund Novak, Georgeanna Seegar Jones and Howard W. Jones, *Novak's Textbook of Gynaecology* (7th edition, 1st edition 1941), (Baltimore: Williams Wilkins Company, 1965); Richard W. Te Linde, *Operative Gynaecology* (2nd edition, first edition 1946), (Philadelphia: Lippincott and Co., 1953). Its brilliant illustrations took it onto the shelves of Australian gynaecologists after the 'Enlightenment' of the mid-1950s.

[94] Frederick P. Zuspan and C.R. Christian, *Reid's Controversy in Obstetrics and Gynaecology-111*, (USA, W.B. Saunders, 1983).

[95] S. Joel Cohen, *Abdominal and Vaginal Hysterectomy*, (Oxford: Alden Press, 1972). Many visitors attended his operating sessions at Beilinson Tel Aviv University Hospital in Israel to see this master surgeon at work.

[96] F.A. Maguire (1888-1953), *Anatomy of the Female pelvis*, (Sydney: Angus and Robertson, 1922), became a classic in Australian literature.
Reginald Davies, *Lectures in Gynaecology*, (Glebe: The Australian Medical Publishing Company, 1936), needs mention. See McCalman, *Sex and Suffering*, 380. See also, J.W. Johnstone, *Lectures in Obstetrics and Gynaecology*, Books 1, 2 and 3, (Melbourne: Melbourne University Press, 1951). And also Bruce T. Mayes, *Textbook of Obstetrics* (revised edition, 1st edition 1950), (Sydney: Australasian

Academic obstetric and gynaecological journals expanded at this time as well. The important role of the *Journal of Obstetrics and Gynaecology of the British Empire,* begun in 1902, has been mentioned. In the USA the 'Grey' Journal, the *American Journal of Obstetrics and Gynaecology*, began in 1921, although it is considered to be a legitimate successor to a fifty year old predecessor. Howard C. Taylor as Editor made it more international in flavour, but it was not until 1962 it increased publication to twice monthly. The 'Green' Journal, *Obstetrics and Gynaecology*, only began in 1953, originally as the organ of the American Academy of Obstetrics and Gynaecology, which later became the American College of Obstetrics and Gynaecology. *Surgery Gynaecology and Obstetrics*, the organ of the American College of Surgeons, began in 1905. The *Quarterly Review of Obstetrics and Gynaecology* began in 1943, which was succeeded by the *O and G Survey* in 1946, by Eastman and Novak, and this continues. There are a number of less well known journals.[97] All the above confirms the rapid explosion of refereed journals after WW2.

The Australian and New Zealand Journal of Obstetrics and Gynaecology was not published until March 1961, and although it initially struggled, it survived to become a significant publication for the Asia and Oceania region.[98] Additionally, there have always been a number of scientific articles in the general surgical journals of interest to gynaecologists, so many also felt obliged to subscribe to the *Journal of the Royal College of Surgeons of Edinburgh*, the *Australian and New Zealand Journal of Surgery*, and the *Surgical News of the Royal Australasian College of Surgeons,* all of which are now accredited reading material in the RANZCOG Continuing Medical Education programme.

Inevitably advances in other disciplines with the increasing knowledge base, more journals and professional interaction led to obstetricians having to enlarge their knowledge of related disciplines, particularly paediatrics and neonatology with 'spinoffs' of attending conjoint meetings and reading relevant literature. Paediatrics only established itself as a discipline in medicine from the 1960s, as prior to that the

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Publishing Company, 1959), arising from *Obstetrics for the wartime graduate in the services*, a series of 12 bulletins on obstetric subjects, 1944-1946, to assist exservicemen to re-enter obstetric practice after World War Two.

[97] Harold Speert, *Obstetrics and Gynaecology in America, A History,*'Journals and Texts' (Baltimore: Waverly Press, 1980), 124-126.

[98] McDonald, Cope and Forster, *Super Ardua*, 61-66.

care of children was done by the family doctor or general adult physicians with an interest in younger age groups.[99] Perinatology was even later, and became important because of increasing knowledge of the special needs of the low birth weight infant requiring closer cooperation with Neonatologists.

Further publications in the Basic Sciences related to the discipline also grew rapidly from the 1950s, and became an obligatory prerequisite to certification in the discipline, with the necessity for candidates to prove they possessed a sound knowledge in basic sciences.[100] Pharmaceuticals also changed rapidly after WW2. *The Royal Prince Alfred Pharmacopoeia* (1949) the standard text for all undergraduates going through the University of Sydney at that time, contained only 170 medications, the rest of the little volume covering treatment for poisoning and immunisation, with Metric and Imperial doses, an obstetric table of normal length of gestation, and including doses of Avertin to produce twilight sleep in obstetrics. The medications outlined ostensibly covered all branches of medicine, but astonishingly for the modern practitioner, there were only six pills or tablets. The rest were all pastes, mixtures and ointments. All were listed in Latin, and made the assumption that the doctor may have to dispense the preparation as well as write out the prescription.[101] *The Pharmacopoeia of the Royal Alexandra Hospital for Children* (1947) similarly had very few medications, but did include incompatibilities, correct doses for children, and equivalent doses from the *British Pharmacopoeia* [1932]. But again, no tablets or pills were listed, apart from a dose schedule for the (new) Sulphonamides.[102]

The reason for so few pills is clarified by Cope and Garrett, who comment that 'pills' as we know them were only developed in the late 1930s at the RWH Paddington.[103] Apparently this advance did not go across the city of Sydney to

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[99] Robert Evans, "The Development of Paediatrics as a Specialty in Australia", PhD thesis, University of Newcastle, 2007. See also John Yu, *College Roll, RACP*, Sir Lorimer Fenton Dods (7/3/1900-7/3/1981). "Australias first Professor of Paediatrics".

[100] Elliott E. Philipp, Josephine Barnes and Michael Newton, *Scientific Foundations of Obstetrics and Gynaecology*, (London: William Heinemann, 1970). Multiple choice questionaires (MCQs) and written papers on the basic sciences from 1960s were now necessary for trainees, mirrored in a Part One Examination for the Diploma of the obstetric college as well, which became obligatory for GPs wishing to practice obstetrics (see Glossary).

[101] *Royal Prince Alfred Pharmacopoeia*, published by the Royal Prince Alfred Hospital, 1949.

[102] The Royal Alexandra Hospital for Children, Sydney, *Pharmacopoeia and Reference Book* (7th edition), (Sydney: Australian Medical Publishers, 1947).

[103] Cope and Garrett, *The Royal*, 128.

Camperdown and RPAH. The pills which were made in the dispensary at RHW were handmade, varnished to seal them from the atmosphere and moisture, and were dispensed in 'wood chip boxes'. The Galenicals as listed in the pharmacopoeias persisted until the early 1950s.[104] As another indication of the information explosion which had to be absorbed by both teachers and students, consider the pharmaceutical scene since then. The standard *M.I.M.S. Index Guide to Drugs 2010* lists 9,775.[105] It would be impossible to commit this enormous list, and their indications, contraindications, and incompatibilities to memory, but fortunately computerisation of data and laptops on the desk of every doctor enables them to keep up with this particular explosion of information.

However every practitioner, including obstetricians, must attempt to keep up with the growth of pharmaceuticals to provide optimal care for the patient: another example of the obligatory scientist/clinician mindset. For the obstetrician it is even more complicated, as many drugs are contraindicated, or have specific warnings attached to their use in particular stages of pregnancy, so that time consuming counselling of patients is legally required.[106] Teaching of specialist doctors was and is vital to this management of the post 1950s knowledge explosion.

The Revered Teachers of the Peri and Early Post WW2 Era

The teachers of that earlier period had an enormous influence on both undergraduate and postgraduate students. Because of the paucity of solidly based scientific factual data, much of the teaching was dogmatic and didactic, and largely based on the 'handed down' teaching of the previous generation, with the experience of the teacher added. Teaching was the Pedagogue model, with little room for discussion and contrary views, and much depended on the personality and mindset of the teacher. It is little wonder that the products of that generation left medical school mindlessly parroting the views of their teachers, knowing that they had passed their examinations

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[104] Cope and Garrett, *The Royal*, 128. The 'Galenicals' are medications derived from plants, a tradition beginning with Galen the Greek physician in the 2nd Century of the Christian era.
[105] *MIMS Australia*, Issue 4, 2010.
[106] *Medicines in Pregnancy, Australian Drug Evaluation Committee: An Australian Categorisation of Risk*, (2nd edition), (Woden, ACT: Commonwealth of Australia, 1992). See also Rodney Ledward, *Prescribing in Pregnancy*, (Cambridge, England: Burlington Press, 1997), 63.

by doing just that.[107] Fortunately the experience and essential humanity of the old school of consultants usually shone through and engendered enormous respect, even affection, from both students and patients, and it was not until years later that students of the time realised that their teachers were admirable role models whose characteristics they had almost unconsciously absorbed. However, the downside of the old way of doing things was that those senior obstetricians with an excellent clinical reputation could write and teach while they expounded views with little scientific basis. Or even worse, views which were outside the usual practice of the time.

One obvious example is the publication by the respected Dr H. Bruce Williams in 1957.[108] This provided a very personal and iconoclastic approach to obstetrics, including his conviction that a patient with a breech presentation should not be told that she had a baby presenting by the breech (and that there may be problems), arguing that this knowledge would result in the patient approaching labour 'in a state of profound mental trauma:' He stated: 'it is the obstetrician's duty to accept the responsibility of obtaining a live infant, and to save the expectant mother any undue anxiety.'

This dogma sounds absurd in today's obstetric practice, and it certainly was not the view of other specialists at that time either, but that statement from one of Sydney's leading obstetricians did not produce the furore we would expect. On the other hand he was ahead of his time on another subject when he stated 'I hate the term labour ward. Birth room or delivery room are I think better terms'. The 'likeable eccentric' has disappeared from the medical scene partly due to the litigation crisis, including the Bolam Decision, which essentially provided a defence to the doctor having a bad outcome by measuring his decisions and actions against the

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[108] For a prime example of this mindset see J.W. Johnstone, *Lectures on Obstetrics and Gynaecology for Medical Students in the University of Melbourne*, (Melbourne: University of Melbourne Press, 1951). The introduction dedicates the work to the memory of two distinguished members of the Melbourne Medical School, '*whose teaching form the basis of these lectures'*, Arthur Wilson and R. Marshall Allan. Allan was the first Professor of Obstetrics in Melbourne from 1929, a WW1 hero awarded the Military Cross and the Mons Star; spoke fluent French, German and Italian and was responsible for the later appointment of Lance Townsend (later Sir) to the Chair of Obstetrics. There was a similar pattern for the Sydney Chairs in the same field. Johnstone also states in his introduction that '*the use of these notes is confined to students who are taking the University of Melbourne course … and are not available for public purchase'*. This was the mindset of the time and designed to ensure the exclusiveness of the information.

[108] H. Bruce Williams, *Obstetric Practice,* (foreword by Professor FJ Browne), (Sydney: Angus and Robinson, 1957).

practice of his peers. In other words he had a reasonable defence if he had done what many of his peers would do, but conversely he had difficulty if he varied from the norm.[109]

The paternal mindset of that generation is evident in personal memoirs, and Professor Bruce Mayes' book *Babies for Ladies* is a prime example of the often condescending but affectionate relationship between obstetrician and patient.[110] Mayes was the first fulltime Professor of Obstetrics at the University of Sydney, and scaled the heights of achievement in the Australian world of obstetrics. As the publicity cover states, 'His sixty years of love and care will touch at your heart strings. Babies for Ladies is a rare insight into the special friendship and trust between a woman and her gynaecologist'.[111] It is instructive, as a contrast, to review the CV of Professor Rodney Phillip Shearman (1928-1993), successor to Professor Mayes at the University of Sydney in 1968, who was initially mentored by Professor Mayes. He, like his mentor, had an enormous impact on both students and postgraduates of his era, but their backgrounds and interests were completely different.[112] Rodney Shearman had, to quote the author of his obituary, 'an immense and daunting intellect, whose achievements included a major role in the development of the Royal Australian College of Obstetricians and Gynaecologists of which he was the first President'.[113] He was a highly respected researcher, recognised on the world stage, a pioneer in reproductive endocrinology, respected leader of numerous Government Enquiries and Working parties on obstetric issues, an outstanding administrator (Chairman of the Board of RPAH for 1974-1986), and the author of highly regarded texts on endocrinology. He was a world leader in Planned Parenthood Organisations, and a pioneer in the development of the subspecialties.

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[109] Roger V. Clements (ed) *Risk Management and Litigation in Obstetrics and Gynaecology*, (London: Royal Society of Medicine Press, 2001). See also Bolam vs. Frien, *Hospital Management Committee Judgement*, 1957. Cited in the Litigation chapter *'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area'.*

[110] Bruce T. Mayes, *Babies For Ladies: My Sixty Years in Caring for Women*, (Sydney: John Ferguson, 1987). See Ian Fraser, "Obituary, Bruce Toomba Mayes (1903-1996)", *RACOG Bulletin* 1 (1), (April 1997), 11, 16.

[111] Extract from cover description of the text.

[112] Ian S. Fraser, "Rodney Phillip Shearman, 1928-1993, Obituary", *Australian and New Zealand Journal of Obstetrics and Gynaecology* 34 (3), (June 1994), 230.

[113] RACOG Archives, Melbourne,

Rodney Shearman was universally admired by all his contemporaries, but that is beside the point. In the last twenty years of his tenure he had little to do with the actual teaching of clinical skills in obstetrics.[114] He was a unique individual, but all the above is a far cry from the academic obstetricians of previous generations who were role models in the 'one on one' world of obstetrics.[115] He was a prime example of the 'scientist clinician' of the new generation. Professor Roger Pepperell in Melbourne, Eric Mackay in Brisbane, and Jeffrey Robinson in Adelaide, in many ways exhibited similar attributes, with their strong emphasis on research, teaching, and the scientific aspects of the discipline. Clinical skills and emphasis on the close personal relationship between patient and clinician can so easily be downgraded in that environment, even if there is a nominal commitment to that concept. Fortunately in Australia, visiting clinicians in teaching hospitals can potentially redress the balance, but there obviously is an issue of importance here at the teaching level, as these part time clinical teachers now play a much smaller role in teaching, a matter to be addressed in the Role Delineation chapter.

Another example of the attitude to the teachers of the previous era is recorded, and illustrated, in the biography of Professor F.J. Browne by Herbert Reiss. [116] He describes his attendance at 'FJs' last lecture at University College Hospital in London. Reiss wrote:

> FJ was tall, slightly stooped, with a receding silver grey hair, a high forehead, prominent nose, slightly bulging eyes, and black moustache. He spoke with a soft Irish accent, was wearing a long white coat, the lecture theatre was packed, he lectured without notes on Postpartum Haemorrhage. The subject was covered in a masterly manner and I still remember its substance. He communicated directly with his audience, looking at them as he addressed them, and speaking to them, not at them. Here was the real teacher.

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[114] Alan Hewson, personal file, related to the teaching of clinical skills to undergraduates from Sydney University at Royal Newcastle Hospital.
[115] See J.C. Windeyer, *Diagnostic Methods Used During the Later Months of Pregnancy and During Labour*, (Sydney: Australian Medical Publishing Company, 1977); first published 1933, still being used in 1977, a meticulous, profusely illustrated practical text much loved by students.
[116] Herbert E. Reiss, *Francis J Browne (1879-1963) A Biography*, (London: RCOG Press, 2007).

There are many other examples of an almost reverent attitude to the teachers of those days, and people like Professor Shedden Adam ('Sheddy') in Brisbane, Professor Gordon King in Perth and Dr Robert (Bob) Zacharin in Melbourne were typical inspiring teachers.[117] Professor Joe Correy in Tasmania among others was also a prime example of the genre.[118] It is relevant that both Bruce Mayes and F.J. Browne spent many years in general practice. 'FJ' for thirteen years was a GP in a tiny Welsh mining town, before entering specialist practice in the years when therapy for many illnesses was non-existent or purely symptomatic, so inspiring confidence and trust in the patient was all important. Perhaps admiration of and gratitude to teachers is inherent in those practising obstetrics. One of the most used and respected recent publications in obstetrics is Baskett's text on eponyms in obstetrics.[119] This 282 page volume includes the names and biographical data on 310 obstetricians, and others, who have contributed to the knowledge base of obstetricians over the centuries. The introduction states:

> Few specialties have a longer or richer eponymous background than obstetrics and gynaecology. Eponyms add a human side to an increasingly technical profession in which both the providers and recipients of medical care continue to crave the human touch and are diminished by its absence.[120]

This recent publication received rave reviews and went on to the bookshelves of thousands of obstetricians, providing hope that the human side of obstetrics may survive the trauma of the recent decades associated with a perceived lack of trust and respect by patients. In non-medical literature in the past there was often a perception of the physician as being someone above the ordinary in the eyes of the layman. In

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[117] Robert Zacharin, from the Alfred Hospital in Melbourne wrote the definitive text on obstetric fistulae in Australian literature: *Obstetric Fistula*, (New York: Springer –Verlag Wien, 1988): He was the most respected fistula surgeon in Australia, gave unstintingly of his time to teach others, and was a wonderful role model to young gynaecologists.

[118] Professor Joe Correy (1925-2002), who held the Chair in Obstetrics and Gynaecology in Hobart, Tasmania for many years came from a pure clinician background, was President of the RACOG 1981-1983, and was a pioneer in In Vitro Fertilisation. He was a significant figure on the world stage, greatly enhancing Australia's reputation by his iconoclastic addresses and close friendships with most of the world's best and brightest in obstetrics and gynaecology. His autobiography "What a Pain in the neck", self-published in 1997, is a hilarious read and documents a remarkable episode in Australia's obstetric history.

[119] Thomas F. Baskett, *On the Shoulders of Giants: Eponyms and Names in Obstetrics and Gynaecology*, (London: RCOG Press, 1996), 35.

[120] Baskett, *Shoulders of Giants*, introduction.

the book of *Sirach* in the *Apocrypha*, under the heading of *Honour the Physician*, there is long adulatory essay attributing almost Godlike powers to the physicians, the maker of medicines, stating that his 'healing powers come from God, he has the skills to heal, to take away pain' and 'from him health is upon the face of the earth'[121]: Even though at that time in history we know that there was little that the physician could actually do. These unrealistic perceptions and comments made in the early 20th century, possibly led to the 'God doctor' syndrome of previous times, which when it inevitably exploded, contributed to the increasing cynicism of the post 1960s generation of patients in obstetrics, as well as the rest of medicine.

Another example of the attitude and mindset of the previous generation of obstetricians themselves is documented in the memoirs of one of the giants of that era in Australia, Dr Bob McInerney, in his *Triumph of the Spirit.*[122] This entertaining book describes 'Bob' McInerney's climb from poverty as one of nine children via an outstanding military career (where he was a combatant, not just a medical officer behind the front line) then working for nothing at a hospital to get more experience, and after training and achieving his specialist degree, finally becoming the senior obstetrician at the prestigious St Margaret's Hospital in Sydney. He gave Honorary (i.e. *pro bono*) service to his teaching hospital for thirty years, ran brilliant teaching sessions on Saturday mornings at Concord Hospital for many years also free of charge, delivered over 17,000 mothers over sixty five years, and was idolised by patients, the hospital administration, students and postgraduates. He was a role model for generations of embryo doctors and obstetricians. But by today's standards he had an extremely patronising, albeit fatherly, attitude to his patients, which comes through in every page of the book and would be completely foreign to today's graduates.[123] A more balanced view on this subject comes from one of Australia's most respected doctors, Ronald Winton, who was editor of the *MJA* from 1957-1977, and Chairman of the World Medical Association from 1967-1973. He commented that: 'a few

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[121] *Sirach*, ch 38, v 7, *Common Bible, Revised Standard Version,* (US: Collins Fontana Books, 1973).
[122] Robert McInerney (1918-2014), "Triumph of the Spirit", *(*self-published autobiography), (Sydney: Crows Nest, 2011). All sales from the book were donated to Father Riley's work for drug addicted youth.
[123] L.P. Hartley, *The Go Between*, (London: Hamish Hamilton, 1953), begins with the line "*The past is another country, they do things differently there*". This comment seems appropriate in reading McInerney's memoirs.

doctors are incompetent, greedy, or just bad, but most are ordinary, fallible people who can get tired, can make mistakes and who unless they are blind, know it.'[124]

The Profound Influence of British Obstetrics and Gynaecology

The necessity for aspirant Australian obstetricians to work, study, and be examined in the United Kingdom up until 1979 had impacts which persist to this day. It ensured that all the teachers in the discipline in Australia learned their craft almost exclusively in the UK, so that their teaching and practice was entirely British for all those decades. Every one of the Australian obstetricians mentioned in this thesis thus far were trained in Britain, and the Academic chairs were all occupied by British trained obstetricians. Certainly they had trained in different centres across the UK, and some aspects of teaching and practice did vary across that country, but there was unanimity in the essentials of obstetric practice, as all obstetric trainees had to pass a common examination with a set curriculum of knowledge.

The world of obstetrics in Europe, just thirty kilometres away across the English Channel, might as well have not existed so far as the obstetricians of the 'British Empire' learning in Britain after WW2 were concerned.[125] In the early post war period, trainee specialists from New Zealand, South Africa, Canada, Rhodesia, the West Indies, India, Pakistan, Ceylon, Hong Kong, Malaysia and Nigeria attempted to gain access to British training posts or to attempt to pass British examinations, given the long term links through the old British Empire, the acknowledged expertise in postgraduate teaching in Britain at that time, and their knowledge of the English language.[126]

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[124] Ronald Winton, *From the Sidelines of Medicine, Misrepresentation of Doctors*, (Sydney: Australasian Medical Publishing Company, 1988), 63-64.

[125] This scenario should be viewed in the context of the time. It is understandable that Britain should remain aloof from Europe for many years after the Second World War, and the development of the National Health Service by Aneurin Bevan in the Attlee Government in 1946 was a revolutionary step in health care unlike anything in Europe, which further exacerbated the separation. The knowledge and practice gulf between continental European medicine as compared with Britain (and the British Empire) as well as the USA, continued until recent times. See Lynn Payer, *Medicine and Culture, Varieties of* T*reatment in the United States, England, West Germany and France*, (New York: Henry Holt and Co., 1988).

[126] At the Radcliffe Infirmary in Oxford where this author worked in 1957-1958, breakfast often resembled a meeting of the United Nations, but only included representatives of the old British Empire, all speaking a common language, and learning to practice medicine 'the British way' to take back to their own countries.

Fortunately Australian graduates could more than hold their own in that company because of their previous very sound general medical training. The pattern of Australian medical thought being premised in the UK was a continuation of the original educational and training programmes of the Colony being sourced in England and Scotland from 1882 as already discussed. The continuing personal medical links between British and Australian professionals forged in the World Wars was also a factor. Inevitably the senior members of the new Australian College in 1979 had their roots firmly in their British training hospitals.[127] The New Zealand Royal College had the same completely British heritage.[128] Even though trainee surgeons and physicians could do an Australian specialist examination, most went to the UK to enlarge their experience, and to training programmes in the UK as well.[129]

Over the years from 1945 to 1979 there was an intimate relationship between obstetricians in Britain and Australia as well as in New Zealand. Inevitably, enthusiastic trainee Australian obstetricians travelling by ship (virtually always) to Britain to get further training and do the British examination, developed close and continuing links with particular units in Britain where they had worked, and after returning to Australia, recommended promising candidates from Australian hospitals for appointments to their old units in Britain. This was a positive situation for everyone. The appointee had a guaranteed job on arrival in Britain, the chief in Britain knew he was appointing a candidate who came with a warranty, that the appointee would work hard to acquire more experience, stay for the full appointment time, and that the appointee would not be adding to the embarrassing number of Senior Registrars in the UK who wanted a consultant appointment, as they would be returning to Australia or New Zealand after completing training and gaining the specialist degree.[130] There was another huge plus for the future obstetric care of

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[127] The members of the First Council of the new Australian College in 1979 had all been trained in Britain (see Appendices).

[128] The members of the first New Zealand College Council (1982) were all trained in Britain. Amalgamation of the two colleges occurred in 1998.

[129] The *Annual Reports of the Royal Newcastle Hospital* in the 1950s confirms that every one of the 'new breed' of post war consultants in all disciplines at this author's original teaching hospital had spent time in the UK before their appointment as a consultant. Not one had worked in a country overseas other than Britain before 1970. There was a perception that it was a little easier to pass the specialist examination in the UK, mainly because the training programmes were so good, and the higher degree was accorded equal status in Australia.

[130] This pattern became established just after WW2 and became the norm. The Blue Funnel, Bay, and the Port lines were favourites, with English speaking crews, and the shipping lines were happy to get a fully qualified doctor on board for virtually nothing. Air fares were still expensive and saving the fare

Australian patients. The Australian going to Britain had already had some training, and quickly gained the confidence of their employers. The Australian MBBS degree has always been equal to the best in the world, and particularly in the regional centres: it was not long before the Australian graduates were given increasing responsibility and so rapidly enlarged their experience. Apart from the central London teaching hospitals, busy regional centres like Oxford, Manchester, Liverpool, Leeds, Birmingham and Sheffield, as well as prestigious Scottish centres like Edinburgh, Glasgow, Aberdeen and Dundee all developed links with Australian teaching hospitals. This author was the fourth registrar to go from Hobart directly to a job in Oxford because of a personal link between John Stallworthy in Oxford and William Wilson in Hobart who had served together in a WW2 hospital in Oxfordshire.

The Multiple Diplomatosis Syndrome

One of the issues which became important in the 1950s and beyond was the acquisition of an impressive CV, as the new world of the scientist clinician dawned. The fact that all of the new breed of specialists would have equivalent experience in training institutions, evidence of being better than the next one was seen to be based on evidence of broader training, confirmed by a qualification in a related discipline. In obstetrics and gynaecology the most obvious one was general surgery.[131] Certainly, in the United Kingdom to rise above the status of Senior Registrar and become a consultant in a major teaching hospital, Fellowship in one of the surgical colleges as well as the basic MRCOG, which everyone had, became a necessity. Competition for consultant posts in Britain at that time was intense, and many experienced senior registrars faced years of working at that level before getting a consultant post. Everyone had forgotten that the formation of the RCOG was supposed to discourage 'would be' obstetricians from wasting time in a related discipline on the way to achieving specialist status in obstetrics. Also, in practice, having a surgical Fellowship made it easier for selection panels to use that as a guide to who made it to the 'short list' for an appointment. As all young training

was a bonus, as few of the trainees had excess money after working in Australia for one to three years on the very low wages of the time, usually less than the basic wage. This author came back to Australia as ship's surgeon on the Suevic. See also Joe Correy, "What a Pain in the Neck, the Autobiography of the Professor who Made Laughter the Best Medicine", (Hobart: self-published, 1997), 59.

[131] This obviously did not automatically apply to a candidate for a purely academic post, who often did an MD in a related study in obstetrics.

obstetricians spent time in the UK, some aiming for senior consultant status in Australia also went down that path, as is evident in the changes in qualifications of obstetricians in teaching hospitals from the mid-1950s onwards, with many returning from the UK having dual qualifications. It could be argued this was a reasonable approach, as the post-1950s protocols for specialist status in obstetrics made it easier to just do a basic two year generalist intern post, then two years of obstetrics/gynaecology, get an MRCOG, and be immediately registrable as a specialist. Evidence of wider training had its advocates, and it did ensure that the young gynaecologist was better fitted to deal with the 'unexpected' in abdominal surgery in particular. There were other benefits, as at that time MRCOG candidates did not need such a rigorous grounding in the basic sciences. There was no equivalent Part One examination in basic sciences in obstetrics, as distinct from a very searching examination in the basic sciences in all the surgical Fellowships. This deficiency was later remedied in the RCOG by introducing a formal Part One in the basic sciences. There was another factor present which specifically affected graduates from the first cohorts after the Second World War, and a personal anecdote illustrates the issue.

This author's CV shows that, after graduating with Honours in 1952, doing three years of general training posts, then four years of specialist training, passing the MRCOG in 1957, and returning to specialist practice in Australia in 1958, the writer later elected to take a Sabbatical year off from practice, return to the UK to study and satisfy the examiners for both sections of the Edinburgh Fellowship in Surgery in 1965-66.[132] There were good reasons for this quite costly personal decision and it is relevant to the pressure to become a 'scientist clinician' at that time. Firstly this author and many others had not really done any detailed study of the basic sciences since the 1940s during initial undergraduate training. Secondly it was already obvious that the author's generation were being left behind by the explosion of scientific knowledge which had occurred since that time. It was thus becoming more difficult to retain credibility as a teacher/consultant in a teaching hospital. Thirdly the educational programme available in the UK, especially Edinburgh, for those doing a Surgical Fellowship was recognised among the best in the world, as it included an update of all the necessary basic sciences, including anatomy at an advanced level,

[132] Alan D. Hewson, Curriculum Vitae, personal file, 2013.

but particularly physiology, pathology, biochemistry and bacteriology as well as all the advances in general surgery.[133]

Clinicians who embraced this explosion in knowledge did so with the right motives, but did this change in mindset led to a progressive loss of communication skills and empathy with patients in the undergraduates and postgraduates they taught? That is a critical issue to be addressed later in this thesis. The changes to the MRCOG later (1966) with the introduction of the 'Part 1' in the basic sciences were necessary but again this increase in the knowledge base was potentially threatening to their teachers unless they made efforts to 'catch up'.[134]

Another important change with the coming of the new breed of consultants was the necessity to publish in a peer reviewed journal if the young consultant was to succeed. They were all urged to read the text *Publish, Don't Perish.*[135] Although there are strong arguments for this, and the obligatory presentation of papers at a specialist College meeting, the fact remains that both these exercises are time consuming, and again take time that used to be spent in the clinical practice of the discipline. As part of this type of activity, involvement in running time consuming clinical trials is common, and gradually involvement in a research project during training became obligatory. Controversy continued regarding the pros and cons of these initiatives, and again the necessary expertise for teachers and supervisors became an issue. This will be addressed again in elaboration of the programmes of the new Australian College. A later article by Cribb highlighted a conflict in academia regarding appropriate contributions to the literature from Academics in general which added to the controversy in the Australian College.[136]

The Rise of a New Type of Medical School

The emergence of the new breed of doctors in general, and consultants in particular, produced criticism from within the profession itself as well as the community, and led finally to the development of the newer type of medical schools, the first in

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[133] "Fellowship Examination Papers for the Diplomas of the Royal College of Surgeons Edinburgh, 1960-1965", (Edinburgh: E. & S. Livingstone Ltd, 1966). Alan Hewson's private collection.
[134] The Part One examination changed in format to short answer questions then increasingly to multiple choice questionaires, which produced a new wave of publications to assist candidates.
[135] Joseph M. Moxley, *Publish Don't Perish: The Scholars Guide to Academic Writing and Publishing*, (London: Praeger, 1992).
[136] Julian Cribb, "Academics don't live by the printed word", A*ustralian*, (13 January, 1993), 13.

Newcastle NSW in 1978 following the recommendations of the Karmel report into medical education.[137] That development will be discussed in more detail in the chapter on the Hunter region.[138]

Many changes occurred to undergraduate education in obstetrics and gynaecology after 1970 and these have impacted on the postgraduate training of obstetricians. As stated above the new school at Newcastle was the first of these. It was designed to be a community oriented school, with a five year programme using the principles of adult learning, and with a different selection process, emphasis on group discussion, rather than formal lectures, a vertically oriented curriculum and early exposure to patients. This needs some discussion as it had implications for the training of specialist obstetricians in the long term. The philosophy behind the school is described in many articles by Professor David Maddison, the first Dean.[139] Professor John Hamilton, who was Dean for fourteen years from 1983, also had a major influence on its final form.[140] In this and other schools which opened later, or emerged as modifications developed in the older schools, a major problem was the development of a curriculum which was appropriate for the times.[141]

One of the issues discussed in all these schools was the place of obstetrics and gynaecology in the undergraduate curriculum; i.e., is it an undergraduate or a postgraduate discipline? How much time should it have in the undergraduate curriculum? How many undergraduates will actually do obstetrics? How much should a general practitioner know about obstetrics and gynaecology? How much time could be taken from obstetrics (and other disciplines) so as to fit in subjects such as communication skills, counselling, patient choice, privacy, public health, and similar topics?

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[137] Peter Karmel, *Expansion of Medical Education: Report of the Committee on Medical Schools to the Australian Universities Commission*, (Canberra: AGPS, 1972).
[138] Flinders in Adelaide was already moving towards an innovative curriculum at that time. See Gus Fraenkel, "Progress at Flinders", *MJA* 1 (1975), 754-758.
[139] Ian Hicks, "Newcastle to get a dose of Maddison's medicine", *Sydney Morning Herald (SMH)*, (26 August, 1974), 7. Maddison claimed: "we want a school where we don't cram young doctors with knowledge".
[140] John D. Hamilton, *A Community and Population Oriented Medical School*, (Newcastle: University of Newcastle, 1983).
[141] L.W. Cox, "New Medical Course for Adelaide", *Medical Journal of Australia*, (26 June, 1971), 1395; G Gordon Lennon, "Undergraduate Medical Education, Six Years or Five, Faculty of Medicine University of Western Australia", *Medical Journal of Australia*, (26 June, 1971), 1397; Leslie Sedal, "Medical Education, RPAH", *Medical Journal of Australia*, (4 November, 1972), 1081; John Read, "Dilemmas Facing Curriculum Framers, Faculty of Medicine, University of Sydney", *Medical Journal of Australia*, (26June, 1971), 1388.

The controversies in Australia were reflected in most Western medical schools and increased in the 1970s, 1980s, and 1990s, with North America leading the way. But in the UK in 1993, Lowry assistant editor of the BMJ also provided a wake-up call to everyone in Britain concerned with medical education.[142] To summarise, the training of obstetricians and other specialists had to take into account what was now happening at the undergraduate level, and a controversial issue was always the recognition that some essential parts of the training in surgical disciplines, like anatomy and pathology, were having time taken out of their allocation in undergraduate curriculums. This meant that these deficits had to be remedied at postgraduate level. All these issues are still controversial.[143] This raises another issue: has the pendulum in some schools swung too far towards emphasising the perceived deficit in communication and similar skills, to the detriment of some very basic elements of clinical practice?

The development of the Australian College of Obstetrics and Gynaecology in 1979 was a watershed development that produced dramatic changes in the discipline in Australia with important short and long term implications. The timing of this development is important, as it occurred at a time when Australian society was also changing dramatically, as detailed in other chapters of this thesis The latter impacted on the philosophy of the new College, And the congruence of social, political, and professional pressures were all important in the eventual outcome. The decade of the 1970s was marked by a vigorous debate regarding a whole range of issues related to the education and training of medical professionals. It was this climate of controversy which was the cradle of the new Australian obstetric College, as it strove to find its home in Australia at the physical, educational, political, legal and cultural levels. The earlier system of education and training of obstetricians persisted until the early 1970s, but during the 1970s it became increasingly obvious that conditions of practice, and training in Australia had increasingly diverged from the British

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[142] Stella Lowry, *Medical Education*, (London: BMJ Publishing Company, 1993).

[143] Randall Williams, "A Surgeons Perspective on Recent Changes to the Medical Education Curriculum", presented at the Australian Doctors Fund Symposium, 'Rescuing Medical Education', Sydney, 18 February, 2005. Professor Michael Cousins, President of the Australian and New Zealand College of Anaesthetists, claimed that: "we are finding that we have to do more (basic sciences) work with students, especially those coming out of four year programmes, in bringing them up to speed. It raises concerns with us that those who do not come to us for further education but go out practicing (in other fields) may not have as much knowledge as they should have", *The Australian*, 13 May, 2006. See also, Carolyn de Costa, Ajay Rane, "Should Australian medical students deliver babies?" *MJA* 198 (6), (1 April, 2013).

dominated pattern. Fortunately the 'mother college' in Britain agreed with the Australian view that there had to be changes, And even in early discussions gave strong support to Australian moves to autonomy. Practice, finance, and organisational matters also made it imperative that an Australian national College should be considered as a separate entity from the RCOG. Problems were exacerbated by the change of Government in Australia, as it was becoming more difficult to get enough teaching 'material' through the public teaching hospitals, so training time increases had to be considered to meet the accepted criteria for experience. The MRCOG had always been accepted as a registrable specialist qualification in Australia, but in the UK by then further training was required to be accepted as a trained specialist. The process by which the transition occurred is outlined in detail in S*uper Ardua* under the title of *Exodus*. It was initially agreed to establish a new degree in Australia to be the equivalent of the UK degree: a Fellowship in Australia in Gynaecology and Obstetrics (FAGO), only available to Australians, but including another three years of advanced training after the MRCOG. However this still did not solve the problems of needing to involve private patients in teaching, and financial issues remained, as much of members' subscriptions went back to Britain. Finally with agreement from the RCOG a referendum was held in 1977 which overwhelmingly supported an autonomous Australian College.[144]

During the development of the new College the Regional Council of the RCOG in Australia agreed that the increasing expectations of our modern society and the changed social environment of our time demanded a more formal approach to the issue of continuing medical education in the new College. Articles of Association were therefore developed which included two new principles:

1. That elevation to Fellowship of the College should be for a limited period, with conditions imposed for renewal at the end of that time, and
2. That such renewal of Fellowship would be dependent on the Fellow providing evidence of appropriate involvement in a continuing medical education programme.

The way in which this programme was initiated and developed over the following years is outlined in the published paper by the author on this subject, in 1989, when the whole programme had been finalised and was in operation, but some

[144] McDonald, Cope and Forster, *Super Ardua*, 80-82.

elaboration is required. [145] That paper argued that any career in medicine should involve a commitment to lifetime learning, a principle enunciated by William Osler in 1905.[146] This principle had been reiterated frequently since that time with increasing support from the community and the profession.[147] This was the first time in the western world of medicine in which an authoritative medical College proposed making continuing education compulsory, and although controversial at the time, gradually over the next two decades virtually all Australian Colleges followed suit.[148]

As this was a time of rapidly increasing litigation, a rise in consumerism, beginnings of conflicts regarding roles in obstetric care, quite marked changes in midwifery education, and questioning of the rationale of many medical interventions, there was a hope in the obstetric fraternity that the new approach would both reassure the community and lead to better outcomes in medical care.[149] But as well it was hoped that this proposal would improve the image of obstetricians in the community and diminish the rising tide of litigation.[150] Unfortunately these hopes were not realised in most instances, for reasons which will be explored in later chapters, particularly the chapter on the litigation crisis in obstetrics. The community and Government have never given credit to the Australian College of Obstetricians (later RACOG) for this now internationally recognised initiative.[151] The RACOG developed the Obligatory CME programme without any Government support of any

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[145] Alan D. Hewson, "The Development of Obligatory Education and Certification Programme of the Royal Australian College of Obstetricians and Gynaecologists: A Practical Response to the Increasing Challenges of a Modern Society", *Medical Teacher* 11 (1), (1989), 27-37

[146] William Osler, "The Student Life: Farewell Address to American and Canadian Medical Students", *Medical News,* New York, 1905.

[147] B.V. Dryer, "Lifetime Learning for Physicians", *Journal of Medical Education* 37, (1962), 22. See also George Miller, *An Enquiry into Medical Teaching,* 72nd Annual meeting of Association of American Medical Colleges Montreal Canada, Nov 13, 1961, *(Journal of Medical Education* 37, (March, 1961); Sydney Sax, *Report of the Steering Committee for the National Workshop on Medical Education and the Medical Workforce,* (Woden: Australian National University, 1986); D. Duffy, "CME and its Role in improving Medical and Health Care", *Proceedings of the First International Conference on Continuing Medical Education,* Annenberg Centre for Health Sciences, Eisenhower, Rancho Mirage, 1986.

[148] Alan D. Hewson, "CME and Re-certification in Australia in 1995", *Postgraduate Medical Journal* 72, supplement 1, (February, 1996).

[149] L.S. Steyn, "The Effectiveness of Continuing Medical Education: 8 Research reports", *Journal of Medical Education* 56, (1981), 103-120; M.R. Raymond, "The Effectiveness of Continuing Medical Education in the Health Professions, a Real Analysis of the Literature", Annual Convention of the American Educational Research Association, San Francisco, 16-20 April, 1986.

[150] Alan D. Hewson, "CME and Quality Assurance: A Bulwark Against Medico Legal Mayhem", paper presented at the International Meeting, Opening of the John Hunter Teaching Hospital, Newcastle, NSW, September, 1991.

[151] Raymond L.G. Newcombe, "CME- The Government, Universities and Colleges", *MJA* 157, (5 October 1992), 491-492.

kind. It was a very expensive exercise, as it entailed time consuming workshops involving many busy obstetricians, all of whom gave of their time without cost. Developing a workable programme was a difficult exercise, and persuading an initially sceptical specialist group to put themselves into a 'strait jacket' for the future was also philosophically challenging, particularly as no other College was prepared to face the problem. It also meant developing an educational centre of high quality to provide appropriate programmes, acquiring expertise in adult education, and a specialty-wide supervisory and monitoring system which was affordable and acceptable to the whole discipline.[152] A schematic representation of the methodology used and the nationwide approach is outlined in the cited paper by this author and in the Appendices.

All of these were new initiatives, with no model to guide the Committee entrusted with the task.[153] The evidence for its success is the fact that all the Australian Colleges (including the RACGP) later adopted almost identical obligatory educational programmes, because of community and professional pressure.[154] The model has now been exported overseas to New Zealand, Canada, and the United Kingdom.[155] In the latter country, a variation is to be used for the Revalidation programme which has been legislated by the UK Government, following widespread consultation with the profession.[156]

The final chapter of obligatory CME (now more accurately described as Continuing Professional Development or CPD) is yet to be written, as progressive changes have been made over the last thirty four years, but the basics are unchanged. A problem is that although judged on outcomes obstetricians in Australia are equal to

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[152] Roger Gabb, see reference below.
[153] Roger Gabb, "Recertification: An Australian Perspective", in *The Certification and Recertification of Doctors, Issues in the assessment of Clinical Competence*, eds. David Newble, Brian Jolly, Richard Wakeford, (Cambridge: Cambridge University Press, 1994).
[154] Alan D. Hewson (ed), *Careers in Medicine* (16th edition), (Newcastle: The Hunter Postgraduate Medical Institute, 2012). This publication is a guide to the choice of a career in medicine, and outlines the obligatory CME requirements for each discipline, following the other colleges subsequently embracing obligatory CME. The timeframe of other Colleges adoption of obligatory programmes is included in the Appendices.
[155] Alan D. Hewson, "Continuing Medical Education and Recertification in Australia in 1995", Conference on "Continuing Medical Education in Europe: The Way Forward", London, 30th March, 1995, unpublished, Author's personal files.
[156] Graeme Cato, President, General Medical Council (UK), "Winds of Change", *GMC Today*, (January/February, 2008), 7.

the worlds' best, the profession has faced, and continues to face, significant problems. These will be further explored in subsequent chapters.

An Australian College in Obstetrics and Gynaecology (ACOG)

The formation of the new Australian College in Obstetrics and Gynaecology in 1979 (which became the RACOG) was more than merely establishing its independence from the traditions, mindset, protocols, and history of its mother college in the United Kingdom. It continued the principles and formalities of the British College by establishing democratic election to its governing Council, by the establishment and monitoring of approved training posts in the teaching hospitals, and by establishing an education program and a system of examinations. The underlying ethos remained the education of the profession and the establishment and monitoring of standards of practice of those belonging to the discipline.[157] But it rapidly took on a wider range of other roles in the Australian context. It had to become the face of the discipline at both national and state levels and to interact with the changing demographic of Australian society of the time. It became necessary to be part of the national debate in the whole field of medicine, to become part of governmental decision-making, to present the views of obstetricians for other members of the medical profession, to become part of the Asia Oceanic framework of debate and interaction, as well as continuing its links with Britain.

Because of its independence, it began to develop closer links with the North American continent, and this included not only contacts and discussions at the highest level but also a move to North America becoming another preferred destination for postgraduate training. American textbooks and thinking, particularly in education, became more prominent.[158] Continuing education became much more important in the Australian scene. At a time when consumerism and the increasing visibility and consciousness of the independent midwife movement was occurring, the Council of the College had to confront these issues and take part in the national dialogue and debate. The increasing stridency of the consumer movement meant that the College

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[157] See Companies Act 1961, Memorandum and Articles of Association of the Royal Australian College of Obstetricians and Gynaecologists, RACOG, Melbourne, 1979. Also names of Subscribers, see Appendices.

[158] This occurred rapidly in spite of the fact that every one of the original Council had been trained and qualified in the United Kingdom.

was under increasing pressure to provide public comment, to develop new approaches and adapt to changing attitudes while remaining focussed on maximum safety for both mother and child.

Litigation reached a crescendo in the decades between 1980 and 2000, and the Body Corporate of the College was involved at every level. Discussions with the legal profession, the insurers and both National and State Governments became increasingly stressful and divisive.[159] The development of the more overtly medicopolitical organisation of NASOG, as an associated organisation, is discussed in the medicopolitical chapter. The long-standing close relationships between obstetricians, general practitioner obstetricians, midwives and hospitals came under increasing strain and scrutiny, and changes in financial arrangements related to developments in the health insurance field, following changes in government policy, contributed to a potentially explosive mix which also challenged the new College.[160] So it was necessary to progressively adapt and, where necessary, alter the basic mindset and traditions inherited from its British forebears to enable the College to deal with the contemporary situation in Australia.

The College became the coordinating national agency for obstetricians and gynaecologists. The original small headquarters of the Regional Council in La Trobe Street Melbourne was totally inadequate to accommodate the infrastructure necessary for the new College. The acquisition of 260 Albert Street next door in March 1991, the development of the Education Centre, and the later initiative to welcome the Australian College of Midwives as a tenant into the building was of benefit to both organisations.[161] The original staffing of just one secretary and an assistant had to be rapidly expanded, and the employment of an experienced CEO in 1983 with accompanying support staff was an urgent necessity. The amalgamation of the Australian and New Zealand Colleges was completed in 1998.[162] However these changes were less important than other initiatives of the College.

The initial commitment of the College to an obligatory time-limited certification program meant that a rapid expansion of educational opportunities and

[159] See chapter 5.
[160] See chapter3.
[161] This initiative arose following a visit by this author to Washington USA where it was noted that the National Midwives Board was a tenant in the American College of Obstetricians and Gynaecologists building, which had led to much better liason between the two bodies.
[162] RANZCOG Bulletin, "A chronology of events in the College history", 1998. See appendices.

programs for members of the College was required. The series of workshops and consultation with members of the college had to be carried out rapidly and efficiently so as to establish a consensus and overall structure acceptable to the general body of members of the college. A great deal of preliminary work had already been done by a number of members of the college with educational expertise. The basics of the program were completed in the first three years. Again the College had the foresight to involve outside educational expertise to advise on the implementation of the programme and to ensure that the final form of the programme would be 'owned' by the members of the College. The details of the methodology are outlined in the cited article by this author.[163]

Hilary Schofield and Cyril Driver of the Centre for the Study of Higher Education Melbourne University were commissioned to carry out a survey of all College members to get their input into the new system, so that they would own the system.[164] The Survey Questionnaire elicited an 80% response rate, and laid the foundation for the system which essentially continues today. College Fellows requested a Resource manual, and forty two Fellows of the College evaluated the *American Resource Manual (Precis 2)* generously provided by our American colleagues, but decided the College should develop its own Australian Manual.[165] Similarly a review of the American Audiotape programmes convinced the College to develop its own programme of Audiotapes. Curriculum development was aided by the generous permission of the American Association of Obstetricians and Gynaecologists (also founded in 1929) to use their text as a basis for developing our own College Curriculum.[166] Peer review and Quality Assurance was strongly supported, and the College later published its own Guide Book after reviewing the American College publication.[167] The College opted for a Cognate points system, which provided a wide variety of opportunities to acquire Cognate points to confirm

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[163] Alan D. Hewson, "Obligatory Education in the RACOG", *Medical Teacher* 11 (1), 1989.
[164] Hilary Schofield, *Continuing Education, the Views of Australian Obstetricians and Gynaecologists*, (Melbourne: University of Melbourne, 1986).
[165] *The RACOG Resource Manual*, published by the RACOG, Melbourne, 1986.
[166] *Instructional Objectives for a Basic Curriculum in Obstetrics and Gynaecology*, published by the American Association Foundation Obstetricians and Gynaecologists Inc., USA, 1975.
[167] Alan D. Hewson and Roger Gabb, *A Guide to Quality Assurance in Obstetrics and Gynaecology*, (Melbourne: RACOG, 1987).

involvement in approved educational activities. The overall plan is shown in the Appendices. Over time the educational activities were expanded.[168]

The appointment of Dr Roger Gabb in 1986 was a major step forward as he brought wide experience and skills to the task of finalising the obligatory continuing education program, and was a major factor in making its features acceptable to the Fellows of the College in company with the now experienced members of the Education committee. The initial review of the first ten year cohort of College members regarding continuing education was carried out during 1988, the predetermined assessment year.[169]

The other issues faced by the national College meant that the committee system had to be rapidly expanded during those initial years, so the committee structure was enlarged to include a Therapeutic and Scientific Committee, a Joint Consultative Committee to liaise with general practitioners, and later groups to liaise with midwives, government, government boards and instrumentalities, the specialist qualification authority (NASQUAC), and with specialist societies in Asia and the Pacific, as well as developing for the first time initiatives to address the enormous problems of Indigenous ill-health in the field of obstetrics and gynaecology.[170] Another major difference between the Australian College and the British College was the necessity to develop State-based committees to deal with State issues; and again this involved the development of committees to represent the College in the various instrumentalities of State governments and hospital networks, particularly in the area of recognition of hospital posts and accreditation of hospitals for training. In addition, teaching networks needed to be established and expanded in each state with increasing emphasis on provincial matters and obstetric services.[171]

The planning and coordination of professional education meetings and workshops at the national level became increasingly important because of their links to the obligatory continuing education program of the College under the overall

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[168] Every Fellow of the College now receives annually a list of acceptable activities, including approved overseas meetings research, and methodology to assess their own practice. See Appendices.
[169] See Education Committee Report to RACOG Council, 1989.
[170] The National Specialist Qualification Advisory Committee is the Government appointed body which advises on Specialist Qualifications in Australia. Professor Pricilla Kincaid-Smith chaired that committee at the time.
[171] See Current Structure on the RANZCOG Website.

authority of the Education Committee.[172] Organisational matters such as annual meetings, induction of new members into the College, and the invitation of appropriate international visitors to formal College meetings occurred regularly, and protocols for all of these events were important. Fortunately, the diplomatic and protocol knowledge of David Dodd proved invaluable for this area of College activity in the early years.

Gradually the Committees expanded to include Family Health, Asian Affairs, a Perinatal committee, a Joint Birth Consultative Committee, Remote Areas, a House Committee, Archival Committee, and an Ultrasound Committee in 1984. Later still, Bio- ethics, Casemix, the Subspeciality groups, Fellowship Review, Honours, Indigenous Women's Health, Information Technology, Provincial Fellows and Quality Assurance and Workforce Committees were all added.[173] Appropriate individuals from outside organisations who had views of interest and impact on the world of obstetrics were invited to join College committees, notably the Family Health Committee. In the difficult era of litigation reform and political controversy in 1990, a permanent committee was established to liaise with the politically active National Association of Obstetricians and Gynaecologist (NASOG).

The inherited British organisational pattern basically continued for the first twelve years of the College history, but between 1991 and 1994 changes became evident. David Dodd resigned in 1993 and was replaced by an appointee from an area completely different from the medical College background, but that appointment only lasted for twelve months. Dr Gabb resigned in 1996 to move to another academic appointment and was replaced by Dr Eleanor Long, who had an academic background in mathematics, but did have educational and administrative expertise. Although she initially had little knowledge of the medical world and the specialist medical colleges, Dr Long proved an able and diplomatic appointee. When the second CEO resigned after twelve months, Dr Long was appointed to the dual role of CEO and Director of Education in 1996. This was a turning point in the college history,

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[172] The Education Committee exercised overall control of all major educational meetings, being guided by 'needs assessments' and regular feedback from each meeting. By this time the Chair of Education and the Director of Education had attended a number of International meetings on CME and put into effect the international views of best practice.Virtually all of these contacts were with North American centres, leading to close working relationships with Phil Bashook, David Davis, Thomas Meyer, William Felch, George Miller, Malcolm Walsh and Phil Manning.

[173] See Annual reports of the RACOG Council to all Fellows of the College.

leading to an increasing emphasis on corporate management and community involvement, partly because of an increasing interaction with government agencies and other bodies working in that intellectual framework. Changes in Company law also meant that the structure of management had to change to comply.[174] The Joint Birth Consultative Committee was established in 1990 to improve liaison with the Australian College of Midwives and the RACGP, and this is explored in the chapter on the Home Birth controversy. Hilda Bastian from the Home Birth Alliance was a valuable member of that Committee. This led to a national summit in 2000 to discuss contentious issues, as discussed in the Role Delineation chapter.[175]

These conditions also led to further major expansion of the workforce in the College to facilitate applications for grants for research and to cater for all the new activities. Finally the overall structure of the college was further modified to enable it to deal with the challenges of working in the developing corporate world, as occurred with the other professional medical colleges. The impact of the ACCC and Competition law now began to affect the way the college functioned, as well as its relationship with the wider community.

These developments were reflected in the publications and communications network of the College Council, and the way in which it kept in touch with the members of the College. In the early years, a short but informative *President's Newsletter* was circulated three to four times annually, but this was replaced in 1987 with a *College Bulletin*, published quarterly, as well as the Annual Report. The *Bulletin* was much more elaborate, the cover in College blue emblazoned by a photograph of College house in East Melbourne. The first Bulletin included the reports from each of the Committees of Council, reports from the State committees, a historical segment, details of the now very extensive congresses and conferences which would attract cognate points, and a copy of the submission of the College to the Committee of Enquiry into Medical Education, as well as a study of the *Obstetric Workforce* in May 1987, pictures of the new councillors, a list of those elected to Fellowship and Membership, and a report from Dr Robert Zacharin regarding a trip to Burma to carry out fistulae surgery. Another major initiative was the regular

[174] See Annual report, RACOG, Melbourne, 1995.
[175] See the Birth 2000 National Conference discussed in chapter.3 Also"RACOG College House Organisational Chart", *RACOG Bulletin* 11 (3), (December, 1997), 16.

publication from March 1988 of the *Diplomates Newsletter,* providing information for GPs with the Diploma of the College, a qualification confirming their expertise in 'obstetrics in the field of general practice, and eligibility for appropriate hospital appointments'.[176] By 1998 College house staff numbers had grown to over 30, covering the fields of education, secretarial and information services, the library, publications, building, reception, the Museum, finance, and caretakers' committee.

The amalgamation of the Australian and New Zealand Colleges occurred in 1999 after discussions between the individual Councils, and was a natural development. The new organisation became the RANZCOG.[177] There was a further change with the launch of the new contemporary format magazine *O and G* which was now accepting advertisements from drug firms, a picture and profile of new councillors, and an expanded section on current issues in obstetric practice with updates on examinations, obituaries and a report from the medicolegal committee, established in 1996. The publication had now grown to over 140 pages.

There was also another subtle change in that the original motto of the college, *Ab Umbris Ad Lumina Vitae* (literally 'Out of the Shadows into the Light of Life') had been superseded on the College letterhead by 'Excellence in Women's Health', again marking a break from tradition, although the original Latin motto remained below the formal College Crest of the amalgamated Colleges.[178]

Inevitably there was also a steady change in the rigid formalities associated with the old British College, related to the conduct of annual meetings and congresses, which in the RCOG had always involved the use of formal gowns, not only by members of the Council but also expected from members of the College attending formal national meetings. The original Tudor Bonnets worn by Councillors on formal occasions slowly disappeared. The College after its inception had invited distinguished people to be Patrons, and patrons were always invited to the annual College dinner. The national profile of the early College was increased by the agreement of prominent Australians to become patrons, importantly the Joint Patrons

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[176] *RACOG Diplomates Newsletter* 1 (1), (March, 1988), launched by President John OLoughlin, RACOG Annual Report, 1988.
[177] Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
[178] *Ab Umbris Ad Lumina Vitae*, literally "Out of the shadows into the Light of Life", could be criticised because it only referred to obstetrics and ignored the other essential remit of College activities, the medical and surgical care of the non-pregnant woman. The new wording was certainly more inclusive but was still criticised by academic purists in the College.

Sir Ninian and Lady Stevens, but the formal protocols previously observed at special occasions have become less prominent.

Another sign of the times was the election in 1994 of the first female President of the College, Dr Heather Munro from Canberra. Increasingly women became more prominent both on the Council of the College and taking major roles on its major committees, a move obviously inevitable in a discipline which is essentially concerned with the care of the female population of Australia, and with female membership of the college steadily increasing.[179]

Finally it should be noted that the Australian Government, through the Australian Medical Council, accredits training by each of the specialist colleges, after review of their current programmes on a regular basis. The accreditation process is rigorous and includes entry criteria, accessibility, standards required, including matters like gender and race equity**.**[180] The cost and time of providing all the information required is a major burden on the College, all paid for by the members, but the process is accepted as necessary**.**

CONCLUSION

This section of the thesis is critical to the understanding of the changes within the discipline itself over the past sixty years which have been just as dramatic as those emanating from the environment in which these professionals practice. The change from obstetrics being part of the stock in trade of the ordinary GP in the Australian community to a very sophisticated specialty informed by the knowledge explosion after WW2 necessitating a prolonged apprenticeship usually spent in Britain until 1979, made this discipline unique in the Australian medical scene. The original conservatism in theory and practice took some time to change and the coincident dramatic social changes in Australian society produced major dilemmas for the emerging College in 1979, and its leaders. The courageous step to introduce compulsory continuing education with the new College complicated the difficulties.

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[179] See appendices for the current gender distribution.

[180] Australian Medical Council, *Accreditation of Specialist Medial Education and Training Programmes and Continuing Professional Development Programmes, Standards and Procedures*. This was approved by the Australian Medical Board on 15 December 2010.These reports are available online:
http://www.medicalboard.gov.au/Accreditation/Specialist-medical-colleges.aspx, (accessed 24 January, 2015).

Further, the change in attitude, looking increasingly to the USA for new initiatives and expertise provided more challenges as did re-orientation towards Asia and nearer neighbours from the 1980s onwards.

This reflected national sentiment, but it had implications for training and education and international relationships, and produced a new paradigm in Australian obstetric practice. Again, the initial emphasis on training and education by the new Australian College was steadily overtaken by a whole range of imperatives arising from its expanding role in the Australian medical scene. Dilemmas arising from the effects of Government decisions, relationships with other professional groups, the litigation explosion and controversial community issues, including what the community expected from the professionals charged with the responsibility of caring for the women and mothers of the nation was an explosive mixture. The author had a ringside seat in this drama and has attempted to identify the critical incidents in an important part of Australian medical history, particularly those which have had long term sequelae. The internal and external tensions described set the scene for the ensuing chapters, which will explore in more depth the environment in which obstetricians have practised over the past sixty years.

In the early years there was usually an ecumenical religious service at the beginning of National Congresses, following the pattern in Britain, and notably a large service in the Anglican cathedral at the Brisbane Congress in 1989. This also disappeared from the College calendar as its continuation in multicultural Australia became more controversial. The Royal Australasian College of Surgeons and the Royal Australasian College of Physicians still feature some of these traditional customs at their annual meetings, in contrast to the RANZCOG. Only time will tell as to whether they will eventually move away from the centuries-old traditions of the British Medical Colleges.

Importantly, in 2011 the total number of obstetricians in the College was 1,729 with 1067 males and 662 females.[181] The new Australian College has evolved into a 'body corporate' type organisation which reflects changes in contemporary Australian society, and has made strenuous efforts to make itself more relevant, more accessible, and more responsive to the community it serves. Posterity will decide

[181] Data from Rosalind Winspear and Kate Lording, RANZCOG Co-ordinators, database, October 2012.See also graph of gender distribution in 2014 in the appendices.

whether these aims have been achieved, and whether the downgrading of many of the older traditions has been appropriate and timely.

CHAPTER 2
SOCIAL AND CULTURAL INFLUENCES IMPACTING ON THE SPECIALITY

> *Liberal Reformers have abolished hanging, changed the laws on abortion, homosexuality, divorce, gambling, theatre and literary censorship, and discrimination on grounds of sex, colour or race; Government has made available money for birth control clinics, and the permissive society is with us; a place where sleeping around is cool, where homosexuals flourish, where marriage is a drag, birth control free for all, divorce and abortion instant, censorship extinct, and conventional morality is dead.*
>
> ***T.L.T. Lewis, Gynaecology in a Permissive Society, 1970***[1]

While writing primarily about contemporary United Kingdom, this emotive sociological comment by Lewis in the official journal of the Australian College in 1970 encapsulates many of the dilemmas facing gynaecologists who were trained to practice in the early post WW2 Australian society, but had to adjust to the massive changes in society which occurred in Australia and elsewhere during their subsequent years in the profession. These changes and these dilemmas are the subject of this chapter.

The prelude to these changes occurred in the early 1940s which were almost completely overshadowed by WW2 and home front restrictions in Australia. Importantly for this study there had been a change in the position of women in society during the war. Many had taken over the employment roles of men, not always by choice but by necessity, as explored extensively by Reiger.[2] Mackay also analysed what he called the 'lucky generation' born in the 1920s, emphasising their positive traits which he believes provided a sound basis for the next two decades, becoming the role models to continue the tradition of sacrifice and service seen in both World

[1] T.L.T. Lewis, "Gynaecology in a Permissive Society", *ANZJOG* 10, (1970), 244-249.
[2] Kerreen M. Reiger, *The Disenchantment of the Home, Modernising the Australian Family 1880-1940, the Sexual Enlightenment of the Young*, (Melbourne: Oxford University Press, 1985), 172-189; also Kerreen M. Reiger, *Our Bodies Our Babies, the Forgotten Women's Movement*, (Melbourne: Melbourne University Press, 2001), 57-83.

Wars.[3] The social traditions of the interwar period had continued some of the Victorian and Edwardian ideals of pretentious middle class womanhood, exemplified by national competitions like the Miss Australia competitions, but that was to change.[4]

Women played an enormous role in the war effort in WW2, but most went into traditionally female areas with low wage rates, even though the wages rose steadily during the war. Some women who entered the services enjoyed a liberating experience and sought jobs after the war which continued that experience. However the majority were happy to return to 'normal' domestic life, having survived the privations of the Depression years and the war, and most women had continued their normal domestic role during the war.[5] The 'populate or perish' policy was also pushed at all levels. The dramatic increase in the birth rate post WW2 supports this analysis.[6]

There were many elements of potential instability emerging in the aftermath of the war, and this sense of coming change is described by Bolton.[7] Blainey described the period after WW2 'as an economic miracle which benefitted that generation because it brought full employment among other benefits'.[8] The post war education revolution is also well documented. Mendelsohn comments that there 'is no parallel in Australian educational history with the three active decades after 1945'.[9] Booth and Kee analysed the steady increase in females attending University, from

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[3] Hugh Mackay, *Generations, Baby Boomers, Their Parents and Their Children*, (Sydney: McMillan, 1997), 14-58.

[4] Judith Smart, "Feminists, Flappers and Miss Australia, Meanings of Citizenship Femininity and Nation in the 1920s", in *Journal of Australian Studies* 71, (2001), 1-15.

[5] "The Australian home front during WW2- women", *Anzac Day*, http://www.anzacday.org.au/history/ww2/homefront/women.html, (accessed 13 November, 2015). See also Lynn Beaton, *Shifting Horizons*, 1985. See also Suzanna Clarke, "Women Man Jobs", *The Peace Generation*, http://www.couriermail.com.au/extras/ww2/women.htm?nk=df79cd80b95d2304c2f46897762a09ed-1459125815.

[6] ABS Data, Australian Social Trends, 4102.0, "The Baby Boom, 1945-1962", fertility the highest on record, *Australian Bureau of Statistics*, http://abs.gov.au/AUSSTATS/abs@nsf/7d12b0f6763c78caca25706100, (accessed 13 November, 2015).

[7] Geoffrey Bolton, *Oxford History of Australia, Volume 5, 1942-1988, The Brink of self discovery*, (Melbourne: Oxford University Press, 1986), 26.

[189] Geoffrey Blainey, "Turning Point; How the Forties Changed us Forever", *The Australian Magazine*, (2 October, 1996), 12-21.

[190] Ronald Mendelsohn, *The Condition of the People, 1900-1975*, (Sydney: George Allan and Unwin, 1979), 294; Alison Booth, Hiau Kee, *The University Gender Gap*, (Canberra: ANU, 2009). See also Rise of University Enrolments after WW2 in Appendices.

20% in 1952 to 50% by 1987, which had an impact on the increasing sophistication and educational level of patients attending gynaecologists over the period.

Judith Brett's essay, an overview of changes in mainstream society in that early postwar period, emphasised changes in religion, class, race and ethnicity as dominant. She stressed the marked religiosity of the first decade, noting the popularity of the Billy Graham Crusade of 1948 when 143,750 people filled the Melbourne Cricket Ground. The Catholic Protestant divide impacted on schooling, social interaction, loyalty, marriage, attitudes to contraception, abortion, and voting patterns, and these issues also impacted on medical consultations.[10] Bolton agreed on the dominance of religion through the 1950s, in particular through the Catholic School system.[11]

Brett and Bolton also agreed on the effects of a stable economic climate under Prime Minister Menzies.[12] Bolton commented on 88% of Australians being married in a church in 1962, the ritualisation of schools, the new norm of being born in a hospital, with most infants breast fed, attending the local Baby Health Centres usually run by the Country Women's Association, and morality being shaped at school.[13] Brett described the subsequent change in the community into 'believers' and 'non believers' which blurred the previous distinctions and also impinged on medical consultations for gynaecological problems.

A major impact on medical practice over this period was the massive immigration programme begun by Labor Prime Minister Ben Chifley in 1945, masterminded by Arthur Calwell, and continued under the conservative Menzies Liberal-Country Party coalition Government from 1949.[14] Some 4.2 million immigrants arrived between 1945 and 1985, with 40% from Britain and Ireland. But failure to attract sufficient UK immigrants from 1953 led to an influx of southern and central Europeans, mainly from a lower economic background and willing to do

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[10] Judith Brett, "Historical Perspectives on Difference", in *People Like Us*, ed. Gretchen Poiner, (Canberra: Independent Scholars Association of Australia, 2014), 31-39.
[11] Bolton, *History*, 112. See also Edmund Campion, *Rock Choppers: Growing up Catholic in Australia*, (Victoria: Penguin Books, 1982), introduction, 1-45.
[12] Bolton, *History*, 89-110; Brett, "Historical Perspectives", 35.
[13] Bolton, *History*, 112. See also John Ramsland, The Correspondence School, Presidential Address, 1990, Australian and New Zealand History Society, emphasising the standards of behaviour expected right across the school system at the time.
[14] C.A. Price, "Post War Immigration 1945-1998", *Journal of the Australian Population Association* 15 (2), (1998), 17.

manual labour.[15] Many were from European camps for displaced people. Few in these large ethnic groups spoke English and as all were under the age of 45, and beginning families in their new country, Australia's GP obstetricians and specialist obstetricians servicing teaching hospitals faced new language challenges, especially in the industrial areas and in towns close to the Snowy Scheme.[16] The frequent cultural isolation of the women in these groups with husbands not supportive of them learning English, and relatively few translators available in the 1950s, made antenatal care very difficult.[17] The parochial Australians of that generation had little idea of the traumatic background and assimilation difficulties of so many non-English speaking (NES) migrants, and it often awaited their children attending school to interpret and translate in medical consultations.[18] A side issue of this Southern European migration was a rapid increase in Catholics in the population with a very different mindset to the Irish heritage Catholics of the old Australia.[19]

The rapidly increasing availability of cars for youth, with a front bench seat, drive-in theatres, the expansion of the beach culture, the coming of TV in 1956 and increasing urbanisation led to progressive lessening of parental supervision and control during the 1950s.[20] The coming of the bikini two piece costume in 1956 was an emblem of more to come, with overt sexuality and more explicit films getting through censorship.[21] With the increasing display of the female human body in the popular beach culture, there was a resultant change in gynaecological practice as patients began demanding low transverse scars which did not show above the new costume lines. The popularity of Roger Vadim's 'And God Created Woman'

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[15] *Fifty Years of Post-War Migration*,Public Affairs information and publishing section, Department of Immigration and Ethnic Affairs, Fact sheet 30,Canberra ACT, 1995
See also Bolton, *History*, "The planners", 55-58.

[16] The Snowy Mountains hydro-electric scheme employed over 100,000 persons from over 30 countries from 1949 to 1974. See Culture and Recreation portal, Department of the Environment, Water, Heritage, and the Arts, 2008.

[17] Alan Hewson Memoirs, Royal Newcastle Hospital, 1958-1970. One consultant called his non-English speaking patients his 'Veterinary practice' as no history could be taken.

[18] Paul Krauss, *A New Australian, a New Australia*, (Sydney: Federation Press, 1994), foreword, 3; see also B. Newman Jubal, *The Smile of Herschale Handle*, (Sydney: Currawong Publishing, 1947), 10.

[19] Edmund Campion, *Rock Choppers*; see also the author's experience in North Sulawesi with a Dutch Catholic Nun gynaecologist who ran the Province Family Planning service, recorded in the Hunter valley chapter.

[20] Bolton, *History*, "Being Australian", 119. See also "Remembering Australia's Drive-ins, Powerhouse Museum," at http://www.powerhousemuseum.com/insidethe collection/2016/02/-remembering (accessed 12 April, 2016). Also "Bench Seat Designs" exemplified by the mass produced Holdens in the post war Years (See bibliography re bench seats)

[21] See Karen Hutchings, "Beauty Begins at 7 AM, the Beautiful and the Damned", *Journal of Australian Studies* 24 (64), (2000), 44.

produced more pressure to ensure scars were not seen. The Brigit Bardot film of 1956 had an immediate impact because the bikini costume exposed more skin below the navel. The new incision was an improvement anyway as it was stronger, and was less painful with less chance of herniation.

CONTRACEPTION AND SEXUALITY

Contraception and sexuality before 1960 remained influenced by Victorian prejudices in that period. Reiger argues that in some quarters sexual issues and reproduction were more openly discussed, and had moved from 'the moral to the scientific' in the early years of the 20th century.[22] She relates this to an increasing interest by the State in children's welfare, and some enlightened moves to provide education in these areas.[23] However such enlightenment was probably patchy and regional, and was not the experience of this author growing up in a country village between the World Wars.[24] Uninformed but well-meaning parents at that time who themselves had not had any education in the 'facts of life' often satisfied their consciences by giving the teenagers of the time booklets like *The Guide to Virile Manhood* for boys or *A Guide to Womanhood* for girls, which often raised more questions than providing answers, usually began by discussing birds and bees, avoided explicit language, and mirrored Victorian prejudice.[25] *The Guide to Manhood* was edited by Professor Harvey Sutton, Professor of Public Health at Sydney University, and a prominent eugenicist, who emphasised the driver of preventing disease. Reiger also refers to the control of Venereal Disease as a major driver of many doctors supporting sex education.[26] Contraceptive methods were inherently unreliable, and influenced the attitude of both married and unmarried to a sexual relationship. Bolton noted that in 1962 about 13% of children were still conceived out of wedlock, but in two thirds of this group the parents married before the baby was born.[27]

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[22] Reiger, *Disenchantment*, 190.
[23] Reiger, *Disenchantment*, 183.
[24] Alan Hewson, Memoirs, Lisarow, NSW, unpublished. During the 1930s these subjects were not discussed either at home or as part of country schooling; the prevailing conservative church influence presumably still dominated thinking in many communities.
[25] Percival Kenny, *The Guide to Virile Manhood*, ed. Harvey Sutton, (Sydney: Father and Son Welfare Movement, 1935).
[26] Reiger, *Disenchantment*, 192.
[27] Bolton, *History*, 112.

Australian pharmacists were not allowed to advertise contraceptives until the 1950s and many refused to stock them.[28] In spite of these barriers to using contraceptives during WW2, 50% used some type of contraception, which rose to 75% after the war.[29] The Services had a vested interest in keeping servicemen healthy, and condom use was enforced particularly on overseas postings. Almost 1 million Australians served in WW2 so brought knowledge of protection from STDs back from war service.[30]

Various intravaginal sponges, tampons and douches had been used for centuries but were inherently unreliable and unaesthetic, and the so called 'Dutch cap' covering the cervix did not achieve popularity because of the need for regular medical re-fitting.[31] The estimated failure rates for the common methods used during the 'pre-pill' era are recorded as pregnancies in 100 fertile women using the method for one year: withdrawal (*coitus interruptus*): twenty; sheath or condom (French letter): eight; avoidance of the fertile period (safe period): three; diaphragm (Ortho Cap) and spermatocides: six.[32] However all these methods, apart from the diaphragm, did not need the involvement of a doctor, and so avoided the embarrassment of confiding in the local GP and having intrusive medical examinations, so were relatively inexpensive at a time when money was tight.[33] But the fear of Venereal Disease (Sexually Transmitted Diseases or STDs) continued even after the development of Sulphonamides and Penicillin.[34]

Sexuality and contraception were not discussed openly through those decades. Reiger describes the long term conflict between individuals in Victoria, one side trying to provide scientifically based information on sexuality, and the other trying to

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[28] Bolton, *History*, "Being Australian", 121.
[29] Bolton, *History*, 121.
[30] Australian War Memorial, "Second World War, 1939-45", *Australian War Memorial*, https://www.awm.gov.au/atwar/ww2, (accessed 29 September, 2015).
[31] O'Dowd and Philipp, *History*, 458-463. See also Helen Townsend, *Baby Boomers, Growing up in Australia in the 1940s, 50s and 60s*: *If You Can't Be Good, Be Careful*, (Sydney: Simon Schuster Australia, 1988), 168.
[32] Stanley Clayton and John Newton, *A Pocket Gynaecology*, (New York: Churchill Livingstone, 1978), 123; Evelyn Billings, *The Billings Method*, (Penguin Books, 1980), 215; see also Derek Llewellyn Jones, *Everywoman, a Gynaecological Guide for Life*, (London: Viking, 1971), 97.
[33] Alan Hewson, Memoirs; Many patients of that era used euphemisms when discussing contraception, i.e., "my husband looks after me" (withdrawal); "I think he uses something" (sheath); "we only make love just after 'me monthlies' " (safe period); "he is a wonderful husband–he hardly ever worries me" (abstinence).
[34] Dianna Wyndham, *Norman Haire and the Study of Sex*, (Sydney: Sydney University Press, 2012, 384-395): Haire refers repeatedly to the risks of Sexually Transmitted Diseases even in his later years. Haire died in 1952.

obstruct every attempt to provide it.[35] Judging from books written for the laity (but based on actual experiences) her comments seem very accurate, and were still relevant to the baby boomer generation in the 1940s to 1960s.[36] Sexologist Norman Haire suffered from criticism for decades after graduating from Sydney University medical school in1915, spending time in London, meeting many of those fighting for rational discussion of sexuality and birth control, and spending the rest of his life in the cause.[37] Writing under the pseudonym of Wykeham Terriss in the magazine *Woman*, he played a key role in demystifying sexuality and contraception after returning to Australia in 1940. He began writing for *Woman* in 1941, and his articles were compulsory reading for anyone searching for information on these subjects.

There was widespread ignorance at the time, even in medical circles. The passive obstructionism and lack of interest by the medical world now seems inexplicable. Fortunately the popular press began to fill the gap from the 1950s, and Edith Weisberg of the Family Planning Association (FPA) later became a strong voice for openness in discussing sexuality.[38] *Healthright*, published by the FPA from 1982 provided authoritative information.[39] Alex Comfort's *Joy of Sex* in 1972 and its sequel *More Joy* dispelled much ignorance.[40] Derek Llewellyn Jones' book, *Everywoman*, published when he was Professor of Obstetrics at the University of Sydney, but written for the laity, was first published in 1971 but still raised eyebrows, even though he wrote as an experienced gynaecologist.[41] The RACOG after its foundation in 1979 established a Family Health Committee to provide factual information for the public through an open website.

The Birth of More Effective Contraception

The Graafenberg Ring from 1940 was a reliable intrauterine device, but was only used in a small number of patients as it required a trained specialist to insert it and

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[35] Reiger, *Disenchantment*, 178-209.
[36] Townsend, *Baby Boomers*, 165-181.
[37] Diana Wyndham, *Norman Haire*, 15-21.
[38] "Edith Weisberg, Director of Research, at the FPA", http://www.zoominfo.com/p/Edith-Weisberg/49847469, (accessed 23 September, 2014).
[39] Family Planning Australia, *Healthright, A Journal of Womens Health* 1 (1), (January 1982).
[40] Alex Comfort, *The Joy of Sex*, (London: Quartet Books, 1972); *More Joy*, (Sydney: Penguin books, 1975).
[41] Lewellyn Jones, *Everywoman*, 41-83. See also, Bruce H. Peterson, *Growing in Love and Sex*, (Sydney: Family Life Movement, 1981).

monitor its use.[42] 'Bung' Hill in Melbourne was an exponent.[43] However the majority of medical graduates prior to the 1950s had texts which were inadequate and had no practical training in contraception before graduation, and so felt unsure in giving advice.[44] The problem of unplanned and unwanted pregnancies, and the criminal law making access to legal termination of pregnancy almost impossible for most of the population, made the position of gynaecologists during the 1950s and 1960s extremely difficult. So criminal abortion remained one of the most common methods of family planning up to 1960.[45]

The coming of the Oral Contraceptive Pill was a seminal event in 1960, completely changing the face of the discipline of obstetrics for all time, occurring at a time when the world's scientists had suddenly realised the looming catastrophe of uncontrolled population growth.[46] This was a particular problem in the Third World.[47] The development of 'the pill' followed years of preliminary work by many scientists, beginning with Haberland in Innsbruck in 1919 and Fellner in Vienna in 1921, who showed that infertility could be produced by giving oestrogens. However it awaited the production of synthetic oestrogens and progesterones and then the production of orally active compounds in large amounts which made oral compounds feasible, arising from research from the pharmaceutical companies.[48] Gregory Pincus (1903-1967), Margaret Sanger (1879-1966) and John Rock (1890-1984) were all involved in the final trials of a combination of oestrogen and progestogen in Puerto Rico in 1956 with help from Ramon Garcia, as trials were not legally possible in

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[42] See Baskett, *Shoulders of Giants*, 80. Ernst Grafenberg (1881-1957) developed the stainless steel ring in Germany, brought it to Margaret Sanger in the USA in 1931, and escaped to the USA from the Nazis in 1940. It was effective and formed the basis of all later IUCDs.

[43] See the Advances Chapter.

[44] The standard gynaecological texts (J.W. Johnstone's *Gynaecology Notes*, in Melbourne, Reginald Davies' *Gynaecology* in Sydney), used by undergraduates up till 1950 did not even mention Family Planning or Contraception. See also L.O.S. Poidevin, *The Lucky Doctor*, (Adelaide: Gillingham Printers, 1988), 49; he describes the limited knowledge of the medical undergraduate in 1936.

[45] See David McCourt, "Incomplete Abortion, Analysis of Management", *MJA* 11, (14) (1 October 1966):640-642. Alan Hewson, "When Abortion was Illegal", International Institute Lecture, Newcastle 2007; Llewellyn Jones, *Everywoman*, 95, "Induced abortion is still the most usual way for women to limit their family"; see also the Hunter Valley chapter, and comments later in this chapter.

[46] John Guillebaud and Anne Macgregor, *The Pill, the Facts* (7th edition), (Oxford University Press, 2009), Foreword, vii. See also R.T. Ravenholt, "Epidemiology of World Fertility", *International Planned Parenthood Federation*, Sydney, 14 August, 1972, 1-28.

[47] See Maurice King, Glen Mola, *Safe Motherhood in developing countries*, (Marie Stopes International, 2004), 1. See also Harold Speert, *Obstetrics and Gynaecology in America*, "Role of Government in Population Control", (Baltimore: Waverley Press, 1980), 162; Guillebaud and Macgregor, *The Pill*, Foreword, vii.

[48] Baskett, *Shoulders of Giants*, 181.

Massachusetts in the 1950s. The resultant paper was published in 1958.[49] The pill Enovid was finally approved by the USA Food and Drug Administration (FDA) on 9 May 1960.[50] Rock, a devout Roman Catholic from Boston, was unable to persuade the Pope that oral contraception did not contravene Catholic theology on family planning, ensuring continuing controversy.

Medical experts were cautious towards the Pill. Guttmacher described the new pill in the *Consumers Family Planning* publication in 1962, but stipulated that it should only be prescribed to married women, they must have a full physical examination every six months including blood serology.[51] In the UK *The Practitioner*, Centenary Edition, in 1968, featured an article on 100 years of obstetric advances by John Peel but failed to mention the introduction of the Pill eight years earlier, even though there were advertisements for the Pill in the same Journal.[52] Australia had introduced the pill on 1 February 1961, but again it was initially limited to prescriptions to married women.[53]

Aldous Huxley was much more astute and in *Brave New World Revisited* foresaw the dramatic implications of this advance. He stated 'it is not merely (solving) a problem in medicine, in biochemistry, in physiology; it is also (dealing with) a problem in sociology, in theology and in education'.[54] Llewellyn Jones discussed the new world 'post pill' in a positive light.[55] He stated,

> That it is now accepted that women have no less enthusiasm for sex than men, no less enjoyment and no less drive; that a women's sexual response is not intrinsically different from the male, they feel more comfortable in telling the male when they wish to have sex, and that dependence on the male has been changed to mutual respect.

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[49] Gregory Pincus, JohnRock and C.R. Garcia, "Fertility Control with Oral Medication", *American Journal of Obstetrics and Gynaecology* 75, (1958), 1333-1346.
[50] Baskett, *Shoulders of Giants*, 182. ENovid (Searle) was the first oral contraceptive pill authorised by the FDA.
[51] Alan F Guttmacher, *The Consumers Report on Family Planning*, (USA: Mount Vernon, 1962), mentioned Enovid, norlutin and Orthonovum.
[52] John Peel "The Practitioner", *A Century of Obstetrics* 201, (July 1968), 85-93.
[53] Ian Frazer, "Forty Years of Combined Oral Contraception", *MJA* 173, (20 November, 2000), 541-544.
[54] Aldous Huxley, *Brave New World Revisited*, (New York: Harper and Rowe, 1958), 138, 139.
[55] Llewellyn Jones, *Everywoman*, 67.

He believed these changes should create an atmosphere in which sexuality is more open, more honest, and more fulfilling. However he warned of two dangers. The greater chance of contracting an STD by either partner, if multiple partners exist, and the still present slight risk of a contraceptive failure, and pregnancy, 'if the rules regarding pill usage are not followed'.[56]

The situation could be summarised as 'the patient has now become a woman', with all the independence and self-confidence previously the sole province of the male. The woman could now control family planning, rather than the man as was previously the case.[57] All this had changed with the separation of coitus from the method of contraception.

The early pill formulations were far from ideal. Anovlar (Schering) had a high concentration of oestrogen, so had a number of annoying side effects including nausea, irritability, fluid retention, migraine headaches, acne, depression, elevation of blood pressure and weight gain.[58] Concerns were raised about increased risks of blood clotting, effects on breast tissues, development of tumours in animal experiments, and masculinisation of the female foetus if pregnancy occurred. Sceptics pointed out that the population was embarking for the first time on massive dosage of powerful agents in perfectly normal women, and that final judgment on these agents should be deferred.[59]

In spite of side effects and concern about long term problems, there was a dramatic uptake of the oral contraceptive pill (OCP). By 1969, 500,000 Australian women were using oral contraception.[60] The change in use of contraception in Australia over the period from 1934 to the 1990s is documented in the Australian Bureau of Statistics (ABS) database.[61] Most of the early side effects reported were solved by lowering the oestrogen doses and development of newer progestogens.[62]

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[56] The incidence of STDs doubled after the pill became available. See T.L.T. Lewis, *ANZJOG* article, 1970.
[57] Caroline Deys, "Cultural Aspects of Male Sterilisation", Marie Stopes Centre London, *International Planned Parenthood Federation* (IPPF), Sydney, 14 August, 1972, 188.
[58] Llewellyn Jones, *Everywoman,* 112-113.
[59]T.L.T. Lewis, *Progress*, 490. See also John Schrogie, "Evaluation of the Carcinogenic Effect of the Sex Steroids", *IPPF*, (1972), 59-64.
[60] Derek Llewellyn Jones, *Fundamentals of Obstetrcs and Gynaecology, volume 1*, (London: Faber and Faber, 1969), 129.
[61] ABS, *Australian Social Trends*, "Family Formation", 1998, 1-4, http://www.abs.gov.au/AUSSTATS/abs@nsf/2f762f95845417aeca257, (accessed 21 February, 2013).
[62] Ian S. Fraser, "Forty Years of Combined Oral Contraception", *MJA* 173, (20 November, 2000), 541-544. See also Collaborative Group on Hormonal risk factors in breast cancer and hormonal

The thromboembolic risks were clarified as related to older age groups and smoking.[63] The fertility rate, low during the Great Depression, rose during and after WW2, peaking in 1961, then falling after the OCP became available. The days of large families were over, another factor lowering the maternal mortality rate.[64] The age of mothers having their first child rose as women continued education or stayed in the workforce longer. The ABS database notes the effects of adding the OCP to the Pharmaceutical Benefits Schedule (PBS), removing restrictions on family planning advertising, removing the sales tax on contraceptives in 1972, and recognising family planning as a major preventive health measure.[65]

Effects and Implications for Gynaecological Practice

The change in community attitudes already noted with availability of oral contraception presented gynaecologists with significant problems. The necessity to have a doctor's prescription meant inevitable requests from teenagers for the OCP, a major problem in teens under the age of 16 who saw no reason why they should not engage in extramarital sex, nor any reason why their parents should take any part in the decision. Gynaecologists knew that if they were not given the protection of the OCP, an unplanned and unwanted pregnancy would result. That generation of conservative gynaecologists had to struggle with both moral and pragmatic issues, as access to legal termination of unwanted pregnancies was still years away. Counselling regarding the risks of STDs and the emotional trauma of broken short term relationships was often not welcome.[66]

Availability of the OCP also affected advice given to practising Catholic couples regarding contraception after the Papal Encyclical of 1968 forbidding the use of the OCP to prevent pregnancy.[67] However, there are documented therapeutic benefits from the OCP, including lighter periods, less menstrual pain, usually diminished premenstrual tension, no ovulation pain and predictability of cycles,

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contraception, "54 Epidemiological Studies", *Lancet* 347, (1996), 1713-1727; also R.D.T. Framer, R.A. Lawrensen, J. Todd, "Oral contraception and Venous Thrombembolism", *Human Reproduction Update*, 1999, 563-771.

[63] Fraser, "Oral contraception", *MJA*.

[64] See the Education(1) and Hunter Valley(6) chapters.

[65] Australian Social Trends, 1998, 1-4, see above reference.

[66] Guillebaud and Macgregor, *The Pill*, "Young People, Sex and the Pill", 157.

[67] *Humanae Vitae, Papal Encyclical, 1968*, condemned artificial contraception. See O'Dowd and Philipp, *History of Obstetrics and Gynaecology*, 458.

which has social benefits.[68] Inevitably requests came from Catholic patients, usually to non-Catholic gynaecologists for treatment of these symptoms knowing that protection from pregnancy would occur as well.

Developments and refinements of the OCP were to follow. The continuing importance of hormones acting on the reproductive tract was evident over the next 40 years, notably the 'morning after' pill (high dose oestrogen dose after unprotected intercourse), and continuous low dose progestogen as an alternative to combined hormones (progestogen only pill or POP) when oestrogen was contraindicated.[69] Other methods of hormonal protection against pregnancy included Implanon (Croxatto and Segal, 1969), Depot Provera injections every 12 weeks (from 1967) and the combined pill patch or ring.[70]

The Mirena (Bayer) deserves special mention. This is a levonorgestrol releasing intrauterine device which, as well as preventing pregnancy, markedly reduces menstrual loss and has diminished the need for endometrial ablation (removal of the endometrium) and even hysterectomy. Its disadvantage is the necessity for skilled professional insertion, but it remains effective for five years.[71] The Copper intrauterine device (IUD) also lasts for 5 years but also needs professional insertion. These IUDs are later, more sophisticated developments of the original Grafenberg ring, and are designed to return to their original shape after insertion.[72]

In summary, a woman now had available a wide range of methods of ensuring a pregnancy would not occur, all of which were used separately from intercourse and gave her complete control. The gynaecologist had to acquire appropriate knowledge as each of these methods became available, so that the patient could receive the advice best suited for her particular life situation. These advances also produced treatment options in other areas of women's gynaecological health, particularly the menopause.

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[68] Guillebaud and Macgregor, *The Pill*, 43. See also Clifford Kay, " 'The Happiness pill', James Mackenzie Lecture 1979", *Journal of the RCGP*, (January 1980), 8.
[69] Guillebaud and Macgregor, *The Pill*, 22.
[70] See Guillebaud and Macgregor, *The Pill*, 20, 21. See also, Suzanne Pearson and Sumudu Cooray, "Contraception, A New Focus", *O and G Magazine* 16 (3), (Spring, 2014), 14-16.
[71] *Mirena, Your Questions Answered, Bayer Intrauterine Delivery System*, (Pymble, NSW: Bayer). See also Edwina Morgan, "Mirena, Modern Day Miracle", *O and G Magazine* 16 (3), (Spring, 2014), 21-23.
[72] O'Dowd and Philipp, *History*, Intrauterine Devices, 464-466. See also, illustration of varying types of IUCDs in the appendices (O'Dowd and Philipp, 465).

The management of the menopause has been controversial since the 1950s when the role of hormones in control of the menstrual cycle became established. The symptoms of a failing ovary are well documented and led to efforts to replace the hormones to produce a state of 'feminine forever' and to either keep cycles going or to provide enough replacement therapy to control symptoms.[73] As the age at which it begins often coincides with midlife stresses, management usually requires more than just hormone therapy.[74] Conflicting views regarding the risks of breast cancer, effects on osteoporosis, heart disease, and dementia made 'facts based' counselling by gynaecologists difficult.[75]

Sterilisation

Sterilisation concerns the operative procedures aimed at producing permanent infertility by partial removal or obstruction to the genital tract in either male or female. Permanent sterilisation steadily increased in popularity during the 1970s and 1980s, after resolution of the legal and ethical issues which had been a barrier to this method of contraception.[76] The previous constraints requiring the husband's consent were overcome by Women's liberation pressure and became irrelevant.[77] The techniques used include tubal surgery by either the transvaginal route (Culdoscopy or posterior Colpotomy) or by an abdominal approach using laparotomy or laparoscopy.[78] Since 1970 open operation has been almost completely replaced by laparoscopic fibre-optic technology which dramatically reduced operation time, complications, postoperative hospital stay and increased safety, making the procedure much more acceptable and less expensive.[79] Other methods are now available to occlude the Fallopian tube in the female, and some authorities advocate removal of part of the tube to lower failure rates, but the details are not relevant to this

[73] Robert Kistner, "The menopause", in *Clinical Obstetrics and Gynaecolgy Volume 16*, (Maryland, USA: Harper and Rowe, 1973), 106-120; Llewellyn Jones, *Everywoman*, 379.
[74] Barry Wren and Margaret Meere, *Menopause, Change, Choice and HRT*, (Summer Hill: Rockpool Publishing, 2013), 166-172.
[75] See the Women's Health Initiative (WHI), USA; Margaret Smith, *Midlife Assessment, a Handbook for Women* (Perth, WA: Caring for Women Publications, 1988).
[76] G. Sartow, "Trends in Contraception and Sterilisation in Australia", *ANZJOG* 31 (3), 1991.
[77] Discussed in more detail in the Hunter Valley chapter.
[78] John J. Sciarra, *Clinical Obstetrics and Gynaecology: Endoscopy, Volume 12, no 2*, (New York: Harper and Rowe, 1969), 461.
[79] Robert S. Neuwirth, C*linical Obstetrics and Gynaecology: Laparoscopy*, (New York: Harper and Rowe, 1969), 514-526. See also Tawfik Rizkallah, *Clinical Obstetrics and Gynaecology: Laparoscopy and Electrocauterisation*, Volume 16, no 3, (New York: Harper and Rowe, 1973), 7-20.

discussion.[80] The advantages of sterilisation is that the failure rate is extremely low and the procedure is permanent.[81] Up until that time, the prevailing conservative approach followed the '120 rule': age times parity should be over 120 before sterilisation was offered. In Australia by 1995 the number of females sterilised had risen to 19%, and of males to 14%.[82] By that time 'two thirds of Australian women aged 18 to 49 either used some method of temporary contraception or had permanent contraceptive protection'. [83] Failures resulting in unwanted pregnancies led later to expensive Court cases, particularly the Cattanach case.[84] Fortunately reversal procedures (reanastomosis of tubes) or IVF technology to make pregnancy possible are now available.[85] Nevertheless patients require warning regarding the dangers of laparoscopy, particularly bowel and blood vessel perforation, as outlined by the Medical Defence Union.[86]

Acceptance of vasectomy by male partners was influenced by the emancipation of women in the sexual revolution. Deys analysed the reasons for acceptance of vasectomy by males, noting that it was more common in the 'macho' occupations who were used to accepting responsibility.[87] Evidence discounting fear of antisperm antibodies after vasectomy encouraged acceptance.[88] Removal of high parity, high risk patients from obstetric cohorts was a major positive result of a more aggressive approach to permanent sterilisation, a benefit publicised by Baird and

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[80] Marcus Filshie, *Clip System, Success Rates from the Literature*, (UK: Femcare Nikomed, 1998); Assure Budden, "Hysteroscopic Sterilisation", *O and G Magazine* 16 (3), (Spring, 2014), 17-20.
[81] See G.M. Filshie, J.R. Pogmore, A.G.B. Dutton, E.M. Symmonds and A.B.L. Peake, "The Titanium /Silicone Rubber Clip for Female Sterilisation", *BJOG* 88, (1988), 655-662. In the USA in 1970, three million married couples under 45 had opted for permanent sterilisation, and by 1973 the method was used more often than the OCP. Harold Speert, *Obstetrics and Gynecology in America*, "Sterilisation", 172.
[82] ABS Data 4102.0, "Australian Social Trends, family planning, types of contraception", 1998, http://www.abs.gov.au/AUSSTATS/abs@nsf/2f762f95845417aeca257, (accessed 21 February, 2013).
[83] Abs Data, 4102.0 Social Trends, Contraception, 1998.
[84] See the Litigation /medical malpractice chapter.
[85] Douglas M Saunders, "Fertility Society of Australia: A History", self published, 2013.
[86] Medical Defence Union, *Cautionary Tales, Complications of Laparoscopy, 1969-1984*, (Sydney: AMDU, 1988), 61.
[87] Carolyn Deys, Marie Stopes Clinic London, reported in *The Age*, Melbourne, 18 August, 1972. Deys is a female medical practitioner who was doing vasectomies for this charitable Trust , and was indicted for allowing an article about her work to be published in the popular press.
[88] Mark A. Barone, Janet Ominde Achola, "Long Term Risks of Vasectomy", *Journal of the Global Library of Women's Medicine*, (May 2015). This literature overview confirmed that anti sperm antibodies after vasectomy do not increase the risk of autimmune , cardiovascular or any other diseases in long term followup.

others as early as the 1950s in the UK.[89] However the need for appropriate pre sterilisation counselling became obvious.[90]

Sexually Transmitted Diseases

Researchers noted an increased incidence of Sexually Transmitted Diseases (STDs) after the Sexual Revolution.[91] Lewis, and Guillebaud and Macgregor, and others, have documented the doubling of the incidence of STDs since the 1960s.[92] Chlamydia and Gonorrhoea are usually implicated and have been a major problem in the Australian Indigenous population.[93] Earlier detection of Chlamydia has been improved by new screening methods, but Couldwell has emphasised the increasing incidence in young people, the male gay community, and Indigenous people.[94]

However, the sudden appearance of the HIV/AIDS virus in 1982 in Australia impacted directly on obstetrical and gynaecological practice as the virus can be transmitted from mother to foetus during pregnancy, delivery, and when breast feeding.[95] There was a dramatic effect on the male gay community, once the high risk male–male sexual relationship (MSM) was clarified. Unfortunately high risk unprotected sex, with a high risk of transmission across the rectal mucosa, is still a major issue, with 75% of new HIV infections in 2014 in Australia acquired by MSM.[96] Drug addicts sharing needles and transferring HIV/AIDS in general has

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[89] Dugald Baird and James Walker, "Stillbirth Causes", in *British Obstetric Practice*, eds. Eardley Holland and Alex Bourne, (London: Heineman, 1955), 851-879. Also Neville Butler and Dennis Bonham, "Parity and Infant Loss", in *Perinatal Mortality*, (UK: E. and S. Livingstone, 1963), 24-25.
[90] James Smibert, "Pitfalls of Sterilisation", *MJA*, (14 October, 1972), 901-903. See also Phillip Greenberg, "Sterilisation, the Psychological Indications and Effects", *Postgraduate Committee in Medicine Bulletin* 25 (3), (1969), 53-54.
[91] This refers to peacetime incidence; the major problems during wartime are well documented. See A.G. Butler, *Official History of the Australian Army Medical Services, 1914-1918, Volume 2: The Western Front*, "infections", 410; (Venereal Disease, 18% of all infections**).** See also, *World War 2 Military Sex Education* (quoting over 600 servicemen incapacitated by STDs every day),
[92] T.L.T. Lewis, "Gynaecology in a Permissive Society", *ANZJOG* 10, (1970), 244; Guillebaud and Macgregor, *The Pill*, 118.
[93] Catherine Jones, Xiaohua Zhang, Karen Dempsey, Naomi Schwartz, Steve Guthridge, *Health and Wellbeing of Northern Territory Women*, "Sexually Transmissible Infections", (Darwin: NT Government, 2005), 125-127.
[94] Deborah L. Couldwell, "Management of Unprotected Sexual Encounters", *MJA* 183 (10), (21 November, 2005), 525.
[95] National Advisory Committee on AIDS, *AIDS Report: AIDS and Women*, 1988, 11-12.
[96] Editorial, "STIs Climbing in Men Who Have Sex With Men (MSM) in England, *Lancet* 386 (9988), (4 July, 2015), 2.See also *HIV Media Guide*, Kirby Institute 2015 Annual Surveillance Report, at http://www.hivmediaguide.org.au/hiv-in-australia/hiv-statistics-australia, (accessed 2 May, 2016).

been well controlled in Australia. Infection of obstetric patients is a continuing risk in the bisexual group. Fortunately the development of anti-retro viral drugs can now control most cases but do not cure the disease. [97]

The Termination of Pregnancy Debate

Another controversial and challenging area for obstetricians and gynaecologists arose from increased social debate over the safe and professionally mediated termination of pregnancy. It is important to distinguish between spontaneous abortion (miscarriage), which is often associated with an abnormality in the embryo, and therapeutic abortion of a normal pregnancy which may be by medical or surgical means (STOP).[98] There are references to therapeutic abortion from early prehistory.[99] Different civilisations had different views, varying from regarding it as a capital crime to acceptance as a population control measure. Hippocrates (400BC) opposed abortion. [100] Some civilisations did not recognise pregnancy existed until quickening occurred.[101]

Abortion remains a global problem of massive proportions. To quote from the *BMJ* of 2007:

> In 2003 an estimated 1/5th of all pregnancies world-wide end in abortion; in Europe this proportion is near a third; with some post Soviet Union countries it is probably 45%. 1995 data suggested there had been a fall in absolute numbers except in the developing world. In 2003, 48% of all abortions were unsafe, up from 44% in 1995.[102]

Emmens documented abortion around the world.She states that annual numbers worldwide are estimated to be from 40 to 60 million, 'of which 30 to 40 million are

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[97] Editorial, *Journal of Infectious Diseases*, 06 April, 2015. Initially death rate within 5 years was 93% in 5 years. Now 35% die within 5 years after infection.
[98] Allen Wilcox, Clarence Weinberg, John O'Connor, Donna Baird, John Schlatterer, Robert E. Canfeld, Glenn Armstrong, Bruce Nisula, "Incidence of Early Pregnancy Loss", *New England Journal Medicine* 319 (4), (July, 1988), 189-194; confirmed a 31% early pregnancy loss rate (most unrecognised).
[99] O'Dowd and Philipp, *History*, 47-50.
[100] See Francis Adams, *The Genuine Works of Hippocrates*, (London, Alabama: Sydenham Society, 1985), 779; Hippocratic Oath "I will not give a pessary to produce abortion". See also the *Declaration of Geneva* in the Litigation chapter.
[101] O'Dowd and Philipp, *History*, 47-50.
[102] Alison Tonks (ed.), "News from other Journals", *BMJ* 335 (20 October, 2007), 797.

probably legal.'[103] About 24% of the world's population lives where abortion is illegal or restricted, but about 33% allow abortion on request.[104] Emmens further notes the extreme variation in laws regarding abortion around the globe, but comments that no matter what the law states, abortion continues on a massive scale.[105] Callaghan in 1972 summarised the intellectual, moral, ethical, social, religious and medical issues surrounding this debate and his text became a classic.[106]

As with the training of obstetricians and gynaecologists, the British experience of abortion was influential in Australia, and so a brief outline of changing attitudes in Britain and other western nations will position the Australian experience.

Before 1803 in the UK abortion was a crime after 'quickening', but the law was then changed to include the period before quickening, and in 1861 the Offences against the Person Act mandated a lifetime prison term; but actions were normally against abortionists, not against the woman. The controversy became very theological, with the concept of 'ensoulment' the union of sperm and egg, endorsed by Pope Pius IX in 1869, so abortion was then banned for all of pregnancy in most of Europe.[107]

In 1939 a consultant, Dr Alec Bourne in London, carried out a termination of pregnancy on a 14 year old girl who had been gang raped by soldiers.[108] He challenged the police to arrest him, and the subsequent trial proved a landmark. The presiding Judge, Mr Justice McNaughton summed up by saying:

> that the law implied that there was a difference between unlawfully terminating a pregnancy and lawfully terminating it, and that if the doctor is of the opinion on reasonable grounds and on adequate knowledge that the probable consequence of the continuation of the pregnancy would indeed make the woman a physical or mental wreck then he can operate in that honest belief for the purpose of preserving the life of the mother.[109]

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[103] Carol Emmens, *The Abortion controversy*, (New York: Julian Messner, 1991), 112-131.
[104] Emmens, *Controversy*, 113
[105] Emmens, *Controversy*, 114.
[106] Daniel Callaghan, *Abortion; Law choice and Morality*, (London: Collier-McMillan, 1972), 1-15.
[107] See Emmens, *Controversy*, 101.
[108] R.F.R. Gardner, *Abortion, the Personal Dilemma, (*Exeter: Paternoster Press, 1972), 29.
[109] Gardner, *Abortion*, 30.

Bourne was acquitted and the McNaughton judgement formed the basis for therapeutic abortions carried out for the next 30 years. McNaughton also stated that a person whose religious convictions meant they would not terminate a pregnancy under any circumstances should not be an obstetrical surgeon, as if he refused and the mother died he could be charged with manslaughter. So in the UK legal termination became more easily available, but in practice it was easier for the well-off who could 'afford a private psychiatrist to provide a legally advisable confirmatory second opinion'. In spite of the McNaughton judgement opposition to therapeutic abortion continued in the UK, led by Jeffcoate from Liverpool who, in his widely used textbook and in public medical forums, expressed continuing disquiet.[110]

In the UK after a prolonged public debate and questionnaires to doctors, finally on 27th October 1967 the UK Abortion Act was passed. This was still surrounded in controversy with John Peel from the RCOG lamenting insufficient medical input into the wording of the Bill, which ignored the practical problems of providing a virtual 'termination on demand' service, its effect on other important gynaecological treatment, dealing with doctors who had ethical objections to this service, and its effect on their appointments and career paths.[111] After the Act there was a flood of applicants for abortion, and by the early 1970s the rate was more than 90,000 per year.[112]

Liberalisation of the law in the USA and Canada followed the changes in the UK from 1967, but still varies across different USA States.[113] The debate regarding the laws governing legal abortion in the US had an even more tortuous course than in the UK, because of the inbuilt sovereignty of each State, and are outlined by Speert. The Consumer and Women's Liberation movements campaigned vigorously on the issue over years.[114] It was not until the Doe vs Bolton case in 1973 and the Roe vs Wade case that the Supreme Court, USA, upheld the right of a woman to request abortion and in spite of many amendments to block this right, by 1974 the legal

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[110] T.N.A. Jeffcoate, "Indications for Therapeutic Abortion: Report from the AGM, BMA, Norwich, 1959", *BMJ*, 27, (February, 1960), 581. See also, T.N.A. Jeffcoate *Principles of Gynaecology, Termination of Pregnancy* (4th edition), (Edinburgh: Butterworths, 1975), 632.
[111] Gardner, *Abortion*, 63-70. This controversy affected Australian obstetric trainees working in the UK after that time.
[112] Gardner, *Abortion*, 75.
[113] Harold Speert, *Obstetrics and Gynaecology in America*, "Abortion", 166-170.
[114] See chapter 4.

abortion rate was rising rapidly; but the need remained unmet for several years, and the medical profession remained divided on the issue.[115]

In Australia, it had always been assumed that the UK McNaughton Judgment would be agreed with in Australian Law but it had never been tested. During that twilight period the situation of gynaecologists in Australia was very difficult. Any doctor who gained the reputation as an abortionist suffered intense criticism from colleagues, was usually ostracised, could be disciplined by the State Medical Board or even disqualified and dismissed from hospital posts. The law was still unclear, its interpretation by legislators inconsistent, so the vast majority of gynaecologists avoided carrying out terminations except under very strict guidelines, as described in the Hunter Valley chapter. Many community activists have failed to appreciate the very real dilemmas of the profession at that time, ascribing their reluctance as means to control the reproduction of women.[116]

Following the passage of the 1967 Abortion Act in the UK, the debate in Australia increased. In 1968 the National Health and Medical Research Council (NHMRC) made recommendations regarding changing the legislation.[117] The AMA also made recommendations; in 1969 Victoria clarified the existing law, and South Australia introduced a law similar to the UK, but insisting that any patient requesting abortion must have lived in South Australia for two months. The criminal law in Australia is a State matter, so action for change occurred on a State by State basis. The NHMRC recommended that only medical practitioners should have responsibility for terminations, that the procedure should always be in a hospital and that there should be no grounds for legal action against a medical practitioner for refusing to perform an abortion.[118] On 22 May 1969, Justice Menhennitt in Victoria clarified the Victorian law, stating that a termination was lawful if necessary to preserve the life, or physical or mental health of the woman, 'in circumstances not out of proportion to the danger to be averted'. He also stated that the Crown had to establish that the one involved 'did not honestly believe that the above propositions

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[115] Speert, *Obstetrics and Gynaecology in America*, 171.
[116] Reiger, *Disenchantment*, 114. See also Luker, A*bortion and the Politics of Motherhood*, (San Francisco: Berkeley, 1984), 15. See also Lisa Featherstone, "Breeding and Feeding", PhD thesis, University of Newcastle, 2007.
[117] Ronald Winton, "Medical Practice and Abortion Law in Australia", *World Medical Journal* 17 (4), (July, 1970), 88-89. This journal issue covered abortion in many countries around the world.
[118] Winton, "Medical Practice", 89.

were correct if the action was questioned'.[119] The Government believed that no further clarification was necessary at that time. The actions of Dr Bertram Wainer in Melbourne at that time was a confounding factor as he was campaigning to have the laws changed. The publicity he used led to conflict with the Victorian branch of the AMA, and he later resigned. In November 1969 he then alleged that high ranking police were involved in taking bribes to cover up criminal abortion, leading to an official inquiry and changes in the law.[120] But differences between the States continued.

A review of Abortion law in Australia was carried out in August 1998 concentrating on how law and practice compared with other countries and within States.[121] It pointed out that in every State and Territory except Western Australia it was still a major crime to unlawfully administer any poison or noxious thing or use any instrument with intent to procure a miscarriage based on the English law of the 19th Century, and that the provisions prohibiting abortion applied to any stage of pregnancy. As an *MJA* editorial noted in 2004,

> Many State laws were unclear or outdated and were inconsistent across the States. Most current laws have grey areas which leave doctors vulnerable to accusations, negative publicity, and career damage especially in relation to late abortions.[122]

The editor believed all jurisdictions should follow the ACT''s lead in allowing women access to abortion without fear of criminal prosecution; and Federal, State and Territory governments should introduce a single clear national law on abortion both in early and late pregnancy. Pamphlets targeting doctors who might refer patients for termination continued, listing alleged risks to the referring doctor under the Consent provisions. [123] Unfortunately the lack of a common approach to laws

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[119] Justice Menhennitt, *Crimes Act, 1969*, (Vic), s65. See also Lachlan J. de Crespigny and Julian Savulescu, "Abortion: Time to Clarify Australia's Confusing Laws", *MJA*, 181 (4), (2004), 201-203.
[120] Bertram Wainer died in 1987, after much had changed in the debate. His wife later published a book of the harrowing stories of those who had been seeking an abortion before the law was changed. See Jo Wainer, *Lost, Illegal Abortion Stories*, (Melbourne: Melbourne University Press, 2006).
[121] Natasha Cica, *Abortion Law in Australia, Research Paper 1, 1998-99*, (Canberra: Law and Bills Digest Group, 31 August, 1998). http://www.aph.gov.au/abaut-Parliament/Parliamentary-departments/, (accessed 7 April, 2014).
[122] "Editorial", *MJA* 181, (2004), 201-203.
[123] Doctors Legal Safeguards Group, A*bortion Information and the Law*, 2nd edition, 2000.

covering termination of pregnancy continued across State jurisdictions.[124] Kennedy in 2007 concluded that unhelpful variations in the law across State boundaries still persisted. Changes have occurred since in Western Australia and Tasmania.[125] A stressful case occurred in Victoria which achieved national press coverage.[126] The conscientious objection clause became a battle ground as well.[127]The difficulties surrounding action in practice were addressed in the *MJA* by Carolyn de Costa.[128]

In spite of the queries raised by differences in the State laws, the number of legal terminations steadily rose in Australia and are now estimated at about 90,000 annually, compared with total annual births of approximately 300,000. [129] Chan quoted NHMRC and ABS data of 95,200 in 1995-1996, and Guttmacher Institute data of 91,944 in 1995-6 estimated an abortion rate of 22.2 per 1000 women. Only three States demand notification, and the data we have comes from adding Medicare Statistics to public hospital data, the latter coming from hospital morbidity data. Chan documented the sources of potential error in Australian statistics and estimated the Australian rate at 19.7 per 1000.[130] This puts Australia at the higher end compared with other Western countries, with Germany at 7.7 per 1000 and the USA at 21.3 per 1000.

The situation regarding access to and the actual incidence of terminations has been complicated by the introduction of Mifepristone and Misoprostol used to produce medical termination of pregnancy. The original difficulties regarding access

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[124] Elizabeth Kennedy, "Abortion Laws in Australia", *O and G Magazine* 9 (4), (Summer 2007), 36-37.
[125] Department of Health and Human Services, *Pregnancy Terminations, New Law*, (Tasmanian Government, 12 February 2014). Western Australia had enacted a similar law 20 May 1998; See Jasmina Brankovic, *Fresh Cuts*, eds. Elizabeth Ruinard and Elkspeth Tilley, (Queensland: University of Queensland Press, 2001), 286; and Justin Healey, ed., *Abortion issues* 312, Spinney Press, http://spinneypress.com.au/books/abortion-Issues, (accessed 4 March, 2014).
[126] Lachlan de Crespigny, "Controversial Case Brought Anguish", *The Age*, 2007, http://www.theage.com.au/news/nationa/controversial-abortion-case-thatr-brough-a do, (accessed 4 March, 2014).
[127] Anne O'Rourke, Lachlan de Crespigny, Amanda Pyman, "Abortion and Conscientious Objection: The New Battleground", http://ssm.com/abstract=2262139, (accessed 5 October, 2015).
[128] Carolyn M de Costa, Darren Russell and Michael Carrette, "Views and Practices of Induced Abortion in the RANZCOG", *MJA* 193 (1), (2010), 13-16. See also Carolyn de Costa, *Never Ever Again, Why Australian Abortion Laws Needs Reform*, (Brisbane: Booralong Press, 2010), and also Carolyn de Costa et al., "Abortion Providers Knowledge and Use of Abortion Law in NSW and Queensland", A*NZJOG* 53, (2013), 184-189.
[129] Annabelle Chan and Leonie C. Sage, "Estimating Australia's Abortion Rates 1985-2003", *MJA* 182 (9), (2005), 447-452.
[130] Chan and Sage, "Estimating", 449.

to these agents has been dealt with and the method now has official endorsement.[131] Again, the over the counter availability of the morning after pill Prostinor 2 complicates the estimates, so that as most of these terminations can be managed without hospitalisation or a surgical procedure, the actual number of terminations being done will be even more difficult to calculate. However, even when National Registration Legislation (AHPRA) for Health Professionals was passed in 2011, varying legislation regarding abortion persisted, continuing the difficulties of gynaecologists practising across State borders.

The Feminist Movement in relation to the Discipline.

These groups became much more active and vocal as part of the emancipation of women in the new Australian Society. According to Martin, the feminist movement goes back for centuries.[132] However the election of the Whitlam Labor government in 1972 coincided with new activism, and Gillett's contribution to Wilson's publication was typical of the time.[133] Gillett identified sexual liberty and the sexual role as fundamental, highlighted areas of perceived manipulation and male subjugation and the negative role of the women's media, proposing a more 'group oriented' society, facilitated by the new contraceptives, abortion on demand, and removal of current taboos in society, 'claiming that the modern family oppresses its members'.[134] Hirst's article in 1972 on Birth control was again ahead of its time, pointing out that in spite of the pill, many women were still afraid of pregnancy and that their pill would fail.[135] Wilson and Brown wrote candidly about the abortion debate in the same publication. [136]

Germaine Greer's book *The Female Eunuch* in 1971 created major controversy, seen as the beginning of the second wave of feminism.[137] However, Lake described the long history of women's groups demanding change from 1910,

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[131] Mifepristone (RU-486) followed by misoprostol, medical termination up to 49 days gestation, *NPS Radar*, (August, 2013), 3-9.
[132] Angela Martin, "Simply a History of Feminism", *New Internationalist*, (January, 1992), 227.
[133] J. Gillett, "Women - Liberation – Revolution", *Australian Social Issues of the 70s*, ed. Paul R Wilson, (Sydney: Butterworths, 1972), 137-141.
[134] Gillett, *Social Issues*, 139.
[135] J.A. Hurst, "Birth Control, the Views of Women", *Australian Social Issues of the 70s*, ed. Paul R Wilson, (Sydney: Butterworths, 1972), 142-148
[136] P.R. Wilson, J.W. Brown, "Recent Developments in the Abortion Debate", *Australian Social Issues of the 70s*, ed. Paul R Wilson, (Sydney: Butterworths, 1972), 149-152.
[137] Germaine Greer, *The Female Eunuch*, (UK: McGibbon and Kee, 1970).

and continuing over subsequent decades.[138] Mary Wollstonecraft led the women's liberation movement in Britain after Thomas Paine wrote about the *Rights of Man* in 1791, and Emmeline Pankhurst led the Suffragettes fighting for equal voting rights for women from 1903, so there was a long history of women's activism.[139] Greer's book was, to many, confronting, and she listed the enemies of the revolutionary woman, with doctors leading the list.[140] Obstetricians had difficulty in being categorised as women's enemies having always seen themselves as aligned with women's rights and supporters of improving women's role in society.[141] Similarly Greer's criticism of the Catholic Church and its rigid views ignored the views of other Christian churches with more balanced views.[142] On the world wide scene, Marx and Engels saw Women's liberation as part of the socialist revolution, but in 1940 Stalin turned the clock back. In the West it lay dormant, until the publication of Betty Friedan's *The Feminist Mystique* in 1963, which is credited with a major impact on the eventual repeal of the abortion laws in the USA.[143]

Michaels states that feminism takes many forms so that it cannot be characterised in a seamless way but that 'it encompasses the struggles of women to secure their economic and political agency'.[144] It is not surprising that it was reinvigorated by the changes in society in the 1960s and 1970s, and some embraced the power/knowledge theories of Michel Foucault at that time as weapons to confront the then male dominated discipline of obstetrics and gynaecology. When women moved into hospitals to have babies, intervention rates rose and many women felt disempowered by this process.[145] However Foucault's theories have frequently sparked controversy, criticism and even outrage because of the way in which he

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[138] Marilyn Lake, "Personality, Individuality, Nationality: Feminist Conceptions of Citizenship1902-1940", *Australian Feminist Studies* 19, (Autumn), 25-38. See also Wendy Weeks, "Womens citizens struggle for citizenship", in *The Australian Welfare State*, ed. J. Wilson, (Sydney: Macmillan Education Australia, 1996), 70-85.

[139] Thomas Paine, *The Rights of Man*, (London: J.S. Jordan, 1791); Emmeline Pankhurst (1858-1928) founded the Women's Social and Political Union.

[140] Greer, *Female Eunuch*,'Summary' 8.

[141] See discussion in other chapters.

[142] See William Barclay, *Ethics in a Permissive Society*, "Person to Person Ethics", (UK: Collins Fontana Books, 1971), 210. See also Herbert J. Miles, *Sexual Happiness in Marriage*, (US: Zondervan Books, 1969), reprinted 1967, which sold over 350,000 copies.

[143] Betty Friedan, nee Goldstein, 1921-2006, founded the National Organisation for Women in 1966.

[144] Meredith W. Michaels, "Feminism and Women's Nature", *The Oxford Companion to the Body*, eds. Colin Blakemore and Sheila K Jennet, (New York: Oxford University Press, 2001), 283-284.

[145] Discussed in the Role Delineation chapter(3).

allegedly extrapolates theories from dubious and often unrelated facts.[146] The social and intellectual background of Foucault's post-modernist views of the 1970s are critically analysed by Evans and also Zomera, who outline contradictions in his theories.[147] The impact of his views on some of the controversies which developed in the discipline of obstetrics are discussed in the Role Delineation chapter.

One publication in this area is Lynne McTaggart's book about doctors, written from a feminist perspective.[148] The book criticises many medical treatments including some by gynaecologists. She targets gynaecology for prenatal tests, HIV/AIDS tests, laparoscopy, biopsies, ultrasound, foetal monitoring, AFP tests, chorionic villous sampling, amniocentesis, Caesarean section, cancer screening, 'hormonal mayhem', Viagra, endometrial resection, hysterectomy, mammography, and some aspects of surgery. This type of well researched book challenges professionals to provide well balanced information to patients to guide them in making decisions, but illustrates the time management difficulties for gynaecologists in the modern world. On the other side of the picture, there is now an 'antifeminist' backlash regarding the 'sisterhood', from activists who denigrate the views of females with whom they disagree.[149]

There are significant differences of opinion across national boundaries regarding many gynaecological treatments which must be considered when treating those from other countries even within the Western block. Lynn Payer's book demonstrates that many accepted treatments in one country are not accepted in others and that cultural biases are more the rule than the exception. Mammography, the management of uterine fibroids, the attitude to removal of ovaries, consumption of alcohol in pregnancy, use of homeopathic remedies, management of breast malignancy, and approach to prolapse treatment are significantly different in the

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[146] Anna Green and Kathleen Troup, "The Challenge of Post Structural /Post Modernism", in *The Houses of History*, (Manchester: Manchester University Press, 1999), 297; See also Ann Curthoys and John Docker, *Is History Fiction,? Postmodernism and post structuralism*, (NSW: University of NSW Press, 2008), 180-205, especially 183 onwards.

[147] Richard J. Evans, *In Defence of History*, "Knowledge and Power", (UK: Granta Books, 1997), 196-203; Daniel Zomora, "Can We Criticise Foucault?", *Jacobin*, (2014), https://www.jacobinmag.com/2014/12/,.foucault-terview/ (accessed 14 January, 2015). See also John Burrow, *A History of Histories*, (London: Allen Lane), 498.

[148] Lynne McTaggart, *What Doctors Don't Tell You, the Truth About the Dangers of Modern Medicine*, (London: Harper Collins, 1996).

[149] See websites of the anti-sisterhood groups, plus articles in the popular press. See Janet Albrechtson, "Sticklers for Labels Tagged as Groupthink Suckers, Feminism has Become a Dirty Word", *The Australian*, (Wednesday, 12 March, 2014), 10.

USA, Australia, the UK, Germany and in France, and Payer claims that Evidence Based Medicine (EBM) practice has thus far made little difference.[150]

Consumerism and Changes Supported by the Discipline

Increasing feminist activism coincided with the Consumerism Movement of the time. Beder provides an overview of the movement which she states began when manufacturers began aggressive advertising after the depression.[151] In medicine the concept is different, and Torrey, who describes herself as a patient advocate, defines it as the concept of patients taking over responsibility for their own medical care decisions. She claims it marries the concepts of medical care and the patient as a consumer, and is also a 'framework for discussing blame and fraud'.[152] In Australia, the Consumers Health Forum celebrated its 25th anniversary in 2012, and claims to have effectively promoted consumer-led changes to the health care system.[153] It states that it has played a key role in establishing many Government initiatives in consumerism, but medical professionals are more familiar with its patient advocacy at the patient doctor interface.[154]

Changes supported by the discipline over recent decades were frequently initiated by consumer pressure, and the increasing impact of evidence-based medicine on obstetric practice in the latter part of the century.[155] The latter development quietly revolutionised medical practice, particularly obstetric practice, and procedures shown to be ineffective or harmful were abandoned. Changing community attitudes led to changes in the laws affecting obstetric practice, and inevitably to changes in hospital by-laws and practices, discussed in appropriate chapters. However, many other changes were significant but little publicized during the second half of the 20th

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[150] LynnPayer, *Medicine and Culture, Varieties of Treatment in the USA, England, West Germany and France*, (New York: Henry Holt, 1998).
[151] Sharon Beder, "Consumerism, an Historical Perspective", *Pacific Ecologist* 9, (Spring, 2004), 42-48.
[152] Trisha Torrey, "Medical Consumerism Definition, *Every Patient's Advocate*, (20 February, 2007), 1.
[153] Consumers Health Forum of Australia, media release, 11 October, 2012, Manuka, ACT.
[154] See discussion regarding Birth Plans and other controversial issues in other chapters; Also the Birth Wars, discussed elsewhere.
[155] See Murray Elkin, Marc Kierse, James Neilson, Carolyn Crowther, Lelia Duley, Ellen Hodnett and G. Justus Hoffmneyr, *A Guide to Effective Care in Pregnancy and Childbirth* (3rd edition), (Oxford University Press, 2000). This revolution followed post-WW2 work by Cochrane. See also Archie Cochrane, "Effectiveness and Efficiency, Random Reflections on Health Services", Rock Carling Lecture, 1972. See also, National Perinatal Epidemiology Unit, Oxford, http://ukcc.cochrane.org/our-history, (accessed 1 October, 2014).

century particularly in medical protocols. [156] Reiger wrote about the struggles of disparate groups in the community seeking changes to an authoritarian culture in hospitals in particular.[157]

Privacy and courtesy for patients were often lacking in teaching hospital practice in the earlier years, as described by Poidevin at RPAH pre WW2 war, and still unchanged when this author was a student in 1949. [158] Multiple vaginal examinations, and absence of real consent were commonplace. The practice of students examining patients under anaesthesia without their consent did not cease until the 1980s.[159] Paid surrogates have been employed in some medical schools to ensure students acquire the appropriate clinical skill.[160] Chaperones during vaginal examinations are now required by law except in emergency situations, and protect the gynaecologist from false charges of assault as well. The architecture of antenatal clinics had to change to improve patient privacy and improve communication with patients.[161] After WW2 routine antenatal care had become the rule, but the protocols used varied from practice to practice. Routine urine testing, weighing and abdominal palpation were still not rigidly enforced, as the Crown St Hospital protocols had still not become standard, mainly because continuing medical education was still in the future.[162] Attendance of partners or support persons at hospital visits became standard from the 1970s.[163] Protocols for admission to delivery suites had to change from the routine shower, castor oil, enema, suppository, and pubic shave of the 1950s and 1960s – which were all discontinued. [164] The wearing of tight corsetry during pregnancy continued until the late 1950s. [165] The importance of minimising fear during pregnancy and labour was pioneered by Grantley Dick Read (natural childbirth) from 1943, later expanded with protocols by La Boyer and Vellay in

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[156] Patrick Pietrioni, *The Greening of Medicine*, (London: Victor Gollancz, 1991), vii.
[157] Reiger, *Our Bodies Our Babies*, 37-61.
[158] L.O.S. Poidevin, *The Lucky Doctor*, 53.
[159] Discussed in the medicolegal chapter(5).
[160] See the Hunter Valley chapter(6).
[161] See the design of the John Hunter Hospital clinics, 1990, in the appendices. Also Hosplan, *Planning and Design of Maternity Units*, NSW Advisory Centre, June 1981.
[162] This author confirmed these deficiencies during an obligatory GP locum while a RMO at Royal Newcastle Hospital in 1952.
[163] See author's Memoirs, unpublished. The value of support persons during labour has been demonstrated in the literature (discussed elsewhere).
[164] The standard protocols from this author's original teaching hospital in 1955 are included in the appendices.
[165] This author's experience at Royal Hobart Hospital in 1955-56.

France during the 1950s and 1960s, which significantly altered Delivery Suite practices.[166] The importance of continuity of midwife care through labour is now accepted.[167] Other changes include antenatal preparation for childbirth classes, routine screening for metabolic and sexually transmitted diseases, detection of drug addiction, smoking and alcohol use, detailed blood group testing, obligatory carrying of an antenatal record card, and routine ultrasound screening.

In summary the previous laxities of antenatal care have changed to intensive supervision which is intrusive but believed necessary to achieve optimal outcomes. During labour the previous rigidities of positions for labour and delivery are gone, water bath pain relief is usually available, the old left lateral position for delivery went in the 1950s, and rigid protocols for the length of the expulsive stage of labour are gone.[168] Rectal examination is gone, forceps delivery has mostly been displaced by Ventouse suction cup assistance, and Caesarean section rates have gone from the early post war incidence of 1-2% to 25-35%.[169] Electronic monitoring in labour was almost routine at one stage but is now restricted to clinical indications, late clamping of the cord is routine, general anaesthesia is now replaced by regional or local blocks for most procedures and absorbable sutures replace non-absorbable.[170] Early contact of mother and baby is now routine, rooming in facilitated, anti-thromboembolic measures routine, early discharge encouraged, follow-up rigidly enforced to ensure vaccinations occur, contraceptive advice given, and liaison with the GP via a Discharge Summary is mandatory.[171] Another overdue but early change was the introduction of Bereavement Counselling for parents losing a pregnancy.[172] Benjamin Spock's books on the normal child with a change from the Victorian style

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[166] Grantley Dick Read is discussed in the Role Delineation chapter; see also Pierre Vellay, C*hildbirth without Pain*, (London: Hutchinsons, 1959), 117-154; also C. Lee Buxton, *Study of Psychophysical Methods for Relief of Childbirth Pain*, (Philadelphia: Saunders and Co., 1962), 91-94; also Buxton, *The Trained Midwife*, 81-89. Buxton analysed the 'pro' and 'anti' views regarding the presence of support persons in delivery suites.

[167] See the *Shearman Report NSW*, 1990 and the *Judith Lumley Report Victoria*, 1990, documented elsewhere.

[168] Geoffrey Chamberlain and Malcolm Stewart, "Walking Through Labour", *BMJ* 295, (3 October, 1987), 802.

[169] See "Annual Report, Crown St Hospital", *JOGBE*, (1955); see also "Type of Birth across NSW", tables 35 and 36, *NSW Mothers and Babies 2010*, (NSW: NSW Health, 2012). This will be discussed in the final chapter of this thesis.

[170] See Protocols for John Hunter Hospital as typical (appendices).

[171] Protocols, John Hunter Hospital, 2015.

[172] Beverley Raphael, "Grieving Over the Loss of a Baby", *MJA* 144, (March, 1986), 281.

disciplining also impacted on early post-delivery care of obstetric patients beginning in the mid-1950s.[173]

One important but often overlooked change during the 1950s and 1960s was a steady improvement in dental health following improvement in social conditions, and fluoridation of most of Australia's water supply. The high rate of dental caries, and the deterrent of cost meant that the negative effect of poor mouth hygiene and a high rate of dental prostheses impacted on the whole population, especially pregnant women. Australians born after 1970 have half the level of tooth decay of their parents.[174]

Australian Gynaecology in the New Era

Changes in gynaecological practice have mirrored the changes in general surgery, and significantly day of operation admission is now facilitated, major changes to day surgery for many procedures especially laparoscopic work have occurred, there is no routine shaving of perineum or abdomen before operation, and clipping hair is used to avoid skin trauma. Catheterisation occurs only after anaesthesia, the midline incision avoided by using the Pfannenstiel low transverse type for most gynaecological surgery, abdominal wall infiltration with anaesthetic agents to minimise postoperative pain is routine, routine anti emetics are used post-operation, with an intravenous drip to avoid injections, there are no rectal infusions, early ambulation and anti-thromboembolic stockings and anticoagulants are standard, endotracheal tubes have been replaced by pharyngeal airways where possible, and more user friendly absorbable sutures are standard. The protocols of 60 years ago are attached in the appendices for comparison.[175]

In terms of operative procedures, Australia has always had one of the highest rates for hysterectomy in the world and this subject has often produced controversy both in the community and within the profession. The health economics of the

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[173] Benjamin Spock, *The Common Sense book of Baby and Child Care*, (1st edition), (Sloan andPearce, 1946), ran to nine editions. The controversy arising from Spock's books and his political activities continued until his death in 1998.
[174] Australian Government, "Health Effects of Water Fluoridation", *NHMRC*, (2007), https://www.nhmrc.gov.au/health-topics/health-effects-water-fluoridation, (accessed16 November, 2015). See also Growing up in the Depression, Alan Hewson, Memoirs, unpublished.
[175] See Royal Hobart Hospital protocols from 1955 in appendices.

operation was reviewed by Garry in 2005.[176] The incidence varied from 5.4 per 1000 women in the USA to 1.2 per 1000 in Norway with 550,000 performed annually in the US, 100,000 in the UK, 60,000 in France and 30,000 in Australia. In Australia, the rates are steadily falling as distinct from other countries.[177] Ray Garry showed that the total Australian rates are now lower than most western countries and the rate of vaginal hysterectomies is much higher. The use of the Mirena IUCD is credited with helping this fall. The alternatives to hysterectomy for benign disease were studied by Nassera et al, who concluded that the more conservative approaches were usually less effective in the long term.[178] The increasing use of vaginal hysterectomy and early discharge is a factor in evolving attitudes.[179]

In terms of the management of the ageing female, the ABS database confirms that Australian are living much longer, so the number of gynaecological patients in older age groups is rising. Life expectancy rose from seventy four in 1960 to eighty four in 2011. There were over three million persons over the age of sixty five in 2011, the percentage rising to 14% in that year. The number of women over sixty five is projected to rise to four million in 2031 with the number to be between 16% and 18% of the population by 2021. The rate of increase is highest in the older age groups.[180] The older patient now occupies an increasing amount of time of the specialist gynaecologist and has deserved increasing attention in the literature.[181] Breen's multi-authored text noted that even in 1983, there were more elderly people in the USA than teenagers, and that a woman of 65 could expect to live another 18 years, and that by 2000 there would be 3.7 million women over 85. These women visit doctors more

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[176] Ray Garry, "Health Economics of Hysterectomy, Best practice and Research", *Clinical Obstetrics and Gynaecology* 19 (3), (2005), 451-465.
[177] Erin Hill, Melissa Grahame and Julia Shelley, "Hysterectomy Trends in Australia, 2000/01 to 2004/5", A*NZJOG* 50, (2010), 153-158.
[178] S. Nassera, Banu and Isaac T. Manyonda, "Alternative Medical and Surgical Options to Hysterectomy, Best Practice and Research", *Clinical Obstetrics and Gynaecology* 19 (3), (2005), 431-449.
[179] T.G. Stoval, R.L. Summitt and Bran F.W. Ling, "Outpatient Vaginal Hysterectomy", *Obstetrics and Gynaecology* 80 (1), (1992), 809; Peng Hoong Ng and Patrick Hodgson, "Early Discharge After Major Gynaecological Surgery", *ANZJOG*, 34, (1994), 474; also Shirish S. Sheth, "Vaginal Hysterectomy Best Practice and Research", *Clinical Obstetrics and Gynaecology* 19 (3), (2005), 307. See also discussion in the Hunter valley chapter(6).
[180] ABS data, http://www.abs.gov.au/ausstats/abs @ nsf/lookup/3222.Omain+features3, (accessed 2 October, 2014).
[181] Warren R Lang, "Gynecology in the Woman Over 65, Symposium", *Clinical Obstetrics and Gynecology*, (September, 1967), 443-561; Alan D. Hewson, "Surgical Problems of the Older Gynaecological Patient", (Melbourne: RACOG Resource Unit, 1985); James L Breen, *The Gynaecologist and the Older Patient*, (Maryland, USA: Aspen Publications, 1988), xv –xvii.

often than men and are hospitalised at higher rates.[182] Lebow comments that: 'we have moved from where our health concerns were the death of women in childbirth and childhood infections, to the care of the aged female.'[183] Large sections of the American literature assume that the gynaecologist is the first line carer of the ageing female, not the GP as in Australia. However, in Australia gynaecologists are becoming increasingly involved in the care of the older female and perioperative evaluation is now very important.[184]

The treatment of pelvic relaxation (uterovaginal prolapse) is a major reason for referral to the gynaecologist. This may vary from conservative (rings and pessaries and hormonal cream) to operative repair of varying types. Until the1990s use of the patient's own tissues for repair was the norm, but over the past 10 years foreign meshes have been used increasingly, and controversy regarding advantages and the risks involved has increased. High profile court cases, awards of damages, withdrawal of some meshes and actual deregistration of a surgeon has occurred.[185] The potential for long term harmful sequels led to a recent official statement from the Urogynaecological Society of Australasia warning of the problems.[186] This scenario is a typical example of the risks of using new technology in a litigious environment, and will be discussed in the final chapter.

Australian gynaecologists took a leading role in the development of Invitro Fertilisation, as outlined later in the Advances chapter.[187] The collection of human eggs by John Rock in his efforts to produce the contraceptive pill in the 1940s began trials to fertilise the eggs. Professor Carl Wood's team in Melbourne began work in 1971. Steptoe and Edwards in the UK had been working on the idea since 1965 without success. The Melbourne team actually had a successful transfer of a fertilised egg into the uterus in 1973, but due to a surgical mishap the pregnancy was lost. In

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[182] Morton A. Lebow, "A Look at Older Americans", in *The Gynaecologist and the Older Patient*, ed. Breen, (Maryland, USA: Aspen Publications, 1988), 9.
[183] Lebow, "A Look At Older Americans", 12.
[184] Bruce Leff, Colleen Christmas and Knight Steel, "Perioperative Evaluation of Older Gynaecological Patients", *Geriaric Update in Obstetrics and Gynaecology* 10 (5), (2003), 247-252.
[185] "Mesh problems", *Newcastle Morning Herald*, (16 September, 2014); Circular from Johnson and Johnson re withdrawal, March 2013; FDA comments regarding mesh, legal settlements up to US$830 millions in mass actions, http:www.drugwatch.com/transvaginal-mesh/, (accessed 21 July, 2015).
[186] *RANZCOG statement regarding mesh*, *C-Gyn 20*, March 2013; see also *Scotland NHS Executive Statement* banning the use of mesh, except in Authorised Clinical Trials, *RCOG Newsletter*, David Richmond, President, January, 2015.
[187] Douglas M. Saunders, *Fertility Society of Australia, A History*, (Cremorne, Sydney: 2013), 11-15.

1978 Steptoe and Edwards succeeded in achieving fertilisation and progress of a pregnancy to term.[188]Although that team provided little information as to how they achieved success, the Melbourne team independently also succeeded when Candice Reed was born in 1979.[189] This led to world acclaim and the subsequent explosion of IVF in Australia. From the beginning this technology was subjected to fierce criticism.[190] This came from some churches, especially the Catholic Church, Right to Life groups, Ethics committees at Monash University, some in the feminist movement, and individuals who objected to the whole principle of IVF, who queried the saving or destruction of embryos, and argued about multiple pregnancies and the possibility of manipulating the process for gain. The early work using natural cycles, before hormonal manipulation and the necessary laparoscopic collection of eggs, with many failures, made the work very stressful. Finally in Victoria very restrictive and punitive legislation was introduced in 1984 and 1985 which prohibited embryo biopsy, stem cell research and surrogacy.[191] This initially stopped IVF research in Melbourne, but it continued in other States, and Australia is now a world leader in research, legal controls, quality assurance and effectiveness of IVF programmes, with success rates of up to 40% per cycle.[192] Stem cell research is now a new frontier with use of the patient's own cells for experiments getting away from the ethical issues surrounding embryo cells.[193] Every country has struggled with legislation to deal with the ethical and moral issues surrounding IVF. A formal Canadian document produced by the Society of Obstetricians and Gynaecologists of Canada provided a balanced approach to this difficult area.[194]

Finally gynaecologists have become increasingly involved in the care of the gay and lesbian community. This group of patients have been neglected by gynaecologists until recent years, but public health physicians have begun

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[188] Le Fanu, *The Rise and Fall*, the first test tube baby, Louise Brown, 127.
[189] Saunders, *Fertility Society History*, 14.
[190] Alan Trounson, "Interview with Saunders", in *Fertility Society History*, 16-18.
[191] John Leeton, "Controversies", *Fertility Society History*, 23.
[192] Andrew Hedges, director Hunter IVF, personal communication, August, 2015. See also the Hunter IVF website, which now quotes success rates of 50% in patients under 35 years of age.
[193] National Stem Cell Foundation of Australia, "Stem Cell Research, Information", *Stem Cell Foundation*, http://www.stemcellfoundationb.net.au/about –stem-cells/stem-cell-research, (accessed 8 November, 2015).
[194] *Ethical Considerations of the new Reproductive Technologies*, Report of the Combined Ethics Committee, Society of Obstetricians and Gynaecologists of Canada, (Toronto, Canada: Ribosome Communications, 1989).

contributing to the literature and highlighting the increasing health problems of the group, contributed to by their failure to present for cancer screening and STD checks, now being attributed to their reluctance to identify their sexual preferences.[195] The frequency of bisexuality in the group is a major risk factor.

CONCLUSION

The above outline provides an overview of the challenges faced by the discipline over the past 60 years arising from changes in community attitudes, alterations to the law, and the educational explosion, all impacting on a basically conservative profession which had to review many of the practices and protocols handed down to it by its predecessors. New approaches driven by the discipline of Evidence Based Medicine added to the difficulties. There are new problems to be faced as health problems escalate in the gay community, and the indications are that the challenges will continue to increase, as the community demands more accountability and transparency, and the ethical and moral issues surrounding new technology increase. Bureaucratic intrusion into gynaecological practice is increasing, and all operative procedures and medications of doubtful efficacy are to be to be evaluated in the near future for cost effectiveness.[196] A desirable outcome would be agreement by all health professionals to accept Evidence Based Medicine outcomes to avoid controversy, so that the consumers of health care get the best value for money in health care.[197] The next chapter will address a sequel to the cultural changes in Australia; the changes in role delineation in obstetric and gynaecological care.

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[195] Tao Guoyu, "Sexual Orientation and Related Viral Sexually Transmitted Disease Rates Among US Women Aged Between 15 and 44 Years", A*merican Journal of Public Health* 98 (6), (2008), 1007-1009; See also, "Papanicolau Test Screening and Prevalence of Genital Human Papilloma Virus Among Women Who Have Sex With Women", A*merican Journal of Public Health* 91 (6), (June, 2001), 947-952; see also "Cancer Related Risk Indicators and Preventive Screening Behaviours Among Lesbians and Bisexual Women", A*merican Journal of Public Health* 91 (4), (April 2001), 591-597.

[196] Minister for Health Announcement. Inquiry into Cost Effectiveness of Health Care, 28 October 2015.

[197] Professor Max Brinsmead, personal communication to the author regarding avoidance of conflict between obstetricians and midwives, November 2014.

CHAPTER 3

ROLE DELINEATION IN OBSTETRICS AND GYNAECOLOGY: FROM DANGEROUS ISOLATION TO THE OBSTETRIC TEAM

It takes a whole village to grow a child.

Igbo and Yoruba (Nigeria) Proverb[1]

This chapter will explore the changes in role delineation of those entrusted with the care of women during pregnancy and childbirth, and the diseases of women, with particular reference to the European and especially British tradition out of which the Australian profession of obstetrics developed. Until the immediate post-WW2 period, little had changed in the roles of those concerned with the medical and nursing care of women over the previous 150 years. The framework in which they worked, their education, and the medical and nursing system, had ensured that everyone knew their role, status and the limits of their expertise and power. The wishes of patients sometimes could be ignored apart from changes at the margins, such as the site of delivery and pain relief in labour. The care of women was largely isolated from general medical care, because of the philosophy that, because childbirth was essentially a normal function, it should be in a separate category to care of the ill. So when the change from home births began, maternity hospitals developed as 'stand-alone' institutions, and midwives and doctors doing obstetrics stood apart from those concerned with treating the ill. The argument behind this is still current, and the comparative isolation of midwives and obstetricians had significant implications. Many came to believe that they did not need to become involved in broader aspects of medical care, so that they could have a much closer personal relationship with patients than their general medical and nursing colleagues. So midwives and obstetricians developed very close bonds both at the personal and professional levels. However all that was to change during the period under consideration. Every one of these assumptions mentioned was to be challenged by the explosion of knowledge in general medicine, increasing specialisation, financial imperatives, the increasing

[1] This old African proverb is explained at http://www.afriprov.org/african-proverb-of-the-month/23-1998proverbs/137-november-1998-proverb.html, (accessed 1st November, 2015).

importance of new types of health care professionals, and the rising demands and expectations of patients. Gynaecology to some extent stood apart from the 'isolationist' view, remaining a subset of general surgery.

This review is a much broader approach than the limited 'Birth Wars' concept popularised recently which assumes that the care of pregnant women is a contest or argument between female midwives and male obstetricians with the contest for power as the motivating force. [2] That debate has a well-documented historical basis, related to the emergence of the 'man midwife' in the early 18th century after the development of safer instruments to deliver infants, which remained in the hands of male doctors with a developing interest in obstetrics.[3] It is important to document briefly that era as well, because of its continuing effects on obstetric practice over subsequent decades. The rapid development of scientific medicine after WW2, the increasing safety of midwifery care, the involvement of an increasing number of other health professionals, and a greater focus on outcomes, meant that the concepts developed at that earlier time became increasingly challenged. This is a different debate to that simply concerned with the increased medicalisation of childbirth, the change from home births to hospital confinement, increased intervention rates, and the concerns regarding safety and legal issues in the 20th century. Because the various professional groups increasingly interacted in the total care of the woman, evaluating the history of the various 'carers' inevitably crossed the boundaries between the groups involved. This review will tease out the strands to ensure that the focus will remain on each group being evaluated.

Initially, some definitions are important, beginning with the traditional birth attendants who gradually metamorphosed into the professional midwives of today. The group is still very important in the Third World and is described by the World Health Organisation (WHO) as:

> The traditional birth attendant is usually an older woman, almost always past the menopause, and who must have borne one or two children herself. She lives in the community in which she practices and operates in a relatively

[2] Mary-Rose MacColl, *The Birth Wars, the Conflict Pulling Australian Women Apart*, (Queensland: University of Queensland Press, 2009), 81.
[3] Herbert R. Spencer, "The Chamberlains and the Midwifery Forceps", in *The History of British Midwifery, from 1650 to1800*, (London: John Bale Sons and Danielson, 1927), 11.

> restricted zone, usually limited to a home village. Many of her beliefs and practices are related to the reproductive cycle dependent on religious or mystic sanctions and were often reinforced by rituals which were performed with traditional ceremonies intended to maintain the balance between the absence of ill health and the state of ill health.[4]

The next group is that of the modern midwife. The role, training and, status of the modern midwife is defined in very specific terms. The international Confederation of Midwives (ICM) defines a midwife:

> as a person who has completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM essential competencies for basic midwifery practice, and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered, and, or legally licensed to practice midwifery and use the title midwife and who demonstrates competence in the practice of midwifery.[5]

The definition goes on to clarify the scope of practice, covering care during pregnancy, and delivery and post-partum care, an emphasis on education and preventive measures, detection of complications and accessing of expert medical care, as well as the sites of practice, and necessity to adhere to a code of competencies and ethics.[6] These current concepts of midwifery are a contrast to the practice of traditional birth attendants of the past, which we will now briefly explore.

The History of Midwifery in the West

The art of midwifery has a long history. O'Dowd and Philip claim that although as far back as 40,000 BC it is possible that men delivered their 'wives', by 6000 BC, women had taken over all deliveries. In 1700 BC, in the Bible, midwives had a very

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[4] M.C. Verderese, *The Traditional birth attendant and child health and family planning*, Publication no. 18, (Geneva: World Health Organisation, 1975).
[5] Nursing and Midwifery Board of Australia, Fact sheet, 2014. http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements /FAQ/Scope, (accessed 4 August, 2014).
[6] *Ibid*.

important place in society.[7] Other ancient sources record that Greek midwives enjoyed a very high social status from 800 to 500 BC. Traditional birth attendants carried out their work in the same way for 2000 years. French midwives in the 15th century were treated with great respect, and Henry VIII in Britain in 1512 passed an Act to increase the supervision of midwives. In 1513 Roslin's book on midwifery for midwives was published in Latin, just before the foundation of the College of Physicians in England in 1518.[8] The church granted licences to midwives, and between the 15th and 18th century midwives delivered royalty in Britain.

In 1720 the secret of the Chamberlain's forceps (discussed below) was divulged, thus providing a reason for men to be called to deliveries more often. The 18th century saw the foundation of the British maternity or 'lying in' hospitals, and, in 1902, the Midwives Act was passed. The Central Midwives Board was established in 1936, and the Midwives Act established a countrywide comprehensive service of well-trained qualified and salaried midwives in Britain.[9] This very brief overview does not mention many of the major controversies surrounding the topic of midwifery, but it emphasises the central position in history of women as midwives.

There was a change in attitude to the care of women during childbirth over the centuries, with Haggard criticising the attitude of the church to the subject, and others like Chamberlain, Roy Porter and Bynum taking the opposite view.[10] Blainey is positive about the influence of the church.[11] Growing urbanisation, increasing the risk of spreading infection, and continuing cultural indifference to women all increased the risks of childbirth.[12] A lack of education and illiteracy continued for centuries, and epidemics like the Bubonic plague and childbed fever devastated more closely

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[7] O'Dowd and Philipp, *The History of Obstetrics and Gynaecology*, (quoting Towler and Bramall, 1986), 167. Book of Exodus, *The Old Testament*, King James Version, 1611, chapter 1, verses 15-22; there are other references to midwives in the early Old Testament of the Bible: Genesis, 35:17; and 38:28.

[8] Eucharius Roslin, *Garden of Roses for Women and Midwives*, (Worms, 1513,but some authorities claim Strasbourg as source).

[9] O'Dowd and Philipp, *History*, 180.

[10] Howard W. Haggard, *Devils, Drugs and Doctors, the Story of Healing, From Medicine Man to Doctor*, (New York: Blue Ribbon Books, 1929), 4; Chamberlain, *Witchcraft to Wisdom*, 4-118; Roy Porter, *The Greatest Benefit to Mankind*, (Norton and Co., 1997), 129; William Bynum, *The History of Medicine*, (Oxford University Press, 2008), 24.

[11] Geoffrey Blainey, *A Short History of Christianity*, (Penguin Books, 2011), 92-107, 136, 154-159.

[12] Anne Savage, *The Anglo Saxon Chronicles*, (London: Greenwich Editions, 2002).UK up to the 12th Century. (Women were ignored).

settled communities.[13] The theories of Galen and Aristotle dominated medical thought, retarding progress until the Renaissance, when the different anatomy of the sexes was explored more explicitly.

The Chamberlains invented the obstetric forceps in the early 1600s and kept their design secret for over 100 years.[14] The availability of the obstetric forceps from 1720 coincided with important changes in knowledge due to the work of the brothers Hunter in London from 1735. William Hunter (1718-1783) established an anatomy school and spent 30 years dissecting the bodies of parturient females, publishing his work in 1774.[15] His brother John is recognised as the father of British surgery.[16] Both came from Lanarkshire in Scotland. William Smellie (1697-1763) is recognised as the father of British obstetrics, and also came from Lanarkshire.[17] It is not surprising that the impetus for change was initiated by Scotsmen, because as has been noted, Edinburgh was the centre of the Enlightenment. The new knowledge of anatomy of pregnancy, plus the availability of the obstetric forceps, meant that the male midwife could now offer a panacea for the difficult and obstructed labour, and males began to be appointed to hospitals as *accoucheurs* in Britain.[18] A whole generation of new maternity hospitals were built in Britain in the late 1700s, with male appointees, accelerating the changes.[19] Wilson argues that the changes were driven by the choices of women: 'which summoned man midwifery into being, and not the desires of medical men altering the centuries old sociocultural dimensions of childbirth.'[20]

Changes had occurred earlier in Europe. In Paris males had been appointed to maternity hospitals from the middle of the 17th century. The changes came because

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[13] Simon Sharma, *A History of Britain*, 1300BC-1600 AD, BBC Television series; Robert McCrum, William Cran and Robert MacNeil, *The Story of English*, (Middlesex, UK: Penguin Books, 1992), 6.
[14] "The Chamberlens, 1600-1728", in *Obstetric Forceps*, ed. Leonard E. Laufe, (New York: Hoeber Medical Division, Harper and Row, 1968), 4.
[15] William Hunter, *The Anatomy of the Human Gravid Uterus*, (Birmingham, Alabama: Classics of Medicine Library, 1980).
[16] John Kobler, *The Reluctant Surgeon, the Life of John Hunter*, (Surrey, UK: Heineman, Windmill Press, 1960).
[17] Baskett, "William Smellie 1697-1763", *Shoulders of Giants*, 220.
[18] Accoucheur, an alternative term for 'man midwife', who claimed superior expertise. See Porter, *Greatest Benefit*, 273.
[19] Spencer, *British Midwifery*, appendix 11.
[20] Adrian Wilson, *The Making of Man Midwifery, Childbirth in England, 1660-1770*, (Massachusetts: Harvard University Press, 1995).

there were concerns about the competence of female midwives, and males began to receive Royal patronage, so became fashionable.[21]

In Scotland changes also occurred rapidly. Up to that time midwifery had been completely the province of female midwives. McGregor summarised the situation at that time, emphasising the unsanitary conditions of domiciliary midwifery, the variability of standards, illiteracy and lack of training. A Professorial chair in midwifery was established in Edinburgh in 1726, the first in the world.[22] To Joseph Gibson, the initial appointment, goes credit for recognising that there were serious issues in the variable standards in midwifery, and he established the first School in Midwifery in the world. The Civic authorities backed his initiatives, so that midwives could not practice unless they had received training and accreditation. He also mandated that midwives and medical students were taught together, that competence in midwifery was necessary before a medical licence was issued, and wrote texts on the craft. He established a separate maternity hospital so that the pattern in Edinburgh was 200 years ahead of practice in England. [23] The discovery of Chloroform by Simpson for pain relief in labour in 1847 continued the dominance of the Edinburgh school, and the establishment of the first antenatal clinic in the world by Ballantyne in 1912 progressively enhanced the role of midwives in the discipline.[24] As was shown in Chapter Two, the dominance of Edinburgh in the establishment of the medical school of the University of Sydney was a great benefit to the Australian discipline in later decades.[25]

The period from 1800 to 1900 was a time of stagnation in obstetric care in Britain in spite of the above changes.[26] Important discoveries were occurring, notably the work of Semmelweiss (1818-1865) in Vienna (1847); Wendell Holmes in the USA (1843); Koch (1876); Pasteur (1879); and Lister in England (1866) all impacted

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[21] James Drife, "The Start of Life: A History of Obstetrics", *Postgraduate Medical Journal* 78, (2002), 311-315.
[22] Thomas N. McGregor, "The Rise and Development of the Edinburgh School of Obstetrics and Gynaecology, and its Contribution to British Obstetrics", *JOGBE* LXVI (6), (Dec, 1959), 998-1006.
[23] Spencer, *British Midwifery*, "Lying in Institutions in Scotland", 182.
[24] O'Dowd and Philipp, *History*, 619. See also Baskett, John William Ballantyne (1861-1923), *Shoulders of Giants*, 10. Midwives previous role as" homebirthers "or "care in labour " metamorphosed into the"front line in antenatal care visits" in maternity hospitals , as antenatal care became standard .See ODowd and Philipp,*History* ,84
[25] See Education chapter of this thesis.
[26] Irvine Loudon, *Death in Childbirth, Maternal Care in Nineteenth Century Britain*, (Oxford: Clarendon Press), 172-206.

on the great killer in maternity care, childbed fever.[27] Florence Nightingale's work in nursing, with its emphasis on ventilation, separation of infected from non-infected, cleanliness and better training of nurses from 1860 should have brought rapid changes.[28] However transfer of new knowledge into practice was slow. Doctors doing obstetrics in England were really general practitioners, although that term had not been invented. They belonged to the Obstetrical Society of London, but there was no group to look after the interests of the discipline, and in medical schools it was still a neglected subject, as students could practice without training in obstetrics until the Medical Act of 1886.[29] There was strong opposition by the senior physicians and surgeons of the time to the idea that doctors should engage in obstetric practice, believing it should be left to midwives.[30]

A source of major difficulty at the time was the tyranny of distance, namely transport and communication in 19th century Britain. In spite of the network of roads left by the Romans, the railroads from 1825, and the benign topography, this problem always favoured the onsite midwife. Help from a doctor with obstetric forceps depended on access over poor roads, clearly worse in country areas.[31]

The status of midwives in the 19th century is described in detail by Loudon who confirmed the difficulty of getting reliable data, mainly because most were itinerant, and often delivered just a few babies apart from their normal occupations. He concluded that midwives delivered most of the babies in the country areas, and that most doctors no matter where they were or what their label, delivered babies. He was convinced that there was already competition between doctors and midwives for deliveries. He cites a study by the Obstetrical Society of London in1860 to confirm this and records that in 890,000 annual births only 1% were in the Poor Law hospitals and 0.3% in the voluntary hospitals, the rest being home births. Of the 19,000 doctors, 8000 practised midwifery.[32] There were already claims that doctors were using forceps to get mothers delivered. Doctors were increasingly supportive of

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[27] Porter, *Greatest Benefit,* "From Pasteu r to Penicillin", 428- 461. See also Chamberlain, "Unmasking Puerperal Fever", *Witchcraft to Wisdom*, 146.
[28] Florence Nightingale, *Notes on Nursing and Hospitals*, (Birmingham, Alabama: Classics of Medicine Library, 1982), (originally London: Harrison and Co., 1859).
[29] Loudon, *Death in Childbirth*, 173.
[30] Loudon, *Death in Childbirth*, 174.
[31] See James Boswell, *Boswells London Journal, 1762-1763,* (London: Heinemann, 1950), 244, (describing a day long trip from London to Oxford).
[32] Loudon, *Death in Childbirth*, 174.

midwives being trained, following the lead of Florence Nightingale. Lobbying from the Obstetrical Society of London, the Registrar's Office and the Midwives Institute, led to the first Midwives Act, passed in 1902. The monthly Nurse was also important in obstetric care, as she came to the home and did the domestic chores, but had limited midwifery knowledge. Midwives had been poorly rewarded, and Loudon provides a scathing comment on the lack of knowledge of doctors regarding infection. The attitude of the two specialist Colleges, in Medicine and Surgery, at the turn of the century, still remained a major problem. They both opposed the teaching of midwifery to medical students, and criticised doctors who practised midwifery, in contrast to views in Scotland.[33] It is fortunate that the University of Sydney looked to Edinburgh for its medical faculty in 1882 as those clinicians brought the Scottish views regarding midwifery with them, including the importance of training in midwifery for students, and the importance of closely aligning their training with midwives. Loudon confirms that medical graduates from Oxford and Cambridge could enter practice without any training in midwifery through most of the 19th century, as only London mandated obstetric training. It was not until the Medical Act of 1886 that midwifery training became compulsory for students in England, but the training was appalling and teachers were inexperienced or unavailable.[34] The point has been made elsewhere that many of these English graduates, poorly trained in obstetrics, came out to Australia over the next three decades.

Ten new maternity hospitals were built in the 19th century across England, Scotland and Ireland. These were designed to keep maternity cases away from the general hospitals, and were funded by public subscriptions.[35] Mitton paints a depressing picture of standards, and notes the exclusion of single mothers from many facilities.[36] The Voluntary hospitals had doctors providing free services, a system which later came to Australia as the 'Honorary system', which lasted to the late 20th century. Finally the Florence Nightingale type hospital design philosophy began with

[33] Chamberlain, *Witchcraft to Wisdom*, "Battle between the Disciplines", 130-131.
[34] Loudon, *Death in Childbirth*, 191.
[35] Chamberlain, *Witchcraft to Wisdom*, 153.
[36] Lavinia Mitton, *The Victorian Hospital*, (UK: Shire Publications, 2001), 3.

'St Thomas' Hospital, in 1868.[37] These events had a marked influence on Australian medical practice as was shown in Chapter Two.

There were many changes in treatment of pregnant women in the UK in the 20th century, including a greater rate of hospital confinement**.** New maternity hospitals were still being built, including twelve women's hospitals, founded and staffed by women for women between 1872 and 1921. [38] However financial difficulties, rationalisation, and the outbreak of WW2, with associated increasing medical knowledge, led to takeovers by Government and municipal authorities, with later the overriding needs of the military. [39] Geoffrey Chamberlain refers to competition for deliveries between midwives and doctors during this period. In 1918 funds were made available to pay doctors who were called in by midwives, and midwives were paid 15 shillings for a confinement up to the beginning of the National Health Service (NHS) under the Attlee Labour Government in 1948.[40] By 1927, 15% of deliveries were in hospitals, rising to 35% in 1937. As late as 1935 the RCOG had stated that: 'Adequate provision for universal hospital confinement could only be made at great expense, and overcrowding could be a great error, so it is safer to keep hospital admission strictly for abnormal cases and to improve domiciliary service.' However, after the NHS, the trend to hospital confinement accelerated. Indeed Chamberlain emphasises that the decline in home births was primarily 'patient driven' in Britain, not by midwives or doctors who stood to lose fees.[41] The stagnation in development of obstetric services from the mid-19th century was summarised by Victor Bonney at the Royal Society of Medicine in 1919, in colourful language: 'Taking the conduct of labour in general not much more than a bowl of antiseptic stands between the practice of today and the practice of the 1860s'.[42]

So the end of WW2 came to Britain with a health care system riddled with inconsistencies, varying standards, massive financial difficulties, and archaic staffing

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[37] Walton et al eds., *The Oxford Companion to Medicine*, *Volume 2*, "Nightingale, Florence, 1820-1910, St Thomas Hospital Nurses Training School, 1868".
[38] Geoffrey Chamberlain, *Witchcraft to Wisdom*, 170, 171.
[39] Mitton, *Victorian Hospital*, 29.
[40] Porter, *Greatest Benefit*, "The Beveridge Report (the Plan for a National Health Service, 1942)", 652.
[41] Chamberlain, *Witchcraft to Wisdom*, 182-183.
[42] Victor Bonney, "Address to the Royal Society of Medicine", 1919, quoted by Chamberlain, *Witchcraft to Wisdom*, 189.

arrangements. It is not surprising that the promise of major reforms by the Labour party was embraced by the electorate at the first post-war election. The coming of the National Health Service (NHS) in 1948 caused dramatic changes in the delivery of obstetric care in Britain. All hospitals came under direct government control, and all medical and midwifery services became salaried by Government.[43] Domiciliary midwifery gradually declined, but in the 1950s some 30% of deliveries were still home births under the care of midwives or general practitioners. Those allowed to deliver at home were screened by the regional hospital, to remove as far as possible high risk pregnancies. In the Oxford Area (where this author worked in 1957-58) in 1959, 40% of patients were booked for home confinement, 40% for hospital delivery and 13% in the GP units. Domiciliary deliveries were backed by a Flying Squad service, and still in 1964 there were 79 emergency calls to home births in the year in the Oxford Region.[44] The expected continuation of home births is documented in the standard 'Maggie' Miles midwifery text of the time, with no suggestion of a conspiracy to persuade mothers to move to hospital delivery, confirming Chamberlain's statement.[45] That text remained the gold standard for the time and was used in Australia into the 1970s. This obstetric system was the one encountered by all Australian post graduates going to Britain for their obligatory training and examination after WW2, so this background is relevant to Australia. We will now move to the Australian midwifery scene.

Midwives in Australia

Our knowledge of the role and importance of midwives in the early years of the first colony in Australia (named 'New South Wales') is limited, presumably due to the low priority given to the care of women in those early years, which we have already seen in European history in previous centuries. Sax, in his overview of health care in the early colony, only mentions nursing in passing, with no mention of midwifery.[46] The limited knowledge available regarding Aboriginal birthing rituals is not directly relevant to this thesis but historians provide a confusing picture of this subject. It

[43] John Walton, Paul Beeson, Robert Scott, eds., *Oxford Companion in Medicine*, "National Health Service Acts 1946", (Oxford: Oxford University Press, 1977), 814.
[44] "United Oxford Hospitals Annual Report", Department of Obstetrics and Gynaecology, 1963-1964.
[45] Margaret Myles, *A Textbook for Midwives*, (Edinburgh: E. and S. Livingstone, 1953).
[46] Sydney Sax, *Medical Care in the Melting Pot, An Australian Review*, (Sydney: Angus and Robertson, 1972), 68.

appears that there were many different patterns across the vast continent and the tribal groupings.[47] White women in the new colony were treated by the naval surgeons. Dewdney records that when the First Fleet left Port Jackson (NSW) returning to Britain in 1788:

> It left a forlorn band of 1000 souls, and a 'national health service'. The five (naval) medical officers were to care for the health of the transportees and their guards. They were all employees of the Crown, the drugs and equipment used were supplied by the British Government and patients were not required to pay fees. But this national, or rather colonial service, was soon to be augmented by private charity and private professional practice.[48]

This led to the development of the Benevolent Society of NSW in 1813, and a detailed history of this development is outlined in Cope and Garrett's history of what became the Royal Hospital for Women at Paddington (RHW) from 1820 to 1997.[49] Forster's history provides an overview of the atrocious conditions of convict women who became pregnant, a frequent occurrence because of their sexual mores, socioeconomic circumstances of both males and females, and the gross imbalance of the sexes, with 24,960 women among a total of 163,021 convicts between 1788 and 1840. He also mentions that the first delivery in Australia on 26th January 1788 was not a convict. William Balmain (1762-1803) delivered a member of the NSW Corps, Sergeant Whittle's wife, of a son on a transport ship on that day.[50] After the landing, attempts were made to separate the convicts by gender, but most failed, resulting in many unwanted pregnancies and the development of the 'Female Factories' in the colonies, the most notorious being at Parramatta and Cascade in Hobart. Forster confirms that there was a midwife at these factories, called a 'finger smith', so they were really Australia's first maternity institutions. After delivery and recovery the women were sent out as wet nurses to the citizenry. The orphaned children were placed in orphanages. The illegitimacy rate was high. In 1810 in NSW there were

[47] Lisa Featherstone, "Birth", *Dictionary of Sydney*, http://dictionaryofsydney.org/entry/birth, (accessed 4 April, 2015). See also Ion L. Idriess, *Our Living Stone Age*, (Angus and Robertson, 1963), 4. Jilpia Nappaljari Jones, "Birthing: Aboriginal Women", AIATSIS Native Title Conference, Brisbane, 1 June, 2011, Geoffrey Blainey, *The Story of Australia's People*, (Viking, 2015), 95-99.
[48] J.C.H. Dewdney, *Australian Health Services*, (Sydney: John Wiley, 1972), 13.
[49] Cope and Garrett, *The Royal*.
[50] Frank M.C. Forster, *Progress*, 9-13. See also Michael Cathcart, *Manning Clarke's History of Australia*, (Melbourne: Melbourne University Press, 1997), 7.

5500 men, 2200 women and 2700 children, with about 50% 'illegitimate'.[51] Forster gives credit to the work of William Redfern, Australia's first real obstetrician (d 1833). He was a qualified 'Surgeons Mate' in the Royal Navy, became involved in a revolt, but was transported, and later given a pardon, but had to pass examinations, so was Australia's first graduand. He later became the most celebrated obstetrician in the colony.[52]

Dewdney describes the slow change from 'tent hospitals' to more substantial buildings in Sydney, and the later development of convict hospitals in settled areas. Paupers and free settlers were later admitted to these hospitals, which included the infamous Rum Hospital. The more affluent did not wish to enter these convict hospitals, and this need led to the development of the charitable institutions. Later these institutions had to seek Government financial help, so gradually their supervision and control improved. Dewdney also comments that expectant mothers did not expect to have a hospital delivery under supervision by a doctor, just as their forbears in Britain had decided in previous generations. However, the 'lying in home' became an alternative in the latter part of the 19th century.[53] Their variable standards finally led to legislation to licence them, led by Victoria in the Victorian Public Health Act of 1890, with NSW following in 1899. Over time most doctors became private practitioners but provided *pro bono* service to the public institutions.[54] The development of the Friendly Societies and Lodges came later, and are discussed in the medicopolitical chapter.[55] Education for medical students awaited the development of the medical schools at the Universities of Melbourne (1865), Sydney (1882) and Adelaide (1885).

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[51] See Robert Holden, *Orphans of History, The Forgotten Children of the First Fleet*, (Melbourne: Text Publishing, 1999), 1-5. He gives details of the 34 children who embarked on the First Fleet, two belonged to officers, 16 the children of Marines, two convicted, and 13 accompanying convict mothers. It is believed 27 were born during the voyage. High illegitimacy rates in the early colony were a continuation of high rates in Britain, made worse by the lack of a Catholic priest to solemnise marriage for Catholics.The lack of records of midwifery during the voyage is confirmed by Holden (pp. 111-116). See also John F. Cleverley, *The First Generation*, (Sydney: Sydney University Press, 1971), 7.

[52] Forster, *Progress*, 13.

[53] Dewdney, *Health Services*, 15.

[54] Dewdney, *Health Services*, 19.

[55] See David Green and Lawrence Cromwell, *Australia's Friendly Societies*, (Sydney: George Allen and Unwin, 1984), 217. Already in 1892, the percentage of the population covered by Friendly Societies varied from 9% in WA, to 46% in SA.

Forster also claims that there were few midwives available in the early decades, resulting in the care of pregnant women being left to untrained women. He states there was no real incentive for trained midwives to emigrate and they were seldom found among the convict women, so doctors (when available) were the ones mostly in charge of pregnant women in Australia, a situation quite different from Europe.[56] There are parallels to the situation in the USA, with increasing dominance of obstetrics by doctors, lack of training and regulation of midwives until the mid-20th century, and a rapid change to hospital delivery in the 20th century.[57]

The training of women in medical work was limited until the 1860s. Formal nursing instruction began at the Melbourne Lying In Hospital in 1862. Forster asserted that the 'monthly nurse 'developed in Victoria, when nurses with limited training contracted to care for mothers at home after delivery. Nursing instruction coincided with the establishment of the Melbourne medical school in 1862, where lectures in midwifery finally began in 1865. Female medical students became a feature of the Australian medical schools quite early, in contrast to the UK and the USA. Dagmar Berne in Sydney was the first student, did not graduate there, but later qualified in Scotland and practised in Australia from 1883. Laura Fowler graduated in Adelaide in 1891, and thirteen women graduated from Melbourne from 1889-1896. By 1900, 37 women were registered to practice including 13 with overseas qualifications, mostly from Scotland.[58]

The RHW in Paddington in Sydney played an early pivotal role in serving the needs of pregnant women. This began in 1813 as the NSW Society for 'promoting Christian Knowledge, and to provide relief for the Destitute', later replaced by the Benevolent Society of NSW. From 1820 it extended its aims 'to attend the needs of poor married women in confinement'. Originally in the heart of the city, the move to Paddington, and the change from an asylum to an infirmary is described in the Cope and Garrett history.[59] Its initial medical officer was William Bland (1789-1860) and from 1814, it grew rapidly. From 1840 the males were moved and maternity cases increased to 99 in 1860. Forster notes a major problem was that there were few

[56] Forster, *Progress*, 14.
[57] Judith Walter Leavitt, *Brought to Bed, Childbearing in America, 1750-1950*, (Oxford University Press, 1986), 5. See also, Speert, *Obstetrics and Gynaecology in America*, 9-21.
[58] Jaqueline Healy, ed., *Strength of Mind, 125 years of Women in Medicine*, (Melbourne: Melbourne Medical History Museum, 2013).
[59] Cope and Garrett, *The Royal*, 19-36.

doctors and even fewer midwives to deliver mothers over those years outside the hospitals.[60] Home birth was the norm, with family support, a nurse with minimal training, rarely a midwife with training, or the occasional doctor. There were stormy years at RHW from the 1850s, with epidemics, staff resignations, and later overcrowding due to a new policy of accepting unwed mothers. Remarkably, due to the skills of Glasgow graduate Arthur Renwick, a very low maternal death rate was achieved in the ten years to 1870, with 1118 women delivered with only three deaths.[61] In 1864, Mrs Drew was appointed as matron, and a formal course in midwifery began in the late 1870s with an overwhelming number of applicants. Medical Students from the new Sydney School came from 1888. Mrs Blundell from the Nightingale school was the next matron, and began the Nightingale principles of Nursing and training, which spread to other hospitals.[62] Training lasted 12 months, and five trained in 1888. In 1901 the hospital moved to Paddington, and from then 10 to 12 midwives graduated each year. Epidemics of infection still occurred and the hospital was closed on occasions.[63] The inherent difficulties of obstetric and midwifery practice in the community in the small isolated settlement of Sydney compared with an established city like Edinburgh has been documented by Potter.[64] It is evident that the close association between midwives and doctors in Edinburgh was in marked contrast to the independent practice of those in Sydney at that time.[65]

Communication and transport problems are mentioned repeatedly as major factors in mothers losing their lives over those decades. In 1902, the records show that there were 219 indoor births and 39 'on the district' by midwives working from the RHW Hospital.[66] One of the first antenatal clinics in the world was established at RHW in 1912, where midwives were instructed in antenatal care.[67] A

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[60] Forster, *Progress*, 15. See also, Dewdney, *Health Services*, 15, and *The Annual Reports of the Benevolent Society from 1819 to1878,* quoted by Cope and Garrett, *The Royal*, 17.
[61] Milton Lewis, "Obstetrics, Education and Practice in Sydney, 1870-1939, Part 1", *ANZJOG* 18 (3), (August 1978), 162.
[62] R. Lynette Russell, *From Nightingale to Now, Nurse Education in Australia*, (San Diego: Harcourt Brace Jovanovitch Inc., 1990)
[63] Cope and Garrett, *The Royal*, 6-7.
[64] Leslie Potter, "Independent Women: Midwives of Two Cities, Sydney and Edinburgh in Mid 19th Century", *Journal of the Royal Australian Historical Society* 101 (1), (June, 2015), 79-92.
[65] Lesley Potter, "Independent Women", 89.
[66] Cope and Garrett, *The Royal*, 14.
[67] Cope and Garrett, *The Royal*, 27.

recommendation in 1897 that Sydney have a central maternity hospital however never eventuated.

The establishment of Crown Street Women's Hospital in 1893 was followed by other obstetric facilities; St Margaret's in 1894, and Home of Hope, later South Sydney Women's Hospital, in 1893. Crown Street was founded with the specific aim of training midwives. One of its founders, Dr Graham, stated in 1898 that its aim was 'to displace these dangerous Sarah Gamps by giving the public a supply of intelligent and properly instructed obstetric nurses'.[68] By 1900 a Certificate of training became standard, and the Australian Trained Nurses Association (ATNA) was formed to provide voluntary registration as well. Dr Graham introduced a bill to formally register midwives as well in 1895, but it was opposed by successive governments. The medical profession as a whole had reservations about poorly trained midwives attempting more than they were trained for, and fears that they would take away private patients who would normally go to doctors. The Nurses Registration Act was finally passed in NSW in 1924, providing for the registration of all general, psychiatric, and midwifery nurses. Argument continued between the States as Victoria refused to certify midwives who had not done general training first, so Victoria stayed out of the ATNA organisation. Victoria required three years of general training plus six months at the Royal Women's Hospital in Melbourne as well for midwifery licensing.

Lewis provides compelling evidence that the continuing high maternal mortality in Australia up to the 1930s was not just due to poor midwifery practices, even though the large number of untrained midwives still present and practising before WW1 supervised most deliveries .[69] After WW1 the number of deliveries carried out by midwives dropped. In 1901, only 10% of midwives were trained, and by 1930, 90% were trained but the maternal mortality stayed high. After the war, doctors delivered many more mothers. It was estimated that in the 1870s, two out of three deliveries were in the home by midwives, mostly untrained. [70] In 1914 many babies were still delivered by midwives, 401 out of 826 births.[71] After that the percentage by doctors rose and in 1914 in Sydney, it was 58%. But maternal

[68] Milton Lewis, "Obstetrics, Education and Practice", 162.
[69] Milton Lewis, "Obstetrics, Education and Practice", 165-168.
[70] J. Faithful, "Letter to the Editor", *NSW Medical Gazette* 4, (1874), 289.
[71] J.S. Purdy, *Medical Journal of Australia* 1, (1921), 39.

mortality rates remained very high in Australia in the 1920s and early 1930s, and Loudon is convinced that this was due to poor obstetrics by many GPs, post-partum sepsis, increasing virulence of the streptococcus, and eclampsia. But most importantly there was a major rise in deaths from criminal abortion, up to ten times the rate in the UK. He found no evidence that the rise was due to the trend to hospital confinement as often alleged.[72]

Basic knowledge of the mechanism of transfer of infection had confirmed that childbed fever was due to an 'infection carrying' attendant, not from mother to mother. Certainly the medical profession had to share the blame for the continuing high death rate. Morris, in 1925, criticised the way obstetrics was being practised, citing traumatic interference, operating on infected patients, not using consultants, not dealing quickly enough with complications, and asepsis failures.[73] This was a worldwide problem at the time.[74] Lewis has some serious criticisms of obstetric practice from the 1920s onwards.[75]

Featherstone's thesis, which provided a discourse analysis on the changes affecting obstetric and midwifery care from 1880 to 1925 in Australia, was wide ranging and filled a gap in the literature. She ascribed the literature deficit to the low priority given to the health care of women by historians over the decades prior to WW2, a view strongly supported by this thesis. Her thesis, among other things, explored the feminist view of the reasons for this neglect. While referring to the knowledge /power theories of Foucault and other postmodern writers, she pointed out the potential error of attempts to simplify the complex situation of childbirth in the global sense while ignoring the views of individual women.[76] It had been postulated that the change from home births to hospital deliveries was mainly due to male domination, and the desire to increase the control of women's bodies by changing the natural process of birth into 'a male doctor controlled artificial process', eliminating the female midwife role in the process.[77] However, Featherstone deconstructed some feminist notions about doctors and medicine as the enemy, and depicted them as

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[72] Loudon, *Death in Childbirth*, "Abortion in Australia", 473.
[73] E.S. Morris *Medical Journal of Australia* 2, (1925), 301.
[74] R.S. Hooker, "Maternal Mortality in New York City", *Commonwealth Fund* (report), 1933.
[75] Milton Lewis, "Obstetrics, Education and Practice", 167.
[76] Lisa Featherstone, "Breeding and Feeding", 2003.
[77] See Michel Foucault's writings on these issues.Michel Foucault, *Stanford Encyclopedia of Philosophy*, (especially on Discipline and Punishment and the History of Sexuality), At http://plato.stanford,.edu/entries/foucault/, (accessed 18 November, 2015).

'people of their time'.[78] Featherstone's article in *Birth* comments on male machination, but again criticism is more nuanced.[79]

While some feminists' views on this issue are understandable, they should be measured against other evidence, including the fact that there was trenchant criticism of obstetric practice from within the profession itself at that time, as just discussed.

However it is obvious that the massively disadvantaged and neglected women of both early and late colonial times suffered discrimination, and have also been poorly served by most historians, even though it remains difficult for this author to reconcile Foucauldian theories with the recorded obstetric history taken from hospital, medical and midwifery records of that time. Some writers also saw the changes as part of a national movement to deal with the need to increase the white birth rate.[80]

Ignorance of midwives and doctors, self-interest, and the continuing myth that childbirth was essentially a safe natural event, appear to be more likely culprits of the tragedies of childbirth at that time. Kerreen Reiger's text covering 1880 to 1940 stands out as a balanced non-medical assessment of the competing views of the time, noting that many doctors genuinely wanted to improve the safety of childbirth; others had a selfish pecuniary interest; enlightened midwives were striving for higher standards; mothers were becoming more aware of the dangers of childbirth; but the community was often unwilling to face reality and even opposing reform.[81] Reiger's later publication, *Our Bodies Our Babies,* is also an excellent overview of competing views.[82]

The gaps between the leading medical knowledge and the average country practitioner are supported by doctors' accounts of the time. Doctors who had served in the armed services in WW1 and survived, acquired enormous practical experience in fields other than obstetrics which they brought back into practice, many becoming

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[78] Lisa Featherstone, "Breeding and Feeding", 412.
[79] Lisa Featherstone, "Birth", *Dictionary of Sydney*, 2008. Michel Foucault's work on Power and Control is still controversial, and it is difficult to find intellectual support for his views on its application to Midwifery practice in standard texts. See Ruth Bennett and Linda Brown, *Myles Textbook for Midwives* (13th edition), (Edinburgh: Churchill Livingstone, 1999); Louise Silverton, *The Art and Science of Midwifery* (Royal College of Midwives), (Hertfordshire, UK: Prentice Hall, 1993); Margaret Miers *Gender Issues and Nursing Practice*, Sociology and Nursing Practice Series, (London: Macmillan Press, 2000), 118.
[80] Lisa Featherstone, "Breeding and Feeding" 13.
[81] Reiger, *Disenchantment*, 84-105.
[82] Reiger, *Our Bodies, Our Babies.*

leaders in the profession. Some obtained higher degrees as well and took their skills to the country, particularly in Surgery. David Browne's book on his experience in country Victoria after acquiring a Surgical Fellowship after WW1 is enlightening.[83] His traumatic experiences in trying to bring new knowledge in obstetrics to his town, introducing antenatal care, and being obstructed by an untrained midwife and a blinkered semi-isolated community, make compelling reading. An episode in which the community opted for a better football stadium rather than getting a small hospital established was extremely traumatic, and almost caused him to leave the town.

Walter Pye in Scone NSW provides another contemporary story.[84] The insularity of the isolated communities, extreme retiscence in discussing female and pregnancy problems, and the sequels provide a fascinating insight into country obstetric practice. These accounts accord with the information provided by Lee in NSW over the same timeframe and are discussed in the Hunter Valley chapter.[85]

The combination of ignorance, poor transport, and poor communication was almost certainly an Australia-wide phenomenon during the 1920s and 1930s and contributed to the continuing high maternal mortality particularly in the country areas. Loudon commented on the maternal mortality figures in Britain and Australia, with the rates higher in Australia than Britain in 1887, but with the rates in general running parallel. Between the late 19th century and early 20th it declined slightly, reaching 48.3 per 1000 births in 1912 in Australia but climbing to 59.8 per 1000 by 1936, then falling steeply. Loudon comments critically on the disarray and varying standards across the States regarding midwifery training, legislation, and licensing between the World Wars, and notes the increase in nursing home deliveries and increasing involvement of doctors.[86] Morris was also extremely critical of GP obstetric practice at that time, stating:

> In the practice of midwifery there seems to be an unwritten law that every medical man who considers himself competent should be prepared to

[83] David D. Browne, *The Wind and The Book, Memoirs of a Country Doctor*, (Melbourne: Melbourne University Press, 1976), 34.
[84] Leslie Poidevin, *Come in Doctor, A Country Practice Revisited*, self-published, 1990, 69.Walter Pye was a legend in his own lifetime, having begun GP practice with a Surgical Fellowship in Scone 1934 and staying for 40 years .
[85] Michael Lee, "A Disgrace to Our Civilisation: Mothers, Miners, and the Commemoration of Mortality in NSW", *Illawarra Unity –Journal of Australian Society for the Study of Labour History* 4 (1), 2004, 3-28.
[86] Loudon, *Death in Childbirth*, 469-473.

> manage successfully, and generally single handed, each and every serious obstetric operation compared with which from the point of danger, the majority of surgical operations dwindle into insignificance.[87]

He also noted that the forceps rate was much higher in home deliveries than in the larger maternity hospitals looking after more high risk cases, and Constance D'Arcy and Halford were also highly critical of medical practice of the time.[88] Loudon concludes a major problem was a poor standard of obstetric education in Australia, including a lack of knowledge of the risks of operative delivery in home births.[89]

From 1930 onwards, the major move from domiciliary to hospital confinement in Australia had a marked effect on midwifery theory and practice which has continued to the present time. The foundations for modern midwifery training had been laid down, certification and registration were legislated for, and the basis for modern obstetric care was in place by 1930. Home births became less common, and most midwives apparently accepted that their role would henceforth be primarily in the hospital system.[90] Concurrently doctors doing obstetrics in Britain and later in Australia began to separate themselves out from the previously all-embracing medicine and surgery. In Britain the Royal Colleges of Physicians and of Surgeons continued to oppose this development for a further ten years after the formation of the Royal College of Obstetricians and Gynaecologists in 1929 (see the Education chapter, footnote 66??). In Australia, although individuals began to join the new British College, it was not an official entity until the formation of the Australian Regional Council of the RCOG in 1946. These developments progressively changed the whole dynamics of obstetric care, and led to clarification of the role of the specialist obstetrician in the second half of the 20th century.

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[87] E. Sydney Morris, "An Essay on the Causes and Prevention of Maternal Morbidity and Mortality", *MJA* 11, (1925), 319.
[88] Constance Darcy, "The Problem of Maternal Welfare", *MJA* 1, (1935), 385; A. Halford, "Maternal Mortality", *MJA* 1, (1935), 34.
[89] Loudon, *Death in Childbirth*, 471.
[90] See "Nursing in the 1960s: The Ward Sisters Were Pretty Fierce", *Nursing Times*, (4 February, 2008), (a UK series looking at the NHS 60 years ago).See also Audrey Armitage, *A Golden Age of Nursing, RNH ,1891-1991*,The Postwar Years, 105-161: which describes the transition from old style nursing and midwifery' training' to 'educated professionals' with expanding activities solely directed to scientifically based patient care , with the non- nursing duties removed.

Specialist Obstetricians and the Role Delineation of Midwifery

The specialist obstetrician of today is defined by the education and training received at tertiary level, and their now established place in the matrix of health care. Excellence at entry level as an undergraduate is demanded, followed by at least five years of general medical education in schools accepting direct secondary school entry, or a total of seven years of tertiary education including four years of medical study in graduate entry programmes. This is followed by at least two years of general medical training in hospitals under supervision. Entry to specialty training is a competitive process with limited spaces available. Another five years of specialty training in hospitals under supervision follows, with formative assessments throughout and summative evaluation at conclusion, including the Objective Structured Clinical Evaluation (OSCE) examination to ensure competence at the practical level. Log books of experience acquired, and certification by supervisors are necessary, before the trainee is certified to have the knowledge, skills and attitudes to safely care for women in all age groups, including pregnancy care, with the average age of 30 years on completion of all basic training.[91]

The significant difference between the education and training of the specialist obstetrician, compared with the three years of general nursing plus just one year of midwifery for the modern midwife after secondary school education, and a different mindset regarding the management of labour, is one of the reasons why there will always be different skill sets and ethos between the two professional groups. The potential gap is even greater with the recent pathway to allow 'direct entry' midwifery nursing training without any general nursing training, and a University curriculum in midwifery nursing which has a limited hospital practice component and varying protocols.[92] This is the reason why their different skills should always be complementary and why teamwork has become the agreed goal of the formal

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[91] "Obstetrics and Gynaecology Specialty Profile, Training Requirements, Integrated Training Programme", *Careers in Medicine* (15th Edition), (Newcastle: HPMI, University of Newcastle, 2011), 106-110.

[92] *Australian College of Midwives*, "So you want to be a midwife? Listing of the wide variety of qualifications backgrounds, training protocols, practice environments, tuition plans, length of courses, questions which should be asked, and organisations to be consulted by the prospective entrant to midwifery training", http://www.midwives.org.au/scripots/cgiip.exe/WServiuce=MIDW/ccms.r, (accessed 12 June, 2015). See also, Parkland School of Nurse Midwifery, *The History of Midwifery (USA)*, http://www.swmed.edu/homepages/parkland/midwifery/txt/mdwfhisorytxthtml, (accessed 19 July, 2014).

organisational bodies controlling the disciplines in modern units.[93] In the USA the term 'nurse–midwife' is often used to make the distinction between the nursing professional and the medical professional in obstetrics.

The increasing numbers of trained obstetricians after WW2 led to increased stratification in major teaching hospitals where all midwives received their training, so that some of the training of midwives became part of the duties of specialist obstetricians. This was inevitable given the comparative professional isolation of most maternity care hospitals with their own medical and nursing staff. This involved formal lectures and tutorials and supervision in the antenatal and gynaecological clinics as a supplement to education by Tutor Sisters in midwifery. The texts for midwives written before WW2 reflected the overwhelming importance of good nursing care which was so often vital to recovery in the years before safe surgery and specific effective medications. These were supplemented by texts or notes usually written by obstetricians. This system became entrenched in the decades of the 50s, 60s, and 70s until nursing education moved from the hospital to the University.[94]

The interim period between home birthing and hospital delivery included the development of nursing homes owned and run by midwives, seen as an alternative to hospital births. The increasing preference of mothers for hospital delivery exceeded the availability of beds, and the problem was exacerbated by the baby boom after WW2. However this type of care was countrywide and described in books written by doctors in practice at the time, and local historical museum records, as the norm.[95] Midwives were authorised to carry out normal deliveries by the Nurses Registration Board from 1940 to 1960, but they had arrangements for a doctor to be available if needed and local doctors also delivered their own patients in these facilities. This phase in the midwives' role also gave them the opportunity to develop commercial enterprises which was unusual in the society of the time, when women were usually denied access to this type of activity and usually sacked from employment once they married.[96]

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[93] The RANZCOG and the Australian College of Midwives. See chapter 1.
[94] Typical examples are quoted in the Hunter Valley chapter.
[95] See Browne, *The Wind and the Book*, also Poidevin, *Come in Doctor*, "The Lying in Nursing Homes in Singleton", (Singleton Historical Museum) as typical examples.
[96] Reiger, *Disenchantment*, l. See also Paula Watts and John Ramsland, "Midwifery in the Lower Hunter River District 1940-1960", *Journal of the Royal Australian Historical Society* 88 (2), (December, 2002).

Sociology and its interaction with nursing now became an important issue and has particular implications for midwifery. Dependence, autonomy, changing professional roles, and gender issues increasingly intruded into midwifery as the necessity to be involved in the team approach to care became important. However debate about these sociological issues is not new. The attitude and forcible arguments of Florence Nightingale in the 1860s and beyond would put her in the camp of 'aggressive feminist' thought of the later decades, as she challenged many of the male shibboleths, stereotyping and denigration of females prevalent in that generation. She is now universally admired as being decades ahead of her time in her social and philosophical thinking, as well as in purely nursing matters.[97]

Bevis discussed philosophical issues in nursing, and her views are ventilated in Capper's Nursing Education thesis.[98] Bevis believed that four basic philosophies existed in nursing: asceticism, romanticism, pragmatism and humanistic existentialism, and that at different times, one or the other became dominant.[99] Capper believes that pragmatism became dominant after WW2, leading to concentration on practical task orientation because of the shortage of nurses, so education was down-graded for some time, a problem also discussed by Heath.[100] However the close relationship and interaction between the British and Australian obstetric care systems during and immediately after WW2 is also a factor in the sequence of events addressed in this chapter, especially the change from home births to hospital delivery. There were marked differences in the two countries in the overall medical systems, which are discussed elsewhere, and the change from home to hospital births occurred much earlier in Australia. In the Nationwide Birthday Trust study in 1958 in Britain, still over 30% of deliveries were at home.[101] But among all the recommendations arising from that enquiry there was none pressing for universal hospital delivery, nor did the *Second Report on Perinatal Mortality* in 1969, nor the

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[97] Monica Bailey, *As Miss Nightingale Said*, (London: Baillierre Tindall, 1997).
[98] Betty Capper, "The History of Nurse Education at the Royal Newcastle Hospital, 1870-1985", Masters thesis, University of Newcastle, 1990.
[99] Em O. Bevis, *Curriculum Building in Nursing, A Process*, (St. Louis: C.V. Mosby Co., 1978), 33.
[100] See also Patricia Heath, *National Review of Nursing Education Discussion Paper*, Canberra, ACT, December, 2001.
[101] Neville Bonham and Denis Bonham, *Perinatal Mortality, the First Report of the British Perinatal Mortality Survey*, (London: E. and S. Livingstone, 1963).

Report on maternal mortality in the same decade.[102] In contrast, by that time, as in the USA, the great majority of deliveries in Australia were already in hospital.[103] In Victoria in 1925, 67% of patients were already delivered in hospital.[104] Loudon also stresses the enormous differences between the USA midwife and her British and Australian counterparts, with major differences in training and expertise across the USA.[105] Already experts like De Lee (1869-1942) from 1921 were advocating routine forceps delivery for all patients.[106] Loudon contrasts the interventionist approach of De Lee in Chicago with the ultraconservative non- interventionist approach of Whitridge Williams (1866-1931) from Johns Hopkins.[107] They were both stridently anti-midwife and saw no place for midwives in obstetric practice, whereas British and Australian practice has always been 'pro-midwife' involvement in obstetrics.

Many authors stress pain relief in labour as one of the major drivers towards hospital confinement over this timeframe, while others hardly mention it. All standard texts in obstetrics devote major sections to pain relief, and Simpson's discovery of the effects of Chloroform in 1847 is credited with being one of the great leaps forward in obstetric care in the 19th century, particularly after being popularised by Queen Victoria, who in 1853 allowed John Snow to use it during the birth of Prince Rupert. As Loudon comments 'she knew all about the pain of labour and so the method of pain relief became Chloroform a la Reine'. The whole subject of pain relief in labour deserves more space than is possible in this thesis, but it appears to be a 'blind spot' in home birth literature. Giving the labouring mother the right to make her own decision about pain relief seems a fundamental right, but the options are very limited in the home birth situation and can be a problem for a midwife supervising birth in

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[102] *Report on Confidential Enquiries into Maternal Deaths in England and Wales1958-1960*, (London, Her Majesty's Stationary Office, 1963).
[103] ABS Data, "Home Births in Australia". Percentage fell from 30% in1960 to 1% in 1976: https://www.google com.au/blank.html, (accessed 8 December, 2015); Judith Walzer Leavit, *Brought to Bed, Childbearing in America, 1750-1950*, (Oxford University Press, 1986, 5). An American perspective on this critical period of change is contained in Leavit's work and the changes and the criticisms are the same.
[104] Loudon, *Death in Childbirth*, 466.
[105] Loudon, *Death in Childbirth*, 297- 300: "The midwife in the USA was all but abolished by the end of the Second World War."
[484]. J.B. De Lee, "The Prophylactic Forceps Operation", *American Journal of Obstetrics and Gynecology* 1, (1920), 34, quoted by Loudon, *Death in Childbirth*, 354.
[107] Loudon, *Death in Childbirth*, 353-357.

isolated circumstances. It is not a simple matter, as Caton's text demonstrates.[108] As an anaesthetist, he attempted to analyse the complex social, psychological, and intuitional influences which can have major effects on the individual patient and their attitude to labour pain.[109] He outlines Simpson's unsuccessful search for an alternative to Chloroform, driven by the discovery of its occasional deadly cardiac toxicity. Surprisingly, it continued to be used in Australia, and was still in use for deliveries when this author was a student in 1949. The complex issues of Nitrous Oxide inhalation, Trilene, the place of parenteral injections of analgesics and their dosage, and which health care professionals should have the authority to use them, add another layer of complexity and potential conflict to the issue of roles in obstetric care.

Education and training for midwifery and gynaecological nursing from 1950 to 2010 became more organised and regulated. As there was little opportunity and demand for delivery outside the hospital system, midwives now mostly stayed within it. This did not lead to a diminution of their role and expertise as they remained essential to the provision of both inpatient and outpatient care. The education explosion after WW2 impacted on nursing of all types, necessitating increases in their theoretical and practical knowledge base, and managerial skills. The knowledge standard in gynaecology had been set by texts written for nurses by leading gynaecological surgeons in the previous decade, an example being Comyns Berkeley's text in 1945, with exhaustive detail, illustrations, and examination questions after each section.[110]

The standard text from the mid-20th century was the British text by Margaret Myles published in 1951.[111] Her Scottish background was an obvious advantage. Its scope was impressive, practical issues were highlighted, as nursing was still taught under the apprenticeship system both in the UK and Australia, and its popularity

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[108]Donald Caton, *What a Blessing she had Chloroform, the Medical and Social Response to the Pain of Childbirth from 1880 to the Present*, (New Haven: Yale University Press, 1999), preface, x.
[109] Julie M. Fenster, *Ether Day, the Strange Tale of America's Greatest Medical Discovery and the Haunted Men Who Made It*, (New York: Harpur Collins, 2001). Fenster's *Ether Day* provides another perspective on this subject.
[110] Comyns Berkeley, *Gynaecology for Nurses and Gynaecological Nursing*, (London: Faber and Faber, 1945).
[111] Myles, *Textbook for Midwives*.

lasted for decades.[112] The book was supplemented by tutorial notes published by the teaching hospitals, used by medical and nursing tutors and lecturers. The former usually gave ten lectures per term, as well as doing practical tutorials in the antenatal clinics wards and labour wards. For 40 years after 1940, this teaching was provided free of charge by obstetric consultants, in the same way as they provided free tuition to registrars and junior hospital medical staff.[113] This system produced a very close working relationship between medical and nursing staff which lasted throughout their future careers. It could be criticised as being overly hierarchical, didactic, and rigid, like many other aspects of society of the time, but the development of a co-operatively close relationship did have great benefits. The publications by the senior nursing staff of Royal Newcastle Hospital covering that era are a convincing testimony to the 'team spirit' engendered by the system, but histories of other obstetric teaching hospitals of the time confirm this view.[114] The pros and cons of the compulsory 'living in' requirement for trainees, the requirement to not marry, and the restrictions on individual freedoms from the 19th century up until the early 1970s, are outlined in the Capper thesis. Capper also covers the acceptance of males into nursing from the early 1970s, and the increasingly important role of Tutor Sisters which again brought major changes. [115]

The training for general nurses lasted for four years until 1969 when it altered to three years, and midwifery nursing took another year full time.[116] So all of the midwifery trainees were already 'Sisters' with considerable clinical experience and status when they came to the obstetric staffs of the hospitals over that timeframe, and had experience of administration, medication regulations, staff management and liaison with other staff. Gearside confirmed that some nurses later on were allowed to do midwifery training without a general certificate but were called 'midwifery nurses'

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[112] Bennett and Brown, *Myles Textbook for Midwives* (13th edition) was published in 1991 by Churchill Livingstone, Edinburgh.

[113] Jack R. Elliott, *RNH Midwifery Lecture Notes*, 1951, was a typical example at Newcastle, covering 53 abnormalities of pregnancy and 57 on manipulative obstetrics, and was used by junior medical staff as well.

[114] *Reminiscences of the Royal*, RNH Heritage Committee, 1997, see also Audrey Armitage, *A Golden Age of Nursing, The Royal Newcastle Hospital 1891-1991*; Cope and Garrett, *The Royal*; Susan Marsden, *The History of Crown Street Womens Hospital* (in press); the Womens Hospital Melbourne (*Sex and Suffering*).

[115] Beryl Gearside, First Tutor in Midwifery, RNH from 1957, personal communication, 2014.

[116] See Capper, "Nurse Education", 199, for an overview of the changes following the Sax Enquiry of 1978.See also Marion Watson, *Newcastle Regional Nurse Training Council and Regional School of Nursing* 1972-1986 covering changes in a region.

and not sisters at the completion of training. This has relevance to a later modification to midwifery training at the College of Advanced Education (CAE). Gearside also commented on the enormous experience acquired by trainees at that time, related to the almost universal public hospital deliveries for both public and private patients up to 1980, the degree of delegation of responsibility to midwives, and the long working hours.[117] It was inevitable that new texts would be developed by local expertise in the new generation of nursing teachers being appointed to educate those entering the nursing profession and being taught in the Colleges of Advanced Education. These teachers were required to have tertiary degrees in education as well as experience in nursing. A *Nursing Procedures Manual* was published in 1972, relevant to all branches of nursing.[118] Within the decade another document was produced by the NSW Midwives Association of a high standard and specifically aimed to provide a text with a distinctly Australian perspective on midwifery practice.[119]

There were many changes in general nurse education from 1955 to 1970 including alterations to the curriculum, a gradual change of teaching and tutorial duties from medical staff to the increasing number of qualified tutor sisters, and an increasing prominence of formal theoretical education in the life of all nurses.[120] However in midwifery training, obstetricians were still involved in giving formal lectures as well as 'on the job' tuition during the 1970s. They were still setting examination questions and giving special tutorials to trainee midwives studying for the NSW midwifery examinations. This era only came to an end in 1981, when the position of Chief Examiner in Midwifery (then occupied by the author) was abolished, and the examination system came entirely under the jurisdiction of the nursing profession through the Nurses Registration Board without any direct input from the medical profession.[121]

Another milestone in nursing education was the *National Review of Nursing Education* in 2001, which built on the findings of the Sax Committee of 1978, and the

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[117] Capper and Gearside, personal communications 2014, re roles of Enrolled Nurses, Nursing Aids, and Casual Nurses at that time.See also *Reminiscences of the Royal*, (Newcastle: RNH Heritage Committee, 1997), the Doctors, 16-17.
[118] *Nursing Procedures and Instruction Manual,* (Hunter Valley Region: The Newcastle Regional Nurse Training Council, May 1972).
[119] *Review for Student Midwives*, NSW Midwives Association, (Sydney: W.B. Saunders, 1982).
[120] Capper, "Nurse Education", outline.
[121] Chief Examiner in Midwifery NSW, 1979-1980-1981, an appointment abolished in 1981 as part of the role changes in Midwifery.

1994 *Review of Nurse Education* in the higher education sector, which looked at the early results of the transfer of teaching to the Education sector in 1983.[122] Capper describes the early development of scholarships for nurses to proceed to postgraduate degrees in nursing from 1959. Nurses later proceeded to Bachelors, Masters and Doctorate degrees in nursing, curriculum development, and related issues, but it took time for administrations to recognise that educational priorities should be placed before service needs. Sister Gearside, the first accredited Midwifery Tutor sister in Newcastle from 1956, was responsible for writing the midwifery curriculum, later approved by the Nurses Registration Board.[123] Academic Departments in Universities covering general nursing and midwifery developed from the 1980s and now virtually all Universities offer academic degrees in both aspects of nursing, separate from the Medical faculties.[124] Study online is also possible with an appropriate website. Newcastle was one of the first to develop an Academic Midwifery Unit, and Marilyn Fourier, from the Mater Hospital unit, later moved to an academic chair in New Zealand, and then to the University of Technology in Sydney, after doing a PhD at the University of Newcastle in 1984.[125]

This change further expanded the role of midwives as professionals. These Departments maintained their own identity within the larger Divisions of Faculties of Health in many Universities. In the fullness of time midwives and general nurses came under the Australian Health Professional Registration Authority (AHPRA) umbrella.[126] The rapid development of new hospital units such as Intensive Care and oncology nursing posed challenges to gynaecological nurses, and the specialised areas of IVF and Ultrasound impacted on the discipline and its nursing arm.[127] Australia was a leader in many of these fields, and all required adoption of new nursing technology and knowledge, again altering the role of midwives.

There has been considerable debate regarding the effect of the newer educational approaches in nursing and midwifery which remove trainees from the

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[122] *National Review of Nursing Education*, Discussion Paper, December 2001, Commonwealth of Australia, Canberra.
[123] Beryl Gearside, letter to the author, May 2015.
[124] Australian College of Midwives, "So You Want to be a Midwife?", http://www.midwives.org.au./scripts/cgiip, exe/WService=MIDW/ccms.r, (accessed 12 June, 2015).
[125] Marilyn Foureur, personal communication, April 2014. See information in the Hunter Valley chapter and in the Bibliography.
[126] See the Medico Political chapter.
[127] Douglas Saunders, *The History of IVF in Australia*; also Malcolm Coppleson /Bevan Reid, "Advances" chapter, Garrett and Kossof, RHW.

hospital environment for most of their training. As a result, clinical experience is much less than in the old apprenticeship model. It is ironic that at the same time that medical students were given much earlier contact with patients (from their first year) in the late 1970s, nursing trainees were taken out of the hospitals into the University and direct contact with patients became much less.[128] The teaching of midwifery was now completely controlled by the academic Nursing Faculty but with blocks of practical experience throughout the course. There is recognition of the potential risk of inadequate practical exposure.[129] A more significant criticism of the modern midwifery training relates to some schools increasing the prominence of a radical feminist view into teaching which, whatever its theoretical value, potentially alienates graduates from their lifelong working colleagues in obstetrics.

The Emergence of the Team: Other Health Professionals Involved in the Care of Women

Physiotherapists became more involved in the care of antenatal patients in particular following the work of Grantley Dick Read in the 1940s. Read's book on childbirth had a marked impact on the thinking and approach of both midwives and obstetricians in preparation for childbirth.[130] Antenatal classes, already well established, became more important but because physiotherapists had the expertise to teach abdominal and pelvic floor exercises, they initially became much more involved than midwives. Physiotherapists had been involved in this field for over 20 years, with Randell's text first published in 1939.[131] The book included many innovative ideas, including involvement of husbands in the labour wards. Read proposed the concept of relaxation to minimise pain and fear. Fernand La Maze, Pierre Vellay, and Odette in France in 1958 expanded on these ideas and Buxton in the USA provided a

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[128] See the Education, Hunter Valley, and Social changes chapters.

[129] Kathleen Fahy, "Sense of Connection", *UNINEWS, Newcastle,* (October, 2002), 7. See also, Steven M. Kelly, "A Descriptive Analysis of the Influences on Learning for First Year Graduate Nurses", thesis for degree of Bachelor of Educational Studies, University of Newcastle, 1992.

[130]Grantley Dick Read, *Revelation of Childbirth,* (London: William Heinemann, 1943);.*Childbirth without Fear*, (New York: Harper, 1944); *Introduction to Motherhood*, (London: William Heinemann, 1950).See also Thomas F Baskett ,*On the Shoulders of Giants*, Read, Grantly Dick 1890-1959"Natural Childbirth":which provides an overview of his life.

[131] Minnie Randell, *Training for Childbirth, From the Mother's Point of View* (3rd edition), (London: J. and A. Churchill, 1943), (dedicated to Barbara Thomas, a masseuse, Sydney graduate killed in the Blitz).This booklet written by a London physiotherapist had a major impact on antenatal care.

comprehensive overview of the whole field in 1962.[132] It is too simplistic to simply categorise all these methods as primarily physiotherapy as Buxton's review makes clear. There is evidence that these approaches can reduce the need for analgesic drugs for pain relief, and that mothers appreciate the confidence they can engender.[133] However the wide variability of methods, and the difficulty of comparative evaluation, have always made effectiveness difficult to assess.

Hypnosis has also had advocates for decades, but remains controversial. There has been only one randomised trial of hypnosis in labour and there was no difference between the experimental and control groups.[134] The Active Management of Labour has advocates, and is summarised in a text on the subject.[135] Kieran O'Driscoll and the National Maternity Hospital Dublin have been strong advocates since 1958 and produce excellent results but the methods have not been widely adopted.[136]

Immediately before and after WW2 the general practitioner was the major provider of obstetric care for the Australian population. Professor Mayes' Bulletins on the management of major obstetric complications in 1944 to help returning ex-servicemen provide complete obstetric care for their patients, were based on the assumption that they would not have specialist help, and provide a window on obstetric practice of the time.[137] Australia's geography probably encouraged the medical schools to continue their commitment from the 1940s to the late 1960s to include a significant component of obstetric training for undergraduates, pending a movement of obstetricians into the provinces. The Hunter Valley chapter graphically illustrates changes in the years from 1955 to 1990, showing the gradual displacement of general practitioner obstetricians by specialists in spite of efforts to keep them in the obstetric workforce. This dilemma in general practice was foreseen years

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[132] Pierre Vellay, *Childbirth without Pain*, (trans. Denise Lloyd), (London: Hutchison, 1959); C. Lee Buxton, *A Study of Psychophysical Methods for Relief of Childbirth Pain*, (Philadelphia: W.B. Saunders, 1962).

*[511]133 Murray Enkin, Marc J.N.C. Kierse and Iain Chalmers, *A Guide to Effective Care in Pregnancy and Childbirth Antenatal Classes*, (Oxford University Press, 1990), 25.

[134] Enkin et al., *Effective Care*, 218.

[135] Kieran O'Driscoll and John M. Strong, "Active Management of Labour", *Clinics in Obstetrics and Gynaecology* 2 (1), (April, 1975), 3-17.The management of labour mandates active intervention in every primigravid pregnancy guaranteeing delivery within 12 hours, using oxytocin ,early rupture of membranes,one on one supervision by a midwife,close monitoring of rate of cervical dilation ,and effective pain relief.The Dublin experience now runs to over 300000 cases,with satisfactory outcomes.

[136] O'Driscoll and Strong, "Active Management of Labour", 3-17.

[137] Bruce T. Mayes, *Textbook of Obstetrics*, (Sydney: Australian Publishing Co., 1950); *Obstetrics for the Wartime Graduate in the Services, Bulletins 1 to12*, August 1944, (to educate GPs in managing all obstetric complications as few Specialists were available).

earlier.[138] The problems of changing health insurance arrangements, the referral system, litigation risks in obstetrics, lack of modern anaesthetic and paediatric support in country areas, restrictions on appointments at major hospitals, obligatory consultation rules, increasing difficulty in getting adequate training in emergency obstetrics, and difficulty in rostering in practices, all combined to make continuing obstetric practice for most GPs unattractive and stressful. The overall effects at the national level were obvious in the collected data in 1987 which showed that specialist obstetricians provided antenatal care for 53% of all patients, public hospitals for 21% and GPs for 19%. [139] A further increase in rules and recommendations for consultation and referral in the Shearman report in 1989 increased the hassles and stress and medicolegal risks of caring for obstetric patients.[140] This was followed by another report specifying more stringent criteria for care.[141] In Victoria, the Judith Lumley report in 1990 also introduced a new range of recommendations regarding birth plans, patient options, and other time consuming protocols, with no extra remuneration for the time spent with the patient. In Victoria only 11% of women were delivered by GPs in that year.[142] There were significant criticisms of hospital delivery in that survey and 45% of deliveries were by obstetricians, but only 0.5% of births were home births out of 63,542 total births. The C. Section rate was 8.6% elective and 7.3% emergency sections. However the sustainability of rural obstetrics covered by GP obstetricians remains a subject of major concern.[143]

The Shared Care Option in Obstetric Care

The development of the 'shared care' option was supported in both the Shearman and the Lumley Reports, as well as the development of Birth Centres in hospitals to

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[138] "Has the General Practitioner a Future?", *World Medical Journal* 6, (1970), 127-135.
[139], See Tony Geraghty, "Provincial Fellows", *O and G Magazine* 17 (1), (Autumn, 2015), 62-63, itemising the GP obstetrician's problems in the country.
[140] *Maternal and Perinatal Care in NSW* (3rd edition), ed. Rodney Shearman, (NSW Department of Health, 1989), warned that "failure to carry out appropriate tests for pregnant women could have serious consequences".
[141] Christine Bennett, *Maternity Services in NSW, Supplementary Volume*, (January, 1989), and *Appendices to the Final Report of the Ministerial Taskforce on Obstetric Services Planning*, (January, 1989).
[142] Judith Lumley, *Having a Baby in Victoria (Lumley Report),* (Melbourne: Health Department, 1990), 25.
[143] Alan Chater, "The Future of Rural GP Obstetrics, a View from ACRRM", *O and G Magazine* 6 (1), (March, 2004), 9; Diane Mohen, "The Future of Obstetric Practice in Provincial Australia", *O and G Magazine* 6 (1), (March, 2004), 10.

provide a more homelike atmosphere and encourage early discharge. The shared care approach attracted GPs who previously provided total care, as they could leave care during labour to the hospital staff or an obstetrician.[144] This option was adopted widely in the Hunter region from the late 1980s and is now a closely integrated system. There are potential medicolegal issues regarding shared responsibilities, discussed in the medicolegal chapter. The programme is yet again a change in roles for all involved. The patient gains from having most of the care given by her GP, who is familiar with her social background, it provides reduced travelling, and the obstetrician or hospital clinic gains from a reduced workload of normal patients. An initial assessment by the consultant or clinic specialist is necessary, appropriate tests are ordered and repeated, ultrasound monitoring is routine, repeat assessment occurs as appropriate, and the patient carries her record with her at all times. In recent years the availability of all investigations online immediately has been a major advance. Accreditation of GPs into the Hunter scheme is achieved by a two day updating programme, now held every two years, with tutorials and hands on training, lectures and tutorials by obstetricians, GP obstetricians, midwives, physiotherapists, lactation consultants, paediatricians, psychologists, medical social workers, dieticians, geneticists, family planning providers, grief counsellors, parenting education providers, drug addiction experts, child psychiatrists and obstetricians with special expertise in ultrasound. The whole programme began in 1989, was organised by the Hunter Postgraduate Medical Institute (HPMI), affiliated with the medical school, and attendance is open to any professional involved in obstetric care. HPMI provides certification for attendees and a summary of the lectures.[145]

The above list is an indication of the complex team work now necessary to provide optimal obstetric care in the modern world. It has been said that it takes 'a whole village to raise a child' and it can now also be said that it takes 'a whole team of trained professionals to birth a child with optimal safety'.[146]

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[144] Judith Lumley, *Baby in Victoria*, 26.
[145] Maxwell Brinsmead, *Shared Obstetric Care Resource Manual* (6th edition), (HPMI, 1994), (first published 1989).
[146] Hilary Clinton, *It Takes a Village, and Other Lessons Children Teach us,* (New York: Simon and Schuster, 1996).

Obstetricians argue that the team approach is validated by the continuing fall in perinatal loss rates across the nation, documented in other chapters.[147] As will be shown, the contrast between the current protocols of care, and the isolated cottage hospital and home birth precursors which were 'the norm' in Australia is stark, and indicates the dramatic changes over the past 60 years. Until the late 1940s even basic antenatal care was often non-existent or fragmentary. An obstetric axiom states that 'the hours of labour are the most dangerous in any individual's life' and the shared care option ensures that those hours are supervised optimally.[148]

Role delineation has also occurred in the hospital setting. There has been a steady re-organisation of hospital services over the past 60 years.[149] Pure maternity hospitals became absorbed into general hospitals and smaller units were closed.[150] The dilemma of planners has been to provide acceptable basic services in country areas and to ensure that adequate referral patterns exist.[151]

Meanwhile the 'Birth Centre' concept also arose out of these changes. A homelike atmosphere and more 'one on one' midwifery care in hospital can lead to less use of analgesia and less intervention in labour.[152] The Birth Centre concept was supported by both the Shearman and the Lumley Reports. Arguments continue as to whether they should only exist within the hospital environment even after screening out higher risk pregnancies. An alternative is to make every delivery 'suite' user friendly 'by concealing the technical equipment of the delivery suite, promoting easier access for family, and by having more relaxed routines'.[153] These discussions became more public because of the rising intervention rates in recent decades, particularly in the USA.[154] However the debate was also prominent in Australia.[155]

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[147] *The Shearman Report, 1989*, appendices IV and V, 117, 118.
[148] Femi Ogunyemi, "The Most Dangerous Day in a Woman's Life (Her Birthday)", *Vanguard News*, (10 September, 2014).
[149] Sax, *Melting Pot*, 1972; Dewdney, *Health Services*; L.J. Opit and R.M.K.F. Southby, *Medical Specialist Practitioners in Australia*, (Melbourne: Monash Medical School, 1978);.Bernie Amos, *The Richmond Report*, (Sydney: Mental Health Commission of NSW, 1983); *New Teaching Hospital, Greater Newcastle Area Master Plan*, (December, 1983), are examples.
[150] Cope and Garrett, *The Royal*; Godden, *Crown Street*; King George Fifth, Royal Prince Alfred and St Margarets, Sydney, are examples discussed elsewhere.
[151] See the *Shearman Report, 1989*, NSW, and the *Having a Baby in Victoria (Lumley) Report*, 1990.
[152] "Clinical Report", Family Birth Centre, Royal Womens Hospital Melbourne, 1991, 42.
[153] "The Planning Committee Report", John Hunter Maternity Suite, Newcastle Area Health Service, 1985.
[154] Ellen Lazarus, "What do Women Want, Issues of Choice, Control, and Class in American Pregnancy and Childbirth", in *Childbirth and Authoritative Knowledge*, eds. R.E. Davis-Floyd and Carolyn F. Sargent, (Los Angeles: University of California Press, 1997), 132-158.

One of the variations of this programme has been successful: the independent midwife practising in the hospital environment, using protocols agreed with the hospital, and providing 'one on one' care during labour.[156] However there is continuing polarisation of views regarding the safety of Birth Units away from hospital facilities, because of the hazards of time delays in emergencies.[157]

Alongside the Birth Centre concept was the development of the early discharge programmes. This protocol also makes hospital birth more acceptable, saves money, and is now used more extensively.[158] Essential safeguards must be built into the protocols, to ensure that Guthrie tests and infant follow-up by a qualified and experienced midwife visiting daily with complete documentation do occur.[159]

Anaesthetists also have a pivotal role in the sharing of modern obstetric care. The use of the rather crude general anaesthetics in obstetrics since the time of Simpson and his chloroform in Edinburgh (1847) and ether in the USA by Morton (1847) gave mothers the option of avoiding the much publicised 'curse of pain in childbirth' mentioned in the old Testament of the Bible.[160] This has been already discussed briefly but the sophisticated techniques of modern anaesthesia and pain relief have now placed the anaesthetist in a crucial role in the management of labour. Epidural, caudal, spinal and pudendal block, used judiciously, can relieve most labour and delivery pain and ensure that if Caesarean section is required the mother and partner can still be a conscious part of the delivery. With appropriate counselling and

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[155] Carolyn Hastie, "Hunter Needs a Birthing Centre, Evidence to Ministerial Task Force to Review Obstetric Services", *Newcastle Morning Herald*, 8 December 1987, 6; Maralyn Rowley and Carolyn Hastie, "Need for Birthing Options; Maternity Crisis Forces Pregnant Women to Travel, Harder to Give Birth", *Daily Telegraph*, 28 August, 2005, 22; Elizabeth Solday, "Childbirth in a Technocratic Age, the Documentation of Women's Expectations and Experiences", *Birth* 40 (2), (June, 2013).

[156] Maralyn Rowley, Michael Hensley, Maxwell Brinsmead and John Wiodarczyk, "Continuity of Care by a Midwife Team Versus Routine Care During Pregnancy and Birth, A Randomised Trial, *Medical Journal of Australia* 163, (18 September, 1995), 289. See also letter from Dr Bernie Amos to author, re independent midwives, 23 July, 1991.

[157] "New Birth Centre Debate", Australian Broadcasting Corporation, Sally Tracy (midwife), Peiter Mourik (obstetrician), reporter Nick Grimm, broadcast 19 September, 2005. Alice Kelly, "Stand and Deliver, Controversy over Belmont Birth Centre", *NMH*, Saturday, 25 June, 2005, 6. Peiter Mourik, Brain Damaged Child, Canberra Birth Centre, Shoulder Dystocia, Legal action, personal file, Albury Wodonga, 2005. See also Dag Moster, Rolv Terje Lie and Trund Markestand, "Neonatal Mortality Rates in Communities with Small Maternity Units Compared with Larger Units", *BJOG*, 108, (September 2001), 904-909.

[158] Alan D. Hewson, "An Early Discharge Programme in Obstetrics in a Teaching Hospital, 4 Years Experience", Australian Gynaecological Travellers Society Meeting, Margaret River, WA, September 1991, (also presented at the RACOG Congress, Perth, WA, October 1987).

[159] Jane F. Thompson, Christine L. Roberts, Marian J. Currie and David Ellwood, "Early Discharge and Post-natal Depression, a Prospective Cohort Study", *MJA* 172, (5 June, 2000), 532.

[160] *The Bible*, Old Testament, (King James translation, 1611), Genesis, chapter 3, verse 16.

supportive staff, this is now acceptable practice, and is offered in most modern units.[161] Additionally a transverse abdominal plane anaesthesia block provides a pain free recovery for over 24 hours, encouraging early ambulation and comfort so the mother can care for her infant.[162] It is not surprising but still of concern that the Caeserean section rate has now reached over 30% in Australia and has also escalated in less well-developed countries.[163]

Other issues for obstetricians and midwives at the workface include the presence of third persons in the delivery suite or theatre. There was initially controversy over the presence of partners or other relatives in the delivery suite or operating theatre during labour or operative delivery of infants when this trend began in the 1960s.[164] The subsequent course of the debate is outlined in the *Effective Care* publication already quoted.[165] Although there have been trials indicating the benefits of partner, friend, or extra mural professional support, the authors caution that many trials have variables raising doubts regarding the alleged improved outcomes. Informed consent issues can sometimes cause arguments between the mother, partner, and carers regarding medication or intervention, and the presence of lay persons in operating theatres has the potential to cause breaks in aseptic protocols when the abdomen is opened. In spite of the potential for problems there is little in the literature to confirm increased risks, but there is the potential to increase stress on less experienced personnel.[166] It is appropriate to now discuss another role delineation issue, home birth supervised by a midwife.

The Home Birth Debate

This contentious topic is discussed under the heading of role delineation as in the past there were unskilled providers of care during labour in a home birth setting as well as

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[161] Prasad Vitikori, Consultant obstetric anaesthetist, Newcastle, has provided anaesthesia for over 2000 Caeserean sections with partners present over the past 16 years without major problems, and confirms that his experience is the norm. Personal communication, January, 2015.
[162] Peter Hebbard, "Subcostal Transversus Abdominal Plane Block Under Ultrasound Guidance", *Anaesthesia and Analgesia* 106 (2), (February, 2008), 674-675.
[163] Documented in the Hunter Valley chapter. See also Susan Hellerstien, "Is China's 50% Caesarean Section Rate Too High?", *BJOG* media release, (23 August, 2014).
[164] See discussion in the Hunter Valley chapter(6).
[165] Enkin et al. *Effective Care*, 171-178.
[166] Alan Hewson personal files, from 1990. It requires the assuredness of many years of experience to deliver an infant with Ventouse or forceps under a local block without alarming the mother or partner. See later discussion regarding the loss of manipulative skills in recent trainees.

qualified midwives.[167] The home birth movement became more strident in its criticism of hospital birth as intervention rates rose during the second half of the 20th century. The change from home birthing dominance through nursing home deliveries by midwives and GPs to almost universal hospital delivery from the mid-1950s has already been outlined. In spite of a great deal of positive press publicity, some uninformed and misleading, the number of home births in Australia has always been extremely low since the 1950s, and in 2010 it remained at 1345 out of 294,814 births, approximately 0.5% of all births.[168] It is accepted that there are in addition a small number of unreported home births in spite of mandatory notification under Australian law. The Homebirth Australia website provides details of the age distribution of 'home birthers'.[169]

The controversy regarding home birth became a progressively more contentious issue at the time of establishment of the RACOG in 1979, and in the first two decades after its formation. The matter became an article of faith to some in the feminist movement who saw the move to hospital delivery, increased obstetrician (usually male) control, and increased intervention as a gender dominance issue to be confronted vigorously.[170] It has been influenced by the thinking, philosophy and literary contributions of Michel Foucault and the post structural/postmodernism school, particularly the knowledge/power nexus in the field of obstetrics.[171] An important feature of home birthing is detailed in Myles' text, when the author documents the quite extensive preparations necessary before home birth is authorised in the UK.[172] The extensive list of necessities to be provided by the mother, the midwife and the Health service are impressive, but do not include any provision for

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[167] Loudon, *Death in Childbirth*, 191, 208, 311, 405, 408, 418, 465.
[168] Australian Bureau of Statistics, "Australia's Mothers and Babies, 2010", http://www.abs.gov.au.AUSSTATS/abs@nsf/Lookup/4102.0Main +Features10Mar+20, (accessed 4 August, 2014).
[169] Homebirth Australia, http://homebirthAustralia.org/statistics, (accessed 6 August, 2014). See also Jeffrey Kluger, "Doctors Versus Midwives: The Birth Wars Rage On", (from *Time Magazine*),and TAFE Courses online, 16 May, 2009.
[170] See "The Future of Midwifery and Homebirth in Australia", *Midwife Thinking*, http://midwifethinking.com/2014/01/02the-future-of-midwives-and-homebirth-in-aus, (accessed 30 April, 2014).
[171] Green and Troup, "Challenge of Post Structuralism", 302-306.
[172] Myles, *Textbook for Midwives,* "Confinement in the Home", 650-656.

an IV line for unexpected haemorrhage, provision for pain relief, nor authority for midwives to deal with serious sepsis or the need for urgent delivery.[173]

Obstetricians had a different point of view with regard to the Home birth debate. The post war generation of obstetricians had worked and trained in a system in which there was a clear understanding of respective roles in obstetrics and gynaecology. The rigid medical and nursing hierarchies had been in place for many decades, and the view that male dominance of the birthing process was facilitated by 'hospital birthing' is only part of the story. The senior midwives had significant power and authority, certainly greater than the junior medical staff, who learned many of their practical skills from midwives.[174] The authoritarian regime in nursing in the period from 1920 to 1970 is well documented and possibly contributed to subservience to medical staff.[175] Obstetricians returning from their obligatory training in the even more hierarchical British system after WW2 were mentally programmed to continue the system. More importantly, they had all worked in units with a Flying Squad to deal with unexpected complications in home births in Britain and knew the difficulties of these situations first hand.[176] They were all determined to oppose any suggestion to promote home births in Australia.[177] There was already evidence of better outcomes from hospital births in the literature.[178] The Newcastle on Tyne paper influenced the Peel Committee in the UK to recommend 100% hospital confinement in 1970.[179] They were also aware that even in Britain there were variations in

[173] The delivery pack for planned home birth mandated by the Monash unit in Melbourne (1980) included much more, including an IV giving set, Hartmans solution, haemacel, pethidine, ergometrine, syntocinon, and resuscitation equipment for the infant.
[174] Beryl Moore nee Gearside, reminiscences of RNH and Matron Hall, private communication to the author, 2015. Sister Gearside trained at the Womens Hospital Melbourne, and was the first Tutor Sister at RNH from 1951. See also Poidevin, *The Lucky Doctor*, on mentoring by midwives at RHW Sydney, in 1936.
[175] Capper, "Nurse Education". See also Susan Marsden, *RNH, A Castle Grand, A Purpose Noble*: *A History of the Royal Newcastle Hospital 1817 to 2005*, "Matron Hall 1915-1958", (Newcastle: Hunter New England Area Health Service, 2005), 100-102.
[176] Flying Squads were set up in the 1950s specifically to deal with home birth emergencies. See the documentation from the Oxford Region in the chapter on Education.
[177] See the report of the *Cranbrook Committee UK* in 1959, which confirmed that most patients in Britain already preferred hospital confinement. See also "The Aberdeen Survey", *BMJ* (27 February, 1960), 642 which confirmed that only mothers who did not want to leave home responsibilities preferred home birth.
[178] S.L. Barron, A.M. Thomson and P.R. Philips, "Home and Hospital Confinement in Newcastle on Tyne, 1960-1969", *BJOG* 84 (6), (June, 1977), 401-411.
[179] *Report of the Peel Committee*, Department of Health and Social Security, UK, 1970.

standards in home birth midwives, and documented increased risks and higher perinatal death rates in home births, rural areas, and areas with fewer hospital beds.[180]

Every debate regarding the safety of home births includes a discussion of maternity care in the Netherlands, where home birth was still the norm in 1958 (74%). It has steadily declined since then and is now at 30%.[181] A complete overview of the Netherlands situation published by de Costa and Pols in 2011 pointed out that there have been increasing problems, resulting in a steady swing to hospital confinement and an increasing Caeserean section rate, to deal with a worrying perinatal loss rate.[182] A whole issue of the *O and G Magazine* in 2011 was devoted to the subject, and numerous other 'Position Statements' in the same issue were drawn from a wide variety of institutions and individuals.[183] In summary, all agreed that the continuing interest in the subject seems out of proportion to its incidence. In the Australian context, the RANZCG remains firmly opposed to home births, which has medicolegal implications for any obstetrician who actively supports home births.[184] This author spent one week in the Netherlands in 1992 to get the facts on the system in practice and confirmed that the alleged 'independent midwifery practice' for home births was not true. The system involved very close collaborative practice with obstetricians.[185]

McCaulay's study of over 700 physicians in Ontario Canada is relevant.[186] This study of family practice doctors confirmed that isolation from colleagues was the major reason for poor medical practice. Although this has not yet been confirmed in nursing practice it seems highly likely the any home birth midwife working in isolation, just continuing to carry out the practice of previous generations, would inevitably have progressively falling standards.

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[180] *Perinatal Problems, Second Report of the British perinatal Mortality Survey*, (E. and S. Livingstone, 1969), 252-254.
[181] Carolyn de Costa and Hans Pols, "Shifting Paradigms, Homebirth", *O and G Magazine* 13, (Summer, 2011), 16.
[182] Hans Pols, "Trouble in Paradise", *O and G Magazine* 13, 16. See also Stephen Robson, "An International Perspective on Home Birth", *O and G Magazine* 13, 19.
[183] Anthony Falconer and Gerald Chan, "Whose Choice is it? RCOG (UK)", *O and G Magazine* 13, 26; Hannah Dahlen, "Australian College of Midwives, Can we Reach Middle Ground?", *O and G Magazine* 13, 28; Karen Guilliland, "NZ College of Midwives, Birth at Home, NZ Position", *O and G Magazine* 13, 19.
[184] Defending a home birth 'poor outcome' by an involved obstetrician would be very difficult when the documented condemnation of home births by the College is on the public record.
[185] Alan Hewson 'Homebirths in the Netherlands", lecture, John Hunter Midwives, 1992.
[186] R.G. McAuley, "Peer Review of Physicians, the Ontario Experience", *International Conference on CME*, University of Southern California School of Medicine, 1988.

The home birth issue was a major problem for the fledgling Australian college in the 1980s, and many discussions took place between GP obstetricians, the RACOG Council and the College of Midwives. An important event was a National Homebirth Conference in 1989, with an attendance of over 400 people. At that meeting, it was stated by one speaker that:

> Home birth now has the support of the NHMRC, and that even though the RACOG and the Australian College of Paediatrics do not encourage home births, they believe that a woman choosing this option should be appropriately catered for by a suitably trained team including a community based midwife; and that the College is supportive of a woman's right to choose the place of birth and follows the World Health Organisations definition of a midwife operating in a variety of settings including home.[187]

In spite of maximum publicity for the event and the above qualified endorsement, the incidence of home births remained virtually unchanged at about 0.5% of total births in Australia. Following that conference, dialogue continued between the RACOG, the ACM, and the RACGP over some months, culminating in a National meeting, 'Birth 2000, Who Will Deliver the Women of Tomorrow?'[188] The meeting was sponsored by the Joint Birth Consultative Committee of the Colleges. Papers were presented by representatives of the Colleges including the RACOG perspective presented by the author of this thesis.[189] A continuing dialogue was established between the Colleges, and the confrontational mindset receded to some extent. However the later publication of papers by Bastian and Lancaster on home births, and by Bastian, Kierse and Lancaster in 1998, cast further doubt on the safety of home births.[190]

A critical event which influenced the national debate at that time was an adverse legal decision against Australia's highest profile home birth midwife, Maggie

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[187] *Celebrating a Revolution in Birth*, Proceedings of the 10th National Homebirth Conference, Sydney 1989, (Sydney: Star Printery, 1989).
[188] *Birth 2000, Who Will Deliver the Women of Tomorrow?*, Sydney Hilton Hotel, published by the RACOG, Melbourne, 30 November, 1991.
[189] Alan D. Hewson, "The Role of the Specialist", *Birth 2000 Conference*, 8.
[190] Hilda Bastian, Marc J.N.C. Kierse and Paul A.L. Lancaster, "Perinatal Death Associated with Planned Home Birth in Australia: Population Based Study, *BMJ, (*August, 1998), 317, 384. Also Hilda Bastian and P. Lancaster, "Home births in Australia 1998-90", (AIHW/NPSU and Home Birth Australia, 1992).

Leckie-Thompson in 1998.[191] The tragic stillbirth of a normal infant in a home birth led to a Tribunal finding that the midwife had been guilty of major errors of management. She later faced another tribunal regarding five other home births which had bad outcomes. All the tragedies were in 'high risk pregnancies'. Attempts to provide excuses for these deaths by home birth supporters was very counterproductive to their cause. Maggie Leckie-Thompson was subsequently deregistered by the Nurses Registration Board for her home birth practices in the period from 1996 to 1998.[192] The debate continued in the National Disputes Centre, when the Health Care Complaints Committee (HCCC) and the Nurses Registration Board began a complaints hearing into the home birth practices of Maggie Leckie-Thompson, with home birth advocates still alleging a conspiracy against home birth.[193]

The problem of role definition in obstetrics continued in 2005.[194] Fortunately the number of obstetricians moving back into obstetrics increased during 2005, mainly due to a healthy private sector, a more stable indemnity sector, better fees, and more confidence regarding workforce projections, so the inadequate obstetric workforce issue was less prominent.[195]

Andrew Pesce, President of the AMA and a practising obstetrician, spoke vigorously against a 'fringe group of militant midwives' and the 'free standing birth centres' at the time of trials of such centres in 2005.[196] The interview was reported by Miranda Devine in the *Sydney Morning Herald*.[197] Pesce pointed out that Australian women are now 40 times less likely to die during pregnancy than they were in the

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[191] Deborah Smith, "Delivering a Tragedy", *Sydney Morning Herald*, Thursday, 12 November, 1998, 13.
[192] Margaret Wallace, "The Game of Expertise, Investigating the Use of Science in a Professional Disciplinary Setting", PhD thesis, regarding the deregistration of Maggie Leckie Thompson, 1998. See also Stephanie Bond and Boon H. Lim, "Homebirth After Caesarean Section, A Choice Too Far", *BJOG* 122 (3), (February, 2015), 410 (describing a case of stillbirth after uterine rupture in a home birth in Hobart).
[193] "Medical Monopoly Targets Homebirth", *CAFMR Newsletter*, (Spring Issue, 1996).
[194] "Big Push from Midwives, Interview with Dr Andrew Pesce, on Network Nine TV Regarding Safety and Role Substitution", A*ustralian Medicine* 17 (17), (September, 2005), 2; Andrew Pesce, "Birth Centre/Low Intervention Care Models: Deinventing the Wheel?", *NASOG Newsletter*, (September, 2005), 3.
[195] Scott Giltrap Chairman, *NASOG News* 11 (1), (September, 2005), 1.
[196] Fiona Davies, "Concerns Over New Belmont Birthing Unit Opening Tomorrow, Doctors Debate Midwife Led Obstetrics Unit", *NSW Doctor*, (July, 2005), 3, 15.
[197] Miranda Devine "Mum and Baby Caught in the Middle", Interview with Andrew Pesce, *Sydney Morning Herald*, 22 September, 2005, http://smh.com.au/articles/2005/09/21/1126982126719.html, (accessed 23 September, 2005).

1940s, and perinatal deaths are a third of 1972 rates, quoting de Costa's and Robson's paper in the *MJA* in 2004. He also criticised the politicisation of childbirth, highlighting articles utilising post-modernist theories of Michel Foucault in the *Australian Journal of Midwifery*. Other contributions to that debate are the articles by Kitzinger and other authors in *Childbirth and Authoritative Knowledge, Cross Cultural Perspectives*.[198]

The debate in the popular press continued through 2005 to 2009.[199] However, most involved in actual obstetric care continued to press for a continuation of the teamwork approach which had worked so well in recent decades. After all the trauma and confrontation of the 1990s and the 2000s, there is now a degree of accommodation in this area. The *National Midwifery Guidelines* for consultation and referral, issued by the Australian College of Midwives, 2nd edition in 2008, with wide ranging input from the medical and nursing professions, attempts to balance current views by categorising risks throughout pregnancy and delivery, encouraging teamwork, and giving clear guidelines for assessment and appropriate referral across disciplines.[200] It includes clear advice to follow if a woman chooses care outside these recommended guidelines.

A final comment from Andrew Pesce, former President of the AMA and NASOG, followed two further official enquiries into the risks of home births.[201] As a result, the policy in South Australia now is that all home births should be conducted in accordance with a set policy which mandates 'immediate transfer to hospital care if meconium stained liquor occurs'. Further, 'twins, breech presentations and post term infants and previous Caesarean section are all contraindications to home births'. The ACM published a position statement in August 2011 reinforcing the importance of

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[198] R.E. Davis-Floyd and C.F. Sargeant, eds., C*hildbirth and Authoritative Knowledge, Cross Cultural Perspectives*, (California: University of California Press, 1997) Sheila Kitzinger discusses the importance of 'Authoritative Touch in Childbirth ' and its underutilisation in childbirth (209-232)and other contributors discussed the conflict between regimentalisation, hierarchy, and cultural norms in different societies.

[199] Claire Harvey, "Birth Wars Rage in Your Delivery Room", (a review of Mc Colls text), *Sunday Telegraph*, 31 August, 2009, http://www.news.com.au/opinion/birth-wars-rage-in –your-delivery-room/story-e6frfs99, (accessed 7 November, 2013).

[200] *National Midwifery Guidelines for Consultation and Referral* (2nd edition), Australian College of Midwives, 2008.

[201] South Australian Maternal Perinatal and Infant Mortality Committee outcomes for 2009 found a perinatal death rate of 3.1% in home births (i.e. 3 per 100), as against 3 per 1000 in hospital births, all home births being cared for by registered midwives. The Perinatal and Infant Mortality Committee of Western Australia in 2005-2007 found the perinatal death rate for term home births was 3.9 times higher than for hospital births – and all home births were cared for by registered midwives.

limiting home births to low risk pregnancies, supported by the Nursing and Midwifery Board. [202] Pesce further noted that:

> In the Netherlands, with a long history of a delivery system including the home birth option, high risk pregnancies are not considered suitable for home births, and women are transferred to hospital when any risk factors emerge in pregnancies previously classified as low risk.[203]

The more recent development of a network of Doulas should be mentioned. Doulas are relatively new to the Australian scene, but are now receiving more publicity, especially on the internet. Doulas claim to be experienced in childbirth, and in many ways resemble the traditional birth attendants referred to earlier.[204] They come into the home or hospital, and support the mother with household tasks, and during the pregnancy, labour and the puerperium give her support. They are expensive to hire and their place in overall pregnancy care is yet to be determined, as are the type of women likely to hire them.[205]

Another difficulty should be mentioned - the increasing problem involved in training General Practitioners for obstetric practice in the last two decades. Providing adequate training opportunities for doctors who wish to practise obstetrics in general practice, as older GPS retire and their skills are lost, is proving a challenge. Falling numbers in the public hospital system and the necessity to provide sufficient training for trainee specialists, midwives and medical students have all contributed to the problem. [206] The development of manipulative skills for GP obstetricians is a particular problem and also the ability to carry out an emergency Caesarean section. This issue is now the prerogative of the RANZCOG in consultation with the Rural

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[202] Andrew Pesce, formal statement to the media on behalf of NASOG, 2012.
[203] Andrew Pesce, "Home Births in Australia, More Light and Even More Heat", *NASOG Bulletin*, 2012. See also, Susan Ieraci and Amy Tuteur, "Publicly Funded Homebirth in Australia, Outcomes Over 6 Years", *MJA* 199 (11), (16 December, 2013), 742; also Donald M. Clark, "Publicly Funded Homebirths", letter to the *MJA* 199 (11), (16 December, 2013), 743; also Andrew Pesce, "De-inventing the Wheel", 3.
[204] "What is a Doula and why do so many women want one?", http://www.bellybelly.com.au/pregnancy/doulas-what-is-a-doula, (accessed 14 August, 2014).
[205] Amie Steel, Jane Frawley, David Sibbritt and Jan Adams, "A Preliminary Profile of Australian Women Accessing Doula Care: Findings from the Australian Longitudinal Study on Women's Health", *ANZJOG* 53, (2013), 589-592.
[206] Andreas Obermair, Amy Tang, Deryck Charters, Edmund Weaver and Ian Hammond, "Survey of Surgical Skills of RANZCOG Trainees", *ANZJOG* 49, (February, 2009), 84-92: the survey showed advanced trainees lacked confidence in a range of surgical procedures, and urged that these deficiencies be addressed.

Doctors (ARRM) group and the RACGP.[207] The trends are worrying as shown in the quoted literature.

Subspecialisation in Obstetrics and Gynaecology

The development of subspecialisation in obstetrics and gynaecology was foreshadowed in the submission of the RACOG to the Committee of Inquiry into Medical Education and the Medical Workforce in May 1987.[208] The subspecialties requirements included: oncology, three years training; perinatal medicine, two years training; reproductive endocrinology and infertility, three years training; ultrasound, two years training; and urology, three years training; training to begin in the penultimate year of advanced training for Fellowship. The programme included special training posts, certification of 'grandfathers' (already practising in the subspecialty subject to certain conditions) and an examination leading to certification in the subspecialty.[209] A major issue in debate was whether to follow the British system and just recognise expertise by completion of a specified training programme, or to adopt the United States system of a special examination as well and formal certification, with the potential of an additional fee being charged by holders of the certification. The decision to follow the American system was accepted by the Council after much debate. Workforce planning was built into the system to ensure standards were maintained and that need for subspecialists was balanced against the number of trainees allowed into the programmes.[210]

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[207] It is not so long since there was a vigorous debate as to whether general practice had a future at all. See "Has the General Practitioner a Future?", *World Medical Journal* 6, (1970), 127-135, reporting a World congress, The Oslo Assembly of the World Medical Association in August 1970; see also, "GP Obstetrics, is it an Endangered Species?", *O and G Bulletin* 6 (1), (March, 2004); see also, Alan Chaturthi, "The Future of Rural GP Obstetrics, a View from ACRRM (Rural Medicine)" in the same journal, documenting the progressive fall in procedural GP obstetricians in NSW over 10 years, from 263 in 86 communities to 166 in 74 communities, and that 33% would be ceasing practice in the next 5 years.

[208] The Royal Australian College of Obstetricians and Gynaecologists, "Submission to the Committee of Inquiry into Medical Education and the Medical Workforce, May 1987", *RACOG Bulletin*, (August, 1987), 29-52. This important historical document outlined virtually all the issues impacting on the discipline of obstetrics and gynaecology including undergraduate, graduate and postgraduate training and education, coming as it did when the college was completing its 8th year since formation. It included great detail about examination results, the philosophy and implementation of the College obligatory continuing education programme, training of GP obstetricians, data regarding the obstetrics workforce in comparable countries, and included extensive appendices.

[209] Warren Jones, "Subspecialisation in Gynaecological Oncology", *RACOG Bulletin* 1 (2), (August, 1987), 9

[210] "Subspecialty News", *RACOG Bulletin*, (December, 1994), 20.

Further changes in role delineation in gynaecology are being discussed, driven by seemingly inexorable changes in the discipline itself.[211] A special issue of *The O and G Journal* was devoted to this topic, including contributions from subspecialists, general gynaecologists, trainees, and the President of the RANZCOG. The precipitating factors were and are increasing difficulty in providing sufficient training opportunities for trainees in the specialty, and an increasing diversity of views on what is now required for the different types of specialist gynaecological practice in the next decade. Molloy, an infertility specialist with expertise in laparoscopic surgery, advocated that there be a complete rethink of the training programme with earlier streaming of trainees towards office practice, obstetrics, and advanced open and laparoscopic practice.[212] He points out that the number of open operations is falling, the number of laparoscopic operations is slowly rising, while investigative laparoscopy and hysteroscopy is also rising, and vaginal hysterectomy is relatively stable. It is argued that with a demand from younger specialists for a more reasonable lifestyle, obstetrics only on a rostered system is becoming more common: he admits that in gynaecological surgery there must be provision for a limited number of real generalists to serve regional and some city centres. The rapid rise in the number of women in the speciality is also compounding the problem, and earlier retirement, with an ageing workforce are also factors, as noted previously. [213] Weaver's ageing data showed that age itself could not be used as a reason to enforce retirement, as cognitive testing has shown that even over age 70, 38% compared favourably with younger surgeons.[214] Weaver, President of the RANZCOG, also suggested means of usefully employing senior specialists in hospitals and academia, as well as modifying re-certification requirements to recognise the restricted practice of senior specialists. There will continue to be changes in all these areas in the foreseeable future, which

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[211] Brett Daniels, "Is the General Gynaecologist an Endangered Species", *O and G Magazine* 12 (1), (Autumn, 2010), 11.
[212] David Molloy, "The Time to Stream the Specialty is Coming", *O and G Magazine* 12 (1), (Autumn, 2010), 30.
[213] Ted Weaver, "The Ageing O and G", *O and G Magazine* 14 (4), (Summer, 2012), 61. Weaver showed that of the total number of all specialists, 14.3% are over 60, and in obstetrics and gynaecology, 12% of males were over 65, and 23% over age 60, with many expected to continue working over age 65.The gender distribution in the College now is rapidly approaching 50/50, with most female obstetricians working shorter hours, less likely to go to country centres, and more moving into subspecialty work.
[214] R.G. Adler and C. Constantine, "Knowing – or Not Knowing – When to stop; Cognitive Decline in Ageing Doctors", *MJA* 189, (2008), 622-624.

will have an impact on role delineation in the speciality. Jonathon Morris, Professor in Obstetrics, University of Sydney, in a recent lecture agreed that there are enormous problems training the current generation of postgraduates to the clinical skill level necessary for safe practice. He saw no way of this problem being solved in the short term. [215]

All obstetricians of previous generations accept that optimal outcomes of care are dependent on real team care. Obstetricians and midwives have complementary skills, and both benefit from appropriate role delineation informed by evidence-based medical and nursing practice. The Courts now determine the different levels of expertise expected by both groups, as discussed in the litigation chapter, with the bar set much higher for the obstetrician.[216]

CONCLUSION

This chapter encompasses a very large part of obstetric history, but it would have been difficult to understand role changes over the last 60 years without analysing the previous 150 years. The dominance of female midwives up to the 18th century is well documented, but the sudden appearance of the male midwife from the 1730s had an enormous impact. One remarkable man, the Scot, William Hunter, in 1735 was the catalyst for this change. His genius, with that of his fellow Scot, William Smellie, opened the world of obstetric care to the male, an extraordinary achievement considering the barriers to the change involving breaking down female modesty, time honoured practice and the understandable hostility of female midwives. The coincidence of the invention of the secret Chamberlain's obstetric forceps, and Hunter's genius for dissection and artistry, opened the scientific mysteries of the pregnant female to the world in 1774, shown in his magnificent atlas. The breakthrough he began continued, with males now progressively allowed to care for women in pregnancy, and they began to be used by female midwives to help in obstructed labour. The beginning of formal education for midwives in Edinburgh in 1730 assisted by the 'flow on' of Enlightenment thinking led to the progressive

[215] Jonathon Morris, invited lecture to the Senior Obstetricians Group, NSW, Friday, 10 October, 2014 "Are we providing enough training in procedural skills to trainees?"
[216] As discussed in the Litigation chapter.

improvement in the status of trained midwives over decades, and eventually registration and recognition of the professional midwife in society.

The appalling maternal mortality was a driving factor to progress, but the killers of infection, the toxaemias, and haemorrhage remained untamed for 150 years until the 1930s. Home births remained the norm in Australia until the 1930s, and difficulties of transport, communication, and the failure to translate the new knowledge of the second half of the 19th century about bacteria and cross infection meant that mothers still faced a death risk of five to ten per 1000 over that period. The coming of maternity hospitals did not help, as cross infection remained a major killer. Florence Nightingale's revolution in nursing practice and her advocacy for nursing as a profession were landmarks in the emancipation of the nursing profession from 1860, but the gradual change from female midwives to male doctors doing confinements over the period from 1890 to 1920 often made the obstetric situation worse, as doctors carried infection from an ill patient to a healthy mother. There was a high incidence of criminal abortion, making the situation even worse between the two World Wars. In Australia, as most medical graduates were still British-trained until the late 1920s, the deficiencies of the British medical educational system, and lack of knowledge of European continental medicine remained major problems. Even Lister's carbolic spray successes in 1870 in England seem to have been lost in the translation. Then the dramatic discoveries of antibiotics, better knowledge of blood transfusion, and the epoch changing methodology of preventing eclampsia at Crown Street Hospital in Sydney in the 1940s, changed the world of obstetrics and gynaecology forever. The devolution from home births to hospital delivery over the years from 1930 to 1950 was a social change which remains controversial, and had a significant effect on the roles of those caring for women.

This chapter has attempted to clarify the exact sequence of events. The change in which GPs were gradually displaced as the carers for pregnant women due to the appearance of the specialist obstetrician, produced conflict about appropriate roles. The founding of the British College of Obstetricians and Gynaecologists in 1929 against strong opposition was a first step in the progressive growth of a specific specialty aimed at improving the care of women, again effecting a further change in roles. The intra-medical conflicts of this era are often overlooked. The establishment of Physicians and Surgeons opposed the involvement of medical practitioners in

obstetrics for decades, and also opposed midwifery care in hospitals. The links between the University of Sydney medical school with the pro-midwifery Edinburgh school was a happy accident of history for Australian obstetrics and gynaecology, as it probably made the path to the specialty easier in Australia. The rigid hierarchical systems in maternity hospitals of the mid to late 20th century required discussion, and the final breaking down of this rigidity, together with the liberation of nursing from its colonial straitjacket, through the establishment of professional nursing education, again led to a change in the role of the professionally educated midwife.

However the change in roles of professionals other than midwives and doctors also affected the care of women in the 20th century. The increasing complexity of medicine led to the dissolution of the isolated maternity hospitals, as they were absorbed into the general hospital systems, with more professional groups becoming involved, particularly physiotherapists, anaesthetists and other health care workers. Specialist obstetricians faced difficulties, as they felt impelled to increasingly intervene in abnormal labours to improve outcomes, and to protect themselves from legal action, particularly with growing opposition from the natural childbirth movement, who supported non-interventionist carers. The final scenario saw the establishment of team midwifery, with a rethink of the roles of each of the professional groups.

So this chapter has explored a fascinating mix of multiple influences acting on the central players in the drama, as they each responded to factors outside their control over the period of this thesis. Nevertheless, the outcome for mothers and their babies over the last 60 years has seen a remarkable transformation from a life threatening experience for expectant mothers to a sense of safety not dreamed of 60 years ago. In spite of the significant difficulties, the current roles of those involved in the care of women have achieved outcomes of which they can be very proud, and are a tribute to their professionalism. The next chapter will address the medical and political influences which have affected the profession.

CHAPTER 4
MEDICO-POLITICAL INFLUENCES ON OBSTETRICS AND GYNAECOLOGY

All issues are political issues, and politics itself is a mass of lies, evasions, folly, hatred, and schizophrenia.

George Orwell[1]

Medico-political factors impacted seriously on the profession in the second half of the 20th century, including attempts at nationalisation of medicine, controlling decision-making, attacks on the integrity of the profession and its members, direct confrontation, funding issues, and bureaucratic manipulation of the levers of government to a degree not seen previously. The substrate was rapid population growth, controversies regarding the adequacy of the medical workforce, the increasing prominence of hospital care, the knowledge and technological explosion after WW2 placing enormous strains on providing adequate monies for medical care, and an increasingly diverse workforce compared with the previous norms. The balance between private and public care altered significantly, with the necessity for obstetricians to alter their patterns of practice. All of the above factors affected obstetric practice to a greater or less degree and require analysis.

The Australian population grew from 8,177,000 (1950) to 22,183.000 (2010).[2] National expenditure on health increased steadily over that time. Health is Australia's largest industry, more than five times larger than defence.[3] Health expenditure in 2010 was $130.3 billion, up from $77.5 billion in 2000, and was 9.3% of gross domestic product.[4] Governments of all persuasions have taken an increasing interest and control over health matters since WW2. Funding decisions, ideological conflicts, and the intrusion of bureaucracy became increasingly important in the second half of the 20th century. As a great deal of specialists' working time is spent in the hospital system, changes there had the greatest effect. However, alterations to

[1] George Orwell, "Politics and the English Language", Essay, 1946.
[2] "Michael Krokenberger,*Population Growth in Australia*,The Australia Institute, ACT,March 2015,
[3] Gwen Gray, "Health Policy in Australia", APOS Briefing Series, (UNSW Press, February, 2005).
[4] A.I.H.W., "Health expenditure in Australia", media release, 2010-11, 26 September, 2012.

funding arrangements, and those issues which affected the doctor-patient relationship are important. Fundamental changes which affect access to consultants and to hospital services are also an important concern of obstetricians.

A survey of general histories of Australia reveals that surprisingly little attention has been paid to health issues or the medical profession.[5] However, Manning Clark did analyse the political career of Dr Earle Page and his efforts to provide a 'bulwark against socialism' in the Menzies era.[6] This lack of emphasis is surprising as health services are always a major item in overall expenditures, currently absorbing approximately 8% of the budget and rising steadily.[7] Even early in the timeframe of this thesis in the early 1970s, health services expenditure used up 5.3% of Gross National Product (GNP) and employed some 250,000 people out of a total civilian workforce of 5.6 million (4.5% of the workforce).[8] Controversies on health matters occupy large segments of the media, are a prominent election issue, and engender strident debates in Parliament. Changes in health care often alter the outcome of elections, and impact on the day to day contact between doctors and patients. Labor Prime Minister Chifley's failed attempts to introduce a nationalised health service like the British National Health Service (NHS) after WW2 produced some long term suspicion toward the Party by politically conservative doctors of influence, which reignited in 1970s when Medibank Mark One was introduced.[9] A vitriolic campaign against the medical profession before the Labor Party came to power in 1972 also increased hostility.[10] William (Bill) Hayden's role in introducing one of the hallmarks of the Whitlam era's agenda, the new National Health Scheme, is not prominent in general histories.[11] The implications for Australia's health system,

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[5] Russell Ward, *The History of Australia, the Twentieth Century*, "Reconstruction and Reform", (London: Harper and Rowe, 1977), 269-272; See also, R.M. Younger, A*ustralia and the Australians, a New Concise History*, (Adelaide: Rigby, 1974); Geoffrey Blainey, *A Land Half Won*, (Sydney: MacMillan Australia, 1980), 38; Michael Cathcart, *Manning Clarke's History of Australia*, (Melbourne: Melbourne University Press, 1993), 579, 591, 597; Geoffrey Bolton, *The Oxford History of Australia Volume 5, 1942-1988*, (Melbourne: Oxford University Press, 1990), 208.

[6] C.M.H. Clark, *A History of Australia, Volume V1, The Old Dead Tree and the Young Tree Green, 1916-1935*, Melbourne: Melbourne University Press, 1987, 139-93, 143-5.

[7] A.I.H.W. Health Expenditure, 2012-13, Canberra, No. 52, 2.2.

[8] William Hayden, *National Health, the ALP programme*, Victorian Fabian Society Pamphlet, 1971.

[603] See *More Than Just a Union, History of the AMA*, (2012), 72.

[604] This was mostly related to the Fees issue, which had plagued relationships with the previous Conservative Government. See *More Than Just a Union*, 69-70.

[11] The definitive document by Scotton and Deeble in 1968 in the Australian Economic Review followed a previous paper by Drs Moss Cass and Gold in 1965, and Cass with T.J. Doyle in 1964. The Fabian Society, and later the ALP, adopted this idea. See *More Than Just a Union*, 64.

and Australian society, of many of the issues canvassed in this thesis also receive little attention. Essays and commentaries on social security matters are more useful references, and provide important background statistics and analyses of health issues affecting the community. A Hayden document analysed the Health expenditures by the Federal Government in 1971, and showed that expenditure on health had risen from $778 million in 1965-1966 to $1178 million in 1969-1970. Most of the expenditure and regulation on health is entrusted to the States, but Commonwealth expenditure had continued to rise over the years, and the Commonwealth relied on its dominant economic position to attach conditions to its Grants to the States.[12] Scotton showed that Commonwealth revenues allocated to health rose from 2.7% of GNP in 1963 to an estimated 5.0% in 1977-8.[13] The Labor Party used the argument of increased Federal funding as another reason for its proposed health scheme in 1972. The changes brought about by the final implementation of a compulsory universal health insurance scheme and its other features altered most aspects of practice. This chapter will provide background regarding the events of these tumultuous years as they affected obstetrics and gynaecology, with particular focus at times on the state of New South Wales (NSW).

MEDICO-POLITICAL INFLUENCES BEFORE THE CONTROVERSIES OF THE 1970s

The origins of the Australian hospital network from the beginnings of the Colony in 1788 is provided by Sydney Sax.[14] Written in 1972, this important work assists understanding of the critical issues in NSW during the confrontations of the 1970s. The development of the original Colonial hospital in Sydney, primarily for the care of convicts, was followed by development of a system akin to the voluntary hospitals of England, and private medical practice emerged later. The voluntary hospitals were administered privately for public benefit, but were not under Government control. Later hospital boards developed, but the standards of hygiene and nursing were poor, until nurses arrived who had been trained by Florence Nightingale in London late in

[12] Terry Carney and Peter Hanks, *Australian Social Security Law Policy and Administration*, (Melbourne: Oxford University Press, 1986), 167.
[13] R.B. Scotton, *Public Expenditure and Social Policy in Australia, Volume 1: The Whitlam Years 1972-75*, (Melbourne: Longman Cheshire, 1978).
[14] Sax, *Melting Pot*. See also Dewdney, *Health Services*, 13.

the 19th century. Sax stated many of the later problems in the hospital system went back to these uncoordinated beginnings, as the development of a private hospital system, quite independent of the voluntary and Benevolent hospitals, he believed was not ideal. They were profit driven, less well equipped, and with no casualty system. By 1971 in a study in western Sydney, 23% of all admissions were to private hospitals.[15] The number of approved hospitals in 1970 was 1088, 766 public and 322 private. There were 1176 Nursing homes, 122 public, and 1054 private. But the large public hospitals had 62,687 beds, and the private hospitals only 13,142. Sax pointed out that it was these public hospitals which were equipped to change roles to accommodate the new scientific medicine of the post 1970s era. This led to a progressive increase in size with increased areas for accommodation, requiring a much more sophisticated management structure.[16] All of these changes led to increasingly impersonal care in the public system, particularly for patients coming through the hospital's out-patient clinics. In States other than NSW, the private hospital system was much more developed, an important factor in the confrontation with Government from the 1970s.

After WW2, the payment to doctors in private practice for service in the public hospitals in NSW was not coordinated. GPs had provided most of the services in the public charity hospitals for the indigent under the Honorary system, but were being displaced by emerging Honorary specialists, and staff specialists were virtually unknown. Some medical care was provided in private nursing homes and private hospitals, but most confinements were still at home until the late 30s, particularly in the country areas.

The Chifley Federal Labor Government after WW2 sought to follow the pattern of Britain and introduce a nationalised health service, but this was ruled unconstitutional by the High Court after a bitter battle with the medical profession. The critical issue was that the Australian Constitution does not allow civil conscription by the Commonwealth in peacetime, and the plans of the Commonwealth at that time were judged to amount to civil conscription.[17] However

[15] A. Adams, A. Chancellor, C. Kerr, "Medical Care in Western Sydney", *MJA* 1, 507, quoted by Sax, *Melting Pot*, 73.
[16] Sax, *Melting Pot*, 73.
[17] See BMA vs Commonwealth of Australia, 1949, 79, CLR, 201.

the Pharmaceutical Benefits System (PBS) was introduced by the Commonwealth at that time and continues today.[18]

The funding of medical services in Australia has a tumultuous history. The Friendly Societies were a source of a steady, if limited, part of the income for GPs in many areas of the country during the early decades of the 20th Century, and persisted in places like Newcastle, the Hunter Valley, Broken Hill and some isolated country towns until after WW2.[19] They worked on the capitation system, the GP being paid a quarterly sum to care for the whole family, and this included unlimited house calls, care in hospitals, and often prescribing and dispensing medications as well, in the days of massive outbreaks of infectious diseases.[20] Confinements were excluded.[21] Private patients paid one half guinea (ten shillings sixpence) per visit. Even before WW1 a National Health Insurance scheme had been discussed, as the profession was aware of the scheme which was begun by Lloyd George in the UK, modelled on a scheme originally suggested by Bismarck in Germany. But the First World War, followed by the Great Depression, put this on hold.[22] An outline of 'out of hospital' services after Robert Menzies came to power in 1949 is also provided by Sax.[23]

The Menzies era extended from 1949 to 1968, and over that time many changes in the organisation of health care occurred. Health strategy moved from the planned wartime Labor's nationalised British-style health model. The Menzies Government had a commitment to the voluntary health insurance model, but there was targeted assistance to the needy in its programmes in parallel with the Earle Page Scheme, discussed more fully below. A time line of changes over those years gives an outline of the major developments.

1951 - Pensioner Medical Service (PMS) began.

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[18] The Pharmaceutical Benefits Scheme (PBS) was established in 1948. It provided 140 lifesaving and disease preventing drugs. It was not ruled as unconstitutional by the High Court. These drugs were free to the consumer until 1960, when a nominal user charge was introduced.
[19] Poidevin, *The Lucky Doctor*, 18.
[20] William Holley, *Memoirs of the Old Docs*, (Newcastle: Hunter Postgraduate Medical Institute Archives, 1991), who was paid one shilling and eleven pence per fortnight per family in West Wallsend in 1945. See also, Memoirs of other GPs in the Hunter region in the HPMI Archives. And also Ludwig Brook, "The Sweating of the Medical Profession by the Friendly Societies", *Australian Medicine*, (15 July, 1991), 5. (This is a report from 1896, recording that one quarter of patients were part of the 'Lodge' system).
[21] A good reason for GPs to continue obstetrics.
[22] Health Care in Germany. Germany has the oldest social health insurance system in the world dating from Otto von Bismarck's Health Insurance Bill of 1883, Accident Insurance Bill of 1884, and Old Age and Disability Insurance Bill of 1889.
[23] Sax, *Melting Pot*, 335.

1952 - Hospital Benefits scheme (PBS) introduced.

1953 - Earle Page scheme began.

1955 - Restriction of PMS and pharmaceutical benefits announced.

1956 - All States except Queensland now had charges for public ward accommodation.

1959 - Increased gap coverage announced.

1960 - A charge for prescriptions on the PBS began.

1961 - Australian Medical Association (AMA) formed from a union of the State branches of the British Medical Association (BMA).

1967- Public Medical Officers Association formed and registered as a trade union.

Dr Earle Page was Minister for Health in the Menzies Coalition Government in 1953 and introduced a new scheme which provided a better organised system.[24] The 'Earle Page Scheme' as it became known signalled more Government involvement in the provision of health care. It was a voluntary system whereby every person in the community was free to choose or not to take advantage of the benefits to which he/she was entitled. The scheme operated within the existing framework for the provision of medical and hospital care, including freedom for the doctor to accept patients, and patients to choose who would care for them.[25] It depended on the hospital facilities being provided by the States, local communities or religious organisations, and freedom to opt in or out of the doctor/patient relationship was preserved. It stipulated that standards of treatment should be maintained at a high level and that the scheme should aim to cover a wide proportion of the community. The obligation to provide care was mandated by the BMA ethical guidelines, which the vast majority of doctors accepted.[26] This scheme continued throughout the

[24] Sir Earle Page (1880-1961) was a GP surgeon and a prominent politician, born in Grafton. He was a World War One veteran, founded the Country Party, began the moves to establish the Commonwealth Bank, and grants and loans to the States. His health insurance scheme lasted from 1953 until 1972. See Carl Bridge, *The Australian Dictionary of Biography Volume 11*, (Melbourne: Melbourne University Press, 1988), 122.

[25] In the pre-existing Lodge practice system, freedom of choice was limited. The availability of doctors in many districts was also an issue. But 'freedom of choice' was to be threatened by the later proposals of the Labor Party regarding hospital care.

[26] Doctors do have an obligation to treat the sick, but this is qualified. See Michael Gorton, RACS solicitor, *Surgical News* 9, (July, 2008), 8 for the legal position, especially anti-discrimination legislation of later years.

Menzies Government, and Page was able to claim in November 1953 that five million people were already in the voluntary scheme.[27] The scheme covered four distinct areas of health care: hospital benefits, medical benefits, pensioner medical services and pharmaceutical benefits. It relied on integration with a large number of private insurance providers, Friendly Societies, hospital insurance funds and trade union schemes. The Commonwealth subsidised the cost of care, so that the contributors' subsidy from the insurer, plus a small contribution from the patient, covered most of the fees. It depended on the GPs charging a 'Common Fee' agreed to by them after negotiation with the Government. Specialists set their own fees.[28] Observance of the 'Common Fee' was always an issue between Governments and the profession, and the AMA boosted its case by publicising its observance in the AMA Gazette.[29] The original scheme was planned to cover 90% of the fees, but it gradually fell short, and even in the first year, insured patients ended up paying up to 37% out of their own pocket, so that for 15 years patients paid on average up to 30% out of their own pocket, leading to progressive dissatisfaction with the scheme. Dr Repin, Secretary General of the AMA, reminded critics that patients as well had free access to public hospitals and public wards subject to a means test, and all public (uninsured) patients at that time were treated free of charge by the 'Honoraries'.[30]

Private patients were charged directly by the specialist or GPs who had access to the public hospitals.[31] In obstetrics, those with Honorary positions at the public hospitals were able to deliver their patients from their private consulting rooms, and charge what they believed was an appropriate fee.[32] The accommodation provided by hospitals for these private patients was usually little different from those classified as 'Public' after means testing. They were often in adjacent beds in the same ward, and had identical nursing care. A similar situation existed for private gynaecological

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[27] "Five Million Now in Health Scheme Says Dr Page', *Canberra Times*, 11 November, 1953.
[28] George Repin, "They Can't Say They Were Not Warned", *MJA* 173, (3 July, 2000), 17. Dr Repin was Secretary General of the AMA from 18 June, 1973 to 1987. The Common Fee concept was initially controversial in the profession.
[29] Sir Kenneth Anderson, Minister for Health, "How the Most Common Fee is Observed", *AMA Gazette* 57, 13 July, 1972.
[624] Alan D. Hewson, "The Honorary Medical System - Archaic or Future Survivor?", *AMA Gazette*, (March, 1979), 15.
[625] For details regarding the way the Honorary system worked in practice see the *AMA Gazette* article above.
[626] Fees charged had varied markedly depending on the professional reputation of the individual specialist, but the later introduction of the' most common fee' principle produced some levelling out of charges.see *More Than Just a Union*, 64, 65.

patients, and the private patients were usually involved in the teaching programmes of the departments, although this varied from hospital to hospital.

In many Sydney teaching hospitals the privately insured patients had a separate ward, such as Gloucester House at the Royal Prince Alfred Hospital. Again there were variations across the State. In the outpatient clinics at public hospitals, the obstetric care there was provided by the midwives, resident and registrar staff, with specialists available for overall supervision, and for opinions as necessary on an 'on call' basis. The outpatients in obstetrics came into hospital for delivery, cared for by midwives with residents in attendance, again with back up by consultants as required. All patients came in nominally under the care of a specialist who was called as necessary by the attending midwives or registrars. There was variation from hospital to hospital regarding the extent to which the specialist became involved in individual cases, but they had the option to insist on caring for any difficult case throughout pregnancy.[33] Mostly the care was made available on a rostered basis so that the public uninsured patient may not have the same consultant on a regular basis. This difference was what the private patient was paying for when they consulted their doctor.[34] To add to the confusion, in country hospitals the attending GP usually provided continuing care in hospital to all of his/her obstetric patents both public and private, and some public patients in city hospitals opted to come to direct financial arrangements with the attending specialist doctor to ensure they had continuing care from the same doctor. This flexibility was to be directly affected by the proposals of the Labor Party which would lock all 'public' patients into a standard ward with no choice of doctor.

The Referral System was a most important part of the scheme. It ensured that a patient who needed to see a specialist was penalised financially if they went to them directly. If they went through the GP, the Commonwealth paid a higher contribution towards the cost, and this system has persisted.[35] Although this feature of the Australian health care system has a long history, it was not until 1970 that it received

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[627] At RNH 'at risk' patients had a red sticker on their chart indicating that the consultant must be informed of their admission.

[628] See the Hunter Valley chapter(6). Even though Royal Newcastle Hospital had many staff specialists, this pattern of service continued for decades.

[35] The referral system was designed to ensure that the GP remained the gateway to the medical system in Australia. The system does have problems in the field of obstetrics where patients often want specialist care even if they are 'normal'.

Government support and financial recognition. As recorded in the *AMA Gazette* in September 1970:

> A formal notice of referral to be signed by the referring doctor will be introduced by the Commonwealth Health Department, the target date being November 1st. The patient will require the notice if he is to receive the higher specialist and consulting physician rates of medical benefit, which apply to more than 300 services under the new Health Scheme.[36]

This followed the formal report of the 1968 Nimmo committee set up to review medical services in hospitals.[37]

Australia's medical profession received an international appraisal of the Australian health scheme by Sir Theodore Fox, the Editor of the *Lancet*, in a series of three articles in 1963 which identified the strengths and weaknesses of the Australian system, as seen by an outsider. Fox observed that even though the Australian doctor mostly practices in a city, he still has an image of himself as an isolated doctor, ready and willing to tackle anything. As Fox comments, 'He too has a stereotype, like the outback man.' He believed the British system is seen as 'more geared to the patient than the doctor', but conceded that Australia showed that 'a system which favours the doctor can work'. He also quoted Bernard Shaw, who stated that 'a hungry doctor is a dangerous doctor' but said 'so in the long run is a depressed doctor'.[38] Fox identified the risk of the GP surgeon doing too much, but noted the often impossible alternative of transporting an ill patient long distances for treatment, and stressed the advantage of very close personal care, the difficult transition due to a steady increase in trained surgeons, the differences in the States regarding hospital arrangements, the 13 year experience of the Earle Page scheme, which most doctors liked, and the pros and cons of over 100 health funds, commenting that 'they cover all their expenses and so save the taxpayer money'.

He noted that 'the whole Australian National Health Service is run by a staff of only 50 people in Canberra'; that the average surgery consultation is usually under

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[36] "Referral Notice is On the Way", *AMA Gazette* 28, (September, 1970), 1.
[37] The Nimmo Committee, chaired by Mr Justice Nimmo, was established by the Coalition Government in 1968 as a Committee of Inquiry into Health Insurance, but only in the context of a voluntary scheme and the existing arrangements with State Governments.
[38] Theodore Fox, "Private Practice Publicly Supported", *The Lancet*, (1 April, 1963), 875-879; *The Lancet*, (27 April, 1963), 933-939; *The Lancet*, (4 May, 1963), 968-993.

one pound, of which the patient gets back up to 16 shillings (or 80% of the payment), and commented that the scheme was designed to restore the prestige, position, and fullest usefulness of the GP. He forecast that the time would come when there would be a 'differential fee' structure to give a higher fee to specialists, and that the profession would have to devise a system which discourages GPs from doing work they are not specially trained to do. He commented that the NHS discourages GPs from 'doing much', but the Australian system encourages the GP 'to do more'. He emphasised the research of Jungfer, who studied 140 general practitioners in Australia, and noted:

> the fear of nationalisation lurks in the mind of every Australian doctor, and they were concerned that if nationalisation came, their specialist colleagues would desert them as happened in Britain.[39]

Fox recorded that the great public hospitals' special grants from the Commonwealth were largely funded by Government money, supplemented by fees, and donations from appeals to the public. He noted that 'the teaching hospitals are in a special category with special grants from the Commonwealth', and he was surprised to see most of the clinical work for public patients still being done on an Honorary basis by visiting specialists, or experienced GPs with an appointment, noting that these staff were expected to survive financially by income from their private practice, and so had to juggle time commitments to the hospitals.[40]

This overview provides a backdrop to the problems faced by the trained obstetricians coming back from Britain with their specialist degrees, discussed in Chapter Three. They were expected to take over obstetrics from experienced GPs who were paid the same as them via insurance, many of whom were very experienced and felt that delivery of the baby in the family was essential to providing 'complete' family care. [41]

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[39] Clifford Jungfer, *General Practice in Australia: A Report on a Survey*, (Sydney: Australian College of General Practitioners, 1963). Aneurin Bevan, who introduced the NHS in 1946, stated openly "we will stuff the specialists' mouths with money" to get their support, after 70% of doctors voted against the scheme.
[40] Fox, "Private Practice Publicly Supported, The Hospitals", *The Lancet*, 937.
[41] See Hunter Valley chapter(6) for discussion.

The Gathering Storm 1965 -1972

The drive for compulsory universal health insurance, 1968-1972, and the rise of the health economists were the major features of this period. The decade from the late 1950s to the late 1960s was one of turmoil for the medical profession, when what should have been its major concerns - education and standards of practice - were increasingly overshadowed by medicopolitical and financial issues. There were differing views within the profession regarding the role of general practice and the emergence of the RACGP in 1958.[42] The gradual incursion of the new breed of specialists into many areas previously under the control of GPs in medical practice, and unresolved matters in the medical undergraduate curriculum, were all controversial. [43]

There were also dramatic changes in nurse education during the late 1960s and early 1970s, culminating in the transfer of responsibility from the Minister of Health to the Minister of Education.[44] The establishment of the Nurse Training Schools, and later university degrees in nursing and midwifery, had a profound effect on the practice of obstetrics and gynaecology, because the previous close association of the two professions in the training environment of the hospital altered. It is ironic that moving the education of medical students into their future working environment from their first year in the new medical schools occurred at the same time as nursing moved trainees out of the hospital environment from their first year. While the case for change was rational, the final results of the change remains the subject of intense debate decades later.[45]

Another significant change to hospital care related to the remuneration of RMOs and registrars for 'call back' duties in hospitals. Mr Justice Cahill, in the State Industrial Commission on 3 April 1973, varied the Public Hospitals (Resident Medical Officers) Award to allow payments to these categories for call back duties

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[42] Fay Woodhouse, "*Cum Sciential Caritus, With Skill Tender Loving Care*", the Robyn Connolly Bequest Essay, The Royal Australian College of General Practitioners, Sydney, NSW, 2010.
[43] John Read, "Dilemmas Facing Curriculum Framers", *MJA* 1 (26), (26 June, 1971), 1388.
[44] Capper, "Nurse Education", 95-106. See also Committee of Enquiry to Study Education of Nurses in NSW, V.J. Truskett, chairman, Sydney, April, 1969; and also "Appeal to Premier Over Nurses Education", *NSW Branch AMA Monthly Bulletin*, (July, 1972).
[45] See the Hunter Valley chapter, and also Beryl Moore nee Gearside, *Reminiscences of the Royal*, "Innovation", (RNH Heritage Committee, 1997), 111.

for the first time, against strong opposition from all public hospitals. [46] This added to already legislated payment for extra shifts in the award. This was a step in 'wage justice' for RMOs, but as one thousand employed doctors were affected, it increased the costs of staffing public hospitals enormously, and in time progressively diminished the time available to train residents and registrars, which had significant flow on effects on recognition of training programmes, and the years of training demanded by colleges had to be increased.[47]

Remuneration of visiting doctors became increasingly important, and the AMA for the first time had supported the replacement of the old Honorary system by 'fee for service' in the public wards of public hospitals in 1969.[48] This principle became a major focus in the coming conflict with the Federal Labor Opposition, who were already championing a salaried arrangement for all public (i.e. no private health insurance) patients in the public wards. How hospitals should be staffed, including the role of staff specialists in public hospitals, was also a major issue, increasing the tense relationship between the profession and Government.[49] Even if the political conflicts between the ruling Liberal Government and the Labor Opposition had not existed, the profession would still have had enormous problems to solve at that time. Contributions to the literature by Sidney Sax, Paul Gross, and the AMA via its Presidents, were informative but were hotly debated by the profession at large.[50]

Dr Paul Gross addressed Australia's obstetricians at a National meeting in 1970. He predicted the role of the discipline would change dramatically and it would face increasing pressure to focus on preventive medicine rather than curative. He believed there would be an oversupply of specialists; it was likely that they would encounter diseases for which there is no known cure; and that consumers and providers of care would have to become aware of the costs of care and alter their

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[46] "RMOs, Registrars Get On Call, Call back Pay", *NSW AMA Monthly Bulletin,* (23 April, 1973), 3.
[47] This problem continued for years. The RACOG Training and Accreditation Committee was forced to regularly extend length of training, as shorter working hours became law. See Council minutes of RACOG, Author's files, 1981-1993.
[46] Editorial; "Medical Teachers Unpaid: AMA Seeks Payment for Teaching Hospital Visiting Staffs", *AMA Gazette,* (3 April, 1969), 1.
[49] Staff specialists were appointed in increasing numbers by the McCaffrey administration at the Royal Newcastle Hospital from 1949.
[646] Sax, *Melting Pot,* 1972, 1-6; Paul Gross, "Specialist Care in Australia, Advanced Course in Obstetrics and Gynaecology", *RACOG,* 12 May 1970; Clarence O.F. Reiger, "Fees Not Main Cause of Rising Costs", *AMA Gazette,* (2 October, 1969), 3. "Fees Will Not Be Fixed", *AMA Gazette,* (19 December, 1968), 1.

thinking on many issues. He felt that obstetricians and paediatricians had not come to grips with preventive medicine, and that the changing age demographic would make many changes to practice. Money going to health care would have to consider outcomes as the primary driver, and the issue of continuing education was going to become more important. His analysis of the future was accurate.[51]

Documentation from the British National Health Service was always front page news, especially for expatriate British GPs who had fled the NHS.[52] There were now hundreds of doctors who had immigrated to Australia because of their dissatisfaction with the British National Health Service and their attitudes were published in the *Journal of the Voluntary Health Insurance Council of Australia* in March 1968. From 730 names and addresses with British degrees practising in Australia, personal interviews were conducted with 360. 70% of these doctors believed the British system led to an unsatisfactory standard of service to patients; 90% said it created an unsatisfactory relationship between the patient and doctor; 94% said the NHS led to overuse of doctors and medical facilities; 78% believed that the free enterprise system with choice of doctor promoted greater efficiency; and 85% would not consider returning to the NHS.[53] The new Canadian Health Scheme was also being watched carefully.[54] The continuing campaign in the United States against Government involvement in health care was widely publicised.[55] The basis for that concern was echoed in Australia.[56]

There was growing dissatisfaction with the existing voluntary system of health insurance. The Opposition set up a Senate Select Committee on medical and hospital costs in 1968, and the Government responded by establishing the Nimmo

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[51] Gross, "Advanced Course, 1970".
[52] "Gloom in Britain over Doctors' Pay", *AMA Gazette,* (3 September, 1970), 7.
[53] "A Special Report: Survey of British Doctors in Australia", *Voluntary Health Insurance Council of Australia* 1 (2), (March, 1968), 1.
[54] "Hospital Insurance in Canada", *Health Quarterly: Journal of the Commonwealth Department of Health* 17 (4), (December, 1967); "Biggest Block for Canadian Medicare, Toronto Turns its Back on Scheme", *AMA Gazette,* (8 April, 1969), 2. See also "Better Care for Canadian Outpost", *AMA Gazette,* (13 July, 1972), 14.
[55] Even after Australia had embarked on a national insurance scheme from 1972, opposition to Government involvement continued in the USA. See Richard Egdahl, Cynthia Taft and Kenneth Linde, "Editorial: Method of Physician Payment, and Length of Stay", *New England Journal of Medicine,* (10 February, 1977).
[56] Australia's first heart transplant was performed at St Vincent's Hospital in Sydney by Harry Windsor in the middle of this political turmoil, and the AMA reported on the deliberations of its group on medical education. See "Medical Education and the AMA Study Group", *MJA* 2 (4), 22 July, 1972.

Committee.[57] The Health Economists, Richard Scotton and John Deeble, from the Melbourne Institute of Applied Economic and Social Research, developed proposals which were to form the basis of the ALP health policy platform of the 1969 election. [58] The proposals included a National Hospitals and Health Services Commission to cooperate with the States, a national Aboriginal health program, a universal health insurance system, nursing home and home-based services, a national school dentists program, upgraded preventative occupational and rehabilitation services, new community mental health services and psychiatric hospital care integrated into general hospitals, with ongoing evaluation of all programs.

In 1969 the Gorton Coalition government responded by introducing a new Health Benefits Scheme, including a co-payment by patients per service of five dollars, and the notion of the 'Most Common Fee'; to be a median fee for each service on which to base medical benefits for health insurance purposes. The fee was to be based on the fees most commonly charged for over 1000 medical services. The benefit was set so that the fee charged to patients should not exceed five dollars. For GP services, the patient was expected to pay $0.80 and $1.20 respectively of the common fee for consultations and visits. There was controversy in the profession regarding the common fee principle and the AMA's support of higher fees for specialists than for GPs, and GPs warned the AMA that its stance threatened the unity of the AMA.[59] The General Practitioners Society of Australia (GPSA) was formed in 1968 in reaction to the AMA's co-operation with the government over the common fee, and the Fee Differential issue.[60] The AMA section of General Practice NSW branch was also critical of much that was proposed.[61] Anti-government sentiment increased in the profession generally. Soon after the introduction of the Gorton government's new system, the media began reporting that doctors were charging

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[57] *Australian Commonwealth Committee of Inquiry into Health Insurance*, (Canberra: Commonwealth Government Printer, 1969), (Nimmo Committee).
[58] Richard Scotton, "Voluntary Health Insurance in Australia", *Australian Economic Review*, (2nd Quarter, 1968), 37-44; Richard Scotton and John Deeble, "Compulsory Health Insurance for Australia", *Australian Economic Review*, (4th Quarter, 1968), 9-16. Also R.B. Scotton and Christine Rose Macdonald, *The Making of Medibank*, (New South Wales: University of NSW, 1993).
[59] Bob Browning, *Health Funding and Medical Professionalism*, Gorton Government Health Benefits Scheme, AAMS, (December, 2000), 6.
[60] The General Practitioners Society was formed in 1968, as GPs were disillusioned by the AMA's approach to many issues including any Government intervention into Health care. See Bolton, *Oxford History of Australia*, 209.
[61] Warwick Ruscoe, the Committee of the Section of General Practice, NSW, *Critical Commentary on the Minister of Health Address, 31 March 1970*, circulated to all AMA Members, 27 April, 1970.

more than the common fee for their services, and that doctors' fee increases were well above increases in the Consumer Price Index. It was claimed that the 'Common Fee' concept for estimating benefits at the beginning of the scheme had now become the 'minimum fee'. Some of the media called for the Federal government to control doctors' fees.

In spite of a generally negative press coverage of the controversy regarding the insurance issue, occasionally a journalist put the other side of the argument.[62] An article in the *Australian* newspaper compared the real costs to consumers of getting health care in Australia, Great Britain, France and Denmark, concluding that the Australian scheme compared well with other countries, and was positive about an appropriate outcome from all the enquiries then under way, the Nimmo Inquiry in the Senate in particular. But that analysis was the exception, and the continuing official enquiries were very critical of the existing system. Dr William Refshauge, later associated with the Doctors Reform Society and a New South Wales Labor Minister for Health, claimed that in Australia individual doctors now 'have greater authority to spend public funds than government officials'.[63] Others claimed that the rising costs and government expenditure was due to a combination of factors affecting all developed countries irrespective of their health system. Obstetricians became irritated by the fees issue criticisms, having a historically low fee base, with no recognition of the unsocial hours and the then obligatory seven days a week cover expected by their patients, with remuneration still linked to other 'limited hours' specialty groups.

The Nimmo Report found that the existing scheme was too complex; the benefits received were too low; the contributions were beyond the capacity of many patients; bureaucratic red tape was causing hardship; too much of contributors' money was being absorbed by the operating expenses of the multiple insurance funds; many health services were not covered by the scheme; and that the failure of the Earle Page Scheme was due to failure of the partnership of all those it needed to make it work. Justice Nimmo recommended an independent body to administer the scheme and to supervise its operation. Another panel, the Commonwealth Committee of Enquiry into Health Insurance, found serious inadequacies, and made 42 recommendations about standard public ward charges and doctors' fees. It also

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[62] John Hallows, "Your Money or your Life", *The Australian*, 24 October, 1968.
[63] Browning, *Health Funding*, 7.

recommended that larger firms and government authorities should be encouraged to establish closed Health Insurance Funds, so encouraging competition between funds. The government introduced subsidised medical service arrangements to assist some Social Services Act beneficiaries, and the Handicapped Children's Benefit was introduced. In 1970, the final *Report of the Senate Select Committee* was tabled, which confirmed the inadequacies reported by the Nimmo Committee, and added another 59 recommendations.[64] A minority report recommended a completely new national system based on a levy on taxable income.

The Gorton Government's revamped health insurance scheme then began operation. Despite strong opposition from some, a plebiscite of AMA members approved the government's new health benefits scheme. The AMA claimed that it had 80% of all doctors as members validating its survey, but this figure went down to approximately 50% in the 1980s. But the profession was divided on many issues including the common fee issue, the referral system, the role of specialists *vis-a-vis* GPs, and whether withdrawal of services was justified, and obstetricians were drawn into these arguments as their role in medical care straddled the GP/specialist divide. In many places they were displacing GPs who had previously carried out the obstetrics, and the referral controversy was a difficult issue. The AMA in November 1971 issued a statement signed by all the State Presidents and the Federal Executive pleading for unity of purpose and asking for endorsement of the AMA to negotiate on behalf of the whole profession.[65] In 1971 the Senate Standing Committee had also revealed serious deficiencies in services and facilities for the mentally and physically handicapped, and the government raised the charge for PBS items from $0.50 to $1.00.[66] In view of all the confusion and changes outlined, it is not surprising that when the opposition Labor Party went to the 1972 election with what appeared to be a much simpler and better organised system, it became a major factor in its electoral success.

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[64] Senate Select Committee on Medical and Hospital Costs, Parliamentary Papers, Canberra, 1970, Session No. 2.
[65] *AMA Official Circular to all Members*, (NSW: AMA Glebe, 29 November, 1971). See also Dewdney, *Health Services*, 73, who commented on the many divisions in the profession at that time.
[66] The above account is a summary of information from "The History of Medicine, Australian Academy of Medicine and Surgery", *AAMS*, http://www.ams.org.au/contents.php?subdir=library/history/funding_p, (accessed 25 November, 2013).

AMA Secretary General, Dr George Repin's overview of these events in 2000 asserted that the Labor Party's agenda was driven by ideology and not by facts.[67] He believed that by the time the Federal Labor Government was elected in December 1972, many of the perceived deficiencies of the previously existing arrangements had been corrected, as there were amendments under the existing Coalition government to close the gaps between the fees charged and the benefit, reducing the patient's proportion of the fee of 34% to 18%, a subsidy health benefit for low-income earners, and improvement in the arrangements for the unemployed and migrants, as well as changes to increase the benefits for long-stay hospital patients and patients with pre-existing illnesses. So the argument that change was necessary because a large group of people were not covered was no longer sustainable. He argued that at any given time, only about 5% of the population was not adequately covered.[68] He quoted letters from trade union officials to the AMA stating: 'This union will support the campaign being waged generally within the trade union movement in support of nationalised medicine.' He claimed that many journalists in both the print and electronic media, instead of reporting the news impartially, were active advocates of change. He stated that the AMA had difficulty in getting its position presented fairly in the media and instanced 'the hostile reception' given to the President, Dr Keith Jones, at a National Press Club address. In spite of efforts by the AMA to put the views of the medical profession directly through doctors' consulting rooms via pamphlets, the profession was unable to make the public aware of what it saw as the negatives of the 'Big Brother' type National Health Service with centralised control; identification of billing patterns; disincentives to providing services and requesting tests; and Government's commitment to control costs without input from the profession, which inevitably would constrain and influence clinical decision making. All these negatives were already apparent in the existing Canadian health scheme.[69]

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[67] Dr George Dimitri Repin was Secretary General of the AMA for many years, and prepared many of the profession's submissions to Government.
[68] George Repin, "They Can't Say They Weren't Warned", *MJA* 173, (3 July, 2000), 17.
[69] "Hospital Insurance in Canada, Information Provided to the Profession by Mr R.B. Rofe", *Journal of the Commonwealth Department of Health* 17 (4), (December, 1967), 16.

Medico-Political Confrontation After 1972

Medico-political confrontation was a difficult issue at the community level, not just inside of the medical profession. This author was President of the local branch of the AMA in 1970-1972, and was subjected to considerable harassment from the trade union movement, in private and in the local press, because he had published the profession's concerns about the proposed Labor scheme in the *Newcastle Morning Herald*.[70] There were threats to cut off doctors' petrol supplies by Mr Jack Kidd, the secretary of the AMWU, and to begin a black ban on any work by trade union members for the medical profession. This type of intimidation is difficult to believe in today's world, but it was considered normal behaviour when union power was at its height in Newcastle in the 1970s.

Another complicating factor in New South Wales became prominent in April 1973 related to *Section 36 of the New South Wales Public Hospital Act*. This Act stated:

> that no medical practitioner shall charge a patient who was under treatment by him in the hospital with any fees in respect of the treatment unless such patient has been classified as a private or intermediate patient in accordance with the regulations, saving circumstances referred to in subsection 1 of this section and no contract between the patient and a medical practitioner for payment for such treatment shall be enforceable.[71]

This section of the Act produced major problems for country doctors, particularly in those areas where the population accident rate was greatly increased with school vacations and weekend holiday traffic. The AMA had sought to remove this anomaly for many years but succeeding governments had refused to change it. It became of major importance after the election because of the controversy regarding fees for

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[70] Alan D. Hewson (President, CNMA), "Costly Propaganda to Buy the People", *NMH*, (4 October, 1973), 2. See also Philip Furey (GP Society), "Scheme Hasty, Ill Advised", *NMH*, (4 October, 1973). Letter to the *Newcastle Morning Herald* from R.M. Adamson, AMWU, 25 July, 1975, seeking details of any doctors who did not bulk bill "so action can be taken". See also, letter from Trevor Best protesting about "bans being imposed on doctors by the Builders Labourers Federation", *NMH*, (16 November, 1973). Also comments by Shepherd and Catts regarding Union criticisms and threats in their texts.

[71] Monthly *Bulletin of the NSW Branch of the AMA*, (23 April, 1973), 1.

public ward patients, and the AMA again asked for this section of the Act to be reviewed at that time, but no action was taken.[72]

Dr Keith Jones, president of the AMA, looking back, stated in the annual 1975 report of the AMA:

> Throughout the turbulent medico political activities of the past three years I have at all times been concerned that all the disciplines making up the AMA must remain united as a profession. My further concern is for the professional image of medicine. It should not be tarnished or destroyed further by these medico political conflicts.

He 'believed that the profession had emerged still united and untarnished, but the danger of splintering and division was still there and remained as the greatest threat to the practice of medicine as we know it'.[73]

The incoming Whitlam Federal Labor Government in 1972 lost no time in planning for its National Insurance Scheme. In April, 1973 a *Report from the Health Insurance Planning Committee* was published.[74] That committee was co-chaired by the two advisors to the ALP mentioned earlier, Deeble and Scotton, who, while holding doctorates, were not medical practitioners, and administration personnel from the Department of Social Security and Health, who were given directions on the overall scope of the report by the incoming Minister for Social Security, Bill Hayden. The report covered matters like eligibility and registration, the benefits to be provided, hospital services, health programme grants, the revenue of the Health Insurance Fund, private insurance, the organisation and systems necessary, and financial estimates. In November 1973, Hayden provided more information regarding the scheme, but his document only included details regarding the way in which specialists in the hospital system would work and be remunerated, and its impact on

[72] This part of the Act being fair to obstetricians depended entirely on diligent assessment of Insurance status of emergency admissions. It remained a source of conflict and controversy for years.
[73] Keith Jones, Annual Report, AMA, 1975, in *More Than Just a Union*, 74. See also "Medibank, Looking Back after 25 years", *MJA* 173, (3 July, 2000), 15.
[74] *Health Insurance Planning Committee Report*, Australian Government Publishing Service, Canberra, 1973.

the then existing 'fee for service' system plus Honorary service.[75] It was this area which had caused conflict with the profession.

In spite of the reassurances that the Government would seek to retain a personal and fiduciary relationship between doctor and patient, it was clear the Government was planning for fully salaried hospital doctors to take over the care of standard ward patients, and the existing one-on-one relationship between visiting doctors and patients to die out. The document stated the continuing demand for a 'fee for service' pattern in the public (standard) wards would not be allowed. So the profession saw the envisaged system as another step in de-personalising the doctor-patient relationship once the patient entered hospital, and was one of the main reasons why the profession continued in opposition to the scheme.

Another document for medical practitioners was published later.[76] This aimed to exert pressure on doctors to 'bulk bill' the Government directly for all services both within and outside hospitals, breaking the long established nexus between the service and the payment, again raising the spectre of nationalisation. Limitation of services and control of fees were already occurring in Canada.[77] The disappearance of private hospitals in Canada had led to absolute Government control of doctors and their workplaces.[78] The document stated that no benefits would be payable for 'hospital' (standard ward) patients, as the scheme envisaged all services there would be covered by sessional or salaried payments. Increasing bureaucracy was confirmed in the increasing number of forms to be completed in claiming payment, and the profession became increasingly alarmed by this intrusion into their relationship with patients.[79] The profession had made its views clear on this matter of 'capitation', or Government salaried approaches to payment for health care, as far back as the first AGM of the newly formed AMA. Dr Colville as President had commented that:

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[75] *The Australian Health Insurance Programme*, authorised by the Minister for Social Security, (Canberra: Australian Government Publishing Office, 1973).
[76] *Medibank Information for Medical Practitioners,* (Canberra: Australian Government Publishing Service, 1975).
[77] There was a significant difference between the Canadian Scheme and Medibank. In Canada all fees were remunerated on a 'fee for service' basis, so the only way in which the Government could control costs was by limiting services or fees. When the inevitable increase in waiting times occurred, Canadians began going over the border to the USA for private services. Australians would not have that option.
[78] Peter Arnold, "Why did Canada's Medicare Fail?", in *Let's Take a Look at Medicare*, eds. P.V. Brassil, L.J.M. Cooray, (ACFR Community Project, 1984), 19.
[79] The anger over "increasing form filling" then must be related to its virtual absence previously.

> Capitation and salaried medical service involving as they do the intrusion of a third party into every phase of the doctor patient relationship must inevitably lead to a deterioration in the standards of medical practice.[80]

He also believed it would lead to damage to the 'trust' relationship as well, as patients became aware that their doctors could have extraneous influences directing decisions. Dr E.S. Meyers, in a senior position in the NSW State Public Health Service, was highly critical of the p**r**oposals in the *AMA Gazette*, quoting from the relevant literature and the review by Sir Theodore Fox. He was critical of the proposals to change GP status in hospitals to a salaried service, with the breakdown of the direct relationship previously enjoyed by patients.[81] The AMA history, *More than Just a Union*, points out that there was a 'furious reaction' to the announced plans from private hospitals, insurers, many in the community, and the AMA, which stated that the proposals 'amounted to nationalisation of the profession'.[82] National and provincial newspapers headlined the matter.[83]

After intense lobbying and pressure from the AMA and other bodies, the original proposals were modified only slightly. They left private hospitals alone, removed the banning of private health funds, and tinkered around the edges of financial remuneration for public ward patients. The controversy regarding Labor's plans came to a head with the refusal of the Senate in 1973 to support key elements of the legislation, resulting in a double dissolution election. After the re-election of the Whitlam government in 1974, its Health Bills were passed by a joint sitting of both houses of Parliament.[84] But there were many remaining problems, including the refusal of the Liberal governed States to sign agreements with the Federal Government regarding the hospital arrangements; the refusal of most doctors to bulk bill patients, except for special categories such as pensioners and the indigent; and continuing controversy regarding fees. Through this time the reputation of the profession was under attack, Government alleging that the whole controversy was

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[80] Cecil Colvill (Sir), Presidential address, AMA first annual meeting (AGM), May, 1962, reported in *More Than Just a Union*, 62.
[81] E.S. Meyers, "Labor GP Hospital Plan Would be Disaster", *AMA Gazette*, (18 May, 1972), 4.
[82] Colvill, *More Than Just a Union*, 73.
[83] "AMA Attacks Labor Health Scheme: Nationalisation of Doctors Forecast", *NMH*, (5 September, 1972), 1.
[84] Bob Browning, "Labours Medibank did not come into operation until four months before the dismissal of the Whitlam Government in 1975", *Health Funding*, 8.

about money, that doctors were greedy and interfering with the care of the needy. This further antagonised specialists like obstetricians who were still providing their services and emergency cover in the public wards free of charge as Honorary Medical Officers.[85] An important decision by the Federal Assembly of the AMA in 1975 was to urge all doctors to avoid bulk billing under any circumstances.[86] This ongoing dispute was overshadowed by the financial crises which enveloped the Whitlam Government during late 1974 and through 1975.[87]

The Fraser Coalition Federal Government 1975-1983

Following the election of the Frazer Government, many of the problems remained, and although it had promised to get rid of Medibank, the Government began a review process aiming for a scheme which retained some of its features, had some appeal to the community but removed the more controversial aspects.[88] The frustration of the profession with the Frazer Government was that it did not use its majority in both houses of Parliament to legislate on health as was expected, a frustration outlined in the *History of the AMA* document. Over the next three years there were a series of enquiries and submissions to Government, with changes in policy related to bulk billing, the future of the Medibank Private Health fund, the private hospital system and the remuneration for services to public uninsured patients. What was called 'Medibank Mark Two' was becoming what the AMA President called 'an unholy mess' in late 1977, and people were dropping out of private health insurance at an alarming rate. By 1980, 40% of people were outside the private health insurance system. [89] The Frazer Government was re-elected with a greatly reduced majority in 1980, and following the Jamieson Enquiry some positive steps were taken which were acceptable to the profession. Health insurance was made more attractive and States' hospital funding was changed to 'Grants' instead of sharing of costs as in the previous scheme. But the controversy which most affected obstetricians, the public hospital arrangements for care and charges, remained unresolved. Most confinements were still being carried out in the public hospital system by obstetricians and a

[85] Most obstetricians refused to move from Honorary Service to Sessional service for public patients at that time.
[86] "Assembly Decides: Never Bulk Bill or Assign", *AMA Gazette*, (26 June, 1975), 3.
[87] Paul Kelly, *The Unmaking of Gough*, (Sydney: Angus and Robertson, 1976), 355.
[88] Colvill, *More Than Just a Union*, 79.
[89] Colvill, *More than Just a Union*, 81.

diminishing number of GPs. In NSW there were few well equipped private hospitals in which obstetricians were comfortable to care for potentially complicated deliveries. So obstetricians were particularly vulnerable to Government dictates regarding public hospital care. It is a tribute to the medical and nursing professions that through this time of turmoil, the evidence points to a continuing high standard of care in the public hospital system.[90] Surprisingly, through the 1970s, a large number of new initiatives in medical care, undergraduate and post graduate teaching and research were launched which were to markedly change the structure of the whole health care system in Australia, in spite of the political turmoil.

Important Changes in the 1970s

The first of these changes was the curriculum planning for Australia's Medical Schools that was occurring, making headline news in the *Medical Journal of Australia*, with a whole issue devoted to the topic in 1971.[91] In November 1972, the AMA made a major submission to the Australian Universities Commission Committee on Medical Schools which included a detailed analysis of Australia's medical manpower problems. It pointed out that the main problem was the poor distribution of doctors in the community and stated that: 'there is a disproportionately high number of specialists compared with general practitioners, and a need for more doctors, both general practitioners and specialists for services in country areas.'[92]

There followed a recommendation for greater use of community health centres. In 1972, *General Practice and its Future in Australia*, the first report of the AMA Study group on medical planning, recommended the establishment of Community Health Centres to preserve the 'new' general practice. It noted the work of the GP had altered over the last generation, and the amount of surgery performed appeared to be decreasing. The report stated:

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[90] Colvill, *More Than Just a Union*, 81.

[91] *The Medical Journal of Australia* 1 (26), (26 June, 1971), 1357-1400:
Editorial: "Curriculum Development in the Medical School",
"Dilemmas Facing Curriculum Planners" by John Read,
"Medical Education and Training Programmes Based on Five Years Undergraduate Study and Two Years Graduate Study" by F.F. Rundle,
"New Medical Course in Adelaide" by LW Cox,
"Undergraduate Medical Education: Six Years or Five?" by G.C. Lennon,
"Undergraduate Curriculum in Medicine: Current Trends" by B.C. Bromhead and co-authors.

[92] Planning Australia's Medical Manpower, AMA submission to the Australian Universities Commission on Medical Schools, *AMA Gazette*, (30 November, 1973).

> An appreciable number of GPs still do surgery and give anaesthetics, and 73% of GPs practice obstetrics. In the city the GP performs most of his (*sic*) surgery in private hospitals but his involvement in large hospitals is now limited.[93]

Further, a report from the National Hospital and Health services Commission, chaired by Dr Sidney Sax, recommended major changes to Community Health over the next three years.[94]

Another change occurred in 1972 when medicopolitical pressure groups began to form. The AMA was seen by many groups in the profession as unable to adequately represent their views in continuing confrontations with Government. This led to the formation of 'discipline specific' groups which confounded attempts by the Government to reach agreement on contentious issue. The major groups were the Australian Society of Orthopaedic Surgeons (ASOS), led by Bruce Shepherd; the Australian Association of Surgeons (AAS), led by Michael Aroney; and the National Association of Medical Specialists (NAMS), led by Boyd Leigh and later Nils Korner. In addition the National Association of General Practitioners (NAGPA) claimed to represent general practitioners, separate from the AMA. All had similar philosophical positions in completely opposing what they saw as creeping nationalisation of the profession and attempts by Government to interfere with the traditional relationship between doctors and patients. They each developed extensive networks of communication, held national conferences, provided alternative health care plans, and their relationship with the AMA was often tense and confrontational. The professional colleges were ill equipped to deal with many medicopolitical issues, because of their Articles of Association, and at times found themselves in conflict with the pressure groups. In the long term many of these pressure groups outlived their roles, and transferred residual funds into the Australian Doctors Fund.[95]

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[93] *General Practice and its Future in Australia: First Report of the AMA Study Group on Medical Planning*, (AMA, May, 1972).
[94] Sidney Sax, *A Community Health Programme for Australia, from the National Hospitals and Health Services Commission*, (Melbourne: Advocate Press, 1973).
[95] The Australian Doctors Fund is a public company, established in April, 1989. Its aims are to "strengthen, defend and promote the patient doctor relationship". It is still active, publishes a weekly newsletter, conducts meetings of doctors to discuss important medicopolitical issues and lobbies governments as appropriate, http://www.adf.com.au, (accessed 8 March, 2015).

With regard to the private hospital sphere, the conflict between the Government and the profession was intense in NSW because of the shortage of private hospital beds in NSW compared to other States. In NSW it was accepted that a public hospital appointment was the ultimate goal of the rising consultant, and as a result, the private hospitals had suffered from a lack of expertise on their staff and were often limited in equipment. St Margaret's Maternity Hospital, St Luke's at Darlinghurst, the private wing of St Vincent's, and Gloucester House at RPAH were exceptions in Sydney. In the other capitals well equipped private hospitals were common, and were a safety valve for the profession if the proposals of the Labor Government proceeded. This private hospital issue was important in obstetrics, because the 24 hour staffing required was expensive. A Newcastle investigation found that annual deliveries needed to approach 1000 before a unit became economically viable.[96] This was the reason why a new private hospital, in 1974, did not include an obstetric wing, even though its development was a direct response to the changes planned by the Labor Party.[97] The hospital was built because the profession recognised that their utter dependence on public hospital facilities made them vulnerable, and the same thinking drove the development of other private facilities at the time. It was now obvious that the profession needed access to modern hospital facilities apart from the public system, and the extensive network of quality private hospitals which are now an important part of medical care began at that time. Making sure that an alternative private hospital network was viable became a central issue of the later campaign by the profession.

It is ironic that the attempted nationalisation of the 'hospital dependent specialities' by the Whitlam Government in 1974 was the major driver for the present nationwide network of modern private hospitals. This process took some years and did not occur in NSW until unrelenting pressure from the profession and the community forced the Liberal State Greiner Government to remove the *Private Health Establishment Act*, which prevented real progress in private hospital development.[98]

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[96] "History of Christo Road Private Hospital Newcastle", personal memoir of Alan Hewson, unpublished.
[97] See the Hunter Valley chapter.
[98] Peter Catts, *How to Knife the Surgeons, the Life and Times of a Crusading Surgeon*, (Rhodes: Healthy Lifestyle Publishing, 2014), 382-384. To quote Catts "the most important goal set by the

After the dismissal of the Whitlam government, the Fraser government established the Medibank Review Commission Committee in January 1976. The committee findings were not made public, but a new program was announced in a Ministerial statement to Parliament on 20 May 1976. Medibank Mark Two was launched on 1 October 1976, and included a 2.5% levy on income, with the option of patients taking out private health insurance instead of paying the levy. Other changes included reducing rebates to doctors and hospitals, reverting to Grants to the States which were reduced if the States provided unrestricted free care.[99] But there were more changes to come with another change of Government.

The Medicare Debate

The 1983 election was won by the Federal Labor party under the leadership of Bob Hawke and health care changed again, with a return towards the original Medibank model. Although the financing arrangements were different and there was a name change from Medibank to Medicare, little else differed from the original. Medicare came into effect on 1 February 1984, following the passage in September 1983 of the Health Legislation Amendment Act 1983, including amendments to the Health Insurance Act 1973, National Health Act 1953, and the Health Insurance Commission Act 1973.[100] The statements from the current Medicare website makes no mention of the many features of the scheme which were still completely abhorrent to the practising profession, nor that there were many critical issues still unresolved. The one which caused the major confrontation was the Commonwealth-State hospital arrangements regarding the contracts which doctors were expected to make with their State managed hospital, including the infamous 'Section 17' provision. The Labor Government was aware that its previous attempt to nationalise the profession in 1948 was declared invalid by the High Court, and sought to get around this by forcing the States to agree to only receive grants under the legislation, if the doctors working in

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profession in 1984 was to achieve deregulation of private hospital licensing". The number of private hospitals in Australia in 2011-12 was 592, with the number of beds and chairs now 29,004, and 3.9 million patient separations, an increase from 3.7 million in 2010-11. NSW now had 185 private hospitals compared to 225 public hospitals with nationally 30% of beds in private hospitals, excluding day care facilities. See AIHW Australian Government, http:www.aihw.gov.au/haag12-13/public-and-private-hosptals, (accessed 8 May, 2014).

[99] Browning, *Health Funding*, 9.

[100] Medicare: Background briefing, http://www.aph.gov.au/library/intguide/SP/medicare.htm, (accessed 3 December, 2013).

the public hospitals signed contracts acceptable to the Commonwealth Minister of Health, with no right of appeal.

This meant that every doctor with a public hospital appointment had to sign the new type contract which contained some completely unacceptable conditions. The AMA published a document outlining all the problems which doctors would face with the new system.[101] It then called a national meeting of all the medical groups including NAMS, NAGPA, the AAS, ASOS, the Australian Association of Anaesthetists, and State branches of the AMA. A united front emerged which agreed the profession was willing to continue to work under its existing contracts, but would not sign any new contracts which contained the unacceptable clauses. There were many unacceptable parts to the envisaged new contracts, but Section 17, which gave the minister almost total power over conditions of service and fees, was the key issue. There were issues related to diagnostic services in hospital, with the new Act deliberately designed to favour members of the profession providing these services under sessional arrangements, and disadvantaging others. This was seen as another device to divide the profession. In an atmosphere of confrontation, meetings dragged on for three months with Dr Neal Blewett as Minister for Health refusing to alter his position.[102] This was the beginning of massive confrontation between the Labor Government and the profession, with the public embroiled in the crossfire. Obstetricians were directly involved, as they had thousands of patients booked for confinement in public hospitals when all this developed and had no other alternative for their care.

One attempted compromise was a committee chaired by Professor David Pennington of the University of Melbourne which the AMA agreed to join.[103] Most of the States agreed to await the findings of the Pennington Review before implementing their part of the new Medicare program. Dr Blewett inflamed the situation by alleging that there was a 'cancer of medical fraud and over servicing' occurring which was costing the public purse nearly $10 million per year.[104] At the end of February, government confrontation continued by presenting the guidelines already rejected.

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[101] *A Handbook on the Practical Effect of Medicare*, prepared by Arthur Anderson & Co., published by the Centre for Professional Development (Melbourne, 1983).
[102] Colvill, *More than Just a Union*, "The History of the AMA", 89.
[103] David Pennington, *Committee of Inquiry into Rights of Private Practice in Public Hospitals*, Canberra, AGPS, 1985.
[104] Browning, *Health Funding*, 2000 (re Blewett on alleged over-servicing), 11.

The AMA responded that the proposals were in effect introducing 'price control for medical services rewarding mediocrity, ignoring excellence, and disadvantaging those it was meant to benefit'.[105]

In spite of the intervention of Prime Minister Hawke the government refused to deal with medical concerns, nor undertake any form of compromise on the essential issues, so the threatened industrial action by different sections of the medical profession began. The government had been warned that chaos would develop if they did not see reason, and procedural specialists and radiologists in NSW, supported by the NSW Branch of the AMA, began to withdraw all non-urgent services. This began on a one-day basis, but as the confrontation continued across virtually all States, various sections of the profession began withdrawing services on a rotational basis. During March on the initiative of the Australian Democrats a temporary truce was called, immediately before a nationwide withdrawal of services was to begin. This was the first time in Australia's history when a doctors' strike occurred, and although there were many attempts at compromise by the end of 1984, the parties had still not reached common ground. The situation was worst in NSW where there had been a long running dispute in the public hospitals regarding the terms and conditions under which private practice would continue in the public hospital system. Already many orthopaedic surgeons had put their resignations in writing and given them to Bruce Shepherd to be activated when he decided to do so. General surgeons were angry but holding back from actually resigning.

A critical step by the new NSW Wran Government was the recall of Parliament to pass legislation which decreed that any doctor who resigned from a public hospital appointment would be thenceforth 'black banned' from any future appointment in the public hospital system.[106] This infuriated the whole profession, and at a historic meeting at the Regent Hotel in Sydney on Saturday 16th June, over 1000 visiting surgeons voted unanimously to resign from the public hospital system unless their demands were met. They were later joined by the anaesthetists, and high profile cardiac surgeons at St Vincent's hospital, Victor Chang and Harry Windsor.[107]

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[105] Colvill, *More Than Just a Union*, "Contracts", 89

[106] The sequence of events is detailed in Catt's book referred to earlier (*How to Knife the Surgeons*, 397). Hansard records the passage of the *Public Hospitals Visiting Practitioners Amendment Bill*, 14 June, 1984.

[107] Catts, *Knife the Surgeons*, 392-407.

The newly formed Council of Procedural Surgeons (COPS) was chaired by Dr Bruce Shepherd, who recalled in his Memoirs later that by the end of the year the medical profession in NSW was 'back to midwinter'.[108]The hostility and tensions produced by the dispute are summarised in the *Australian Doctors Fund Dispute Edition* produced to commemorate the 30th Anniversary of the Dispute in 2014.[109]

Unfortunately the Pennington Committee report pleased no one, particularly procedural professionals in NSW, many of whom had already resigned from the public hospital system over previous months. The problems with the Pennington report were that it recommended a whole range of measures on fees, but made no attempt to address the major issues facing the profession. Dr Shepherd reported by October of that year 100 orthopaedic surgeons had permanently resigned their VMO appointments. For many this was a wrench, as they had spent many years providing honorary service to the public hospitals and their communities. The dispute continued and worsened. Aggravated by a threat from Mr Wran to bring in overseas doctors to provide a service, overseas medical organisations were now warned not to apply for medical posts in NSW while the dispute continued, and salaried doctors had already committed to not carry out work normally done by Visiting Doctors.[110]

By early December, 200 doctors' resignations had taken effect in NSW and 250 more were in process, resulting in a chaotic situation in the public hospital system. The story of the continuing disillusionment of the procedural specialists is outlined in the Bruce Shepherd narrative as the steady deterioration of the relationship between the procedural groups (including obstetricians), the AMA, and the Hawke Labor government.[111] At one stage Dr Shepherd was provided with police protection because of threats from members of the trade union movement, and there was the vindictive action of the Minister for Youth and Community services, Mr Frank Walker, who announced that his Department was pulling back the $50,000 it had previously approved for the Shepherd Centre charity for Deaf children, initiated and

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[108] Shepherd, *Memories*, 254.

[109] *ADF Health Headlines*, Dispute Edition, (April to July, 1984) –see appendices. There were other major industrial confrontations between the NSW Government and the Union movement going on at the same time which made the overall situation worse.

[110] The various Australian Specialty Colleges notified their overseas equivalent Colleges that because of an industrial dispute, they should warn any members considering applying for Australian appointments to contact the relevant Australian College. This author was on the RACOG Council at that time. However, it was already very difficult for any overseas obstetrician to be registered in Australia (see the Education chapter).

[111]Shepherd, *Memories*, 260. See also Catts, *Knife the Surgeons*, 368.

sustained by Dr Bruce Shepherd and his family. Bruce Shepherd writes that, by January 1985, doctors continued to submit their resignations and the NSW public hospital system appeared to be nearing collapse. He stated: 'people were angry at what was happening in the hospitals and rightly so' and that 'patients were innocent victims caught in the crossfire between two implacably opposed adversaries, the government and the doctors'.[112]

Each side said it was fighting for patients' welfare, and the Labor government kept repeating that their aim was free quality medical care to every Australian who wanted it, but the doctors who had submitted their resignations believed that quality medical care could be at no cost to pensioners and the needy, but never free to all patients, and that quality care required a viable system of private medical practice as well. The differences between these two points of view, though central to Australia's health-care future, were lost on the average citizen, 'who just wanted to see the chaos ended'.[113] Every doctor involved in the dispute wanted to relieve the dismal situation in the hospitals where they had worked for most of their lives, and where they had developed close personal and professional relationships with nurses and administrators.[114] It was a stressful and difficult time for all medical professionals, but particularly for obstetricians in NSW because of their dependence on the public hospital system.

The situation was complicated because many doctors had submitted their resignations but had not activated the resignations to bring pressure on the government to come to the negotiating table. Just before the resignations were due to be activated, the surgical groups designated 'crisis centres' to ensure that patients continued to receive emergency treatment, but the NSW hospital administrators refused to recognise these on the basis they would be giving over control of emergency services to doctors. The New South Wales Government took the action of massively increasing the salaries of those in salaried positions, aiming to recruit specialists from overseas, raising the question of the foreign doctors' qualifications and fitness to practice, and this resulted in specialist Colleges contacting their colleagues overseas, warning them to contact the local College in NSW before

[112] Shepherd, *Memories*, 230-245.
[113] A frequent comment from patients to this author during the Dispute.
[114] Shepherd, *Memories*, 258.

applying for any advertised positions.[115] In February the Presidents of the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, and the Royal Australian College of Obstetricians and Gynaecologists, jointly appealed to specialist doctors to delay the resignations, but 600 of the Proceduralist Group again met and voted unanimously to proceed with their resignations.[116]

Bruce Shepherd became a major focus in the prolonged dispute. Because of continuing concerns in major sections of the surgical disciplines regarding the commitment of the academic leaders of the profession and the AMA to take a firmer line with government, Dr Shepherd was elected a member of the Council of the Royal Australasian College of Surgeons, receiving the highest number of votes. Shepherd used this new status to attend private meetings with the Prime Minister Mr Hawke, but any prospects of a breakthrough were doused by Dr Blewett, who when asked exactly what was his concept of private practice in public hospitals, stated unequivocally that doctors in private practice should be paid on a sessional basis for any work they performed on private patients in public hospitals. This was followed by yet another meeting with a wide range of specialists involved, who, after hearing Dr Blewett's views, all decided this was unacceptable.[117] Meanwhile the Wran Government stated that it would proceed with plans to recruit overseas specialists. This was vigorously opposed by full-time staff specialists, who stated that they would not work with anyone recruited under these circumstances. By March 1985, 1500 VMO positions were vacant in New South Wales, and at an emergency general meeting of the NSW AMA, branch members voted to recommend that all VMOs should resign from their public hospital posts.[118] Following a peace proposal from the Hawke government on 2 April 1985, aimed at getting doctors back to work, the AMA recommended a return to work temporarily, as they were concerned that patients should get reasonable care while negotiations continued. But essentially an armed truce continued over subsequent months.

From early 1987 conditions in the State's public hospitals worsened, with backlogs for almost every elective surgical procedure, and increasing inefficiencies in

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[115] Catts, *Knife the Surgeons*, 409.
[116] The editorials in some newspapers urged the Wran Government to take even more draconian action against the profession, with an Editorial in the *Sydney Morning Herald* urging the Wran Government to use its 'emergency powers'. See Bob Browning, *Health Funding*, 13.
[117] Shepherd, *Memories*, 265.
[118] Shepherd, *Memories*, 267.

the management of hospitals. The cost of medical care as a percentage of GDP had declined from 7.8% to 7.4% since Medicare's introduction but the NSW government continued to attack doctors' fees, and its bureaucrats chased cost savings by closing down smaller public hospitals, reducing the number of beds in wards, reducing the number of beds in hospitals, and 'idling' operating theatres to avoid paying overtime wages to nurses and other salaried employees, which all added to the public hospitals' patients' misery.[119]

In April 1987, instead of resigning from the AMA, Bruce Shepherd decided to run a complete 'ticket' of reform minded doctors, as 27 vacancies were coming up in the next election. He assembled a team of 23 candidates of 'like mind', and he agreed to run for President elect. A letter was sent to every doctor in NSW telling them about the candidates, and asking for their support. By this time the AMA had suffered a steady loss of membership, with only about 40% of doctors now belonging to the AMA. All but one of 'Shepherd's candidates' were elected to the NSW Branch Council, which now became a major agent of change in the AMA's approach to dealing with government. In due course Shepherd became Federal President of the AMA, and from this position was able to exercise his leadership qualities effectively. [120] The situation in NSW continued unresolved, until the election of a Liberal government under Mr Greiner. Finally in 1989 a hospital contract was developed which was acceptable to those who had still been working as Honoraries. This represented the end of a struggle they had begun four and a half years earlier, when Shepherd first invited his fellow orthopaedic surgeons with VMO appointments to join him in resigning from the public hospital system. In 1985 an increase in Sessional pay rates and removal of objectionable conditions following the Macken (NSW) Determination made a return to duties more palatable. As Shepherd concludes in his memoirs:

> By holding out over those years I was convinced that I had helped to preserve the private practice of medicine in Australia. Had we not resigned,

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[119] Regionalisation of hospital services had been discussed for some time and the government took the opportunity to begin the process. See *Report on Rationalisation of Hospital Facilities and Services: A Discussion Paper* (Canberra: Australian Government Publishing Service, 1979). Also Hansard NSW Government, discussion, speech by Rosemary Foote, (7 June, 1984), on bed closures.
[120] Shepherd, *Memories*, 324.

all of us would have become part of a de facto government workforce and I doubt that there would have been any private hospitals left in Australia.[121]

The 'Doctors' Dispute' in NSW

The dispute between government and the medical profession was at its most intense in NSW. One reason for this was that many previous actions of the Wran Labor government had already alienated the profession. Neville Wran was elected as Premier in May 1976 and Mr Kevin Stewart was appointed his Minister for Health. The Wran government depended heavily on the votes of Western Sydney and he was determined to improve that region's unsatisfactory hospital services. Within a month of Mr Stewart's appointment, Crown Street's Women's Hospital Board heard rumours about a possible change of location or role. The stressful episode of the moves to close Crown Street Women's Hospital is about to be published in Judith Godden's History.[122] The government was determined to progressively close some obstetric beds in central Sydney and relocate them to the western suburbs. Between 1976 and 1978 increasing pressure was brought to bear on all connected with the Crown Street Women's Hospital with the aim of its eventual closure. The moves culminated in a change from Mr Stewart to Mr Laurie Brereton in October 1981, who increased the pressure for closure by announcing in January 1982 that 500 beds needed to be transferred from the inner city to the newly built Westmead hospital. In spite of opposition by medical staff, trade unions and community groups, he proceeded with the plan, using the excuse that grants from the Commonwealth were dependent on redistributing beds to needy areas.[123] The disruption of the unique work being done by the Honorary visiting staff at Crown Street was ignored, and he alienated the whole of the obstetric and gynaecological workforce of Sydney. All of the specialists had to face massive disruption of their practices, their consulting rooms, their hospital clinics, research work, families, schooling for their children, and similar issues. Confrontation was at its height in 1982. The immediate issue for all obstetricians was to find consultant appointments at equivalent hospitals, either in the central city area, or to face up to moving thirty kilometres to the west and to apply for

[121] Shepherd, *Memories*, epilogue.
[122] Judith Godden, *The History of Crown Street Women's Hospital* (in press), chapter 19.
[123] *Final Report of the Independent Committee on Hospital Consolidation*, The Minister for Health, the Hon L.J. Brereton, 30 June, 1982.

appointments at the Westmead Hospital complex. Not only the Crown Street consulting staff were affected, as every hospital in the inner city area had to review its obstetric staff to try and find space for at least some of the displaced consultants. As every obstetrician in the Sydney metropolis had a conflicted interest in these negotiations, the RACOG decided that a consultant from outside the Sydney city area should take over as Chairman of the New South Wales State committee of the College as an independent arbiter. The author of this thesis was appointed as New South Wales State Chairman for the twelve months covering this massive rearrangement.[124] The antagonism between the obstetric fraternity and the State government continued for the life of the Wran government, and was a major factor in the later development of the Doctors' Dispute in NSW, when the Wran State government sought to implement the Hawke Federal Government's plans for the hospital system. The battle lines were already drawn so far as the consultant obstetricians of NSW were concerned, so there was little hesitation from obstetricians in joining the other proceduralists in resigning during the dispute.[125]

The dispute was seen as a brutal game by Rees and Gibbons.[126] The Doctors' Dispute had ramifications for the trust between obstetricians and their patients, and the publication of this book aggravated the harm. During 1984 and 1985 a coalition of trade unionists and representatives of professional and consumer organisations 'campaigned to defend and extend Medicare'. This group embarked on research using a grant from the Australian Consumers Association. The report was published in May 1986 and pointed out that in previous disputes involving doctors, there had been no documentation of the consequences of such disputes for patients. Between March and May 1985, 128 aggrieved patients were interviewed about their attempts to obtain surgical treatment during the Doctors' Dispute. Although many types of patients were represented, its major flaw was that the group was self-selected. The authors admitted that they could not extrapolate the findings to the behaviour of doctors in general. The records of the patients were studied by doctors from the Sydney University's Department of Community Medicine, but they did not interview the patients and just gave opinions on information provided. In spite of its flaws the book provided a

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[124] Godden, *History of Crown Street Hospital*, chapter 13.
[125] See the role of NASOG in the Social Changes chapter.
[126] Stuart J. Rees and Leonie Gibbons, *A Brutal Game: Patients and the Doctors Dispute*, (Sydney: Angus and Robertson, 1986).

wakeup call to parties to the dispute, as it detailed the anger, confusion, and feeling of helplessness in some members of the public who suffered inconvenience and delays in treatment. A contrary view was expressed by Diana Horvarth from RPAH in a recent lecture, who stated that not one patient complained to her as Superintendent of RPAH at the time.[127]

At the height of the dispute in NSW, most of the Honorary staff had withdrawn their services from the public hospitals, apart from maintaining the emergency care rosters. Many outpatient departments were not being staffed for routine work but registrars and residents continued to staff them, backed up by full-time specialists. Obstetricians were to some extent shielded from much of the dispute, as it was agreed by other specialists that the care of pregnant patients was different, as their care could not be deferred. So antenatal clinics continued, the emergency roster was staffed, but gynaecological surgery was limited to emergencies and cancer treatment.[128] By the end of the 1980s some semblance of normality had returned to public hospital services. [129]

The Role of RACOG

Between 1979 and 1990 the RACOG took up its role of maintaining standards and providing education for obstetricians. It had the task of setting up examination and training committees, developing its education and continuing education programs, setting up a State committee network, and taking over the role of representing obstetricians nationally on many committees. It had to deal with the medicopolitical chaos outlined, and which had not been envisaged by all those working parties involved in the development of its *Articles of Association*, which were modelled on the Royal Colleges of the United Kingdom. This problem led to the development of the more politically oriented NASOG organisation.[130] However, within the public hospital system the protocols for training and education of trainee obstetricians had to be preserved and developed, which depended on close cooperation between the Honorary and salaried staff and hospital administrators. It was difficult for these

[127] Diana Horvarth, "The 1984 Doctors Dispute", History of Medicine Conference, Sydney, May, 2015.
[128] Emergency Rostering at RNH, Newcastle records, 1985-1990.
[129] The enormous internal problems of the AMA over the years 1984 to 1993 are covered in *More Than Just a Union*, 90-107, but are not directly related to this thesis.
[130] See "NASOG", chapter on Education.

groups to carry out their roles conscientiously under the stress of the Doctors' Dispute, and it is a tribute to all concerned that they were able to achieve workable solutions. State, National and International clinical meetings, examinations, and the development of the unique continuing education system continued through this period. There were many obstacles to be overcome within the profession itself over this period.[131] The obligatory medical education program of the College had now attracted national attention, with the other Clinical Colleges progressively developing similar systems over the next decade.[132] A further landmark was an invitation to the RACOG to present its system of continuing education at the First International Meeting on Continuing Medical Education held in California at the Annenberg Centre in 1986.[133]

There was a further difficulty for the College in that to ensure that every obstetrician in Australia was obliged to be involved in its education program, it needed to convince the National Specialist Qualifications Advisory Committee (NASQAC) that no obstetrician should be qualified to practice in Australia unless they were involved in the College program. As the Obstetrician's College was the first to introduce this requirement, there were difficulties in convincing NASQAC to support the concept that this new approach to medical education should be the national standard, as it set a precedent.[134] There was the additional problem of obstetricians who may not wish to join the Australian College but continue with their British RCOG qualification and still claim to be registered to practice in Australia. This was finally solved after two years of discussions with NASQAC.[135] An additional problem was a diminution in the numbers of patients attending outpatients and being in the public hospital system. As the private hospital insurance system became more stabilised, more patients began to choose care in private hospitals, so

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[131] Alan Hewson, "The Development of the Obligatory Education and Certification Programme", RACOG, *Medical Teacher* 11 (1), (1989), 27.
[132] The other specialist Colleges introduced obligatory continuing medical education in the following sequence: RNZCOG, 1981; RACGP, 1981; RCCPS, 1990; RNZCP, 1994; RACS, 1994; RACP, 1994; RACPaed., 1994; FFARACS, 1994 (personal files, A.D. Hewson, 2013). See also extended list in the Glossary section.
[133] Alan Hewson, "Continuing Education /Certification in the RACOG", First International Conference on Continuing Medical Education, Palm Springs, California, December, 1986.
[134] Correspondence from NASQAC, 1988 to 1990, finalising obligatory CME and removing the FRCOG as acceptable (Alan Hewson personal files, RACOG).
[135] *NASQAC List of Acceptable Specialist Obstetrician Qualifications in Australia 1989*, (Alan Hewson personal files, RACOG).

the College had to begin assessing private hospitals to see whether it was appropriate and feasible to carry out some specialist training in the private hospital system.[136] Over that timeframe there was further rationalisation of the public hospital system, as governments and administrators adopted the principle that it was safer, more cost-effective, and more rational to have obstetric units as part of major general public hospitals, a major change from the previous philosophy in which freestanding obstetric hospitals were built, as outlined in the Role Delineation chapter.

In spite of the medicopolitical conflicts surrounding obstetric practice during that decade, the RACOG took part in a number of important enquiries, including the *National Workshop on Medical Education and the Medical Workforce* in Canberra, at the Australian National University from 7th to 10th July 1986, organised by Sidney Sax. The representatives were a 'Who's Who' of the Australian medical establishment. The topics discussed were undergraduate, graduate, and postgraduate education, manpower issues, and the curriculum problems.[137] This workshop preceded the Formal Enquiry into these matters which was published in April 1988.[138]

Government Reports on Women's Health and Continuing Pressure on Obstetricians

A stream of government reports on Women's Health issues continued from 1988. A typical example was *National Women's Health Policy: Advancing Women's Health in Australia*.[139] This report was presented to the Australian Health Ministers conference in Burnie on 21st March 1989 and subtitled 'Towards the development of a National Women's Health Policy' and went out over the signature of the Prime Minister Bob Hawke. Only one of the central working party was medically trained, Dr Cathy Mead, who was an employee of the Department of Health. In the State committees group only one, Dr Ruth Fitzharding, a senior medical officer in the Department of Health, in Queensland, was medically qualified, apart from Dr Pauline Wilson, Director of

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[136] See "Recognition of Private Hospitals for Training", in the Education chapter.
[137] National Workshop on Medical Education and the Medical Workforce, University of Canberra, 7-10 July, 1986.
[138] *Enquiry into Medical Education and the Medical Workforce*, (Canberra: Government Printing Office, 1988).
[139] *National Women's Health Policy: Advancing Women's Health in Australia* (Canberra: Government Printing Office, 1989).

Health in the Northern Territory, an Administrative position. All the rest were bureaucrats or administrators with no experience of clinical medical or nursing practice.[140] This report was designed to establish specific objectives for Women's Health Policy, and was referred to the RACOG 'for comment' in 1991, one of many such surveys and commentaries which were sent to the College. It canvassed issues including reproductive health and sexuality, the health of ageing women, women's emotional and mental health, violence against women, occupational health and safety, the health needs of women as carers, and the health effects of gender role stereotypes. The report covered 57 pages, the generally supportive response of the RACOG was not acknowledged, and the RACOG Council was disappointed that many of the worthwhile and overdue measures were not vigorously pursued, as they coincided with longstanding College policies.[141] A later publication in 2009 seems predicated on the fact that there is still much to be done to genuinely advance women's health issues.[142]

In the *Making it Better* report published in 1991, subtitled 'Strategies for improving the effectiveness and quality of health services in Australia', compiled by Lloyd Harvey, the author provided a critique of the cost effectiveness of health care in Australia, commented on a wide variety of obstetrical and gynaecological services, and also noted the importance of litigation in obstetrics and gynaecology on Australian practice.[143] The report provided a broad overview of medical practice, and commented on the value of the RACOG initiatives on peer review and quality assurance as part of obligatory continuing medical education. The RACOG Council provided a positive response to the government, but this did not lead to any Government changes in health care. However there are some important statements made in the 5th appendix of that document, under the heading of *Science, Practice,*

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[140] *National Women's Health Policy*, appendix 4, 147.
[141] The necessity for Australia to become the only country to have a comprehensive policy on Women's Health was documented by Gray, "How Australia Came to Have a National Women's Health Policy", *International Health Serv*ice, 28 (1), (1998), 107-125.
[142] B. Bennett, "A New National Women's Health Policy: Legal, Ethical and Policy Initiatives to Support Women's Health", *Journal of Law in Medicine*, 17(1), (August, 2009), 9-15.
[143] *Making it Better, Strategies for Improving the Effectiveness and Quality of Health Services in Australia: Background Paper No. 8*, (Canberra: Australian Society Publishing Company, October, 1991).

and Professional Responsibility, quoting a set of principles from the Trade Practices Commission 1990.[144]

The report of the *Ministerial Task Force on Obstetrics Services in New South Wales* was produced by Professor Shearman after wide consultation with hospitals, obstetricians, midwives and other professionals.[145] The Shearman Report, as it became known, documented current practice in obstetrics, in midwifery and paediatrics, and advocated a more user-friendly obstetric service. It set the pattern for the delivery of obstetric care in NSW for the next two decades. There was strong specialist support for this report, in marked contrast to some other reports which the RANZCOG was asked to review over that decade.[146]

There were continuing problems for obstetricians in the early 1990s, evidenced by the content of the New South Wales *RACOG Newsletter*, in September 1992. The Chairman discussed a problem regarding the supply of obstetric services in rural areas of NSW, and paid tribute to the number of obstetricians who had organised the Diploma in Obstetrics course at St Margaret's Hospital, as well as Members who had represented obstetricians on various government agencies as *pro bono* work. The Committee also discussed Working Papers on Nurse Practitioners, the NSW Health Outcomes Initiative, compulsory retirement, structural efficiency programs, and the implications for hospital services arising from the Macklin report.[147] The issue also included coverage of Conjoint Seminars with the NSW Midwives Association, and positive feedback related to Women's Health Nurses being established throughout NSW. Professor Carolyn de Costa was coordinating a meeting between the NSW State committee, the Women's Health Unit of the Department of Health, the AMA, and the College of General Practitioners, to develop

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[144] Science, practice, and professional responsibility: After documenting the track record of medical science and its successes the report confirms its high status, and agrees that this justifies strong government support as outlined in the *Trade Practices Commission 1990*, 8.
[145] NSW Maternity Services, *The Shearman Report*, Ministerial Taskforce, (Sydney: NSW Department of Health, 1989).
[146] Bernard J. Amos, "The Shearman Report - Milestone or Millstone?", *ANZJOG* 34 (3), (June, 1994), 360. This review was carried out by the Director General of Health in NSW, designed to demedicalise childbirth while retaining its safe supervision. Ross Sweet, "Strategic Planning of Obstetric Services: The Australian Way", *ANZJOG* 34 (3), 368, summarised reports reviewed by the RANZCOG, 1981-1990. See also Alan D. Hewson, report to the Hunter Area Health Board on the Shearman Report from the Health Care Committee, 25 July, 1989 (see Hunter Valley Chapter).
[147] David Woodhouse, Chairman, NSW State Committee, *RACOG Newsletter*, (September, 1992), 2.

protocols for the practice of Women's Health Nurses. This development would have an increasing effect on obstetric practice in the decade ahead.

The *Jigsaw in Australian Health Integration* paper was sent from the Commonwealth Government to the RANZCOG for comment in 1999.[148] The College agreed with the main thrust of the paper, which called for greater integration between the various elements involved in the provision of health care in the community, and that the duplication, inefficiencies in funding, plus the administration of the delivery of services engendered by the current diversity of sources of funding, must be addressed. It also agreed that the problem of the ageing female should be addressed, and confirmed that gynaecologists would assist in this program. The College pointed out that the average length of stay in hospital had been progressively reduced, saving taxpayers money, and noted these shortened stays in hospital, although diminishing the overall cost to the State budgets, actually increased costs for the Commonwealth, as present funding arrangements made it more profitable for private funds to encourage privately insured patients to enter public hospitals rather than private hospitals. The document claimed that public hospital outpatient services per person had increased by an average of 5.5% over a 10 year period, but it was pointed out that this was not in accord with reports from College specialists working in the public hospital system, who use outpatients for the teaching and training of medical trainees. It was suggested that the 'services rendered' figure may well apply to paramedical or allied health professionals rather than attendance by obstetricians. The College also outlined the importance of short-stay, 'day stay' and minimally invasive surgery, its effect on costs, and associated anomalies and discrepancies in the present reimbursement system, particularly the recent development that many private funds were allowed to reimburse midwives for very large fees to carry out confinements because they are outside the Medicare system. The funds could not provide such reimbursements to patients cared for by obstetricians or GPs under the present legislation.

There were comments regarding the appointment system for Area Health Board members, doubting they were always appointed on merit and their ability to improve healthcare outcomes, with concerns regarding the administrative processes. The College was also concerned that one section of the report was progressing 'de-

[148] *Australian Health Jigsaw Issues No. 1,* (Canberra: Australian Government, July, 1999).

medicalising' health care programs, downplaying the role of the family doctor. There was concern about the teaching and training of medical students, interns, and registrars, by not addressing funding. The matters raised in that report and the necessity for a detailed response by the RANZCOG is an indication of the amount of time spent by the RACOG responding to Government reports. The RACOG Council again saw little evidence that the concerns raised by the College were ever integrated into definitive government policy.

Medico-Political Influences into the 2000s

The *More Than Just a Union* history of the AMA records continuing conflict between the profession and the government in the early 1990s.[149] This included increasing concern regarding medical litigation, various changes in legislation which the AMA believed had the long-term goal of further controls on the medical profession, and the so-called 'Lawrence amendments' to medical insurance, which although ostensibly aimed at preventing further decline in private health insurance, intervened directly in relationships between the profession, the private hospitals, and health insurance funds. The Lawrence amendments were included in the Health Legislation Private Hospital Insurance Reform Amendments Bill.[150] The AMA had its own internal problems associated with restructuring to include Craft Groups, an initiative in which obstetricians took a major role, but political conflict continued during the later years of the Keating government until the election of the Howard government in 1996. The problems regarding medical malpractice Insurance in the 1990s involving Government are covered in the appropriate chapter.[151]

The AMA hoped that it would develop a better working relationship with the new Coalition government elected in 1996 under the leadership of John Howard.[152] However the first four years of the Howard administration were marked by major budget restrictions to health, which impacted on obstetrics and gynaecology. A furore also erupted over limiting Medicare Provider Numbers for new graduates. The initial decision was finally revoked, but in the interim led to significant antagonism to the

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[149] *More Than Just a Union*, 108.
[150] Health Legislation Private Hospital Insurance Reform Amendments Act 1995, www.aph.gov.au/Parliamentary_Business/Committees/…99/index, (accessed 19 May, 2015).
[151] See the Tito Report controversy in that chapter.
[152] *More Than Just a Union*, 110.

government. But the introduction of the 30% private health insurance rebate was a positive move for the profession and for obstetricians, as it encouraged a rise in private insurance. During 1997 and 1998 the long-awaited Relative Value Study for fees was begun, with major attempts by the AMA to cater for the various craft groups which were now well-established within the Association.[153]

The *MJA* issue of 3 July 2000 provided an overview of the development, implementation and the sequels of the Medicare programme in Australia.[154] It included contributions from Gough Whitlam, Dr Scotton, John Menadue, Sir Keith Jones (ex-President of the AMA), Dr George Repin, (ex-Secretary General of the AMA), Dr Alf Leobald from the Doctors Reform Society, Mr Hayden, and other representatives of medical practice. The editor did not ask for a representative of specialist obstetric practice to contribute, even though the specialty was affected by the introduction of Medicare, and he also omitted General Practitioner obstetricians' representatives. In the last five years of the Howard government, there were improvements to the Medicare system, particularly after Tony Abbott took over the Health portfolio and took action to deal with the litigation crisis, as well as improvements in the 'Gap Cover' scheme, and the development of 'lifetime health cover', important to gynaecologists.[155]

The new Federal Labor Government led by Kevin Rudd in 2007 was greeted with cautious optimism.[156] A number of potentially useful reforms were floated such as a national approach to take funding to a 50/50 sharing of hospital costs, with significant implications for obstetricians. However there were major problems emerging for GPs who were diminishing in numbers, with increasing problems in distribution of obstetric manpower.[157] Later proposals of the Rudd Government led to increasing hostilities. It cut many programmes which had been helping the survival of general practice, pushed for the development of Health Centres, many of which seemed designed to displace GPs, and not sited in areas of need. The decision to proceed with a proposal to dumb down medical care by authorising eight other health care professional groups to prescribe medications was viewed by the medical

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[153] *More Than Just a Union*, 113.
[154] "Medibank, 25 Years On, Looking Back, Looking Forward", *MJA* 173, (3 July, 2000), 2-52.
[155] Discussed in the Medical Malpractice chapter.
[156] *More than Just a Union*, 125.
[157] Australian Institute of Health and Welfare, AIHW Media release, 6 December, 2007.

profession with alarm, and the introduction of a National Health Practitioner Register including all healthcare professions, to replace the State based system, was also of concern. A National Registration system had been explored under the Howard Government and deferred because of the major bureaucratic organisational framework necessary, and difficulties in establishing national standards for registration, because each of the States had significant variations in their criteria for particular health professional registration. The AMA had always supported a system of national registration to facilitate transfer of skills of doctors across State boundaries, but the Rudd proposals meant a major increase in bureaucracy, increased intrusion into the privacy of doctors and their patients by an expanded auditing system, increased costs and time loss for practitioners, with no modelling or assessment of whether the new system would work. AMA President, Dr Rosanna Capolingua (2007-2009) was highly critical of many of the measures being introduced by the Rudd government, described in the history of the AMA.[158]

The Launch of the AHPRA Era in 2010

The Australian Health Professionals Registration Agency (AHPRA), established in 2010, produced mixed reactions from the medical profession. The individual States of the Commonwealth had always had registers of practitioners licensed to practise in that State even in colonial times. In NSW, this register had improved following the reforms introduced after the litigation crisis of 2001. In NSW the Medical Board had published a *Code of Professional Conduct* in 2005 which covered the duties of a doctor registered with the NSW Medical Board.[159] This document was prescriptive regarding medical practice and included several intrusive provisions, in particular a legal obligation to identify doctors or colleagues whose health, conduct, behaviour, or performance may be a threat to the public, and an obligation to report such individuals to an appropriate person such as hospital Chief Executive or the Medical Board. It also placed the onus on practitioners to report adverse events which 'reflect on the professional performance or conduct of colleagues' to a hospital Chief Executive or the Medical Board. All this appeared laudable, but there was a problem

[158] Rosanna Capolingua, "Standing Up For the Profession", *More Than Just a Union*, 127.
[159] *Code of Professional Conduct: Good Medical Practice*. Duties of a doctor registered with the New South Wales Medical Board, Gladesville, New South Wales, reprinted 2008.

in practice because it had now become very uncommon for a hospital CEO to be medically trained. Their expertise is in the area of administration, but that regulation assumed that they would have the knowledge and training to make an informed decision on the clinical practice of any medical practitioners referred.

Previous attempts at reform by producing a national register had been bedevilled by variations in the Regulations in each State. In NSW there had always been a provision to allow doctors who had retired to retain some of the privileges of medical practice for an indefinite period, including the right to prescribe, request investigations and to continue to have the title of 'Dr' on their stationery. In the other States all of these privileges ceased immediately the practitioner ceased active practice, and this proved a major barrier to change.[160]

AHPRA began operating in 2010 after agreement by the Council of Australian Governments (COAG). Medical Boards were retained in each state, and continued to make registration and notification decisions about individual practitioners, based on national policies and standards set by the National Board. The National Board delegated some powers to the State and Territory Boards to enable them to carry out their disciplinary work. However AHPRA became the overarching national body responsible for annual registration of all medical practitioners as well as the eleven other health care professional groups covered by the legislation. When Medicare was introduced, as already mentioned, the whole of the Commonwealth Department of Health was managed by 55 people, but the number had now increased to over 3000.[161] It was known that bureaucracy would increase exponentially with the scheme, and the Government decided that the professions would contribute to the costs. In NSW, the annual registration fee rose from $270 in 2010 to $612 in 2013 without any benefit to doctors apart from easier access to interstate practice but accompanied by major increases in bureaucracy. The underlying philosophy was to ensure that all registered doctors remained competent, and in its *Newsletter*, medical professionals were reminded that in the United Kingdom, the USA, Canada, Ireland, and New Zealand similar methodology had been set up.[162]

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[160] "Medical Board Incurs Wrath of Retiring GPs", *Australian Doctor*, 8 October, 2010.
[161] Stephen Milgate, Doctors Reform Society, *ADF Health Headlines*, 2014.
[162] *Medical Board of Australia Update: Issue no. 7*, November, 2013. United Kingdom, document, "Revalidating Doctors, Ensuring Standards, Securing the Future", *General Medical Council*, London,

The underlying philosophy was outlined in a document sent to every practising doctor in April 2010. It stated that the new National Board 'will be setting standards and policies for the regulation of all medical practitioners registered in Australia'.[163] From 1 July 2010, a new National law came into effect, following agreement in principle by all governments.[164] According to the introductory document, the new scheme brought mobility, consistency of standards, transparency, collaboration between the professional groups, efficiency in administration, and would improve public protection.[165] New registration requirements were outlined. The obligations included requirements to have professional indemnity insurance, evidence of continuing professional development, documentation of the nature and extent and recency of practice, evidence of English language skills by all applicants for registration, and criminal history checks.[166] Further 'there will be a national register of medical practitioners including a specialist register published online', which will show 'details of any current conditions on practice'. When the registration process began, every medical practitioner had to provide documentary evidence of their age, marital status, practising and private address, telephone numbers, email address, years in practice, as well as their original medical qualification, and if in specialist practice, appropriate confirmatory documentation. The Board provided a *Code of Conduct* document on 1 July 2010, and this is updated regularly.[167]

The Uniform National Accreditation Register is of significance to practising obstetricians, particularly those members who had been providing a locum service to rural areas, because of the lack of on-site specialist medical cover in many rural areas. The ability of obstetricians to work in all States because their registration was now valid across State borders was a very helpful change, particularly for the national locum scheme, an initiative of the RANZCOG following a sustained lobbying campaign by Dr Pieter Mourik.[168] In addition to these requirements enforced at the

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25 September, 2000. Tricia Briscoe, "New Zealand's Health Practitioners Competence Assurance Act: A Missed Opportunity for Improvements to Medical Practice", *MJA* 180, (6 January, 2004), 4.

[163] Medical Board of Australia, *A New Era in Regulation from July 2010*, (AHPRA), Circular, June, 2010.

[164] *Health Practitioner Regulation National Law Act*, 2009, Canberra, ACT.

[165] Critics noted that the new system was so efficient that the cost to doctors more than doubled, and there were doubts regarding most of the alleged benefits apart from improved mobility of practitioners.

[166] These were already law in NSW since 2001.

[167] *Good Medical Practice: A Code of Conduct for Doctors in Australia*, Australian Medical Council Ltd, 1 July, 2010.

[168] Pieter Mourik, "Memoirs of a SOLS Locum", *O and G Magazine* 9 (1), (Autumn, 2007), 52.

national level to practice medicine, there are a large number of rules and regulations which must be complied with before a hospital appointment, essential for obstetricians, is granted.

Hospital Obstetric Appointments in NSW

Obstetricians involved in the clinical care of either obstetric or gynaecological patients must have an appointment to an appropriate hospital, unless practising purely 'office' gynaecology. In NSW the majority of confinements are still carried out in the public hospital system so obstetricians need to obtain an appointment in a public hospital, and are subjected to very stringent requirements. Because of medicolegal imperatives, private hospitals also insist on high standards for appointed staff, and there is little difference between the requirements enforced in both systems.[169] Apart from documentation to confirm the applicant's medical qualifications, the applicant must sign a 'contract of liability coverage' to ensure that the hospital's legal responsibilities are covered. Under the terms of settlement of the litigation crisis in 2001, covered in the Litigation chapter, public hospital appointees have indemnity cover for public patients provided by the Treasury Managed Fund (TMF), but they must have private insurance cover for the care of private patients in the public hospital system.[170] In addition they must satisfy the 'Working with Children' check including disclosure of any offences in the past. The applicant must provide evidence of being protected against infectious diseases, undertake to carry out the responsibilities of the professional position occupied, including an undertaking to carry out clinical management and treatment of all patients under their care, and must attend patients admitted under the doctor's care at a frequency 'appropriate to the clinical needs' of those patients. The doctor 'must take reasonable steps to ensure that the clinical records related to the service provided by the officer and those provided for any patients under the officer's care, are maintained adequately' and that such completed records include details of diagnosis, treatment, and operations performed with a discharge summary completed in the manner determined by the hospital. They must participate in the teaching and training of postgraduate medical officers, and

[169] The details of the above documents are taken directly from standard 'appointment documents' for public and private hospital appointments, 2013. See also HNELHD - Medical System Administration, HNELHD-MedSysAdmin@hnehealth.nsw.gov.au, (current document, 2015).
[170] These requirements are discussed in the Medical Malpractice chapter.

take part in committees established/authorised by the administration. They must participate in an on-call roster for the provision of services to any patient as required, must be readily contactable at all times, and be prepared to attend the hospital within a 'reasonable' period of time.

The doctor must maintain a record of the services provided to patients on the form specified by the administration and provide that record to the administration. They may be suspended from the appointment 'whenever the organisation considers it necessary in the interest of the hospital'. If the officer is suspended, the respective rights and obligations of the 'parties under this contract are suspended for the duration of that suspension'. In addition there is a long list of situations in which the contract shall be terminated, agreement in advance to participate in a dispute resolution procedure, to comply with NSW's health policies, *and any other conditions which the administration may wish to attach to that particular appointment*. In addition there is a list of situations which may lead to a legal claim against the hospital or the doctor, and guidelines are laid down which must be adhered to by the appointee. There is also a requirement to take part in clinical Quality Assurance activities, quality improvement or risk management processes, and a list of items which require the doctor to report to management. Another document covers a review of the applicant's health status, to be completed and appropriately documented.[171]

The 'Information Privacy Protection Guidelines Confidentiality Undertaking' requires the applicant to provide an undertaking that any confidential information regarding patients, administration, statistical information, research, financial information, or human resources data 'will not be disclosed'. It states that the appointees must notify their supervisor immediately if they become aware of any breach of privacy or security, they undertake to ensure that any access they have to confidential material cannot be accessed by any other person, and they must report any suspected misuse of personal or confidential information to their supervisor immediately. They must affirm that they understand that a breach of any of these undertakings may result in disciplinary legal action being taken against them. They also must state that they understand that upon cessation of employment with the

[171] See the HNELHD-MedSys.Admin documents, (30 October, 2015) quoted above - identical with the 2013 documents.

particular hospital they will 'remain bound' by the confidentiality agreement. This provision is an 'anti-whistle blower' clause which may yet be challenged in the Courts.[172]

The effects of all these bureaucratic interventions into obstetric practice (costing time and money and for which no remuneration is given) have a negative impact on doctor-hospital relationships and the doctor-patient relationship. Further, the requirements enforced on doctors approaching retirement have resulted in many more retiring earlier. In 2013, over 1600 senior doctors, including some obstetricians, retired because of the 'Recency of Practice Provision' and the cost of continuing insurance cover.[173]

The differences between the conditions of employment and the contracts between obstetricians and their hospital which apply in the current environment are a dramatic contrast to the simple contracts required 60 years ago. The effects of litigation in obstetrics and gynaecology will be outlined in a later chapter, and many changes in the relationship between obstetricians and their hospitals have arisen as a result of the litigation explosion from the 1980s onwards, with sequels in the medicopolitical environment. The legal entanglements, both real and potential, do have a significant effect on the practice of obstetrics within the hospital, on the decisions which obstetricians make regarding management, and, on the doctor-patient relationship. In addition, the political scandals of recent years which resulted from completely inappropriate appointments following deception by a small minority of practitioners and incompetence by some administrators, have necessitated a more scrupulous appointment process.

CONCLUSION

This chapter has covered the broad range of medicopolitical events which impacted on the profession over the past 60 years. The earlier post WW2 attempts by the Chifley Federal Labor Government to nationalise the profession, although judged unconstitutional by the High Court, produced long term suspicion of the ALP by

[172] See the HNELHD-MedSys.Admin documents quoted previously.
[173] Data from the Australian Senior Active Doctors Association, 2015, http://www.asada.net.au/forum/discussion/1099/ageism-and-age-discrimination, (accessed 30 May, 2015).

many in the profession, which persisted through the whole of the 20th Century. It was necessary to briefly review the history of Australia's hospital system in this chapter as that became a crucial factor in the second attempt to nationalise the profession by utilising the State public hospital system in the 1980s.

The long term role of the Lodge and Friendly Societies to cover medical costs had lasted from the mid-19th century, through the period of the Two World Wars and for the rest of the 1940s in under- privileged parts of Australia, until the Earle Page scheme of the Menzies Coalition Federal Government (1949-1968) began in 1953. This rather complex scheme was an improvement from the profession's point of view, even though it signalled increasing Government involvement in health care; but in spite of modifications, there were enough criticisms to make the universal national insurance scheme, masterminded by Mr Hayden and the economists Deeble and Scotton, capable of garnering electoral support. The profession saw the ALP Medibank scheme as nationalisation by stealth, and this was the beginning of a long drawn out confrontation with Governments of both persuasions as the later Fraser Liberal National government left much of the Medibank scheme in place. The collapse of the Whitlam Labor Government and the brief period under Frazer, the return of Labor under Hawke, and the re-ignition of confrontation during the Doctors' Dispute were stressful times for obstetricians because of their dependence on the public hospitals, particularly in NSW.

Financial issues in the hospitals, including dramatic rises in salaries for resident staff, the gradual dissolution of the Honorary system, increasing numbers of staff specialists, the development of a private hospital system, and conflicts within the profession itself as specialist obstetricians replaced general practitioners in obstetrics, made specialist obstetric practice difficult. It was impossible to remain neutral in the Doctors' Dispute which took up an enormous amount of the professionals' time and it is surprising that a reasonable level of patient care was maintained.

In spite of the conflict a number of important initiatives in medical education occurred including the development of new medical schools after the Karmel Report in 1972 and the gradual acceptance of obligatory continuing medical education following the lead of the new Australian College of Obstetricians in 1979. The incorporation of maternity units into general public hospitals, the development of regional hospital networks and the stresses of obstetric consultants having to change

long standing hospital appointments, coupled with a move to private hospital practice, continued the uncertainty of earlier years, and training and education adjustments to cater for increasing numbers of women in the obstetric workforce coupled with laws guaranteeing equal opportunity were all challenging. Government-instigated Shearman (NSW) and Lumley (Victoria) Reports in 1989 and 1990 strove to make hospital confinement more 'user friendly' and became the benchmarks for modern obstetric practice. The litigation crisis reached its zenith in the 1990s during the term of the Keating Federal Labor government, driven by changes in the law and community expectations, and was not finally solved until the Howard Coalition Federal Government and the NSW Labor State government were forced to intervene in 2001. The ensuing financial solution, while preserving obstetric practice, introduced a whole range of bureaucratic controls on the profession, including obstetricians, which have inexorably increased during the first decade of the 21st century. Finally, the COAG sponsored establishment of the AHPRA in 2010, now including mandatory reporting of colleagues, has continued controversy.

The fifth chapter will explore the increasing medicolegal impacts of consumerism and the growth of litigation and scandals in Australia which also had a dramatic impact on the profession of obstetrics and gynaecology in Australia.

CHAPTER 5
THE EFFECTS OF MEDICAL MALPRACTICE AND SCANDALS

> *Never have the arcane precincts of medical ethics been so heavily penetrated by philosophers, lawyers, the courts, economists, politicians, and that ubiquitous company of patients and patients-to-be, the 'consumers'. Medical ethics has burst the confines of intra-professional debate, and the privacy of the physician–patient relationship. It has become a subject of the widest public interest and very much a media event.*
>
> ***Percival, Medical Ethics*[1]**

Contemporary medical malpractice litigation is an important factor influencing the practice of medicine in Australia, and in particular the discipline of obstetrics and gynaecology. It overshadows progress in this area of medicine.[2] Indeed medical malpractice litigation and indemnity issues have been a major concern of the Australian Medical Association **(**AMA) for decades, and the catalogue of recurrent crises, conflicts between medical groups and Government, is documented in the Association's history, *More than Just a Union*, which opined that medical indemnity was:

> …arguably the most difficult that the AMA had ever had to deal with. Its solution had to be extruded from the Government very slowly and often painfully. Over more than ten years, though it almost certainly had the odd ministerial file on it and probably its own interdepartmental committee, the problem had been meandering along with no apparent timetable or sense of priority.[3]

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[1]Thomas Percival, "Of Ethics, Virtue, Medicine and the Physician"(Quote from the 1803 edition) *Medical Ethics*, (Birmingham, Alabama: Classics of Medicine Library, 1985), 2.
[2] Le Fanu, The Ten Definitive Moments of Modern Medicine, in *The Rise and Fall of Modern Medicine*, xvii. The list of 36 'advances' includes seven directly related to obstetrics and gynaecology.
[3] *More than Just a Union*, 120.

Further, although initiatives in obligatory continuing education in obstetrics and gynaecology in Australia led the world of medicine from 1980 onward,[4] and despite the fact that Australia has amongst the lowest rates of maternal and foetal mortality in the world,[5] medical malpractice negligence litigation directed at obstetricians has continued to increase. This phenomenon has adversely affected the reputation of the profession, practice decisions, stress levels and recruitment. This chapter addresses these important issues, but first some definitions will assist the analysis.

DEFINITION AND HISTORY OF MEDICAL MALPRACTICE

The common law 'duty of care in tort' refers to a general and comprehensive duty owed by one individual to another, and thus applies between all doctors and their patients.[6] Medical malpractice is professional negligence by an act or omission by a healthcare provider in which the healthcare provider falls below accepted practice in the medical community and causes injury or death to the patient, usually involving medical error. Standards and regulations for medical malpractice vary from country to country, and between jurisdictions within countries.[7] Clements states that the medical practitioner has four duties. First, there is the duty to the profession which began with the Hippocratic Oath,[8] reinforced by the United Nations Geneva Convention Declaration in 1948.[9] It was subsequently adopted in the United Kingdom, the General Medical Council (GMC) in Australia, and the Australian Medical Boards. It also now implies the recognition of 'consent' issues. Second, there is a duty to society: that is, compliance with the law up to and including manslaughter. This encompasses a duty to the patient, that is, the duty of care in tort, that is required in order to avoid entanglement with the law, and this includes a duty to inform, and the

[4] Alan D. Hewson, "The Development of the Obligatory Education and Certification Programme of the RACOG: A Practical Response to the Increasing Challenges of a Modern Society", *Medical Teacher* 11 (1), (1989), 27-37.
[5] Australian data became more accurate after definitions were changed in January 1969, with the lowering of the recorded measurable weights to 400 grams (or 20 weeks) at birth standardised across the country. The definitions are included in the Glossary.
[6] John M. Bishop, *Australian Legal Words and Phrases*, (Sydney: Blackstone Press, 1990), 223.
[7] Clements, *Risk Management and Litigation*, 4.
[8] *Genuine Works of Hippocrates*, 779. The oath comes from Hippocrates on the Greek island of Cos about 460 BC.
[9] The Declaration of Geneva, 1948 is the modern version of the Hippocratic Oath, which has traditionally formed the basis of medical ethics. It was amended in 1968 and again in 1983 in Venice.

duty of confidentiality. Third, the common law duty of care in a contract applies both to private and public patients and a reasonable standard of care is required. Fourth, for obstetricians there is also a duty of care to the undelivered infant: but to whom is this duty, and what is the extent of that liability are areas of controversy and legal argument. The obstetrician must also be aware of claims brought by a mother, that is, financial consequences which may be actionable, such as failed sterilisation and resultant action for pain and suffering, the costs of pregnancy termination, loss of income, and, for instance, the costs of another procedure.

The professional liability of doctors is clarified by Plueckhahn and co-authors.[10] They document the issues of Breach of Contract, uncommon but often taken with actions for negligence. Trespass also applies, for example, touching without consent. Negligence may include failure to provide care or provide information, and breach of fiduciary duty arising from the special relationship between the doctor and the patient.[11]

There is limited information on the long term history of malpractice litigation, but Mohr in 2000 addressed this when outlining the critical issues of medical malpractice litigation in the USA and its perpetuation and growth.[12] It was almost unknown in the first fifty years of the American Republic, but it has grown almost continually since. Sir William Blackstone in the United Kingdom (1768) was the first to link the concept of liability to doctors ('mala praxis'). Blackstone wrote commentaries on the law in England but his views were not mentioned in the first 30 years of the 18th century. Mohr states this may have changed about 1840 due to a decline in religious fatalism and the rise of religious perfectionism and 'an interest in food, better living, bodily awareness, and an emerging criticism of the doctor'.[13] He links this change to the rise of 'market place professionalism' in the USA; increasing criticism of elitism, especially in law and medicine, influenced by the opening up of professions to unqualified people; and aggressive advertising (the 'snake oil salesmen') so that the real professionals had to fight for themselves. The warring

[10] Vernon D. Plueckhahn, Kerry J. Breen and Stephen M. Cordner, *Law and Ethics in Medicine for Doctors in Victoria*, (Geelong: V.D. Plueckhahn, 1994), 81.
[11] Judgements and opinions from British Courts also carry weight in Australian Courts, and are governed by legal agreements between the two countries See http://www.ag.gov.au/international relations/PrivateInternationalLaw/Pa, (accessed 27 November, 2014).
[12] J.C. Mohr, "Medical Malpractice Litigation in Historical Perspective", *JAMA* 283 (13), (5 April 2000), 1731-1737.
[13] Mohr, "Litigation", 1735.

factions ranged from 'the woman with herbs in the garden up to a person with a medical degree from a prestigious European medical school'.[14] He contends that the law itself was out of control in that era, as virtually anyone could practice law.

Increasingly the law was asked to adjudicate regarding complaints about treatment, so from 1840 until 1860 malpractice lawsuits increased by 950%, and medical journals began to talk about this phenomenon. So there were at last reputable general publications available to the medical profession to ventilate issues of concern. The editors of these journals addressed issues related to general medicine, special articles on disease, and litigation was discussed.[15] The medical profession had hoped the legal profession would help them 'sort out the mess', but in fact the opposite occurred. The principle became established that malpractice could not occur unless there were standards of established practice against which professionals could be judged. So 'proper doctors' could be judged against set standards, whereas the non-professionals did not have a set standard to use as a yardstick, so it was the professionals who were attacked. One doctor commented that it was much better to not have a diploma, and to say 'I just tried to help my neighbor'.[16] However there were other reasons why litigation against doctors increased. Until that time, for example, the risks of trying to save an injured limb were so great that amputation was the optimal approach, but with the new knowledge of infection doctors were attempting to save limbs, so patients could be left with obviously damaged limbs. Doctors were much wealthier than the quacks and charlatans, so they were better targets for lawsuits.

So Mohr postulates that the traditional antagonisms between doctors and lawyers are based on what began over 150 years ago, and he puts forward other reasons why the antagonism continues. Firstly, it is in the nature of medical practice that doctors always strive to try new methods, but if things go wrong, lawyers can attack them 'for varying from current practice'. So they 'are damned if they do and damned if they do not'. He instances the introduction of X-rays and 'over exposure' cases. Secondly, even though the American Medical Association began at a meeting

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[14] Mohr, "Litigation", 1735.
[15] Walton et al. eds., *The Oxford Companion to Medicine Volume 1*, 747. The *New England Journal of Medicine (and Surgery*) was first published in 1812; the *BMJ* began in 1828 as the *Midland Reporter*, became the *BMJ* in 1840; but see also the many American Journals listed in Speert, *Obstetrics and Gynecology in America*, "Journals and Texts", 1980, 124-130.
[16] Mohr, "Litigation", 1735.

in Philadelphia in 1847, it still took decades before it finally achieved a strong control over medical practice and started pushing standards in practice, including licensure. So 'by the 1930s the lawyers had pushed doctors back to where they were in the 1850s'.[17] The later advent of insurance to spread the risk among doctors had the opposite effect as 'it made doctors even more worth suing'.[18]

Contingency fees ('no win no charge') are a long established part of the American legal scene, the argument being that it allows the poor litigant a chance to have their day in court with minimal risk. The American Medical Association has always opposed this approach, claiming that it militates against a fair and reasonable result, and fundamentally militates against 'finding the truth'. The sacrosanct role of juries in the USA is also a problem. Untrained jurors are poorly placed to assess evidence and can be influenced by glib lawyers, so they often award large sums.[19] A further problem is the way the tort system works in the USA, addressed in the Australian context later in this chapter. The tort system did slowly improve over time, and early in the 20th century, some States in the USA introduced the *res ipsa loquitur* rule (literally, the facts speak for themselves). But shifting the burden of proof to the doctor, that is, proving they were not negligent, was a mixed blessing, and as local standards weakened, more national laws were developed, meaning that doctors had to keep up with current practice, in turn leading to more lawsuits. The consumer conscious era of the 1960s caused another explosion of lawsuits, and settlements increased as well, the amount of awards tripling between 1975 and 1985.[20] Of the six factors - contingency fees, tort, the jury system, high doctors' incomes, insurance, and consumerism - five are still operating in the USA, and the insurance issue is the only one where changes have occurred, as insurers have been forced to take action to protect themselves. However, even in 2014, enormous settlements still occurred, and recently an amount of US$28,000,000 was awarded for a brain damaged child

[17] Walton et al., eds., "Medical Institutions Associations Societies and Colleges in the USA and Canada", *The Oxford Companion to Medicine Volume 1*, 742.
[18] Mohr, "Litigation", 1736.
[19] Laurie R Kuslansky, "Are Jurors on Your Team? Using Group Membership to Influence Jurors", *The Litigation Consulting Report*, 2014, http://www.a21c.com/blog/bid/71234/Are-Jurors-on-Your-Team-Using, (accessed 14 August, 2015).
[20] *USA Justice Department Report of the Tort Policy Working Group on the Causes and Extent and Policy Implications of The Current Crisis in Insurance Availability and Affordability*, (Washington DC: US Printing Office, 1986), 1.

resulting from a home birth with a bad outcome after transfer to a hospital.[21] There are a number of other relevant articles and comments on this subject as detailed in the attached literature.[22]

One of the reasons behind the escalation of litigation over the past four decades includes the assertion that the increasing direct cost to the patient has increased litigation. If this were the case one would expect that in countries where there is no direct cost to the patient, such as the United Kingdom, there would be no rise in litigation. But the problem is at least as serious in the British National Health Service (NHS) and one of the first major national meetings on the growing problem of medicolegal concerns was held in the United Kingdom in 1985.[23] The problem has continued, and an article in the *British Medical Journal* in 2000 warned that 'NHS Compensation costs will soar, rising by over 300%, to a maximum of 3 Million pounds'.[24] A recent report from the NHS Litigation Authority confirms that the NHS has already paid out over three billion pounds in compensation for legal claims relating to maternity claims alone.[25] An article by UK historian and sociologist Kim Price is pertinent, providing a contrast to Mohr. Price cites a 'culture of blame' as the greatest cause of litigation in medical error today. Price suggests that medical negligence is a complex relationship, a 'space' more than a thing, 'a shifting malleable interaction between time and place', and 'to a varying degree, society, law, ethics, medical practice, health professionals, and patients are players in this interaction'. Her paper instances the brief flirtation in the USA with contract law, but she believes jurisprudence sat uneasily with the 'unequal doctor-patient relationship as patients

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[21] Johns Hopkins Hospital, 2013; this verdict was overturned on appeal. See "Johns Hopkins Hospital Wins Reversal of $28Million Award for Birth Injury", *Thomas Reuters Blog*, http://blog.thomsonreuters.com/index.php/johns-hopkins-wins-reversal-of-28-million-award-for-birth-injury/, (accessed 17 September, 2015).

[22] Statement in the USA for the *JAMA* Editorial Board to the Committee on the Judiciary, the US House of Representatives (The Legislative Hearing on Litigation), presented by Donald J. Palisano, MD, reported by the AMA in 2003; M.L. Milleson, "Pushing the Profession to Safety and Media Quality", *Safety in Health Care* 11, (2002), 63; "Law Unto Themselves, Antagonism Towards Lawyers", *Surgical News*, October, 2012; Xu, K.A. Siefert, P.D. Jacobson and S.B. Ransom, "Michigan Malpractice Burden, Women's Malpractice Burden", *Women's Health Issues* 4, (July/August, 2008), 229.

[23] Geoffrey Chamberlain, C.J.B. Orr, F. Sharp, *Litigation and Obstetrics and Gynaecology*, (UK: RCOG, May, 1985).

[24] "Editorial: Compensation Costs to Soar", *British Medical Journal* 320, (March, 2000), 599.

[25] Catherine Dixon, CEO, NHS Litigation Authority, "More Than 3 Billion Pounds Paid Out in Maternity Claims", reported to the RCOG Annual Conference, Liverpool, June, 2013.

could not be expected to understand medical nomenclature or diagnosis'. Doctors did not want to be like tradesmen. [26]

This echoed a view across Europe and some European colonies. Price argues that in Britain it is more difficult to identify clearly the chronological incidence of litigation, but suggests that there were six discernible periods. From the mid-19th century to the end, doctors gained the upper hand due to advances in diagnosis, knowledge, skill, technical advances and professionalisation. But patients retained the upper hand in law, and medical negligence was viewed like a trade contract. However in the first half of the 20th century, new Acts were passed in the UK: national insurance, pension rights, 'state doctoring', and 'voting', bringing doctors 'closer to the State'. [27] Many developments in medicine, welfare and public health were important influences in reminding the public to look more critically at doctors, but in English law, doctors were beginning to gain the upper hand. The law began to regard doctors' negligence as separate from regular trade negligence, so that the era up to the 1980s 'were a golden age for doctors in the power game'. [28] During the 1950s, developments in the NHS and English courts led to the 'infamous Bolam precedent' in 1957. The Bolam Judgement was given in the *Bolam v Friern Hospital Management Committee*.[29] In that case, the Judge stated:

> The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art… there may be one or more perfectly proper standards and if he conforms with any of those proper standards then he is not negligent… a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds.[30]

The House of Lords expanded on the rule in another case, *Maynard v West Midlands Regional Health Authority*:

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[26] Kim Price, "Towards a History of Medical Negligence", *The Lancet* 375 (9710), (January, 2010), 192-193.
[27] Price, "History of Negligence", 192.
[28] Price, "History of Negligence", 193.
[29] Bolam v Frien, Hospital Management Committee, 1, WLR58, 1957.
[30] Clements, *Risk Management and Litigation*, 14.

> It is not enough to show that subsequent events show that there is a body of competent professional opinion which considers there was a wrong decision, if there also exists a body of professional opinion equally competent which supports the decision as reasonable in the circumstances…. There is seldom any one answer exclusive of all others to problems of professional judgement. A court may prefer one body of opinion to another but that is no basis for a conclusion of negligence.[31]

Price's view is that from *Bolam* on, 'doctors had complete control of diagnosis, and they essentially governed the law of medical negligence'; patients had 'fewer rights in law, diagnosis and policy than ever before'. From the 1980s to the end of the century, the conservative Governments in Britain began the gradual introduction of privatisation into the NHS. This then continued under Labour, so competition entered the NHS, and Price argued 'so did patient expectations'. Price continued: 'Doctors retained the power of diagnosis and were essentially self-regulating in negligence law', but negligence claims increased just the same, and ethical issues, human rights, patient's rights, and consumer expectations 'converged over that period, and exacerbated the change'.[32] There is however an alternative view to Price. Lawyers argued that the Bolam judgement brought some objective guidelines into the Court room, and in spite of criticism, that judgement was used for decades as a useful aid throughout the areas of the world influenced by the British system of law, including Australia.[33]

In the 21st century greater calls for 'patient's rights' (more involvement of the public on statutory bodies, for example) led to the Bolam rule being increasingly challenged, leading to the Bolitho decision, which implies that juries in exceptional cases can judge between experts.[34] The Bolam test under English law had meant the

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[31] Clements, *Risk Management and Litigation,* 15.
[32] Price, "History of Negligence", 193.
[33] Clements, *Risk Management and Litigation, 56-59,* points out that repeatedly in Appeals Court, and the House of Lords, the Bolam principle was upheld over years until the Bolitho Ruling.
[34] *Bolitho Judgement* was summarised by Clement in *Risk Management and Litigation,* 18. In principle a judge has to be convinced that the medical opinion given is 'responsible reasonable and respectable'. So the final arbiter is the legal opinion not the medical one. See Judge Browne-Wilkinson in *Bolitho v City and Hackney Health Authority,* (1998), AC232*; Lloyds Med. Rep.*, 26. See also C. Stone, *From Bolam to Bolitho, Unravelling Medical Protectionism.* Importantly in Australian courts and in the USA, the paternalistic view of Bolam does not dominate. See Plueckhahn et al., *Law and Ethics,* 108-109.

medical profession sets its own standards of medical care; this produces an awkward juxtaposition for historians assessing negligence in the UK. Price analysed the principles involved in the Bolam Judgment as follows.

> After Bolam the law could be summarised under three headings:
> [1] The patient was owed a duty of care, i.e. the doctor is a defendant.
> [2] Was the doctor in breach of that duty in failing to reach that standard of care by law?
> [3] It had to be proved that the breach caused, or contributed to, the damage or injury, so causation was always central.35

But the approaches, theories, and methods to establish it changed, so that crucially, the by-product of 'standard of care' meant that 'patients' rights' moved to the centre of medical negligence'.[36]

Informed Consent

Informed consent is another vital issue for obstetricians.[37] While the case of *Whittaker vs Rogers* in 1992 occurred at a critical time in the medicolegal chaos enveloping the discipline of obstetrics and gynaecology during the 1990s, and will be discussed later, some general comments are appropriate. Informed consent from a patient must meet certain minimum standards. An informed consent should be based upon a clear appreciation and understanding of the facts, implications, and future consequences, of an action.[38] In order to give informed consent, the individual concerned must have adequate reasoning faculties, and be in possession of all relevant facts at the time consent is given. Impairment to reasoning and judgement which may make it impossible for someone to give informed consent includes such factors as basic intellectual or emotional immaturity, high levels of stress, severe mental retardation,

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[35] Price, "History of Negligence", 193.
[36] Price, "History of Negligence", 193.
[37] Informed Consent has a long history and is basic to ethical practice. See Thomas Percival, *Medical Ethics, Professional Conduct of Physicians and Surgeons,* first published in 1803, comments by Edmund Pellegrino, (Alabama: Classics of Medicine Library, 1985).
[38] Plueckhahn et al., *Law and Ethics*, "Consent and Informed Decision-making", 105-111. See also, *Medico-legal Handbook, a Guide to Legal Issues in Medical Practice*, (United Medical Protection, 2003), 30-40; Clements, *Risk Management and Litigation,* 311; Chamberlain et al., *Litigation and Obstetrics and Gynaecology,* 6.

severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease or being in a coma.

The term was first used in a 1957 medical malpractice case by Paul Gebhardt, so is relatively recent. Some actions can take place even if there has not been ordinary informed consent. In cases where individuals are considered unable to give informed consent, another person is generally authorised to give consent on their behalf. For example, parents or legal guardians of a child, or a conservator for the mentally ill, can act in this situation. In cases where individuals are provided with insufficient information to form a reasoned decision, serious ethical issues can arise, for example in a clinical trial in medical research. These are normally anticipated and prevented by an Ethics Committee or Institutional Review Board.[39] It is agreed that informed consent can be complex to evaluate because of different expressions of consent, a failure to understand implications, or a full comprehension of relevant issues not being internally digested.[40] There is thus always a degree to which informed consent must be assumed or inferred based upon observation or knowledge or legal reliance on medical circumstances. Explicit agreement by means of signature, which may normally be relied upon legally regardless of actual consent, is the norm. For an individual to give valid informed consent three components must be present: disclosure, capacity, and voluntariness, which are usually self-evident.[41]

In medical procedures, the subject of informed consent has already been discussed under the heading of duty of care, and in the UK and other countries, informed consent in medical procedures requires proof as to the standard of care to be expected. This resulted in the Bolam test already discussed, and arguably this is 'sufficient consent' rather than 'informed consent'. In the USA, Australia and Canada, a more patient-centred approach is taken and this approach is usually what is meant by the phrase 'informed consent'. It is required that significant risks are disclosed, as well as risk which would be of particular importance to that patient.[42] This is a higher standard of informed consent, and significantly, causation must be shown. In other words, that had the individual been made aware of the risk he would not have

[39] Plueckhahn et al., *Law and Ethics*, AMA Code of Ethics, 173-175.
[40] See also Michael Kirby, "Principles of Health Care Ethics, Consent and the Doctor Patient Relationship", *Australian Forensic Science Journal* 25, (1993), 21-29.
[41] Clements, *Risk Management and Litigation*; Robert Francis, *Consent*, (London: RCOG, 2001), 25-33.
[42] See the Rogers v Whittaker case discussion.

proceeded with the operation or perhaps with that surgeon. This was particularly relevant in the *Rogers v Whittaker* case.

In obtaining informed consent, typically, hospital management systems use paper-based consent forms to scan and store these in a document handling system, after obtaining the necessary signatures. Deception must be avoided. This is particularly relevant in research programs, including clinical research, and was particularly important in the New Zealand Cartwright Enquiry regarding the Women's Hospital allegations of scandal, related to pre-invasive cervical cancer treatment.[43] Abortion laws are again a grey area, because there is often controversy regarding the language used in counselling, which may be biased. The Nuremberg Code developed during and after the post-WW2 trials has resulted in the importation of important principles into research trial ethics.[44]

Historical Background on Litigation in Obstetrics and Gynaecology from the 1950s

The lack of significance of litigation in the 1950s and 1960s is clear on review of the booklet published by the NSW Department of Health in 1962, which provided extensive information regarding obstetric practice, but with no mention of litigation.[45] In 1967, the Fifth World Congress of the International Federation of Gynaecology and Obstetrics in Sydney, Australia, produced a massive 934 page text but did not mention litigation. In 1976, the overview of obstetric and paediatric care in NSW from the Health Commission likewise did not mention litigation.[46] Nevertheless Australian obstetricians were well aware of the problem of increasing malpractice insurance premiums in the USA in the 1970s, outlined in an article from a US correspondent in 1970. The contributor reported that the dramatic rise was worrying doctors, insurers and politicians in New York State, forcing doctors to practice defensive medicine, and shirking more hazardous methods of treatment which might benefit patients.

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[43] *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Womens Hospital and into Other Related Matters*, Government Printing Office,Auckland 1988 .The Hawthorne effect (those involved must be aware that their responses are being studied) is important in research trials.

[44] Plueckhahn et al., *Law and Ethics*, 161-173.

[45] *Obstetric Practice in New South Wales*, NSW Department of Health, Division of Maternal and Baby Welfare: Information for the Guidance of Medical Practitioners and Obstetric Hospitals, (Sydney: Mastercraft Printing, 1962).

[46] *Maternal and Perinatal Care in NSW*, Prepared for the Maternal and Perinatal Committee, (Sydney: The Division of Perinatal Medicine, 1976).

Settlements had reached over $100,000, in some cases over $1,000,000. The situation was serious in Hawaii, New Mexico and New York State, and was much worse in anaesthesia and obstetrics, with 'loadings' for doctors who had been sued. The issue was pushing up patient costs and premiums. Some insurers were leaving the field of negligence insurance, young doctors were avoiding the high risk specialities and talented undergraduates were avoiding medicine altogether. At an enquiry in New York State, no one had answers.[47] The Australian Medical Association (AMA) appeared unaware of the problem, with no mention of it even in its *Annual Report of 1983*.[48]

The situation began to change in the mid-1980s. In 1985, the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK organised a national conference on Litigation, inviting many of the prominent authorities in obstetrics and gynaecology. Their deliberations were published in 1985.[49] The *Foreword* stated the reasons for the conference:

> Many Fellows and Members of the Royal College of Obstetricians and Gynaecologists are finding themselves involved with legal proceedings. This is an increasing trend and when the RCOG contacted the three Defence Unions, it was confirmed that our speciality now has the dubious privilege of having the greatest number of cases brought out against it.[50]

Professor McNaughton on litigation in obstetrics and gynaecology commented:

> The overall relationship between the profession and the public has undergone a profound change in the last century. An Edinburgh writer on ethical matters in 1772 described medicine as 'a liberal profession to be exercised by gentlemen of honour and ingenious manners'. But three major social upheavals have occurred since then. Firstly, education has become greatly widened; secondly, men and women with scientific minds and technical skills were added to the somewhat dilettante ranks of medicine;

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[47] "Malpractice Insurance Premiums Soar in the US", *AMA Gazette*, 5 November, 1970, 14.
[48] Australian Medical Association Annual Report, Sydney, 1983.
[49] G.L.P. Chamberlain, C.J.B. Orr and F. Sharp, eds., *Litigation and Obstetrics and Gynaecology*, Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists, RCOG, London, May, 1985.
[50] Chamberlain et al., *Litigation*, Study Group.

> thirdly, the National Health Service in 1948 transformed the doctor into an employee of the people from being a dispenser of charity…. Society now demands more and more from medicine. Personal involvement by the patient has been encouraged by the media but the law has unfortunately lagged far behind. Doctors are therefore left operating in an atmosphere of legal uncertainty in many cases. Articles have appeared in legal journals entitled 'Doctors as murderers', and in the medical literature, 'The legal threat to medicine', putting the other side of the picture.[51]

McNaughton went on to explore the complex relationship between the law and medicine and discussed the 'need for more openness on the part of the profession'. He outlined the picture of medical litigation in North America, which he said Britain found 'particularly distasteful', and noted that, as the tide of medical litigation was rising in the UK, there was a fear that the frequency of claims against doctors will reach the level of the USA. He also discussed the 'no fault' system then operating in New Zealand and further commented that:

> …one of the problems in the United States legal system is the contingency provision. In this system the lawyer may take on the case and can only be paid if he manages to get damages. If he does not win his case he does not get paid. The result of this may be that the patient comes off very badly, and may get very little money whereas the lawyers collect a large sum. [But] that in the UK there was not the same incentive in legal cases because there is no contingency system.[52]

Australian doctors were aware of the developing problem in the USA. As far back as 1972, they had read reports of up to 40% of Surgeons having been sued over the previous 12 years, in response to a questionnaire sent out to Fellows of the American College of Surgeons, to which 15,000 surgeons replied, and reported in the *Bulletin of the American College of Surgeons* in that year.[53] The issue was already widely discussed in the media and popular press. By 1985, of all medical specialists, obstetricians had become most vulnerable to legal action. In some States, their annual

[51] McNaughton, *Litigation Study Group*, 3-7
[52] McNaughton, *Litigation Study Group*, 4.
[53] "40% of US Surgeons in Malpractice Claims", *AMA Gazette*, (13 July, 1972), 6.

medical malpractice premiums were as high as $70,000 and as many as one in four were quitting their practices.[54]

At the end of the 1980s, there was concern regarding the worsening situation, and the AMA set up a national hook-up by teleconference, to look at the problems of obstetricians, on 2 April 1991.[55] The groups invited were part of the AMA Coordinating Committee of Obstetricians and Gynaecologists.[56] That group had previously reviewed documents regarding medical indemnity schemes in Australia and around the world, including the Victorian Health Services Conciliation and Review Act of 1987, dealing with complaints and quality assurance, and Statutory Immunity of Records from 1 July 1988.

This development attracted support from the committee, as it aimed to minimise the risk of 'doctor suing doctor' arising out of comments made in a Quality Assurance Committee. It recommended that the responsibilities of medical insurers under Australian law be clarified, and also that the new concept of risk management be pursued, stating: 'it is likely to have significant long-term effects on medical education, medical practice, and the medicolegal arena.'[57] The committee urged the AMA to carry out a wide ranging review of all relevant literature on medical indemnity, medical misadventure, and compensation systems, and it also requested all of its branches, the Royal Colleges and special interest groups to comment upon this whole subject. The conference endorsed the following motion:

> That this National Conference calls upon the Federal Council of the AMA to assess the concept of no-fault compensation for medical misadventure and to consider the introduction of a national no-fault compensation scheme without delay. This national conference notes the continuing problem of recruitment, especially of specialist obstetricians and gynaecologists and general practitioner obstetricians, brought about by the increasing incidence of litigation and consumerism, as well as lifestyle problems, and calls upon the AMA to take steps to remedy this situation.

A further comment regarding obstetricians was expanded in the report:

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[54] Alistair Cooke, *The Patient has the Floor*, (London: Bodley Head, 1986), 151.
[55] W. Coote, Assistant Secretary General, AMA, Circular: WBC eb/636, 22 March 1991.
[56] The AMA Coordinating Committee, including AMA, RACOG and NASOG representatives.
[57] Alan Hewson, personal files from that Committee.

> Obstetricians are presently very concerned as to the level of their medical defence subscriptions, now up to $12,000 per annum. There is also a likelihood of a class action involving the copper seven IUCD. Upwards of 500 obstetricians may be involved in this action.[58]

An overview of the increasing litigation problem from then on is summarised in the text *Law and Ethics for Doctors in Victoria*, published in 1994.[59] This text described the situation in Victoria, but the text applied to other States of Australia. It introduced the subject of rising claims and premiums saying that in Victoria, the number of new claims had increased by about 10 to 20 per cent each year.[60] The value of claims had increased, and awards of several hundred thousands of dollars were not uncommon. The claims were reflected in premiums which had risen dramatically over twenty years: the average annual subscription payable to Medical Defence Associations in 1975 in Victoria was $10 but it had risen for anaesthetists and pathologists to $55 by 1985, and in 1993-4, subscriptions varied from $1600 for a non- procedural GP to $2750 for a procedural physician, to $3000 for gynaecologists, anaesthetists and pathologists, and was $5500 for specialist obstetricians.[61]

This occurred in Victoria, even though during that period Victoria had an excellent mechanism for Complaints Resolution, the Victorian Complaints Commission, with Ms Merralyn Walton as the Chairperson. That programme for dealing with complaints was favourably reviewed by the 1992 'Tito' Report.[62] However UK lawsuits are important in the Australian context, because of reliance on case law from the UK in Australia. The authors of the Plueckhahn text quoted Chief Justice Tindal in 1838, who established the principle that the standard of care and skill required by a surgeon is that 'possessed by a person of ordinary competence in the same calling'.[63] The text goes on:

> For a plaintiff to succeed in an action in negligence, he or she must establish on the balance of probabilities that, firstly, a duty of care was owed by the

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[58] *AMA Coordinating Committee Report,* April, 1991.
[59] Plueckhah et al., *Law and Ethics,* v.
[60] Plueckhahn et al., *Law and Ethics,* 85.
[61] Plueckhahn et al., *Law and Ethics,* 86.
[62] *Compensation and Professional Indemnity in Health Care* (*The Tito Report*), (ACT: Department of Health Housing and Community Services, 1991).
[830] Plueckhahn et al., *Law and Ethics,* 81.

> defendant. Secondly, the defendant fell below the required standards of care. Thirdly, the breach of duty caused or materially contributed to the damage suffered, physical, mental or economic. Fourthly, the loss or damage suffered was reasonably foreseeable.[64]

An important ancillary principle is 'vicarious liability'. This imposes a legal liability on one person or organisation for the wrong of another without any personal fault being attached to the person or the organisation sued. So that, at law, an employer may be held responsible for the negligence of any employee in the course of his or her employment, important in a situation where a doctor is employed by a hospital. In this area also, there has been some ambiguity. In the *Medical Journal of Australia* (*MJA*) Gerber pointed out that there was continuing controversy about decisions made previously in the UK regarding the vicarious liability of hospitals as against errors made by their employees. He also pointed out that even though recent case law had overturned many of these decisions, the current view is that hospitals had to accept vicarious liability for their employees and agencies.[65]

Some reasons for the increasing incidence and the amounts claimed have already been mentioned, but there are others. Firstly, breakdowns in communication between doctor and patient have greatly increased with the change from the personal family physician to a relationship with a group practice or community systems of health care. Secondly, there has been a demystification of the art of medicine in that during this century medicine has emerged more as a science than a mystical art, and many non-doctors are now involved in health care. Thirdly, there has been increased utilisation of health care services and an increasing level of expectation by patients. Bulk billing and direct governmental payments to doctors have removed much of the direct patient-doctor contract for the payment of medical service. Fourthly, patients can have unreal expectations. Fifthly, technological advances have increased the risk of harm. Sixthly, the costs of medical care and hospitalisation have increased as have the costs of defensive medicine. Seventh, there is a growing propensity to litigate

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[64] Justice Tindall, 1838, quoted by Plueckhahn et al., *Law and Ethics*, 81.
[65] Paul Gerber, "Legal Liability of Public Hospitals", *Medical Journal of Australia* 144, (17 March, 1986), 319.

across the community. And finally, there is an increasing number and availability of lawyers seeking lucrative work.[66] Plueckhahn concluded that:

> All the above have unavoidable deleterious effects on the practice of medicine. They may not only impair the doctor-patient relationship, but can also encourage the doctor to order more tests and procedures to protect him or herself from criticism rather than specifically for diagnosis and treatment. The possibility of a lawsuit contributes also to lowering job satisfaction in some doctors, and in others to seek an early retirement from medicine.[67]

As a result of medical concerns, the Keating Federal Government set up a special committee, the Compensation and Professional Indemnity in Health Care group, chaired by Ms Fiona Tito (the Tito Committee) with the following Terms of Reference:

1. To examine and report on (a) current arrangements relating to professional indemnity insurance for health professionals; (b) current experience with compensation for medical misadventure; (c) the effect of (a) and (b) on the performance, delivery, and quality of services by health professionals; (d) any difficulty with these current arrangements;
2. To develop a range of options to address [1(d)];
3. To make recommendations… on the feasibility, appropriateness, and estimated costs and benefits of the options.[68]

The Tito Committee had been charged with examining the current arrangements relating to Professional Indemnity, and, to quote the AMA, 'after four years and eight million dollars, the Tito Report, which was not released until January 1996, had offered very little in the way of practical solutions, and was a huge disappointment to the AMA'. The AMA history describes its continuing frustration on this issue, stating that: 'for years members had expressed alarm and despondency at

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[66] Michael Kirby, "Negligence and the Physician: The Arthur E Mills Oration", *ANZ Journal of Medicine* 14, (1984), 867-874. Justice Kirby warned of this in 1984, and of the results of computerisation of conveyancing with lawyers looking for work.
[67] Plueckhahn, *Law and Ethics*, 87.
[68] *The Tito Report*, 1991.

the mischief that the problem was wreaking on medical practice and the AMA had been warning the Government about it.'[69]

The Tito Committee reviewed a large amount of material, and interviewed many individuals and representatives of many organisations, including the RACOG. The committee had enormous difficulty in getting accurate financial data on medical indemnity, particularly the commercial in-confidence financial data of the Medical Indemnity Insurers.[70] However national data was also a problem, and the Tito Report looked to the Harvard Practice Study (1984) for guidance.[71] But even that report was limited to hospital admissions in New York which limited its usefulness.[72] The Harvard study highlighted the lack of empirical data about health care injuries, and lack of any systematic approach to collecting data. The Tito report commented on a similar lack in Australia, noting that the Australian Medical Defence Union reported that in 1990 an average of only 4% of its members brought new indemnity matters to its attention.[73] The Medical Protection Society reported that in some States the rate of actions was actually falling. But contrarily, Danton documented that the total number of incidents had doubled between 1984 and 1986.[74]

Steeves Lumley, the broker operating on behalf of the Health Department in Victoria, stated that since 1981 they had processed over 100,000 incident reports involving litigation, but of all claims notified, no more than 2% had gone to trial, and less than 1% proceeded to a verdict.[75] The South Australian Health Commission reported that 1062 claims had been brought against it over the previous four years, worth $9,438,940, and that during 1989 and 1990, 127 claims were brought against one medical defence organisation with payouts of $23,000,000.[76] Historically, NSW had been regarded as the centre of malpractice litigation, but the Tito Committee was unable to obtain detailed historical data confirming this up to 1990, and enquiries

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[69] *More Than Just a Union*, 120.
[70] *The Tito Report*, 15, 17.
[71] T.A. Brennan, "The Relationship Between Malpractice Claims and Adverse Events Due to Negligence", *New England Journal of Medicine* 325 (4), (1991), 245-251; T.A. Brennan, "Incidence of Adverse Events and Negligence in Hospitalised Patients", *New England Journal of Medicine* 324 (6), (1991), 377-384.
[72] *The Tito Report*, 11.
[73] *The Tito Report*, ref. 8.
[74] P. Danton, "The Crisis In Medical Malpractice: A Comparison of Trends in the USA, Canada, the UK and Australia", *Law, Medicare and Health Care* 18 (1-2), (1990), 48-58.
[75] *The Tito Report*, 17.
[76] *The Tito Report*, 17.

from this author have also not uncovered any additional data on that period; apparently because the medical indemnity crisis of 2001-2002 caused the liquidation of the major insurer in NSW, United Medical Protection (UMP) so that access to the historical data was lost.[77]

The RACOG made a submission to the Tito Committee. This submission emphasised a continuing deterioration in the litigation situation, with documentation confirming the perilous situation of obstetricians in private practice, the impossibility of them paying rapidly rising premiums without increasing charges to patients, and the fall in the number of GPs doing obstetrics with serious implications for rural services in obstetrics. Obviously in a Court, a judge seeing a brain damaged child was under enormous pressure to award damages, knowing the obstetrician and/or hospital had insurance coverage, no matter how flimsy the evidence of negligence. The evidence in the literature of the stress on the obstetrician and his or her family arising from a prolonged court case was also documented.[78] Also, the lack of evidence that most cases of asphyxia in labour were the cause of brain damage during labour and delivery was emphasised.[79] One comment from the Tito Committee which caused alarm was the comparison between doctors' and lawyers' litigation costs, ignoring the group coverage for lawyers and the stress on medical personnel involved in negligence actions. The Committee failed to recognise that unless drastic action was taken to curtail costs and dubious actions for negligence, the discipline of obstetrics may not be able to continue to deliver competent, cost effective services to the community.[80] Dr Richard C.T. Tjiong, the Chairman of the Board of Australia's largest medical insurance organisation, United Medical Defence, was very critical of many aspects of the report when it was published.[81] He commented that in the final report: 'much relevant material had been overlooked or not addressed', including compulsory insurance, provider financial solvency, shifting of risk to Government

[77] Its successor, Avant, has been unable or unwilling to provide additional data, in spite of repeated requests from this author.
[78] Paul Niselle, "The Stress of Being Sued", *Australian Medicine*, (19 June, 2000), 10.
[79] See peer reviewed articles supporting this view, publications by the Common Law Rights Committee, and David N.B. Hall, *British Medical Journal* 299, (July, 1989), quoting articles from the *Lancet*, *Obstetrics and Gynaecology*, *Obstetrics and Gynaecology Survey*, and the *Australian Journal of the Medical Defence Union* which argued that cerebral palsy had a multifactorial origin, much of the causation was prenatal, and that only 8% may be caused by perinatal (i.e. intrapartum) factors.
[80] Alan D. Hewson, Secretary, RACOG Council, *Report to Council*, 1993, personal file.
[81] Richard T.T. Tjiong, "The Professional Indemnity Review, A Lost Opportunity for Reform", *Medical Journal of Australia* 164, (18 March, 1996), 371.

support, lack of assurance that doctors would remain viable, policy limits for coverage, coverage each year for the claims of the year, overall affordability and availability of cover, and the difference between mutual funds and insurance funds.[82]

Tijong demonstrated that many insurance funds would be non-viable unless action was taken, there would be unaffordable premiums for doctors, the report had ignored the special problems of high payouts in obstetrics, had not distinguished between the data from private versus public obstetrics, and had discounted the courts' approach to the cerebral palsy cases which ignored recent evidence. Furthermore it had ignored current unresolved claims; ignored the move to specialists; ignored the drop in GP obstetrics because of rising premiums; and had recommended premiums be based on income not risks, only recommending Governments cover obstetric risk in public hospitals and not in any other specialty. Tito had not costed a recommendation that the Commonwealth Government cover all risks, including self-employed midwives, nor IBNR claims, believing these should come out of a doctor's future income, estimated at $100,000,000 to $250,000,000, by a loading. Nor had it looked at cost effectiveness. Tijong's conclusion was 'that the review had failed to tackle the funding issues crucial to most of its recommendations'. The RACOG had made the same criticisms, stating that the situation would just get worse.[83]

The discipline had to address the medicolegal issue and decide whether its present organisational structure and Articles of Association allowed it to deal with all these new issues.[84] The College supported forming a specific organisation to represent the discipline in negotiations with Government. The National Association of Specialist Obstetricians and Gynaecologists (NASOG) resulted and was launched in 1989.[85] There was effective cross-representation across the two bodies. At Executive level, and within two years, the majority (80%) of Fellows of the College became

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[82] An article, by Philip Podzebenko of Tress, Cocks and Maddox, "Medical Malpractice - Are You Covered?", set out to clarify this matter, emphasising essential differences between 'Discretionary Assistance' and 'Medical Malpractice Insurance'.

[83] Alan D. Hewson, *Report to the Council of the RACOG*, personal file. See also the concerns regarding GP obstetrics surviving, A.D. Hewson, "GP Obstetrics: Is it an Endangered Profession?", *O and G Magazine* 6 (1), (March, 2004), 9-28.

[84] *Memorandum and Articles of Association of the Royal Australian College of Obstetricians and Gynaecologists* (Companies Act, 1961), Melbourne, 1978.

[85] National Association of Specialist Obstetricians and Gynaecologists (NASOG) is a not for profit association representing the professional and political interests of obstetricians and gynaecologists (PO Box 576, Crows Nest, NSW, 1585).

accredited members of NASOG.[86] Many financial and other issues impacting on obstetrics were canvassed with Minister Howe, including the *National Health Strategy*, and the *Making it Better* document, authorised by Jenny Macklin, then director of the Federal Government's National Health Strategy in 1991.[87]

The National Health Strategy in 1991 was developed by a non-medical committee, addressed delivery of health care, and collected a large amount of material. It made recommendations regarding improvements. Much effort went into the final document, but it failed to utilise available international expertise available in Australia at the time.[88] The Harvey document, *Making it Better*, highlighted the critical role of the medical profession in health care.[89] It emphasised the importance of the profession in maintaining standards and testing competence, referring to a paper by Roger Gabb on the subject of recertification.[90] However, there was a failure to make a critical connection between maintaining the competence of doctors, and the issue of negligence and malpractice. Harvey also looked at the quality and appropriateness of care in other countries, variations in the rate of surgery in the various countries, and adverse outcomes, quoting the Brennan study of 1991.[91] Harvey also quoted the steadily rising malpractice insurance rates in the United States, in 1986 over $ 31,000 annually.[92] In Canada, Lynton and Peachy in 1990 recorded rising malpractice premiums, and in the UK, Harvey and Roberts raised similar concerns.[93] However, the Tito Report downplayed the significance of rising settlement amounts and premiums, claiming that in more recent years, there had been

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[86] David Molloy, ed., *NASOG NEWS* (Newsletter of the National Association of Specialist Obstetricians and Gynaecologists) 1 (4), (July, 1991), 1.
[87] Roy Harvey, *Making it Better: Strategies for Improving the Effectiveness and Quality of Health Services in Australia,* National Health Strategy Background Paper No 8, Canberra, October, 1991.
[88] David Newble, Brian Jolly and Richard Wakeford, *The Certification and Recertification of Doctors*, "Issues in the Assessment of Clinical Competence", (Great Britain: Cambridge University Press, 1994).
[89]Ray Harvey, *Making it Better*, 98.
[90] Roger Gabb, "Recertification: A Perspective from an Australian College" (draft paper), Fifth Cambridge Conference on Medical Education, Adelaide, July, 1991; See also Roger Gabb, "Recertification of Specialists", *MJA* 155, (15 July, 1991), 71.
[91] Brennan, "Incidence of Adverse Events", 370-376.
[92] M.I. Rosen bach and A.G. Stone, "Malpractice Insurance Costs and Physicians Practice", *Health Affairs,* (Winter, 1990), quoted by Harvey,1991
[93] A.L. Vinton and D.K. Peachy, "Guidelines for Medical Practice: The Reasons Why", *Canadian Medical Association Journal* 143 (6), (1990), 485-490. I.A.M. Harvey and C.J. Roberts, "Clinical Guidelines, Medical Litigation, and the Current Medical Defence System", *The Lancet*, (17 January, 1987), 145-147.

a decline in some premiums for some groups of practitioners.[94] In some States in the USA, medical malpractice insurance rates were expected to fall: by 5% in New York, 1990 to 1991, according to the New York Insurance Superintendent, quoting administrative changes, defensive medicine, reduction in payouts and insurance investments. Legislative changes in a number of States to cap the damage awards and to provide arbitration instead of litigation were also quoted.[95] The Tito committee was probably influenced by this data. In retrospect, this was a major error, and the National Health Strategy was seen as an expensive political distraction.

NASOG engaged in other activities. It began a public awareness campaign to remind the public that women in the community were being 'sold short' in new gynaecology item numbers, so providing a grossly inadequate fee reimbursement for obstetric services.[96] This initiative attracted attention and support.[97] The 5th issue of the *NASOG Newsletter* in 1992 was devoted to extensive discussions on medical litigation, shared care in obstetrics, a paper on the brain damaged child, ultrasound fees, and the allegedly sexist Medical Benefit schedule.[98] The report from the Tito Committee was still awaited at that time. Concern increased in the profession regarding the gathering storm of litigation. An initiative from the AMA in 1991 was the paper on *No Fault Compensation or Tort Liability*, circulated to all branches of the AMA, and involved groups.[99] It also placed on record the major problem in obstetrics, as follows:

> The AMA's preferred position is to find an immediate resolution of the problem of neurologically impaired infants followed by an improved tort system.
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> 1. The AMA believes that the most urgent problem relates to infants born with neurological impairment whether congenital or acquired antenatally or perinatally;

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[94] *The Tito Report*, 17.
[95] S.L. Sapp, "Medical Malpractice Crisis: Rethinking Issues and Alternatives", *Defence Counsel Journal* 55 (4), (1988), 373-388.
[96] David Molloy, "Is the National Medical Benefits Schedule Sexist?", *National Circular to all NASOG members*, 19 June, 1991.
[97] David Molloy, ed., *NASOG newsletter* 1 (4), (July, 1992), 1.
[98] David Molloy, ed., *NASOG newsletter* 1 (5), (January, 1992), 1-11.
[99] P.S. Wilkins, Assistant Secretary General, Health Services Circular B, as/5 (663/91).

2. The AMA believes that doctors should be held responsible for their negligent actions;
3. Very little attempt has so far been made to improve the Tort system;
4. Before considering abandoning a system with a long history and with so little hard evidence substantiating a need to change it would be worth first modifying it to overcome the many criticisms made of it;
5. Only if it proved impossible to modify the tort system to meet the identified needs of persons disadvantaged by it should an alternative be considered;
6. Most proposals for tort reform have faltered because of resistance by the legal profession;
7. All proposals for alternative no-fault schemes had foundered on the question of costing. Indeed, many proposals have totally avoided the issue.[100]

The position paper canvassed all the issues already discussed. The facts and protocols outlined could have been used as a model when considering medical litigation compensation, but it is unlikely that the Tito Committee used this document in its deliberations beginning the following year, as there was no mention of it in the final Tito report.

The Law Society Common Law Rights Committee published a paper putting a 'lawyer centred' view on this matter which stated:[101]

> That the (Australian) doctor at present has the most comprehensive system of defence both as to disciplinary proceedings and civil suits which could be imagined, and no similar system is maintained by any other professional group in Australia, or it would seem elsewhere in the world.[102]

It went on to argue that obstetricians could not expect to be able to defend themselves to the degree they do, instancing the long running McBride case, and then claim that their premiums are too high and should be cut back. They also outlined the benefits

[100] Wilkins, Health Services Circular B as/5 (663,91).
[101] *Obstetric Litigation, Options for Reform, In Defence Of The Present System*, notes prepared by the Law Society Common Law Rights Committee, 1991.
[102] Law Society Common Law Rights Committee, 1991.

under Common Law, recent advances in obstetrics concerning causation, including the brain damaged child issue, and concluded that litigation on this must diminish. It reminded readers of the potential cost of a 'no fault' scheme, quoting research from the Harvard medical practice study group, which showed that only 10% of patients injured actually commenced litigation, contrasting with an expected 100% in a no fault system estimated in Canada to cost around $800 million. They quoted the NSW Medical Defence Union, which did not support a no fault system.[103] The report claimed that there was: 'no substantial evidence to support the conclusion that the use of contingency fees led to a growth in civil liability claims against doctors', and blamed increased claims against hospitals, plus an overall tendency for the community to sue, and unwarranted findings of negligence by Courts, so argued for continuation of the *status quo.* But the international climate regarding litigation continued to give concern, particularly the USA and in the UK, because of the implications of case law from the UK on litigation in Australia. The spectre of even higher damages being awarded to a mother who delivered a brain damaged child was seen as inevitable by obstetricians and insurers at the time of the Tito Report.

There were significant changes in the legal system in the late 1980s, with a negative coincidence for obstetricians. Up until 1987, advertising by legal firms was not the norm. The new *Legal Professions Reform Act* 1987 in effect removed many of the legal restrictions on advertising, apart from restrictions relating to false, misleading, or deceptive conduct specified in the *Trade Practices Act*.[104] The second change was the progressive introduction of the 'contingency option' (no win, no charge) by lawyers. Regulations for the legal profession are State-based, and NSW and South Australia were the first States to introduce this change, but the Commonwealth supported it, and went further, stating that: 'In the event that other State and Territory Governments do not move to permit contingency fees the Commonwealth is prepared to introduce uplift contingency fees in Federal matters.'[105] The principle of offering to act for a client without charging was previously only

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[103] Edson Pike, "Dubious Justice in No Fault Schemes", *Australian Doctor Weekly*, 1 November, 1991.
[104] *The Legal Professions Act (NSW) 1987*, Schedule 8, subsequently amended in 1989, 1993, 1996. http://www.austlii.edu.au/au/legis/nsw/repealed-act/lpa1987179/sch8.html, (accessed 8 October, 2013).
[105] Justice Statement, chapter 3, "Lawyers", (following an agreement in April 1995), *Competition in the Legal Profession, Contingency Fees*, 13, http://www.austlii.edu/au/austlii/articles/scm/jchap3.html, (accessed 8 October, 2013).

offered to the poor and indigent client. Whatever the benefits to the community from these changes, the effects on litigation against obstetricians were catastrophic. Litigation firms such as Slater and Gordon, and Maurice Blackburn, began aggressive advertising campaigns under the 'no win no charge' mantra.[106] So during the decade 1990 to 2000, the situation steadily deteriorated. Added to this there was still controversy over the nature of cerebral palsy and the brain damaged child.

The Brain Damaged Child

Articles continued in the medical press claiming that the legal arguments behind an intra-partum cause of cerebral palsy were flawed. The dubious nature of alleged predictors of neonatal encephalopathy were highlighted.[107] Fiona Stanley and her co-workers in Perth, WA, concluded that 'many aetiologies of neonatal encephalopathy originate in the antepartum period'. Doubt was also cast on the value of electronic foetal heart monitoring in predicting cerebral palsy.[108] The conclusions from this study were important as although finding that specific abnormal findings on monitoring were associated with an increased risk of palsy, the false positive rate was extremely high, and as Caesarean section is often done on these findings, they expressed concerns that 'if these indications are used many Caesarean sections would be performed without benefit and with the potential for harm'. A significant contribution to the debate was a *Consensus Statement on the Origins of Cerebral Palsy*, published in 1995. This arose from a Conference held in Adelaide on 26 August 1994, sponsored by the South Australian Health Commission.[109]

The conference involved all the most prominent perinatologists in Australia and they made a statement, summarised as follows. They referred to the current crisis in obstetrics litigation related to cerebral palsy, and the increasing likelihood hospitals

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[106] Typical websites; *Clinical Negligence Australia: Obstetrics and Gynaecology Medical Negligence Solicitors Compensation Claims*, email@ medneg.com.au.

[107] Stuart J. Adamson, Louisa M. Alexander, Nadia Badawi, Paul R. Burton, Patrick J. Pemberton and Fiona Stanley, "Predictors of Neonatal Encephalopathy in Full Term Infants", *BMJ* 311, (2 September, 1995), 598.

[108] Karin B. Nelson, James M. Dambrosia, Tricia Y. Ting and Judith K. Grether, "Uncertain Value of Electronic Foetal Monitoring in Predicting Cerebral Palsy", *The New England Journal of Medicine* 334 (10), (7 March, 1996), 614.

[109] Alistair McLennan, "Consensus Statement on the Origins of Cerebral Palsy", *MJA* 162, (1995), 85-90. See also Alister H. McLennan, International Cerebral Palsy Task Force, "A Template for Defining a Causal Relation Between Acute Intrapartum Events and Palsy, International Consensus Statement", *BMJ* 319, (1999), 1054-1059.

may be unable to afford adequate insurance to continue their services. They pointed out that cerebral palsy is not a single entity, that it is the most common physical disability in childhood, affecting about 2 to 2.5 per thousand children born. The frequency of cerebral palsy has not changed over the last 40 years, despite a fourfold drop in both perinatal and maternal mortality. They reviewed the literature regarding the timing of the onset of pathological brain lesions in the new born and the contribution of imaging of the brain, and addressed the question of whether obstetric care can prevent cerebral palsy. They also addressed the problem of detecting foetal distress. They stated that birth asphyxia is not a well-defined term, and reviewed the literature to clarify whether cerebral palsy ever originates in labour. They documented the response to acute hypoxaemia, and explored the issues of causation and fault. They pointed out that most infants who develop cerebral palsy are born from uncomplicated pregnancies and deliveries which had no signs of foetal distress, or major abnormalities in the intranatal cardiotocograph (CTG), low Apgar scores, acidosis at birth or any abnormal neurological signs in the neonatal period. It was their opinion that the lesions causing cerebral palsy are rarely initiated in labour and are rarely preventable. What little evidence exists suggests that less than 2% of cerebral palsy could be attributed to sub-optimal intrapartum care, and it was their opinion that this figure could even be lower than that. They stated that the public had been given unrealistic expectations about pregnancy, and that many seem unaware that based on current Australian data, more than 15% of pregnancies will miscarry, 6 to 8% will be born preterm, 1% of babies will die around the time of birth, 5% will have a notifiable birth defect, and 0.2 to 0.25% will have cerebral palsy.[110]

The William Power Memorial lecture in 1991 to the Royal College of Midwives, by Sir Donald Acheson, the Chief Medical Officer of the Department of Health in the UK, added critical material to the ongoing debate about the brain damaged child.[111] In summary, firstly, he reviewed the definition by Dr William Little in his original papers in 1843 and 1862, which focussed on damage to the developing brain in the foetus and early infancy. Secondly, he noted that 60% of cerebral palsy patients had normal intelligence. Thirdly, he commented on an upward

[110] McLennan Report, 1057.
[111] Donald Acheson, Chief Medical Officer, William Power Memorial Lecture, *Annals*, Royal College of Midwives, London, 1991.

trend in litigation, noting that the numbers rose from 50 cases per year in 1983 to 257 cases per year in 1989. According to insurers covering two thirds of cases, the national total would be about 200 in 1989. He believed this could be expected to rise, with up to three times as many cases in 1990, a total of 600 cases. Fourthly, he noted the marked increase in awards, the average in 1991 being £700,000, with awards of over £1 million being made. He commented: 'These costs will soon be unaffordable.' The Medical Defence Union (MDU) in the UK showed that 72% of claims were commenced within five years of birth, but many did not begin until much later, with 15% after the lapse of over 10 years, and 13 cases over 20 years after the birth. He asked:

> How likely is it for someone attending a birth 20 years ago to remember accurately the details of that? Those in authority should ask what will be the effect of obstetricians attending a birth today, when they are aware that they may be sued for negligence 21 years after the event? How will that affect their career choices?

He added also that 'almost 30% of all costs and damages paid for by the whole medical profession were in respect of actions against obstetricians, even though they represent only 1500 doctors. That is, 2.5% of the UK workforce, including the trainees'.[112] He commented on the outcomes in the USA where the American College of Obstetricians found that 71% of their members had been sued at least once: 69% confirmed that fear of litigation had affected the way they practice, with many leaving the specialty, finding ways of reducing their deliveries, and refusing to look after high risk mothers. This had led to many counties in the USA without obstetric care. He also covered the scientific data regarding cerebral palsy, noting the fact that in spite of steadily falling perinatal loss rates, increased operative delivery and monitoring by CTG, the rate of cerebral palsy had been unchanged. In other words: 'it is not logical to suggest that palsy is due to the passage of the baby through the birth canal.' He believed that 'the vast majority are almost certainly due to prenatal events as yet largely unknown'.[113] Finally he explored the options of a 'no fault' system and structured settlements, and emphasised that unless action was taken in the UK and the

[112] Donald Acheson, Power Lecture, 1991.
[113] Donald Acheson, 1991.

USA, 'a medico legal disaster would be inevitable'. But in spite of the evidence regarding cerebral palsy, lawsuits continued. The destructive effect continued to damage the reputations of both obstetricians and hospitals, damage the relationship between obstetricians and their patients, and erode the resources of the insurers.

A Grave Situation Getting Worse

Difficulties being faced by obstetricians in NSW were outlined by Stuart Boland, chairman of UMP in 1999.[114] He summed up the situation:

> Since 1987, obstetricians in NSW and Queensland plus MDU obstetricians in the rest of the country have as a group paid $80,000 in subscriptions, but have generated $170 million in claims costs. They form only 1.2% of members, generating 12% of total claims by numbers and 24.6% by costs, and currently O and G claims held represent 50% of those over $1 million. The $90 million shortfall of O and G claims cost subsidy is more than the total subscription income of United, Australia wide in 1998. In NSW the figures mean that other medical colleagues were subsidising obstetricians by about $250,000. [115]

Boland concluded that the system was unsustainable.

It was not only the insurers who were deeply concerned at this situation, as the AMA Council on 1 December 2000 approved a grand plan to take the majority of negligence cases out of the adversarial common law system.[116] This was never entertained by the Government. This issue was highlighted by Trevor Mudge, AMA Vice President in *Australian Medicine* in November 1999.[117] He stated: 'that rebates were set too low initially, then GPs could not afford to do obstetrics, so more patients went to specialists, then insurance costs for obstetricians rose.' He reminded readers that when he began obstetrics twenty years previously, premiums were $100 per year.

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[114] Stuart Boland, Chair UMP, "Unsustainable Medico Legal Madness", *Australian Medicine*, (15 November, 1999), 17.
[115] Boland, "Unsustainable", 18.
[116] As reported in *Australian Medicine*, AMA Australian Council, December, 2000, 3. See also *More Than Just a Union*, 17.
[117] Trevor Mudge, "A Matter of Choice", *Australian Medicine*, (18 December, 2000), 4.

> Now obstetricians pay $40000 per year, and it has been calculated actuarily that the cost of covering an obstetric practice is actually nearer $90000, due mostly to the enormous payouts for cerebral palsy babies.[118]

One result was that it was now increasingly difficult to get obstetric cover for country areas, and he predicted 'that we would follow the USA pattern of deteriorating services for the rural areas if nothing is done'. He noted that we can still attract trainees to the specialty, but many are females who will not practice private obstetrics because of the strain on family life, so in the longer term the current problem of having to transfer mothers to larger centres away from their home will get much worse. He reported that GPs are now paying subscriptions ranging from $1700 in Tasmania, to a high of $2500 in more populated states, and obstetricians in some States had gone from $15,000 in 1987 to over $41,000 in 1999.[119]

Paul Nisselle of the Medical Protection Society also alleged biases in judges and paid expert witnesses, leading to incorrect decisions which were often overturned after expensive retrials.[120] Another criticism in the literature by two highly respected surgeons, Dr Thomas Hugh and Professor Douglas Tracy, began with a quote from the past: 'all real decisions are made under uncertainty. A decision is therefore a bet, and evaluating it as good or not must depend on the stakes and the odds, not on the outcome.'[121] They noted that:

> even though there appeared to be new attitudes of Australian Courts to medical evidence, expert reports remain the cornerstone of most medical negligence cases, and there is evidence that hindsight bias may cause the expert to simplify, trivialise and criticise retrospectively the decisions of the treating doctor, inevitable when the expert knows there has been an adverse outcome.[122]

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[118] Mudge, "Choice", 5.
[119] *Medical Observer*, April, 2000, 18.
[120] Paul Niselle, "The Problems of Biased Judges and Expert Witnesses", *Australian Medicine*, (December 2000), 6.
[121] W. Edwards, "How to Make Good Decisions", *Acta Psychologica* 56, (1984), 5-27.
[122] Thomas B. Hugh and G. Douglas Tracy, "Hindsight Bias in Medico legal Reports", *MJA* 176, (18 March, 2002), 277.

And they made the plea that if the probability of hindsight bias was to be avoided, outcome information should be withheld from experts providing reports.

The issue of risk management in cerebral palsy remained a very difficult area in spite of the Consensus statement. Alistair MacLennan, who had written the Consensus statement, outlined measures for minimising the risk of legal action in cerebral palsy cases in another article.[123] He recommended an eight stage protocol to be followed, providing detailed information on possible causes and documenting evidence collected at and around the time of birth, plus the provision of counselling, and offering a review by an independent expert.

Another theme was later taken up by the High Court in Informed Consent cases following the *Rosenberg vs Percival* case, as reported by lawyer Loane Skene.[124] In this case, the patient alleged that she was not adequately informed regarding a possible postoperative complication which in fact occurred. Woodrow and co-authors also drew attention to the increasing medicolegal problems in obstetrical and gynaecological ultrasound, based on a survey of obstetricians doing ultrasound. Their findings suggested that there was considerable medicolegal activity in obstetrical and gynaecological ultrasound in Australia.[125]

Rogers v Whittaker (1992) and Informed Consent

Informed consent became more prominent after the case of Rogers versus Whittaker in 1992.[126] In this case, a patient became totally blind in her normal eye after she underwent surgery in the other eye.[127] Dr Rogers had not warned Mrs Whitaker, who was blind in one eye, that the proposed operation would carry a one in14, 000 risk of causing blindness in the other eye. The surgery was for cosmetic reasons. In this case not warning of the risk of Sympathetic Ophthalmia occurring in a good eye meant not warning a patient. Mrs Whitaker had agreed to the surgery only after incessantly

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[123] Alistair MacLennan, "Risk Management in Cerebral Palsy", Issues Medico-Legal, *O and G Magazine* 2 (2), (April, 2000), 88.
[124] Loane Skene, "High Court Warns of the Retrospectoscope in Informed Consent Cases: Rosenberg vs Percival", *Medicine Today*, (October, 2001), 79. See also, Michael Gorton, RACS Hon. Solicitor, "Informed Consent", *O and G Magazine* 2 (2), (April, 2000), 98.
[125] Nicole Woodrow, Lachlan J. de Crespigny and Ross H. Gillies, "Medico legal Activity in Obstetrical and Gynaecological Ultrasound", *MJA* 171, (2 August, 1999), 147.
[126] Plueckhahn et al., *Law and Ethics*, Rodgers v Whitaker, 109.
[127] Paul Nisselle, "Making Sense of the Duty to Warn", *Modern Medicine of Australia*, (September, 1999), 105.

questioning the surgeon about possible complications, and argued that if she'd been told it was a one in one million chance that she would be left totally blind, she would not have had the operation. The skill and care of the surgeon was not questioned.

Dr Rogers argued it was acceptable medical practice not to disclose a risk unless the patient had specifically asked about the possibility of the left eye being affected. Other ophthalmologists stated they would not have warned of the risk, so Dr Rogers relied on the Bolam test. The High Court found in favour of the patient and that the doctor had a duty to disclose the risk. The court found that had she been so advised Mrs Whitaker would not have had the surgery. The court did not agree with Dr Roger's argument that his conduct was acceptable because other doctors would have acted in the same way. 'The court's view is that it is for the courts to adjudicate on "what is the appropriate standard of care".'[128] The implications of this decision for doctors were quite serious. Doctors have a duty to disclose any material risks to which a reasonable person in the patient's particular position would attach significance. The risk rate is based on both the incidence of the risk and to its severity. The other factors relevant when deciding what to tell a patient included, firstly, the nature of the matter to be disclosed; secondly, the nature of the treatment; thirdly, the patient's desire for information; fourthly, the patient's temperament and health; and fifthly, the general surrounding circumstances.[129]

Later in the year the High Court handed down a decision about the duty to disclose in *Chappel v Hart*, in which the patient underwent non-elective surgery. In this case the patient underwent surgery for a progressive condition that would have required surgery.[130] During the procedure the patient's oesophagus was perforated, infection set in and led to paralysis of the patient's vocal cord. Mrs Hart provided evidence that the risk of perforation diminished with the skill and experience of the surgeon, and she argued that, but for Dr Chappel's failure to disclose the risks, she would have deferred the operation and taken steps to have it performed by the most experienced surgeon. Dr Chappel argued that even if he had disclosed the risk she would still have needed the surgery, so failure to disclose the risk did not cause Mrs Hart injury. The court found that Dr Chappel's failure to warn caused Mrs Hart's

[128] High Court of Australia, *Judgement*, (19 November, 1992), 109, ALR 625.
[129] L. Skene and R. Smallwood, "What Should Doctors Tell Patients?", *MJA* 159, (1993), 367-368.
[130] "Chappel vs Hart: Obligations on Medical Practitioners to Warn of Risks", *Health Law Update* 1 (4), (1998), 1-3.

injury, by denying her the chance to defer the surgery and to find a more experienced surgeon. Before this case, if the doctor could prove that the patient would have had the operation even if he or she had been warned of the risks, the patient's claim would have failed. According to Blake, Dawson, and Waldron, 'since this case there is greater scope for damages to be awarded, once the doctor's failure to warn has "been established, because it is less likely that" a causation defence "will succeed"'.[131]

As a result, Medical Defence Union advice is that when doctors are dealing with a particularly anxious or difficult patient, they should document all conversations fully, and may wish to consider amending consent forms to incorporate a warranty by the patient that they have no unanswered questions. Referral to a second practitioner or a counsellor may be desirable. Doctors believed the judgements represented an unacceptable intrusion of the law into medical practice, but the Medical Indemnity Insurers stated that they reflected not the dominance of law over medicine, but of consumerism over paternalism. The concept that the doctor knows best is dead both as matter of law and as a matter of good medical practice. It is no longer 'doctor's orders', but 'patient's choice', and the doctor has a duty to ensure that the choice is informed.[132] Other points made by Nisselle were that the duty to inform is non-delegatable, and that there is no separation between the duty to diagnose and treat and the duty to inform and record. So the issue of patient autonomy and informed consent was becoming increasingly important.

Merralyn Walton outlined the new rules of engagement for the medical profession with the patient.[133] She reminded readers that 'respecting patient's autonomy' is more than a platitude, but an ethic for doctors to effect. It includes assisting patients to comprehend the pros and cons of treatment options, and of treatment refusal. Again, the paternalism of the past is on the way out, but some doctors still believe in concealing information or over-riding patient's wishes 'because in the end it will be for the best'. Walton lists reasons often given for withholding information from patients including: doctors are the experts, that is, their scientific information is always accurate; it is impossible to know how much information should be provided to patients; and many patients do not want to make decisions about their

[131] Blake Dawson Waldron, *Health Law Update* 1 (4), (November, 1998), 3.
[132] Paul Nisselle, Medical Defense Union, Newsletter, 1998.
[133] Merrilyn Walton, "Patients Autonomy: Does Doctor Know Best?", *Medicine Today* 3 (6), (June, 2002), 7.

treatment. Walton also outlined the fallacies in all these. The passage of time has made the position of all medical practitioners, particularly obstetricians, more difficult. There has now been a case in which a patient sued because there was an issue as to whether the consent she gave was specific enough.[134]

Increasing litigation caused deleterious effects on medical practice. Documentation of the stresses and sequels of litigation in all fields of medicine had been accumulating in the literature for more than a decade. An article by Hartigan, based on interviews with the leaders of the profession, in 1990, confirmed the reality of resultant defensive medicine, its effect on medical decision making, the increased referral rates, increased tests carried out, and alteration of practice patterns, which would inevitably damage patient care.[135] Dr Kinder of the RACGP was also concerned that General Practitioners with their Diploma in Obstetrics were increasingly reluctant to practice obstetrics because of the fear of litigation. By 1995, an AMA *ad hoc* medicolegal committee had been set up to advise Federal Council on means to press this matter, urging short term State tort law reform, and longer term National reform to allow structured settlements, instead of lump sum payments, because of the worsening situation.

A lecture in London by Mr Justice Kirby in 2000 addressed the international implications of litigation in Medicine.[136] Kirby agreed that the problems constituted a major issue with no easy solutions. He believed the Netherlands conciliation system had merit, but he commented:

> The foundation for successful future strategies lies in a lesson which reformers can learn from the techniques of medical research rather than the law's technique of verbal rhetoric, in painstaking empirical studies and statistical data, and we should learn from those countries that have introduced improved systems of conciliation and compensation which are cheaper, quicker, and less traumatic. [But he warned]... that unless health

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[134] Michael Gorton, RACS solicitor, "Informed Consent Must be Specific", *Surgical News* 9, (October, 2007), 7.
[135] Peter Hartigan, "Litigation: Every Doctor is Nervous These Days", *Medical Observer,* (13 April, 1990), 11.
[136] Hon Justice Michael Kirby, "Medical Malpractice - An International Perspective of Tort System Reforms", Address to the Royal College of Physicians, UK, 11 September, 2000, http://www.hcourt.gov.au/assets/publications /speeches /former-justice s /kirbyj/kirbyj, (accessed 26 December, 2012).

care professionals make out a compelling case for change, negligence will continue its expansion.[137]

The NASOG newsletter of February 2000 detailed the gathering storm of medicolegal problems facing obstetricians. Molloy provided the only positive note regarding improved remuneration for Ultrasound. But Chris Maxwell, Federal AMA Councillor representing obstetricians, outlined sobering facts.[138] The national average for current MDO subscriptions was $30,304, increasing at 20% per annum; private confinements were falling at 5% per annum; specialists were now averaging 91 confinements per annum, with 60% providing fewer than 100 per year; GP obstetricians were averaging 7 confinements per year with 96% providing fewer than twenty services per year, making most practices non-viable. He explained that other sectors cross subsidising obstetricians would have to stop; and that the costs of cerebral palsy claims were escalating to an average of $7.5 million, so that with the known incidence of cerebral palsy cases this gave a national litigation cost of $30 million, to be borne by 711 specialist and 967 GP obstetricians, resulting in a cost of $416 per confinement, or $38,178 per specialist and $2900 per GP. Andrew Pesce in the same issue agreed the cross subsidy from other disciplines could not continue forever.[139] David Molloy reported that medical indemnity premiums were now the single largest practice cost for obstetricians.[140]

The Senate (Crowley) Inquiry into Childbirth Practices was also released in 2000.[141] This followed the Shearman 1989 report in NSW, the Lumley 1990 report in Victoria, the Turnbull report 1995 in Western Australia, and the NHMRC *Options for Effective Care in Childbirth*, 1996. Crowley claimed that most of the recommendations of those reports had not been acted on, a statement trenchantly criticised by the profession. However it did agree that childbirth in Australia led the world in safety, with maternal mortality having fallen to 5.3 maternal deaths per 100,000 and infant deaths to 5.9 per 1000 live births.[142] However there was criticism of the steadily rising elective Caesarean section rate across the country, and a

[137] Michael Kirby, "Medical Malpractice", lecture.
[138] Chris Maxwell, "The Current Medical Indemnity Situation", *NASOG News* 7 (1), (February, 2000), 5.
[139] Andrew Pesce, "NSW Obstetric Indemnity Update", *NASOG News* 7 (1), (February, 2000), 7.
[140] David Molloy, *NASOG News* 7 (1), (February, 2000), 2.
[141] Rosemary Crowley, Chair, *Senate Inquiry into Childbirth Practices*, ACT, Canberra, 2000.
[142] Crowley, "Senate Inquiry Report", *NASOG News*, 8.

recommendation that programmes be developed to aim at a rate of 15%.[143] A recommendation to address the longstanding problem of unacceptably high perinatal loss rates in Indigenous mothers was included, but no realistic measures to address the looming medicolegal crisis.

An improvement for obstetricians in NSW public hospitals occurred on 23rd February 2001, when the Government agreed to provide indemnity cover through the Government insurer, the Treasury Managed Fund (TMF).[144] Up until that time these obstetricians had to cover their own indemnity for public (uninsured) patients even though this was a high risk group to care for, and the obstetricians were reimbursed at very low sessional rates for this work. In other States this cover had been provided by the State Government for many years. This cost the State $24,000,000 for the year, but obstetricians at that time were paying $132, 000 each per year in premiums. It was hoped this change may actually reduce premiums overall, but it merely reduced the rate of rise.[145] By the beginning of the year 2000, it was evident that a calamity was inevitable. It just needed a trigger to begin the cascade downwards. The Indemnity insurers were under increasing pressure because of rapidly increasing payouts on obstetrics claims, and they were dealt another financial blow by the collapse of the insurance firm, HIH, in March 2001.[146] UMP had $60 million dollars invested in HIH, seen as a safe haven for members' funds.[147] This added to its financial problems.

The Indemnity Crisis: A Complex Legal Situation

The complexity of the Indemnity Crisis was analysed by Cashman in 2002.[148] He was critical of the issues of accounting methodology of the Mutual Insurers (which was commented on by Dr Richard Tjiong after the *Tito Report*) and their failure to provide for large future claims, the IBNR claims noted previously. It was only recently that insurers had addressed this problem, and this had led to a major increase in estimated

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[143] This issue is addressed elsewhere in this thesis.The rate is now over 30%, and rising.
[144] *NSW Doctor*, (September, 2001), 8.
[145] *Report of the NSW State committee of the RANZCOG* to all members, 2001.
[146] HIH Insurance Limited, Australia's second largest insurer, collapsed on 15th March, 2001, and were subsequently placed in liquidation in August 2001. See "HIH Insurance", http://www.hih.com.au/, (accessed 17 October, 2013).
[147] *Report from UMP to Subscribers*, 2001.
[148] Peter Cashman, "Tort Reform and the Medical Indemnity Crisis", *University of NSW Law Journal* 25 (3), (2002), http://www.austlii.edu.au/aqu/journals/UNSWLJ/2002/57.HTML, (accessed 15 February, 2013).

liabilities, and a subsequent call on members in the form of increased premiums for the next five years. A drop in income for insurers following '9/11', the September 11 terrorist crisis, had made matters worse. Additionally claims processing had accelerated.[149] Funds were going out more rapidly, so there was less capital available to accrue monies.[150] Cashman also noted a spike in claims recently, initiated by foreshadowed changes in legislation 'in an effort to claim under the previous law'.[151]

The increased premiums and levy were a divisive issue in year 2000. The AMA noted that the situation had now become critical, as UMP and its subsidiary, Australian Medical Insurance (AMIL) had asked for a full year's membership fee plus a general increase in premiums of 8% in year 2000.[152] At the time UMP was Australia's largest medical insurer, covering 60% of doctors nationally and about 90% in NSW and Queensland. In the annual report of UMP, Chairman Dr John Quayle looked back, remembering that in 1979, all MDU members paid a standard $75 annual subscription regardless of specialisation. This remained unchanged until 1988, when the rate reached $1992. Differential rates came in 1989, and GPs fell to $1000, but the obstetrics rate rose to $5000. But worse was to come after a court decision in the Calandre Simpson case.

In *Diamond v Simpson*, Dr Robert Diamond in 1979 attempted to deliver the baby Calandre Simpson with three different types of forceps and was successful but subsequently the baby was found to be severely disabled with brain damage. Calandre Simpson sued Dr Diamond, UMP, and AML and, after 14 years, Mr Justice Wheatly awarded a sum of $13.5 million, with no contribution by St Margaret's Hospital. United appealed to the NSW Court of Appeal, and in April the Court reduced the verdict to $11 million. In December the Court determined that St Margaret's Hospital was also liable to the plaintiff, and that 50% of the verdict sum should be paid by the hospital. St Margaret's Hospital appealed to the High Court in 30 November 2004 but was unsuccessful. Interest of $1.5 million was paid to United by St Margaret's Hospital. This case had serious implications for the insurer, UMP, Dr Diamond, the hospital and obstetricians. Spokesperson Dr Philip Cocks stated that last year

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[149] Cashman, *Tort Reform Crisis Paper*, 'Medical indemnity cases previously took an average of nine years to resolve, from 1980 to 1989 the average was six years. In 1990 to 1999 this dropped to 2.9 years'.
[150] Janine Mace, "Making Sense of the MDO Market", *Australian Doctor*, (23 February, 2001), 43.
[151] Cashman *Tort Reform*, 891.
[152] *More than just a Union*, 120.

premiums had been $58,000, and could rise to over $100,000 next year. The Plaintiff Lawyers Association stated that the insurer had known for 14 years that the payout was coming and should have prepared for it.[153] UMP was placed in receivership, as it was technically insolvent, and continued to operate in that mode in the short term, but in practical terms, obstetricians now did not have real insurance cover to continue practising. UMP stated later that it did not defend the Simpson case to show that indemnity claims were out of control.[154]

The AMA asked for legislative intervention in a statement by the President Dr Kerryn Phelps in November 2001.[155] Dr Phelps stated that it was likely that obstetricians would face premiums of up to $250,000 in the next year, outlining the massive impact this would have on women having access to an obstetrician, and foreseeing a crisis in rural obstetric services, with obstetricians being forced out of the specialty and the safety of mothers put at risk. She finally stated 'Obstetricians are now an endangered species.' The same theme had been pushed strongly by NASOG at the highest level, but there was continuing intransigence by insurers and both State and Federal Governments.[156] Pesce referred to increasing turmoil and competition across State boundaries between Insurers, and the only progress evident was a Working Party from the Department of Aged Care, the AMA, NASOG, and RACOG looking at no fault compensation for neurologically impaired infants. Pesce calculated that the increased costs generated by the new proposals by UMP amounted to a 30% increase in costs for obstetricians in 2001.[157]

In response to the crisis, the Government introduced legislation to avert a shutdown of obstetric services in NSW. Minister Craig Knowles announced wide ranging changes which drastically altered the way medicine and particularly obstetrics was to be practised in NSW. A Bill was announced which would virtually abolish punitive damages in medical malpractice cases, limit non-economic loss damages to $350,000 maximum, limit past and future lost earnings to $2603 a week net for the plaintiff, and make domestic nursing or other care services not compensatable unless a

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[153] Philipa McDonald report, ABC, 5 November, 2001.
[154] AAP article, Sydney Morning Herald, "UMP's Costly Court Case a Ploy Says Lawyer", *SMH*, (March, 2003). http://www.smh.com.au/articles/2003/03/09/1047144874172.htm, (accessed 17 October, 2013).
[155] Kerryn Phelps, "Medical Indemnity Now a Community Concern", *Australian Medicine*, (November, 2001), 5.
[156] Andrew Pesce, Secretary NASOG, *NASOG NEWS*, (September, 2000).
[157] Andrew Pesce, "Indemnity Update, RACOG", *NSW State Committee Newsletter*, (March, 2001), 3.

Court decided otherwise. In addition to capping negligence claims, Medical Defence organisations would be forced to improve financial transparency.[158] As well, the Act laid down some extensive legislative changes affecting medical practitioners and Insurance organisations. These included an obligation for all medical practitioners to be covered by approved professional indemnity insurers, and also included mandatory requirements relating to data collection, reporting, risk management and requirements that may be imposed by 'Insurance Regulation' orders. There were general provisions relating to orders and the 'Minister may prohibit a person from providing approved professional indemnity assurance.' The Bill prevented medical practitioners from 'going bare', that is, they were forbidden to practice without medical insurance cover.[159]

It also gave insurers more power to disqualify doctors from cover so they could not practice. But it included measures which would make part time and 'near retirement' practice non-viable, because of the insurance provisions. These measures sent shock waves through the profession, the insurers and the legal profession. In the same issue of *Australian Medicine*, UMP announced it had lost $56 million in the 'HIH' company collapse.[160] It also announced it did not intend to increase premiums in the short term, but it transpired that UMP had not reported $445 million of incurred but not reported claims (IBNRs), which could come up for payment in future years. The long term implications of some of the legislative changes were not immediately apparent to many doctors, but were later identified by the legal profession.[161]

The NSW Medical Board had been working on measures to regulate and oversee standards in medical practice in the State for three years. *The Medical Practice Amendment Act* was passed in the last days of the autumn session of Parliament in year 2000, to become active on 1 October 2000. It modified the previous Act of 1992.[162] This new Act introduced a performance assessment system to

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[158] Catriona Purcell, "Medical Negligence Claims to be Capped", *Medical Observer Weekly*, (29 June, 2001), 1.
[159] Health Care Liability Act (NSW) 2001, no. 42, http://www.legislation.nsw.gov.au/tocview/inforce/act% 2B 42%2B2001%2Bed% 2BO, (accessed 19 December, 2012).
[160] Catriona Purcell, "UMP Says No Premium Rise or Levy Call", *Medical Observer Weekly*, (29 June, 2001), 3.
[161] Pamela Burton, AMA Legal Counsel, "The Sting is in the Tail", *Australian Medicine*, (20 August, 2001), 12.
[162] "Medical Practice Amendment Act, NSW", *Medical Board Newsletter*, Issue 16, Gladesville, NSW, August, 2000.

provide the Board with a mechanism to deal with medical practitioners with substandard practice. It extended the definition of unsatisfactory practice, required evidence of continuing medical education each year, required information about illness or criminal offences, included a more exacting regime for notification of criminal offences, and added powers to exercise disciplinary action. Even though there was some disquiet about some of the more draconian elements, at least confirmation of continuing medical education by the appropriate Medical College was included, a long standing request by the Colleges. However the changes meant that the system would be monitored by a Government instrumentality. This was probably inevitable, given the changes in community attitudes over recent decades.[163]

In spite of the new legislation, serious issues remained unresolved at both State and the National level, summarised for obstetricians in the *NASOG Newsletter* of early 2002.[164] Events had begun with the ramifications of the initial call by UMP, raising approximately $100 million, even though the value of unreported claims was still not documented. The change to 'claims made' cover from 2001 began. The consequences of the NSW Government introducing Tort Reform from June 2001 was still unclear, as even though the medical profession had accepted compulsory indemnity insurance as a price for tort reform, there was still no evidence that this would cause a fall in premiums. The HIH collapse had raised concerns regarding all MDO's financial exposure, and a requested Ernst and Young report into UMP for the AMA was still not released. Then UMP released an estimated 'reinsurance recovery' programme over 20 years to cope with its losses from the HIH collapse. This assumed a fifty cents in the dollar recovery programme, but it would write off $30 million over 20 years. Independent advice suggested that estimate was very optimistic.

The situation was complicated by the World Trade Centre disaster in September, 2001, as associated insurance costs placed huge upwards pressure on all of the insurance industry, leading to predictions of significant rises in reinsurance costs for all MDOs. Further, the NSW Supreme Court had just set a new record for a severely brain damaged infant in the *Simpson vs Diamond* award of $13.9 million, almost double the previous record of $7.8 million. The draft regulations for the *Health*

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[163] Alan D. Hewson, "The Obligatory Education Programme of the RACOG, a Practical Response to the Increasing Challenges of a Modern Society", *Medical Teacher* 11 (1), 1989.
[164] Andrew Pesce, "2001 in Review", *NASOG News* 9 (1), (March, 2002), 4.

Care Liability Act had been released, and a compulsory subsidy for obstetricians and neurosurgeons via a prescribed 'rate relativity', and levy on other craft groups was now publicised. UMP now released estimated liabilities of 'unreported incidents', with a cost of $455 million. With reserves of only $90 million, after costs of known claims, this meant they had an unfunded liability in excess of $350 million. The estimated cost of premiums for comprehensive cover for NSW obstetricians was now $135,000 per year, with the Treasury Medical Fund (TMF) cover possibly decreasing this to $75,000 for the year. UMP then released subscription rates for 2002, resulting in increases of 50-120%. St Paul's Insurance Company, the world's largest insurer, announced it was exiting the medical indemnity market worldwide which would make the whole situation worse still. The NSW Government announced all public patient indemnity would be covered by the NSW TMF including events not yet reported. A 10% across the board increase in VMO sessional rates was announced, in return for no further claims for five years. This was a positive, but a frightening financial scenario facing obstetricians during 2002, over and above the normal stresses of obstetric practice.

Dr Pesce commented that a whole range of issues still needed to be addressed, including the possibility of private practice only insurance, the continuing problems of insurance for other disciplines working in the public hospital sector, affordable cover for those with small practices, and those planning retiring needing their continuing insurance cover. There was a possibility that cover for public hospitals could still collapse, and consent issues for public hospital patients were still unresolved. Pesce paid credit to Minister Knowles in NSW for what he had done, his recognition that more was necessary, and his announcement that a National Summit was being convened to consider all the above issues. A small number of obstetricians took on the onerous task of presenting the professions' views over a prolonged period, but they received little recognition for their work.[165]

Agreement was reached on some issues at a National Summit in April 2001, including a commitment by doctors to safety and quality programs. The

[165] Consultant obstetricians in full time practice spent hundreds of hours of their own time without remuneration over that time attending numerous meetings with Government, preparing discussion papers and consulting colleagues, including Drs David Molloy, Andrew Pesce, Philip Cocks (NSW), Chris Maxwell, Michael Sedgley (and many others) nationally. The profession owes them an enormous debt of gratitude.

Commonwealth agreed to support Medical Defence organisations (MDOs) and set up a community funded facility to care for and rehabilitate injured patients. It asked for other jurisdictions to carry out more medicolegal reforms to deal with 'contingency based' lawyers, and to make structural settlements more attractive. But the National Coalition Government again stated that Tort Law Reform was a matter for the State Governments. Unfortunately, on the same day as the summit, the media reported that the NSW Government had rejected a request from UMP for more assistance for AMIL to help it to continue providing insurance cover. Six days later, UMP applied for provisional Receivership and this was another disaster.[166] UMP had a membership of 30,000 doctors, or two-thirds of the country's doctors, with unfunded liabilities of $460 million, so 90% of NSW doctors were left without cover for their private practice work. Around 1200 Victorian doctors and about 80% of Queensland doctors had also been covered by UMP, so doctors around the country threatened strikes and resignations, as they could not practice without insurance cover.

It was not until October 2003 that the Federal Government conceded it faced a crisis in healthcare. The Government agreed to provide a guarantee for UMP/AMIL until the end of the year. Attempts to get adjustments to the outstanding issues failed, and because the problem of the IBNR matter was not fixed, doctors held protest meetings, numbering up to 4000 doctors, and a massive confrontation developed. The proposed IBNR levy was labelled 'Patterson's Curse', after the minister Senator Kay Patterson, who did not seem to have the skills to solve the problems.

The Safety Net

Another irritation was minimised by urgent legislation regarding the safety net. A major issue in obstetrics related to bulk billing controversies and the costs of necessary medications under the Medical Benefit Scheme. Routine medications were a financial burden on pregnant patients, and the introduction of the Safety Net Legislation by the new Health minister Tony Abbott improved this situation through the *Health Legislation Amendments Bill 2003*.[167] It was introduced to provide a safety net for 'out of pocket' and 'out of hospital' services. However, it had taken fifteen

[166] Medical Indemnity Update, *RACS Bulletin* 4 (9), (October, 2003), 6.
[167] *Health Legislation Amendment (Medicare) Bill 2003*, Digest No. 85, 2003-2004, (accessed 9 September, 2013).

years of anguish for the medical profession, the community and the Government to get to some sort of workable compromise on a whole range of issues. All the above were of great importance to the discipline, partly because it was under other stresses related to the home birth issue, increasingly vocal advocates of so called 'natural' childbirth, tensions in their previously good relationship with midwives, and increased activism from some in the feminist movement who were targeting the predominantly male obstetricians of the time. Obstetricians felt that they were a persecuted species.[168] The major risks continued into 2012 and beyond.[169] It was not only the insurers who were deeply concerned at this situation. The AMA Council in 1 December 2000 approved a plan to take the majority of negligence cases out of the adversarial common law system.[170] The idea was to focus on getting patient welfare improved, by avoiding doctors being on the defensive, and the plaintiff less aggressive. This would reduce costs, and plaintiffs could go to common law if not satisfied. The Government was not interested in this proposal.

The legal issue of the 'Long Tail' was publicised by Pamela Burton, AMA Legal counsel.[171] She highlighted the recent change from 'occurrence based' to 'claims made' or 'claims notified', meaning that if a doctor changed insurer, they may not be covered for the 'long tail'. However this was later modified in a High court case, *FAI v Australian Hospital Care*. The Court ruled that Section 454 of the Act prevented insurers from denying claims made after the insurance expired, so again 'insurers may have to increase premiums'. However privacy laws prevent disclosure without the patient's consent, so the whole issue became more complicated for doctors, but especially for obstetricians with the 'long tail' of the brain damaged child. Some obstetricians were actually refused insurance even if they had not ever been sued.[172]

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[168] Chris Maxwell comments earlier in *NASOG Newsletter*, 1990; Bruce Shepherd, *Shepherd, Memories of an Interfering Man*, (Bowral, NSW: self-published, 2010)*;* Paul Nisselle, *Medical Newsletter*; see also Mario Bochelli, "Obstetrics and Gynaecology, Still a Marker for Litigation Claims in Australia", *NSW Doctor*, (September, 2001), 8; and Mario Bochello, "The 1 in 14,000 Risk", *NSW Doctor*, (August, 2001).

[169] Maurice Blackburn Lawyers stated in 2012, that 'mistakes' by obstetricians account for more than half of all compensation claims currently before litigation lawyers. See email@medneg.com.au, (accessed 10 October, 2012). See also http://www.solicitoradvice.com/mednegcaselaw.htm, (accessed 22 October, 2013).

[170] AMA Council Committee Report, *Australian Medicine*, (4 December, 2000), 3.

[171] Burton, "Sting is in the Tail".

[172] A colleague informed that in a large country hospital which was contracted out to a private hospital network, he and his three obstetrician colleagues could not be given any insurance cover, because of

Another controversial issue was the difference between MDOs and other insurers.[173] Apart from the mutuality principle of the MDOs, these organisations provided cover on a 'claims incurred' basis. This means that they will cover most claims, provided the doctor had cover with them in the year the claim was made so it does not matter when the claim is made. But insurance companies provide cover on a claims made basis so the doctor needs to notify them the same year the claim might arise. If the doctor ceases cover the next year, or they refuse to renew cover, and at that time, the doctor has not been notified of a claim but subsequently is notified, then they are not covered unless they have a special extension of that policy documented. However the cataclysmic events of years 2000-2001 produced legislation requiring all insurers to document a whole range of data covering claims made (IBNRs), claims being activated, the numbers being taken to court, claims settled outside of court, the total reserves of each fund, and the numbers of doctors covered. UMP chairman Dr John Quayle outlined the cascading effects of the costs of growing medical liability awards, concluding that: either way 'society pays'.[174] He further commented that at the time UMP had 105 outstanding claims valued at $1 million or more, and these accounted for 45% of overall claims cost.

Earlier UMP revealed that the cost of unreported incidents as at 30 June 2001 'is likely to be around $455 million to be paid out over the next 20 years', on top of $549 million of recognised claims already included in its accounts. These reports sent shock waves through the whole community, the Government and particularly the obstetric workforce, and led to the legislation already referred to in the State of NSW, followed by national legislation to save obstetrics from extinction. Again in this crisis issue Dr Paul Nisselle, from another insurer, Medical Protection Society (MPS), mentioned allegedly biased judges and 'paid expert' witnesses, leading to incorrect judgements which were overturned on appeal.[175]

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the insurance structure of the private public hospital arrangements. Until the Government acted this would have meant that a whole country town would have lost their obstetric services.

[173] *The Tito Report*, 32.

[174] John Quale, *UMP Newsletter to Members*, June, 2001.

[175] Paul Nisselle, *The Medical Observer*, (April, 2000).

A COMPLICATED SERIES OF EVENTS

The complicated series of events which occurred from 2001 to 2003 are crucial to understanding the resultant change in relationship between the obstetric specialty, the community and Governments, both State and Federal. A research paper by Drabsch summarised the events in chronological order, and it is appropriate to provide a summary of this information, before commenting on the results of the changes.[176] There had been numerous legislative changes in NSW, including an overhaul of health care and civil liability law. United Medical Protection, the principal medical defence organisation in NSW, had entered provisional voluntary liquidation and emerged again, the first body to do so in Australian corporate history. But by now the debate surrounding medical indemnity insurance had become a national issue evidenced finally by the development of a comprehensive rescue package by the Commonwealth government.

The Negligence Review Panel, chaired by Justice Ipp, published a review of the Law of Negligence in 2002, with many of its recommendations subsequently implemented by the States, including NSW. Medical defence organisations were now required to operate as insurers under the supervision of APRA, rather than as mutual and indemnity societies. The paper contains a timeline of events from 2001 onwards which have influenced both the shape and effectiveness of reform, as documented by Drabsch. The reforms include action taken by the NSW government from *Healthcare Liability Act of 2001* through the *Civil Liability Act 2002, the Civil Liability Amendment or Personal Responsibility Act of 2002*, and the *Civil Liability Amendment Act 2003.* The paper also discussed the findings of the Negligence Review Panel published in the *IPP Report,* and the extent to which the panel's recommendations had been implemented in NSW. The Commonwealth Government now developed an extensive medical indemnity rescue package paying particular attention to the IBNR scheme and the controversy which surrounded it. The paper also discussed the findings of the *Medical Indemnity Policy Review Panel* and the extent to which the government had accepted the panel's recommendations, in the Executive Summary.

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[176] Talina Drabsch, "Medical Negligence, an Update", NSW Parliamentary Library Research Service, Briefing paper No. 2/04, 2004. See Litigation appendices for full details.

There have been major changes in the relationship between obstetricians, the community and State and Federal Governments since these laws were passed in 2003. The obligations of all doctors including obstetricians have been markedly increased.[177] Annual registration has become a national requirement each September, with all health professionals licensed nationally under the authority of the Australian Health Practitioner Regulation Agency (AHPRA). All States still have a Medical Board, appointed by the relevant State Government, but there is now also, since 2010, a Medical Board of Australia.[178]

National registration had been a long standing goal of medical organisations to facilitate interstate practice, but the establishment of a new major bureaucratic framework covering all health professionals has been controversial, and the obligation for online registration has been criticised. The Complaints procedures have been changed and are now notified to the local AHPRA office, except in NSW where all complaints go to the Health Care Complaints Commission. Circulars to all doctors are now sent electronically, rather than being placed on the website every six months.[179] The Board has subsequently published revised conduct guidelines related to *Good Medical Practice Guidelines for Mandatory Notification, Guidelines for Advertising Regulated Health Services,* and a *Social Media Policy,* coming into effect in March 2014. Notifications (complaints) to the Board are relatively frequent in medicolegal assessment matters when there is major disagreement regarding the content of a report or the manner in which it was conducted, just to illustrate one of the many areas into which the Medical Board can and does now intervene.[180]Auditing of practitioners has now begun to determine whether they have complied with registration requirements related to recency of practice, continuing professional development, professional indemnity insurance, and recent criminal history of interest to the Board. [181] Notifications, Tribunal Hearings, and Panel hearings are published online, their

[177] Notification matters, Medical Council of NSW, Section 140, *Health Practitioner Regulation National Law (NSW) Guidelines for Mandatory Notifications* (by doctors), circularised in 2013. See also *Medical Indemnity Insurance, Sixth Monitoring Report*, Australian Competition and Consumer Commission, Commonwealth of Australia, 2009.
[178] HPMI, *Careers in Medicine Handbook* (14th edition), (Australian Medical Boards, 2010), 177.
[179] *Medical Board of Australia*, update, March 2014, http://www.medicalboard.gov.au/News/Newsletters/March-2014.aspx, (accessed 11 March, 2014).
[180] "Medico legal Assessments", *Medical Board of Australi*a, update, June 2014, 1, http://www.medicalboard.gov.au/News/Newsletters/June-2014.aspx?utm-medium=e, (accessed 27 June, 2014).
[181] *Medical Board of Australia*, update, June 2014, 3.

newsletter states that doctors' names are not published, even though the NSW Health Care Complaints Commission regularly publishes health professionals' names of those where legal action has been taken.[182] The annual registration fee has now risen to $680 per year to pay for the bureaucracy, from a level of ten pounds in the 1960s.

The increasingly onerous responsibilities and litigation risks of health care facilities has led to a major increase in bureaucracy. From a simple, usually one page document application in previous decades, the current application forms and protocols for simple reappointment to a teaching hospital post now occupy 22 pages, plus supporting CV and references.[183] Application to a private hospital recently involved reviewing and agreeing to 35 pages of By-laws, and a five page formal application plus references. [184] Applications for *Locum Tenens* positions are even more bureaucratised, because of the inclusion of the requirements of direct billing practices to insurers.[185] Collateral damage occurs when a doctor notifies AHPRA regarding concerns about a colleague, and now the AMA runs seminars regarding the legal risks to members for notifying AHPRA.[186]

This chapter has so far traced the explosion of litigation in Australia as it has affected obstetricians over 60 years. The reasons for little change from 1950 until the 1970s is consistent with the overall community attitudes to litigation at that time in Australia's history. Later attitudinal changes related to the information explosion, the questioning of past norms, a naïve belief in the effectiveness of modern medicine, increasing affluence, and a more secular society, all played a part in the increasing incidence of litigation from the mid-1970s. But the breakdown of the 'old fashioned' medical care with its close personal relationships, and the emergence of the new breed of scientist clinician also played a part. Changes in the law to allow lawyers advertising and contingency fees amplified the process in the 1990s. The delay in providing scientific evidence regarding the aetiology of the brain damaged infant was tragic, and caused enormous additional trauma to families and obstetricians alike. Finally, Government intervention to essentially preserve obstetric practice in the year

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[182] NSW Health Care Complaints Commission, News and Media Releases June 2014, 1, http://www.hccc.nsw.gov.au/ (accessed 27 June, 2014).
[183] Alan Hewson, personal files, 2012, application to local teaching hospital, 2012.
[184] Alan Hewson, personal files, 2012, application records.
[185] Professor Maxwell Brinsmead, personal communication to the author, 23 September, 2014.
[186] *AMA Mandatory Notification of Health Professionals Seminar*, 8 May, 2014, AMA House, Sydney. See also Andrew Keegan, "Mandatory Reporting of Colleagues", *NSW Doctor*, (2 March, 2008), 3.

2000 led to extensive legal changes which have had wide ranging effects across the whole range of medical care, so that medical practice will never be the same again. Before leaving this important topic of medical malpractice, however, another difficult area which has damaged the relationship between obstetricians and their patients over the past 60 years needs to be addressed. Scandals have involved individuals, organisations and administrators and deserve a separate section.

SCANDALS IN OBSTETRICS AND GYNAECOLOGY

There are many documented instances internationally of the medical profession producing harm to patients, usually due to ignorance.[187] In *The Alarming History of Medicine* by Gordon, little is said about harmful practices of obstetricians and gynaecologists, apart from criticism of hysterectomy and clitoridectomy.[188] This section documents five main episodes in which members of the obstetric fraternity have acted in an unethical or dangerous manner, but also includes episodes in which the profession was associated with harmful outcomes, and so brought the discipline into disrepute. Those cases occurring in Australia and New Zealand are highlighted, with a list of class actions which were damaging noted at the end of the chapter.

The first case concerns The Douglas Inquiry. This Inquiry into obstetrics and gynaecology services at the King Edward Memorial Hospital in Perth in 1990-2000, identified performance deficiencies at State, Board and hospital level, contributing to poor outcomes for women and babies and their families.[189] It raised important issues about clinical governance, leadership, culture, accountability, responsibility, safety and quality systems, staff support and development, as well as concerns regarding patients and their families. As the report states:

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[187] Robert Youngson, and Ian Schott, *Medical Blunders, Amazing True Stories of Mad, Bad and Dangerous Doctors*, (London: Robinson, 1996), has a separate chapter on dangerous doctors; Ferdinand Sauerbruch, *A Surgeons Life* (trans. Fernand Renier and Anne Cliff), (London: Andre Deutsch, 1953); Roy Porter, *Blood and Guts, a Short History of Medicine*, (London: Penguin books, 2003), 21-53 provides an overview of medical fads and fallacies, but no instances of deliberate harm to patients. And Porter's T*he Greatest Benefit to Mankind*, also provides no comment on harmful acts by individual doctors but covers public health issues and iatrogenic illnesses.

[188] Richard Gordon, *The Alarming History of Medicine*, (London: Sinclair Stevenson, 1993), 158.

[189] Jenny Maclean and Michael Walsh, "Lessons from the Enquiry into Obstetrics and Gynaecology Services at King Edward Memorial Hospital 1990 to 2000", *Australian Health Review* 26, (1 November, 2003), 12-23.

> The health care industry must ensure effective clinical governance supporting a culture of enquiry and open disclosure, and must build rigorous systems to monitor and improve healthcare safety and quality.[190]

The Douglas investigation covered 1990 to 2000, lasted 18 months, but followed a series of previous enquiries into the hospital's activities.

The King Edward Memorial Hospital is Western Australia's only tertiary referral service in obstetrics and gynaecology. It is the centre of teaching for undergraduates, graduates, postgraduates, and midwifery training, delivers 5000 babies annually and performs approximately 5000 gynaecological operations each year.[191] A public debate about the hospital's services arose during the late 1990s as there had been criticisms in a previous investigation's findings. That inquiry noted many instances of excellent clinical practice and a concerted effort by some to address long-standing clinical performance and management problems, but continuing problems had still resulted in poor outcomes for patients and their families, related to non-existent or substandard care in planning, coordination, documentation, lack of supervision of junior medical staff, poor management of high risk cases and medical emergencies, and non-existent systems to identify, review, and respond to adverse events. Documentation was 'often incomplete, lacked important clinical information, outcomes of discussions with senior staff were rarely minuted, and in most cases it was impossible to determine the extent of consultant involvement in decisions about care.' It continued: 'Errors were common in 372 high risk obstetric cases reviewed, and one or more clinical errors occurred in 47% of cases; 50% of those were very serious.'[192]

The hospital's performance was compared with similar tertiary referral hospitals across the other States and it identified major differences among hospitals. The report recommended that:

> King Edward hospital further investigate its high rate of stillbirths, obstetric interventions, its relatively large number of hysterectomies for postpartum

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[190] "The Douglas Enquiry, Australian Council for Safety and Quality in Health Care, Executive Summary", *Australian Health Review*, (2003), 1.
[191] "About King Edward Memorial Hospital, Women and Newborn Health Service", http://kemh.health.wa.gov.au/general/about _us, (accessed 5 January, 2016).
[192] Maclean and Walsh, "Lessons", 14.

> haemorrhage, its maternal deaths, deaths following gynaecological procedures, and the high proportion of women transferred to the adult special care unit during admissions for laparoscopic procedures and hysterectomy.[193]

Comparisons were also made between this hospital inquiry, the Bristol Royal Infirmary inquiry from 1988 to 1994 in the United Kingdom,[194] and one involving the Royal Melbourne Hospital, in 2002,[195] particularly around delays in investigations about unsatisfactory medical and nursing staff behaviour and management.

A further official report on the King Edward Hospital was issued in 2005.[196] This report provided information on the implementation of 237 recommendations from the original inquiry, and reported that there had been satisfactory implementation in most instances, but some were ongoing.[197] The reports together received widespread publicity in the local and national media over the years 2000 to 2005. Any patient or member of the public reading these reports would have serious reservations about the standard of obstetric care in its tertiary obstetric hospital and its obstetrics staff. The impression that these errors in hospital care may not be uncommon, and need serious attention has been reinforced by a recent overview.[198]

The second case resulted in The Cartwright Inquiry. This involved the 'Unfortunate Experiment' at the National Women's Hospital in Auckland New Zealand and received wide publicity in the Australian and international press. Because of the close links between the obstetric fraternity in the two countries, it led to serious criticism of the discipline of obstetrics and gynaecology in both New Zealand and Australia.

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[193] KEMH Inquiry Recommendations, Ref No.s R 1.5 to R 14.4.11.
[194] The Bristol Inquiry was conducted in October 1998 by Professor Sir Ian Kennedy into children's heart surgery carried out at the Bristol Royal Infirmary Hospital between 1984 and 1995, because of an apparently high death rate at the hospital. 'Bristol. NHS must change after inquiry into Bristol baby Deaths 'Daily Mail editorial, at http://www daily mail.co.uk.article60959NHS change-inquiry-Bristol–heart, (accessed 6 April, 2016).
[195] *Royal Melbourne Hospital Inquiry Report*, Office of the Health Services Commissioner, August, 2002, http://www.health.vic.gov.au/jsc/resources/rmh-inquiryreport.htm, (accessed 28 May, 2014).
[196] *Implementation of the Douglas Inquiry Recommendations*, Review, Final Report, Department of Health Government of Western Australia, April, 2005.
[197] *Implementation of the Douglas Inquiry*, 4.
[198] Leslie Russell and Paresh Dawda, "Lessons for the Australian Healthcare System From the Berwick Report", *Australian Health Review* 38 (1), (13 December, 2013), 106-108.

The history of the 'Pap Smear', as it has become known, provides essential background to this inquiry. In 1943 a pathologist, George Papanicolaou (1883-1962) and Herbert Traut (1894-1963) described a technique to stain exfoliated cells from the female genital tract, which could identify abnormal cells, especially malignant cells.[199] The cervical smear test is often called the Pap Smear to perpetuate Papanicolaou's name. It took some years before it was realised how useful the test might be to detect early malignancy in the cervix, and so allow early treatment to avoid invasive cancer.[200] A large Canadian study confirmed its effectiveness.[201] However controversy continued for some years regarding the rate of progression to invasive malignancy, and the percentage of abnormal smears which could revert to normal. Major contributions came from Australia, particularly from Bevan Reid and Malcolm Coppleson of Sydney regarding colposcopy examination of suspect cervices, which provides a magnified view of the cervix and improves diagnosis and treatment.[202] By the mid-1960s, widespread screening programmes had become a standard part of gynaecological practice in Australia and New Zealand, and protocols had been established for the management of patients with abnormal smears.[203]

However, a small minority of pathologists and gynaecologists remained sceptical of the risk of progression of what came to be known as 'pre-invasive cancer' to invasive cancer, and Professor Herbert Green at the National Women's Hospital in Auckland remained a continuing sceptic.[204] He initiated what was essentially an experiment to compare a 'non treatment' option in all women seen at the National Women's Hospital because of an abnormal smear with a 'treatment option'. The patients were not told that his approach was an experiment, and the study went on from 1966 to 1984, when it was published.[205] In June 1987, Bunckle and Coney

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[199] George Papanicolaou and Herbert Traut, *Diagnosis of Uterine Cancer by the Vaginal Smear*, 1943.
[200] Ralph M. Richart, "Natural History of Cervical Intraepithelial Neoplasia, in *Clinical Obstetrics and Gynaecology*, (New York: Harper and Row, 1967), 769.
[201] D.A. Boyes, B. Morrison, E.G. Knox, G.J. Draper and A.B. Miller, "The Foundations of Cervical Cancer Screening, A Cohort Study of Cervical Cancer in British Columbia", *Gynaecological Oncology*, ed. Malcolm Coppleson, (New York: Churchill Livingstone, 1981), 381. See also Fidler, Boyes and Worth, "Cervical Cancer Detection in British Columbia, a Progress Report", *Journal of Obstetrics and Gynaecology of the British Commonwealth* 75, (1968), 392.
[202] Malcolm Coppleson, Ellis Pixley and Bevan Reid, *Colposcopy, A Scientific and Practical Approach to the Cervix and Vagina in Health and Disease* (2nd edition), (Springfield, USA: 1978).
[203] National Guidelines for the Management of Abnormal Smears, Australian Department of Health.
[204] G. Herbert Green, "Carcinoma in Situ", *ANZJOG* 10 (41), (1970), 41-48.
[205] McIndoe, McLean, Jones and Mullins, "Natural History of CIS of the Cervix", *Obstetrics and Gynaecology*, 1984.

published an article in *Metro Magazine* in New Zealand, 'An unfortunate experiment at National Women's Hospital', labelling the research as unethical, dangerous and resulting in some women losing their lives with cancer.[206] As a result the Government set up an Inquiry, chaired by Judge Silvia Cartwright, which investigated the matter and issued a report on 5 August 1988, essentially confirming the allegations made in the *Metro* article.[207] Senior clinicians at the hospital, especially its head Professor Bonham, as well as the Board, were implicated, as even when deaths began to occur in the 1970s no action was taken, and critics within the hospital were marginalised. The subsequent outcry led to charges being laid against Professor Bonham, Professor of Obstetrics; Professor Seddon, President of the Royal New Zealand College of Obstetrics and Gynaecology which had not acted on the matter; and Dr Bruce Faris, another obstetrician. The Medical Council of New Zealand upheld charges against all three. Professor Green escaped legal action as he was judged unfit to face charges.[208]

The women's movement in New Zealand understandably played a major role in the whole process but public opinion as well led to major changes in a whole range of issues related to the discipline of obstetrics which altered obstetric practice in that country. To summarise, the changes included an understanding of treatment which went beyond medical procedures to include respect for human dignity, effective communication and informed consent, a human rights approach to patients' rights, a legislated Code of Patient Rights, and an independent Health Commissioner to adjudicate on medical providers.[209] It led later to the development of a National Cervical Smear programme, involvement of the community in Ethics Committees, and related changes.[210]

Nevertheless there has been continuing controversy on this episode, with claims that the evidence was manipulated. Linda Bryder provided a historian's view

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[206] Phillida Bunkle and Sandra Coney, "An Unfortunate Experiment at National Womens Hospital", *Metro Magazine*, June, 1987.
[207] "An Unethical Experiment at the National Womens Hospital", *Cartwright Inquiry*, http: //www.cartwright inquiry.com/ (accessed 29 May, 2014).
[208] Summary of the findings and recommendations from the Cartwright report, http://www.womens-health.org.nz/summary-of-findings-and-recommendations–from, (accessed 29 May, 2014).
[209] *Cartwright Inquiry Report*, 2.
[210] Lynda Exton, *The Baby Business, What's Happened to Maternity Care in New Zealand?*, (Nelson: Craigpotton Publishing, 2008).

on the inquiry.[211] Letters to the ANZJOG continued the debate.[212] Wherever the truth lies in this matter, the controversy diminished trust in obstetricians and gynaecological medical providers on both sides of the Tasman, as most women by then were having regular smears done and were entitled to have confidence in the integrity of the process. In 1984 a gynaecologist, Professor Ron Jones, who worked at the hospital, had put his career on the line by co-authoring an article expressing concerns, but no action was taken.[213]

The repercussions of the Cartwright inquiry continued in New Zealand, evidenced by a scandal involving gross errors in Pap Smear reports in Gisborne New Zealand.[214] The pathologist was found guilty by the Medical Practitioners Disciplinary Committee, but subsequently more misdiagnosed smears were identified and the media had a front page medical story. It was reported that the original pathologist had only limited training in cytology, was at an advanced age and living in an isolated area without any peer support, recognised as a high risk factor for substandard practice.[215] The Surgeon's Journal concluded that the New Zealand Ministry of Health had failed to establish adequate quality controls for its screening program, and that it was prepared to allow the pathologist concerned to take much of the blame for what had taken place. However this well publicised sequence of events reminded the whole population of the original saga of the Cartwright enquiry.[216]

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[211] Linda Bryden, *A History of the Unfortunate Experiment at National Womens Hospital*, (Auckland: Auckland University Press, 2009). See also Caroline M de Costa ,Book review, *MJA*, vol 192,number 2,18Jan 2010.

[212] Graeme H. Overton, "Letters to the Editor, The 1987 National Women's Hospital Unfortunate experiment", *ANZJOG* 51, (2011), 184. See also Margaret McCredie, *ANZJOG* 51, (2011), 184; Natasha Frawley, "Participating in the Study", *ANZJOG* 51, (2011), 187; Carles Paul, "Participating in the Trial", *ANZJOG* 51, (2011), 187; See also "The Facts", *Cartwright Inquiry*, http://www.cartwrightinquiry.com/, (accessed 17 October, 2013); and also" NZ Medicine after Cartwright", *BMJ* 300, (7 April, 1990), 893.

[213] Martin Johnson, "Professor Ron Jones, 1984 Whistleblower, Calls it a Day", *NZ Herald*, 3 June, 2010.The original article by McIndoe ,McLean ,Jones and Mullins ",The invasive potential of carcinoma in situ of the cervix "was published in *Obstetrics and Gynaecology* (US), in 1984(Oct,64,(4):451-458. A follow up article in the Lancet in 2008 again highlighted the risk of progression to cancer--but it was the Metro article by Sandra Coney and Phillida Bunkle in 1987 which led to the Judge Cartwright Inquiry.(Ron Jones, personal communication to this author)

[214] John Simpson, Executive Director SurgicMc Indoe .McL ean and Jonesal Affairs, "New Zealand, Is History Repeating Itself? Another Cervical Cancer Inquiry in New Zealand", *RANZCS Bulletin* 1 (6), (July, 2000), 9.

[215] R.G. Mc Cauley, "Peer Review of Physicians, the Ontario Experience", Canada, International Congress on CME, UCLA, 1988.

[216] Simpson, "Is History Repeating Itself?", 9. See also another incorrect Pap Smear reports scandal reported in Paul Symonds, Nick Naftalin and Paul Shaw, "A Smear on Audit, Implications of the Leicester Cervical Smear Audit", *BJOG* 110, (1 July, 2003), 646-648.

Dr William McBride (b. 1927) forms the notorious subject of the third case. McBride was a specialist obstetrician and gynaecologist on the staff of the Crown Street Women's Hospital and St Margaret's Hospital in Sydney. He is credited with being the first obstetrician to realise that the occurrence of a large number of birth defects in a pattern in the early 1960s was due to the mother having taken the drug Thalidomide during pregnancy.[217] For this achievement he was honoured by a prestigious Institute of the French government.[218] With that money he established Foundation 41, a Sydney-based Medical Research Foundation concerned with the causes of birth defects. He was subsequently awarded an AO, and a CBE, and was named 'Father of the Year'. Subsequent to that in 1981, he published a paper claiming that the drug 'Debendox' was the cause of birth defects if taken during pregnancy.[219] However, his co-authors reported that the published paper contained manipulated data and the matter went to court.[220] There were also multiple court cases in which mothers who had taken Debendox during pregnancy sued the Merrell Company for damages, including many high profile cases in the USA.[221] McBride was struck off the Australian medical register in 1993. A subsequent application for reinstatement on the Register in April 1996 was refused, again generating more negative publicity.[222] Because of his high profile and his subsequent fall from grace not only he but the whole discipline of obstetrics and gynaecology was damaged, as he had also written an autobiography called *Killing the Messenger* in which he had not shown any insight into his previous deception.[223]

The dangerous drugs - Thalidomide and Diethyl Stilboestrol (DES) - brought fear and mistrust regarding drugs designed for use by women, and are the subjects of case number four. Thalidomide was developed in Germany in the late 1950s and

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[217] William McBride, "Letter to the Editor", *Lancet*, (December, 1961).
[218] L'Institut de la Vie, France.
[219] Debendox (pyridoxine, doxylamine, produced by Merrell) came on the market in the mid-1950s for nausea in pregnancy and was very effective.A court case encouraged by the (false) McBride allegations forced its manufacturer to withdraw the drug in the USA in 1983. See GeoffreyD Quinlan,D Ashley Hill,Nausea and Vomiting in Pregnancy,.*Am. Family Physician*,July 1st,68,(1)121-128
[220] Gerald Lawson, "Painting the Mice", *O and G Magazine* 14 (2), (Winter, 2012), 45-47.
[221] Robert Millikin, "Thalidomide Doctor Guilty of Medical Fraud", *The Independent*, Saturday, 20 February, 1993, 1. http: //www.independent.co.uk/news/world/thalidomide –doctor –guilty –of, (accessed 1 November, 2013).
[222] *Decision of the Medical Tribunal in Relation to Dr William McBride and the Medical Practice Act*, delivered on 28 April, 1996.The application for restoration was refused.
[223] Norman Swan, "When Healthy Scepticism Helps", *The Bulletin*, 11 June, 1991, 40.

widely used for nausea in pregnancy. In 1956 the first German pregnant patient delivered a child with gross phocomyelia (absence of portion of limbs) but it was not until 1961 that a German paediatrician and McBride in Australia realised the link with drug ingestion and the defect, and it was withdrawn from sale.[224] As a result, in 1963, the Australian Drug Evaluation Committee was established to monitor and evaluate all new drugs entering the market, but the trauma of the thalidomide episode for patients and obstetricians lasted for years.

Another substance, Diethyl Stilboestrol (DES), the first synthetically produced oestrogen, was announced in 1938. It was produced cheaply but in 1940 the Federal Drug Administration (FDA) in the USA rejected the drug from listing due to disturbing animal studies and overall scientific uncertainty. Despite evidence of adverse events in animals, suspected links to uterine cancer, and sexual differentiation of offspring when given in pregnancy, as well as abortifacient qualities, DES was still placed on the market for use in humans without any trials.[225] It was also marketed as a potential treatment to prevent miscarriage. In 1947 the FDA approved its use in pregnant women with diabetes. Between 1947 and 1959 it was widely used as a 'growth promoter' in poultry, cattle, and pigs, in spite of reports of devirilisation in males eating these products. It was not until 1971 that researchers in Boston noticed a rare vaginal cancer in women who had been exposed to DES in utero, but this was not in textbooks up to 1976.[226] The FDA finally banned its use, but by that time millions of women had been given DES, and an estimated two to five million children were exposed in utero, apart from the millions who were exposed through their food intake. DES is now known as an endocrine disruptor, and has been linked to a multitude of diseases and disorders including breast cancer. Its long-term effects are being studied over multiple generations and results have demonstrated higher rates of premature births, miscarriages, ectopic pregnancies, infertility, and early menopause in DES

[224] "The Thalidomide Tragedy", http://www.tga.gov.au/book/fifty-years–independent-expert-advice-prescription-medicines-02, (accessed 14 October, 2015).
[225] "Problems in Research: Regulations - the Diethyl stilboestrol Tragedy, a Call for Stronger Regulations", *The Medical Bag*, 12, 1, http://www.themedicalbag.com/article/problems-in-research-regulations, (accessed 30 December, 2013).
[226] T.N.A. Jeffcoate, *Principles of Gynaecology*, (1976): "Tumours of the Vagina", 389, records the occurrence of clear cell adenocarcinoma of the vagina, being found in girls less than 25 years in the past decade, and in most cases having a history of in utero exposure to stilboestrol in high doses to their mothers before the 18th week of pregnancy. He estimated the risk as being less than 1 in every 1000 patients so exposed.

daughters. DES sons have been shown to have an increased risk of testicular abnormalities, undescended testes and cysts in the epididymis.[227]

There is now accurate follow-up data on females exposed to DES in utero with benign changes (such as vaginal adenosis) in approximately 90%, either showing abnormal appearances on colposcopic examination or on biopsy. Fortunately the incidence of invasive adenocarcinoma is much lower and the risk to exposed female offspring is of the order of 0.14 to 1.4 per thousand up to the age of 24. Most cases become evident between the ages of 14 and 24, and there is spread to the pelvic nodes in about 16% of all stage one lesions. The treatment is radical surgery including removal of the vagina and the uterus, usually followed by radiotherapy, a devastating outcome for a young woman.[228] Obstetricians were the clinicians most involved in prescribing DES in pregnancy, so this was extremely damaging, but fortunately in Australia there was not widespread use of DES compared to the USA. But this unfortunate saga, and the later thalidomide disaster, has led to great reluctance on the part of many expectant mothers to take any sort of medication during pregnancy.

Finally, this brief foray into scandals affecting obstetrics and gynaecology concludes with the recent case of Dr Grahame Reeves (b. 1949). Dr Reeves qualified as a member of the RACOG in 1981 and became a Fellow in 1983.[229] He worked as a specialist from 1985 until 1997, when his obstetrics practice was restricted, but he continued in gynaecology until year 2000. There were numerous complaints about him over a 15 year period from June 1986 coming from other doctors, nurses, and patients. In January 1997 a hospital Advisory Committee made an adverse finding about Reeves, and a Professional Standards Committee handed down a decision in August placing limits on his practice in obstetrics. He was also suspended from the gynaecology clinics at his hospital in December 2000. Psychiatric reports dating from as early as 1996 reported that Reeves had a 'narcissistic personality disorder'. In spite of the NSW Medical Board's restrictions on his practice, Reeves was appointed to hospitals in the Greater Southern Area Health Service (GSAHS) on the south coast

[227] "Problems in Research", *The Medical Bag*, 4.
[228] S.N. Hajj, W.R. Welch and A.L. Herbert, "Clear Cell Adenocarcinoma of Cervix and Vagina and DES Related Abnormalities", *Gynaecologic Oncology*, ed. Malcolm Coppleson, (London: Churchill Livingstone, 1981), 363.
[229] Register of Fellows and Members of the RACOG published by the RACOG Melbourne, Victoria, August, 1986.

of NSW from April 2002 until January 2003, until his gynaecology contract was terminated in July 2003. [230] This occurred because he provided only partial information about the restrictions on his registration, and GSAHS did not verify his record with the Medical Board. Even after complaints at Bega Hospital, he was allowed to continue. As a result of this unacceptable omission the GSAHS Deputy Director of Medical Services was suspended in May 2008, and a formal Inquiry initiated by Government. Reeves was struck off the medical register of doctors in 2004. The very extensive media reports about his conduct in both the printed media and television, in which he was called the 'Butcher of Bega', and an increasing number of complaints from patients about his gynaecological operative procedures, was very damaging to the specialty.

Significant changes to the conditions for medical registration by the NSW Medical Board which were instituted in 2008 in part arose from the actions of Dr Reeves.[231] Subsequently police action was initiated. In 2011 a NSW District Court found him guilty of maliciously inflicting grievous bodily harm on a patient, and he was sentenced to serve a minimum of two years in gaol.[232] Even though some of the harm to patients and damage to the specialty of obstetrics and gynaecology was due to the failure of appropriate action at the hospital level, the negative publicity reflected badly on the specialty.

CONCLUSION

Besides these regrettable cases, there have also been numerous consumer class actions related to the discipline. These have included actions involving some contraceptive pill formulations, intrauterine contraceptive devices, the effect on the incidence of cancer of the breast related to hormone ingestion at and beyond the menopause, complications of laparoscopy, and more recently complications related to

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[230] Adam Cresswell, "Outrage as Banned Doctor Graeme Stephen Reeves Exposed", *The Australian*, 26 February, 2008; See also,NSW Parliament,*Health Care Complaints Committee*, Mr Graeme Reeves,3/54, 2008

[231] The Minister for Health in NSW, Ms Meagher, on 6 March 2008 confirmed that a range of protocols related to hospital appointments had been changed by the NSW Medical Board since the Reeves case; http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/L, (accessed 31 May, 2014).

[232] "Dr Graeme Hughes Jailed for Mutilation, *AAP News* (online), 1 July, 2011, (accessed 31 May, 2014).

the use of mesh in pelvic floor repair.[233] In these actions the discipline of obstetrics and gynaecology, individual obstetricians, and the commercial industry supplying the discipline, have been subjected to serious criticism and negative publicity.[234]

It has been difficult to find objective data in the literature which assessed the effects of all these incidents on the public at large and in particular on the patients of specialist obstetricians.[235] However anecdotal evidence provided by individual obstetricians in practice over the years has consistently emphasised the resultant concerns which they have noted in their relationship with patients, and a progressive increase in the time required for counselling of pregnant patients even on relatively simple issues like the taking of medication during pregnancy reinforces this view. Every time any of the issues which have been summarised in this section are re-publicised, and new fears and concerns engendered, patients remind the obstetrician carers of what has gone before. Obstetricians have to live with this legacy, and this is going to continue as a permanent part of the complexities involved in caring for obstetric patients.

This chapter covering medical malpractice has emphasised the effect on obstetric and gynaecological practice of these actions. Every one of the cases of brain damaged infants, allegations of negligence in gynaecological operative procedures, and instances of alleged 'failure to warn' have always received widespread publicity. Though understandable, the failure of the press to present a balanced view of the background to most of the cases of brain damaged infants has caused enormous harm.

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[233] Referred to in other chapters of this thesis.

[234] Peter Cashman, "Consumers and Class Actions", *UWS LawRw2* 5 (1), (2001), University of Western Sydney Law Review, 9, (accessed 29 December, 2013); Farmer, Jaffe, Weissing, Edwards and P.L. Fistos, "Was there a Mirena Recall?", http:www.pathtojustice.com /Mirena–lawsuits/, (accessed 29 December, 2013); "Dalkon Shield, A.H. Robbins Company Inc., Lawsuit, Health Facts May 1996", http://en. Wikipedia.org/wiki/Dalkon_shield, (accessed 29 December, 2013); See also, Morton Mintz, *At Any Cost: Corporate Greed, Women and the Dalkon shield*, (New York: Pantheon, 1985); Andre Picard, "Time to Discuss Risks of Surgical Meshes", *The Globe and Mail*, Canada, 7 May, 2012, http://www.the Globe and mail.com/life/health- and- fitness/time- to- discuss- risks- of- surgical- mesh, (accessed 29 December, 2013).

[235] The author of this thesis was a member of the governing Board (Council) of the RACOG over the years from 1981 to 1993, and was involved in most of the educational programs and workshops carried out by the College over those years. In the many discussion groups held at these meetings the damaging effects and concerns of the profession regarding the scandals occupied a great deal of time.See also Bronny Hanfield,Sue Turnbull,Robin Bell,What do obststricians think about media Influences on their Patients?,*ANZJOG*,46,,2006,,379-383

CHAPTER 6
OBSTETRICS AND GYNAECOLOGY IN THE HUNTER VALLEY

AB UMBRIS AD LUMINA VITAE

'OUT OF THE SHADOWS INTO THE LIGHT OF LIFE'

RANZCOG MOTTO

This chapter evaluates the ways the changes in the discipline over the past 60 years affected a major region and modified its history. The chapter also provides more detailed background history to the scope of the thesis from 1950 to 2010, and also evaluates the varying influences before these decades in a major region of NSW. The chapter provides a better understanding of the outcomes which have emerged in those more recent decades after the 1950s. The earlier sedate progression of the discipline in the region dominated by midwives and later general practitioners was dramatically altered during and after WW2, not only by the knowledge explosion, but by the significant influence of visionary individuals, as well as the influence of specially trained obstetricians. Such people set in train a series of events which not only produced remarkably rapid changes in medical practice, but also gave the region a national profile in obstetrics and gynaecology as well as other disciplines. The development of an innovative hospital staffing system in the mid-1940s, and later, a new ethos and controversial medical school in 1978, pushed the region onto the centre of the national and international stage, with many new approaches to education in obstetrics and gynaecology. The development of the nation's last major hospital of the 20th century in 1990, with its regional tertiary referral obstetric centre, completed the metamorphosis from colonial times into a world class obstetric centre. This chapter is an essential element in the thesis by moving from national trends to the practical regional issues which affect patients. The study is informed by an extensive data base of primary sources from the author's own files and records. The account begins with some essential background on Newcastle and the Hunter Valley as a prelude to the discussion.

NEWCASTLE IN THE PRE-COLONIAL AND COLONIAL PERIODS

The temperate region of the Hunter Valley includes the tributaries and flood plains of the Hunter River, and encompasses a variety of landscapes, soils, seascapes, as well as Australia's largest salt water lake, and mountains rising to 1,500 metres north and south. The variation in topography in a circumscribed area has led to a variety of economic development, occupations, social class differences, cultural and community activities and it is often claimed to be a microcosm of Australia. Originally the home of the Indigenous peoples, the Valley has been a fertile field for historians since the European discovery of the Hunter River by Lieutenant Shortland in 1797 when searching for escaped convicts.[1] The second and successful penal settlement at Newcastle was begun in 1804 with convicts sent to mine the seam of coal that Shortland had found. After the 1820s, with the change from a penal outpost, the colonisation of the Hunter Valley began to accelerate. The Australian Agricultural (AA) Company, formed in England in 1824 to begin agricultural exploitation in the colony, started large scale coal mining near Newcastle at Hamilton. Thereafter new free migrants came from the industrial areas in the north of the England, especially Yorkshire. As well they migrated from the mining districts of Wales, Scotland and Ireland, especially after 1860. This had significant implications on the development of medical services as the migrants brought with them their rich working class culture, and its institutions like Miners Lodges, trade unions, Mechanics Institutes, sports and chapel churches.[2] From 1855 other companies followed the AA Company to mine adjacent areas.[3] These companies shaped the lower Hunter pit-head towns and the port city. They acquired land, sank shafts and attracted thousands of immigrants, who lived adjacent to each pithead.

So Newcastle developed as a series of towns, sited around each coal mine, a pattern still evident today. When tramlines developed, they basically ran from one

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[1] Greg Blyton and John Ramsland, "Mixed Race Unions and Indigenous Demography in the Hunter Valley of New South Wales 1278-1850", *Journal of the Royal Australian Historical Society* 98 (1), June, 2012.

[2] John Ramsland, *The Rainbow Beach Man, Life and Times of Les Ridgeman Worimi Elder*, (Sydney: Brolga Publishing, 2009), 22. See also John Ramsland, *The Struggle Against Isolation, History of the Manning Valley*, (Sydney: Library of Australian History, 1987), 17-35.

[3] See also J.W. Turner, *Coal Mining in Newcastle, 1801-1900, Newcastle History Monographs No 9, maps 9, 10, 11, 12* regarding sites of coal mines.

village to the other so conurbanisation did not really occur.[4] This pattern influenced the later development of GP practices (including obstetrics) specifically related to each mining community.[5] In the 1901 *Federal Directory* this distinct separation of the adjacent communities was obvious.[6] Each town, later to become a suburb, is clearly identified with boundaries; distance from the city centre, its population, and the means of communication with the city are all outlined. McEwan has calculated that between 1860 and 1900 a quarter of the British born residents of the Newcastle coal mining districts came from Scotland, 10% from Wales, 7% from Ireland, and the remaining 58% were English in origin. About 40% of the English-born inhabitants of the Newcastle coalmining district were from the English counties of Northumberland and Durham and many of their descendants are still in Newcastle.[7] The Celtic groups brought with them particular physical characteristics and susceptibility to specific disease entities which persist in the region.[8] The Protestant faith predominated, with 'above the State average' numbers of Presbyterians, Congregationalists and 'Primitive' Methodists, who recreated the religious faiths and social mores of the land they had left. The first district Coalmining Union started in 1860, and the first Co-operative Store at the Borehole at Hamilton in 1861.[9]

As the city mines were worked out and closed, the miners followed work to the developing Maitland and Cessnock fields, resulting in a drop in the Lower Hunter population in the period between 1890 and 1910.[10] This separation ensured that there remained a clear demarcation between the mining communities of the lower and upper Hunter from the city of Newcastle. This predetermined the separate community-based provision of medical care for the two areas. Newcastle only began to develop as a city with the coming of the Broken Hill Proprietary (BHP) steelworks

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[4] J.C. Docherty, *Newcastle, the Making of an Australian City*, (Melbourne: Hale and Ironmonger, 1983), 13.
[5] Confirmed in the *Old Docs Memoirs* files, HPMI, which describe the local GP/obstetricians as limiting their work to the local suburb (village) into the 20th century.
[6] *Federal Directory of Newcastle and District*, Newcastle: Davies and Cannington, 1901.
[7] Docherty, *Newcastle*, 16.
[8] These include red hair, blue eyes, susceptibility to the streptococcus organism, and inherited skin diseases. See Arthur McGeoch, "Memoirs of Dermatological Practice in Newcastle", *Joint Medical Newsletter*, 1991.
[9] Barbara Heaton, "Education for the Working Class", in *Science Success and Soirees*, Barbara Heaton, Gregory Preston and Mary Rabbitt, Newcastle History Monographs No. 14, Newcastle Regional Library, 1990, 4.
[10] See Norman Barney, *A to Z of Newcastle and the Hunter*, (Newcastle: Newcastle Papers Pty Ltd, 1998), "Edgeworth David, the Greta Seam, 1986", 31.

in 1915, the impetus being the Trans-Australian railway and WW1.[11] The 1922 to 1923 recession caused by problems in the coal industry, and the later great depression from 1927 to 1933, had a profound effect on Newcastle and the lower Hunter with significant medical consequences.

Newcastle, a Culture of Fatalism and Women's Health.

Over one third of the males in Newcastle were unemployed in the Great Depression, but as Sheilah Gray points out, women were even more affected:

> A destitute woman or one who is unemployed was almost automatically suspected of immorality, so they kept their plight secret. Domestic service was a last resort if they applied through relief, in an age when it was accepted that the average woman's destiny was to marry and rear children.... In the early 1920s Newcastle had a crude birth-rate about 29 per thousand, considerably higher than the state average, but by 1928 it had fallen to 24 per thousand, but still higher than the state average. With the onset of the depression the birth-rate in Newcastle fell dramatically, reaching its lowest point of 15.9 per thousand in 1933.[12]

This was relevant to obstetrics and gynaecology. Gray cites Dr John Harris, who claimed that contraception was employed among the wealthy, but in the lower income group, abortion was the more frequent solution in reducing family size. On the other hand, while there were regular advertisements in the local newspapers about contraception and 'abortifacients', it seems likely that poor women either could not afford them or were not sufficiently sophisticated or educated to use them. It was pointed out that 'babies were in plentiful supply in the depression even though everything else was scarce'. Some families had eight, nine or ten children. One female doctor at the time commented that the fear of pregnancy was women's greatest worry.[13]

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[11] Barney, *Newcastle A to Z*, 13.
[12] Sheila Gray, *Newcastle in the Great Depression* (2nd edition), Newcastle History Monographs No. 11, Newcastle Regional Public Library, 1989, 33.
14. Sheila Gray, *Newcastle in the Great Depression* (2nd edition). Comments from Dr Frank Firkin of Wallsend quoted by Sheila Gray are noteworthy. He was still in general practice with obstetrical appointments in 1958 when the author of this thesis began practice in Newcastle.

There is little extant historical documentation on the care of women and pregnancy in the region during the early decades caused by secretive attitudes during the 19th and early 20th century. The community just accepted the ever-present risk of death in childbirth at that time, which was between 5 and 10 in every 1000 births.[14] In *Dawn in the Valley,* childbirth and maternal death were not even mentioned up to 1833.[15] Other texts confirm this tendency of ignoring deaths in childbirth.[16] The tragedies of failed surgery in the female were also horrifying during the 19th century.[17]

This period has been fully explored by historians, but they commonly focussed on positive issues related to exploration, establishment of settlements, transport links and the like. But equally important negative elements, including the illnesses and high death rates of the wives, mothers and children in the early colony, the tragedies of Aboriginal peoples, the loss of life leading to family breakdowns, and the enormous stress on, and economic consequences for, the resultant motherless children in the large families are frequently overlooked. Research on the early mining communities of the valley and the admirable mutual self-help organisations they brought with them from the United Kingdom, confirms that the hospitals they built in the coalfields were primarily directed to caring for the miners and other outdoor workers. The welfare of the wives and children were either ignored or neglected until they were beyond medical and midwifery help.

But there were reasons for this apparent inhumanity and community indifference, which was certainly not limited to the Hunter Valley. The fact that everywhere the expectant mothers were delivered at home, usually in unsanitary conditions, and looked after by midwives and doctors with very limited knowledge of pregnancy and childbirth, was a recipe for disaster. They had limited knowledge of what could be done to save the mother from the three big killers of difficult childbearing - haemorrhage, infection and the toxaemias - even though from the 1850s onwards much had been discovered about treatment for these in the wider

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[14] The appalling death rate remained at that level during the whole of the 19th century but was higher in remote settlements because of no access to skilled help, discussed elsewhere in this thesis.
[15] W. Allan Wood, *Dawn in the Valley, the Early History of the Hunter Valley Settlement to 1833*, (Sydney: Wentworth Books, 1972).
[16] Loudon, *Death in Childbirth*, 14, shows graphs confirming the number of deaths in childbirth stayed at 47 per 10000 from 1850 to 1910 in the UK, an average of about 10 deaths per day. This was mirrored in the USA, Australia and New Zealand.
[17] "Women's Old Time Surgical Lottery", *Sunday Telegraph*, 26 June, 1994, 128.

world.[18] It was just that these new discoveries had not become common and accepted knowledge in the frontier communities at that time. Intervention in childbirth was still discouraged and feared by most carers, and so the birth attendants could by and large only give sympathy and support, and passively 'leave it to nature', or, in the mindset of the time, leave it to 'God's will'. The enormous problems of poor communications and transport difficulties in the more isolated regions compounded the problems.

So a protective fatalism about the commonality of death in relation to childbearing, particularly in these more isolated communities, is understandable. Further, the insularity and inward looking mentality of the Hunter community led to prolonged continuation of conservative nursing home and lying in care, with a delay in the movement towards larger hospital care and more intervention in childbirth compared to the Sydney metropolis.[19] The development in Newcastle of the series of separate villages around the pitheads and the spirit of mutual self-help evidenced by the Miners Lodges, Friendly Societies, the Mechanics Institutes, and the School of Arts and libraries, was a remarkable achievement. However, the degree of acceptance of the plight of the wives and mothers who faced the risks of childbirth in unsanitary surroundings with midwives and doctors poorly equipped to provide a sufficient degree of safety is a sombre story. The development of the Lodge system which provided affordable care to the miners and their families still often left the mothers and their infants virtually to the vagaries of nature, and contributed to the numbers of widowed men in the Hunter region.

The period from the 1890s to the 1930s, when knowledge of how to deal with some of the risks of childbirth was already available elsewhere, but was not utilised or understood in the more isolated Hunter region, is particularly tragic. It remains as an indictment of both the community and the nursing and medical professions. Mining is a dangerous occupation with a high accident rate so the emphasis to provide hospital facilities for injured miners is understandable. But childbirth in Australia in colonial and post-colonial times was infinitely more dangerous. Lee

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[18] The work of Holmes, Semmelweiss, Koch, Pasteur and Lister in the mid to late 19th century was well publicised.in the media of the time. For example, Pugh of Launceston gave an ether anaesthetic in 1847 after reading about it in the *Illustrated London News*: John Paul, *Not just an Anaesthetist, Dr William Pugh*, (Tasmania: Foot and Playsted, 2013).

[19] Paula Watts and John Ramsland, "Midwifery in the Lower Hunter River District 1942-1960: Female Entrepreneurial Activities in a Masculine Work World", *Journal of the Royal Australian Historical Society* 88 (2), (December 2002), 184-199.

showed that the risk of dying in childbirth over the period from 1875 to 1914 was almost five times the risk of a mining death.[20] As it was, practices and beliefs remained governed by the outdated prejudices of the previous century. It is arguable that the cataclysm of the First World War, and the Depression, followed rapidly by the Second World War, provided some excuse for this period when the care of mothers and infants was accorded such a low priority. All that was to change in the next decade.

HUNTER OBSTETRICAL AND GYNAECOLOGICAL SERVICES AFTER 1940

Regional medical services had developed slowly, and were linked to the separate mining communities as well as the local hospitals. The Lodge system and the Friendly Societies so familiar in the mining communities of the United Kingdom were imported to Australia. The miners received comparatively poor wages, and the Capitation System (sometimes called the 'Club' System) was a blessing for them.[21] The attending doctor contracted with the Lodge or Friendly Society to provide comprehensive care for the miner and his family, at a low cost. Even in the 1930s and 1940s a quarterly fee varying from one shilling (about 20 cents) per family in the mining suburb of West Wallsend pre-war, up to 11 shillings per quarter in Merewether in 1946, was usual. Out of the 11 shillings in the Merewether practice, the doctor gave three shillings per quarter to the chemist for medicines prescribed.

Importantly this capital charge did not cover care during pregnancy, minor operations, nor the cost of a circumcision (one guinea) if the child was a male. Dr Holley from West Wallsend remarked that inevitably 'most males were circumcised'. Dr McLaughlin of Merewether stated that the usual fee for a confinement including antenatal care delivery and post natal care when he began practice just after the WW2 was two guineas (two pounds two shillings).[22] Dr McLaughlin's memoirs confirm that the GPs limited their practice to a particular community that later became a

[20] See Henry Lee, "A Disgrace to Australian Civilisation, Miners' Mothers and the Commemoration of Mortality in NSW, Illawarra Unity", *Journal of the Illawarrra Branch, Australian Society for the Study of Labour History* 4 (1), (2004), 3-28.
[21] Doctors William Holley and Peter Roberts, *The Old Docs Memoirs*, (Newcastle: Hunter Postgraduate Medical Institute Archives, 1991).
[22] Peter McLaughlin, Memoirs, Old Docs, HPMI Archive 1991, audiotapes and personal files of the author.

suburb, presumably a 'carry over' from the original pit top village ideology, and he has left a detailed record of the names and site of practice.[23] He confirmed that there were very few specialists immediately post WW2, apart from Ear, Nose and Throat, and Eye specialists, and that the general practitioners all did their own obstetrics in private hospitals and nursing homes.

The few 'hospitals' in existence included 'Hillcrest', the old Merewether family home, which had been taken over by the Salvation Army in 1925.[24] It catered for private obstetrics and was also the only hospital between Sydney and the NSW border which catered for single mothers. The others were 'Fettercairn' in Lindsay Street Hamilton, 'Gowan Brae' in Samdon Street Hamilton, 'Centaur' in Church Street Newcastle, which later became Woodlands Hospital, and also various small nursing homes run by midwives.[25] Dr McLaughlin recorded the large number of house calls, usually 28 to 30 daily, because they were covered by the Lodge membership. There were morning and afternoon surgeries, most opened Saturday mornings, some Saturday evenings, and Sunday morning so they 'could fix up their certificates for the coming week'. There was a stark contrast between general practice then, and private general practice which developed under the Earle Page scheme from 1953.

Peter McLaughlin followed the pattern of others of his generation who obtained a specialist degree. After service in the RAAF, he did a resident year at Crown Street, wrote his book of twenty obstetric and gynaecological cases, then travelled to London by ship, spent three months doing a course in London, and then did examinations and vivas during 1954.[26] He returned from England, and practised obstetrics and gynaecology part time until 1960, continuing to spend most of his time in his general practice, including the house calls. This pattern of that generation of gynaecologists doing years in general practice before they moved into the specialty

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[23] McLaughlin, Memoirs, HPMI Archives, 1991.
[24] "Maternity Hospital, Salvation Army Enterprise", *Newcastle Morning Herald*, 6 July 1925.
[25] 'Fettercairn' Hospital in Lindsay St Hamilton was a major obstetric facility of that era and still exists. In 1942 there were 27 private hospitals in the Newcastle area, and 'Fettercairn' had 17 midwifery beds usually managed by midwives with private doctors visiting. With 17 midwifery beds, if there was only one mother per week per bed would give a total number of deliveries of 884 mothers per year assuming an average stay of one week, http://www.hiddenHamilton.blogspot.com.au, "Ruth Cotton", 4 (accessed 9 December, 2014).
[26] Peter McLaughlin did his specialist examination with Dr William McBride, who later became involved in the Debendox scandal (see Scandals chapter).

has been explored in the education chapter, and Dr McLaughlin is a typical example from the Hunter Valley.[27]

Deliveries were mostly home births up until the mid-1930s. It seems certain that the great majority of obstetricians who were the early teachers after WW2 were themselves born at home or in small private hospitals or nursing homes.[28] These facilities continued until the mid-1950s, confirmed by Drs McLaughlin, Merewether, Roberts (Newcastle city) and Holley (West Wallsend) who were in general practice at that time.[29] Watts and Ramsland concluded that the largest number of babies during 1940 and 1941 were delivered in the private hospitals and nursing homes in the district.[30]

Delivery in a persisting Aboriginal community in 1939 was referred to in Taree in the immediate north of the Hunter Valley in 1963 by Dr Bayldon, a local doctor. He referred to 'intra-community' care and delivery of indigenous pregnant patients in Purfleet Reserve in that year with a delivery by the last of the midwives, Kate Hart, an Aboriginal woman, including some rudiments of asepsis, the active involvement of other members of the community, and the presence of a juvenile audience who 'enjoyed the performance'. He summarised this as a 'sharing of life experiences' from birth to death, and commented that delivery in the Reserve was preferred because of difficulty of transport, a bed shortage, and that the indigenous women preferred to have their baby in the reserve looked after by their own women as they did not feel welcome in the Taree District Hospital.[31] The best practice care of Aboriginal women in Indigenous communities in recent decades remains controversial, with enormous efforts being made to improve outcomes, but much more needs to be done.

The contrast between home birth delivery between the World Wars, nursing home deliveries, and the experience gained by medical students immediately after WW2 is quite dramatic. All of those post war students attended the large obstetric teaching hospitals in Sydney for training, and were usually unaware that the

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[27] Peter McLaughlan, "Reminiscences of 45 Years of Medical Practice in Newcastle, 15 June 1991", Alan Hewson, personal file (and archived in the RANZCOG Museum, Melbourne, Victoria).
[28] Watts and Ramsland, "Midwifery", 184-199.
[29] Peter Roberts, *Old Docs Memoirs*; William Holley, *Old Docs Memoirs*.
[30] Watts and Ramsland, "Midwifery", 187.
[31] The Mulvey Oration, Taree, 11 March, 1963, held in the Manning Valley Historical Society Archives, Wingham, cited in John Ramsland, *Custodians of the Soil. A History of Aboriginal European Relationships in the Manning Vallrey of New South Wales*, (Greater Taree City Council, 2001), 123.

generation immediately before them had a completely different introduction to the world of obstetrics.[32] It was only when those planning to become obstetricians went to the United Kingdom for further experience that they became aware of the world of domiciliary obstetrics and small unit care.[33]

The Era of Transition

Western Suburbs Maternity Hospital, Newcastle, was opened in 1885, but because the overwhelming majority of confinements were home births, initially there were very few deliveries. In 1934 however they reported that 1000 babies had been delivered in the colonial period.[34] In 1936 they reported that only 18 children had been delivered during that year.[35] However deliveries steadily increased as the trend to hospital confinement continued. In 1960 it was now 75 years old and delivered 1600 babies in that year. So this hospital had become the major institution providing maternity care in the period up to 1945.[36] In its anniversary year of 1985, 1800 babies were born, and many improvements in the buildings achieved, helped by donations from the community.

The hospital was now being used to teach medical students in the new medical school.[37] Both the Mater Misericordiae and Royal Newcastle Hospitals did not open their maternity sections until 1946 and 1949 respectively. The Private Hospital Institutions, such as the Salvation Army 'Hillcrest' Hospital and 'Fettercairn' in Hamilton, were operating from the early 1930s.[38] The rest of the births were either at home or in the small private nursing homes.

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[32] See Curriculum for obstetric training, University of Sydney, 1946 intake. One month's 'live in' at either the RHW or Crown Street Hospitals in year Five was obligatory, attending all deliveries, delivering 20 mothers, and completing a log book (personal files of the author).
[33] See the CV and documented experience of the author in 1957-1958 at Oxford, including Flying Squad experiences, attending home births, discussed elsewhere.
[34] *Western Suburbs Maternity Hospital Annual Report, June 1934*, (Wickham: R.A. Derkenne, printer, 1934), 1.
[35] *Western Suburbs Maternity Hospital Annual report, June 1936*, (Wickham: R.A. Derkenne, printer, 1936), 1.
[36] *Western Suburbs Maternity Hospital Annual Report, 1960*, (including a summary of its first 75 years), (Newcastle: Davies and Cannington, 1960).
[37] *Western Suburbs Maternity Hospital Annual report, 1985*, (Longworth and Goodwin, printers, 1985).
[38] Hillcrest Mothers Hospital, Curry Street, Merewether (1933-1977) was opened after the Maryville Mothers Hospital, Curry Street (1924-1933) closed. The latter followed yet another facility operated by the Salvation Army, Newcastle Maternity and Rescue Home (1906-1927): http: //www.findand connect.gov.au/guide/nsw/NE00216, (accessed 17 January, 2014).

The period from 1945 to 1950, with the return of medical ex-servicemen after WW2 coupled with the information and technological explosion, led to significant changes in obstetric and gynaecological practice, and the major hospitals serving the region became more important in the delivery of women's health.

Royal Newcastle Hospital

The most important of these was the Royal Newcastle Hospital (RNH), founded in 1817 and which continued to serve the city of Newcastle and the Hunter Valley continuously until it finally closed in 2005. At the time of its closure it was the second oldest hospital in NSW. The first building on its prime oceanfront site housed exiled convicts transported from Britain to the colony. The second hospital, opened in 1866, coincided with the beginnings of modern institutions at a time of dramatic growth in free settlement and trade in the city. Construction of the third hospital commenced in 1913.[39] During the later 20th century the third fourth and fifth hospital provided new buildings on the old site, and as well, subsidiary hospitals in other suburbs were built to serve Newcastle as it expanded into an industrial and suburban city. It became the Royal Newcastle in 1949. By the time of the fifth hospital, dating from 1966, it was one of the largest in Australia with over 600 beds, and the hub of a system of regional health services. It was finally demolished in 2005 with the transfer of its residual services to the newly developed John Hunter Hospital complex four kilometres inland.[40]

The administration and organisation of Royal Newcastle Hospital after WW2 was revolutionised by the vision and dominant personality of Dr C.J. McCaffrey, who came to the hospital in 1927 as a radiologist, but took over as Superintendent when Dr K.W. Starr moved to Sydney.[41] McCaffrey began implementing the recommendations of Dr Star's 1939 report.[42] He was aware of the Goodenough Committee's British report in 1944, which suggested a change to the staffing of the major hospitals, and of the changes in United States postgraduate education, which

[39] The Nightingale wards design predominated, with open verandahs, persisting in the North Wing until the mid-20th century. Nightingale trained nursing staff were imported to NSW from 1866. See R. Lynette Russell, *From Nightingale to Now, Nurse Education in Australia*, (Sydney: W.B. Saunders, 1990).
[40] Marsden, *A Castle Grand*, 1.
[41] Marsden, *A Castle Grand*, 106.
[42] Owen James, "A Tide of Talent and Innovation", in *Reminiscences of the Royal* (RNH Heritage committee), ed. John Lewis, (Gateshead: Newcastle City Printers, 1997), 33.

had been revolutionised following the Flexner report into medical education in 1910.[43] A critical part of Flexner's recommendations, first implemented at Johns Hopkins Hospital, was that the major part of teaching and training in the teaching hospitals should be devolved to full time qualified staff specialists, ideally with university appointments and affiliations. While teaching hospitals in the rest of Australia struggled with the problem of part-time clinical teachers attempting to cope with the explosion in medical knowledge, at Newcastle McCaffrey had recruited full-time salaried staff, often called the 'third phase' of Flexner's postgraduate education vision.[44]

McCaffrey was a brilliant administrator and introduced a Clerical Training School to provide a constant supply of trained office staff, a modern records system which enabled seamless transmission of records of patients from outpatients to in-patient care, a state-of-the-art autoclave department, an efficient method of dictating records to a central typing facility, a large dietary, physiotherapy and social work full time staff, a common dining room for all visiting and salaried staff, a weekly 'death meeting' to discuss all morbidity each week, and a weekly meeting of all salaried staff to coordinate care. So in the 1950s the hospital had all the attributes which did not occur in other teaching hospitals for another 20 years.[45]

Local Trailblazers in Obstetrics and Gynaecology

Dr Jack Raymond Elliott (1912-2004) was the first staff specialist in obstetrics and gynaecology and Head of the new Department. He was a prime example of the wide medical experience of that generation before he became a specialist in obstetrics and gynaecology. He was born in Nowra, did his Leaving Certificate there and later attended Fort Street Boys High School so he could matriculate with Latin and enter University in 1933. He studied pharmacy, then a science degree, completed it in 1936, and enrolled in medicine in 1937, then completed the shortened course introduced when war broke out in 1939. After residency training at Sydney and

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[43] "The Goodenough Report, Training of Doctors", *BMJ* 2 (4359), (22 July, 1944), 121-123. Abraham Flexner, *Medical Education in the United States and Canada, Report to the Carnegie Foundation 1910* (reprint), (Alabama: Classics of Medicine Library, Gryphen Editions Inc., 1990).
[44] John Smyth, "A Unique Postgraduate School of Medicine", in *Reminiscences of the Royal*, ed. John Lewis, 83-95.
[45] J.M. Duggan and Chris McCaffrey, "A Pioneer of Quality in Health Care", *Journal of Clinical Practice* 17, (1997), 156.

Newcastle hospitals, he enlisted in the Army in 1941, and saw service in New Guinea. He was demobilised in 1946, and returned to Newcastle Hospital, had further training in a number of disciplines including 12 months of orthopaedics, then had six months specialist obstetrical and gynaecological training with Dr Reg Hamlin, and six months of pathology with Dr Murray Moyes at Crown Street Hospital, coming back at weekends to set up the first obstetric and gynaecological unit at Newcastle Hospital. The Gynaecological Unit had not changed since 1889.[46] The obstetric unit opened in 1949, the same year the hospital became the 'Royal' Newcastle Hospital. He obtained his MRCOG in 1953 in London having worked his way over as a ship's surgeon.[47]

The Achievements of Dr Jack Raymond Elliott

J.R. Elliott was able to develop a whole range of new initiatives in obstetrics and gynaecology. He was the first in Australia to implement the ideas of British specialist Dr Grantley Dick Read,[48] especially regarding the principles of 'natural childbirth'[49] as well as those of Dr Pierre Vellay, which included antenatal preparations for childbirth and Psychoprophylaxis. [50] He gave lectures to expectant mothers, encouraged midwives to become more directly involved with these rather than physiotherapists, and elevated the role of hospital midwives to their rightful place in obstetric care. He wrote new midwifery and gynaecology lecture notes in the specialty, assisted in the training of generations of nurses and developed the 'team approach' to obstetric care many years before it became the norm elsewhere.[51] He improved breastfeeding success rates by changing feeding 'by the clock' to demand

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[46] Jack Raymond Elliott, in *Reminiscences of the Royal,* ed. John Lewis, 25
[47] Jack Raymond Elliott, Memoirs, Alan Hewson, personal file
[48] Grantley Dick Read was born in Suffolk in 1890 and qualified in medicine in 1914. He was wounded at Gallipoli where he was serving in the Royal Army Medical Corps. Between the wars Read developed his management of labour by striving to eliminate fear, and minimising the use of traditional pain relief measures. It took years for his pioneering work to be recognised but finally his books sold in the millions and were translated into ten other languages. He was supported by F.J. Browne and Eardley Holland, distinguished British obstetricians, which gave him increasing credibility. He died in 1959. (see Eardley Holland, "Obituary", *JOGBE,* (1959), 1010).
[49] Grantley Dick Read, *Revelation of Childbirth (Childbirth without Fear*) was published in 1942, produced a minor revolution in approaches to childbirth, but it took years for its principles to become accepted by obstetricians.
[50] Pierre Vellay, *Childbirth without Pain,* (London: Hutchinson, 1959) (trans. from French).
[51] *The Royal Newcastle Hospital Midwifery Lecture Notes*, published by RNH, 1955 (author's private copy); The Royal Newcastle Hospital School of Nursing, *Gynaecology Lecture Notes*, Dr J.R. Elliott, 1955.

feeding, and arranging for rooming in for mothers and babies.[52] The unit was one of the first in the Western world to recognise that husbands being present during labour and delivery should be encouraged, a very controversial move at that time.[53]

Elliott was also the first in Australia to use Magnesium Sulphate treatment to prevent eclampsia as practised in the USA, a treatment which later became the gold standard treatment for this serious problem in pregnancy.[54] He began advocating termination of pregnancy by Caesarean section in severe pre-eclampsia, and recognised that the difficult manipulations and destructive operations in obstetrics carried such risks to the mother and infant that they should be replaced by Caesarean section.[55] With the support of staff paediatricians he urged the earlier introduction of solid feeding for infants. He read widely, was one of the first to travel to the United States to learn from American experts, introduced new techniques for surgery for prolapse, incorporated a number of American ideas, and carried out the first vaginal hysterectomy (removal of the womb through the vaginal passage) in Newcastle in 1948. This was later recognised as a significant improvement on the then common Manchester repair operation favoured by British surgeons.[56] Because of his wide experience he established close relationships with general practitioners through the Hunter Valley and from the late 1950s began carrying out clinics and operating in the country hospitals. This pattern was later adopted in other areas across Australia.[57] The final accolade was the recognition of the RNH unit as an official training post for the Royal College of Obstetricians and Gynaecologists in 1959[58] after two more qualified specialists were appointed to the staff.[59] He rose to national prominence, being elected to the Regional Council of the RCOG in Australia, which laid the

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[52] J.R. Elliott, "Sam Gardiner's Unforgettable Ways", *Reminiscences of The Royal,* 21.
[53] Audrey Armitage, *A Golden Age of Nursing 1891-1991*, Royal Newcastle Hospital, (NSW: Warringah Printing, 1993), 126.
[54] It was not until the MAGPIE trial in 1998 that this treatment was adopted universally in countries influenced by British medicine. Belatedly it was recognised that the United States of America approach had been right all the time.
[55] This author was present when Dr Elliott carried out the last dismembering of a dead infant vaginally to avoid Caesarean section in 1953. The operation was so distressing and dangerous it was agreed it would never be done again (Hewson Memoirs).
[56] William Hawksworth and J.P. Roux, "Vaginal Hysterectomy: Report of 1000 Cases", *JOGBE* LXV (2), (April, 1958), 214-228.
[57] Alan D. Hewson, "Jack Raymond Elliott, Obituary", *MJA* 180, (3 May, 2004), 471.
[58] *Royal Newcastle Hospital Annual Report*, published by Royal Newcastle Hospital Board, 1959.
[59]Alan Hewson, "Overview of Obstetric Practice 1945-1965 as Reflected at Royal Newcastle Hospital", Australian Gynaecological Travellers Society meeting, Darwin, July, 2006.

groundwork for the establishment of a national Australian College in 1979. He was the first obstetrician from provincial Australia to be elected to the Regional Council.[60]

A major difficulty at Royal Newcastle Hospital in the 1950s was the refusal of Dr McCaffrey to accept the fact that the new concepts of neonatal intensive care were essential to improve survival in premature babies. This persisted until the appointment of Dr Robert Evans in 1962, who finally introduced changes to improve the outlook for premature babies. The management of premature infants at Royal Newcastle led to difficulties in integration between the Royal and the other major hospitals of the region. This story is detailed in the Robert Evans PhD thesis covering development of the specialty of Paediatrics in Australia.[61]

Professor F.J. Browne (1879-1963) was appointed to the obstetric staff of Royal Newcastle Hospital after he migrated to Australia in 1951, followed his marriage to the Director of Maternal and Baby Welfare Department of NSW, Dr Grace Cuthbert.[62] F.J. Browne was also appointed to the staffs of teaching hospitals in Sydney, but travelled to Newcastle each week to do clinical rounds and teach. His bedside teaching style was a revelation, and he impressed Dr McCaffrey particularly because of his long campaign to introduce the principle of changing from 'gestation' based 'maturity of the foetus' to one based on the 'weight at birth'. So this system was introduced at Royal Newcastle Hospital in 1956.[63] The system was not introduced in any other hospital in the State at that time and this had far reaching consequences.[64]

Mater Misericordiae Hospital, Waratah

Another major hospital was the Mater Misericordiae Hospital which opened in 1921, staffed by the Sisters of Mercy from Singleton when they took over a two-storey building in Edith Street Waratah, and it became the only Catholic public hospital administered by the Sisters of Mercy outside Sydney. Florence Nightingale, when considering training in nursing in London in the 1840s, sought help from the

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[60] *RCOG Australian Council Annual Report*, Melbourne, 1978.
[61] Robert Evans, "The Development of the Specialty of Paediatrics in Australia", PhD thesis, University of Newcastle, 2007.
[62] Herbert E. Reiss, "Francis J. Browne, A Biography", *RCOG*, 2007.
[63] Francis J. Browne, "Standards in Obstetrics", *JOGBE* 65, (1958), 826.
[64] Kay Farrelly, "Work Sets Lead for Rest of State, Newcastle Baby Deaths Probe", *Newcastle Morning Herald and Miners Advocate*, Saturday 12 November, 1966, 8.

continental hospitals run by Catholic sisters and Lutheran deaconesses, and used these as a model for modern secular nursing.[65] As the Sisters of Mercy had no nursing experience, initially a lay matron was appointed, but because of her early death, a graduate of St Vincent's Hospital in Sydney succeeded her. The hospital grew steadily over the next 25 years, acquiring adjacent land. The Longworth block for the care of children was established in 1927.[66]

The establishment of midwifery at the Mater Hospital began in 1940, when two of the sisters completed midwifery training at St Margaret's Hospital in Sydney and in March 1941 completed their training in Mothercraft nursing at the Tresillian Centre. In 1946 the hospital was recognised as a midwifery training school, the first outside Sydney. The midwifery training school conducted 12 month courses for nurses after their general training, and over the years developed an enviable record for success in the State midwifery examinations.[67]

During the early days of the hospital the medical care of patients was entrusted to a staff of honorary physicians and surgeons who all donated their time. The most famous of these was Dr S.S. Gardiner who was on the staff from 1921 until 1958.[68] Gardiner received his secondary education at Sydney Boys High, and studied theology at Sydney University for two years before changing to medicine. After completing Medicine he became a resident medical officer at Newcastle Hospital and its first superintendent in 1916.

Virtually none of the attending doctors at the Mater had a specialist qualification, and had been in general practice for some years before being allocated to more specialised work from 1945 onwards. Only after 1946 was it necessary to have a higher (specialist) degree to be admitted to the Honorary medical staff. Recognition of the hospital for training in the Surgical specialties followed, and in 1964 pre-membership training for the Royal College of Obstetricians and Gynaecologists was recognised.[69] The hospital had an active Department of General

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[65] Betty Capper, *75 Years of Tender Loving Care*: *History of the Newcastle Mater Misericordiae Hospital 1921-1996*, (Newcastle: Cambridge Press, 1996), 7.
[66] Capper, *75 Years of Tender Loving Care*, 1.
[67] Capper, *75 Years of Tender Loving Care*, 88.
[68] Samuel Stoops Gardiner was a stalwart on the Honorary staff of both the RNH (1917-1958) and the Mater (1921 -1958). He donated his library to the hospitals in 1955, the enlarging library was subsequently named after him, and it was combined with the University Clinical Sciences library in 1981.
[69] Capper, *75 Years of Tender Loving Care*, 69.

Practice and general practitioners were given appointments as clinical assistants. The majority of general practitioners were given obstetric privileges as well so that they could deliver their own patients. The number of deliveries grew rapidly so that by the late 1950s over 1500 babies were delivered at the Mater each year.[70] The hospital became a critical part of the multi- hospital perinatal loss study program initiated in 1960.

The Wallsend District Hospital

The Wallsend District Hospital was opened on 22 April 1893, free of debt because of donations by the local miners and support by the Wallsend Coal Company, which donated three acres of land. In 1903 the hospital was registered by the Australasian Trained Nurses Association as a training school for nurses.[71] Over the decades which followed it retained its close identity with the local community and its mining and union background. It was finally closed as a working hospital during the re-organisation of health services in the Hunter region when the John Hunter Hospital was opened in 1991. Its medical staff for decades comprised the local general practitioners serving in the community, and it was not until the early 1950s that specialists were appointed. The first specialist obstetrician/gynaecologist appointed was Dr Alan Coulthard in 1962.[72] Maternity services were never provided at the hospital but it had an active gynaecological unit initially staffed by general practitioners. Because of its background it always attracted passionate support from the local community and from the medical and nursing staff. There was fierce opposition against the proposal to close the hospital in 1991, but eventually its status was changed to providing clinical support facilities. When John Hunter Hospital opened all the gynaecological staff transferred to that hospital.[73]

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[70] The number of deliveries continued to rise, reaching 1896 in 1961-1962, *Clinical Statistical Survey*, Newcastle Mater Misericordiae Hospital, 1961-1962.
[71] Wallsend Mining District Hospital, http://www.coalandcommunity.com/wallsend-district-hospital.php, (accessed 20 February, 2014).
[72] Dr Alan Coulthard was one of the British expatriates from the NHS who immigrated to the Newcastle region in the 1960s. He died in 2004. See Alan Hewson, "Obituary", *O and G Magazine* 7 (2), (Winter, 2005), 73.
[73] Suzanne Punton-Butler, *Nash's Folly, a History of Wallsend District Hospital, 1885 to 1991*, (Broadmeadow: Newey and Beath, 1993).

HUNTER OBSTETRICAL AND GYNAECOLOGICAL SERVICES 1955-75

From 1955 to 1975, the population of the region showed a slow but steady growth roughly parallel to the growth rate of the country as a whole, and this growth provoked the usual strains on local resources: the population increased from approximately 350,000 to 420,000 (see Hunter Valley appendices). The birth rate over the whole 20 year period showed steady growth in the late 1950s, followed by a rapid fall in the rate in the early 1960s, with the introduction of the oral birth control pill and the intrauterine device (see Hunter Valley appendices). There was then a sudden rise in births as the post-war baby boomers entered the marriage market, persisting up to 1970. This rise was followed by a fall from 1970 onwards, associated with a drop in the number of potential parents coming onto the market, a deteriorating economic situation as well as an increasing percentage of married women of childbearing age in the workforce. The increased availability of termination of pregnancy, and a more liberal approach to sterilisation were also factors in the decline.

In 1955, the general practitioner was the cornerstone of obstetrics in the city and the country areas of the Hunter region. In the city district alone there were over 100 general practitioners 'doing obstetrics', and over 50 'doing obstetrics' in the smaller hospitals in the upper Hunter Valley.[74] There were only two specialist obstetricians in practice in the Valley at that time and one other practitioner with wide experience doing obstetrics and gynaecology full-time, to serve a population of over 400,000 people.[75]

By contrast, in 1975, there were 15 specialist obstetricians in practice including six Fellows of the College and nine Members of the College, with between one and three registrars in the teaching hospital training for the specialty (see Hunter Valley appendices). General practitioners in the city area still doing obstetrics had fallen to approximately 70, and of those only 30 were frequent users of the labour ward. This number was set to continue falling in the years ahead.[76]

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[74] Alan D. Hewson, personal files of General practitioners on the staffs of Western Suburbs Maternity and the Mater Misericordiae hospitals during 1960-1961.
[75] The qualified specialists in 1955 were Dr Jack Elliott and Dr Peter McLaughlin, and the GP who practised solely in obstetrics and gynaecology was Dr Alex Ostinga (personal files, Alan Hewson).
[76] Data collected by Alan Hewson for the Cox Report, 1975.

During this period the larger obstetric units in the hospitals in the city area were undergoing metamorphosis from cottage type hospitals with obstetric facilities, practising the obstetrics of the previous era. They were coming to terms with the rapidly developing concepts and technology of the new era of obstetric practice. As mentioned, Royal Newcastle Hospital was recognised as a training post for the specialty in 1959.[77] At the other two large hospitals in the city there were also changes beginning.

The Mater Hospital did not possess a Medical Board until 1956, but later in that year a Department of Obstetrics and Gynaecology was formed. However most Caesarean sections for difficult deliveries were still being done by the general surgeons on the staff at the invitation of the general practitioners doing obstetrics, and this persisted until 1960. No guidelines for doctors doing obstetrics existed and there were no procedures laid down regarding consultations, and many obstetric anaesthetics were given by family doctors.[78] At Western Suburbs Hospital a similar situation prevailed, and the development of a Medical Board and organisation of the staff did not occur until 1957. In the country hospitals higher up the Valley at this time a conservative approach to obstetrics continued. The local general practitioners did their own forceps deliveries, some their own Caesarean sections if the situation was desperate, and there was very little referral of the complicated patients to the base hospitals.[79]

The obstetrics being practised in the city hospitals was extremely conservative in 1955 resulting from the ethos of minimal intervention of the pre-war period.[80] Caesarean section rates were low, usually between 2-4%. Dangerous intra-uterine manipulations such as internal rotation and breech extraction for transverse position were common; long labours up to 30 hours were not uncommon; rotation and forceps delivery was the common approach to abnormal position of the infant, rather than Caesarean section; bleeding from a placenta praevia (in which the afterbirth was

[77] Dr Charles Barbaro was the first trainee at Royal Newcastle Hospital in 1959. He subsequently became one of Melbourne's most celebrated obstetricians at the Mercy Hospital in Melbourne. He became prominent in the palliative care and holistic medicine movement. He died in 2006.
[78] Capper, *75 Years of Tender Loving Care*, 69.
[79] One major contribution to country surgical practice by Royal Newcastle Hospital was the training of all residents to do Caesarean sections before they went into country GP practice between the years 1935 and 1950.
[80] The author of this thesis was the first of the new breed of fully trained specialists in the Hunter, having three years of general training, followed by four years of specialist training in recognised posts including two years at advanced level overseas.

below the infant) was managed conservatively; and premature infants had delayed delivery because of the expected poor outcome if delivered early. Obviously the technical skills of the GP 'occasional obstetrician' were also limited. [81]

By 1960 it had become obvious that there were areas needing improvement in obstetric care. It was fortuitous that criticism regarding the area's alleged high perinatal loss stimulated a wide-ranging survey in all the western hospitals served by the general practitioners. An independent study of perinatal loss was also done at Royal Newcastle Hospital. Even though the change in definitions at Royal Newcastle Hospital referred to earlier explained some of the problems, others became evident in the survey. It was found that there was an overall perinatal loss rate in infants over 1000 grams approaching 30 per thousand births in the Western hospitals. [82] The results across the State at that time were also poor. [83]

Apart from the rapid growth of knowledge and the influx of specialists into the region after WW2, the event which had the greatest effect on obstetrical practice was the development of the Central Northern Medical Association perinatal loss programme from 1960. The decision by Royal Newcastle Hospital to unilaterally change its definition of what constituted a perinatal death in 1958 meant that many premature infant deaths which would not previously have been recorded now appeared in the infant death data rather than being classed with 'miscarriages'. The result was that the region appeared to have a much worse perinatal loss rate than anywhere in the state of NSW. As a result of that decision at Royal Newcastle Hospital, the number of neonatal deaths reported from that hospital increased, the reason being that infants under 1250g or 28 weeks gestation were not included in perinatal deaths in previous years. As the rest of the State did not include these infant losses, the Royal Newcastle figures for infant loss appeared dramatically worse. This was a consequence of RNH recording the very low birth weight foetus group in its figures following the recommendation of Professor F.J. Browne. [84]

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[81] "The First Report of Central Northern Medical Association Committee on Perinatal Mortality, 1 July 1960 to 30 June 1962, Newcastle, NSW", *MJA*, (29 June, 1963), 960-963.
[82] "CNMA Perinatal Loss Study", *MJA*, (1963).
[83] Rodney Shearman, *Maternal and Perinatal Care in NSW*, (NSW Department of Health, 1989), 118. The Perinatal Death rate in 1955 was 33.60 per 1000; in 1960 it was 30.17 per 1000.
[84] Francis J. Browne, "Standards in Obstetrics: A Plea for Uniform Standards in Maternity Statistics and Hospital Reports", *Journal of Obstetrics and Gynaecology in the British Empire* 65, (1958), 826-830.

This apparent 'bad outcome' data was brought to the attention of the NSW parliament. In October 1959, the Minister for Health released figures showing that an average of 28.08 of every 1000 babies born in Newcastle statistical area in 1957 had died, and he quoted comparable figures of 20.4 per thousand for the metropolitan area and 22.4 for the whole state.[85] The press claimed that obstetric care in the Newcastle region was poor, but the Central Northern Medical Association (CNMA), the local branch of the AMA, defended the standard of obstetric care in the region. No statement was made from Royal Newcastle to explain the background to the data, and the CNM A decided that the reputation of those carrying out obstetric care in the Newcastle region had been damaged. It mounted an extensive perinatal loss study covering all the hospitals in the Newcastle region apart from Royal Newcastle Hospital.

The sequence of events is outlined in an article published in the *Medical Journal of Australia* (*MJA*) on 29 June 1963, which reviewed the Registrar General and the Department of Public health statistics of infant mortality in the area for the period 1954 to 1959. These figures were compared with the statistics of infant loss from the individual hospitals and it was found that the Government Department statistics were inaccurate. The hospitals showed a lack of uniformity in basic definitions of perinatal viability, and prematurity, affecting notification, and in some instances the details in the records were deficient. At Royal Newcastle, death certificates were being issued for all stillborn foetuses weighing over 400 grams, and these were recorded as 'stillbirths' by the Registrar General's Department. The majority of foetuses weighing between 400 and 1250 grams are less than 28 weeks gestation, and so did not fulfil the 'legal' requirements for stillbirths at that time. The inclusion of all such foetuses as 'stillbirths' had inevitably increased the 'apparent' stillbirth rate and some stillbirths should have been classified as neonatal deaths. A retrospective study of this problem would be quite worthless, and a prospective survey was initiated.[86] As no region in Australia had attempted a study of this type, the Scientific Committee collected information from the United Kingdom, where the Birthday Trust had just completed in 1958 its nationwide study of maternal and infant

[85] "Bill Blanch, Local Doctors Lead Australia With New Survey", *The Newcastle Sun*, Monday, 21 August, 1967, 8. In retrospect the figures quoted in Parliament in 1959 were incorrect.
[86] "First report of Central Northern Medical Association Committee on Perinatal Mortality, covering the period July 1, 1960 to June 30, 1962, Newcastle, New South Wales", *MJA*, (29 June, 1963), 561.

mortality, although this was not published until 1963.[87] The American Medical Association's Foundation for Medical Research also provided critically important initial and ongoing advice for the study.[88]

The protocols for the survey are detailed in the article in the *MJA* in 1963, including the numbers of deliveries at the participating hospitals, the individual hospital committees, the central coordinating committee, the review mechanism for assessing each foetal loss, the feedback to each doctor, the recommendations for obligatory consultations, and measures to improve the post mortem rate. Every doctor doing obstetrics agreed to change to a standard antenatal card, ensure their patient always carried the card, and order a set of standard investigations on every pregnancy, including for both private and public patients. The standards recommended by Professor Browne for recording perinatal loss using the weight of the infant at birth from 250 grams were agreed. All hospital charts were changed to facilitate coding and analysis. Fortuitously the firm of Lysaghts had just acquired Newcastle's first computer, and they agreed to analyse the mass of data being collected, with variables related to 70 different aspects of each birth. A grant from the Division of Maternal and Infant welfare paid for a clerical worker to record the data. The details are documented in the 1963 MJA article cited, and a major benefit was the positive press coverage of the study over the years.[89] All those conscientious GPs accepted the necessity for changes to improve the care of their patients, and as they felt that their care was of a high standard, most were anxious to prove that. It has been suggested that this dramatic change in approach to care could only have happened so easily and so rapidly in the Hunter Valley, because of its sociological history and profile. The close personal links between the various sections of the medical and nursing professions, and the closely integrated social network of the region certainly made this easier. None of the medical or nursing staff who spent hundreds of hours devising the scheme and serving on the committees received any payment for their work, and the patients cooperated happily with the new programme. It is arguable that

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[87] Neville R. Butler and Dennis G. Bonham, *Perinatal Mortality: The First Report of the 1958 British Perinatal Mortality Survey*, under the auspices of the National Birthday Trust Fund, (London: E. and S. Livingstone Ltd, 1963).
[88] *A Guide for the Study of Perinatal Mortality and Morbidity*, (Chicago: The American Medical Association, 1958).
[89] "Drop in Rate of Infant Mortality", *The Newcastle Sun*, Wednesday 12 Oct, 1966.

this desire to serve the common good and learn was a carryover from that heritage brought from the industrial areas of the UK in the previous century.

Adequate support services in obstetrics, paediatrics, and pathology were becoming available in the local hospitals mentioned and were increasingly used.[90] All these changes meant a dramatic change in mindset of the very independently minded GPs of the time, particularly the intrusion into the care of private patients which had never occurred before.[91] A list of potentially dangerous paediatric problems was also agreed on and again consultation with a paediatrician was made obligatory.[92] Any recommendations from Review Committees to the attending doctors were strictly confidential. This was some years before the appropriate legislation had been passed to protect the actions of review committees of this type to enable them to be absolutely honest in their opinions.[93] The risk of legal action being taken against members of these committees was recognised, and some protection provided by avoiding any way of identifying either the attending doctor or the particular patient during the discussion by the Review Committees. The close relationship between GP and patients produced a high post-mortem rate on infant deaths. By the second year the post-mortem rate had risen to over 70%.[94]

This study became the longest running regional study of its type in Australia, and continued in its original format until the 1990s. In the later years it was expanded to include all the hospitals in the Hunter Valley region. There were two further reports in the Medical Journal covering the first 25,000 deliveries. This research project, in which the current writer was prominent, is highlighted for a reason. Kierse in his review of perinatal data emphasised that to be effective as a teaching medium it must be locally relevant and geared to deal with specific problems; it must provide

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[90] "Maternity Hospitals Annual Hospital Reports", Mater Misericordiae and Western Suburbs Hospital Annual Reports, 1960.
[91] See "Newcastle Western Suburbs Maternity Hospital, Notes, Rules and Recommendations for Honorary Medical Officers", June 1961, authorised by CEO, J.R. White (private files, Alan Hewson).
[92] The rules for consultation agreed to included any condition in which either the mother or infant was endangered and are detailed in the *MJA* article. Subsequently these rules were adopted across the country to guide all general practitioners doing obstetrics, and became basic guidelines for those doctors attempting to pass the Diploma in Obstetrics**.**
[93] Legal Privilege for these quality and peer review committees was not guaranteed until many years later. Victoria led the way with legislation to ensure 'Privilege'.
[94] In medical practice in 2015 post-mortem rates are worryingly low, often below 10%; "Second Report of Central Northern Medical Association Committee on Perinatal Mortality Covering the Period July 1962 to June 1963", *MJA* 1, (29 June, 1963); Alan Hewson, "A Perinatal Review, Newcastle, 1960-1966", AMA/BMA Conjoint meeting, Sydney, August, 1966.

feedback on problems that are important to practitioners; and it should have the potential of providing reasonably valid and conclusive answers. It also should be easily available to practising clinicians, rather than hidden in obscure reports or camouflaged among a mass of irrelevant figures.[95] The study conducted in Newcastle fulfilled all these criteria and was of immediate clinical benefit to the patients of the general practitioners doing obstetrics. The study also included an analysis of over 300 consecutive perinatal deaths, to pinpoint the type of patient who was at increased risk. The study confirmed the increased hazards to the infant of the older mother, of high parity, and the increasing risk of premature labour in that group. The study also documented the cumulative effect of increasing parity with toxaemia, and the occurrence of accidental bleeding (see Hunter Valley appendices). The identification of these 'high risk' groups was of help to everyone practising obstetrics**.** [96]

Important changes in the way obstetrics was practised followed. After implementation of obligatory obstetric consulation, the general surgeon doing the occasional Caesarean section disappeared, so that the GP always had a trained specialist opinion available for difficult cases. Coincidentally, during the time frame of the study many of the older more experienced family doctors retired, i.e. the ones who carried a heavy workload duringWW2, and the younger general practitioners were less inclined to tackle difficult obstetric problems. A continuing influx of newly trained specialist obstetricians into the region continued so that consultants became more readily available.[97] The number rose from three when the study began, to 15 in 1975. Anaesthetic and pathology services continued to improve, and as well there was an influx of trained paediatricians. The overall perinatal loss rate was halved over the first five years.[98]

The period from 1965-1970 saw heightened awareness and increasing intervention. Involvement of general practitioners doing obstetrics in the survey, analysis of difficult births, and instances of where an infant death occurred, produced a significant change in the mindset of everyone doing obstetrics. Many of the older

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[95] Mark Kierse, "The Use of Perinatal Data to Assess Prenatal Care", in *Antenatal care, Past Present and Future, Clinical Conference*, 21 August, 1987, the Royal Hospital for Women, Sydney.
[96] Alan Hewson. See graphs of perinatal loss related to increasing age, parity and Toxaemia in the Appendix.
[97] Appendix Graph. Data from the personal file of Alan Hewson, 1976. See also Alan Hewson, "The Development of the Hunter Region NSW Obstetric Services 1955-1980", *The Scientific Proceedings AOFOG, Congress*, October 25-31, 1981, Melbourne, 239
[98]See Hunter Valley appendices.

general practitioners were still doing the obstetrics they were taught in medical school in the 1930s and 40s, including the difficult vaginal manipulations which increased the risk to the infant, rather than rescuing the infant by the now much safer Caesarean section.[99] There had been a very conservative approach to accidental haemorrhage, and infants were still being lost as a result.[100] A detailed assessment of the risk when the infant was presenting as a breech had often been lacking, again with increased risk to the infant. The active management of pre-eclampsia was previously not properly appreciated, in spite of the Crown Street Hospital protocols, again with increased risks to the mother.[101]

More interventionist approaches to the management of multiple pregnancy and their care by a specialist, rather than the family doctor became 'the norm' from that time. The advantage of an obligatory consultation with an obstetrician made a significant difference in all these cases, and the benefits in outcomes for the practitioner's patients became obvious. This led to an increase in the intervention rate by forceps delivery or delivery by Caesarean section. The obligatory consultation with a paediatrician produced immediate benefits by better care for the ill neonate, demonstrated by the improving neonatal figures shown in the previous graphs. Another benefit of this regional survey was the demonstration of the potential errors in national statistics, which are based on the registration of births and deaths and are dependent on the accuracy of those registering the information. Lawson showed in his later study of Hunter Valley obstetrics statistics that there was significant under-reporting of stillbirths and neonatal deaths, evident when he examined the birth registers at hospitals in the Hunter Valley.[102] He also provided a continuing detailed analysis of perinatal loss in hospitals of the Hunter Valley up to 1991, extracted from an examination of all the birth registers of each hospital over that period.

Over the decade from 1982 to 1991, the total number of births remained remarkably stable but with an upward trend from 7208 in 1983 to 7727 in 1990. The perinatal loss rate showed little change from 12.9 per thousand in 1983 to 12.8 per

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[99] See J.P. Greenhill, *Principles and Practice of Obstetrics* (10th edition), (Philadelphia: W.B. Saunders, 1951), 836-924.
[100] H. Bruce Williams, *Obstetric Practice*, (Sydney: Angus and Robertson, 1957, (foreword by F.J. Browne) was a text still being used by GP obstetricians of that era, and which recommended ultraconservative risk management from the 1930s and 1940s.
[101] See "Report of the Crown Street Hospital, July 1953-June 1954", *JOGBE* LXVI (6), (1959), 1025, reporting the virtual elimination of eclampsia.
[102] Gerald Lawson, "Under-reporting of Perinatal Mortality", *ANZJOG* 27, (1987), 312-314.

thousand in 1990.[103] Lawson provided further reports covering the whole Hunter Valley. [104] The regional data which he amassed led to other important contributions to the literature on the subject of confusing perinatal loss rates. He showed that the repeated statement that the perinatal loss rate was very low in Holland compared with other Western countries was in fact incorrect. Allowing for different definitions of perinatal loss rates in Holland, it was higher in Holland than in the Hunter Valley of NSW.[105]

The long delay in recognition of the importance of documenting and analysing perinatal loss is puzzling. Finally in November 1979 action was taken. The Commonwealth Department of Health established the National Perinatal Statistics Unit to record and analyse statistics related to the health of mothers and newborn infants, and to undertake research into possible causes of birth defects.[106] Dr Paul Lancaster was appointed as Director, having spent two years overseas on a NHMRC Fellowship in Applied Health Sciences. He later commented 'in Australian populations there is a dearth of critical epidemiological data to evaluate the causes of perinatal mortality'. Dr Lancaster assisted in the continuing study of perinatal loss in the Hunter Valley.

The decade from 1970 to 1980 was turbulent, marked on the national scene by a change in the political landscape, mirrored in the world of medicine in the Hunter Valley, explored in other chapters of this thesis.[107] Changes affecting obstetric practice occurred, resulting in the demise of the general practitioner obstetrician and the rise of specialist care in obstetrics, with changes in the staffing of the region's hospitals. Increasing costs in hospital care mandated substantial re-organisation to maximise efficiency and minimise costs. In medical education the bipartisan agreement to review the medical schools led to the Karmel committee, and the decision to build a medical school at Newcastle.[108]

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[103] Alan Hewson, personal papers, provided by Dr Gerald Lawson in 1991.
[104] Alan Hewson, "A Perinatal Review, Newcastle, 1960 to 1966, Covering 25,000 deliveries", *Proceedings of the AMA/BMA joint Meeting,* Sydney, 1968, 66.
[105] Gerald Lawson, "Statistics Covering Deliveries in the Hunter Valley", personal files of Alan Hewson; Gerald Lawson, "Perinatal Mortality Rates: Holland Versus the Hunter Valley", *ANZJOG* 30 (3), (1990), 211.
[106] "Perinatal Statistics Unit Established", *Journal of the Commonwealth Department of Health* 29 (4), (1979), 1.
[107] Geoffrey Bolton, *The Oxford History of Australia*, 210- 215.
[108] The Karmel Committee, discussed later in this chapter.

Increasing migration of Asian doctors produced a new challenge to governments and the profession, and the spectre of possible nationalisation of the medical profession stimulated the development of a viable independent private hospital sector to ensure it continued to have clinical independence from government.[109] Recognition of the importance of continuing medical education stimulated the profession to begin planning a postgraduate medical organisation in the Hunter region.[110] In nursing and the other healthcare disciplines changes began. Legislated changes were introduced to take the training of nursing professionals out of the hospital system and into tertiary education. All these issues are dealt with in the appropriate chapters of this thesis, but the changes in this decade set the scene for obstetric practice for the next 40 years, and the interplay of political, medical and societal pressures over this time led to more complexity and difficulties still facing the discipline of obstetrics and gynaecology.

The gradual diminution in the importance of the general practitioner in obstetrics was a major change. There had been a slow change in that direction over the previous 15 years but from 1970, the percentage of pregnant patients cared for by obstetricians increased at the Mater hospital from 20% to over 50%; that is, patients under the primary care of a specialist obstetrician. A similar change occurred at the Western Suburbs Hospital (See Hunter Valley Appendices).[111] Another factor which became important was the increasing number of graduates from Asia who were beginning to practice in the region.[112] The CNMA medical school submission confirmed that in many hospitals the percentage of Asian graduates was close to 50% at junior staff level, but those going out into practice were less inclined to involve themselves in the problems of obstetrics.

A major change in the last five-year period, 1970 to 1975, was the rapidly increasing intervention rate during labour, which was true for all hospitals, and the Hunter Valley Appendices show the increased Caesarean section rates for separate hospitals, as well as combined intervention rates. At Royal Newcastle Hospital, the

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[109] The Opening of Christo Road Hospital, Newcastle, September, 1974, outlined elsewhere.
[110] The Hunter Postgraduate Medical Institute, launched in 1981.
[111] Appendix graph. Percentage of patients cared for by specialist obstetricians at the Western Suburbs Hospital 1970-1975 (Hewson files).
[112] Outlined in the CNMA submission to the Karmel Committee. This surge in immigration to Australia only slowed when the new Australian Medical Council introduced guidelines for recognition of overseas degrees to ensure that they were equivalent to Australian standards.

Caesarean section rate over the total 20 year period had increased fourfold, from 2.5% to 10%, the forceps rate increased from 10% to over 30%.[113] At the Mater Hospital the Caesarean section rate remained stable at approximately 5%, but the forceps rate increased from 7% to 27%.[114] These changes reflected what was happening in the rest of Australia and overseas. The increased intervention rate was attributed to earlier intervention in 'delay in the second stage of labour', and in many complicated obstetric situations which had previously been managed more conservatively. Other factors were the increasing use of pudendal block, regional, caudal and epidural anaesthesia, so that anaesthesia for operative delivery was more easily available and accepted as safer than general anaesthesia.[115] The latter had virtually disappeared by the end of that period, and epidural anaesthesia had now reached 25% of all deliveries at Royal Newcastle Hospital. Another factor was a change in policy regarding accidental haemorrhage, because there was now good evidence that earlier operative delivery in cases of significant accidental haemorrhage dramatically improved perinatal survival.[116] The induction of labour rate also increased. At the Mater Misericordiae Hospital in that last five-year period, it had reached 50% and at Western Suburbs Hospital 42%.[117]

Termination of Pregnancy in the Hunter

The fifth dramatic change in that last five-year period was the rapid increase in the numbers of legal terminations of pregnancy. From an infinitesimal number in 1970, this had risen to almost 1000 terminations per year, during 1975 because of a more liberal interpretation of the law.[118] Data on this issue collected from a particular region is important, given the problem of unreliable data leading to great difficulty in

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[113] Appendix graph demonstrating increased intervention rates at Royal Newcastle Hospital, A.D. Hewson, personal file.
[114] Appendix-graph demonstrating intervention rates at the Mater Misericordiae Hospital Waratah, 1970- 1975, A.D. Hewson, personal file.
[115] Fergus Meehan, "A Simplified Safe Technique of Caudal Analgesia", *Proceedings of the Royal Society of Medicine* 62, (1969), 36-38. (Radcliffe Infirmary Oxford, over 6000 patients).
[116] Julian Ward, "The Use of Caesarean Delivery to Improve Survival in Accidental Haemorrhage", NOGS Annual meeting, 1980, unpublished.
[117] Appendix: graph demonstrating increased rate of induction of labour 1970- 1975, A.D. Hewson personal file.
[118] Appendix: graph demonstrating increase in surgical termination of pregnancy numbers 1970- 1975, A.D. Hewson personal file - provided by Dr Lachlan Lang, Newcastle.

analysis.[119] Changes over the timeframe of this study are also important, as this issue raised enormous problems for obstetricians and gynaecologists over the whole six decades being studied. Study of the problem in a local region is a useful way of analysing some of the problems, and can give insights into the national issues, but the general background and controversies are covered in this thesis chapter on social factors impacting on obstetrics and gynaecology.

In 1952 the author began as a resident medical officer at Royal Newcastle Hospital (RNH). At that time termination of pregnancy was illegal and almost 400 septic abortions per year were admitted to the hospital. The great majority of these were criminally induced. Later in that era a review of these cases covering the years 1950-1963 was published in the *Medical Journal of Australia* by McCourt.[120] This is one of the few in the medical literature to document the extent of the problem as seen in a large regional hospital at that time. A total of almost 5000 cases were reviewed, approximately 385 per year, and 4192 were analysed in detail. Approximately 3200 had no serious signs of sepsis, but 1043 had a clinical 'infected abortion'. Their average length of stay was 4.4 days, 7.6% were transfused, 24% given antibiotics, and there were twelve deaths. The ages of those who died were from 22 to 48 years. There was no record of which patients were single and which were married, but a major problem in the unmarried group was that they usually denied pregnancy and also denied any attempt to procure an abortion. In addition to those who died, there were many more who were critically ill for days or weeks and were fortunate to survive. There was one case of tetanus reported in the literature independently who was critically ill for some four weeks on a ventilator. She subsequently complained to the hospital because of a tracheotomy scar in her neck when she needed ventilation via a tracheotomy.[121]

A lecture in Newcastle by the author in 2007[122] outlined the ignorance of sexual matters, the absence of reliable contraception, the dilemma of the woman who became pregnant outside marriage, the social stigma, criticism by family and the

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[119] In National Medicare statistics, surgical termination of pregnancy by curettage is often coded in with curettage done for other reasons, and not placed in a separate category.
[120] David MaCourt, "Incomplete Abortion, An Analysis of Management, Department of Obstetrics and Gynaecology, Royal Newcastle Hospital", *MJ A*, 1 October, (1966), 640-642
[121] Warren Gunner, W.J. Cumming, Ivan Schalit, "The Employment of Anaesthetic Principles in the Management of a Severe Case of Tetanus", *Medical Journal of Australia*, (1956), 402-404. See also Ross Kerridge, "The Birth of Intensive Care in Newcastle Australia", (to be published), *RACS Bulletin*.
[122] Alan Hewson "When Abortion was Illegal", *International Institute Lecture*, Newcastle, June 2007.

community, the tendency to hide the pregnancy and the difficult choices faced including abortion, adoption, keeping the child, or a forced marriage.[123] Termination of pregnancy was illegal, and as a result, the fact of pregnancy was often hidden for some weeks. Hormonal assay confirmation of pregnancy was still not available, so usually final confirmation of pregnancy depended on clinical examination by a doctor, again leading to delays in diagnosis.[124] Mothers seeking adoption were cared for at Hillcrest Hospital at Merewether where they lived in, received free medical care, and free legal help with adoption.[125] Others went to the Lodge at Rankin Park where antenatal care was provided by the RNH staff.[126] Termination of pregnancy in the public hospitals was carried out very rarely in the early years of this author's obstetric career in Newcastle. Most were carried out at the Western Suburbs Hospital, and virtually all were done because of serious concern regarding the physical health of the mother, or proven early pregnancy rubella infection. A three person committee reviewed each case, including two consultant obstetricians and the CEO of the hospital. The committee required: two independent opinions supporting the submission; the consent of the patient; the confirmation that the consultant was prepared to carry out the termination; the matron had to be notified; and staff agreement to take part in the procedure.[127]

Dr Lachlan Lang, on the salaried staff of RNH overcame a great deal of prejudice to begin a termination clinic at RNH in 1970. Later, because of criticism, he left the salaried staff and offered a surgical termination service at a private clinic from 1975. He provided a service which observed all the appropriate checks and balances required by law, and ensured that anyone seeking a termination was appropriately counselled, that the rules regarding referral and joint decisions by the referring doctor and the gynaecologist were strictly observed, and that the patients received the highest standard of medical care including antibiotic cover, appropriate surgical protocols and meticulous follow up. That clinic continued for several years without incident and Dr Lang performed approximately 20 terminations per week over those

[123] Townsend, *Baby Boomers.*
[124] The new generation medical schools have recognised this knowledge deficiency exists even among medical practitioners, so now specific sections of the curriculum cover this area in some detail. See Alison Hamilton, "Human Sexuality; Competent and Aware", *Imperatives in Medical Education, The Newcastle Approach*, eds. Henry, Byrne and Engel, (Newcastle: University of Newcastle, 1997), 115.
[125] Peter McLaughlin, *Doctors Memoirs*, (Newcastle: HPMI, 1991).
[126] Royal Newcastle Hospital Annual report, 1952.
[127] Alan D. Hewson, personal files from original records, 1960.

years.[128] The service ceased in 1985, after a dissatisfied patient took legal action, and was replaced by the pre-term private organisation in Lambton Road, Broadmeadow.[129] Harassment of patients attending that clinic continued for years.[130]

There was also a dramatic increase in the number of surgical sterilisations both interval and postpartum, with an almost fifteen-fold increase over the five years from 1970 to 1975.[131] This change was driven by the development of fibre optic laparoscopy, which opened the way for minimally invasive surgery by producing a pneumoperitoneum (gas in the peritoneal cavity) so that the operator could visualise the pelvic organs and carry out destruction, removal or occlusion of the Fallopian tube to produce permanent sterilisation.[132] This removed the previous necessity for open operation, three to four days in hospital, and greater operative risk. The legal and ethical constraints on permanent contraception remained unchanged at that time but legal opinion was modified to accept that sterilising either male or female was not illegal, providing full and valid consent was obtained from the person concerned. In practice it was still considered wise but not essential in the case of a married couple to also obtain the consent of the spouse.[133] As mentioned by Rizkallah, prior to the 1970s, culdoscopy was widely used in the United States to visualise the pelvic organs without a laparotomy and this technique was also popularised in Australia by Dr Alan Grant at the Crown Street Hospital.[134] The procedure was also used in Newcastle; the

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[128] Lachlan Lang, personal communication to Alan Hewson, June 2014. See graph of terminations, 1970-1975, in Hunter Valley Appendices

[129] Personal communication from Dr Lang to the author, 1985.

[130] Alan Hewson, Memoirs, unpublished.

131 See Hunter Valley appendix graph

132 Herbert B. Peterson, Amy E. Pollock and Geoffrey S. Warshaw, "Tubal Sterilisation", *Te Lindes Operative Gynaecology*, eds. John Rock and John Thompson, (New York: Lippincott Raven, 1997), 530. See also Tawfik H. Rizkallah, "Laparoscopy and Electro cauterisation of Fallopian Tubes", *Clinical Obstetrics and Gynaecology* 16 (3), (September, 1973), 7. This was, the beginning of the era of day stay surgery. Laparoscopic surgery began in Newcastle in the early 1970s. See also, Anne Brawner Namnoun and Ana Alvarez Murphy, "Diagnostic and Operative Laparoscopy", *Te Lindes Operative Gynaecology*, (1997), 389.

[133] Norman Jeffcoate, *Principles of Gynaecology* (4th edition), (London: Butterworths, 1975), 636; Karl Braaten and Caryn Dutton, "Patient Information, Permanent Sterilisation Procedures for Women (Beyond the Basics)", http://www.uptodate.com/contents/permanent-sterilisation-procedures, (accessed 6 March, 2014).

[134] In Culdoscopy the patient is placed face down in the 'knee chest' position, under caudal or spinal anaesthesia, and a trocar is pushed through the Pouch (of Douglas) behind the cervix, air rushes into the peritoneal cavity giving a useful view of the pelvic organs through an endoscope, but the view is limited to the posterior pelvis.

author of this paper carrying out 490 culdoscopy procedures before the laparoscope became available.[135]

An open procedure through the vagina accessing the space behind the cervix (Pouch of Douglas) was also used by a number of gynaecologists in Australia after 1974, prior to the introduction of the laparoscope. The technique was described at the World Congress of Obstetrics and Gynaecology in Moscow in August 1973, and this author refined the technique using tantalum clips, later combining it with partial salpingectomy. The number of patients treated totalled over 900 cases by 1979, allowing the patient to have an overnight hospital stay, no abdominal scar with minimal morbidity, and an extremely low failure rate.[136] The development of fibre optic technology for laparoscopy and improved instrumentation led to the abandonment of this procedure in favour of the laparoscopic approach from 1980.

The Other Main Hospitals of the Hunter Valley

The Maitland Benevolent Asylum was opened by the Maitland Benevolent Society on 1st January 1843 in the former Immigrants Home at East Maitland.[137] This occurred at Maitland rather than Morpeth where the early settlers were established, as floods in the river repeatedly threatened Morpeth.[138] It is difficult to find information regarding hospital care of the pregnant woman, and the lists of early patients at the new facility do not help.[139] In 1847, 81 patients had received treatment, 33 were cured, 17 sent to Sydney, nine died and eleven remained in hospital.[140] On 8 November 1849, a hospital building was completed on Campbell's Hill, and later a new hospital was built on higher ground in 1884 in Regent Street West Maitland. It had a dormitory for 40 patients, and a maternity ward, but no comments were obtainable regarding its function. It was listed as a public hospital in 1898, expanded over the years, became

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[135] Alan Hewson, a personal series of 490 Culdoscopies in the investigation of infertility and endometriosis, documented in private files, 1980.
[136] Alan D. Hewson, "Transvaginal Tubal Ligation/division Using Tantalum Clips", *Proceedings of the Fourth Indonesian Congress*, Jodgakarta, June, 1979.
[137] Maitland Benevolent Asylum, 1843: See http://search.records.nsw.gov.au/agencies/6396, (accessed 3 January, 2015).
[138] Wilfred Gould, *The Birth of Newcastle*, Historical Society, 1981, 24. In Major Morrisett's time convicts worked as far as 70 miles up the river cutting logs, and some were given grants of land.
[139] "Free Settler or Felon? Maitland Hospital", http://www.jenwilletts.com/maitland_hospital1.htm, (accessed 8 April, 2015).
[140] "Free Settler or Felon", 2, 4.

a training hospital for nursing in 1926, and in 1988 became part of the Hunter Area Health Service.[141]

In 1960, when this author first visited as a consultant, the delivery suite was unchanged from the WW2 era, with wet gloves in Dettol used for delivery, cramped delivery area, anaesthesia by ether and mask, no qualified specialist obstetric staff, and it was still basically a large cottage hospital.[142] Several groups of general practitioners supplied medical care, and in general referred anything difficult to a 'specialist in Macquarie Street in Sydney', in spite of well qualified specialist staff available in Newcastle from the early 1950s.[143]

Maitland always regarded itself as a bastion of private medicine and regarded RNH as a 'socialist entity'.[144] Change occurred slowly, with this author beginning public clinic and private rooms from 1960 and offering a consultant service. Dr Rachow from Royal Newcastle Hospital began public clinics and operating sessions in gynaecology, the appointment of Surgeon Superintendent Elwyn Currow from 1958 to 1965, with increasing access by full time staff from Royal Newcastle Hospital (initially opposed by some local GPs), assisting change.[145] It took some ten years for specialists to be accepted as helpful additions to the staff.[146] However the hospital became involved in the perinatal loss study later, with Dr Lawson visiting regularly for years and reviewing the labour ward register of deliveries.[147]

Specialist obstetricians settled in the town from the late 1970s and progressively took over deliveries as older GPs retired.[148] The population grew steadily in our study period, from 23,621 in 1947 to 67,478 in the 2011 census.[149] This ensured its dominance over the other Hunter Valley towns, but as late as 1976, the year of the Cox Report on obstetric services, Maitland was still dependent on

[141] State Records NSW, (accessed 3 January, 2015).
[142] Alan Hewson personal files from 1960.
[143] See discussion earlier in this chapter.
[144] Alan Hewson, private papers, compiled from discussions with GPs before opening private rooms in Maitland. Supplemented with information from Dr Terry Holland, staff specialist at RNH, 2015.
[145] *Reminiscences of the Royal*, Elwyn Currow, re experiences at Maitland, 28.
[146] Alan Hewson, personal files and Memoirs from the 1960s
[147] See previous comments on the Regional Perinatal Loss study.
[148] Drs Pullen, Roberts, Thompson, Paton, from the late 1970s, followed by Dr McGrath, establishing its place in the Area Health network;
[149] Census data, NSW, Local Government area 1947, 6, 2011.

visiting specialists from out of town for obstetric cover.[150] The Newcastle Obstetrical and Gynaecological Society (NOGS) Report of 1976 is an important document as it outlined the workforce issues in the Hunter Valley, the diminishing numbers of GPs doing obstetrics, the need for a central hospital to replace the ageing and inefficient central city hospitals, and the falling bed occupancy rates in the smaller peripheral hospitals.[151] It also confirmed that by 1976, in the two city hospitals, only 22 GPs did more than 30 deliveries in the year and 46 did less than 10.[152] The RACOG later warned that a minimum of 20 deliveries annually were necessary to maintain skills.[153] In the early time of our study several tightly controlled group practices served the community of Maitland. Two of the practices were owned by GPs with strong Roman Catholic backgrounds, the Kevin MacNamee /John Banfield group and the McKerihan group, and presumably the early presence of the Roman Catholic Cathedral and several Catholic Schools in Maitland was a factor in this.[154] The religious persuasion of the referring doctor as well as the patient, had to be considered in acting as an obstetric consultant in the early years of our study, as opinions were much more polarised at that time of sectarianism.

Another important Hunter Valley hospital was located at Singleton. The first medical facility there, the Benevolent Asylum in Hunter Street, Singleton, was founded in 1821, but was moved several times. Prior to the opening of Dangar Cottage Hospital, maternity and general patients were cared for at home or in the private homes of nurses, used as 'lying in' houses. The training of the midwives was impressive, most having been trained at Crown Street.[155] The Dangar Cottage Hospital was opened in 1907 on land donated by the Dangar family. They also contributed funds as well as providing the first hand cart to be used as an ambulance, still housed in the Singleton Museum. A horse drawn ambulance came later. The

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[150] See the *Lloyd Cox Report* on the introduction of teaching, prior to the coming of the medical school, 1976, and the formal response to the Cox Report by the Newcastle Obstetric and Gynaecological Society, 1976, 23.
[151] *NOGS Response to the Cox Report,* ed. A. Hewson, published by the Newcastle Obstetric and Gynaecological Society, 1976.
[152] Data collected from *Annual Statistics at the Mater and Western Suburbs Hospitals* by Alan Hewson, 1976.
[153] RACOG Council Decision, 1983. See Council Minutes, 1983 regarding recognition for the Diploma of the College.
[154] The Catholic Diocese of Maitland was established in 1847, and covered the Hunter, the mid-North Coast, extending west to Merriwa.
[155] *Personalities from the Past,* Singleton Historical Museum, 25.

hospital was renamed Singleton District Hospital in 1954.[156] Fairholme, owned by the Massey family, operated as a private hospital from 1915, and later became a private doctor's surgery where this author consulted from 1960 to 1980. The town was served by some outstanding medical practitioners from 1832, including many who served in WW1 and received decorations for valour. Scholes has listed 37 qualified doctors who served the town from 1832 to 1958, the early ones being British graduates with excellent qualifications.[157]

After WW2 Dr John Jonas came to Singleton having trained in Europe, and built up a general practice group who served the hospital for over 50 years. This was one of the new style of 'group practice' with two qualified surgeons, John Lorang and Neil Miles, providing cover for most of the general surgery and orthopaedics and emergency obstetrics, with Graeme Harrison, an Honours graduate from Sydney University, with wide general practice experience and an excellent anaesthetist, later joined by Pauline Vizzard, Tani Pifoletti, a native of Tonga, Denis Gordon, Barry Thomas and David Sanders. The hospital delivered 200 to 300 patients annually from 1960 to the present, with both general surgeons able to do emergency Caesarean sections. This author provided a consultant service in obstetrics and gynaecology from 1960 to 1980 by visiting every two weeks operating in the morning, seeing patients in the afternoon.[158]

Kurri Kurri Hospital was an important resource for the mining town after which it was named. Coal had been discovered in the Greta seam by Edgeworth David in 1891, with mines at Stanford Methyr, Pelaw Main, and Heddon Greta being started before the town of Kurri was established in 1902. The small villages grew around the pitheads as in the Newcastle district. The mines saw the need for a hospital because of the distance to Maitland. A temporary building was leased, a levy imposed on each miner of three pence per fortnight to raise 125 pounds and pay for maintenance. It could cope with five patients. A ladies committee helped, a government subsidy was obtained and the hospital was registered in 1904. The AA

[156] "Singleton celebrates 90 years", *Hunter Health News*, No. 59, (July, 1997), 1.
[157] Jenny Scholes, *Known Doctors from Singleton District 1832-1958,* Singleton Historical Museum, 2014.
[158] Alan Hewson, Memoirs, Singleton experiences and operative data, 1960-1980.

company assisted, as did 'subs' from the Miners Lodges.[159] A new building opened in 1910 and used a horse drawn ambulance until 1930, when they acquired a Vauxhall motor ambulance, finally handed over to an ambulance station at Weston. During our early study period it was served by Drs Frank and Jean Harrison, surgeon and anaesthetist; Alan Hellestrand, a trained obstetrician; Ian Waugh and Ivor Wonders from Weston, and later William (Bill) Straughan from 1966 to 1982,as well as Jalil Ramzan, all GPs, who collaborated with a visiting obstetric/gynaecological service provided initially by Dr Jack Elliott.[160] The hospital had a maternity section usually delivering up to 150 infants annually until it closed in 1985.[161]

Cessnock District Hospital was opened on 14 June 1914 to cater for miners' injuries on the new Greta Seam pit. When it opened there was no kitchen, no nurses' quarters and no mortuary, no female ward, with a male ward of ten beds and two cots. There was no steriliser, no septic tank until 1916, no hot water supply and no operating theatre. Nurse quarters, a steam sterilising system and a hot water system came in 1917. The kitchen, operating theatre, and X-ray equipment arrived and a verandah was closed in to make a female ward in 1920, and another men's ward added in 1924, plus a laundry. In 1927, a women's ward was added, making a total of 113 beds. Sewage did not come until 1938. Little was done during the Depression and during WW2, but in 1944, a new theatre was built and a maternity unit in 1945.[162] It is not surprising that the mining community put emergency care for injured miners as a high priority. Pogonoski highlighted the loss of life from 1904 up to 2004.[163] During the time of our study, the community was served by several group practices of non-specialist GPs, with specialist obstetric backup from 1960.

Meanwhile Muswellbrook Hospital, named after the Hunter Valley town in which it was built, opened in 1946. The hospital was part of the regional perinatal loss study programme from 1965. Early medical care was provided by a very large group practice originally begun by 'Hank' Rutherford, with surgeon Jim Elder for

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[159] Kurri Kurri District Hospital, http://www.coalandcommunity.com/kurri_kurri_district_hospital.php, (accessed 3 January, 2015).
[160] The Elliott Memoirs, Alan Hewson personal files, 2000.
[161] Dr William Straughan, personal communication, April, 2015. Consultant back up was later provided by obstetricians from Maitland.
[162] "History of Cessnock District Hospital", http: trove.nla.gov.au/ndp/del/article/100039085, (accessed 14 March, 2015).
[163] Ross Pogonoski, *Mining Fatalities of the Cessnock District, 1904-2004,* Coalfields Heritage Group, lists 414 deaths with details.

emergency Caesarean sections. The Brook Medical Centre is a long established practice, and now other groups serve the town with specially trained GP surgeons coming out of the Rural and Remote Doctors training programme.[164] Plans are currently in place to upgrade the hospital.[165]

The first Scone hospital opened in 1872, and the Scott Memorial Hospital in 1913. The medical scene in Scone from the 1940s is documented in detail by Poidevin, who worked as a GP there pre-WW2 with Walter Pye, and returned 50 years later to compare notes.[166] He also moved to obstetrics after time in general practice and war service including incarceration in a Japanese prison camp.[167] He records that the Lodge System was the commonest system of payment in Scone before WW2. It was limited to workers who had low salaries, who paid 32 shillings a year in quarterly instalments to cover everything except maternity care and operations. He had 500 Lodge patients on his books in 1940. Private patients paid ten shillings and sixpence for a consultation.[168] There was no maternity section in the Scott Hospital until 1940, and all deliveries were in two private nursing homes run by nursing sisters, but were delivered by the doctors.[169] Dr Pye (1905-1994) had a higher degree in surgery so could also cover Caesarean sections. He had begun practice in Scone in 1934 and retired 40 years later.[170] He reminisced that he purchased the house and the Goodwill from a Dr Grieve.[171] The later building of Glenbawn dam controlled river flooding, and the horse stud industry put Scone on the world map.

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[164] Brooke Medical Centre, http://brookmedical.com.au/google (accessed 10 April, 2015).
[165] Minister Jillian Skinner, Hansard, NSW Parliament, 6 March, 2014, http://www.parliament.nsw.gov.au/Prod/Parlment/hansart.ns3Key/LA, (accessed 8 September, 2014).
[166] Poidevin, *The Lucky Doctor*, 70-73; Poidevin, *Come in Doctor*, 19-24. Poidevin became a gynaecologist afterWW2, and later was Director of Obstetrics and Gynaecology at the University of Adelaide until retirement in 1981.
[167] L.O.S. Poidevin, *Samurais and Circumcisions*, self-published, 1985.
[168] This was still the usual fee immediately after World War Two (private Memoirs of this author).
[169]Poidevin, *Come in Doctor*, 21.
[170] Scott Hospital was named after Dr Scott who practised in Scone from1892 -1911.
[171] Until the 1960s it was normal to pay for goodwill to begin a GP or Specialist practice from a retiring practitioner. The usual amount was one third of the net income to be paid out over 2-3 years. The assumption was that the patients would stay with the practice and not move to the opposition. The other GP in Scone prewar was Dr Edwin Barton, whose son 'Toby' enlisted in the AIF and later began Medicine with this author in 1946 and returned to GP practice in the Upper Hunter. They were direct descendants of Edmund (Toby) Barton, Australia's first Prime Minister. See Ward, *History of Australia*, 15.

The Consultative Service

The development of a Consultant Service for the Hunter Valley was introduced in 1960 to make obstetric and gynaecological consultations more easily available across the Valley. As no obstetricians chose to live outside the city areas, two obstetricians began making regular bi-weekly visits to the towns of Maitland, Cessnock, Kurri, and Singleton. When the service was begun in the city of Maitland there was reluctance of general practitioners there to use the consultant service offered.

For decades the local general practitioners had persuaded their complicated patients to go straight to a 'Macquarie Street specialist' in Sydney rather than being referred to a specialist in Newcastle. The wealthy landowners of the lower Hunter had always considered themselves to be above the 'working class' population of Newcastle. It took some time for this attitude to change, pushed by patient choice.[172] There were no such problems at Cessnock, Kurri and Singleton. Visits were planned and coordinated in consultation with the local family doctors, with morning operating sessions followed by consultation sessions in the afternoons. The anaesthetic and the assisting was performed by the family doctor so that they could manage postoperative care intelligently. This protocol increased the skill level of the anaesthetist and the assistant, provided 'up skilling' for the theatre and ward staff at each hospital, enabled the great majority of patients seen to be operated on in the local hospital, and benefited the relatives by making visiting easier. The consultant was able to assess the appropriateness of the patient having local treatment, and patients needing central unit care could often be discharged early. This pattern was later adopted in other areas across the State and nationally.[173]

These protocols also worked in obstetrics, diminishing the number of patients transferred as emergencies late in pregnancy or during labour. At the time the Shedden Adam Memorial lecture was given in February 1976, over 1500 major gynaecological procedures had been carried out in the country hospitals with no mortality.[174] These protocols can only function effectively if there is cooperation and collaboration between the consultants and the family doctors, and the consultants

[172] Alan Hewson personal file and Memoirs, 2012.
[173] Alan Hewson, personal file of operative procedures in country hospitals from 1960.
[174] Operative results for 1500 major gynaecological operations at Maitland, Cessnock, Kurri and Singleton in hospitals over 15 years. detailed at the Shedden Adam lecture in 1976. Alan Hewson personal file.

being always available on call to provide advice on a seven day, 24 hours per day basis.[175] This system was developed in 1960, and has continued up till the present time (2015).

The Newcastle Obstetrical and Gynaecological Society (NOGS)

This was an initiative of the obstetric and gynaecological fraternity of the Hunter Valley and is the local section of the RANZCOG already described in Chapter 1. It was founded in December 1967 and was the first of the regional groupings of obstetricians in Australia.[176] The organisational framework of hospitals carrying out obstetrics and gynaecology across the Hunter region has been documented, but between the years 1950 and 1967 there were significant barriers to a cooperative framework because of the different development patterns between Royal Newcastle Hospital including its Belmont subsidiary, and the Western hospitals in Newcastle.

In early 1967 an official visit by Sir John Stallworthy from Oxford was a mechanism to have all the obstetricians meet for the first time in a clinical meeting, followed by a social occasion which was very successful.[177] Stallworthy described the regional obstetric organisations in the United Kingdom, and Dr Elliott had visited the United States, and observed the successful regional grouping in Boston Massachusetts.[178] On 17 December 1967 the nine obstetricians met to form the Society. An appropriate Constitution was agreed and its regional area defined.[179] Regular meetings began on a quarterly basis, and the organisation notified the hospitals of the region, the Australian Medical Association, and the Health

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[175] Jack Raymond Elliott, Memoirs, 1991, Alan Hewson personal file, unpublished.

[176] See "Articles of Association", Newcastle Obstetrical and Gynaecological Society, Newcastle 1967. See also "Newcastle Obstetrical and Gynaecological Society - a Profile", by Novocastrian Scrutator (Alan Coulthard) in *Combined Newsletter*, (HC, University, HPMI, HMA), 1986.

[177] Sir John Stallworthy was the Visiting McIlwraith Professor at King George 5th Hospital in Sydney in 1967, and Stallworthy agreed to visit Newcastle. The clinical meeting was held at Royal Newcastle Hospital. Each obstetrician presented a case and Mr Stallworthy provided comments. A decision was made to form a regional obstetric society along the lines of the British and Boston patterns. The persisting British connection of all obstetricians at that time was a significant factor in the consensus achieved at that meeting.

[178] The American Gynaecological Club was founded in 1911, the oldest organisation of its kind in America. It began as a small group in Atlantic City at the suggestion Dr Howard C. Taylor of New York, it limits its size to 40 active members and has always attracted the cream of the academic and clinical leadership in American obstetrics and gynaecology. The Gynaecological Visiting Society of Great Britain was formed in April 1900 as an initiative of Professor William Blair Bell. See Paul Barnett, *75 Years of the RCOG 1929-2004*, (London: RCOG, 2004), 1.

[179] Alan D. Hewson, "The History of the Newcastle Obstetrical and Gynaecological Society", NOGS Archives, 2012.

Commission. It offered collective obstetric expertise to the members of the medical profession, and the Regional Council of the RCOG was notified. In due course the organisation was recognised as part of the College.[180] Other regional groupings of obstetricians followed.[181]

The Obstetric Department at RNH steadily increased in importance after Dr Julian Ward from Queensland became Director in 1969. He had a strong surgical as well as obstetrical background and experience, and was a passionate supporter of postgraduate training. A whole generation of registrars benefited from his expertise and he later completed a thesis on medical education as well. He took a major role in the campaign for a medical school in the early 1970s, and encouraged contributions to the literature by his registrars.[182]

The Dean of the Medical School was appointed in 1975, and NOGS provided advice on what undergraduates should be taught in obstetrics and gynaecology in the new school, strongly supporting the principle of life-time learning.[183] A new initiative was using the private patients of obstetricians in the teaching program as well as the acceptance of the 'one on one' principle of some of the clinical teaching, following the Oxford medical school model. [184] NOGS was also involved in the development of the Hunter Postgraduate Medical Institute in 1979.

Several individuals advanced obstetric care in the Hunter. Professor Cox from Adelaide provided a report on hospital planning to facilitate student teaching.[185] NOGS subsequently prepared an alternative submission regarding the integration of the three current units.[186] The NOGS submission was accepted and was included in the Olsen Report, which eventually led to the building of the John Hunter Hospital with a centralised Obstetric Unit. The obstetricians also supported the adoption of the 'adult learning' model pioneered in the Australian College of General Practitioners, in particular by Dr Bill Corliss, which again became a hallmark of the new medical

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[180] "Articles of Association of the Newcastle Obstetrics and Gynaecology Society", 1967.
[181] WOGS (Western Sydney); SNOGS (North Shore); SOGS (Southern, based in Wollongong).
[182] Dr Julian Ward, FRACS, FRACOG, B.Ed. Studies, University of Newcastle, 1980.
[183] Planning for the Australian College of Obstetrics and Gynaecology already included a commitment to life time learning for obstetricians, so the philosophy behind the new school was consistent with College thinking (see Articles of Association of the RACOG, 1979).
[184] Cooke, *My First 75 years of Medicine*, 7.
[185] Lloyd Cox, *Report to the Regional Director of Health Hunter Region*, regarding introduction of medical teaching and the development of services in obstetrics and gynaecology in the Hunter Region, 1975
[186] Alan Hewson, *NOGS Commentary on the Cox Report*, 1975.

school.[187] Other important obstetricians included Professor Geoffrey Robinson, appointed to the chair of Reproductive Medicine in 1978.[188] Later Dr Max Brinsmead, a first class Honours graduate from Brisbane, came from research work with Professor 'Mont' Liggins in New Zealand, culminating in a PhD, to the Senior Lecturer position.[189] The main administrative base for the University Department was initially the MMH and WSMH, but RNH was also involved in teaching. In 1975, the discipline had urged the government to plan for a major central teaching hospital on the Rankin Park site as the optimal solution for hospital services in the region, including the centralisation of all obstetrics and gynaecology integrated with an academic professorial unit. This recommendation was finally implemented with the acceptance of the Olsen report in 1982, and the subsequent opening of the John Hunter tertiary referral hospital on the Rankin Park site in 1990.[190]

A regional registrar appointment system was introduced and integrated with the NSW State Committee of the RACOG.[191] Doctors Elliott, Hewson and later Ian Symmonds have been elected to the Council of the RACOG over the past 30 years (1979- 2015). Elliott was on the last Regional Council of the RCOG, 1977-1978, then 1979-1981, Alan Hewson from 1981 to 1993, and Symmonds from 2005 to the present. Alan Hewson chaired the Education committee 1983-1988 and was Secretary from 1989-1991. NOGS became involved in the Indonesian Aid program in 1978, Drs Elliott and Coulthard with anaesthetist Dr Brian Mclaughlin taking a team to Manado in North Sulawesi.[192] In 1979 Alan Hewson and David Morton with paediatrician Dr Robert Morris spent four weeks in Manado and another team went in 1980, teaching and operating. Each team took a great deal of equipment with them,

[187] Dr Bill Corlis, a Foundation Fellow of the RACGP, was a leading protagonist of the adult group learning model, as applied to general practice. His ideas were adopted by other medical Colleges and also introduced into undergraduate learning in the new group of medical schools.
[188] Geoffrey Robinson had an international reputation in foetal physiology and was a brilliant teacher and researcher.
[189] Professor Sir Graham Collingwood (Mont) Liggins (1926-2010), a New Zealander, led research in foetal physiology, and pioneered the treatment of premature labour with Steroids to mature the foetal lung.
[190] Geoff Olsen, *Health Services in the Hunter Region*, Report to the Minister of Health, 1982. A hospital was built at Rankin Park early in WW2 because of the fear of a Japanese invasion and the exposed position of RNH. It later became a TB hospital. The suburb was named after A.A. Rankin, Chair of the Board, RNH, for many years.
[191] Alan D. Hewson, *The History of NOGS*, NOGS Archives, 2012.
[192] Jack Raymond Elliott, *Manado Report*, First Report to RCOG, 1978.

paying for their own expenses.[193] The two universities, Sam Ratulangi in Manado and the medical school at Newcastle, established a bipartisan relationship being the newest university medical schools in each country.[194] NOGS developed a close relationship with Dr Janet Barton, a Dutch Nun and obstetrician who had become a naturalised Indonesian citizen, working in the Tomohon region. She was subsequently honoured by being made a Fellow of the Australian College and visited Newcastle several times.[195]

A number of research programs have been undertaken by NOGS, including a study on placental abruption, a salbutamol infusion study, and an early discharge programme involving three major hospitals.[196] NOGS also expanded the regional perinatal loss study, and arranged a study on screening for cervical cancer, in conjunction with the Hunter Postgraduate Medical Institute.[197] Patient education was provided with lectures to lay groups, and the organisation developed an information pamphlet on circumcision during the controversy regarding that procedure, which became the model for the National RACOG pamphlet on circumcision.[198] NOGS recognised the need for improvement in oncology services, and cooperated with the Area Health administration to support the training and later appointment of a subspecialist in oncology in 1992. The support of all obstetricians and gynaecologists ensured that appropriate referral networks were set up so that all complicated oncology cases would be referred to the new service which operated in both the public and the private sector. Within a short time this service became the second largest in NSW with a comprehensive and integrated organisational framework including surgery, radiotherapy and chemotherapy. This could not have occurred without long-term planning and the support of all the specialists in the region through the NOGS organisational framework.[199]

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[193] Alan D. Hewson, *Manado Report*, Second project, May 1979, *Report to the RCOG Regional Council*, June, 1979.
[194] Alan Hewson, personal file, University of Newcastle, Sam Ratulangi medical school, recorded 1979.
[195] Sally Lindsay, Portfolio, *Life as a Nun and a Doctor*, a profile of Dr Janet Barten, March 1987.
[196] Alan D. Hewson and Anne E. Roughley, "An Early Discharge Programme for Obstetric Patients, March 1987-March 1989", The Australian Gynaecological Society Meeting, Margaret River, WA, 1990.
[197] Alan D. Hewson, *History of NOGS*, Archives, 2012.
[198] *Circumcision, To Be or Not to Be*?, sponsored by the Newcastle Obstetrical and Gynaecological Society, approved by the Hunter Paediatric Group, 1980.
[199] Anthony Proietto, *First Report on Oncology Services in Gynaecology in the Hunter Region*, 1995.

Clinical Practice in the Discipline in the Hunter Region

Hunter obstetricians contributed significantly to the medical literature and to clinical meetings over the years from 1960 to 2000. The tradition of expertise in pelvic surgery established originally by Dr Elliott was continued and expanded by the author who had worked in a centre of vaginal surgery at Oxford, and brought back the techniques to Newcastle. A whole group of registrars went from Newcastle to Oxford over the 15 years from 1960 to 1975 and later to other major centres. The list of appointees up to 1990 is attached in the Hunter Valley appendices. [200].From 1990 a system of regional registrar appointments was introduced expanding the network to Maitland and the Central Coast.[201] They later commenced practice around the country and overseas, so that the centre established an excellent reputation for gynaecological surgery and innovative reviews of obstetric practice.[202] All of the consultants in the early years were generalists, and it was not until the mid-1990s that subspecialisation developed, including foeto-maternal medicine, infertility, obstetric ultrasound and urogynaecology. Many significant and often ground-breaking research programmes were conducted, including a hysterectomy study in conjunction with the Area Health Service, a midwife-centred delivery suite study, one on premature labour, and reviews of vaginal hysterectomy, laparoscopy as well as annual reviews of the Oncology Department work.

Planning for the new teaching hospital at Rankin Park began in 1983 and NOGS was invited to provide detailed regional planning input for obstetrics services related to the new teaching hospital. NOGS took part in many of the committees working on this project, in company with academics, clinicians and administrators; in particular dealing with the amalgamation of the staff from four separate hospitals onto

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[200] See the Hunter Valley appendices.

[201] From 1990, a system of regional appointments for registrars was instituted, including Maitland and the Central Coast.

[202] Alan Hewson, "Technique and Contributions to the Safety of Vaginal Hysterectomy, Experience of 2000 cases", Chinese University of Hong Kong, Hong Kong, March, 1995. Alan D. Hewson, "The Residual Adnexae Syndrome", *ANZJOG* 33 (1), 71; Alan D. Hewson, co author, "Simplified Colposuspension, A 15 Year Follow-up", *ANZJOG* 44, (2004), 39; Alan Hewson, "Overview of Vaginal Hysterectomy", Joint meeting of the AGTS and the American Gynaecological Society, Durham, N.C., 1993; Alan Hewson, *Review of Obstetric Services, HAHS*, 1995. Other contributions are listed in the author's list in the Bibliography.

the staff of the one central teaching hospital.[203] Virtually all the recommendations of the organisation arising from these deliberations were accepted and were implemented in the new hospital, with centralisation of antenatal and gynaecological clinics; their integration with other outpatient clinics leading to a much more cost effective utilisation of resources. Recommendations of NOGS regarding the management of complicated obstetric patients requiring transfer to the central unit were adopted by the Regional Health Authority.[204]

After Professor Geoffrey Robinson moved on to the Adelaide Chair of Obstetrics, Professor William Walters from Melbourne occupied the chair until 2005. He was deeply involved in NOGS, and engaged the clinicians very actively in the Department. Professor Ian Symonds, born in Australia but trained in the United Kingdom, is currently (2015) the occupant of the chair and has continued this active cooperation.

The Shared Care Programme

This enabled general practitioners and midwives to share obstetric care with consultants and the teaching hospital. It was administered through the Hunter Postgraduate Medical Institute from 1990, an initiative of Associate Professor Max Brinsmead. The program ensured that any general practitioners and midwives who wished to update their skills were provided with a program including lectures and practical skills annually which accredited them to be part of the 'shared care' program of the teaching hospital. This program is now in its 25th year. This Newcastle initiative has been adopted in other regions.[205] NOGS has also been involved in trialling clinical Outcomes Indicators, now an important part of obstetric practice.

The University of Newcastle Medical School

The groundwork began when Dr McCaffrey recruited a group of medical and surgical specialists for the staff of the Royal Newcastle Hospital immediately after WW2, and

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[203] *Functional Architectural Brief, Obstetrical Unit, Rankin Park Hospital*, and *Functional Brief, Department of Gynaecology*, 26 October, 1987, prepared by the Obstetrics/Gynaecology development group, A.D. Hewson personal file.
[204] *Strategic Plan for Hunter Region, Maternity Services in NSW*, eds. Greg Hardes and Jenny Williams, Hunter Area Health Service, July, 1989. This document involved a wide range of Health Professionals with a strong presence of obstetricians.
[205] Maxwell Brinsmead, "The Newcastle Shared Care Obstetric Programme", HPMI archives, 1990.

the progress of the plan has been documented by Voutnis in a Masters thesis at the University of Newcastle.[206] By 1958 the clinical facilities at the medical school at Sydney University were overburdened and despite strong representations from Newcastle the next school was established at the University of NSW.[207] The University of Newcastle started as a College of the University of NSW in 1952, became an independent University in 1964, and the new University's main priorities were establishing engineering and science faculties as more appropriate to an industrial region and this may have prejudiced its bid.[208]

In 1961 the NSW Minister for Health requested McCaffrey to prepare a submission for the NSW government cabinet outlining the case for a medical school in Newcastle. The main University campus at Shortland was a difficulty because of its distance from the main potential teaching hospital, the Royal Newcastle four kilometres away.[209] However local representatives continued to campaign on the issue and the sequence of events plus the continuing pressure particularly from the local broadsheet newspaper, *Newcastle Morning Herald,* is summarised in the Voutnis thesis.[210] There was a proposition in 1961 that the Royal Newcastle Hospital be integrated into the University of NSW.[211] However this 'stop gap' solution was opposed locally as this meant that the previous decision to set up the second school at the University of NSW was incorrect.[212]

No progress was made over the next ten years, and deletion of the plans for a Biological Sciences building in the 1967 to 1969 triennium was a further setback.[213] A further submission to the Australian Universities Commission by the University of Newcastle was made in 1970.[214] There was a division of opinion in the Council of the University as well during 1971.[215] Finally The Commonwealth agreed to set up a committee directing: 'the Australian Universities Commission to set up a Committee

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[206] Demetrius Voutnis, "The Establishment of the Faculty of Medicine at the University of Newcastle", Masters Thesis, Department of History, University of Newcastle 1986, 2.
[207] John D. Hamilton, "A Community and Population Oriented Medical School in Newcastle", Faculty of Medicine, Newcastle, 2.
[208] Hamilton,Medical Faculty,2
[209] The *Newcastle Herald* featured many articles supporting Newcastle as a site for a new medical school as detailed in the Voutnis thesis, 10, 11, 12.
[210] Demetrius Voutnis, "Establishment of the Faculty", 10-21.
[211] *The Newcastle Herald*, 2 August, 1961.
[212] Alderman Purdue, *Newcastle Morning Herald*, August, 1961.
[213] *Newcastle Morning Herald*, 5 August, 1966.
[214] *University of Newcastle's submission to the Australian Universities Commission*, 1972.
[215] University of Newcastle Council minutes, 14 May, 1971.

to report on the need for new or expanded medical schools in the light of likely trends in the delivery of health care in Australia over the next 20 years', to be chaired by Professor Peter Karmel.[216]

Only six weeks were allowed to prepare submissions to the Karmel Committee, but the battle for a medical school had produced a great deal of information which was coordinated and prepared rapidly. Submissions came from the Newcastle Chamber of Commerce, the University of Newcastle, the Royal Newcastle, the Mater, Western Suburbs, and Wallsend district hospitals and importantly a 112 page submission from the Central Northern Medical Association, the local branch of the Australian Medical Association. This submission was prepared by the author of this thesis, and a widely representative subcommittee of the CNMA, recognised as pivotal to the successful bid.[217]

In summary, this submission pointed out that there was both a present and future medical workforce shortage, it urged the development of appropriate undergraduate training facilities and a concentration on community aspects of family practice to reverse the trend towards concentration of medical services in the capital cities. Extensive appendices outlined the Newcastle community's social and economic structure and the types of local medical services already provided. It emphasised the already present training facilities and foreshadowed the problem of an increasing number of female medical graduates. The Association committed itself to link undergraduate and postgraduate medical training, and to collaboration with the Royal Australian College of General Practitioners training programme for family practice. It warned of potential changes in the national medicopolitical scene which would make medical practice less attractive, with more Australian doctors likely to migrate to other countries, and alerted the Karmel committee to the implications of a shorter working week. Asian migration needed to be faced and it recommended that the current six-year university medical course should be reduced to five years, but the twelve-month obligatory hospital residency term should be doubled to two years before full registration. It also urged that the content of the University core curriculum should be changed, so as to introduce students to patients at an earlier

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[216] Press release, *The Australian Vice Chancellors committee*, 31 May, 1972, A5675.
[217] *The Central Northern Medical Association, Submission to the Australian Universities Commission*, Committee of medical education on the establishment of a medical school at the University of Newcastle, New South Wales, 26 March, 1973.

stage of their medical education, with early exposure to family practice. It included the already successful perinatal loss study program in the city's hospitals as an example of inter disciplinary cooperation, and also outlined suggestions regarding the curriculum.[218]

The organisations appeared in person before the Karmel Committee, and in the resulting 1972 report Karmel recommended that two new medical schools be set up, the first at Newcastle, and the second at James Cook University in North Queensland.[219] The Committee made observations about the necessity for earlier exposure of students to patients, arising from the concern in the community regarding the predominance of the 'scientist clinician' mindset of the doctors of that generation, already discussed. These comments were expanded in Hamilton's later paper on the new medical school, stressing that the new generation of students must be community minded, interested in people and their problems, and more stimulated to practice medicine in a community setting. Karmel envisaged the development of Departments of Community Medicine to facilitate all of the above.[220] In the current medical schools there had been considerable resistance to any innovation which gave community medicine a higher profile, confirmed later by the incoming Dean, Professor Maddison from Sydney.[221]

The decision to develop the School occurred during 1972, when Edward Gough Whitlam and the Labor Party were swept to power as the Federal Government with a broad ranging agenda to change much of Australian society. In its first four weeks the new Government abolished conscription, released conscientious objectors from jail, and recognised three Communist countries. It announced plans for education reform, spoke of justice for Aborigines, and unveiled its planned free medical scheme. The symbol of 1960s liberation, the contraceptive pill, was placed on the Pharmaceutical Benefits list, and the Labor Party highlighted women's issues, so that feminism was becoming part of the Labor Party agenda.[222]

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[218] See appendices to the CNMA submission.
[219] Peter Karmel, chairman, *Expansion of Medical Education*, Report of the committee on medical schools to the Australian universities commission, (Canberra: AGPS, 1972).
[220] John Hamilton, *A Community Oriented Medical School*, (Newcastle: New South Wales), 5.
[221] David Maddison, "A Medical School for the Future: The Newcastle experiment", *World Health Forum* 1 (1, 2), (1980), 133-138.
[222] Michael Cathcart, *Manning Clarke's History of Australia*, (Melbourne: Melbourne University Press, 1997), 591.

A range of issues which would affect the Discipline of obstetrics and gynaecology as well as the medical profession at large, became increasingly matters for public debate and controversy. Fortunately the chaotic and controversial issues which swirled about the Hunter region's medical fraternity at that time were put aside, and all sections of the community managed to concentrate on the medical school development. Medical education at the national level was also in a state of flux, and medical authorities like Dr Sydney Sax and Dr Paul Gross were contributing to that debate.[223] The relatively new school of Medicine at Flinders University in South Australia was also outlining its new type of curriculum.[224] That medical school had also embarked on an innovative curriculum and had built up an outstanding group of academics under the leadership of Professor Gus Fraenkel.[225] This was also the beginning of the era of student unrest on various campuses across the nation.[226] In all the discussions which went on before the official planning for the school began, most of the initiatives finally put in place in the new school had been strongly supported by the professional groups, the hospitals, and many individuals in their original representations to the Karmel Committee.[227]

The CNMA submission to the Karmel committee outlined what the profession believed should be the type of graduate produced by the Medical School of the future.[228] It covered personal qualities, the ability to evaluate facts and research because of a broadly based training, ability to apply scientific knowledge in day to day care, a commitment to high quality care requiring the ethical basis of practice, necessity to foster close relationships with fellow professionals, ability to self-evaluate, awareness of referral networks and community responsibilities, awareness

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[223] Sax, *Melting Pot*; Sidney Sax, *Hospital Inpatient Services in Newcastle and the Hunter Valley*, Health Services Research and Planning, Health Commission of NSW, November, 1972; Paul Gross, "The Future of Specialist Services in Australia", address to the RACOG, Canberra, 1972.
[224] G.J. Fraenkel, "A New Medical School for Adelaide", *MJA*, (12 August, 1972).
[225] G.J. Fraenkel, "Progress at Flinders", *MJA* 1, (1975), 754-758.
[226] Donald Horne, *The Next Australia*, (Sydney: Angus and Robertson, 1970), 118-120.
[227] The submissions from the CNMA, the Royal Newcastle Hospital, the Mater Hospital, the Western Suburbs Hospital, the Royal Australian College of General Practitioners and the University of Newcastle all supported a change to a five year course with a two year intern programme; closer integration between the basic sciences and the clinical disciplines; an early exposure of students to patients; a much greater exposure to general practice; a greater emphasis on adult type learning methodology; broadening of the curriculum to include sociology and statistics as well as training in communication skills; as well as describing the type of graduate required in the future. See the RNH submission page 14, CNMA submission pages 33-37, University of Newcastle submission pages 2-6, the submission of the Royal Australian College of General Practitioners pages 21 -43, as examples.
[228] "*The Central Northern Medical Association Submission to the Karmel Committee*", Appendix 16, 95.

of advances in care, be formally taught communication skills, recognition that a high intelligence must be combined with all the above skills, and that working in a group would be important.[229] Medical graduates produced by the newer types of medical schools from the late 1970s were measured against the criteria outlined in the above statements. A disparity would obviously lead to criticism of the new graduates. There is evidence that this occurred, and is mentioned in later comments from the College of Surgeons.[230] One of the unspoken hopes of the profession at that time, a diminution in criticism by patients and medical negligence lawsuits, was not mentioned in the above extensive statement, and was not realised. This is also discussed in the chapter on medical malpractice litigation**.**

The sequence of events which led eventually to the appointment of Professor David Maddison, a psychiatrist and Dean of the Faculty from Sydney, as the foundation Dean are outlined in the literature.[231] He recognised the need for a perception of the social origin of health and illness, the importance of communication, and the need for the curriculum to generate a more appropriate style of learning.[232] His criticisms of traditional medical schools was a factor in his appointment.[233] Professor Hamilton, the third Dean, records that David Maddison undertook a two-month study tour overseas visiting the new medical schools at Beersheba in Israel, Southampton in the United Kingdom, Maastricht in the Netherlands and McMasters in Canada to gain further ideas. These medical schools later formed a network of community oriented educational institutions for the Health Sciences. The foundation Professors in the new school all broke new ground in the academic world: Charles Engel in Medical Education; Tony Vinson in Behavioural Science; Steven Leader in Community Medicine; Rufus Clarke in Anatomy; and Geoffrey Robinson in Obstetrics. All shared David Maddison's vision. However the fluctuations of political change, and a change back to a Conservative government after the collapse of the Whitlam regime, all produced major difficulties. At one stage it appeared that the medical school might be absorbed into one of the other schools,

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[229] The CNMA acknowledged material from the AMA symposium on Medical Education, 1971.
[230] See Litigation chapter.
[231] Hamilton, *Community Oriented Medical School*, 7.
[232] David Maddison, "What's Wrong With Medical Education?", *Medical Education* 12, (1978), 97-102.
[233] Ian Hicks "Newcastle to Get a Dose of Maddison's Medicine", *Sydney Morning Herald*, 26 August, 1974, 7.

especially when Prof David Maddison died suddenly in 1981.[234] Professor Geoffrey Kellerman as Acting Dean worked diplomatically over two years and miraculously the school survived and stayed true to its principles. Development of the NSW Health Commission in 1973 introduced another major player into the provision of health services in the Hunter.[235] The ongoing debate about the introduction of Medibank or its alternatives impacted on a whole range of issues directly involving the medical school and medical education, and the hostility of the medical profession to many Government initiatives at the national level was unabated.[236] Because of major concerns related to the provision of undergraduate teaching in 1976, a committee involving nominees of the Australian Vice Chancellors committee and representatives from the Hospital Commission was set up to investigate warnings of an impending 'crisis in the clinical teaching caused by Medibank'.[237] The controversies regarding how medical students were selected and the priorities necessary in their training continued to be hotly debated across the country. A whole issue of the *MJA* was devoted to Medical Education in September 1975.[238] The articles covered a wide range of views and the Journal editorial was instructive, highlighting the current dilemmas, with challenges to academics to be more innovative and proactive, to adopt

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[234] Hamilton, *Community Oriented School*, 9, 12. It is ironic that David Maddison (1927-1981) succumbed to a massive heart attack at a relatively early age. Presumably his smoking addiction was a major factor. Ironic, because he more than anyone else in the Faculty was the champion of preventive medicine and the encouragement of a healthy life style (See.*University of Newcastle Faculty of Medicine Year Book*, 1982, 13).

[235] "The New South Wales Health Commission, its Role, History and Organisation, Health in New South Wales", *The Quarterly Journal of the Health Commission of New South Wales Volume 14*, (1973), 4.
The Minister for Health Mr A H Jago stated that 'the creation of the commission is by far the most important development in the administration of the State's health services for half a century: its aim is to streamline administration, de-centralise control, and strengthen and encourage public participation in the State's health care scheme; the Health Commission Act provides for the appointment of a number of advisory committees and councils to implement its policies'.

[236] G.S. Rieger, "Medibank Not the End of the Battle", *Monthly Bulletin*, New South Wales branch AMA, 28 July, 1975, 10. Dr Rieger was President of the New South Wales branch and warned that 'the starving of State governments into submission, the setting up of so-called free health centres in opposition to established private medical practice, the muzzling of concerted opposition by means of the Trade Practices Act, the attempt to destroy private enterprise insurance, and the intended alteration to medical registration, are all aspects of these proposals which we will continue to fight".
Shaun McIlwrath, "Doctors boycott clinics in Medibank Protest", *Sydney Morning Herald*, Thursday 2 October, 1975, 3.
John Bunton, "Physical and Mental Hardship, Pensioners Not Alone", *NMH and Miners Advocate*, 4 September, 1975. The article reported on a meeting of pensioners and trade union activists discussing methods to be used to force doctors to bulk bill under Medibank, symptomatic of the angry confrontations of the time.

[237] Hospitals and Health Services Commission, Committee on Health Insurance and Medical Education, *AMA Gazette*, 22 January, 1976.

[238] *MJA* 2 (13), (27 September, 1975), 2.

more small group learning methodology and be more critical of some of the 'shiboleths' of education. The editor summarised by saying 'there is always something happening in medical education'.[239]

Training in obstetrics and gynaecology in the undergraduate curriculum was one of the major issues in the extensive discussion regarding what should be taught in the undergraduate curriculum in the newly developing medical schools, including Newcastle. Because of the medicopolitical conflicts regarding outpatient clinics, problems arose in ensuring that there were sufficient numbers of antenatal patients coming through clinics to ensure that teaching could be continued, and particularly in NSW, there was a developing conflict regarding the Honorary Staff continuing to teach in the outpatient clinics under the new system. There were also problems at the inpatient level with increasing difficulty in having sufficient patients available for training in delivery of mothers for medical students, interns, midwives, and registrar training. The diminishing number of general practitioners doing obstetrics in practice and increasing numbers of specialists in obstetrics compounded the problem. The matter was discussed by the AMA following a report from Professor Cox, the President of the RACOG, who recommended that only doctors who had postgraduate training in obstetrics and had passed the Diploma of the College should be doing obstetrics in general practice.[240] The RACGP felt that all undergraduates must have exposure to obstetrics, as many of them would not be able to get an obstetric term after graduation. Training in sexuality at the undergraduate level became an issue as well, because of changing community attitudes and the necessity for increasing the knowledge of graduates.[241]

Professor Cox also alerted the Hospital and Health Services Commission to a serious problem in the teaching of obstetrics at undergraduate level. He pointed out that after graduation and completing the compulsory preregistration year the newly registered doctor was entitled to practice obstetrics, even though undergraduate training in obstetrics 'is currently minimal'. He pointed out that modern obstetrics has now achieved a great deal of sophistication of management and this needs

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[239] *MJA* 2 (13), 27 September 1975, 2.
[240] Federal assembly of the AMA, "Obstetric Training for Students, *AMA Gazette*, May, 1976, Professor Cox report.
[241] M.S.R. Smith and D.C. McCourt, "An Introductory Course in Human Sexuality for Medical Students", *MJA* 2 (13), (27 September, 1975), 52, 55.

sophisticated facilities and highly trained personnel, but the general public and many non-obstetric trained doctors 'seem now to regard birth as a normal process which requires little care other than a sympathetic doctors' attendance'. He noted many contradictions in the present Health Scheme, including a significant gap between 'benefits' and the doctor's bill. He felt more patients now requested attention at public hospitals 'which are often organised more for their convenience and comfort than for sophisticated modern care'. He highlighted the absurdly low obstetric fee, which was encouraging obstetricians to see more patients and spend less time with them, and claimed student education was suffering. He also highlighted a continuing fall in public clinic obstetric patients, and incentives in health schemes for any patient to pay only two months subscription and then receive private care.[242]

Dr Sidney Sax, The Chair of the Commission, undertook to investigate the serious problems the medical profession had identified concerning obstetric training.[243] Another issue becoming more prominent at the time was the recognition that continuing education must be placed higher on the agenda of all branches of medicine, and the *AMA Gazette* had a complete supplement on the issue.[244] Another issue was a critical report by Dr Clare Isbister, relating to the Leichardt Women's Community Health Centre and Liverpool Women's Health Centre, which were accused of holding extreme 'women's liberation' views and displaying 'anti-male' and 'anti-doctor' attitudes. They were also accused of encouraging potentially dangerous self-examination by women patients rather than insisting on adequate trained medical attention. [245] Bob Browning's book, although published later, crystallised 1970s concerns regarding political extreme leftist views becoming a distraction in efforts to improve the health care of women.[246]

The development of a modern private hospital in Newcastle was one of the results of the Medibank dispute which the profession realised must be built to ensure the survival of private medical practice as well as a high standard public sector.[247]

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[242] Lloyd Cox, "Problems in Obstetric Training, *AMA Gazette*, (22 January, 1976), 6.
[243] Sydney Sax, "Problems in Obstetric Training, *AMA Gazette*, (22 January, 1976), 6.
[244] Donald Wilson, "Report to Advisory Committee on CME to the RACP", *AMA Gazette*, (19 August, 1976), 1.
[245] Kath McLean and Robyn Clark, "Womens Health Centre Reply to Criticism", *AMA Gazette*, (22 January, 1976), 11.
[246] Bob Browning, *Exploiting Health: Activists and Government vs The People*, (Victoria: Canonbury Press, 1992), 200.
[247] See Catts, *Knife the Surgeons*, 410-415.

Christo Road Private Hospital was built in 15 months, opening in September 1974, with 64 surgical beds and a prominent gynaecological presence. It was the first modern private hospital in the city, was air conditioned, with a specialist staff, two operating theatres, a high standard of accommodation, telephones to every bed, privacy and the best staff available at the time. It later built a private obstetric unit delivering over 1000 babies per year, and was fully accredited by all licensing authorities. The story of its development has been described elsewhere and it continued operation until 2000.[248] It was the forerunner of a high quality private hospital system in the Hunter region, currently (2015) providing over 700 private beds of high standard.[249] This network now includes a modern obstetric unit at the Newcastle Private Hospital (NPH), delivering over 2000 babies annually.[250] Catts later pointed out that this unexpected expansion of private medical care after the Whitlam Government's plans were modified, led to a massive expansion of private hospitals, giving Australia one of the best balanced hospital systems in the world.[251]

The development of the Newcastle Medical School broke new ground. The Hunter Institute of Higher Education, responsible for the education of nurses and other health professionals, joined the Faculty of Medicine, and then the School of Health in 1993, to form the School of Medicine and Health Sciences. This was an important step in increasing the collaboration between the disciplines of medicine and nursing and the other health professionals. In 2012, the school was nominated for the Prince Mahidol award, based on the overall ethos of the school and its specific academic strengths.[252] The contributions of individual Faculty members to medical education were an important part of the nomination.[253] The Newcastle school always aimed to produce graduates with better 'professional attitudes' than others, using the criteria already mentioned in this thesis and outlined to the Karmel Committee. Another bench mark was the behavioural criteria espoused by Professor Saint, also

[248] Alan D. Hewson, History of Christo Road Private Hospital, Archives of CRPH, Newcastle, 2012.
[249] Data collected by this author, February, 2015. Total Private Hospital Beds, 709. Direct information from all private hospitals in the region.
[250] Information provided to this author from Newcastle Private Hospital, March, 2015.
[251] Catts, *Knife the Surgeons*, 466.
[252] John Hamilton, *Nomination of the Faculty of Medicine, University of Newcastle Australia for the Prince Mahidol Award*, 28 May, 2012.
[253] At that time more than 70 papers in peer reviewed journals on medical education alone (personal communication, John Hamilton, 2014.

quoted in the original CNMA submission to the Karmel Committee.[254] Parker reported on a National Forum evaluating the assessment of professional behaviour of medical students, Brisbane, on 5 March 2010, relevant to a major theme of this thesis.[255]

The Hunter Postgraduate Medical Institute became very important to the obstetrical and gynaecological fraternity in the Hunter region from 1970, particularly its relationship to other medical and health professionals and the community in the field of continuing education.[256] The concept of an organisation to provide quality continuing medical education began in1969, when several different organisations began exploring the idea. The Central Northern Medical Association, the Board of RNH, the other hospitals, the University, and the Health Commission were all involved. The Blandford Report in 1974 was opportune and provided an overall philosophy, and Dr Bill Corlis from the RACGP provided ideas on adult education. By 1974, a draft Constitution was extant and by 1977, the way forward seemed clear. But the coming of the medical school caused a rethink as it was important to ensure that education of doctors was a lifelong process beginning in the undergraduate years. By 1980 an appropriate Constitution involving the University and the medical school and all the Clinical Colleges was finalised and it was launched in March 1981. The office was sited in the medical school building on the Callaghan Campus and the relationship to the University has been crucial to its success, with every Dean strongly supporting its activities. Membership grew from an initial 50 doctors to its current 1250 members. Finances have come from members' annual subscriptions, generous sponsorships, a long term 20 year debenture, and the *pro bono* contributions of hundreds of lecturers and committee members. It now has an annual income of over $500,000. The introduction of obligatory continuing education for all professionals during the 1990s boosted memberships and attendees. It has always taken pride in being at the cutting edge of Continuing Medical Education, now renamed Continuing Professional Development, and most world leaders in CME have visited at some stage. The development of an Area Organiser Network, the Shared Care Obstetric

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[254] Eric Saint, "On Good Doctoring", *MJA* 2 (3), (15 July, 1972), 121-126.
[255] Malcolm Parker, Jane Turner, Paula McGurgan, Lynne Emerton, Lindy McAllister and David Wilkinson, "The Difficult Problem: Assessing Medical Students' Professional Attitudes and Behaviour", *MJA* 193 (11), (December, 2010), 662.
[256] The story of its development has been documented by the author of this thesis. See Alan Hewson, *The History of the Hunter Postgraduate Medical Institute*, HPMI Archives, 2012.

Programme, small group learning in general practice, and the nationally famous *Careers Book* for graduates have been landmark achievements.[257] Membership of the Australian Postgraduate Federation in Medicine (APFM) for 20 years to exchange ideas on CME has been important, and the Secretariat for that organisation was at the HPMI for five years while this author was President of the APFM. Obstetricians have played a leading role in all its activities, and educational programmes in obstetrics have been a feature.[258] The joint appointment of a Director of Studies, HPMI and Assistant Dean of CME on the University side has cemented the links with the medical school.[259] The Institute has embraced modern communications technology to make its programmes available nationally.[260] Finally the close personal relationships possible in the close-knit Hunter community, where most involved in education of medical, paramedical, and nursing professionals are on a first name basis, has been central to its success.[261]

The surgical skills of gynaecologists in the region have always had an excellent reputation, beginning with the early emphasis on vaginal surgery by Dr Jack Elliott with progressive expansion of techniques as members of the Department at Royal Newcastle Hospital came back from working in Britain and elsewhere, and the staff of the western hospitals grew by adding trained gynaecological surgeons to their staffs. All consultants had a very heavy work load and rapidly acquired the experience not so easily acquired in the capitals.[262] Regular visits from overseas experts helped to steadily improve standards. The excellent results of operative procedures resulted in regular requests to give lectures at other centres including overseas.[263] The development of the smaller regional hospital operating lists was a model for other centres, and graduates of the local training programme have achieved recognition both in Australia and overseas, with graduates now occupying

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[257] *The Careers Book*, HPMI, ed. Alan Hewson, annual publication since 1995. Now in its 17th edition.
[258] See the History of the Newcastle Obstetrical and Gynaecological Society discussed earlier in this chapter
[259] The author of this thesis has occupied that position since 1993.
[260] The HPMI website shows all the relevant data regarding its structure and activities, and records of programmes available to all members by using a password.
[261] See the list of HPMI Board members, Programme Committee, and Executive, *Annual Report*, HPMI, 2014.
[262] The archaic appointment systems in the capital cities teaching hospitals from 1950 until the 1980s referred to earlier were never a feature of consultant obstetric practice in the Hunter region.
[263] See lists of overseas lectures quoted elsewhere, including those by the author of this thesis in Hong Kong, the USA, Britain, New Zealand and South Africa.

Professorial posts overseas as well as in Australia.[264] Some of the techniques developed here are now used in other centres, and many of the consultant posts in this region are now occupied by locally trained specialists and subspecialists. It is rare for patients to have to leave Newcastle for gynaecological treatment, subspecialties like IVF and oncology are world class, and the many new initiatives in education in the discipline have received world recognition. Techniques to remove the uterus by the safer vaginal approach and pelvic surgery advances have always been a hallmark of Newcastle graduates, and studies in both the private and public sectors have confirmed these skills as reported in national forums and in the medical literature.[265]

The Development of Obstetric Services at the John Hunter Hospital

This development on the Rankin Park site had a major impact on the provision of obstetric and gynaecological services in the Hunter Valley. In their response to the Cox Report in 1976 the obstetricians of the region supported the creation of a new teaching hospital on that site including the centralisation of all obstetric and gynaecological services as well as neonatal paediatrics.[266] These changes are outlined in detail in Susan Marsden's official history of Royal Newcastle Hospital, 1817 to 2005. [267] She commented that the decision to move Royal Newcastle Hospital followed the release of the Olsen Report for the Rationalisation of Health Services in Newcastle in 1982.[268] This was followed by the strategic plan for the provision of health services in the Greater Newcastle area up to the year 2000 published in 1986.[269] Dr Olson prepared a review of health services in Newcastle and was

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[264] See the list of trainees in the discipline detailed earlier in this chapter. Professors Tony Chung (Hong Kong), David Ellwood (Canberra), Andrew Bisits (Sydney), Warwick Giles (Sydney, North Shore), David McCourt (Kogarah), Charles Barbaro (Mercy, Melbourne) were trained in Newcastle, plus many Associate and Conjoint Professors.

[264] See the Consultant staff listings in the Annual report of the John Hunter Hospital, 2013, also the cited lectures and orations listed in earlier chapters.

[265].See Alan Hewson, contributions to the literature on Vaginal Hysterectomy, Sacrospinous Colpopexy Transfusion rates after vaginal hysterectomy, bladder drainage, post hysterectomy adnexal disease, Colposuspension and vaginal fistulas.

[266] Professor Lloyd Cox from Adelaide had been invited to provide an overview of obstetric and gynaecological services in the city of Newcastle. NOGS was invited to comment on that report and stated the optimal solution for obstetric services was to build a new general hospital in the area of Rankin Park, including centralisation of obstetric and gynaecological and paediatric services (minutes of the meeting of NOGS, Sunday 27 June, 1976, A.D. Hewson personal file).

[267] Marsden, *A Castle Grand*, 167.

[268] Susan Marsden, *A Castle Grand*, 167.

[269] Geoffrey Olson, *The Rationalisation of Health Services in Newcastle*, 1982. See also *The John Hunter Hospital*, published by the Hunter Area Health Service, September, 1989, authorised by Peter

appointed Regional Director of the Hunter health region in 1982, and his recommendations were developed into a strategy to coordinate services at the new general hospital and introduce an Area Board. They also provided a framework for future services at the Royal Newcastle and the other three major public hospitals in Newcastle. All of these changes had a dramatic effect on future planning, and the obstetrical and gynaecological functions of the hospitals, especially the Mater Hospital at Waratah, as outlined in Capper's history.[270]

A Medical Functions Planning Committee was established by Dr James and began meeting monthly from April 1983, chaired by the author of this thesis, and including doctors Olson and James, Professor Burton (Professor of Surgery), Drs Bissett (surgeon), Dalton (medicine), Hendry (Pathology), Professor Kellerman (university, pathology), Dr Kerridge (orthopaedics - staff specialist), Professor Leader (community medicine), Professor Robinson (obstetrics), Professor Saunders (Professor of Medicine), Dr David Walker (visiting surgeon), Dr Keith Walker (visiting urologist) and Dr Noel Walker (visiting physician).[271] The role of this committee was: to act as a forum for the input of professional medical opinion into the planning process; to delineate optional roles for the greater Newcastle area hospitals; to evaluate the possible options; to nominate the preferred strategy; to nominate the priority on clinical grounds for capital works projects; to nominate the medical mix to be developed on the Rankin Park site; to act as a forum for the provision of detailed planning inputs for special areas of medical practice into the production of briefs, sketch plans, and engineering specifications; and to establish role delineation for the various greater Newcastle area hospital sites. This was to be contained within the bed number parameters, and to evaluate material produced by the development planning team and provide expert medical comment on it.[272] This broadly representative team of clinicians and university staff with the administrators worked in a very constructive manner over the next two years to produce the

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Collins, Minister of Health, which provides a detailed overview of the hospital's development and the architectural features including the Obstetrics Department design.

[270] Capper, *75 Years of Tender Loving Care*, 240-243.

[271] Alan D. Hewson (chairman), Committee minutes of the Medical Functions Planning Committee from 19 April 1983, plus subsequent meetings on file.This committee is detailed because it demonstrates the methodology used to integrate current health services with an emergent medical school sector, a situation which can result in irreconcileable conflict.

[272] Department of Health, New South Wales Hunter region, Medical Functions Planning Committee, Delineation of roles, Dr G.G. Olson, Regional Director, March, 1983.

Functional Brief demanded by the architects of the new hospital. The Public Works Department then published a *Design Brief* for Greater Newcastle's new hospital in 1985, and construction of the John Hunter Hospital (JHH) as it was later called, commenced on the land alongside the Rankin Park Hospital.[273]

Obstetric services and midwifery training moved completely to the Mater and Western Suburbs Maternity Hospital in 1986, the latter then closing in 1991-92. The closure of this Newcastle icon was also traumatic for devoted staff and patients and a committed medical staff, as evidenced by newspaper headlines at the time.[274] There were other rationalisations and regionalisation of different services, which are outlined in Susan Marsden's history.[275] The Board of Newcastle Hospital presented its 107th and last annual report in 1985-86 because of the establishment of the Area Health Board for the region.[276] Commissioner John Varnum was made chairman of the new Area Board so the hospital became a unit of the Greater Newcastle Area Health Service, amalgamating with the other services to form the Hunter Area Health Service in 1988.

The 496-bed hospital was built on budget and completed nine months ahead of schedule by a local building company, without losing one day because of industrial issues, a unique achievement in the history of major construction in the 20th century. The development of the 'Med One' building, later called the Madison building, next to the Royal Newcastle Hospital was completed in 1991.[277] The building of the new 'Med Two' building on the Mater Hospital site was opened in 1990, but not until a deferral decision by Minister Brereton had been reversed because of massive community pressure.[278] The Clinical Sciences building on the University campus at Shortland had already been opened by Professors Karmel and Maddison.[279] These were designed to provide the administrative offices and teaching facilities for the new school.

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[273] The Rankin Park Hospital was built early in WW2 to provide a hospital away from the seafront in case of a Japanese invasion.and later became a TB hospital. A.A. Rankin was Chair of the RNH Board for 25 years from 1916, that suburb was named after him, and he was awarded a CBE in 1938.
[274] Faye Lowe, "Death Knell Sounds Louder for Western Suburbs", *NMH*, 20 February, 1982.
[275] Marsden, *A Castle Grand,* 168.
[276] *Annual Report of Royal Newcastle Hospital*, 1985-1986, published by the Board.
[277] Marsden, *A Castle Grand*, 173.
[278] "University Condemnation Over New Med 2", *Newcastle Morning Herald*, December, 1981; Capper, *75 Years of Tender Loving Care*, 243.
[279] Joint Medical Newsletter, *10 Years, 1978-1988,* 3.

The Delivery Suite in the new hospital was separated into four areas, each containing four delivery rooms, including enough space for the specially designed delivery bed, seating for accompanying persons, subdued lighting with all the technical paraphernalia concealed behind a headboard above the bed. These rooms were soundproofed and immediately adjacent to the central midwife control station. The philosophy behind the design was to make the whole area as user-friendly and home-like as possible. At a later stage, birthing baths were added in two of the suites to encourage mothers to opt for hospital delivery rather than consider a domiciliary birth, and to address the criticisms in the previous surveys.[280] The Birthing Suites were located immediately adjacent to the operating theatres so that emergency delivery could be carried out as rapidly as possible.[281]

A feature of the design was the allocation of four delivery rooms into a 'Birth Centre' This was developed with community input to a committee with consumer representatives, an obstetrician, birth centre nurse, a visiting midwife, and one general practitioner, later described in the literature.[282] The Birth Centre opened in February 1991 and 1492 women were admitted to the centre with 82% giving birth there by 1994. No perinatal deaths occurred in women admitted to the centre in spite of open entry. The authors believed that this protocol should become standard care to encourage mothers to avoid home births.[283]

CONCLUSION AND INTO THE 2000s

In both the public and private hospital sector, the trends described up to year 2000 continued into the next decade. The data from John Hunter Hospital confirms increasing centralisation of deliveries and increasing numbers, with steadily rising Caesarean section rates, approximating the national figure of 30% as at 2010.[284] In

[280] The lay press always found this topic of interest and provoked controversy. Politicians were often caught in the middle of resultant claims and counter claims.
[281] Architects Design Plans for the Birthing Areas, John Hunter Hospital, private files of Alan Hewson (see appendices for diagrams).
[282] Marilyn Rowley and Christine Kostrzewa, "A Descriptive Study of Community Input Into the Evolution of John Hunter Hospital Birth Centre: Results of Open Entry Criteria", *ANZJOG* 34 (1), 1994, 31.
[283] "Hunter Needs Birthing Centre", public meeting of the Ministerial task force to review obstetric services, *The Newcastle Herald*, Wednesday, 9 December, 1987, 6.
[284] Data provided by Lyn Kramer, Midwife in Charge, Delivery Suite, March, 2015. See graphs of delivery numbers, Caesarean section rates, at John Hunter Hospital, 2000-2010, in the Hunter Valley Appendices.

the Hunter Valley the Caesarean section rate began at low rates of between 2% and 5% in the 1950s, climbing to what was considered a high rate of 10% in 1970. It then climbed more slowly, reaching 20% in year 2000. Between 2000 and 2005 it reached 25% and in 2010 reached almost 30%.[285] Across NSW, operative assistance to facilitate vaginal delivery has steadily fallen to levels never seen in obstetric practice in the previous 60 years. Forceps incidence is now between 1.8% and 6.3%, and Ventouse assistance from 4% to 8%. Vaginal breech delivery incidence is between 0.2% and 0.7%. Augmentation of labour across the State varies from 5% to 18%.[286] The short and long term sequels of these changes will be discussed in the conclusions of this thesis.

The abrupt change in mindset in the care of women from the mid-1940s and beyond in the Hunter region was a remarkable phenomenon, and the complex series of events leading to a world class obstetrical and gynaecological service at the end of the century is a mirror of what was happening at the national level. The importance of both visionary individuals and serendipitous events provides a reassuring narrative for the Hunter Valley community, as a contrast to the earlier years. However the changes over this period provided significant challenges for both the community and the discipline of obstetrics and gynaecology. Although knowledge rapidly increased and there was a remarkable improvement in safety for mothers and babies, paradoxically, increased intervention led to increasing criticism of the profession. In spite of new approaches to medical education, attempts to provide more information for expectant mothers, and the incorporation of new knowledge into obstetric practice, the later part of the century became extremely stressful and a difficult time for the discipline of obstetrics and gynaecology. Litigation and increasing bureaucracy; increasing political interference with medical practice; significant changes in community attitudes to issues such as termination of pregnancy; the second wave of the women's rights movement, including pressure for changes in terminology; as well as the changing roles of health professionals involved in the care of obstetric and gynaecological patients, complicated the relationship between

[285] See graphs in the Appendices, labelled JHH, LSCS Rates, 2000 to 2010. It is disturbing that even though the original planning of this new delivery suite was to encourage minimal intervention in the more home like environment, intervention rates have steadily risen in much the same way as the rest of NSW

[286] *NSW Mothers and Babies, 2010,* Centre for Epidemiology and Evidence, NSW Government Health Department, 2010.

obstetricians and their patients. The first decade of the 21st century produced a whole set of new challenges which will demand enlightened responses if the care of women is to remain at a high standard, and confidence in their carers is to be maintained.

CHAPTER 7
SCIENTIFIC AND CLINICAL ADVANCES IN OBSTETRICS AND GYNAECOLOGY IN AUSTRALIA 1950-2010

The history of medicine in the fifty years since the end of the Second World War ranks as one of the most impressive epochs of human achievement.

***Le Fanu*[1]**

Statistics showing steadily improving maternal health and diminishing perinatal loss documented in the earlier chapters of this thesis provides *a priori* evidence of the improving care of women in Australia over the timeframe of this study, but did not provide details of progress in the discipline over the same timeframe. This thesis would be incomplete without an overview of why improvements occurred in the overall care of women, with details of those individuals who contributed to progress, and this chapter is included for this purpose. No attempt will be made to analyse the significance of specific advances cited because of space constraints, but the items listed are those of particular relevance in Australian practice. Others which have less direct relevance, but are still important, are listed at the end of the chapter.[2] The advances will be outlined in a broadly chronological order.

MAJOR ADVANCES: AGAINST INFECTION, ECLAMPSIA AND OBSTETRIC HAEMORRHAGE

The knowledge revolution after World War Two enveloped the discipline of obstetrics and gynaecology. The major killers of mothers since time immemorial have been haemorrhage, infection and the so called toxaemias of pregnancy. The management of bleeding in pregnancy did not improve until knowledge of blood groups, the change from *ad hoc* panels of local donors to blood banks, autoclaving

[1] James le Fanu, *The Rise and Fall of Modern Medicine*, (New York: Carroll and Graf Publishers, 2002), Introduction.
[2] H.S.J. Lee ed., *Dates in Obstetrics and Gynaecology, A Chronological Record of Progress in Obstetrics and Gynaecology Over the Last Millenium*, (London: Parthenon Publishing Group, 2000). This material may become a starting point for further historical research on the changes in the discipline over the past 6o years.

and sterilisation improvements, and advances in anaesthesia. Experiences in World War Two accelerated these changes, and revolutionised obstetric practice.[3]

Further dramatic changes in medical practice had been ushered in by the discoveries of the first agents which could fight infection by destroying bacteria without causing harm to the human body, the sulphonamides. Porter notes that a number of antibacterial agents had already been proved to be active against some diseases, including mercury, salvarsan, antimony for Schistosomiasis, and quinine for Malaria, but that all changed with Domagk's work on Prontosil.[4] He found that Prontosil could attack the streptococcus organism without harming the patient, and cured his daughter with it in 1932. It was found that the biologically active part of Prontosil was sulphonamide, which basically stopped organisms multiplying, allowing the body to attack them; a completely new concept. So the term 'antibiotic' entered the medical lexicon.[5]

Prontosil could not be patented, having already been discovered, so became freely available for development, and was synthesised by I.G. Farben in 1936. Colebrook in the United Kingdom found it was effective against Puerperal Fever, the greatest killer in obstetrics, slashing mortality from 20% to 4.7%. In 1938 May and Baker developed 'M and B 693', sulfadiazine, which attacked pneumococci as well as streptococci.

Later it was shown to be active against Gonococci, the cause of Gonorrhoea, one of the reasons given for 'population control' over the centuries because of its contribution to infertility. The drugs were made available to the civilian population in America, although in Australia most supplies went to the armed forces until after the Second World War.

The author of this thesis was critically ill with septicaemia during 1943, and only received life-saving sulphonamide because the son of the family GP brought

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[3] Australian Red Cross Blood Service History. See http://www.donateblood.com.au/about/history, (accessed 20 March, 2016). See also Peter Hendry and Ian Stanger, *Its in Your Blood*: *Recollections of 50 Years, 1938-1988,* (Melbourne: Brolga Publishing, 2004).

[4]Gerhard Domagk (1895-1964), awarded the Nobel prize in 1939, was blocked from receiving it by the Nazis but received the Medal in 1947.

[5] Paul Villeuim (1861-1932) coined the term "antibiosis", signifying one organism destroying the life of another to preserve its own life, later changed to "antibiotic" by Selman Waksman (1888-1973).See Porter,*Greatest Benefit*,455

back sulphonamide from New Guinea when on leave.[6] 'M and B's' came on the Australian market in the late 1930s. Although they were largely restricted to use by the armed forces during the war, their use exploded after 1945.

Penicillin, a natural by-product of the mould Penicillium Notatum, was discovered by a Scot, Alexander Fleming, in 1928, working at St Mary's Hospital in London, purely by accident. The details of the long delay until the Australian Howard Florey, and Ernest Chaim in Oxford in 1940, developed the clinically useful final product, is outlined by Le Fanu.[7] Its final clinical testing on a London policeman in 1941, after a team spent weeks getting enough to treat a human, is inspiring. Fleming then took a tube of the culture to the USA, where the efficient American drug firms began producing the drug in quantity.[8] In Australia, the Commonwealth Serum Laboratories (CSL) began production after receiving a culture, because of work by Percival Bazeley, and in 6 weeks it was going to troops in New Guinea. Very little came to civilians until 1945. [9] In Europe, there were enough supplies available to treat the large number of casualties in the D Day landings in June 1944.[10] This development profoundly affected obstetric practice subsequently, as a whole range of antibiotics were later synthesised following the investigation of a vast number of micro-organisms in the period from 1944 to 1963.[11]

Another important Australian discovery changed forever the measures used to prevent eclampsia.[12] It resulted from the work at Crown Street Women's Hospital on

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[6] Captain Craig Duncan, a medical officer with the 7th Division in Papua New Guinea, son of the Gosford GP, was alerted to the serious clinical problem by his father, and broke the rules to bring the drug home. Alan Hewson, Memoirs, unpublished.

[7] Le Fanu, *The Rise and Fall*, 8.

[8] Porter, *Greatest Benefit*, 457.

[9] George Biro, *Landmarks in Australia in Health and Medicine*: *The Twentieth Century*, (Princeton Publishing, 1999), 7. See also *The Medical use of Sulphonamides*, Hawking and Green, His Majesty's Stationary office, MRC War Memorandum No. 10, Questions of Supply, (Sydney: Angus and Robertsons, 1945), 16. That publication refers to continuing difficulties of supply during the war, with sulphadiazine and suphamerazine still in short supply in Britain even in 1945.

[10] George Biro, *Landmarks*, 7.

[11] Le Fanu, *Rise and Fall*, 13. The list includes Streptomycin 1944, Chloramphenicol 1947, Chlortetracycline 1948, Cephalosporin 1948, Neomycin 1949, Oxytetracycline 1950, Nystatin 1950, Erythromycin 1952, Novobiocin 1955, Vancomycin 1956, Kanamycin 1957, Fusidic acid 1960, Lincomycin 1962, Gentamycin 1963. Ronald Hare gave a lecture in Hobart, Tasmania in 1956, warning that all known possibilities for new antibiotics had been exhausted and medicine would have to manage with the ones then available. He was wrong, as the Cephalosporons and a host of others were subsequently developed.

[12] Judith Godden wrote that Dixon, Hughes, Stevenson and Hamlin at Crown Street Womens Hospital produced "the most important advance in obstetrics in the 20th century" over the years from 1947 to1958; the virtual elimination of eclampsia, one of the three great killers of mothers. See Judith Godden, *The History of Crown Street Womens Hospital* (in press). See also "The Medical and Clinical

the prevention of eclampsia during the 1940s and beyond by Drs Dickson Hughes, R.B. C. Stevenson, and Reginald Hamlin put Australian obstetric practice on the world map. These three men, particularly Hamlin, who had to ensure the system worked in practice, revolutionised the approach to antenatal care by meticulous attention to weight gain and rising blood pressure antenatally, reducing the rate of eclampsia to 1 in 8000 from 1 in 350.[13] This ranked with the beginning of the antibiotic era as arguably the two most important initiatives in the care of women in Australia and around the world, and was a fitting sequel to Australia being at the forefront of regular meticulous antenatal care in Sydney from 1912. A clinic had begun in Adelaide in 1910 under T.G. Wilson, but temporarily ceased during World War One; but another in Sydney in 1912 by Windeyer continued, as noted in the education chapter.[14]

A solution to the problem of Rh isoimmunisation was an important advance in obstetric practice from the 1940s. The prevention of Rh isoimmunisation in Rh negative mothers removed a serious and potentially fatal disease affecting infants.[15] The first exchange transfusion in Australia for a newborn affected by Rh Iso Immunisation was carried out in Perth by Kelsall in 1945. However, total elimination

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Report of The Womens Hospital, Crown Street, Sydney, July 1953 to June 1954", *JOGBE* LXVI (6), 1025, confirming in December 1959, with 4326 deliveries, only 3 eclampsia cases, and a C. section rate of 1.07%.

[13] Dr Catherine Hamlin, *The Hospital by the River*, (Sydney: Pan Books, 2001), tells the inside story of the fight against eclampsia at Crown Street Hospital, her romance with Reginald Hamlin, their trip to Ethiopia to the Princess Tsehai Hospital in 1959, and the later development of the world famous fistula hospital, which has now carried out over 20,000 fistula repairs. Reginald Hamlin, MRCOG (1918-1993) was a New Zealand graduate, served in the Royal Navy in World War Two, and is credited with re-educating most of the ex-servicemen in obstetrics at Crown Street Hospital after the war. He died in Ethopia while still working at the fistula hospital.

[14] J C 'Daddy' Windeyer (1875-1950), appointed to the staff of the RHW in 1904, was the first professor of Obstetrics at the University of Sydney. His classic booklet on *Diagnostic Methods in Late Pregnancy and During Labour* was still in use when this author was studying medicine in Sydney in the 1940s.

[15] Peter Hendry and Ian Stanger, *It's in Your Blood, Pathology Recollections over the 50 years from1938 to 1988*, (Brolga Publishing, 2004), "Rh babies", 85. In 1932 Diamond and Blackfan began work on Erythroblasosis Foetalis, which produces a serious and often life threatening jaundice in infants. In1940, Landsteiner and Weiner identified the Rh factor on red cells. Levine postulated the disease could be due to an antibody/antigen reaction, and Landsteiner and Wiener finally confirmed the damage was due to the development of an antibody to the Rh factor in an Rh negative mother carrying an Rh positive child from an Rh positive father. The subsequent detective story culminating in the prevention of iso immiunisation is outlined in Hendry and Stanger's book. Initially the disease was treated by exchange transfusion after birth via the umbilical vein to remove damaged red cells with the ever present risk of cardiac failure in the infants. See also Hendry's pioneering work at Royal Newcastle Hospital from 1947 in the Hunter valley chapter.

of Rh affected infants took another 20 years.[16] Rh iso immunisation affecting Rh positive newborns carried by Rh negative mothers with antibodies was a major problem in obstetrics before this time. Initially it was treated by giving the infant an exchange transfusion after birth but clarifying the mechanism underlying the problem was a major advance. Much of the experimental work on this disorder was done in Australia and New Zealand, particularly by A.W. Liley in New Zealand and Aileen Connon in Adelaide.[17] It became treatable by giving the mother a blocking antibody during pregnancy and at delivery. The final answer, the injection of AntiD to the mother to prevent the disease, occurred in 1966. The disease has now been practically eliminated.

The work of Sir Norman Gregg in 1943 deserves inclusion as the first who showed that the Rubella virus could cross the placenta and affect the foetus. This was the precursor of increasing concern in modern obstetrics regarding damage to the foetus by noxious agents crossing the placenta.[18] Dr Arthur Machen ('Bung') Hill (1903-1979) in Melbourne was also an innovator, and one of the first in Australia to become an exponent of the Grafenberg ring, an intrauterine stainless steel contraceptive device (IUCD), dating from the 1930s, and a precursor of things to come.[19] Hill, with Butler, pioneered the rapid diagnosis of the organism Clostridium Welchii in abortion cases, facilitating immediate treatment. [20]

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[16] The first exchange transfusion in Newcastle was in 1949.

[17] A.W, Liley, "Intrauterine Transfusion in Haemolytic Disease", *BMJ* 11, (1963), 1107-1109; Aileen Connon, *Obstetrics and Gynaecology* 33 (1), (January, 1969), 72-78.

[18] Sir Norman McAlister Gregg (1892-1966), a Sydney Graduate, served in World War One, was awarded the Military Cross for gallantry in the field, later trained in Ophthalmology, and in the rubella epidemic in 1940 noted a large number of congenital cataracts. He also noted the common occurrence of congenital heart disease in the group. He presented his findings in the Journal of Ophthalmology, "Congenital Cataract Following German Measles in the Mother, *Transactions of the Ophthalmological Society of Australia* 3, (1941), 15-46. Later deafness was added to the triad of damage. Gregg was knighted for this work.

[19]Ernst Grafenberg, 1881-1957, of Jewish background and originally from Adelebsen, Germany, worked with Pfannenstiel in Kiel, moved to Berlin and began investigating intrauterine devices. He met Margaret Sanger, then worked with Robert Meyer, was jailed in Germany in 1937, but with Sanger's help left Germany, went to the USA in 1940, and worked in the Margaret Sanger Research Bureau in New York, inserting IUCDs often in secret, and died in 1957 with his work largely unrecognised.

[20] Arthur M. Hill, "Why be Morbid, Paths of Progress in the Control of Obstetric Infection, 1931-1960", *MJA* (1), (1964), 101-111.

Other Advances in Australia After 1950

In 1950, Dr Kate Campbell (1899-1986), a neonatologist in Melbourne, identified the cause of Retrolental fibroplasia in the eyes of premature newborns, proving that it was due to their treatment with high oxygen concentration in ventilators.[21] Dr F.H. Mills (1910-2008), a survivor of Changi prison camp in the Second World War, trained as a cardiac surgeon and performed Australia's first mitral heart valve operation at Royal Prince Alfred Hospital in 1951. At that time mitral valve damage due to Rheumatic heart disease, caused by allergy to the streptococcus, was a major problem in pregnancy, especially in those of Celtic background.[22] An initiative in Newcastle was the use of Magnesium Sulphate by Jack Elliott in eclampsia from 1952, following reports in the American literature. Although recommended in Professor Bruce Mayes' Australian obstetrics text book in 1959, it was not widely adopted in Australia until after the Magpie Trial in 1990, allegedly because of a 'British teaching bias' against the American protocols for using Magnesium Sulphate.[23]

Richard Doll confirmed in 1950 the relation between smoking and lung cancer, which led to Australia's major attack on smoking. The links between smoking and poor pregnancy outcomes, as well as recognition of the increased incidence of carcinoma of the cervix in smokers which followed, was an important advance. Again much of the basic scientific and clinical work on these problems was done in Australia, evident on reviewing the references on Colposcopy and Cervical cytology by Malcolm Coppleson and Bevan Reid in Sydney, and Ellis Pixley in Perth in the next decade.[24]

In 1951 the Earle Page scheme altered obstetric practice, as is covered in the medicopolitical chapter. The 1952 bequest by Dr Norman Haire (1892-1952) of £30,000 to Sydney University for the study of contraception and sexuality was important, and his contributions to contraception and the sexuality debate are

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[21] George Biro, Landmarks, 8. Kate Campbell (1899-1986) became a legend in her lifetime in the field of neonatal care.

[22] See the Hunter Valley chapter, regarding the new settlers with a Celtic background in the Hunter region.

[23] Bruce Mayes, *A Textbook of Obstetrics*, (Sydney: Australasian Publishing Company, 1959), 435. See also Judith Simon and A. Gray, "Magpie Trial, Evaluation of Magnesium Sulphate for Prevention of Eclampsia", *BJOG* 113 (2), (2002-2005), 144-151. See also the Hunter Valley chapter.

[24] Bevan Reid and Malcolm Coppleson, "The Natural History of Cervical Cancer", in *Scientific Basis of Obstetrics and Gynaecology*, ed. R.R. McDonald, (London: Churchill, 1978), 223.

discussed in the Social Influences chapter.[25] In 1953 the fluoridation debate erupted in Australia, and Professor Noel Martin (1923-2006) from Lisarow, NSW, was Professor of Preventive Dentistry at Sydney University, and became a world leader in the efforts to get fluoride into the water supply.[26] That was important in the discipline of obstetrics, as obstetricians were expected to 'sell' the importance of fluoride to mothers. The worldwide outbreak of poliomyelitis in 1952 was a major challenge to obstetricians, as the management of pregnant patients in a ventilator (iron lung) was extremely difficult, especially their delivery.[27] In 1956 the Salk (and later Sabin, 1966) immunisation against poliomyelitis began, with the Triple Antigen being given to infants, again impinging on obstetric practice counselling, and removing the major hazard of most serious infectious diseases in later pregnancies.

In 1957, Ian McDonald in Melbourne introduced a 'world first' cervical suture for incompetence, still used today. [28] Dr Alan Grant, who pioneered infertility studies at Crown Street Hospital, introduced Culdoscopy to Australia in the 1950s, a valuable diagnostic tool until laparoscopy arrived in the 1970s.[29] Early clinical trials on Progestogens were done in Australia, and recorded for posterity in 1962.[30] These hormonal agents were also destined to alter obstetric practice. Dr Struan Robertson continued Grant's work at Crown Street Hospital over several decades.

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[25] Diana Wyndham, *Norman Haire and the Study of Sex*, (Sydney: Sydney University Press, 2012).
[26] Noel Martin (1923-2007) was Professor of Preventive Dentistry at the University of Sydney from 1955, and was one of the most distinguished Alumni of the 20th century. See *Health Sciences Alumni Association*, https://secura.imodules.com/s/965/index.aspx?gid=16&pgid=544&sid, (accessed 9 November, 2014).
[27] During this author's clinical work in Oxford in 1958, a ward was occupied by pregnant patients with bulbar poliomyelitis on ventilators. The anaesthetist Lassen in Copenhagen in 1952 had revolutionised management with endotracheal intubation and ventilation, keeping the patient alive and enabling access to the pregnant patient. See H.C. Lassen, *Nord.Med* 49 (1), (2 Jan, 1953), 2-9.
[28] Ian McDonald (1922-1990) was a President of the Regional council of the RCOG in Australia before the establishment of the Australian College.See Ian McDonald, "Suture of the Cervix for Inevitable Miscarriage", *JOGBE* 64, (1957), 346-350. He published two books, authored several book chapters, wrote many journal articles and co-authored *Super Ardua*, the History of the RCOG in Australia.
[29]Alan Grant, "Culdoscopy, A New and Telescopic Method of Inspecting the Pelvic Organs, Review of 162 patients", *MJA*, (19 May, 1956), 534 -536. This was one of the first reports in the world literature on Culdoscopy; Alan Grant and Struan Robertson, "Culdoscopy, a Study of 402 Cases, Womens Hospital, Crown Street, Sydney", *ANZJOG* 2 (1), (March, 1962), 2. Culdoscopy involves inserting a telescopic instrument into the space behind the cervix using regional anaesthesia as a day case procedure. It allows the gynaecologist to view most of the pelvic organs avoiding a, laparotomy.
[30] F.A. Bellingham, Chairman, Editor, *A Symposium on Progestogens, The Womens Hospital, Crown St Sydney*, (Sydney: Griffin Press, June 1962), included original contributions from every authority in the field in Australia. Including Shearman, Bockner, Moyes, Mackay, and included the first scientific contribution from Newcastle at a national meeting (Elliott and Hewson) with Swyer from the UK.

Professor F.J. Browne (1879-1963), then semi- retired, published an article on the need for Standards in Obstetrics in 1958.[31] The change in nomenclature altered forever the way infant and perinatal loss was measured. Important data on premature labour appeared in the world literature from Shedden Adam, Professor in Brisbane.[32] The Newcastle Perinatal Loss Study in 1960-1965 also had a major impact on intervention in obstetrics, as well as the relationship between GPs and obstetricians, as detailed in the Hunter valley chapter.

Bruce Mayes, Professor of Obstetrics at Sydney University, 1941-1969, made enormous contributions to the speciality. He invited Professor Edward Hon, a Sydney graduate who became Professor of Obstetrics at Yale University, to come as visiting professor in 1959.[33] Later Alan Bradfield, Warwick Newman, and Jim Roche all worked as research Fellows with Hon at Yale and returned to Sydney with new expertise. Hon was the driving force behind the development of foetal monitoring, now a routine part of obstetric practice.[34]

In 1960 Sir Frank McFarlane Burnett (1899-1985) was awarded the 1960 Nobel Prize in medicine for elucidating the riddle of acquired immunological tolerance, vital in many fields as well as obstetrics. His work on viruses over several decades secured his place as one of Australia's most distinguished scientists and also had important sequels in their management in pregnancy. Sir Gustav Nossal (b. 1931), a Sydney University graduate in 1955, contributed enormously to our knowledge of immunology and won international acclaim.[35] The alert regarding the Thalidomide disaster by Dr William McBride of Sydney made international headlines, and resulted in him developing Foundation 41. His subsequent fall from

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[31] Francis J Browne, "Standards in Obstetrics, a Plea for Uniform Standards in Maternity Statistics and Hospital Reports", *JOGBE* 65, (1958), 826-831.. See also, Ian Cope, "F.J. Browne and His Influence on Australian Obstetrics", *ANZJOG* 28 (2), (May 1988), 85-95. Also Herbert Reiss, *Francis J Browne (1879-1963), a Biography*, (RCOG press, 2007). F.J. Browne was a consultant at RNH Newcastle, and RHW, Sydney from 1951 onwards, after his marriage to Dr Grace Cuthbert Browne and immigration to Australia. He had an enormous effect on many obstetricians in Australia.

[32] G. Shedden Adam, "Aetiological Factors in Premature Labour", *JOGBE* LXV1, (October, 1959), 732-736.

[33] Bruce Mayes (1903-1996), Professor of Obstetrics at Sydney University, 1941-1969, made enormous contributions to the specialty. See his "Obituary", *RACOG Bulletin* 11 (1), (April, 1997), 15.

[34] Edward Hon, "Electronic Evaluation of the Foetal Heart Rate", *American Journal of Obstetrics and Gynaecology* 77, (1958), 1084-1099.

[35]Sir Gustav Nossal became head of the Walter and Eliza Medical Research Institute in Melbourne and remained in Australia for his professional life.S ee Gustav Nossal, *Antibodies and Immunity*, (Melbourne: Nelson, 1969), 3-5. Nossal had the gift of simplifying complex immunological issues for the benefit of clinicians.

grace is outlined in the Litigation chapter.[36] In 1964, Methyl Dopa (Aldomet) for hypertension was introduced into obstetric practice. In 1967, the NSW Red Cross blood transfusion service in Sydney, started by Gordon Archer, gave obstetricians readily available blood for the first time, and a weapon against the trifecta of death in obstetrics. In 1968, Dr Bertram Wainer, the abortion law reformer began his crusade for changes in the termination of pregnancy laws.[37] In 1969, Ventolin use began in premature labour. [38]

A comprehensive overview of the history and practice of obstetrics and gynaecology in Australia was detailed in the USA *Obstetrical and Gynaecological Survey* of April 1967 by Lance Townsend of Melbourne at the invitation of the Editorial Board.[39] This article is unique, and provides early signs of a change in focus from the United Kingdom to the North American continent by the most prominent Australian obstetrician of his generation.[40] It contains details of every medical school in Australia from their foundation, including a list of their consultant staffs, academic appointees, research programmes and clinical achievements. Professor Townsend was an Associate Editor of the Survey Journal, signifying his stature on the international scene. The invitation for the article arose because the World Congress of Obstetrics and Gynaecology (FIGO) was to be held in Sydney in that year, signifying the coming of age of the discipline in Australia internationally. It also provides a contemporary record of the consultant hierarchy of all the teaching hospitals at the time, which still followed the British system of Senior (inpatient) and Junior (outpatient) specialists.

Diagnostic Ultrasound was another major advance. Concerns regarding the potential damage to the foetus by X rays led Professor Ian Donald in Glasgow in 1958 to explore the possibilities of using ultrasound (high frequency sound waves) to

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[36] See the chapter on Litigation and Scandals, the William McBride tragedy, which was the sequel to the Thalidomide episode.
[37] Bertram Weiner. See the section on abortion in Australia, included in the Social issues chapter.
[38] Ventolin is an agent which diminishes uterine contractions (a tocolytic) and is used as treatment for threatened premature labour. It was later replaced by more effective agents like Calcium channel blockers and Magnesium Sulphate infusions.
[39] Lance Townsend, "Letter from Australia", *Obstetrical and Gynaecological Survey* 22, (April, 1967), 203-223.
[40] Professor Sir Lance Townsend (1913-1983) was first occupant of the Chair of Obstetrics and Gynaecology in Melbourne from 1951-1976, and this article contains much information about the discipline at that time.

visualise the foetus.[41] William Garrett and George Kossof at the Royal Hospital for Women (RHW) in Sydney began developing a machine from 1962, and were two of the innovators in the field. The original crude machines were rapidly improved, and the service at the RHW became the prime referral centre for NSW. The unit was the first in the world to develop the 'Grey scale' technology in 1971, which became world's best practice. Dr 'Coll' Fisher at the Royal became a world authority on interpretation of ultrasound films, and played a key role in the development of the subspecialty of Ultrasound. [42] Dr Jim Roche at Crown Street Hospital also studied ultrasound at University College Hospital in London in 1970, and subsequently introduced the Diasonograph to Crowne Street, and in private practice. Dr David Cooper in Brisbane and Beresford Buttery in Melbourne were also leaders in the field of Ultrasound. Hugh Robinson later emigrated from Glasgow, and was one of the pioneers in the development of the subspecialty for the RACOG.[43]

The 1960s and 1970s witnessed the birth of several new medical schools: New South Wales in Sydney in 1961; Monash in Melbourne in 1961; Hobart in Tasmania in 1965; Flinders in Adelaide in 1974; and Newcastle in 1975, all embracing the newer concepts of adult education, with a vertically integrated curriculum, including life-long learning and improved communication skills, as discussed in the Social Influences chapter. Australia was among the first to embrace these new approaches to learning in medicine.[44]

Furthermore, by the 1970s there was a new focus on patient access, contraception and infertility, and accountability. For example, Women's Health Centres become popular in Australia, giving better access to medical advice by women for women. They were initially set up in Perth, Sydney and Melbourne.[45]

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[41] Ian Donald, with MacVicar and Browns paper on "The Investigation of Abdominal Masses by Pulsed Ultrasound", *Lancet* 1, (1958), 1188, began the revolution in Ultrasound in obstetrics. See "Ian Donald", by Beresford Buttery, *RACOG Bulletin*, (December, 1987), 19.

[42] Cope and Garrett, *The Royal*, 86-94. William Garrett was a Sydney graduate who worked in Oxford with Professor Chassar Moir and also did research on new drugs to contract the uterus (oxytocics). He also worked with George Kossof, a brilliant engineer/physicist who turned theory into practice with the new ultrasound machines after returning to Australia.

[43] Hugh P. Robinson, "The Diagnosis of Early Pregnancy Failure by Sonar", *BJOG* 82, (1975), 849-857.

[44] George Biro, *Landmarks*, Australia, 9.

[45] Notably, the Menopause clinic at the Royal Hospital for Women, Sydney, begun by Barry Wren in 1967. See also Barry Wren and Margaret Stephenson, *Menopause, Change, Choice, and HRT*, (Sydney: Rockpool Publishing, 2013); Jean Hailes Centre, Menopause clinic at the Royal Women's

The Dalkon Shield intrauterine device (IUCD) for contraception was fitted to millions from 1970, but was later withdrawn because of infection risks, and justified community concerns. South Australia legalised abortion in 1972, and Vasectomy clinics were begun by the Family Planning Association (FPA) in 1972. The first In Vitro Fertilisation (IVF) pregnancy in the world occurred in Melbourne, and did not progress, but Professor Carl Wood and Alan Trounson became world leaders from 1973.[46] Major teaching hospitals became more aware of the importance of publishing complete annual reports.[47]

Advances continued to occur at breakneck speed in unpredictable but significant ways. Candice Reed was born in Melbourne, the first IVF child in Australia, in 1980. 'Toxic shock' was described, due to super absorbent tampons and a virulent staphylococcus organism; these tampons were withdrawn from sale in 1980. In 1983, freezing eggs and successful thawing was described by Monash IVF, and in 1984 the Acyclovir antiviral, Zovirax appeared. Zovirax (Acyclovir) was a significant breakthrough in antibiotics as it was the first effective treatment against the Herpes Virus. In 1985 Commonwealth Serum Laboratories (CSL) began treating blood to prevent HIV/AIDS infecting haemophiliacs following the first Australian case of HIV/AIDS being reported.[48] Tasmania allowed condom vending machines, and advertising of contraceptives began in 1987. In 1987, the Doherty Committee on Medical Education and the Workforce began work, with implications for obstetrics and gynaecology.[49] In 1988**,** the first antiviral (Retrovir) arrived. [50] In 1989, RU 486, the abortifacient, became available overseas, but was opposed for Australian use by the Right to Life group, which temporarily stopped a trial of the drug in Australia.[51]

Hospital, Melbourne, 1990; see also, Margaret Smith, King Edward Memorial Hospital, Perth, *Midlife Assessment*, from 1979.

[46] Douglas Saunders, *The Fertility Society of Australia, a History*, COM, self published, Cremorne, NSW, 2013.

[47] Norman Beischer and David Abell, *First Clinical Report, Mercy Maternity Hospital, Melbourne*, for the years 1971-1974, (Melbourne: Ramsay Ware, Stockland), 73. This was typical of the meticulous reports from hospitals which now became routine. The Mercy had only two maternal deaths in 12,924 deliveries, and both due to non-obstetrical causes.

[48] George Biro, *Landmarks*, 12.

[49] George Biro, *Landmarks*, "20th Century, 1970-1979", 11.

[50] George Biro, *Landmarks*, 13.

[51] 'Right to Life Australia defends the right to life of all human beings from conception until natural death'. It is a political pressure group seeking legal protection of 'the most vulnerable in society'. It

In 1990, screening for diabetes in pregnancy became routine, and Simvastin for elevated cholesterol levels came on the market. In 1998, women outnumbered men entering medical school for the first time. The Tamoxifen controversy related to breast cancer treatment erupted, as this drug stimulated the lining of the womb, and produced fears of developing uterine cancer. Folic Acid supplements pre-pregnancy to lower the risk of Anencephaly were introduced, and Viagra for erectile dysfunction became available. In 1999, the court case regarding Pelvic Inflammatory Disease (PID) from the intrauterine 'Cu 7' device was rejected by the High Court, the costs of $30 million being a record.[52] This case had significant overtones as the whole issue of the use of Intrauterine devices was at risk. A multibillion dollar industry and the availability of one of the most useful family planning methods was in jeopardy.

Overviews of Progress at the End of the Century

These decadal lists above present the main advances as seen by this author. There have been previous reviews of advances in the discipline of obstetrics and gynaecology, however, and these suggest different lists. For example, Ian Cope reviewed progress from 1914-1994.[53] He listed 'the pill', HRT, the fall in maternal mortality to 1 in 1000 in 1952, and ante natal clinics in Sydney from 1912 as highlights. He also noted the trial of Progestogens at Crown Street from 1954, the Anovlar (pill) arrival in 1961, and the Filshie clip for sterilisation in 1970.[54] A Urogynaecology subspecialty was established from the late 1980s. He also listed: oncology from the late 1970s; colposcopy expertise pioneered by Malcolm Coppleson from the late 1950s; mammography from 1964 at RHW, Sydney; and endometrial ablation trials from the mid-1980s. He added all the literature on advances in surgery for cancer, and quoted the review in the *ANZ Journal of*

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campaigns against abortion, IVF, euthanasia, infanticide, and embryo stem cell research. https://righto life.com.au/index.php/about-us, (accessed 8 November, 2014).

[52] George Biro, *Landmarks*.

[53] Ian Cope, "Obstetrics and Gynaecology in Australia, 1914-1994", *MJA* 161, 4 July, 1994, 13-14.

[54] Marcus Filshie, from Nottingham, developed one of the most successful devices to occlude the Fallopian Tube using the laparoscope. He toured Australia in 1970 promoting the device under the auspices of Tutorial Systems International, an organisation developed by Rodney Ledward, again discussed in the Scandals chapter. See also G.M. Filshie, J.R. Pogmore, A.G.B. Dutton, E.M. Symmonds and A.B.L. Peake, "The Titanium/Silicone Rubber Clip for Female Sterilisation, *BJOG* 88, (1981), 655-662.

Obstetrics and Gynaecology[55]. He also believed cancer screening by ultrasound of the endometrium was important.

Carl Wood and Simon Gordon in 2001 reviewed progress in the discipline as well. [56] Their list included: family planning clinics; cancer screening; Rh immunisation, arising from research by A.W. Liley, 1961; amniotic fluid analysis, which began in New Zealand; sexual dysfunction clinics in Melbourne were opened; and foetal monitoring in labour (ECT) was begun from the mid-1960s, based on a Randomised Controlled Trial (RCT) at the Queen Victoria Hospital in Melbourne in 1969, which confirmed it was useful.[57] Using steroids to mature the foetal lung before preterm delivery was reported by Liggins from Auckland in 1972.[58]

The formation of the RACOG was completed in 1979 and the RANZCOG amalgamation in 1998: these were significant milestones in advancing the professional management of the knowledge explosion by sharing and creating a critical mass of memberships, following the example of the The Royal Australasian College of Surgeons. Ultrasound, epidural anaesthesia, and prostaglandins for surgical termination of pregnancy (S.T.O.P.) became established. [59] Hormonal Replacement Therapy (HRT) as a therapy of its own became prominent. Endoscopic surgery was increasing to avoid laparotomy, and endometriosis treatment was improved by conservative surgery via laparoscopy. Subspecialty training and certification from the late 1980s altered 'generalist' practice.[60]

What is considered important progress depends on the observer. There is a significant variation in the items quoted from the literature by these two respected obstetricians from the same era looking back at events of recent decades, mirroring

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[55] *ANZJOG* 30, (1990), 24-28.
[56] Carl Wood and Simon Gordon, "Obstetrics and Gynaecology", *MJA* 174, (1 January, 2001), 13; Professor Carl Wood was an IVF pioneer in Melbourne, working at Monash Medical School. For the story of his pioneering work in IVF, see Douglas Saunders, *The Fertility Society of Australia, A History*, 16-23.
[57] See the Professor Edward Hon story. Hon was an Australian graduate who worked in the USA, initially at Yale, later at UCLA, California, for most of his career, and pioneered the CTG for foetal heart monitoring during labour. See E.H. Hon and K.S. Koh, "Electromechanical Intervals of the Foetal Cardiac Cycle", *Clinics in Obstetrics and Gynaecology* 6 (2), (August, 1979), 215.
[58] Grant C. (Mont) Liggins, steroids in the prevention of respiratory distress in premature infants: see Liggins and Howie, "A Controlled Trial of Antepartum Glucocorticoids for the Prevention of Respiratory Distress Syndrome in Premature Infants", *Pediatrics*, (1972), 515.
[59] "The Efficacy and Tolerance of Mifepristone and Prostaglandin in First Trimester Termination of Pregnancy, the UK Multicentre Trial", *BJOG* 97, (1990), 480-486.
[60] The Council of the RACOG developed the subspecialties in the late 1980s, including oncology, urogynaecology, foetal maternal medicine, and reproductive medicine and Infertility. See the RACOG section in Education.

their own personal interests. This is the reason for including their listings separately in this chapter. They did not mention the early work of Bruce Mayes in reproductive endocrinology in the 1930s, nor the ground breaking research by Mayes and Rodney Shearman on Pitocin to induce labour and control post-partum haemorrhage in 1956.[61] Nor did they include important work by Shearman in endocrinology in the same field in the subsequent decades, a field in which he became a world authority.[62] Other notable omissions were simple clinical initiatives like identifying congenital dislocation of the hip at birth (the 'clicky hips') by the Barlow's test, the initiatives to detect abnormal babies antenatally like Trisomy 21, 13 and 18 by serum screening and ultrasound, and the simple test for phenylketonuria at birth (PKU), all now part of routine practice.[63] But importantly, they omitted references to progress in defeating the three major killers of mothers, emphasised in this thesis.

Other Australian Advances and Trends

Australians secured a place on the world stage in the fight against genital tract fistulas. The result of an obstructed labour in a young woman can be a permanent opening (fistula) between the adjacent bladder and the vaginal passage. This is rare in Australia, but because two Australian gynaecologists, Reginald and Catherine Hamlin went to Ethiopia in 1958 to set up a teaching unit at the Princess Tsehai Hospital this country had the opportunity to learn how to repair this condition.[64] Dr Robert Zacharin of Melbourne from 1967 travelled every year to Ethiopia to relieve the Hamlins, and became an expert fistula surgeon. Subsequently 'Bob' Zacharin passed

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[61] Bruce T. Mayes and Rodney Shearman, "Experience with Synthetic Oxytocin, Its Use for Induction of Labour and Control of the Third Stage of Labour, *JOGBE* 63, (1956), 812-817.

[62] *RPS Opus Meum, Jubilee Symposium for Professor Rodney Shearman*, 29 September, 1993, Sydney, published by the University of Sydney, included experts from around the world to pay homage to the life and career of Shearman, Sydney's most celebrated graduate in obstetrics and gynaecology in the second half of the 20th century. See also, *Recent Advances in Ovarian and Sythetic Steroids*, Symposium, Sydney, 17 October, 1964, ed. Rodney Shearman, (Sydney: University of Sydney, Globe Commercial, 1965). This 245 page document provided state of the art commentary by the world's leaders at the time including Gregory Pincus whose pill had just been released, 'Mont' Liggins from New Zealand, Lloyd Cox from Adelaide and other local experts including Rodney Shearman.

[63] Jan Dickinson, "Non Invasive Prenatal Testing, Editorial", *RANZJOG* 54, (2014), 397-399.

[64] The Hamlins ended up in Ethiopia by a circuitous route. Reg Hamlin was denied an expected appointment at Crown Street Hospital because of a conflict with Dr Dixon Hughes, worked in Britain and Adelaide before accepting the challenge of going to Ethiopia with his wife Catherine. See Catherine Hamlin, *The Hospital by the River*, 45-50.

on his expertise to a number of Australian Gynaecologists. Zacharin published extensively on the subject, and secured a place for Australia on the world stage.[65]

Another important area of progress was in gynaecological oncology. Papanicolau and Trout in 1943 began the revolution in the detection of malignancy in the genital tract by identifying abnormal cells in smears by cytology. The smear is still called the 'Pap Smear', perpetuating the name of Papanicolau.[66] The later development of the concept of pre-invasive disease in the literature was outlined by Campion.[67] Progress in the prevention of cervical cancer in the western world has been a hallmark of recent decades, with earlier detection, eradication of pre-invasive disease, better management of the established disease with surgery and adjunct radiation, better coordination of controlled trials, and progressive centralisation of most gynaecological malignancy to specialty centres run by subspecialists with greater expertise and equipment.[68] The fall in incidence of cervical cancer is striking, attributed to the impact of screening in detecting early and pre-invasive disease, falling smoking rates, and improved treatment. The progressive fall in mortality from cervical and uterine body cancer in Australia is well documented, falling on the age standardised scale from 26 deaths per year per 100,000 in 1920, to 5 per year per 100,000 in 2000. Importantly, the age standardised mortality rate of cervical cancer decreased from 5.2 to 1.8 deaths per 100,000 women between 1982 and 2011.[69]

Another trend in recent decades has been the increased prominence of experience from the USA and Asia. Most Australian postgraduates seeking more experience after the 1970s increasingly went to the USA, Asian or European centres rather than Britain, as funding and concentration of experience to specialist centres

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[65] Robert Zacharin (1925-2012) of the Alfred Hospital, Melbourne, *Obstetric Fistula*, (Wien, New York: Springer –Verlag, 1988); "A History of Obstetric Vesico Vaginal Fistula", *ANZJS* 70, (2000), 851-854. Other papers in the Australian literature include Caroline M. de Costa, "James Marion Sims, Some Speculations and a New Position", *MJA* 178, (16 June, 2003), 660-663. Also Alan Hewson, "Rectovaginal Fistulae, a Series of 42 Cases, Use of the Martius Graft", Invited lecture, FIGO plenary session, Kuala Lumpur, November, 2006.

[66] George Papanicolaou and Herbert Trout, *The Diagnosis of Uterine Cancer by the Vaginal Smear*, (New York: Commonwealth Fund, 1943).

[67] Michael Campion, "Preinvasive Disease", in *Practical Gynaecologic Oncology* (3rd edition), eds. Jonathan S. Berek and Neville F. Hacker, (Philadelphia: Lippincott Williams and Wilkins, 2000, 271-344).

[68] Neville Hacker, "Cervical Cancer", in *Practical Gynaecologic Oncology*, 345-450. In much of the recent literature on Oncology the prominence of the USA medical centres is obvious. However, an increasing amount has come from Asian centres with a large population base and a high incidence of some cancers plus some outstanding surgeons. http://canceraustralia.gov.au/affected-cancer/cancer-types/gynaecologic, (accessed 25 October, 2014).

[69] See ABS Data quoted elsewhere in this thesis.

appeared to evolve earlier and more easily in the American system in particular.[70] Chemotherapy, particularly for ovarian cancer, has made significant progress since the middle of the century. Before 1980, the treatment of ovarian cancer had been characterised by incoordination, complexity and a lack of knowledge of the pathology, spread, and of measures which may have an impact on the malignancy. A large scientific meeting in Britain in 1980 highlighted some still worrying statistics regarding ovarian cancer. [71] As it is a disease of advancing age the incidence has continued to rise with the ageing population, and with the incidence of death from cervix and body of the uterus cancers falling, the disease has become more important. Further, more than 50% of patients present with advanced disease. The development of specialist centres for gynaecological malignancy has made a difference, concentrating all the modalities of treatment, surgery, radiotherapy, and chemotherapy together; and regular discussion of results, with continuing discussions between centres to share knowledge have all helped. Surgery for advanced ovarian cancer now includes a massive 'debulking' operation by the specially trained gynaecologists (identified by possessing the Certificate of Gynaecological Oncology or CGO) aimed at removing every identifiable site of cancer, which often means resecting bowel and other adjacent organs, followed by treatment with much more active drugs discovered over the past three decades

Clinical practice guidelines for the management of women with epithelial ovarian cancer, Australian Cancer Network, was a sobering document. It showed that in 1999, 1173 women had been diagnosed with ovarian cancer, and 731 women died from the disease. Relative survival nationally was only 42% at five years, reinforcing the fact that ovarian cancer is the most common cause of death from gynaecological malignancy. This reinforced the conviction that all these patients should be treated by subspecialist oncologists. The Certificate in Gynaecological Oncology (CGO) qualification means that the subspecialist has done an additional 3

[70] *Practical Gynaecologic Oncology*, the 900 page text cited, is co-authored by Berek from UCLA in California with Hacker from Sydney; and in Coppleson's major text of over 1000 pages, 64 of the invited contributors out of 99 came from the USA or Canada and 23 from Australia, with the inclusion of one of the great gynaecological surgeons from Japan, Shoichi Sakamoto. Professor Hsui from Taiwan, a close collaborator with Coppleson was a notable omission, as he died just before this book was planned.

[71] *Controversies in Gynaecological Oncology, Scientific meeting of the RCOG*, 22 February 1980, eds. Jordan and Sanger, published by the RCOG, London, 1980, 115; confirming that cancer of the ovary caused the same number of deaths as cancer of the cervix (neck of the womb) and cancer of the body of the womb combined, causing 3700 deaths per year in England and Wales.

years of accredited surgical training, and passed a special examination on top of generalist training in gynaecology.[72] The new Gynaecological Cancer Centre established at John Hunter Hospital is a typical example of what can be achieved, having been established in 1991. In the first three years it treated 371 patients, as general gynaecologists increasingly referred their patients to the centre for specialised treatment. Now for the first time around Australia, patients with advanced disease can get as much as 5 years of good life, a dramatic improvement. The details of these advances are included in the *Clinical Practice Guidelines* already quoted. Another advance has been the development of Tumour Markers to assist in the detection of tumours and also their follow-up to guide treatment.[73]

One of the most important advances in treatment of gynaecological malignancies was the discovery in 1956, confirmed in 1958, of the effectiveness of Methotrexate in Chorionepithelioma, a malignancy which previously had a 100% mortality.[74] This malignancy was the most feared in gynaecology, and was usually fatal within weeks of diagnosis. Although rare in Australia, it is quite common in Asian countries, so that immigrants from Asian countries in Australia are at high risk. Addition of other drugs subsequently virtually guaranteed a cure.

One result of the Australian discipline taking seriously the difficult issue of Indigenous health has been an increasing number of obstetricians becoming involved in this aspect of obstetric care, including one from an Indigenous background, but many others have devoted years to Indigenous health.[75] The Director of the Department of Obstetrics in Darwin, Dr Margaret O'Brien, spent almost ten years in

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[72] See also J.M. Monaghan, "The Surgical Management of Complications of Ovarian Carcinoma", in *Complications in Surgical Management in Gynaecological Malignancy*, (Baillierre Tindal, 1989), 75. The introduction of the Platinum group of drugs, as well as Paclitaxel, originally sourced from the bark of a pine tree in California, has significantly improved the prognosis in ovarian cancer over the past 25 years

[73] The most useful tumour marker in ovarian cancer is Ca 125, an ovarian cancer antigen which is usually but not always elevated in ovarian cancer.It is not reliable enough to use as a screening test (see the quoted references).

[74] See M.C. Li and co workers, *Proceedings of the Society of Exploratory Biology 93,* New York, 1956, 361; and K.D. Bagshawe and co workers, reported in the *Lancet* 1, (1959), 653. The first article in the obstetric literature was by John K. Hamilton, *JOGBE* LX1X (1), (February, 1962), 58. See also Charles B. Hammond, *Obstetrics and Gynaecology Clinics of North America* 15 (3), (September, 1985); *Trophoblastic Disease*, (Philadelphia: WB Saunders).

[75] This culminated in the *RANZCOG Reconciliation Action Plan*, beginning in 2014, described on the RANZCOG website but preceded by many initiatives aimed at improving the health of Aboriginal, Torres Strait, and Maori women after the establishment of the Indigenous Women's Health Committee of the RANZCOG in 2009. See the RANZCOG website. Currently there is one Indigenous Fellow of the College (Marilyn Clark) and three Indigenous trainees, as well as the previous history of elevation of Aboriginal Midwife sister Alison Bush to Honorary Fellowship in 1999.

the outreach programme to remote communities in the Northern Territory, and has enormous experience in working in and with disadvantaged Indigenous communities in North Queensland with Aboriginal spokesman Noel Pearson.[76] A recent Indigenous Health initiative being run by the College has received wide publicity and Government support.[77] The College has for many years provided antenatal skills courses for aboriginal health workers, beginning in the Kimberleys in 1991, a course first run by Dr Michael O'Connor.[78]

A significant milestone in Australian obstetrical and gynaecological history was the staging of the first World Congress in Australia (FIGO) in September 1967, as discussed earlier.[79] Another event of importance was the combined Asian/Australian Congress in Melbourne in 1981, after the formation of the RACOG, which also attracted a large attendance.[80] Annual Congresses and Scientific updates became a hallmark of Australian obstetric practice from then onwards.

Gynaecological surgery advances should be added to the above lists. The vaginal hysterectomy techniques brought back from Oxford in particular in the late 1950s and 1960s by Australians who worked there, and the results of the meticulous

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[76] See, Russell Gruen and Ross Bailie, "Evaluation of the Specialist Outreach Service in the Top End of the Northern Territory", Menzies School of Health Research, *Obstetrics and Gynaecology*, (February, 2000), 113.
See also, Catherine Jones, Xiaohua Zhang, Karen Dempsey, Naomi Schwartz and Steve Guthridge, *The Health and Wellbeing of Northern Territory Women, from the Desert to the Sea, 2005*, Health planning Branch, Department of Health and Community services, Darwin, November 2005, "Fertility, Pregnancy and Birth", 67-79.
See also articles by Margaret O'Brien, "Indigenous Health Issues, *O and G Magazine*, RANZCOG, and by Liz McKenna, re "Cultural Differences", *O and G Magazine* 2 (4), (December, 2000), 236.
[77] *RANZCOG Reconciliation Action Plan 2013-2015*, RANZCOG, Melbourne, 2014.
[78] *RACOG 15th Annual report of Council*, presented by Dr Fred Hinde, 1993, 7.
[79] Carl Wood and William Walters (eds.), *Fifth World Congress of Gynaecology and Obstetrics*, Sydney Australia, (Sydney: Butterworths, September, 1967). This 900 page volume encapsulated world thought at the time. William Refshauge, Director General of Health for Australia but trained as an obstetrician, had opening comments still worth reading in 2014. He noted that 4 of the 10 DGMS in wartime had been obstetricians, and also postulated that the development of antenatal care by the discipline had been the driver of preventive medicine in the mind of the public, 27.
[80] *The 8th Asian and Oceanic Congress of Obstetrics and Gynaecology*, with the *First Congress of the RACOG*, 25 October, 1981, Melbourne, Australia, Programme.This meeting confirmed the new direction of the Australian college, with the Programme Committees drawn from most Asian countries as well as Australia, diseases in pregnancy, poverty and environmental hazards. See also, *Seminar Proceedings, Primary Health Care, Averting Maternal and Infant Deaths*, ed. William A Walters, *8th Asian and Oceania Congress*, Melbourne, 1981. This seminar involved the leading obstetric consultants from India, Malaysia, Indonesia, Japan, China and Singapore as well as Australia.

techniques they learned were reported in the literature in later years.[81] Australians have made major contributions to the scientific literature in this field.[82]

These teachers greatly influenced the steadily rising incidence of the much safer vaginal hysterectomy as compared to the abdominal approach over the decades from 1960 to 1980, again a field in which Australian surgeons were world leaders.[83] The new Sacrospinous Colpopexy, developed by Professor David Nichols at Providence Rhode Island, altered Australian practice after a visit from him in 1990.[84] The Burch type Colpospension procedure was introduced to Australia by Stuart Stanton from the United Kingdom in the 1970s, and dominated stress incontinence surgery for two decades.[85] The technique was developed by the late John Burch (1900-1977) in the USA.[86] The author of this thesis' contributions to the Australian gynaecological literature on some of these subjects are cited as typical examples of the discipline quickly adopting new techniques.

Advanced laparoscopy techniques were introduced from the mid-1970s, and more slowly absorbable sutures altered surgery for the better. The inauguration of the

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[81] William Hawksworth and Jaques Roux, "Vaginal Hysterectomy, Report on 1000 Cases (The Oxford Series)", *JOGBE* LXV, (2 April, 1958), 214-229. This series confirmed the high safety level of this procedure with trained staff, with only one postoperative death, in a patient with no obvious cause of death at post mortem. This caused a major swing away from the previously accepted Manchester repair for prolapse.

[82] A. Watson, "Vaginal Hysterectomy", *MJA*, RPAH, Sydney, 1948 was a pioneer, in Sydney. See also Victor Bonney (1872-1953), the 'father of gynaecological surgery in Britain', who was the role model of generations of Australian gynaecological surgeons. See Geoffrey Chamberlain, *Victor Bonney, The Gynaecological Surgeon of the Twentieth Century*, (Lancashire: Parthenon Publishing, 2000), and his most famous text, *Bonney's Gynaecological Surgery*, (London: Baillierre Tyndall), first published in 1911, and later edited by his trainees Howkins and Stallworthy. His methodology and teaching were continued by Sir John Stallworthy, already mentioned, who was trained by him at the Chelsea hospital. Bonney's portable operating table resides in the RANZCOG Museum, Melbourne. His meticulous, bloodless, operating techniques were continued by Coppleson and Solomon, at RPAH Sydney; Correy, Hobart; Ball, Adelaide; Hewson, Newcastle; Wilson, Page, Brisbane; Chung, Hong Kong; and by the people they taught over the second half of the 20th century. See also comments on the Area Department of Obstetrics and Gynaecology, United Oxford Hospitals, regarding the high frequency of vaginal hysterectomy compared to abdominal approach (295 vs 254) noted in *JOGBE* LXVII (5), (October 1960), 861. See also Otton, Mandaparti, Streatfield and Hewson, "Transfusion Rates Associated with Hysterectomy for Benign Disease", *ANZJOG* 41 (4), (2001), 439-442, confirming the lowest rates ever recorded in the literature.

[83] Alan D. Hewson, "Overview of 2000 Vaginal Hysterectomies", Invited lecture at the Chinese University of Hong Kong, 28 March, 1995.

[84] Alan D. Hewson, "Trans Vaginal Sacrospinous Colpopexy for Post Hysterectomy Vault Prolapse", *ANZJOG* 38 (3), (1998),318-324

[85] Stress incontinence occurs when there is an involuntary loss of urine from the bladder during coughing or lifting, and is usually caused by the loss of support of the neck of the bladder. Operations are designed to provide additional support for the neck of the bladder.

[86] Denise Ladwig, L. Milkovic and Alan Hewson, "A Simplified Colposuspension, 350 Cases, 15 Year Follow Up", *ANZJOG* 44, (2004), 39-45.

Australian Gynaecological Endoscopy Society (AGES) enabled new techniques to be acquired rapidly, and that society acquired a large membership, invited many international experts, and set up scholarships for trainees in collaboration with the RANZCOG.[87]

Perioperative antibiotics for most major surgery became routine after the 1970s, as it had been demonstrated that this did lower the incidence of infection in gynaecological surgery. The steadily rising incidence of Caesarean section, from 2-3% in the 1950s, to over 30% in the year 2010, dramatically altered practice and is discussed elsewhere in the thesis. The introduction of 'minimal access' pelvic floor repair techniques dominated gynaecological discussions in the early 1990s, and much of the controversial work was done in Australia.[88] Colposcopy is a special case, as Australian registrars working in Oxford from 1956 onward learnt colposcopy.[89] Dr Malcolm Coppleson, based at the Royal Prince Alfred Hospital in Sydney, became a world authority, and later published the most comprehensive text on Gynaecological cancer in the world.[90] The Australian contributions on the management of Toxaemia and prevention of Eclampsia led the world for many years, as discussed earlier. Lloyd Cox from New Zealand led the change to more liberal use of Caesarean section in breech presentation to improve survival in the 1970s.[91] Australian prominence in IVF has been mentioned, and currently the Australian IVF success rates are equal to

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[87] The Australasian Gynaecological Endoscopy and Surgery Society was formed in 1990, includes over 600 active members, and promotes the safest and highest standards of clinical and minimally invasive surgical care for women through education, surgical training and research. See http://www.ages.com.au/, (accessed 10 November, 2014).

[88] Peter Petros and U. Ulmsten, *Acta. Obs.Gyn.*, (Scandinavia, 1990). Peter Petros, "The Integration Theory, Minimal Access Approach", *ANZJOG* 36 (4), (1996), 453. The supporters of these operative techniques claimed that properly placed tape supports could yield better results from prolapse surgery, and that most could be done with minimal discomfort to the patient.

[89] In colposcopy, the neck of the womb, the cervix, is visualised by a microscope with a strong light after staining the surface cells. Abnormalities are obvious and can be biopsied and studied by the pathologist. It is particularly useful in a patient who has an abnormal Pap Smear test. The procedure is painless and can be done in the clinic or consulting room.

[90] *Gynaecologic Oncology, Fundamental principles and clinical practice*, ed. Malcolm Coppleson, (London: Churchill Livingstone, 1981). In two volumes, numbering over 1000 pages, with contributions selected from the best authorities in the world, this text is one of many confirming the coming of age of Australian authors. See also Robert Zacharin's text on *Fistulas*, Neville Hackers and Jonathon Berek's text on *Practical Gynaecologic Oncology*, and Barry Wren's publications on the menopause. These volumes would never have been written if Australian gynaecologists had remained under the shadow of their British forebears.

[91] Lloyd Cox originally highlighted this issue in 1950; See Lloyd Woodrow Cox, "Breech Delivery, the Foetal Risk", *BJOG* 57, (1950), 197-209.

the best in the world.[92] The leading role of Australia in championing the importance of obligatory continuing education is documented in the literature.[93]

Outreach to Asia and Oceania began during the term of the RCOG Regional Council in Australia, following the visit of Stanley Devenish Meares to Kuala Lumpur in Malaysia and Jakarta in 1967. Subsequently the RCOG Regional Committee persuaded the Australian Government to bring gynaecologists from Asia to the FIGO congress in Sydney in 1967. Subsequent visits and contacts expanded to include Papua New Guinea and all the countries in Asia and Oceania. The progressive growth in this involvement over the next 15 years is outlined in *Super Ardua, the RCOG in Australia.*[94] Scores of consultants and registrars from the RCOG were involved over the years, donating their time and expertise, taking up both routine equipment and sophisticated materials to allow the local gynaecologists to upgrade their skills and knowledge. Many Australians accepted appointments in Asia for months or years, and Australians occupied many of the teaching posts from the mid-1960s onwards. The Aid contributed by College members over those years has been conservatively valued at over $200,000 according to *Super Ardua*, and the Australian Government contributed $60,000. Qantas Airways transported aid packages free of charge. Some hospitals adopted particular centres or regions and the Newcastle Obstetrical and Gynaecological Society formed a special relationship with Sam Ratulangi Medical School at Manado in North Sulawesi, sending three teams in 1978, 1979, and 1981, and provided reports to the RACOG.[95] This led to Dr Janet Barten, a Nun and medical missionary from the Netherlands working in Manado, being made a Fellow of the RACOG in 1984, the first Indonesian and the first Nun to be so

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[92] Douglas M. Saunders, *Fertility Society of Australia, A History, 2013, Its Precipitate Birth and the Story of IVF*, covers IVF in Australia, including interviews with most of those involved in the field since 1970. The legal and ethical aspects and control of IVF in Australia are now world's best practice.
[93] *The Certification and Recertification of Doctors* by Newble, Jolly and Wakeford is a classic in the world of medical education, and the 'world first' work of the Australian Obstetric College in CME are still regularly quoted in the international literature as well. See also, Alan Hewson, "Does Continuing Medical Education Lead to Improved Performance?", *New Insights in Gynaecology and Obstetrics*, eds. B. Otteson and A. Taber, *Proceedings of the XV FIGO World Congress*, Copenhagen, August, 1997, 274-279, and other papers mentioned previously.
[94] McDonald, Cope and Forster, *Super Ardua*, 67-77.
[95] Alan Hewson and Jack Elliott, "Reports to RACOG Council on the Newcastle Groups from NOGS to North Sulawesi, 1978, 1979, 1981", private files of author (also archived at RANZCOG, Melbourne).

honoured.[96] The close relationship with all the Asian and Oceania countries has expanded with the new Australian College, with a special committee of Council being responsible for this work. Glen Mola, an Australian graduate, now Professor in Papua New Guinea, works closely with Council, and College members still teach, work with, and examine candidates for the specialist qualification in PNG.[97]

In the last decade Australia has retained prominence internationally, with the development of Gardasil, the vaccine to provide immunity to most strains of the Wart virus, HPV, by Ian Frazer from 1991. This is expected to be the greatest boon ever to women's health worldwide because of its proven effectiveness in dramatically reducing the incidence of cervical cancer.[98] Its early adoption in Australia led the world, and Australia's implementation for its use in young males in 2012 was a world first. The development of magnesium sulphate infusions in premature labour to protect neural function, the availability of non-invasive maternal blood screening for foetal abnormalities, and the use of probiotics antenatally, and in premature infants are important advances in the last decade.

Finally, the major dilemma of the difficulty in training obstetricians in manipulative skills, leading to an ever-increasing use of Caesarean section, has been mentioned, but another issue now confronts the profession. While the old killers, infection, haemorrhage and the Toxaemias - have almost been eliminated, maternal deaths are now increasingly due to indirect non obstetric causes. The last ABS Data for 2006-2010 confirms that suicide, drug related deaths and trauma, due to both domestic violence and accidents, are now the major contributors to mothers dying.[99] Over that time frame, indirect deaths were 57 and direct only 39, with women over

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[96] RACOG Council determination, 1984, private files of author. See also Alan Hewson, "Jeanette Barten (1923-2010), Obituary", *O and G Magazine* 13 (1), (Autumn, 2011), 73.

[97] Alan Hewson, personal files and lectures given at the PNG medical school in 2008, 2010, 2011, 2012; also Formal reports provided to the RANZCOG and to AUSAID for each visit, unpublished. In previous years Drs Paul Devenish Meares, Don Aitkin, Peter Vines, Miriam O'Connor, Hugh Philpott, Cindy Farquhar, Aldo Vacca, Brian Peet, Peter Mourik, Tom Tait and Maxwell Brinsmead taught and worked in PNG. The funding for these visits varies; some are assisted by the AUSAID programme of the Australian Government, many obstetricians pay their own fares, and all donate their time, most bring materials as a gift to the various Departments and hospitals they visit.

[98] Francis Tapin and Kym Aguis, Australian Immunologist Ian Frazer given international Award for developing the worlds first Cervical Cancer Vaccine. ABC News, http://www.absnet.au/news 2015-06-ian fraz, (accessed 12 March, 2016).

[99] "Maternal Deaths in Australia, 2006-2010", *UNSW National Perinatal Epidemiology and Statistics Unit*, https://npesu.unsw.edu.au/surveillance/maternal-deahs-australi-2006-2010, (accessed 12 January, 2016).

40, with higher parity, and Aboriginal ethnicity prominent. These are issues which the whole community must address.

CONCLUSION

This overview covers the major new initiatives in the discipline since 1950, and confirms that this country has always been an early adopter of best obstetric practice from overseas. Although some 'brain drain' of talent to overseas has occurred, it has been relatively limited because conditions of practice and remuneration have remained competitive with most overseas countries since World War Two. Most Australian graduates spending some time overseas to further their career have returned to Australia, as is evident from the above narrative, and Australia has benefitted from talented immigration over this timeframe as well. In spite of Australia's relatively small population it has a creditable record in scientific and clinical achievement in the discipline over the past 60 years. As explored elsewhere in this thesis, the issues faced by the discipline over that timeframe have not been related to any lack of achievement as a significant part of the world of medicine. Most of the dilemmas, difficulties and challenges have been sourced external to the profession, and these are addressed in other parts of the thesis.

Following the dramatic increase in the world communications network in recent decades, any new advance in knowledge is rapidly taken up, and the expansion of international travel, together with the availability of electronic hook-ups and videoconferencing, means that an advanced country like Australia can virtually immediately access new knowledge. One important characteristic of this country has been crucial. Its relatively stable governmental and medical care networks, in spite of the medicopolitical confrontations described in this thesis, has made it easier to introduce organisational medical changes to embrace new advances for the benefit of the community. For this reason it is appropriate to add to the above list other advances sourced overseas which rapidly became part of Australian obstetric and gynaecological practice which benefitted patients, listed in the appendices for this chapter.

CONCLUSION
THE ANGELS REJOICE

> *The outlook for the profession has never been brighter; the physician is better trained and better equipped than he was 25 years ago. Disease is understood more thoroughly, studied more carefully, and treated more skilfully. The average sum of human suffering has been reduced in a way to make the angels rejoice*
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> ***William Osler, 'Aequinamitas, Chauvinism in Medicine', Address to the Canadian Medical Association, Montreal, 1902***

In the relative absence of other comprehensive historical accounts, this thesis provides an original analysis of the development of the medical discipline of obstetrics and gynaecology in Australia during the second half of the twentieth century, so far a neglected subject for Australian historians. The thesis began with the knowledge that the dramatic improvement in the care of women in Australian society over the period was self-evident, demonstrated by a remarkable improvement in safety for mothers and their babies, and in many other aspects of the health care of women.[1] Knowledge of the information explosion after World War Two and its effect on obstetric practice was the substrate on which the story of progress is based. The author's intimate involvement in many of the events over sixty years of practice provides a keen insight through insider knowledge into advances and changes in the specialty, many of which were believed impossible earlier in the twentieth century.

Osler's statement of 1902 during a lecture provides a late Victorian view of progress over the previous century. As one of the most prominent medical minds of his generation, his view was representative of the time, and one wonders what he would say if he could see the subsequent events of the twentieth century. That century brought antibiotics, steroids, open heart surgery, dramatically effective chemotherapy for cancer, cloning, the conquest of many of the infectious diseases of childhood, and

[1] Australia began analysing maternal mortality in the triennium 1964-1966. See Stephanie Johnson and Elizabeth Sullivan, "Reporting Maternal Deaths in Australia", *O and G Magazine* 15 (1), (Autumn, 2013), 15-16. See also "Maternal Deaths in Australia, 2006-2010", *UNSW National Perinatal Epidemiology Statistics Unit*, https://npesu.unsw.edu.au/surveillance/maternal-deaths-australkia-2006-2010, (accessed 12 January, 2016).

the introduction of many treatments once believed impossible.[2] The virtual elimination of death in childbirth in the developed western world is another prime example, coupled with dramatic improvements in infant survival.

This thesis has nevertheless striven to avoid the mirage of unbridled optimism or a glow of self-satisfaction regarding the events of the last sixty years. In spite of the reality of Le Fanu's overview of the spectacular rise of modern medicine, even though tempered by a fall in the last twenty years, this thesis argues that, contrary to popular belief, changes in practice in the discipline have provided salutary lessons regarding alleged progress in certain fields, and have highlighted many areas in which major errors were made, so that progress has been in the form of a zigzag trajectory, albeit with an overall steady rise.

The significant achievement of Australian obstetricians to introduce the world's first obligatory continuing education programme, and their contribution to advances in knowledge and practice, has unfortunately been obscured by a succession of negative and sometimes sensational events which have produced disappointment in the 'body politic' of the profession and the community. The overall narrative documents significant progress in the care of women, only some of which can be claimed to be due to the specialty itself. Much stems from overall progress in the whole field of medicine and public health more generally, with positive spinoffs to obstetrics and gynaecology. However, many unfortunate events and sequels become clear, once the events of the last sixty years are subject to rigorous examination, and many are more obvious when events are assessed by an informed observer inside the discipline itself.

WE HAVE MET THE ENEMY AND HE IS US

Self-satisfaction and dismissal of criticism has often been the hallmark of medical practitioners over previous decades, and the second half of the twentieth century has exposed fallacies and failings which in the past may have been hidden from view. This study has endeavoured to follow Oliver Cromwell's popular misquotation to his portrait painter Levy in 1650 to 'paint me, warts and all'.[3] The

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[2] Le Fanu, *The Rise and Fall*, xv.
[3] Elizabeth Knowles, ed., *The Oxford Dictionary of Quotations* (5th edition), (Oxford, UK: Oxford University Press, 1999), 522.

actual statement was ‘pimples, warts, and everything as you see me’. So often in the past those documenting medical events have ignored Cassius’ statement in Julius Caesar: ‘the fault, dear Brutus, is not in the stars, But in ourselves…’.[4] More recently, the iconic Walt Kelly character Pogo Possum’s dictum may well be appropriate ‘We have met the enemy and he is us’.[5] In many instances, major errors in the care of women have occurred, particularly when we review the history of the neglect of women’s health and well-being prior to 1950. Here the advantages of the best instrument in medicine, the Retrospectoscope, has been utilised to attempt an honest assessment of the events of the past sixty years. The thesis opens the way to many areas which warrant further investigation, as so many areas, by necessity, have had to be covered in broad brush fashion because of space constraints. Major areas discussed begin with the significant changes in the education of obstetricians over the past sixty years. In the main chapters of the thesis, consideration is given to a wide range of issues which interact with one another.

Chapter One presented an account of the education of obstetricians which has changed markedly over the past sixty years, moving from that which was profoundly influenced by the British speciality to one firmly under Australian direction. The chapter shows that little had changed over the previous decades in Australian medical education since Anderson Stuart came from Edinburgh in 1882 to set up the School of Medicine at the University of Sydney, at the same time as similar moves began in Melbourne and Adelaide. The fortuitous choice of the Edinburgh model of medical education in Sydney had benefits for Australian education, and the reasons for this are explored, in particular the emphasis on training in obstetrics, a unique feature of the Edinburgh school. Education for many decades was aimed at training all doctors for general practice, and this continued until 1950. The pattern of generalists having general practice work and then gradually moving to the specialty of obstetrics prior to World War Two, had benefits which are documented. Also the happy coincidence of vastly experienced teachers who had come through the horrors of the First and

[4] William Shakespeare, *Julius Caesar, Complete Oxford Shakespeare, Volume 111*, (Oxford, UK: Oxford University Press, 1987), Act 1, Scene 11, lines 140-141.
[5] Walt Kelly (1913-1973), comic strip creator, “Pogo Possum”. See Max Riffner, “Quality Control, an Analysis of Pogo and Walt Kelly”, 1971 Earth Day Poster. http://maxriffner.com/business/quality-control-an-analysis-ofpogo-and-, (accessed 6 February, 2016).

Second World Wars was of enormous benefit to those beginning medicine after the Second War.

The explosion of knowledge after World War Two led to that next generation of doctors changing the face of medical education, with the development of specialisation, and the new 'scientist clinician' was born. Criticisms began to emerge of an alleged loss of the homely communication skills of the old family doctor, a major contributing factor to this being the new pattern of the young specialist going straight into specialty training in the hospital setting, completely divorced from the world of practice in family medicine, particularly home visiting. Obstetric training was a special case study. The programme of specialist training for obstetricians was unique in the Australian specialty scene. Aspirants had to travel to Britain to train and be examined in the British pattern, as there was no Australian obstetric college to provide an acceptable qualification. This was viewed as an advantage at the time but proved to be a significant negative in the long term. They all came back in many senses 'Anglicised' and to some extent reactionary in outlook, ill-equipped to respond to the dramatic social and cultural changes which would occur in Australian society in the 1960s and 1970s. There were a range of other negative professional *sequelae* as well. These obstetricians were locked into the British way of doing things, reading almost exclusively British literature, and their continuing mentors and contacts were in Britain. At the same time the United Kingdom was steadily losing its pre-eminence in the world of medicine and most other areas of importance. It was rapidly falling behind the USA from the 1950s onward, as argued in Andrew Roberts' *History of the English Speaking Peoples since 1900*. Discussing the twentieth century, he opines:

> Few could have expected it at the time, but the British Empire would wane to extinction during that period (the next century) while the American Republic would wax to such hegemony that it would become the sole global superpower.[6]

This era of painful readjustment led to major change. As a response to these global and professional challenges, major efforts to develop an Australian College began in the 1970s. The gradual change in mindset of Australia's obstetricians was

[6] Andrew Roberts, *A History of the English Speaking Peoples since 1900,* (London: Weidenfield and Nicholson, 2006), Introduction, 1.

traumatic, but necessary. The drive to begin an Australian autonomous college became even more necessary through increasing links with Asia, the high costs of moving families to Britain for up to three years on low wages, the upsurge in Australian nationalism, a belated wish to 'decolonise', and recognition that the rest of the world's medical literature and advances, especially that of the USA, had been neglected for far too long. It was serendipitous that the importance of continuing education was becoming a major issue in medicine in the western world at that time, and one thing the new College did well was to use the opportunity to make this an obligatory component of the new College philosophy. Thus, almost by accident, it catapulted the new College onto the world stage at a vital time of its existence, and made it the 'bellwether' college in Australia. All other Australian specialist colleges over subsequent years followed the pattern of the Australian College of Obstetrics and Gynaecology, as did other professional organisations around the world.

Chapter Two addressed important societal and cultural changes. These changes in Australian society over the decades studied had major effects on the discipline. The knowledge explosion in medicine, rapidly increasing education in the community, changes in attitudes to religion, social class delineation and ethnic issues were part of the kaleidoscope of changes. The so-named sexual revolution, the impact of the contraceptive pill, the liberation of women, the abortion and sterilisation debates, rising incidence of sexually transmitted diseases, the gay rights issue, and the explosion in litigation all had profound effects on the discipline. The role of Government and the bureaucracy progressively increased, and those influences which had the most marked impact on obstetrics and gynaecology are discussed. Australian obstetricians and gynaecologists found themselves in a new era, characterised by changing social mores, new evidence-based approaches to practice, and increasing surveillance from governments.

Chapter Three moved to Role Delineation, which became one of the most controversial issues facing the discipline during the late 20th Century, but the differing views are rooted in antiquity. Female midwives had been the traditional carers for pregnant women for centuries and it was not until the 18th century that males became involved, a development which was strongly opposed by not only the female midwives but also by most of the male medical profession. The motivation for change and the other factors in play through that period are detailed. The prominence of

Scotland and the Edinburgh school of medicine in those changes had significance for the fledgling Australian nation over later decades. Increasing intervention in birthing and the movement to hospital delivery with growing involvement of other health professionals in team-based care were hallmarks of the second half of the 20th century, leading to increasing controversy over role delineation.

The modern home birth controversy was discussed in this chapter because it overlapped with the above. The change to hospital birth had attracted some criticism, which increased as intervention rates rose from the 1960s onwards. This was understandable, but surveys carried out in different western countries confirmed that the move to hospital birth was supported by most women, even though the loss of the reassuring milieu of the home remained an issue. In Britain, which moved more slowly to hospital birth, research confirmed that those who still wanted to have home births in spite of possible risks were swayed by social issues like not wanting to leave other children unattended. Most GPs doing obstetrics in Britain opposed hospital births, as it meant they lost considerable income under the NHS system. In Australia, the tyranny of distance and problematic communication, with homes in some cases at a long distance from hospitals making the management of emergencies difficult, dominated the medical debate, and that generation of obstetricians, having worked on the Flying Squads in Britain and seen disasters in some home births, had strong experience-based views. A number of well based statistical studies in the late 1980s and early 1990s confirmed the extra risks of home births in Australia, which convinced all but those ideologically opposed to the institutional environment.

The new Royal Australian College of Obstetricians spent a considerable time negotiating with the Australian College of Midwives (ACM) on this issue, and reasonable compromises were ultimately reached after widely representative National Conferences. The personal involvement of the author in these discussions provides unpublished primary source material for posterity. The debate was often obscured by including midwife supervised births in the hospital setting with the completely different scenario of home births. The continuing protagonists of uncontrolled home birth became increasingly isolated, and a series of bad outcomes from home births ending up in Court with significant damages and often deregistration, made that position very difficult to sustain. Not being able to obtain adequate insurance cover was also a problem, and at the time of writing, legislation mandating strict guidelines

for home birth as well as making unqualified home birth practitioners illegal under the new Australian Health Practitioners Act (AHPRA) in at least one State, is now a major deterrent, as it is likely to become a national trend. Importantly, out of approximately 300,000 births each year in Australia, usually less than 2000 are home births indicating little support by the community.

The medicopolitical environment of the period is important for contextualising the changes in the speciality, and was discussed in Chapter Four. The stable environment of practice up to 1975 was a backdrop to the more challenging years from 1975. The profession became deeply involved in what became known as the 'Medicare Dispute', characterised in the mind of the public as *The Brutal Game* according to one publication at the time.[7] The public did not understand why this issue was so important to obstetricians, who saw their almost complete financial dependence on the public hospital system, particularly in NSW, as being used against them, so that their time honoured insistence on making the final decisions about care of their patients was under threat. Much more should have been done to explain the dilemma of obstetricians who, very much against their wishes, were dragged into the major confrontation, especially with the New South Wales Wran Labor Government in NSW, who passed legislation to put a seven year ban on resigning doctors. The public patients were caught in the middle, and the reputations of clinicians were damaged. This chapter attempts to clarify some of the issues which still produce arguments, drawing on prime sources and confidential documents preserved from that time.

Chapter Five covered both increases in litigation in an increasingly questioning and better informed society and the effects of scandals. In terms of increasing litigation, it describes the change from the 'benign necessity' of medicolegal protection, to litigation as 'malignant destroyer' of the discipline. Obstetricians held that the reasons for the change included such factors as: an environment which fostered the challenging of many of the assumptions of the past; greatly improved community educational standards; and, in the case of obstetrics, the scandals which damaged confidence in the decisions being made by the previously trusted profession. Changes to the law itself, allowing lawyers to act under the 'no

[7] Stuart J. Rees and Leonie Gibbons, *A Brutal Game, Patients and the Doctors Dispute*, (Sydney: Angus and Robertson, 1986).

win no charge' principle common in the USA, and the unsolved issue of the brain damaged child, aggravated the problem. This issue dominated obstetric practice and discussion during the decades 1980 to 2000, and began to threaten the very survival of the specialty. The background to many of the events of those years is provided by primary sources and documents from the author's own files. Unfortunately the dramatic intervention of Government to preserve obstetric and general medical practice in 2001, carried with it a marked increase in bureaucracy and intervention in the medical market place, which has steadily increased and become a problem in itself. The fact that obstetricians were paying the highest insurance premiums and had to charge much higher fees at the time also understandably worried patients.

This chapter on the increasingly litigious medical climate included a discussion of medical scandals involving the discipline. These scandals have been extremely detrimental for the reputation of both the discipline and for individuals in the discipline. Chapter Five thus includes scandals involving obstetric hospitals falling below accepted standards of care, those involving individual departments of hospitals, individuals, gynaecological malpractice, drug manufacturers and gynaecologists, and also those involving gynaecologists overseas which impacted on Australia. Class actions involving the IUCD, laparoscopic injuries, and more recently the use of mesh in prolapse, as well as the high profile cases involving brain damaged children at birth, have produced patient and community concerns regarding the trustworthiness, judgement and integrity of obstetricians. The fact that obstetricians are obliged to undergo continuing education has not prevented these events, and a voracious media has feasted on these worrying episodes.

Chapter Six provided a significant case study of obstetrics and gynaecology in the Hunter Valley of NSW, a major region with a long European history. It outlined the national changes as they played out in a well demarcated and important region in which the author worked, having an intimate involvement over the sixty year period. That involvement included working as a specialist obstetrician in both the public and private sector, as well as in administration, planning, undergraduate and postgraduate education, the establishment of a ground breaking new medical school, the regional specialist organisation of obstetricians, and midwifery. Access to primary source material informed the narrative, and personal interaction with key persons in the region over those years provided clarification on many issues.

The chapter covered the development of services for women over the 200 years since the Hunter region was colonised by Europeans, but space considerations precluded a discussion on birthing among the traditional Aboriginal people. The way in which the obstetric care of the early settlers was influenced by their original homelands of the United Kingdom, and the 'carryover' of so many institutions of the industrial revolution, with community initiatives, led to the development of unique obstetric and general medical services, including the Miners Lodge payment arrangements for local doctors, which persisted until after World War Two.

The tragic story of neglect of the women in colonial Australia and pregnant women in particular up to and during the Great Depression is documented, as well as the revolution in care after World War Two. The post war development of the Royal Newcastle Hospital was detailed as it had a direct impact on the quiet revolution of the next sixty years. National changes were mirrored in the changes in the Hunter region, but there were significant differences related to its topography and coincidental industrial history. The influence of the region on the national changes is included.

The analysis concluded in Chapter Seven, which documented advances in the care of patients**.** It would be a mistake to overlook the enormous improvements in the care and treatment of women which has occurred over the historical period. This chapter provides an overview of documented advances in obstetrics and gynaecology in Australia over the last sixty years that have made 'the angels rejoice'. Although the list is not exhaustive, it is included to provide a sense of balance and to give credit where credit is due. The list highlights those advances in which Australian and New Zealand initiatives have been recognised on the world stage, and those changes in which the Antipodean 'scientist clinicians' of the new generation have embraced change and become prominent in further improving new technology and practice from overseas. This list is provided in a timeline sequence to facilitate understanding of some of the more technical aspects mentioned in the thesis. While major progress has occurred in the discipline over the past 60 years, it still faces difficult challenges. Obstetric practice continues to change, and a brief outline of current issues is included in this final chapter.

THE CHALLENGES FACING THE PROFESSION

It is usual at the tri-annual international meetings organised by FIGO to invite leading members of the obstetric profession to provide forecasts of the future of the discipline. These have proven to be often wildly inaccurate, and a source of amusement in later years.[8] However, prediction of the challenges facing the discipline are usually more accurate. In Australia in the present decade major issues include the rapid feminisation of the obstetric workforce, with now 65% of trainees female, requiring continuing and progressive accommodation of the programmes to ensure adequate training can still occur while allowing them to have time out if necessary for family responsibilities.[9] Practical training in operative techniques is under threat because of larger numbers of trainees and diminishing numbers of suitable patients available: diminishing numbers of many operative procedures adds to the difficulties. The number of skilled obstetric manipulators able to teach their skills is steadily falling, aggravated by the massive increase in caesarean sections with the resultant loss of opportunity to teach the skills of previous generations. The provision of training in laparoscopic techniques is increasingly difficult, and the time honoured pathway of working overseas is now difficult because of immigration restrictions in many countries, plus the increasing costs.[10] However, there are now new issues facing the discipline. This thesis has described the dramatic successes in almost eliminating the old major killers, of infection, haemorrhage and the toxaemias, but the most recent data from the ABS confirms that now major causes of death in childbirth are the 'non-obstetric ones'. Apart from cardiovascular disease, suicide, drug deaths and traumatic deaths including domestic violence now head the list, particularly if the post partum period is extended to 12 months.[11] These threats to pregnant women demand community action, and trained obstetricians may only have

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[8] Eng-Soon Teoh and S. Shan Ratnam, *The Future of Gynaecology and Obstetrics, A Preview of the 21st Century, Towards Safe Motherhood*, (Camforth, UK: Parthenon Publishing Group, 1991), 1-16. There is no mention of most of the new issues detailed in the latter part of this thesis. The contributors to that volume only commented on technologies and clinical issues then current.

[9] Stephen Robson, "Recognising the Women in Women's Health", *O and G Magazine* 17 (3), (Spring, 2015), 13-15

[10] Stephen Robson, "What does the Future Hold for Gynaecological Surgery?", *O and G Magazine* 7 (1), (Autumn, 2005), 17.

[11] Hannah Dahlen, "We Need to Protect New Mothers from Trauma and Suicide", http://theconversation.com/we-need-to-protect-new-mothers–from-trauma-and-suicide, (accessed 12 January, 2016). See also ABS data, 2015.

a limited effect in any further diminution in deaths in childbirth. The obstetricians of the future face a daunting task, as bureaucratic intrusion into clinical practice is steadily increasing.[12]

This thesis is unique in its in-depth study of a medical discipline over a period in which it was impacted by many difficult situations, and which altered the education, training, orientation and mindset of a whole generation of medical professionals. The effects on them, on their work, and on the way they treat patients have been documented for posterity. Neither they nor the manner in which they care for their patients will ever be the same again. Apart from providing a much needed historical record of events, further research has already occurred on many of the issues raised, and is expected to continue in the future.

[12] Saxon Smith, "Who is Going to Control the Profession?", *The NSW Doctor*, (November/ December, 2015), 2.

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--------. “Towards a National Forum on CME,” Education Directors of the Clinical Colleges, Sydney, June 1996.

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--------. “Sacrospinous Colpopexy, A Personal Series of 114 Cases,” AGTS Meeting, Melbourne, November 1996.

--------. “Role of the College in Registrar Training,” University of Sydney, Canberra Clinical School, Workshop Canberra, 14 November 1996.

--------. “Modern Management of Prolapse,” HPMI Symposium, Newcastle, 16 November 1996.

--------. “Continuing Medical Education Leads to Improved Competence,” FIGO International Meeting, Copenhagen, Denmark, 4 August 1997.

--------. “Pros and Cons of Minimal Access Surgery,” Grand Rounds, Royal Darwin Hospital, 23 September 1997.

--------. “Setting Standards in Clinical Practice,” Inaugural Australian Forum on CME and Quality Assurance, Melbourne, September 1997.

--------. “Continuing Medical Education, 20 Years On,” AGTS Annual Meeting, Pokolbin, October 1997.

--------. “Techniques Used for Neovaginal Surgery,” AGTS Annual Meeting, 28 October 1997.

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--------. “The Difficult Vaginal Hysterectomy, Advances and Controversies,” Postgraduate Committee in Medicine Symposium, Sydney, 17 October 1998.

--------. “Vaginal Salpingo-oophorectomy,” Pelvic Surgery Symposium, Liverpool, Sydney, April 1999.

--------. “A Painful Vault Prolapse,” AGTS Annual Meeting, Hobart, September 1999.

--------. “Vault Prolapse, Vaginal Approach Using Sacrospinous Vault Fixation,” Workshop in Urogynaecology and Pelvic Reconstructive Surgery, Liverpool Health Service, 30 October-1 November 1999.

--------. “Urinary Incontinence and Prolapse-Surgical Assessment,” Symposium HPMI, Newcastle, February 24 2000.

--------. “Transfusion Rates in Elective Hysterectomy for Benign Disease in a Teaching Hospital,” AGTS Annual Meeting, Adelaide, June 2000.

--------. “Prolonged Urinary Retention, Post Op.: Solution and Sequel,” AGTS Meeting, Adelaide, June 2000.

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--------. “Focussed Clinical Clubs in CME, Newcastle Experience,” APFM/ANZAME Conjoint Meeting, Auckland, NZ, June 2005.

--------. “Management of Vault Prolapse and Stress Incontinence,” HPMI Symposium, Newcastle, May 2005.

--------. “A Pot Pourri of Obs/Gyn History, 600 BC to 2000 CE,” AGTS Annual Meeting, Launceston, October 2005.

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--------. “Controversies in Management of Uterine Fibroids – AGTS Annual Meeting,” Darwin, October 2006.

--------. “Rectovaginal Fistulae, a Series of 42 Cases, with Martius Graft,” FIGO Plenary Session, Kuala Lumpur, November 2006.

--------. “Traditional Management of Uterine Fibroids,” FIGO Plenary Session, Kuala Lumpur, November 2006.

--------. “Vaginal Hysterectomy Update,” AAVIS – Indonesian Joint Meeting, Sydney, 2007.

--------. “The Newcastle Experience of Recto Vaginal Fistulas,” AAVIS – Indonesian Joint meeting, Sydney, July 2007.

--------. “Muller – Hauser-Rokitansky Syndrome – A Case Report,” AGTS Meeting, Brazil, October 2007.

--------. “Vaginal Hysterectomy – Current Practice,” AGTS Meeting, Brazil, October 2007.

--------. “Latzko Repair of Vesico Vaginal Fistula,” AGTS Meeting, Brazil, October 2007.

--------. “Overview of Vaginal hysterectomy,” Joint meeting, AGTS and the American Gynaecological Society, Durham, N.C., September 1993.

--------. “Future of Laparoscopic Surgery in Gynaecology,” Debate, AGTS Annual meeting, Bali, Indonesia, 1993.

--------. “Simplified Colposuspension, 15 Year Follow up, Current Pelvic Floor Surgery,” Gold Coast Hospital, 6-8 December 2003.

--------. “Vaginal Approach to Pelvic Floor Repair,” Gold Coast Hospital Symposium, December 2003.

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--------. “Vaginal Hysterectomy – A Historical Review and Current Practice,” Grand Rounds lecture, RHW/P.O.W., June 2007.

--------. “Vaginal Hysterectomy Update,” AAVIS International Meeting, Sydney, July 2007.

--------. “Traditional Management of Uterine Fibroids,” FIGO Meeting, Kuala Lumpur, 2006.

--------. “Rectovaginal Fistulae and the Martius Graft,” FIGO Meeting, Kuala Lumpur, 2006.

--------. “Newcastle Experience of RectoVaginal Fistulae and the Martius Graft,” AAVIS Meeting, Sydney, 2007.

--------. “When Abortion was Illegal,” International Institute Lecture, Newcastle, 2007.

--------. “History of the RCOG,” AGTS Annual Meeting, Perth, 2010.

--------. “The Pouch of Douglas Revisited,” AGTS Meeting, Tasmania, 2011.

--------. “Two Centuries of Midwifery in the Hunter,” Senior Obstetricians and Gynaecologists, Sydney, 20 March 2015.

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OTHER LECTURES /CLINICAL OPERATIVE DEMONSTRATIONS

--------. Annual Visitor to Darwin 1993-2007, Lectures to Registrars and Clinical Operative Demonstrations.

--------. Postgraduate Refresher Course, Port Moresby, PNG, June 2008. Lectures given: Surgical Anatomy, Operative Complications, Prevention of Carcinoma Cervix, Overview of Gynae Malignancies, PPH, Genital Tract Fistulae, Suspicious Adnexal Mass, Safe Vaginal Hysterectomy, Uterine Fibroids, Laparoscopic Entry, Outcomes Based CME.

--------. Annual Refresher Courses in PNG in 2009, 2010 and 2012 with similar schedules.

INTERNATIONAL/ NATIONAL CONTINUING MEDICAL EDUCATION MENTORS/ OFFICIAL VISITORS TO HUNTER REGION

APFM Coppleson Orators from 1980 -2005, International Involvement in CME/CPD: Professors Dave Davis (Canada); John Parboosingh (Canada); Sam Leinster (UK); Ronald Harden (Dundee, Scotland); Robert Fox (Oklahoma, USA); Colin Woolfe (Toronto, Canada); Leo Peddle Leo (Halifax, Nova Scotia); David Nichols (Providence, Rhode Island) (APFM and HPMI Archives and files of Alan Hewson).

NOGS Visitors/Lecturers from 1980 -2010: David Nichols (Boston); Shirish Sheth (India); David Molloy (Queensland); Neville Hacker (Sydney); John Stallworthy (Oxford, UK); Rod Baber (Sydney); Barry Wren (Sydney); Robert Zacharin (Melbourne); Shan Ratnam (Singapore).

CME Lectures/Workshops attended overseas: 1986, Ranco Mirage, California; First International Conference on CME, 10 November – 4 Dec 4 1986, with: Phil Manning (UCLA, USA); Wayne Putnam (Halifax, Canada); Nancy Bennett (Harvard, USA);

Penny Jennet (Calgary, Canada); James Leist (Duke, North Carolina, USA). Also Los Angeles, 1989, International CME meeting.

8. THESES

Capper, Betty. "The History of Nurse Education at the Royal Newcastle Hospital, 1870-1985," MA thesis, University of Newcastle, Newcastle, 1986.

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Savige, A.E. "Provisions for the Care and Education of Orphaned, Neglected, and Derelict Children in the Moreton Bay Region, 1825-1911," PhD thesis, University of Newcastle, Newcastle, 1991.

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THE HISTORY OF OBSTETRICS AND GYNAECOLOGY IN AUSTRALIA FROM 1950 TO 2010

Thesis submitted to the School of Humanities and Social Science, Faculty of Education and Arts, University of Newcastle, in fulfilment of the requirements for the degree of Doctor of Philosophy.

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May 2016

DECLARATION

I hereby certify that this thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

…….
Alan Donald Hewson
May 2016

GLOSSARY OF MEDICAL TERMS USED IN THE TEXT

ABRUPTIO PLACENTAE. Separation of some or most of the placenta from the uterus by bleeding.

ABORTION. The end of a pregnancy at any time before independent life is possible. Abortion may be spontaneous (a miscarriage) or induced by an operation or prescribed medication. Doctors often use the term 'termination of pregnancy' (TOP) instead.

AFTERBIRTH. The placenta. This provides the baby with food and oxygen.

AMENORRHOEA. The absence of menstruation for an interval twice that (or more) of the patient's usual menstrual cycle.

AMNIOTIC FLUID. The fluid in the 'bag of waters' (or the amniotic sac) in which the foetus grows.

AMNIOTIC SAC. The sac holding the fluid and the baby inside the uterus.

AMNIOCENTESIS. The procedure of introducing a narrow needle through the abdominal wall into the amniotic sac to obtain a sample of the amniotic fluid.

AMNIOTOMY. Making an opening into the amniotic sac.

ANALGESIC. A pain-relieving drug.

ANDROGENIC. Masculinising, the effect of an androgen such as testosterone.

ANTENATAL PERIOD. The period between conception and childbirth. Also called the prenatal period.

ANTEPARTUM. Prior to the onset of labour.

APNOEA. Cessation of respiration.

AREOLA. The brownish-coloured pigmented area which surrounds the nipple.

AUDIT. A qualitative review (or comparison) of patients' medical charts focusing on a single physician's care or a single procedure or diagnosis. Qualitative findings are classified and tabulated relative to the focus and time frame of the audit.

AUGMENTATION. Medical treatment which helps labour to progress.

BACILLUS. A small form of life, made up of a single cell shaped like a tiny rod. May be harmful to humans, for example the pneumococcus which causes sore throats; or they may be helpful, as the lactobacillis, which lives in the vagina.

BIRTH PLAN. A written plan which states what the patient would like to happen during labour and birth.

BIRTHWEIGHT. The weight of the baby when it is born. ‘Low birthweight’ means weighing less than 2500 grams.

BMI (body mass index). This is the weight of a person in kilograms divided by height in metres squared. It gives the best measure of being overweight (or underweight) as related to one’s height. The normal range of BMI is 19-25.

BTB (breakthrough bleeding). Any unexpected bleeding on the combined pill happening on tablet-taking days, between the hormone-withdrawal bleeds (‘periods’).

BRANXTON-HICKS CONTRACTIONS. Contractions that women feel in late pregnancy. They do not produce dilation of the cervix.

BREECH BIRTH. When the baby is born feet or bottom first.

CAESAREAN. When the baby is delivered abdominally through a surgical incision.

CERVIX. The narrow lower end of the uterus, containing the entrance to it. Sometimes called the ‘neck of the womb’.

CHLAMYDIA. The most common cause of sexually transmitted disease (or STD) of the cervix, fallopian tubes, also known as salpingitis or pelvic inflammatory disease (PID), with pelvic pain as a possible symptom. Importantly, it can be ‘silent’, without symptoms.

CHLOASMA (also known as melasma). Abnormal facial skin pigmentation occurring in some women during pregnancy or when taking the combined pill.

CLINICAL INDICATOR. A measurable dimension (eg, a medical event, procedure, diagnosis, or outcome) that is thought to reflect an important aspect of medical care. Clinical indicators are used as part of a screening process (ie, a simple review of medical records for a few specific facts) to make some preliminary determination about the quality of care.

COC (combined oral contraceptive). A tablet taken by mouth and which contains two hormones: one a progestogen and the other an oestrogen. Usually called ‘the pill.’

COITUS. The act of sexual intercourse, or copulation. The verb is ‘to copulate’.

COITUS INTERRUPTUS. Coitus in which the penis is withdrawn from the vagina before male orgasm, and the semen is ejaculated externally to the vagina.

COMORBIDITY. The existence of two or more clinical conditions simultaneously, increasing the patient’s need for medical services.

COMPLICATION. An untoward patient event, occurrence, or outcome that results from or follows treatment.

CONE BIOPOSY. A minor operation under general anaesthesia to remove some skin at the entrance to the uterus in order to treat some abnormal cells found by cervical smear. Abnormal cells are now more often removed with so-called ‘large loop diathermy’, under local anaesthetic, as an out-patient,

CONCURRENT AUDIT/REVIEW. An evaluation of medical care that takes place while care is still being provided (ie, prior to patient discharge) as opposed to after the fact. The presumed superiority of a concurrent audit over a retrospective audit is that intervention can occur. Utilisation of services is often the target of concurrent audit.

CONCEPTION SAC. The embryo (or foetus) contained in the fluid-filled amniotic membranes is called the conception sac.

CONTRACEPTION. Prevention of pregnancy by a reversible method. This definition excludes the other two types of birth control, which are sterilisation and abortion.

CONTRACEPTION. Any substance or device which reversibly prevents conception (while allowing intercourse).

CONTRACTION. When the muscle in the uterus (womb) tightens.

CONTRAINDICATIONS. Medical reasons to avoid a treatment.

COPULATE. To practise sexual intercourse.

CORPUS LUTEUM. The yellow body formed in the ovary during the menstrual cycle from the largest follicle, after it has released its egg.

CREDENTIALLING. The process of reviewing the qualifications, education, and previous relevant experiences of an individual applying for appointment or reappointment to practice medicine in an institution. Delineation of clinical privileges (see privilege delineation) is part of this process.

CRITERIA/CRITERIA SETS. Something that should or should not occur in relation to a medical event (ie, a standard against which clinical activity can be compared for the purpose of evaluation). RACOG criteria are designed as minimum standards of acceptable care.

CYSTITIS. Inflammation of the urinary bladder, usually caused by infection, provoking a desire to pass urine more frequently and often a burning sensation during voiding.

DEATH. For the purpose of quantifying hospital mortalities, any death occurring within 6 weeks of a diagnostic or therapeutic procedure.

D & C (dilation and curettage). With hysteroscopy, a common minor operation when a narrow telescope and/or a curette is passed into the uterus through the

cervix. The inside of the uterus is looked at, tissue can be taken for laboratory examination (see also endometrial biopsy), or it can be completely emptied e.g. after a miscarriage or induced abortion which has been incomplete.

DEFICIENCY. A variation in practice that represents inadequate judgment, skill, or performance; deviation from accepted norms or care that does not meet present criteria.

DIAGNOSIS-SPECIFIC. Something that is related to a particular diagnosis rather than to any diagnosis (eg, lack of variability is specific to the diagnosis of fetal distress).

DUE PROCESS. Those particular steps that allow an individual to challenge what he or she views as an inappropriate, adverse decision. Each hospital's bylaws should clearly delineate the system of due process for that institution. Written, timely notification by the hospital of allegations, as well as an objective hearing process, are two steps required under due process.

DUTY. An obligation recognised by the law. A health care professional's duty to a patient is to provide the degree of care ordinarily exercised by health care professionals who practise in the same clinical specialty and under similar circumstances.

EE (ethinylestradiol). The main artificial oestrogen used in the pill, not to be confused with the natural oestrogen used in HRT.

ECLAMPSIA. The occurrence of convulsions or fits in a pregnant woman who has other signs of pregnancy-induced elevated blood pressure.

ECTOPIC PREGNANCY. A pregnancy in the wrong place, i.e. anywhere other than in the uterus. The most common site is in the uterine (fallopian) tube. An urgent operation is necessary, because the growing pregnancy can cause internal bleeding. The tubes may have been damaged by a previous pelvic infection.

EDC. Short for 'expected date of confinement' - meaning the date when the baby is due.

EJACULATION. The spurting-out of semen (ejaculate) from the penis when a man has a climax.

EMBOLISM. Transfer in the bloodstream of a mass, such as a blood clot from a vein, to lodge elsewhere, generally in the lungs (pulmonary embolism).

EMBRYO. Name given to the early pregnancy from fertilisation for the first 8 weeks (then called the foetus).

ENDOMETRIUM. The special lining of the uterus, which is prepared by the hormones of the menstrual cycle in readiness for implantation of an embryo - or otherwise shed at the menstrual period.

EPIDURAL. A type of anaesthetic that makes the patient numb below the waist.

EPISIOTOMY. A surgical cut in the area between the vagina and the anus that may be necessary during birth.

EXCEPTION. A deviation from the normal decision/treatment process that is judged to be acceptable. Exceptions should be clearly documented in medical records, and the reasons for an approach different from the norm or accepted treatment should be explained.

EXPERT OPINION. The testimony of a person who has special training, knowledge, skill, or experience in an area relevant to the resolution of a legal dispute.

FALLOPIAN TUBES (or oviducts). Tubes that lead from each ovary to the womb.

FEBRILE MORBIDITY. An oral temperature of 38C (100.4F) on at least 2 postoperative days, excluding the first 24 hours after surgery.

FERTILISATION. The union of sperm and egg cell. The fertilised egg divides to produce an embryo.

FOETAL DISTRESS. A compromise in foetal physiology. Although the term 'foetal distress' is included in manuals because it is often used and therefore familiar, it is not a sufficiently accurate description of foetal condition.

FOETUS (or Fetus). Name for any growing baby after 8 weeks of intrauterine life.

FIMBRIAE. The fringe-like fronds which surround the outer end of each uterine tube.

FOCUSED (problem-oriented) AUDIT/REVIEW. The evaluation of a specific aspect of medical care (eg, all abdominal hysterectomies performed over the course of 1 year) to determine whether there is a deficiency and, if so, what its nature and cause are, and what corrective methods are most likely to resolve it. The initial problem may be identified by any of a variety of quality assurance triggers in place to detect variations in care. Continued monitoring to determine the effectiveness of any action taken is recommended.

FOLATE. An important B vitamin found in many fruits, dark green leafy vegetables and wholegrain foods. Deficiency in the diet in pregnancy can predispose to anencephaly (abnormal brain development).

FOLLICLE. A small fluid-filled balloon-like structure in the ovary, containing an egg cell.

FSH (follicle-stimulating hormone). The hormone produced by the pituitary gland, which stimulates the growth of follicles in the ovary and which in turn produce oestrogen and the maturing of an egg cell in the largest follicle.

GENERIC SCREEN. General elements of medical care and patient outcomes that can be easily extracted from medical records for the purpose of identifying those cases that may require peer review to determine whether medical

care was deficient. These are neither diagnosis-specific nor procedure-specific. The clinical indicators included in manuals are, in most cases, generic screens.

GENETIC COUNSELLOR. A health professional who estimates the risk of the baby having an inherited condition and helps you decide what to do if the baby does have a serious condition.

GnRH (gonadotrophin-releasing hormone). The hormone produced by the hypothalamus, which travels to the pituitary gland causing the release of FSH and LH into the bloodstream.

GUM (genitourinary medicine). The branch of medicine specialising in treating Sexually Transmitted Disease (STDs).

HETEROSEXUAL. A person whose sexual affections are directed to a person of the other sex.

HCG (human chorionic gonadotrophin). The hormone produced by an early pregnancy, which travels to the ovary in the bloodstream and causes its corpus luteum to continue producing oestrogen and progesterone beyond the usual 14 days.

HIV/AIDS. Human Immunodeficiency Virus. The sexually transmissible cause of Acquired Immune Deficiency Syndrome, which without treatment leads to lack of immune resistance to infections and death.

HOMOSEXUAL. A noun (i.e. a person called a homosexual) or an adjective (i.e. a homosexual act) implying that the object of a person's sexual desire is of the same sex.

HORMONE. A chemical substance produced in one organ and carried in the bloodstream like a 'chemical messenger' to another organ or tissue, whose function it influences or alters.

HRT (hormone replacement therapy). Treatment with natural oestrogen, often along with a progestogen, given when women lack sufficient from their own ovaries, e.g. after the menopause.

HYPERTENSION. High blood pressure, above the accepted normal level.

HYSTERECTOMY. An operation to remove the uterus. This may be abdominal, vaginal, laparoscopic or laparovaginal.

HYPOTHALAMUS. The structure at the base of the brain which releases GnRH.

INDUCTION. Using a medical treatment to start the labour rather than waiting for it to happen naturally.

IMPLANTATION. The process of the embedding of the developing embryo in the endometrium.

ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modifications). Lists corresponding codes for diseases and procedures. This was the source of the code numbers assigned to procedures and indications within criteria sets provided in manuals.

INCIDENT REPORT. The official written report of an untoward event that occurred in an institution. Usually the event is directly related to patient care and interaction with the staff. If there is a continuing problem or risk, prompt documentation, and correction must be undertaken by the institution.

INDICATION. The reason for carrying out a particular process or procedure.

INDICATOR. A measureable dimension of an important aspect of clinical care; an event, action, occurrence, or outcome (eg, a laboratory result) associated with a particular clinical event (see CLINICAL INDICATOR).

INFORMED CONSENT. A legal process that requires a physician to obtain the patient's consent for treatment rendered or an operation performed. Without an informed consent, the physician may be held liable for violation of the patient's rights, even if the treatment was appropriate and rendered with due care.

INTERNAL EXAMINATION. The doctor or midwife puts one or two gloved fingers into the vagina to detect abnormalities, check on a pregnancy or progress in labour.

INTERVENTION. Using a medical treatment or instrument to help in labour or birth (eg, forceps or an induction).

INTRAPARTUM DEATH. The death of a foetus during labour.

IUCD (intrauterine device). A small plastic device, which usually carries copper in the form of wire or bands or releases a hormone, and is inserted into the uterus to prevent pregnancy.

IUS (intrauterine system). A small plastic device releasing a hormone, currently always a progestogen, into the uterus to prevent pregnancy.

JAUNDICE. When a baby's skin looks slightly yellow in the first few days of life.

JUSTIFICATION. A clinically valid reason for a failure to follow preset criteria; the determination, often through peer review, that care was acceptable although some aspect of patient care was different from that outlined in pre-established criteria.

LH (luteinizing hormone). The hormone produced by the pituitary gland that causes egg release, and the production and maintenance of the corpus luteum.

LACTATION. Suckling. The period when the child is nourished from the breast. It also means the secretion or formation of milk.

LACTATION CONSULTANT. A health professional (often a midwife) trained to help women breastfeed and provide help with problems with breastfeeding.

LANUGO. The downy delicate hair which is found on the body of the foetus. It is replaced after birth by rather thicker hair.

LIBIDO. The internal drive and urge of the sexual instinct.

LIFE-THREATENING EVENT. Any intraoperative or postoperative cardiac or respiratory arrest, cerebrovascular accident, myocardial infarction, pulmonary embolus, shock, or coagulopathy.

LIPIDS. Fats and associated chemical substances, carried in the blood.

LOCALITY RULE. The traditional rule requiring that an expert witness practise in the same community as the defendant. This rule has now been superceded in most states by a national standard of care.

LOCHIA. The discharge from the uterus which lasts for about 4 weeks after childbirth. For the first few days it is profuse and red, later becoming pale and scanty.

MALOCCURRENCE. An untoward clinical event.

MALPRACTICE. Professional negligence. In medical terms, malpractice is the failure to exercise the degree of care that is used by reasonably careful health care professionals of like qualifications in the same or similar circumstances. The failure to meet this acceptable standard of care is malpractice only if it causes the patient injury.

MASTITIS. Infection in the breast during the period of breast feeding.

MASTURBATION. The mechanical stimulation, usually with the hands or finger, of the penis, the clitoris or other erogenous zones of the body leading to orgasm.

MATERNAL DEATH. The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal Death prevalence is measured by the maternal mortality ratio, maternal mortality rate, lifetime risk of maternal death, and proportion of maternal deaths among deaths of women of reproductive age.

MENARCHE. The time of onset of the first menstrual period.

MENOPAUSE. Cessation of the menstrual periods due to failure of ovulation and hormone production by the ovaries. May be surgically induced through hysterectomy. Often used inaccurately for the climacteric or the

perimenopause time, which is several years before and after periods actually cease.

MENSTRUAL CYCLE. The cycle of hormone and other changes in a woman's body which leads to a regular discharge of blood from the non-pregnant uterus.

MENSTRANOL. An artificial oestrogen, now rarely used.

MIDWIFE. Health professional who specialises in caring for women during normal pregnancy, labour, birthing and the postnatal period.

MISCARRIAGE. The death of a pregnancy before the 20th week of pregnancy.

MONILIA. A fungus infection of the vagina, also called candidiasis or vaginal thrush.

MONITOR (n). A tool with which to evaluate clinical care (similar to an indicator); an incremental bit of clinical data that is examined because of the information that it is expected to convey about broader practice patterns and quality.

MONITOR (v). To track the occurrence of specified, important events and analyse trends that emerge over time. Monitoring is undertaken as part of the process of creating practitioner and department performance profiles.

MONOPHASIC. Combined pills containing a fixed dose of ethinylestradiol and progestogen.

MUCOUS. Such as cervical mucous, a slippery fluid produced by the glands of the cervix. Progestogens change it so that it impedes sperm when they try to enter the uterus.

NATIONAL STANDARD OF CARE. The degree of care and skill expected of a reasonably competent practitioner in the same specialty acting under similar circumstances.

NEGLIGENCE. A legal cause of action arising from the failure to exercise the degree of diligence and care that a reasonable and ordinarily prudent person would exercise under the same or similar circumstances.

NEONATAL. To do with the first 28 days after birth. 'Neonatal care' means care of newborn babies.

NEONATAL MORTALITY. The death of a liveborn infant up to 28 days after birth (up to and including 27 days, 23 hours, and 59 minutes from the moment of birth).

NEONATOLOGIST. Doctor who specialises in caring for newborn babies.

OBSTETRICIAN. Doctor who specialises in caring for women during pregnancy, labour, birthing and the post natal period.

OEDEMA. Swelling of the tissues under the skin due to retention of water in these tissues.

OESTROGEN. The female sex hormone produced by the ovary throughout the menstrual cycle.

OESTROGEN-DOMINANT PILL. A combined pill whose biological effects on the body are due to the relatively stronger effect of the oestrogen it contains than to the progestogen.

OUTCOME. An end point. Outcome evaluation focuses on the patient's health status after actions have been taken and treatment has been provided.

OUTCOME AUDIT. A study of a patient's medical records to assess the effect of treatment provided on the patient's health.

OUTLIERS. Variations from the norm. In quality assurance programs, outliers are cases that do not fit the established criteria and thus require further investigation before the quality of care can be determined.

OVARY. The female sex gland in which ova (egg cells) are developed and which is the main source of natural sex hormones.

OVULATION. Release of the ovum or ova from the ovary.

OVUM. The egg cell, which has matured and is ready to be expelled from the ovary, is called the ovum.

PAEDIATRICIAN. Doctor who specialises in caring for babies and children.

PARTOGRAM. A graphic display of the progress of labour.

PARTURITION. The process of giving birth.

PATTERN OF CARE. An overview of the medical care provided to patients by a practitioner. This overview often involves compiling quantifiable patient data and comparing them to patient data from other practitioners.

PCOS (polycystic ovary syndrome). A condition in which multiple small cysts develop around the outside of the ovary and the woman has androgenic effects such as acne or unwanted hair growth.

PELVIC FLOOR. The muscles which support the pelvic viscera.

PEER GROUP. Individuals of approximately the same age and similar social values who form groups.

PEER REVIEW. An evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise (eg, the evaluation of one physician's practice by another physician). True peer review must be conducted by a professional with the same type of training as the professional being reviewed.

PEER REVIEW ORGANISATIONS (P.R.O). A type of organisation created by legislation (as the successor to professional standards review organisations, or PSRO) to review the utilisation, appropriateness, and quality of hospital care. A primary responsibility is to determine the appropriateness of care.

PERINEUM. The area between the thighs which contains the entrance to the vagina and the other female external genitals, which comprise the vulva.

PERINATAL MORTALITY. The death of a foetus, or live-born infant who survived only briefly (not more than 28 days). Although perinatal mortality is often reported according to age, weight-specific reporting that categorises weights into 500 gram increments is now standardised because it is more accurate than are age-specific reporting categories.

PERINATAL LOSS RATE is usually expressed as the death of still born infants over 400 grams, plus deaths after birth within 28 days, per 1000 live and stillbirths, to compare the effectiveness of obstetric care.

PHASIC. Combined pills containing two (biphasic) or three (triphasic) different doses of ethinylestradiol and progestogen.

PHLEBITIS. Thrombosis and inflammation involving a vein – usually a superficial vein of the leg – which causes it to become hard and very tender.

PICA. A longing to eat substances which are not foods, such as clay or coal.

PITUITARY GLAND. The gland, about the size of a pea, on a stalk at the base of the brain, which produces many important hormones including FSH and LH.

PLACENTA. The afterbirth. This provides the baby with nutrition and oxygen. It is attached to the infant by the umbilical cord.

POP (progestogen-only pill). As the name suggests, a pill with only the one hormone present, an artificial progestogen.

POSTNATAL. After pregnancy and birthing – as in postnatal care or postnatal exercise.

POSTNATAL DEPRESSION. Feelings of sadness and inadequacy which continue for weeks after the birth.

POSTPARTUM. Immediately following delivery.

POSTPARTUM HAEMORRHAGE. Heavier than normal bleeding after giving birth.

PRE-ECLAMPSIA. Serious condition in pregnancy with high blood pressure, swelling, weight gain and can lead to eclampsia (kidney fits).

PREGNANCY-INDUCED HYPERTENSION. A rise of blood pressure occurring in pregnancy, often associated with protein in the urine, is called pregnancy-

induced hypertension, or pre-eclampsia. It used to be called ‘toxaemia of pregnancy’ which was an inexact term.

PREMATURE. When a baby is born before the 37th week of pregnancy (or under 2500 grams).

PRIVILEGE DELINEATION/PRIVILEGING. The act of granting an individual the right to perform specific diagnostic or therapeutic procedures within an institution. Each practitioner’s level and type of privileges must be specified. The basis for hospital approval of a practitioner’s request for privileges must be the applicant’s education, training, experience, and demonstrated ability in each relevant area.

PROCESS. The way in which something is done; the mechanisms and resources brought to bear on a problem or task.

PROCESS AUDIT. An evaluation of clinical activities and resources to determine whether appropriate steps were taken in patient care. Process audits are often contrasted with outcome audits, which focus on the impact of activities and resources on patients’ health status.

PROCTORING or mentoring. Immediate oversight during a clinical procedure, especially a surgical procedure, of a practitioner by a physician viewed as an expert in the procedure being performed as an expert in the procedure being performed. Granting of privileges, delineation of specific privileges, or satisfactory completion of a provisional or probationary period may be contingent upon a favourable report. In some instances, proctoring may take the form of medical record review rather than direct observation.

PROFESSIONAL LIABILITY. The legal responsibility of a health care provider to his or her patient. Health care providers are presumed to owe a duty to the patients under their professional care and may be liable to charges of medical malpractice if injury results from their failure to perform with the same degree of skill and knowledge that any competent practitioner with similar training would exhibit in a similar situation.

PROGESTERONE. The other main sex hormone produced by the ovaries (see oestrogen). This hormone is produced only in the second half of the menstrual cycle, by the corpus luteum. It prepares the body, especially the uterus, for pregnancy. It is one of the general class of progestogens.

PROGESTOGEN. A number of artificial progestogens that are chemically related to natural progesterone.

PROGESTOGEN-DOMINANT PILL. A combined pill whose biological effects on the body are due more to the relatively higher dose of progestogen it contains than to the oestrogen.

PROLACTIN. A hormone produced by the pituitary gland which stimulates the breasts to produce milk and is also involved in the menstrual cycle.

PROMISCUITY. A person may be considered promiscuous if they have sexual intercourse with several casual acquaintances over a short period of time. Premarital coitus with a single partner is not promiscuity. The term has moral overtones and the practice is viewed differently across cultures and historically.

PROPHYLACTIC TREATMENT. Treatment, usually with drugs, given to prevent the onset or spread of disease.

PROSTAGLANDIN. Natural substance manufactured and released within many tissues of the body. Some natural prostaglandins cause the uterus to contract, and these and other artificial variants can therefore be used to cause an induced abortion.

PSYCHOSOMATIC DISORDER. A condition in which a disturbed emotion manifests itself as a disorder of one part of the body or another, and mimics disease of that part.

PUBERTY. The time when a young person begins to develop secondary sex characteristics and then in most cases becomes fertile. In a girl, the most significant event is the onset of periods, correctly called the menarche.

PUERPERIUM. The period between childbirth and the time when the uterus has returned to its normal size, which is about 6 to 8 weeks.

PYRIDOXINE. Vitamin B6.

QUALITY ASSURANCE SYSTEM. A system and process to provide ongoing monitoring and evaluation of the health care offered by an institution and its providers.

QUICKENING. The baby's first movements in pregnancy felt by the mother.

RE-ADMISSION. Any unplanned re-hospitalisation within 6 weeks (42 days) of surgery because of a complaint or problem related to the primary operation.

REGIMEN. A specific course or plan of diet or drugs to maintain or improve health, or regulate the way of life.

RENAL TRACT. The urinary tract.

REPRODUCTIVE YEARS. The years which a woman is ovulating, or able to ovulate, and so is able to have a baby. It is the time when the female sex hormones are regularly and rhythmically produced by the ovaries.

RETROSPECTIVE AUDIT/REVIEW. An evaluation of medical care after its provision, usually after the patient has been discharged.

REVIEW. A formal evaluation of medical care provided. Reviews may be prospective, concurrent, or retrospective. At the preliminary screening level, reviews may be conducted by non-physicians according to predetermined clinical indicators. When a patient record is flagged by the screening process, the final determination of quality is made by physician peers. Re-review is similar to, but broader than, an audit.

RISK MANAGEMENT. The steps taken, usually following an untoward event, to decrease the possibility of a malpractice action being initiated and to prevent ensuing loss (see INCIDENT REPORT).

RISK PREVENTION. Actions taken to decrease the chance that an untoward event will occur (eg, ensuring that care is of the highest quality possible). This includes the identification and reduction or elimination of threats and risks.

SCREEN. A tool used for review (eg, a clinical indicator).

SCREENING. The process of reviewing charts for some predetermined, presumably important and representative, aspect of care. Assumptions about the quality or patterns of care are often based on findings from screening a sample of medical records. Also used to refer to methods of identifying disease in an apparently healthy population.

SEXUAL DRIVE. The desire to have sex. It varies in strength in different people and at different ages of the same person.

SHOW. Passing the mucus ‘plug’ which seals the cervix.

SPECULUM. A small metal instrument, made like a duck’s bill, which a doctor introduces into a woman’s vagina so that the cervix can be seen.

SPERMICIDE. A substance which is capable of killing sperm.

SPONTANEOUS ABORTION. Medical term for a miscarriage.

STERILISATION. An operation in a person of either sex which permanently prevents pregnancy, and which is either impossible or difficult to reverse.

STANDARD OF CARE. Norms of behaviour and action as defined by a particular profession (eg, nurse practice acts, policies, procedures, guidelines). Standards may reflect optimal or threshold levels of care, rather than what the majority views as appropriate levels.

STDs (sexually transmitted infections or diseases). There are many of these, including Chlamydia, Gonorrhoea, Syphilis and HIV/AIDS.

STILLBIRTH. When a baby dies in the uterus and is born after the 20th week of pregnancy, or 400 grams.

TOXOPLASMOSIA. An infection, which can cause blindness and brain damage in the unborn baby.

THRESHOLD LEVEL. The base or minimum acceptable level; often perceived as a starting point. Criteria are intended to represent care below which most physicians would agree that care is unacceptable.

THROMBOSIS. The formation of a blood clot within a blood vessel (artery or vein). Arterial thrombosis can produce heart attacks or strokes; venous thrombosis in the legs can spread to the lungs to cause pulmonary embolism.

'TOXAEMIA OF PREGNANCY' (see PREGNANCY-INDUCED HYPERTENSION).

TRANSFUSION. Any intraoperative or postoperative administration of whole blood or blood products.

TRENDS. Ongoing or repetitive patterns of care.

TRENDING. The process of comparing data collected over a period of time so that quality can be judged on the basis of a number of significant events.

TRIMESTER. Pregnancy is divided into three 'trimesters' – up to 12 weeks, 12-28 weeks and 28-40 weeks.

ULTRASOUND. A procedure that looks inside the body using soundwaves. A safe, non-invasive method to get information.

UMBILICAL CORD. The cord which joins the afterbirth (placenta) to the baby.

UNPLANNED SURGERY. Any surgical procedure for correcting a complication directly related to surgery. Corrective surgery may be performed either interoperatively or postoperatively during the same hospitalisation.

UNTOWARD EVENT. Any occurrence that is undesirable and usually unexpected, such as an adverse patient outcome.

URINARY TRACT. The kidneys, the tubes which connect the kidneys to the bladder (the ureters), the urinary bladder, and the tube between the bladder and the vulva (the urethra) form the renal tract.

UTERINE (fallopian) TUBES. The tubes which in the female conveys the egg to the uterus, and within which fertilisation by a sperm usually occurs.

UTERUS (womb). The hollow organ in which a pregnancy develops.

VARIATIONS. Something that is different from the expected or mandated process or outcome. Variations in practice reflect differences from previously established criteria for patient care.

VAS DEFERENS. The tube in the male which conveys the sperm from the epididymis to the base of the penis. It is the tube that is divided at vasectomy.

VASECTOMY. Male sterilisation.

VOIDING. Emptying the urinary bladder (urinating).

VULVA. The name given to the female external genital structures.

WTB (withdrawal bleeding). Bleeding from the uterus caused by the woman herself when she stops the supply of hormones to it, by taking a break at the end of each packet of tablets as (usually) instructed. It occurs during the pill-free interval.

ZONA PELLUCIDA. The strong translucent outer membrane which surrounds the human egg, rather as the shell surrounds a hen's egg. The zona pellucida only disappears when the fertilized egg reaches the uterine cavity after spending three days in the oviduct (fallopian tube).

APPENDICES

APPENDIX A: ALAN D. HEWSON – A BIOGRAPHICAL EXPLORATION

Alan Hewson was born at home, delivered by the local midwife, in the village of Lisarow near Gosford on the central coast of NSW in 1927, just before the Great Depression of 1930. His mother's family were all Scottish, and his father, from Birmingham in the UK, worked as a farm labourer initially but later as a labourer at the BHP steelworks for most of his life, apart from military service in World War Two. After primary school at Lisarow, Alan attended the Wollongong Junior Technical (High) School, completing the Intermediate Certificate, then went on to 2 years at Gosford High, completing the Leaving Certificate in 1943. He spent two years as a metallurgy trainee at the BHP steelworks at Newcastle, then at Port Kembla during the Second World War. He then changed course, beginning Medicine at Sydney University in 1946, on a Commonwealth Financial Assistance scholarship, with 730 other students, including 300 ex-servicemen. At this time, Latin had been removed as a Matriculation requirement. He achieved a High Distinction in anatomy in first year leading to a Prosectorship in anatomy over the next two years, sparking a lifelong interest in anatomy, the Surgical Sciences, and teaching. He graduated with Honours in 1952, and married a fellow student who later specialised in Paediatrics.

He spent three years doing resident training at Royal Newcastle Hospital (1952-4) which provided a very extensive background in most aspects of medicine and surgery, an opportunity which is now virtually impossible to obtain in resident programmes. He then had four years of Registrar training in obstetrics and gynaecology between 1955 and 1958, the first 2 years at Royal Hobart Hospital, and then two years at the Radcliffe Infirmary Oxford, initially with Professor Chassar Moir, and then with Sir John Stallworthy and Mr Bill Hawkesworth in the Area Department of obstetrics and gynaecology, which provided consultant services to the Oxford region of 1,500,000 people. He obtained his Membership of the Royal College of obstetricians and gynaecologists (MRCOG) in July 1957, and was appointed as Tutor at Oxford during his final year when Senior Registrar. He became enthused with the 'one on one' tutorial system used in Oxford. He returned to Australia and set up private practice in Newcastle at the end of 1958, and has

practised there ever since. In 1965 he took a sabbatical year off from his clinical practice to revise his basic sciences knowledge and extend his general surgical experience at Edinburgh, and acquired the Fellowship of the Royal College of Surgeons Edinburgh (FRCS Ed), passing both parts of the examination at the first attempt, a rare accomplishment in those days. As one of only three fully trained obstetricians and gynaecologists in the Hunter region in those early years serving a population of over 450,000 people he rapidly amassed enormous clinical experience. As well as holding major clinical appointments at the main Newcastle Hospitals, he held consulting appointments at virtually every district hospital from Singleton to Gosford on the Central Coast. He became the trusted consultant for the many general practitioners then providing most of the gynaecological and obstetrical care of the region. This involved being permanently on call for the first 25 years of his clinical career, with direct exposure to major obstetrical emergencies over the whole Hunter valley.

A high point in his early career was his role in setting up a local Medical Association study in 1960 into what appeared to be an abnormally high perinatal loss rate associated with mothers having babies in Newcastle. This involved gaining the cooperation of over 100 doctors doing obstetrics at the time, setting up hospital committees with obstetricians, GPs, paediatricians and pathologists, and achieving the cooperation of the hospital administrators where GPs delivered over 4000 babies annually. The GPs for the first time agreed to allow review of their private patients' records, adopt a common antenatal record, review every infant loss, change to recording of weight instead of duration of pregnancy, and allow confidential anonymous feedback of problems to all other doctors. He arranged for a local firm, John Lysaghts, to use their new computer to analyse the data. This had never been done before, and after being publicised in the *Australian Medical Journal* led to other parts of the country following suit, as the study led to a dramatic fall in perinatal loss. The study continued for the next 3 decades, covering the whole of the Hunter Valley.

In 1960, with his partner Dr Jack Elliott, he setup a consultation service for the doctors and hospitals in the valley. They both saw patients and operated in the local hospitals on a regular basis from 1960 to 1990, until new specialists began to settle in the valley towns. Again this pattern was adopted later around Australia. Alan Hewson's passion for continuing education and the close working relationship with

the country GPs led to regular educational programmes for the doctors in the Valley. From 1959, when the Royal Newcastle hospital was finally recognised for specialist training, he prepared generations of registrars for specialist examinations. He arranged for them to do additional training in the United Kingdom, mostly at his old hospital at Oxford, before doing the specialist examinations in Britain. Over the next 20 years every one of them passed the MRCOG examination at the first attempt, a very unusual result at that time. He was Chief Examiner for the College of Midwives in NSW in 1979-1980 and 1981, and was Examiner for the Diploma of the Royal College of obstetricians .and gynaecologists between 1980 and 1987.

He was a founding member of the Newcastle obstetrical and gynaecological Society (NOGS) in 1967, the regional grouping of specialist obstetricians, the first in Australia, again a pattern followed by other regions across Australia. He was elected to the NSW State committee of the College in 1976, served a term as Chairman, and was elected to the second Council of the newly formed Australian College of obstetricians in 1981, serving for the next 11 years. He chaired the Education Committee of the new college for 6 years and is credited with 'masterminding' the obligatory continuing education and certification programme of the College, the first in the world. He was awarded the Gold medal of the College in 1988 for this work. The programme received world-wide acclaim, and he subsequently gave lectures and ran seminars on the programme in New Zealand, London, Hong Kong, Singapore, the USA, Canada and South Africa as a Visiting Professor. All other Australian medical colleges adopted variations of the system over the next 15 years. It is now a compulsory requirement for continuing registration in Australia in all medical disciplines. In his last 3 years on the Council he served as Secretary, 1989-1992, and represented the College in the national debates on the relationship between midwives, obstetricians and GPs doing obstetrics. This was the period which saw the development of sub-specialities in which he was deeply involved, and he also encouraged a much closer relationship with the Australian College of Midwives, the latter finally moving into the Royal Australian College building in Melbourne to facilitate continuous dialogue. He remains on the History and Archives committee of the College. He was elevated to Fellowship of the Royal College of obstetricians and gynaecologists in 1972 and elected as a Fellow of the Royal Australasian College of Surgeons in 1981.

He served on the Medical Board of Royal Newcastle for many years, with a term as chairman, and served on the executive of the local branch of the Australian Medical Association (AMA), the Central Northern Medical Association (CNMA), for 20 years. He was chairman when local efforts were coordinated to urge the Karmel committee to award the next medical school to Newcastle. Alan Hewson was the senior author of a 200 page submission to the Karmel Committee, and appeared before the committee to argue the case, at the same time being on the Medical school committee from Royal Newcastle hospital. Most of the recommendations from the CNMA committee were included in the innovative programme of the eventual school, including adult education methodology, a vertically integrated curriculum, small group learning programmes, greater exposure to general practice, and increased emphasis on communication skills. He later became Senior lecturer, then Conjoint Professor of obstetrics in the school. In 1990 he was awarded an Honorary MD from the University of Newcastle because of his contributions to medical education. He has been Assistant Dean in continuing medical education in the medical school since 1994.

He was a Foundation member of the Hunter Postgraduate Medical Institute from 1979, and has served on the executive ever since, including a term as chairman. He is currently Director of Studies and was made a life member in 1995. The institute is now Australia's largest postgraduate medical institute with almost 2000 members. He was a member of the Council of the Australian Postgraduate Federation in Medicine (APFM) from 1974, and President for 5 years from 1996. He was made a Fellow of the APFM in 2000. His wide ranging contacts with experts from overseas brought many visitors to Newcastle as well as Australia over the past 50 years.

He held many positions in medical administration in the regional health service from 1983 to 1996 - all on an honorary basis. He was chairman of the Medical Planning Committee in the development of the new John Hunter Hospital from 1983 to 1990, and was Director of gynaecology for the first three years from 1990 at John Hunter hospital. He served on the Board of the Hunter Area Health Service for 4 years from 1988, and chaired the Peer Review and Quality Assurance Committee. He was chairman of the Board of the Christo Road private hospital from 1974, the first fully accredited private hospital in the Hunter region. He has always maintained an interest in the third world, taking a medical team to North Sulawesi in the Republic of

Indonesia in 1979. He served as a visiting consultant at Royal Darwin hospital from 1991 to 2005, becoming an expert on serious childbirth injuries in Indigenous communities. He also taught and worked annually in Papua New Guinea from 2007 until 2012, training registrars in obstetrics for their specialist examination.

Alan Hewson was awarded an AM in 2002 for his services to medical education in the national medical colleges and in the Hunter region. He has always been primarily an active clinician but his extensive CV includes 18 papers in refereed journals; he has presented over 140 formal lectures at medical college meetings and seminars on a wide range of subjects; and has edited two books, one on Quality Assurance in obstetrics, and the other on Careers in Medicine, a major 300 page handbook now in its 16th edition, which is provided free to every medical graduate in Australia. He has always carried a heavy clinical work load, delivered over 7000 babies personally, as well as being the responsible consultant for over 50000 deliveries over the past 60 years. He has a personal series of over 3000 abdominal hysterectomies and over 2500 vaginal hysterectomies, believed by his peers to be the largest series in Australia. His primary clinical interests have included maternal and infant deaths, utero vaginal prolapse, the care of the older gynaecological patient, malignancy, and medical education at all levels.

He has now retired from active practice, but remains a consultant to the Hunter New England Health Service, and has assistant appointments at private hospitals. For the last three years he has been working fulltime on a PhD thesis on the history of obstetrics and gynaecology in Australia between 1950 and 2010, which coincided with his own career in the discipline. This covers the dramatic changes in the discipline after World War Two, due to the information, knowledge, and research explosion, coupled with the transformation from obstetricians being general practitioners with a special interest, to the scientist clinicians of the modern era.

Alan Hewson, AM, Hon. MD., Newcastle, MB BS (Hons) Sydney, FRCOG, FRANZCOG, FRCS Ed., FRACS.

APPENDIX B: EDUCATION IN OBSTETRICS AND GYNAECOLOGY

B.1 Le Fanu's List of Medical Breakthroughs

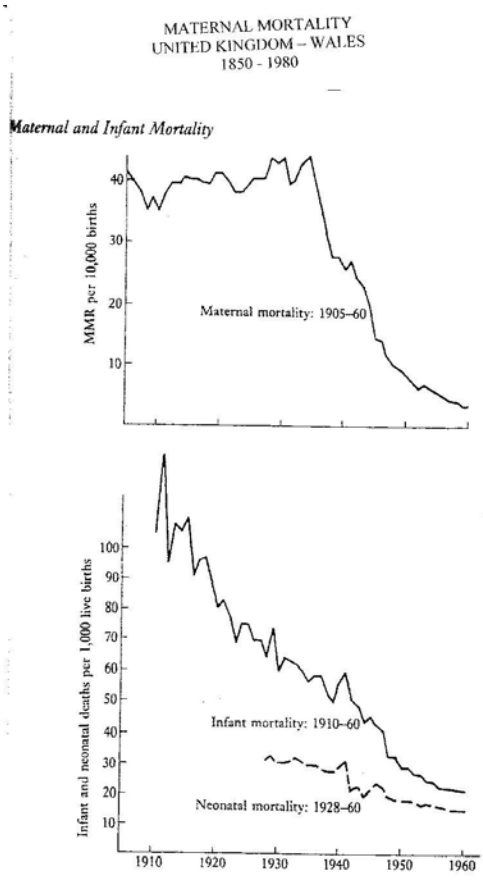
RISE & FALL OF
MODERN MEDICINE
LE FANU. 2002

The Ten Definitive Moments of Modern Medicine

* A 'definitive' moment

1935	Sulphonamides
1941	*Penicillin
	'Pap' smear for cervical cancer
1944	Kidney dialysis
1946	General anaesthesia with curare
1947	Radiotherapy (the linear accelerator)
1948	Intraocular lens implant for cataracts
1949	*Cortisone
1950	* Smoking identified as the cause of lung cancer * Tuberculosis cured with streptomycin and PAS
1952	The Copenhagen polio epidemic and the birth of intensive care
	*Chlorpromazine in the treatment of schizophrenia
1954	The Zeiss operating microscope
1955	*Open-heart surgery
	Polio vaccination
1956	Cardiopulmonary resuscitation
1957	Factor VIII for haemophilia
1959	The Hopkins endoscope
1960	Oral contraceptive pill
1961	Levodopa for Parkinson's
	Charnley's hip replacement
1963	*Kidney transplantation
1964	*Prevention of strokes
	Coronary bypass graft
1967	First heart transplant
1969	The pre-natal diagnosis of Down's syndrome
1970	Neonatal intensive care
	Cognitive therapy
1971	*Cure of childhood cancer
1973	CAT scanner
1978	*First test-tube baby
1979	Coronary angioplasty
1984	*Helicobacter as the cause of peptic ulcer
1987	Thrombolysis (clot-busting) for heart attacks
1996	Triple therapy for AIDS
1998	Viagra for the treatment of impotence

B.2 Maternal Neonatal and Infant Mortality Graphs UK and Wales, 1850-1980



G. 28.3 England and Wales, 1905–1960. Secular trends in Maternal, Infant, and Neonatal ortality
urce: A. Macfarlane and M. Mugford, *Birth Counts*, ii.

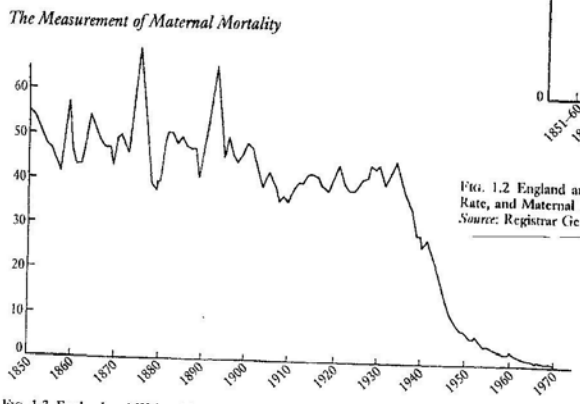


FIG. 1.3 England and Wales, 1850–1970. Annual rates of Maternal Mortality
Source: Registrar General for England and Wales, *Decennial Supplements*.

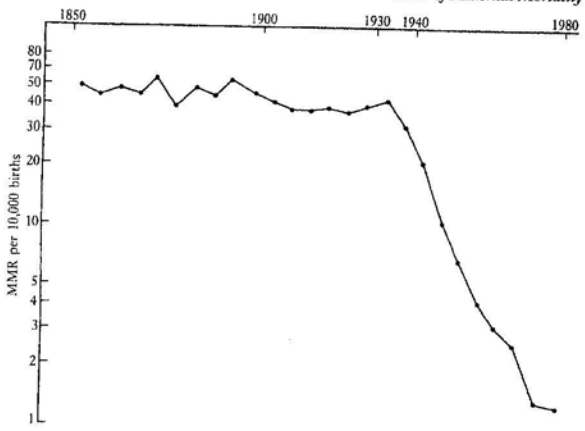


FIG. 1.4 England and Wales, 1850–1980, Maternal Mortality Rates (five-year averages) logarithmic scale
Source: Registrar General for England and Wales, *Decennial Supplements*.

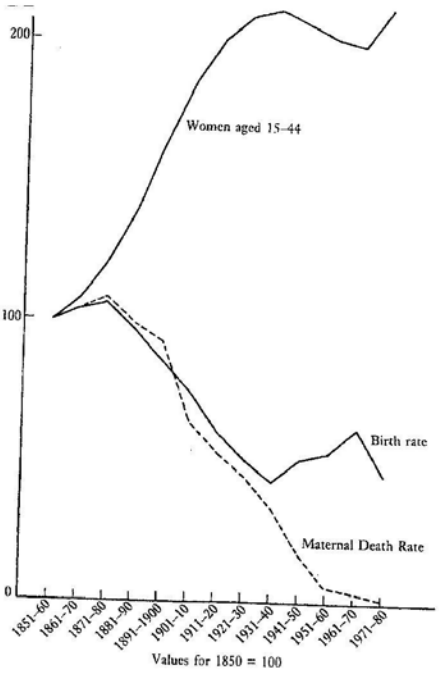


FIG. 1.2 England and Wales, 1851–60 to 1971–80. Population of women aged 15–44, Birth Rate, and Maternal Death Rate
Source: Registrar General for England and Wales, *Decennial Supplements*.

B3. Maternal Mortality, Australia and New Zealand 1905-1950

Fig. 27.1 Australia and New Zealand. 1905–1950, Annual trends in Maternal Mortality
Source: Official Statistics, Commonwealth of Australia and Government of New Zealand.

B4. Maternal Mortality in NSW 1936-1986

		Deaths	
Year	Live Births	No.	Rate*
1936	46193	292	6.32
1940	49382	209	4.23
1945	61662	139	2.25
1950	71592	80	1.12
1955	74407	55	0.74
1960	81983	56	0.68
1961	86392	43	0.50
1962	85439	29	0.34
1963	84065	27	0.32
1964	80518	28	0.35
1965	78069	25	0.32
1966	77758	22	0.28
1967	78841	19	0.24
1968	81696	28	0.34
1969	86036	15	0.17
1970	88448	22	0.25
1971	98466	15	0.15
1972	95278	8	0.08
1973	87332	7	0.08
1974	86162	12	0.14
1975	80918	3	0.04
1976	78492	9	0.11
1977	77996	9	0.12
1978	77773	4	0.05
1979	77469	3	0.04
1980	79801	3	0.04
1981	81971	9	0.11
1982	83908	9	0.11
1983	83307	5	0.06
**1984/85 (average)	82890	2	0.02
1986	84009	6	0.07

* *Number of Maternal Deaths per 1000 Live Births.*
** *1984 and 1985 data are not available as individual years, and a combined average for the 2 years is shown above.*

Source: Australian Bureau of Statistics.

B5. Perinatal Mortality in NSW 1936-1986

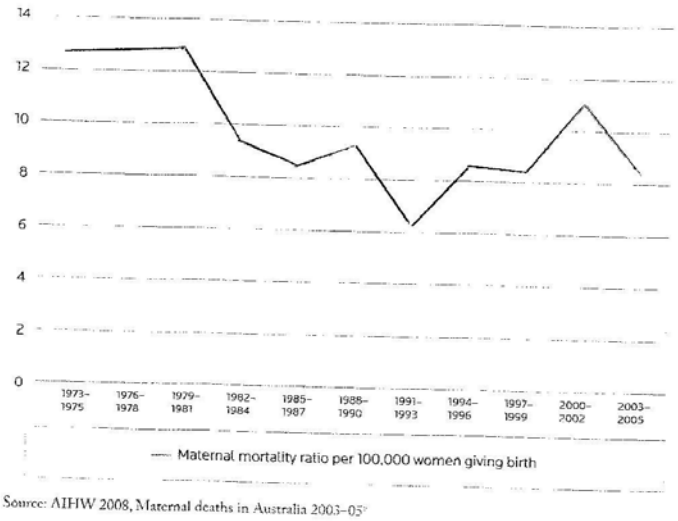
Year	Live Births	Perinatal Deaths					
		Stillbirths		Neonatal Deaths		Total	
		No.	Rate*	No.	Rate+	No.	Rate*
1936	46193	1419	29.80	1366	29.57	2785	58.49
1940	49382	1342	26.46	1263	25.58	2605	51.36
1945	61662	1540	24.37	1344	21.80	2884	45.63
1950	71592	1406	19.26	1345	18.79	2751	37.69
1955	74407	1243	16.43	1288	17.31	2531	33.46
1960	81983	1261	15.15	1250	15.25	2511	30.17
1961	86392	1306	14.89	1284	14.86	2590	29.53
1962	85439	1099	12.70	1321	15.46	2420	27.96
1963	84065	1165	13.67	1185	14.10	2350	27.57
1964	80518	1003	12.30	1152	14.31	2155	26.43
1965	78069	947	11.98	1087	13.92	2034	25.74
1966	77758	964	12.25	1085	13.95	2049	26.03
1967	78841	863	10.83	1058	13.42	1921	24.10
1968	81696	806	9.77	1123	13.75	1929	23.18
ϕ 1969	86036	1080	12.40	1235	14.35	2315	26.57
1970	88448	1154	12.88	1309	14.80	2463	27.49
1971	98466	1182	11.86	1260	12.80	2442	24.51
1972	95278	1151	11.94	1237	12.98	2388	24.76
1973	87332	1028	11.63	1105	12.65	2133	24.14
1974	86162	1036	11.88	1057	12.27	2093	24.00
1975	80918	795	9.73	897	11.09	1692	20.71
1976	78492	836	10.54	838	10.68	1674	21.10
1977	77996	758	9.62	683	8.76	1441	18.30
1978	77773	729	9.27	685	8.81	1414	18.01
1979	77469	718	9.20	610	7.80	1328	17.00
1980	79801	676	8.40	570	7.10	1246	15.50
1981	81971	686	8.30	532	6.40	1218	14.70
1982	83908	685	8.10	533	6.30	1218	14.40
1983	83307	586	7.00	503	6.04	1089	12.98
**1984/85 (average)	82890	599	7.19	473	5.71	1072	12.84
1986	84009	633	7.48	451	5.37	1084	12.81

** Number of Deaths per 1000 Total Births.*
*** 1984 and 1985 data are not available as individual years, and a combined average for the 2 years is shown above.*
+Number of Deaths per 1000 Live Births.
ϕ Revised Definition of Stillbirth Introduced 1 January, 1969.

Source: Australian Bureau of Statistics.

B6. Australian Maternal Mortality 1973-2005

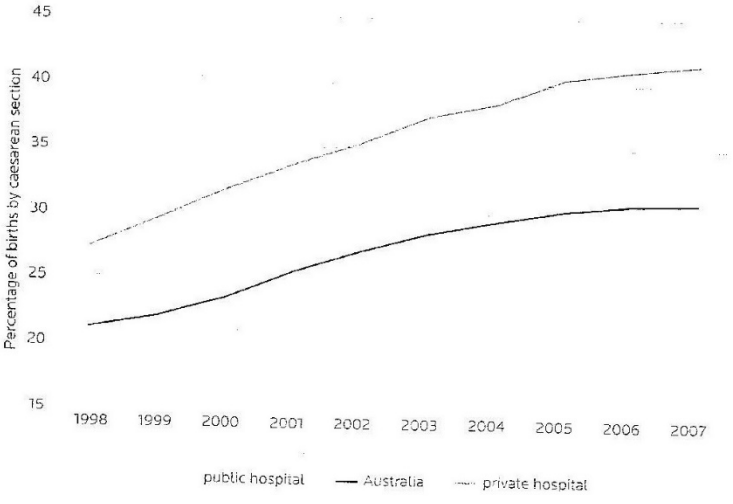
Figure 1 Maternal mortality rate in Australia (1973–75 to 2003–05)



Source: AIHW 2008, Maternal deaths in Australia 2003–05

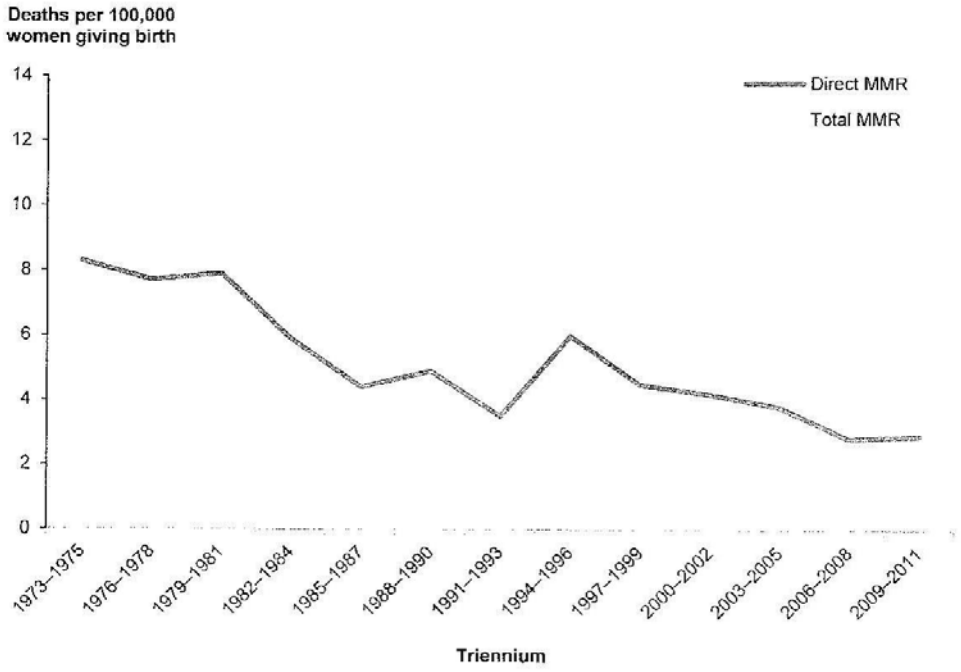
B7. Caesarean Section Rates, Australia 1998-2007

Figure 3 Proportion of births by caesarean section operation by hospital sector (1998–2007)



Source: AIHW Australia's mothers and babies 1998 to 2007

B8. Maternal Mortality, Australia 1973-2011 – Direct and Indirect Causes



Note: 1964–1966, 1967–1969 and 1970–1972 triennia are not included in this figure due to definitional differences in use for those periods.

Figure 3.2: Maternal mortality ratios by triennium, Australia, 1973–2011

B9. Foundation of Australian Specialist Colleges

Royal Australian College of Surgeons (RACS)	1927
Royal Australasian College of Physicians (RACP	1938
Royal Australian and New Zealand College of Radiologists (RANZCR)	1949
Royal College if Pathologists of Australasia (RCPA)	1956
Royal College of General Practitioners (RACGP)	1958
Royal Australian and New Zealand College of Psychiatrists (RANCP)	1963
Royal Australasian College of Dental surgeons (RACDS)	1965
Australasian College of Dermatologists (ACD)	1966
Royal Australasian College pf Medical Administrators (RACMA)	1967
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)	1969
Australian College for Emergency Medicine (ACEM)	1984
Australian and New Zealand College of Anaesthetists (ANZCA)	1992
Australian College of Rural and Remote Medicine (ACRRM)	1997
Royal Australian &New Zealand College of Obstetricians &Gynaecologists (RANZCOG)	1998
Australasian College of Sports Physicians (ACSP)	1999
College of Intensive Care Medicine of Australia & New Zealand (CICM)	2008

B10. Glossary of Medical Colleges/Organisations, Qualifications and Abbreviations

AMA	Australian Medical Association
ANZSOM	Australian and New Zealand Society Occupational Medicine
APFM	Australian Postgraduate Federation in Medicine
ARA	Australian Rheumatology Association
CME	Continuing Medical Education
CT	Computerised Axial Tomography Scan
FANZCA	Fellow of the Australian and New Zealand College of Anaesthetists
FRACGP	Fellow of the Royal Australian College of General Practitioners
FRANZCOG	Fellow of the Royal Australian & New Zealand College of Obstetricians & Gynaecologists
FRACP	Fellow of the Royal Australasian College of Physicians
HPMI	Hunter Postgraduate Medical Institute
HIV	Human Immuno Virus
IVF	Invitro fertilisation
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCQ	Multiple Choice Questions
MDA	Medical Defence Association
MDASA	Medical Defence Association of SA
MDAV	Medical Defence Association of VIC
MDA WA	Medical Defence Association of WA
MDS	Medical Defence Society
MDU	Medical Defence Union
MIPS	Medical Indemnity Protection Society
MJA	Medical Journal of Australia
MOPS	Maintenance of Professional Standards
MPS	Medical Protection Society
MPSNSW	Medical Protection Society of NSW
MRANZCOG	Member of the Royal Australian & New Zealand College of Obstetricians & Gynaecologists
OSCA	Objective Structured Clinical Assessment
MRI	Magnetic Resonance Imaging
OTP	Overseas Trained Physician
OTD	OVERSEAS TRAINED DOCTOR
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian & New Zealand College of Obstetricians & Gynaecologists
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RMO	Resident Medical Officer
SAC	Specialist Advisory Committee
SAPMEA	South Australian Postgraduate Medical Education Association
SAQ	Short Answer Questions
U.M.P.	United Medical Protection
VMO	Visiting Medical Officer
VR	Vocational Registration

B11. Number of Obstetricians in Australia – Members of the RCOG

1938	78
1947	109
1957	230
1966	389
1972	574
1978	852

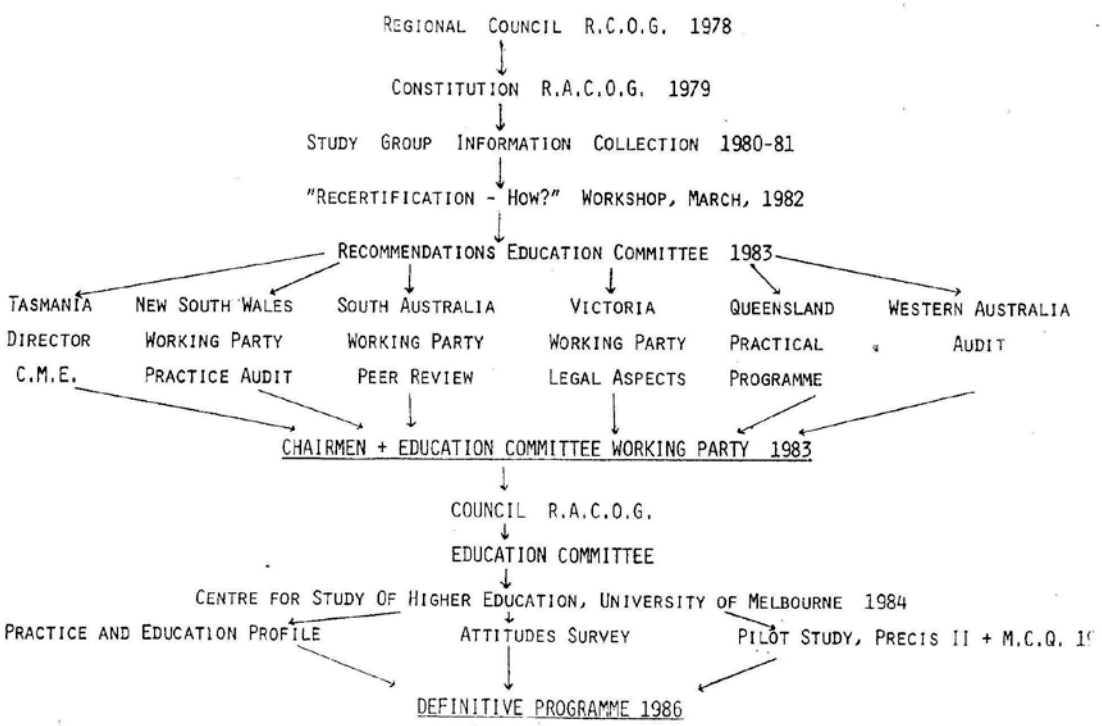
From Ian McDonald, Ian Cope and Frank Forster, *Super Ardua: History of the RCOG in Australia 1929-1979*

B12. Chronology of Development of the RCOG

13 February 1929	Formation of the British College of obstetricians and gynaecologists in UK (later the Royal College of obstetricians and gynaecologists).
1932	The British College of obstetricians established the Dominion Reference Committees in Australia, Canada, India, New Zealand and South Africa. The Australian Committee was named the Australian Reference Committee.
3 December 1938	The British College of obstetricians and gynaecologists renamed the Royal College of obstetricians and gynaecologists (RCOG).
27 February 1947	The Australian Regional Council (later Australian Council of the RCOG provisionally appointed. This council replaced the Australian Reference Committee.
1948	The New Zealand Regional Council of the RCOG was provisionally established.
May 1949	Official formation of the Australian Regional Council of the RCOG.
1950	Inauguration of the New Zealand Regional Council of the RCOG.
25 August 1954	Official opening of College House, 8 La Trobe Street, Melbourne, the Australian Regional Council Headquarters.
20 March 1966	Name of the Australian Regional Council, RCOG changed to Australian Council, RCOG.
6 May 1977	Formation of Steering Committee of the Proposed Australian College of obstetricians and gynaecologists.
29 August 1978	Formation of the Australian College of obstetricians and gynaecologists.
12 December 1980	The Australian College of obstetricians and gynaecologists renamed The Royal Australian College of obstetricians and gynaecologists (RACOG).

February 1982	Formation of The Royal New Zealand College of obstetricians and gynaecologists.
24 November 1983	Official opening of the new College House at 254 Albert Street, East Melbourne.
23 July 1988	Celebration of the Tenth Anniversary of the RACOG. Official opening of College House Extensions (including the Members Room incorporating the Library).
24 March 1991	Official opening of 260 Albert Street, East Melbourne.
19 July 1995	The Library officially named the Frank Forster Library.
21 June 1997	Official opening of College House Renovations, including Eric Mackay Room.
24 October 1997	Official opening of the Museum.
23 October 1998	The Royal Australian College of obstetricians and gynaecologists amalgamated with the Royal New Zealand College of obstetricians and gynaecologists to form the Royal Australian and New Zealand College of obstetricians and gynaecologists (RANZCOG).

B13. RACOG Obligatory Education Programme Development 1978-1986



B14. Initial Cognate Points Programme

To qualify for continuing certification, each Fellow must accumulate 100 points over a three-year period.

ACTIVITIES	COGNATE POINTS ALLOCATION	MAXIMUM IN THE 3-YEAR PERIOD
1. Educator Activities		
(a) Publications in a refereed scientific journal or book	5 points/publication	10 points
(b) Formal presentations at a recognised scientific meeting or postgraduate course	5 points/presentation	10 points
(c) Teaching	1 point/hour	10 points
2. Postgraduate Courses		
(a) RACOG Courses, Seminars & Wkshops (includes Advanced Courses, Basic Sciences Courses, Part II MRACOG Courses, Special Purpose Workshops, Interstate Scientific Weekends)	7 points/day	55 points
(b) Sub-specialty Group Meetings (within Australia)	7 points/day	
(c) RACOG Congresses	5 points/day	25 points
(d) Overseas Meetings *	5 points/day	10 points
(e) Hospital Meetings	1 point/hour	10 points
3. Peer Review/Quality Assurance		25 points
Regular participation in peer review/quality assurance activities		
4. Self-Assessment Tests (MCQ)		
(a) Feedback tests associated with RACOG Resource Manual Units	1 point/test	60 points
(b) Feedback tests associated with RACOG Audio Update tapes	1 point/test	
(c) RACOG Self-Assessment Programme	10 points/exam	

* Points allocated for overseas meetings may be varied for Fellows who reside and practise outside Australasia. Those Fellows must obtain prospective approval of such meetings from the Education Committee of the College.

5th July, 1986 cc.4

B15. International Expansion of Obligatory Education

1977-79-RACIG PLANNING

1979-81 -WORKSHOPS –IMPLEMENTATION

1981—83—PROTOCOLS –FRAMEWORK

1983-89—FINALISATION –FIRST REVIEW

OTHER COLLEGES

RNZCOG-1981

RACGP---1981

RCCPS -1990

RNZCGP—1994

RACS –1994

RACP—1994

ACPAED—1994

FFARACS—1994

INTERNATIONAL -1986—PALM SPRINGS USA –FIRST CME CONFERENCE

1988-RNZCOG[WORKSHOP]-CHRISTCHURCH

19909-FAQC ANAESTHETICS –RACS –DUNEDIN ,NZ

1990-RCCPAND S –CANADA –MC LAUGHLIN –GALLIE TOUR ADH

1993-RCOG [UK]GABB /HEWSON

1994 –SOUTH AFRICA –PRETORIA ALL COLLEGES /MED BOARD S.A.

1995-UK AND EUROPE FIRST CONFERENCE CME [LONDON]-ADH

1997FIRST AUST CME/QA CONFERENCE –ALL COLLEGES /ALL P.G ORGANISATIONS

1997 –COLLEGE MED S.A-IMPLEMENTED

B16. RANZCOG Membership Profile 2014

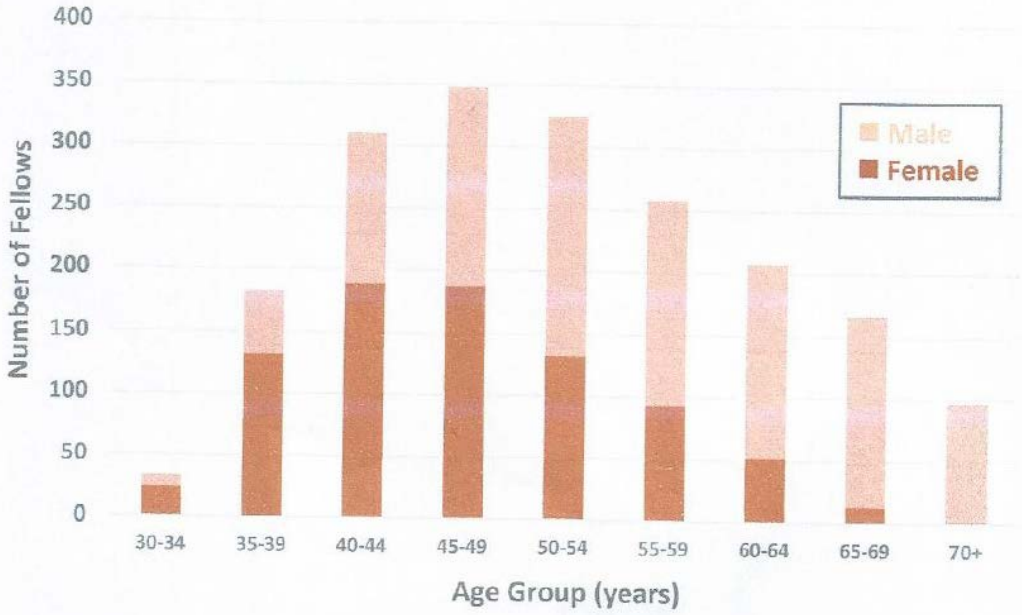
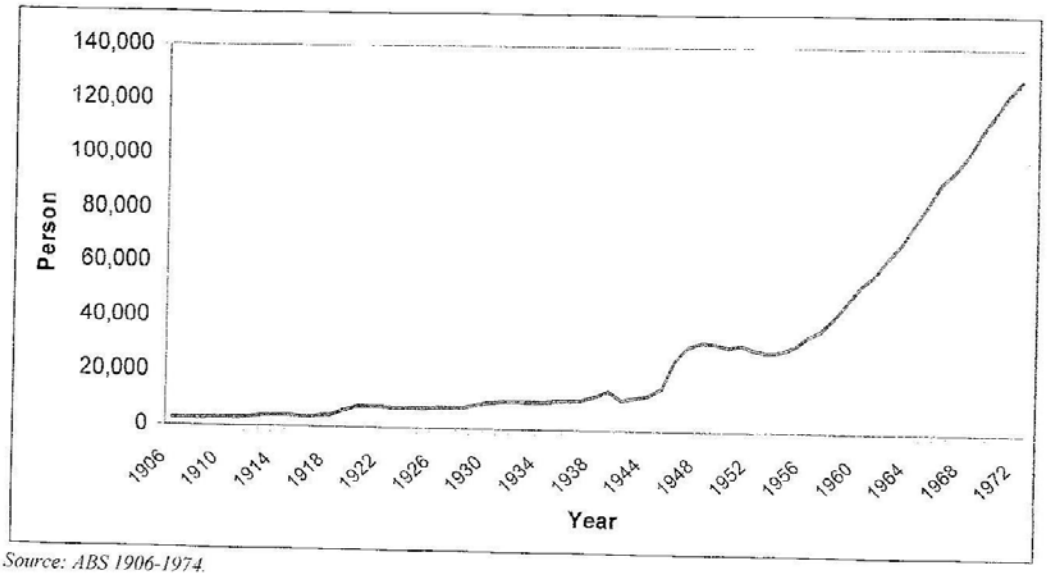


Figure 1. Gender distribution of RANZCOG Fellows in 2014.

APPENDIX C: SOCIAL AND CULTURAL CHANGES

C1. University Enrolments Post WW2

Figure 1: Total university enrolments, 1906-1972



Source: ABS 1906-1974.

The Commonwealth Scholarship Scheme also began not long after the war. A referendum in 1949 approved amending the constitution to allow the Commonwealth in peacetime formal powers to provide direct financial support to students. At the end of 1949, the Chifley Government approved three thousand competitively allocated university scholarships. The Menzies Government legislated this as the Commonwealth Scholarship Scheme, which began operation in 1951 (Hastings, 2008). The Commonwealth Scholarships scheme and the

[3] The Commonwealth Reconstruction Training Scheme (CRTS), introduced in March 1944, provided educational and vocational training to those who had served in Australia's armed services during World War II (National Archives). Since the gender composition of the services was overwhelmingly male, this would have boosted enrolments of men more than women. The last date for acceptance of applications was 30 June 1950 and by the middle of 1951 over 300,000 people had been accepted by the Scheme. Eligibility was a minimum of six months' service and an honourable discharge. Full-time participants had tuition and other fees paid, and they also received living allowances. See National Archives of Australia, Fact Sheet 178. CRTS Administrative Records, http://www.naa.gov.au/about-us/publications/fact-sheets/fs178.aspx.

C2. Hospital Protocols 1955

ROYAL HOBART HOSPITAL
OBSTETRIC & GYNAECOLOGICAL PROTOCOLS 1955

EXPLANATORY NOTES

1. ROUTINE PREPARATIONS OF OBSTETRICAL PATIENTS
The following technique is used at the Royal Hobart Hospital – Hobart

A. The patient on admission has a hot shower, the valvoperineal area is shaved and swabbed freely with Zephiran (1 in 2000). A low soap and water enema is given. In certain cases the hot shower and enema may be omitted.

B. Routine preparation of the hands consists of scrubbing of the hands and forearms to the elbows with soap and running sterile water for five minutes. The hands are then dried on a sterile towel, and a gown is put on with aseptic technique. The hands are dusted with powder and gloves slipped on. The gloved hands are then rinsed in Zephiren (1 in 1000).

C. Caps and masks are worn by all present in the preparation and delivery rooms.

D. Routine preparation of a case for delivery
Normal deliveries are conducted with the patient lying in the left lateral position. The right leg is supported by cloth stirrups from a cross-bar across the bed. Forceps and breech deliveries are carried put with the patient in the lithotomy position. After the patient is placed in position, the following preparation is carried out:-

The right labia and thigh, left labia and thigh, symphysis to umbilicus and vulvo-perineal area from the symphysis pubis to the coccyx, are swabbed in succession, using a solution of Zephiran (1 in 1000), and a fresh swab for each new area.
Four sterile drapes are applied:-

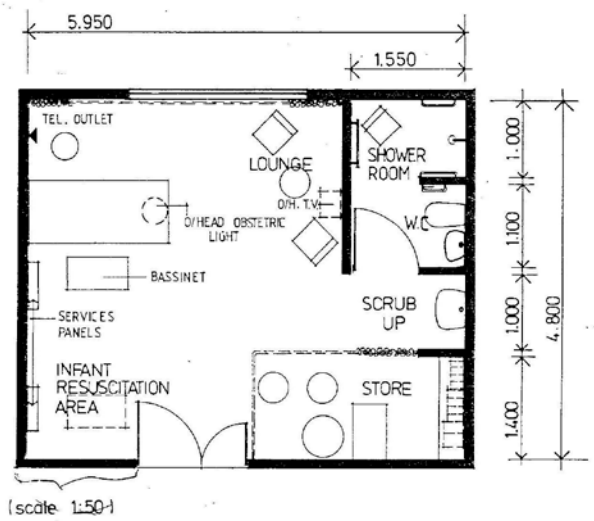
1. Over the left leg
2. Around the right leg
3. Over the abdomen
4. Small towel to cover the anal area and pinned to towels (1) and (2)

The bladder is catheterised

E. Relaxation Classes
At this hospital patients are encouraged to attend classes in 'relaxation' conducted by a physiotherapist, where instruction is given in the principles advocated by Grantly Dick Read. In conjunction these classes, regular talks are given by the Registrar explaining the processes of normal pregnancy, labour and the puerperium.

F. The Puerperium
In the past, fixed schedule breast or bottle feeding, with the infants housed in nurseries between feeds, has been the practice in this hospital. However, this has been recently modified to allow normal primigravidae to 'room in' with their infants, and the method of demand feeding has been adopted in this group.

C3. Modern Delivery Suite, Newcastle 1990

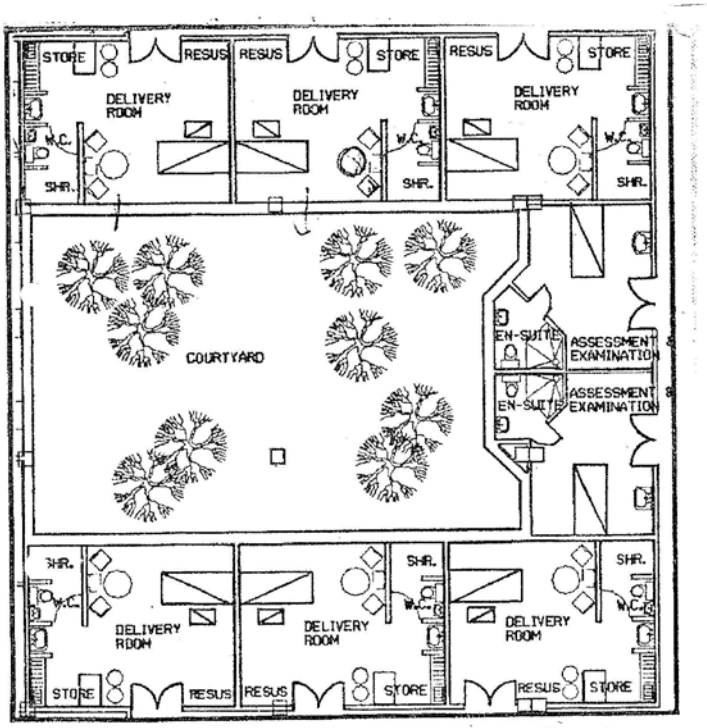


Design Brief
PUBLIC WORKS DEPARTMENT
GOVT. ARCHITECT'S BRANCH

PROPOSED DELIVERY ROOM

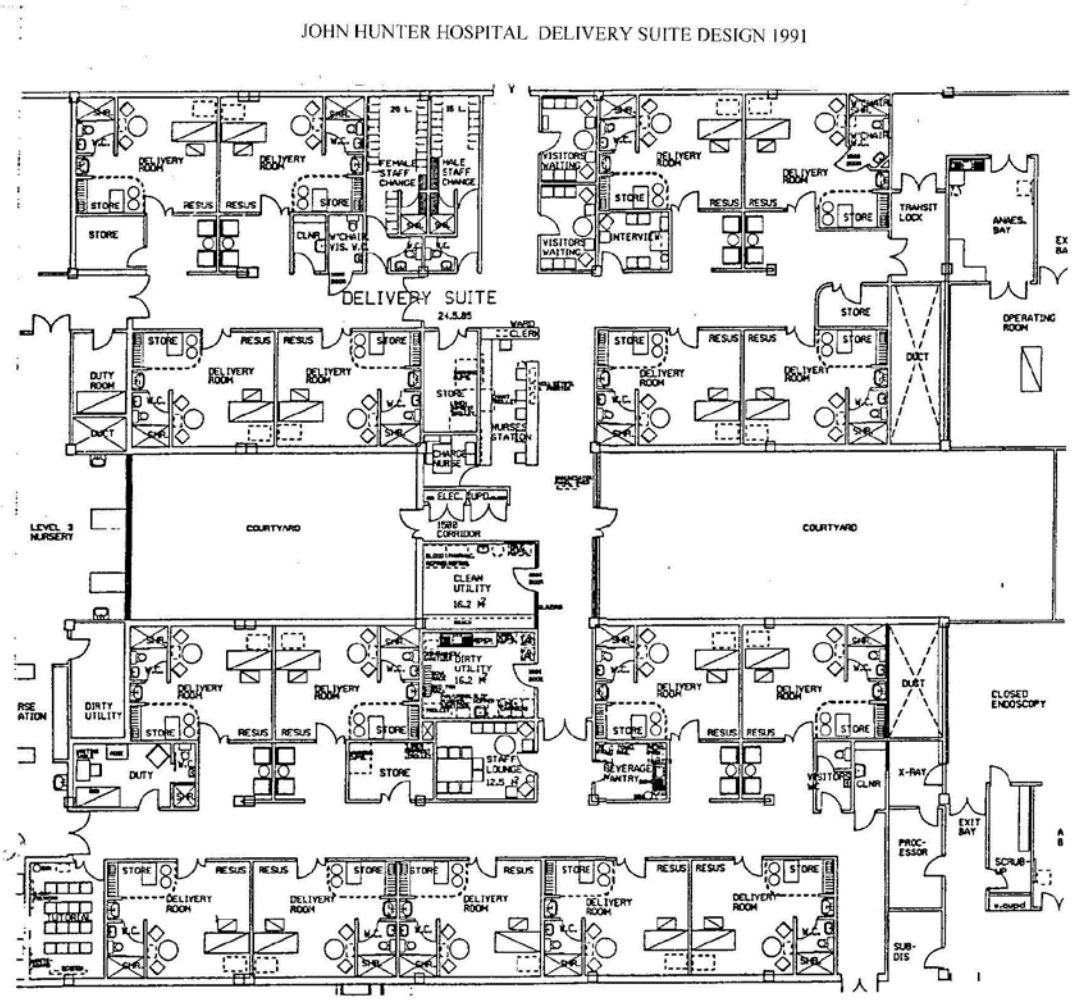
New Teaching Hospital
Greater Newcastle Area

DIAG NO. C2-02
H.P.U NO.



The obstetrics areas have modern concepts such as home-like delivery rooms, six of which have access to a rooftop courtyard.

C4. Delivery Room Detail, JHH, 1990



C5. Protocols March 2016

Clinical Guideline

NSW GOVERNMENT | Health
Hunter New England
Local Health District

Maternity - Care of women in first stage of labour – cephalic presentation

Sites where Clinical Guideline applies	All maternity services in HNELHD
This Clinical Guideline applies to:	All women who are cared for in labour with a cephalic presentation
1. Adults	Yes
2. Children up to 16 years	Yes - Potential for all maternity care guidelines to apply to girls under 16 years
3. Neonates – less than 29 days	No
Target audience	All maternity care providers: includes midwives, obstetricians, medical officers, midwifery and medical students
Description	This document reflects what is currently regarded as safe and appropriate practice for the care of women and their babies in the first stage of labour

Hyperlink to Guideline

Keywords	Maternity, first (1st) stage, labour, management, intrapartum care
Document registration number	
Replaces existing document?	Yes
Registration number and dates of superseded documents	Maternity: NICE Guidelines Summary for Intrapartum Care – Care of Healthy Women and their Babies - HNELHD CG 11_22

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- NSW Health Policy Directive 2014_036 Clinical Procedure Safety
- NSW Ministry of Health Policy PD 2005_406 Consent to Medical Treatment http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf
- NSW Ministry of Health Policy Directive PD 2007_036 Infection Control Policy http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_036.pdf
- NSW Ministry of Health Policy Directive PD 2010_045 Maternity – Towards Normal Birth in NSW http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_045.html
- NSW Ministry of Health GL2016_001 Maternity - Fetal Heart Rate Monitoring
- NSW Ministry of Health Policy Directive PD2010_022 Maternity – National Midwifery Guidelines for Consultation and Referral http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_022.html
- NSW Ministry of Health Policy Directive PD2006_045 Maternity – Public Homebirth Services http://www0.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_045.pdf
- Maternity: Women in Labour - Minimum Standards of Care HNELHD Pol 12_04:PCP 3

Position responsible for Clinical Guideline Governance and authorised by	Dr Henry Murray - Clinical Leader, Women's Health and Maternity (WHAM) Clinical Network
Clinical Guideline contact officer	Mandy Hunter, Clinical Midwife Consultant Maternity HNELHD
Contact details	Mandy.hunter@hnehealth.nsw.gov.au
Date authorised	7 March 2016
This document contains advice on therapeutics	No
Issue date	14 March 2016
Review date	14 March 2019
TRIM number	16/2-3-8

Version One March 2016

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TABLE OF CONTENTS

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GLOSSARY

Acronym or Term	Definition
Latent 1st Stage	A period of time, not necessarily continuous, when: • There are painful contractions • There is some cervical change, including cervical effacement and dilatation up to 6 cm
Active 1st Stage Labor (Established labor)	The onset of **regular** painful contractions that produce progressive dilation of the cervix: • The frequency of contractions will be about 3-4 in 10 mins • Contractions will last about 40-60 seconds • Cervical dilatation (at least 4 cm dilated and effacing)

GUIDELINE

This document establishes best practice for HNE Health. While not requiring mandatory compliance, staff must have sound reasons for not implementing standards or practices set out within the guideline, or for measuring consistent variance in practice.

OUTCOMES

1	To facilitate the process of normal labor and birth
2	To increase the number of women who progress to a normal birth
3	To make a timely diagnosis of active first stage of labor
4	To identify risk factors that may influence the ongoing management of the woman and her infant in first stage of labor

Risk Statement: This local clinical guideline has been developed to provide direction to staff and to ensure that the risks of harm to patients and staff associated with the care of women and their babies in the first stage of labour are identified and managed.

The assessment of the risk to the mother and baby during labour is an ongoing process. Any conditions or abnormalities that are identified by midwives during labour require appropriate consultation and referral to the medical team as per the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral.

Any unplanned event resulting in, or with the potential for, injury, damage or other loss to patients/staff/visitors as a result of this procedure must be reported through the incident Information Management System and managed in accordance with the Ministry of Health Policy Directive: Incident Management Policy PD2014_004. This would include unintended injury that results in disability, death or prolonged hospital stay.

Risk Category Risk Category: Clinical Care & Patient Safety

EXCELLENCE

Every Woman. Every time

All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour.

This guideline should be utilised in conjunction with the Minimum Standards of Maternity Care in Labour
Maternity: Women in Labour - Minimum Standards of Care HNELHD Pol 12_04:PCP 3

Staff Preparation

It is mandatory for staff to follow relevant: "Five moments of hand hygiene", infection control, moving safely/safe manual handling, documentation practices and to use HAIDET for patient/carer communication: Hand hygiene **A**cknowledge, **I**ntroduce, **D**uration, **E**xplanation, **T**hank you or closing comment.

Latent Stage:

Assessment:

On Admission in Labour the Midwife will:

- Perform full and holistic assessment of labour progress upon admission which should include:
  - Pregnancy history
  - Physical observations - temperature, pulse, blood pressure and urinalysis
  - Palpate the woman's abdomen to determine the fundal height, the baby's lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions
  - Record any vaginal loss – show, liquor, blood
  - Assessment of the woman's pain including her wishes for coping with labour along with pain relief options of the woman and her labour progress
  - Ask the woman about the baby's movements in the last 24 hours
  - Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction.
  - Palpate the woman's pulse to differentiate between the heart rates of the woman and the baby
- If the woman does not appear to be in established labour and there are no contraindications offer a vaginal assessment to assist with the proper diagnosis of active labour and to establish a baseline cervical assessment

Duration of Latent Stage:

- The duration of latent stage is variable and can be affected by a number of factors.
- A favorable cervix is associated with a shorter latent stage
- Transverse and occipital posterior position, sedation and analgesia are associated with prolonged latent stage.
- Admission to a birthing unit during latent stage is associated with a longer duration of labour
- Some women who undergo induction or augmentation of labour will not enter the active phase of labour. There is no universal standard for what constitutes a failed induction. The diagnosis may be considered if, after rupture of membranes, regular contractions and cervical change do not occur after 12-18 hours. (Obstet Gynecol. 2014;123(3):693)

Care during Latent Stage:

- Women who are not in active labour should be encouraged to go home to allow a physiologic latent phase, providing there are no contraindications and no clinical concerns about maternal or fetal welfare
- Women who are not in established labour, who are reluctant to go home and/or request analgesia should be offered admission to the antenatal ward or maternal day assessment unit
- Before leaving the birthing suite or assessment unit all women should be given advice on rest, hydration, nutrition, bladder care, and comfort measures such as baths and hot packs.
- All women should be given information on when to return to hospital
- All women with identified risk factors who present to the birthing unit in early labour must have a Normal (Reactive) Antenatal CTG before being discharged home or transferred to the antenatal ward.
- Where the woman is experiencing excess pain and/or lack of sleep discussion with staff specialist or GP Obstetrician should take place. Options to review with the woman and her support person/family include expectant management, admission and analgesia, or labour induction.
- Although some woman may enter the active phase before 6 cm dilation, rates of cervical dilation are more rapid beyond 6 cm in both nulliparas and multiparas.

Alert

It is important to be as accurate as possible about the time of onset of active 1st stage of labour, if it is not confirmed on vaginal examination and diagnosed too early this may lead to a later assumption that the labour is abnormally long. Prolonged labour is a leading cause of caesarean section worldwide

THE HISTORY OF OBSTETRICS AND GYNAECOLOGY IN AUSTRALIA FROM 1950 TO 2010

Thesis submitted to the School of Humanities and Social Science, Faculty of Education and Arts, University of Newcastle, in fulfilment of the requirements for the degree of Doctor of Philosophy.

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A.M., Hon. MD (Newcastle), MB, BS, Hons (Syd Univ), FRANZCOG, FRCOG, FRCS (Edin), FRACS
May 2016

DECLARATION

I hereby certify that this thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

…….
Alan Donald Hewson
May 2016

APPENDIX D: ROLE DELINEATION

D1. USA Home Births / Hospital Delivery

USA HOME BIRTHS TO HOSPITAL CONFINEMENT 1935-1955

The American Midwife 299

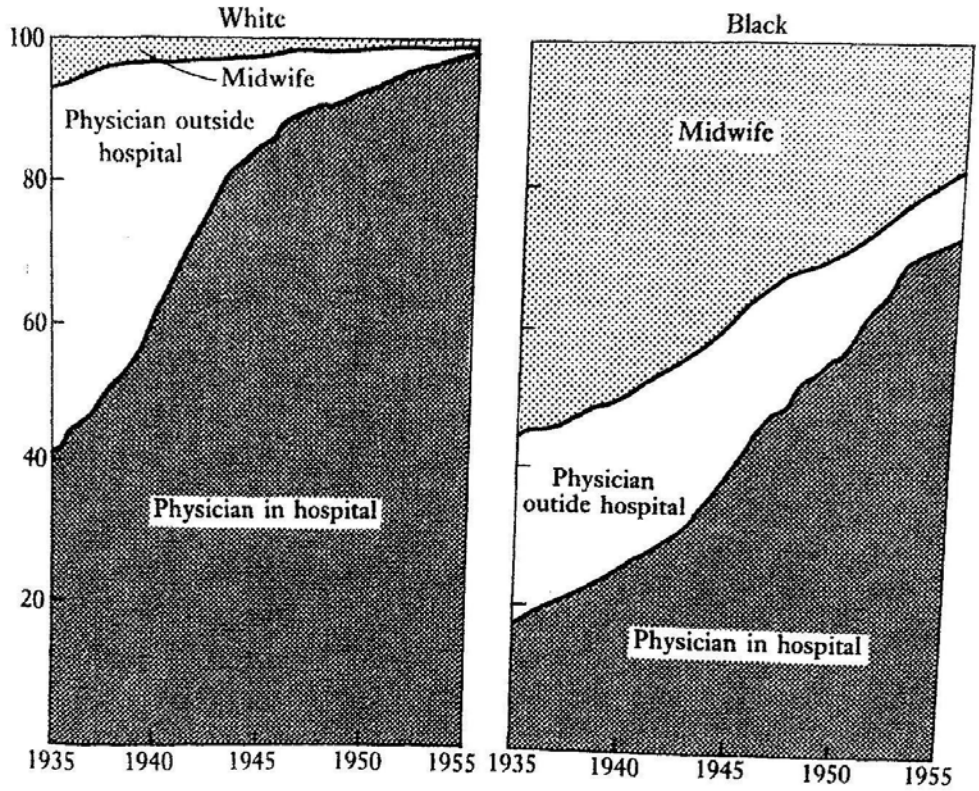


FIG. 18.1 USA, 1935–1954. Live births by attendant
Source: *Perinatal, Infant, and Childhood Mortality, 1954*, Children's Bureau Publications, No. 42 (Washington, DC, 1957).

D2. Home Birth Protocols, Melbourne 1985

QUEEN VICTORIA MEDICAL CENTRE HOME BIRTH PROTOCOLS 1985

LIST A - The responsibility of the patient

Large waterproof sheets - to cover floor and bed
Small waterproof sheets (Inco pads) - 20
Towels - at least four, freshly laundered
*Baby bath
*Plastic bowl
*Plastic bucket
*Nail brush, Velvet soap
Rubbish bin with plastic liner
Baby clothes and equipment inc. cotton buds
Suitcase packed with mother's clothes etc. - in case of transfer to hospita
Sanitary pads.

*Acquisition of the above items may be unnecessarily expensive and suitable alternatives could be discussed by the midwives with the couple preparing for the birth.

LIST B - BIRTH KIT - to be collected from hospital at 37 weeks and kept in the home in a locked resuscitation box.

Birth Centre "Bundles" - to which are added: cotton wool balls
jug
cord clamps
extra small surgical towels x 2

Aprons - 3 disposable
Savlon sachets (2)
Disposable enema
Catheters - Foley (with drainage bag) and Nelaton
I.V. giving set and Jelco needles (16 + 18 gauge) and adhesive tape
Hartmanns 1 litre
Haemacel 1 unit
G6PD cards + tubes for collecting cord blood sequestrene, plain tubes (2)
Baby labels - 2 wrist tags
Basic dressing packs (3)

LIST C - to be carried by the midwife

Sphygmomanometer
Stethoscope
Fetal Stethoscope
Thermometer
Spirit Swabs
Syringes 20 ml x 2
5 ml x 2
2 ml x 2

Needles 19G x 5
22G x 5
23G x 5
25G x 2

Gloves, "Gammex" and disposable
Suture set + catgut + local anaesthetic
Drugs - Pethidine Konakion
Ergometrine Stemetil
Syntometrine Narcan
Syntocinon (40 units)
Baby scales
Amniotomy forceps
Key to open Box B
Emergency cord clamp
Torch/Lantern

LIST C continued

Butterfly needles
Dextrostix
Neonatal resuscitation equipment
Oxygen cylinder small size, e.g. C.I.G. "c" size, 40 litres
Infant mask e.g. Bennett. 2 sizes
Airway, 2 sizes
Suction equipment - mucus extractor, disposable with mouthpiece (Indoplas P/L)
- Y shaped suction catheter with attachment for use with oxygen cylinder. 2 sizes.
Resuscitator with bag and mask, i.e. Penlon or similar type
Laryngoscope with infant attachment.

LIST D to be carried by doctor

Neville-Barnes forceps
Gloves (correct size)
Pudendal block equipment
Drugs - 8.4% sodium bicarbonate 10 ml. vial
10% glucose 10 ml. vial
adrenaline

APPENDIX E: MEDICOPOLITICAL

E1. Australian Doctors Fund Brochure 1984

AUSTRALIAN DOCTORS FUND DOCTORS DISPUTE APRIL –JULY 1984

FUND

ADF Health Headlines – Doctors' Dispute Edition

April to July 1984 - 2 pages

- **The NSW Labor Council has voted unanimously for a total union boycott of doctors involved in the hospital strike.** Labor Council secretary Mr John McBean said "while unionists support the right to strike, **the doctors protest was not a strike in the real sense.**" The meeting also voted to support a lunchtime protest demonstration at Chifley Square next Monday by members of the **Doctors Reform Society, which is opposing the AMA action. Doctors say they face the possibility of bans on delivery of mail and milk, repairs to their telephones, and even work on home building extensions** if they persist in their dispute over hospital contracts. [Jack Taylor, "Doctors face union boycott", SMH, 6 April 1984]
- The secretary of the Department of Health NSW, BV McKay, has run a half page advertisement in The Australian headed "**Vacancies for Orthopaedic Surgeons**". The advertisement on behalf of 26 public hospitals is calling for applications for orthopaedic salaried staff specialists (with rights of private practice) or VMOs. Staff specialist salaries are advertised within the range of $43,501 p.a. (first year) up to $59,199 p.a. for a senior specialist, with **VMOs being offered sessional rates of $46 per hour for a specialist** and $50.10 for a senior specialist. [The Aust., 31 May 1984]
- Senator Shirley Walters (Lib, Tas.) has accused the **Federal Labor government of "being prone to bouts of doctor bashing**" following claims that staff of the Minister for Health Dr Blewett and state Health Ministers were joining in **a rousing satirical chorus containing disparaging references to the Federal President of the AMA, Dr Lindsay Thompson**, Secretary General Dr George Repin, and Victorian AMA President Dr Clyde Scaife. Senator Walters said that the lyrics, which she had incorporated into Hansard, showed what the Labor party really thought of doctors. The song, sung to the tune of "O Tannenbaum" included a verse "*Oh AMA Oh AMA, Neal Blewett says you're bastards, with lots of money in tax lurks, to keep up the payments on the Mercs.*" **A spokesman for Dr Blewett said** that he had not been present at the occasion and had not heard of it until some weeks later, "**We're not responsible for what people say or sing at 1 o'clock in the morning**". [Ken Haley, "Blewett's staff, Ministers in 'AMA Blues in the Night'", The Age, 1 June 1984]
- **A blacklist of doctors**, banned from public hospitals for seven years, may be published by the state government under tough new laws introduced at an emergency sitting of Parliament yesterday. The federal president of the AMA, Dr Lindsay Thompson, called the threat [the seven year ban] a "gross, draconian and discriminatory overreaction". **Dr Thompson appealed to the state government and surgeons to refrain from further action that would inflame the NSW Hospitals Dispute.** [Bob Chisholm, "Doctors to be black listed", The Daily Telegraph, 13 June 1984]
- **Thousands of young general surgeons are ready to replace any doctors who quit the public hospital system** this weekend, the Premier, Mr Wran, said yesterday. Mr Wran's comments followed a chaotic day in the hospitals. More than 80 hospitals and **institutions were thrown into disarray as thousands of workers went on strike in support of a 38 hour week** when health workers walked off the job for 24 hours yesterday. In one 400 bed geriatric hospital in Allandale near Cessnock, sick and elderly patients went without regular meals and received only cold and simple food. [Peter Grimshaw & Arthur Stanley, "Young doctors 'ready' for hospital jobs", Daily Telegraph, 16 June 1984]
- **Ambulancemen have reimposed bans on clerical work as part of an industrial action** by the Health and Research Employees Association (HREA) **in its claim for a 38 hour working week**. The HREA bans, which involve thousands of health workers, were reimposed in about 80 NSW public hospitals. The union claims the government has been procrastinating since 1981. **The ban having the most effect is on the servicing of soiled linen.** Hospitals surveyed yesterday said they were coping adequately despite union limitations. ["Now paper war adds to all the confusion", Sunday Telegraph, 17 June 1984]
- **Reports from a meeting of surgeons at the Sydney Regent Hotel on 16 June described it as "standing room only". Nearly 600 surgeons crammed into a room with only 400 seats**. "The two-hour long meeting was punctuated by hearty bursts of applause and ended when 500 of the surgeons stood to express their intention to resign tomorrow. **The meeting was chaired by Dr Michael Aroney, Federal Secretary of the Australian Association of Surgeons.** Also on the platform were ... Dr David Grosser, of the Australian Association of Surgeons, Dr Bruce Shepherd, Chairman of the Australian Society of Orthopaedic Surgeons, ... Dr Peter Catts, incoming Chairman of the Australian Association of Surgeons, and Dr Noel Dan, secretary of the Association of Neurological Surgeons of NSW." ["600 surgeons say it's not on", Sunday Telegraph, 17 June 1984]

- **The head of St Vincent's Hospital heart transplant team, Dr Victor Chang, has defended his resignation from the NSW public hospital system as "his stand for democracy".** Dr Chang said that NSW doctors were the "foot soldiers in a struggle with state and federal governments which has the gravest implications for all Australians". Dr Chang said the Public Hospitals Amendment Act 1984 made it impossible to work in a public hospital and that he resigned after "a lot of soul searching and deep regrets". **"I didn't want to see nationalised medicine as I saw it in the United Kingdom**". Dr Chang, who last Saturday headed a surgical team which performed its sixth successful heart transplant operation this year, said the British hospital system was appalling. ["Why I am resigning – by Dr Victor Chang", The Australian, 20 June 1984]
- **Doctors last night rejected the NSW government peace plan** for the worsening surgeon's dispute and decided to go ahead with withdrawing all but emergency services from 8am today. The President of the AMA NSW branch, Dr Tony Buhagiar said **"we will not meet with any mediator until this obnoxious legislation is repealed.** We will not meet with the government with a gun held to our heads." Under the Public Hospitals Act, Visiting Medical Officers will be banned for up to seven years if they resign. Meanwhile a spokesman for the Public Medical Officers Association, **Dr Jean Lennane said "no union would countenance the banning legislation and her association demanded its immediate repeal"**. An interim report of the Penington Inquiry into the rights of private practice in public hospitals has been handed to Federal Minister for Health, Dr Blewett. ["5000 doctors walk out of NSW hospitals", The Australian, 20 June 1984]
- **164 doctors from the Sutherland Shire in Sydney have place a full page advertisement in the St George and Sutherland Leader** headed "At last you can read the truth about the "doctors' dispute" because it's brought to you by some people you know and trust." The advertisement has been authorised by the **Sutherland Shire Private Doctors' Association**. [St George & Sutherland Leader, 27 June 1984]
- The Sydney Morning Herald has described **Premier Neville Wran's decision to repeal the draconian provisions of his emergency Public Hospitals (Visiting Medical Practitioners) Amendment Act as an admission that the law with it's seven year ban on resigning surgeons, was a mistake**. The SMH claims in its editorial, "instead of bringing the resignations to a halt, it drove the majority of moderate surgeons into the arms of the militants." ["Mr Wran admits his mistake", SMH Editorial, 28 June 1984]
- The NSW Premier has hit back at full page advertisements by doctors in the doctors' dispute with a full page ad in the Daily Telegraph headed, **"Everything is negotiable except Medicare. What more do the doctors want?"** The advertisement says, "the state government has undertaken to withdraw this legislation once doctors are prepared to withdraw their resignations" and that "the Prime Minister has made it perfectly clear that private practice is a fundamental and essential part of our health care system". **The advertisement has been authorised by Ron Mulock**, Deputy Premier of NSW. [Daily Telegraph, 28 June 1984]
- In a **major retreat in the NSW Public Hospital dispute, the Premier Mr Wran has announced the withdrawal of the seven year ban on resigning doctors.** The announcement followed a cabinet meeting which decided to accept the back down as the price for putting new pressure on doctors to come to the conference table and settle the dispute. Last night's move was announced without any assurance from the doctors on how they would act. The doctors believe they are making two major concessions. They are no longer demanding the repeal of the 1983 legislation and they are offering a resumption of normal hospital services during the negotiating period. **Meanwhile, the government appointed mediator, Dr Ronald Werner, is no closer to playing a role in the dispute. Doctors groups are still refusing to accept him**. Talks have also failed to avert a nurses stoppage. [Paul Bailey, "Doctors: Wran retreats: Pressure now on for settlement", SMH, 28 June 1984]
- **More than 70 orthopaedic surgeons will stop work when the first of specialist resignations takes effect at midnight**. Surgeons will meet today to discuss their position. Leader of the Opposition, Mr Greiner, said yesterday that Parliament should be recalled on Tuesday for an emergency session to repeal the legislation banning for seven years those doctors who resigned and that Mr Wran has placed doctors in a situation where they would be acting illegally if they didn't turn up for work from 1 July. Chairman of the Australian Society of Orthopaedic Surgeons, Dr Bruce Shepherd, said he would be prepared to step down from the chairmanship if members wanted it, but according to letters and telephone calls he had received, he was strongly supported even by people who were previously against his actions. **In another dispute disrupting NSW public hospitals, 8000 nurses held a 24 hour strike yesterday in a campaign for a 38 hour week**. [Cosetta Bosi & John Campbell, "70 surgeons near resignation deadline", The Weekend Australian, 30 June 1984]
- Chairman of the Australian Society of Orthopaedic Surgeons, **Dr Bruce Shepherd, has made his final round at Mona Vale Hospital. Dr Shepherd has nearly 23 years in the public hospital service, 21 of them at Mona Vale**. On Friday, Dr Shepherd made his final round at Auburn Hospital, which he has served for nearly 20 years. "Auburn has one of the best hip replacement centres in Australia. The team is marvellous and I will miss them all." Dr Shepherd's position as Chairman of ASOS was supported with a unanimous vote of confidence from 120 of the 137 orthopaedic surgeons in the state. **Dr Shepherd said he was still hopeful that the dispute would end soon**. [Jennifer Dillon, "Fighting doctor's final round", Sunday Telegraph, 1 July 1984]

APPENDIX F: LITIGATION

F1. Talina Drabsch Summary 2001

APPENDIX X Timeline of significant events since 2001

YEAR	DATE	EVENT
2001	**27 February**	The NSW government announced details of its rescue package in response to the crisis.
	15 March	HIH Insurance entered provisional liquidation.
	19 June	*Healthcare liability Bill 2001* introduced into the Parliament
	5 July	*Healthcare Liability Act* received assent.
	27 August	HIH Insurance went into liquidation. Following the removal of its provisional status, the exposure of UMP to HIH calculated to be $ 64.6 million as at 30 June 2002.
	11 September	Terrorists hijacked US planes and crashed into the World Trade Centre, with major implications for all insurers around the world
	21 November	Australia's largest medical indemnity judgement handed down in Simpson versus Diamond case. The case still remains the largest judgement in Australia regarding medical negligence
	11 December	UMP announced an increase in premiums, affecting the majority of doctors in NSW (approx. 90%)
	19 December	NSW government announced from first of January 2002, it would fully indemnify VM Os for work performed on public patients in public hospitals .It would also cover liability for all claims from previous years.
2002	**1 January**	*Healthcare Liability Act 2001* began. All medical practitioners in New South Wales must be covered by approved professional indemnity insurance. All incidents involving a public patient in a public hospital are to be managed by the Treasury Managed Fund

29th of April. UMP/ A M I L, entered voluntary provisional liquidation with approximately $460 million in unfunded liabilities

May 2002. Commonwealth Department of Health and Ageing established a Medical Indemnity Task Force

31st of May .Federal government announced that it would assist UMP/ A M I L by covering payment for claims finalised and incidents occurring between 29 April and 30 June made under an existing or renewed policy, and the period it covered subsequently extended to 31 December 2002

18th of June. The *Civil liability Act 2002 NSW* received assent . The Act aimed to reduce the number and cost of civil claims in New South Wales. Section 2 of the Act ensured that its provisions apply retrospectively from 20 March 2002.

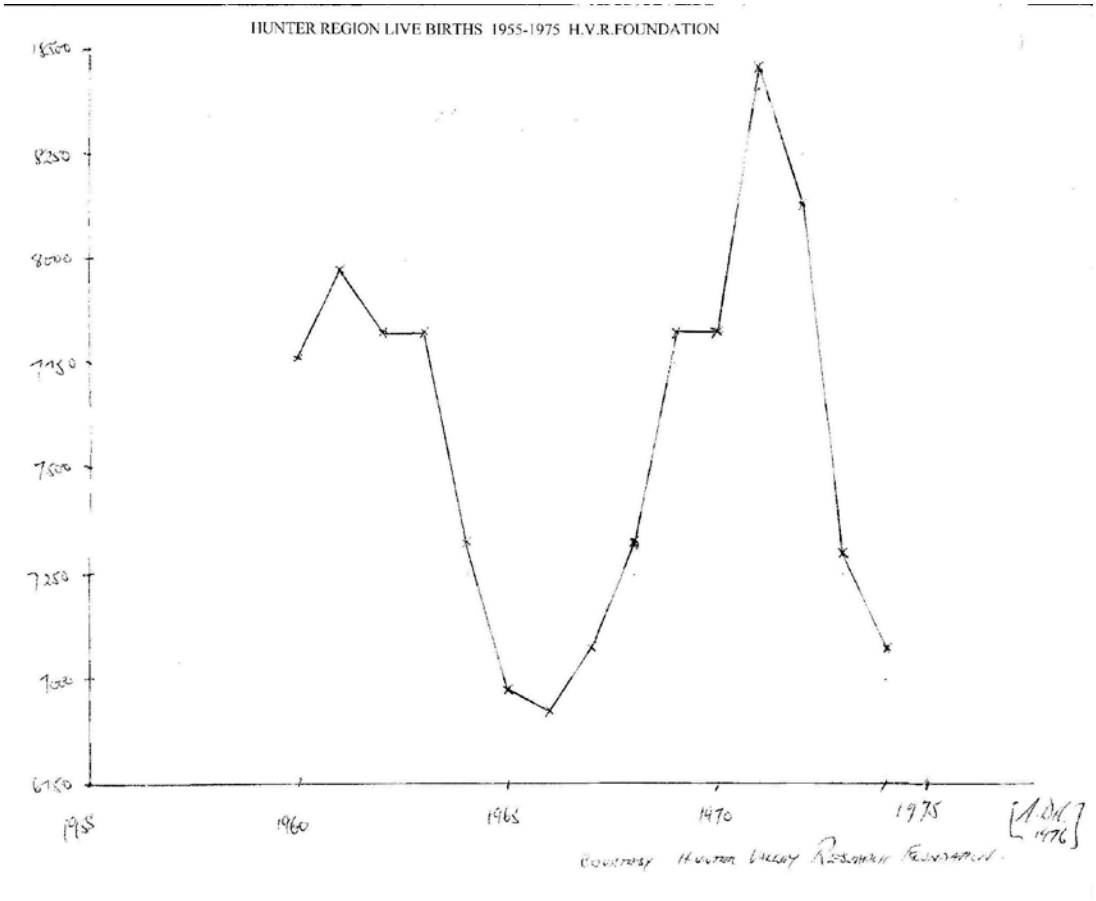
2 July. Terms of reference for the Ipp Enquiry[(Mr Justice Ipp) to review the law of negligence , designed to find a method of compensation to limit liability, because the present system had become unaffordable. Agreed desirable to reform the common law to limit liability and the quantum of damages for personal injury or death .

2 September, Review of law of negligence published, including rules of how to assess liability , duty to inform (including an update of the old Bolam law), standard of care clarified, opinion of peers

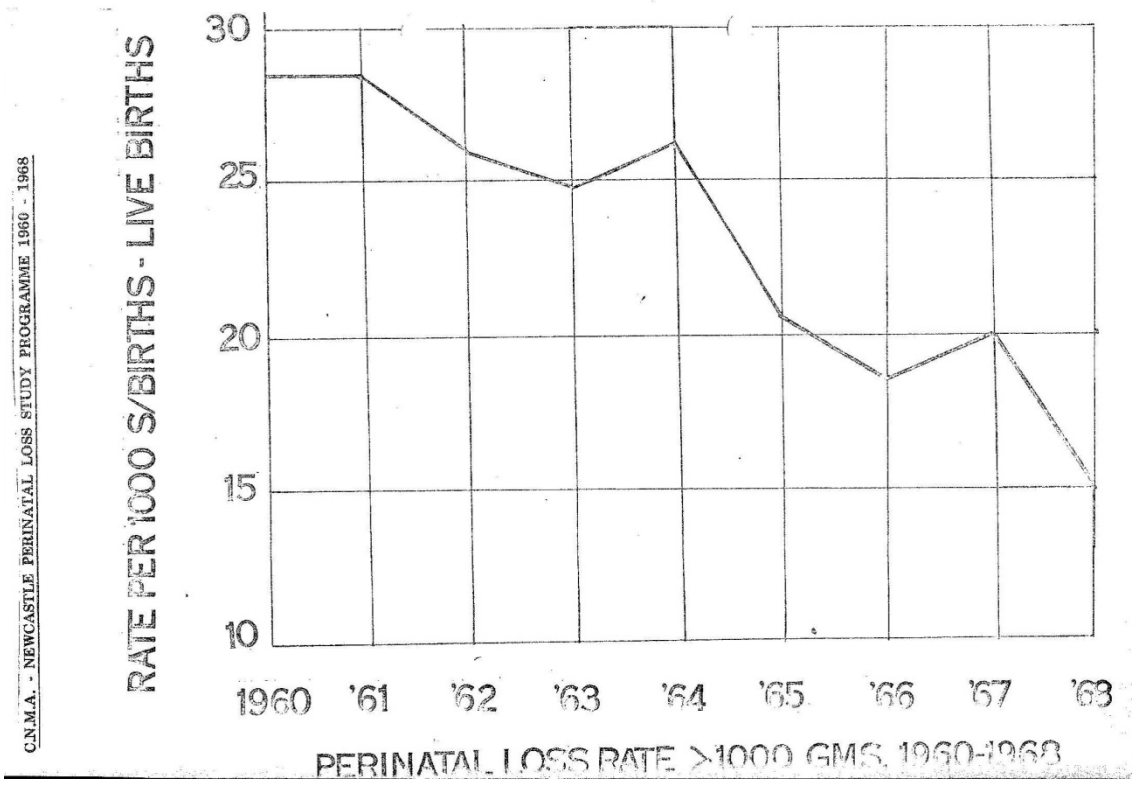
[150] Talina Drabsch ,*Medical Negligence ,an Update*, NSW Parliamentary Library Research Service, Briefing paper No 2/04 , 2004

APPENDIX G: THE HUNTER VALLEY

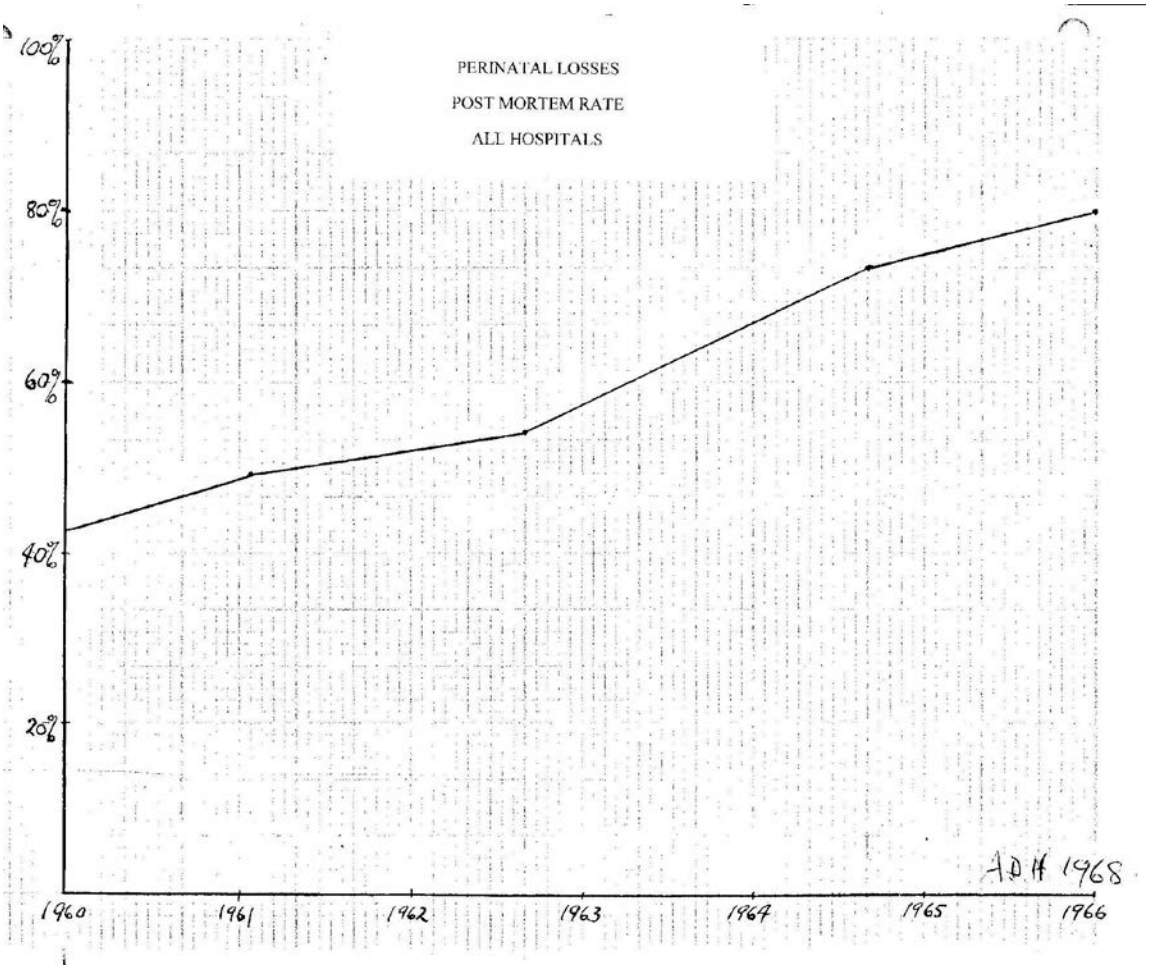
G1. Birth Rates 1955-1975



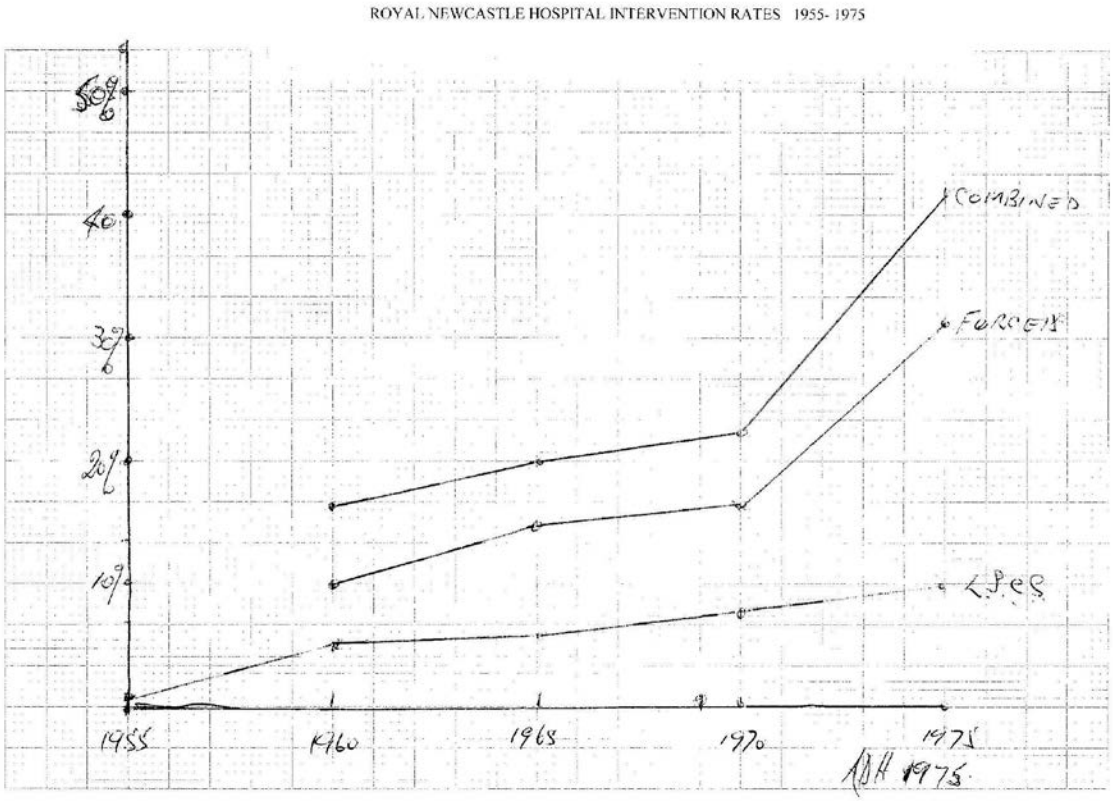
G2. Perinatal Loss Graph



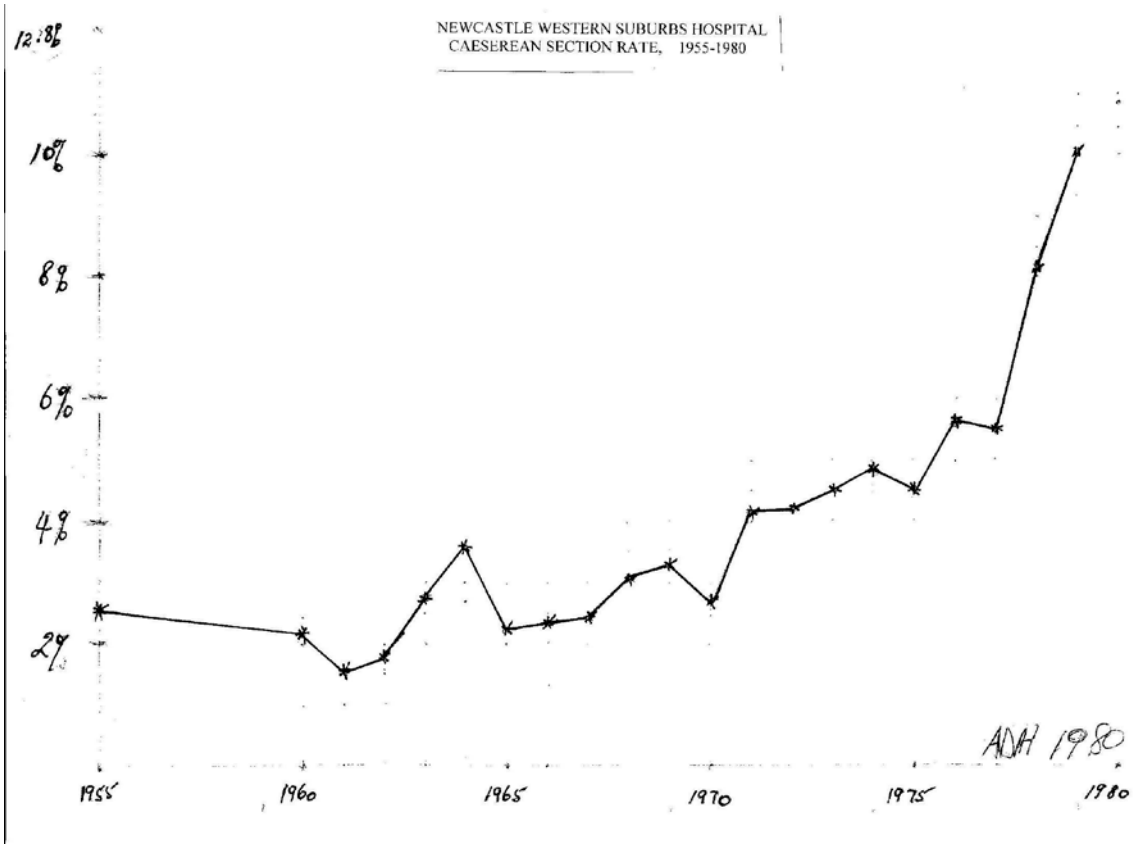
G3. Post Mortem Rates



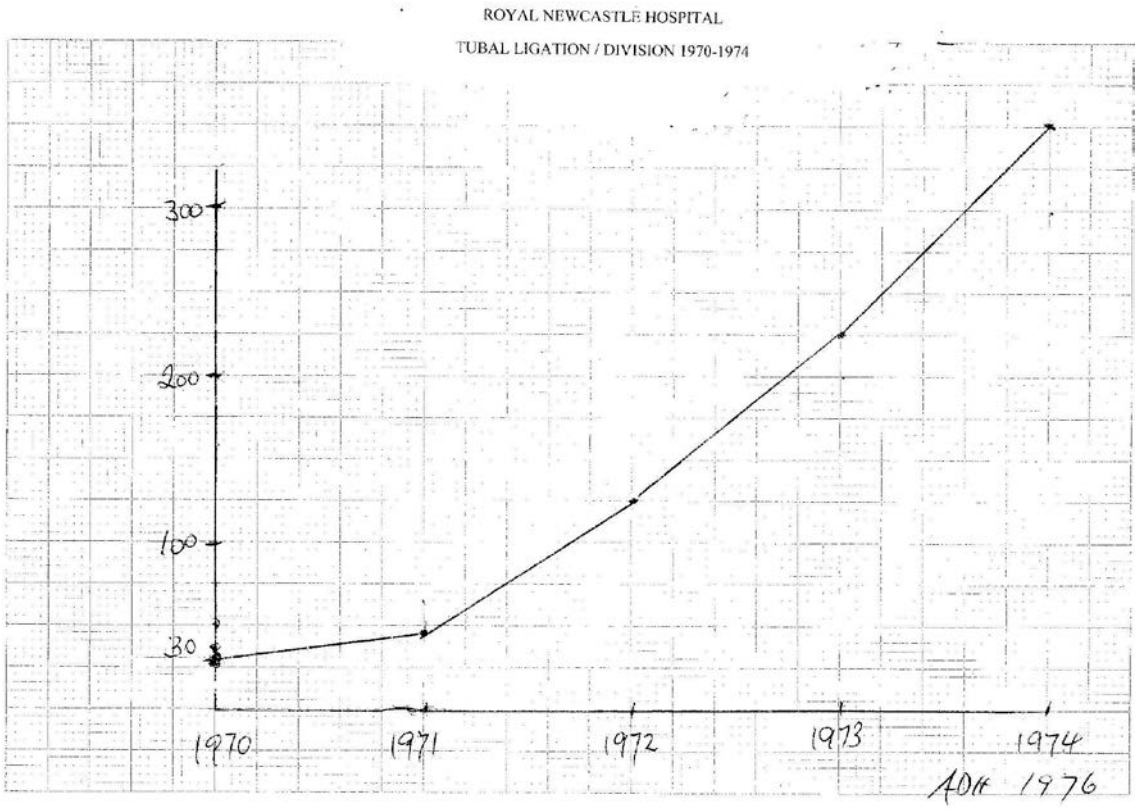
G4. Intervention Rates RNH, 1955-1975



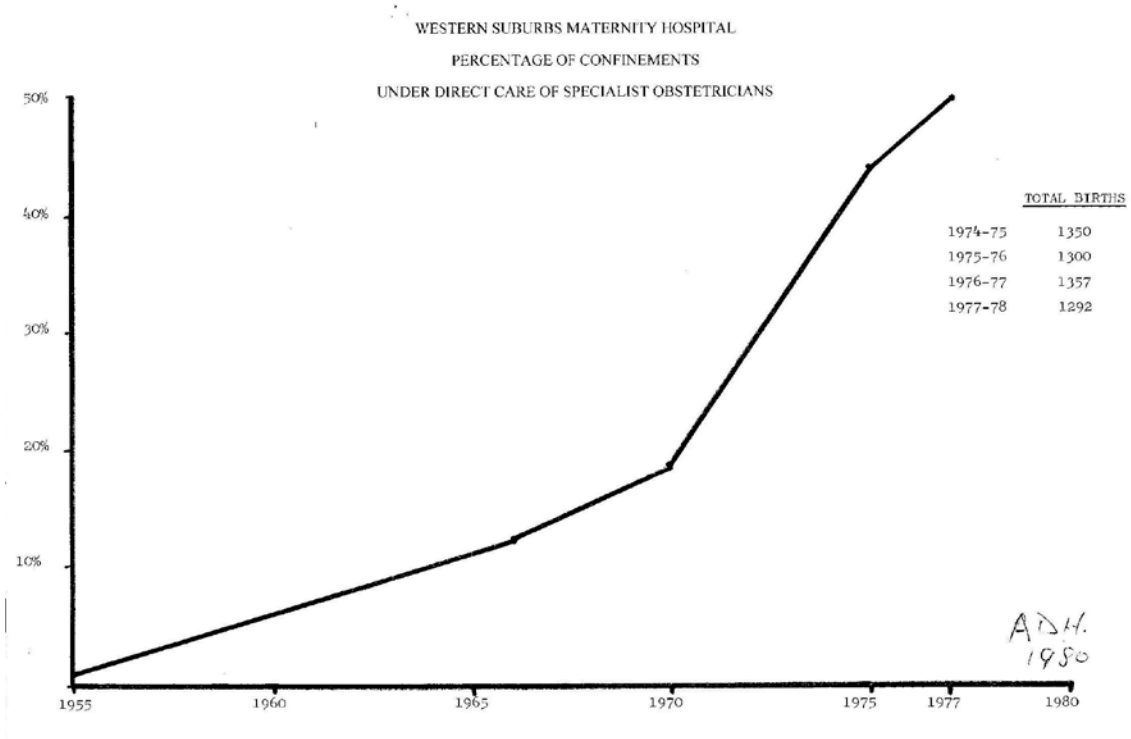
G5. WSH, LSCS Rates, 1955-1980



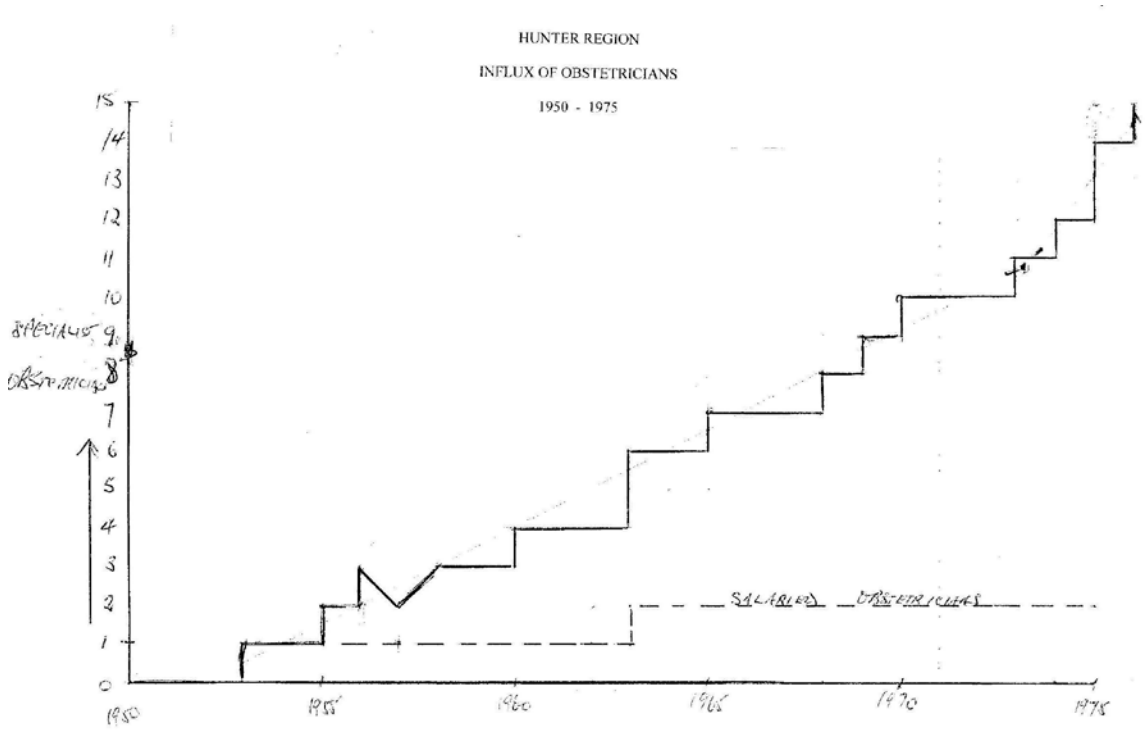
G6. Sterilisation Rates RNH, 1970-1975



G7.GP Delivery to Specialist Delivery, WSH



G8. Influx of Obstetricians 1950-1975



G9. List of Registrars Trained at RNH, 1958-1990

The Obstetric Registrars trained in the Department at RNH began with Charles Barbaro in 1959, then Colin Suchting and David Roxburgh.

1966	Walter Findlay
1968	Steele Fitchett
1971-72	Leon Clark
1973	Ang Ng
1974	Trevor Davies
1975	Geoff Jackel and Robert Richardson
1976	Geoff Jackel, Robert Cuffe, Greg Hicks
1977	Gordon Pullen, Ted Lim, Bob Cuffe, Greg Hicks
1978	John Walton, Greg Hicks, Bob Davidson, George Keladelfos
1979	John Walton, Geoff Jackel, Henry Cho, George Keladelfos
1980	Geoff Jackel, George Keladolfos, Henry Cho, John Tooth
1981	Chris Halloway, John Tooth, Tony Geraghty, Henry Cho
1982	John Tooth, Tony Geraghty, Jeff Tarr
1983	Tony Geraghty, Phil Taylor, John Tooth
1984	Steve Raymond, Tony Geraghty, Phil Taylor
1985	Steve Raymond, David Ellwood, Paul Martin, Tony Egan
1986	Paul Martin, Tony Egan, Phil Walkom
1987	David Morris, Paul Martin, Mia Huensberg
1988	Mia Huensberg, Tony Chung, Glen Lowe
1989	Andrew Bisits, Tony Chung, Glenn Lowe
1990	Steve Raymond, David Ellwood, Andrew Bisits, Glen Lowe, Michael Holland

Data provided by Dr Julian Ward, Director of Department, RNH. Every one of these registrars spent time studying and working overseas.

APPENDIX H: ADVANCES AND CHANGES

H1. Caesarean Section Rates, 2005-2010

HEALTH INSURANCE

TYPE OF BIRTH NSW

2005 - 2009

Insurance status–type of birth	Year 2005		2006		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%
Public										
Normal vaginal	32199	64.9	34649	64.7	38288	65.2	39148	65.3	38889	64.5
Forceps	1313	2.6	1494	2.8	1773	3.0	1872	3.1	1882	3.1
Vacuum extraction	3301	6.7	3390	6.3	3648	6.2	3578	6.0	3847	6.4
Vaginal breech	172	0.3	223	0.4	236	0.4	265	0.4	264	0.4
Elective caesarean section	6457	13.0	7278	13.6	7741	13.2	7913	13.2	8115	13.5
Emergency caesarean section##	6153	12.4	6421	12.0	7037	12.0	7191	12.0	7337	12.2
Not stated	0	0.0	57	0.1	32	0.1	10	0.0	0	0.0
TOTAL	49595	100.0	53512	100.0	58755	100.0	59977	100.0	60334	100.0
Private										
Normal vaginal	13614	48.4	13709	47.2	14464	46.9	15057	46.7	15494	46.6
Forceps	1378	4.9	1313	4.5	1450	4.7	1555	4.8	1452	4.4
Vacuum extraction	2764	9.8	2732	9.4	2989	9.7	3137	9.7	3303	9.9
Vaginal breech	60	0.2	65	0.2	89	0.3	99	0.3	84	0.3
Elective caesarean section	6592	23.4	7176	24.7	7562	24.5	7935	24.6	8332	25.1
Emergency caesarean section##	3738	13.3	3901	13.4	4233	13.7	4454	13.8	4566	13.7
Not stated	0	0.0	138	0.5	32	0.1	4	0.0	0	0.0
TOTAL	28146	100.0	29034	100.0	30819	100.0	32241	100.0	33231	100.0
TOTAL###										
Normal vaginal	54568	61.2	55187	60.4	56648	59.9	56173	59.2	55359	58.2
Forceps	2801	3.1	2885	3.2	3273	3.5	3486	3.7	3383	3.6
Vacuum extraction	6372	7.1	6332	6.9	6779	7.2	6830	7.2	7232	7.6
Vaginal breech	322	0.4	366	0.4	381	0.4	387	0.4	355	0.4
Elective caesarean section	14467	16.2	15507	17.0	15878	16.8	16120	17.0	16649	17.5
Emergency caesarean section##	10610	11.9	10827	11.9	11572	12.2	11854	12.5	12065	12.7
Not stated	0	0.0	211	0.2	71	0.1	14	0.0	0	0.0
TOTAL	89140	100.0	91315	100.0	94602	100.0	94864	100.0	95043	100.0

Source: Linked data of the NSW Perinatal Data Collection and NSW Admitted Patient Data Collection. Centre for Epidemiology and Evidence, NSW Ministry of Health.
Figures for 2005 to 2008 differ to those reported previously as the linkage has been updated.
Emergency caesarean section includes cases where caesarean section was reported but type of onset of labour was not reported.
Total includes mothers where type of health insurance was not stated.

2006 – 2010

Among NSW mothers, the rate of normal vaginal birth decreased from 60.4% in 2006 to 57.7% in 2010 (Table 13). The caesarean section rate increased from 28.8% to 30.5%; while the rate of instrumental birth (forceps and vacuum extraction) increased from 10.1% to 11.5%. Operative and instrumental births are more common among privately than publicly insured mothers (Table 14). Among privately insured mothers the rate of normal vaginal birth fell from 48.4% in 2005 to 46.6% in 2009 and the caesarean section rate increased from 36.7% to 38.8%. Among publicly insured mothers the rate of normal vaginal birth fell from 64.9% to 64.5% and the caesarean section rate rose from 25.4% to 25.6%.

Table 13. Type of birth, NSW 2006–2010

Type of birth	Year 2006		2007		2008		2009		2010	
	No.	%	No.	%	No.	%	No.	%	No.	%
Normal vaginal	55187	60.4	56648	59.9	56173	59.2	55359	58.2	54774	57.7
Forceps	2885	3.2	3273	3.5	3486	3.7	3383	3.6	3843	4.0
Vacuum extraction	6332	6.9	6779	7.2	6830	7.2	7232	7.6	7074	7.4
Vaginal breech	366	0.4	381	0.4	387	0.4	355	0.4	332	0.3
Elective caesarean section	15507	17.0	15878	16.8	16120	17.0	16649	17.5	16849	17.7
Emergency caesarean section#	10827	11.9	11572	12.2	11854	12.5	12065	12.7	12099	12.7
Not stated	211	0.2	71	0.1	14	0.0	0	0.0	25	0.0
TOTAL	91315	100.0	94602	100.0	94864	100.0	95043	100.0	94996	100.0

Source: NSW Perinatal Data Collection (HOIST). Centre for Epidemiology and Evidence, NSW Ministry of Health.
Emergency caesarean section includes caesarean sections where the onset of labour was not stated.

H2. NSW Data by Region: LSCS, Forceps, Ventouse, 2010

NSW DATA 2010

Table 35 shows type of birth for Local Health Districts, and Table 36 for individual hospitals by maternity service level where at least 200 mothers gave birth in 2010.

Table 35. Type of birth by Local Health District of hospital, NSW 2010

Local Health District	Type of birth															
	Normal vaginal		Forceps		Vacuum extraction		Vaginal breech		Elective caesarean section		Emergency caesarean section#		Not stated		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Sydney	3826	55.4	433	6.3	511	7.4	27	0.4	1113	16.1	990	14.3	0	0.0	6900	100.0
South Western Sydney	7093	69.2	185	1.8	657	6.4	48	0.5	1394	13.6	877	8.6	0	0.0	10254	100.0
South Eastern Sydney	4524	57.9	470	6.0	628	8.0	32	0.4	1185	15.2	964	12.3	0	0.0	7807	100.0
Illawarra Shoalhaven	2096	65.3	78	2.4	172	5.4	7	0.2	449	14.0	406	12.7	0	0.0	3208	100.0
Western Sydney	5522	59.4	547	5.9	659	7.1	38	0.4	1350	14.5	1180	12.7	0	0.0	9296	100.0
Nepean Blue Mountains	2774	58.6	94	2.0	360	7.6	16	0.3	804	17.0	685	14.5	0	0.0	4733	100.0
Northern Sydney	2854	56.7	345	6.9	256	5.1	11	0.2	767	15.2	798	15.9	0	0.0	5031	100.0
Central Coast	1504	56.3	122	4.6	197	7.4	7	0.3	450	16.8	391	14.6	0	0.0	2671	100.0
Hunter New England	5793	64.3	283	3.1	540	6.0	60	0.7	1172	13.0	1159	12.9	0	0.0	9007	100.0
Northern NSW	2443	67.9	109	3.0	163	4.5	18	0.5	455	12.6	407	11.3	5	0.1	3600	100.0
Mid North Coast	1500	66.7	68	3.0	95	4.2	8	0.4	311	13.8	266	11.8	0	0.0	2248	100.0
Southern NSW	894	65.3	67	4.9	77	5.6	2	0.1	188	13.7	139	10.2	2	0.1	1369	100.0
Murrumbidgee	1216	62.7	40	2.1	110	5.7	5	0.3	303	15.6	264	13.6	0	0.0	1938	100.0
Western NSW	2251	66.5	78	2.3	171	5.1	10	0.3	485	14.3	388	11.5	0	0.0	3383	100.0
Far West	142	55.7	8	3.1	12	4.7	3	1.2	41	16.1	49	19.2	0	0.0	255	100.0
Private Hospitals	10187	44.0	916	4.0	2466	10.7	36	0.2	6378	27.6	3136	13.6	13	0.1	23132	100.0
TOTAL*	54774	57.7	3843	4.0	7074	7.4	332	0.3	16849	17.7	12099	12.7	25	0.0	94996	100.0

Source: NSW Perinatal Data Collection (HOIST). Centre for Epidemiology and Evidence, NSW Ministry of Health.
Emergency caesarean section includes caesarean section where the onset of labour was not stated.
* Total includes births at home assisted by independent midwives.

H3. Direct/ Indirect/ Incidental Deaths 1973-2011

MATERNAL MORTALITY AUSTRALIA 1973-2011
DIRECT-INDIRECT-INCIDENTAL

Table 3.2: Maternal mortality ratios by triennium, Australia, 1973–2011

Years	Direct deaths[a]	Associated deaths		Number of women who gave birth	Direct maternal mortality ratio[b]	Maternal mortality ratio[c]
1964–1966	202		73	667,649	30.3	Not calculated
1967–1969	166		71	713,064	23.3	Not calculated
1970–1972	150		94	790,818	19.0	Not calculated
		Indirect deaths	Incidental deaths			
1973–1975	60	32	45	726,690	8.3	12.7
1976–1978	52	35	19	678,098	7.7	12.8
1979–1981	54	34	9	682,880	7.9	12.9
1982–1984	42	25	27	713,985	5.9	9.4
1985–1987	32	30	24	726,642	4.4	8.5
1988–1990	37	33	26	754,468	4.9	9.3
1991–1993	27	22	36	769,253	3.5	6.2
1994–1996	46	20	34	767,448	6.0	8.6
1997–1999	34	30	28	758,030	4.5	8.4
2000–2002	32	52	3	753,901	4.2	11.1
2003–2005	29	36	13	773,248	3.8	8.4
2006–2008	24	35	15	859,088	2.8	6.9
2009–2011	26	36	18[d]	886,480	2.9	7.2[e]

(a) Data in this table from periods prior to 2006–2010 are based on historical reports and occasionally do not align with subsequent tables in the report for the 1973–75 and 1991–1993 triennia.

(b) Maternal mortality ratio calculated from direct maternal deaths only, per 100,000 women who gave birth.

(c) Maternal mortality ratio calculated from direct and indirect maternal deaths, per 100,000 women who gave birth. Due to definitional differences, this cannot be calculated for the 1964–1966, 1967–1969 and 1970–1972 triennia. Therefore, these triennia cannot be compared with those that follow.

(d) Includes 3 unclassified deaths.

(e) Includes 2 maternal deaths not further classified as either direct or indirect.

Note: Table does not include 2012 data because triennium data are incomplete.

H4. A Supplementary Chronology of Scientific and Clinical Advances in Obstetrics and Gynaecology Between 1940 and 2000.

Abstracted from *Dates in Obstetrics and Gynaecology*, HSJ Lee, Editor, *Progress in Obstetrics and Gynaecology Over the Last Millennium*, selected items from 1940 to 2000, and other sources used in this thesis.

1942 Edwards and Hingson; Continuous caudal block in labour
1945 James Vincent O'Sullivan; Hydraulic treatment of inversion of the Uterus
1946 Curtis Lester Mendelsohn; Inhalational syndrome during anaesthesia in labour
1946 J. Adriani and Parmley; Saddle block anaesthesia in labour
1946 John Rock and M. F. Menken; Fertilised human eggs in vitro
1948 Joseph Asherman; Intrauterine adhesions (Ashermans Syndrome)
1948 Louis Klein Diamond; Exchange Transfusion for Rh Disease
1949 R. Palmer; Gynaecological laparoscopy
1949 J. E. Ayre; Ayre Spatula for Smears
1950 Harvey Grahame; Published *Eternal Eve*
1950 Philip Hensch; Nobel Prize for suprarenal hormones work
1950 F. J. Browne; Used thyroid extract for hypothyroid patients with amenorrhoea
1950 Terence Millen and Charles Read; The unstable bladder
1952 Karl Dam; Vitamin K and Haemorrhagic disease of the newborn
1952 Worlds First sex change operation - George Jorgenson
1952 G. W. Harris; GNRH factor from hypothalamus to the pituitary
1953 F. Fuchs and P. Riis; Foetal sexing from amniocentesis
1953 T. Maelstrom; first vacuum extractor
1953 B Westin; foetoscopy
1953 Virginia Apgar; Apgar Scoring
1954 Inge Edler and Carl Hertz; Cardiac ultrasound
1954 Anne Forbes; Galactorrhoea amenorrhoea
1954 Vincent de Vigneaud; oxytocin and vasopressin
1954 Thalidomide synthesised in Germany

1955 E. H. Kass; ‘clean catch’ urine testing

1955 O. H. Pearson; oestrogen in breast cancer

1955 O. S. Heyns; abdominal decompression in labour

1956 William Studdiford and Gordon Douglas; septic abortion shock

1958 R. W. Kistner; endometriosis and Progestogens

1958 Ian Donald; first echo ultrasound in obstetrics

1960 P. M. List; B sympatho mimetic drugs and uterine motility

1960 Gregory Pincus; the oral contraceptive pill available

1961 W. McBride; thalidomide tragedy unveiled

1961 Y. Ito and K. Higashi; human placental lactogen

1963 A. W. Liley; Intrauterine transfusion for Rh Disease

1963 E. Huhmer and P. A. Javener; trans vaginal foetal electroencephalography

1963 R. Hertz; methotrexate cures choriocarcinoma

1963 J. H. Holmes and D. H. Howry; detection of foetus by ultrasound

1964 E. H. Bishop; Cervical ripeness–the Bishop Score

1965 Morris Davis; Oetrogens prevent osteoporosis

1965 G. H. Green; preinvasive cytology controversy

1965 R. Nissen-Meyer; prophylactic oophorectomy in breast cancer

1965 Elizabeth Hibbard and R. W. Smithells; folate deficiency and anencephaly

1965 Barnett Rosenberg; Cisplatinum discovered

1966 Charles Huggins; hormonal treatment for breast cancer

1966 Robert Wilson; *Feminine Forever*; HRT for the menopause

1966 P. Chodoff and J. G. Stella; ketamine in obstetric anaesthesia

1967 E. A. Friedman; latent and active stages of labour

1967 A. S. Kantrowitz; first paediatric heart transplant

1967 Patrick Steptoe; laparoscopy, later IVF with Geoffrey Edwards

1968 Down’s syndrome diagnosed antenatally by amniocentesis

1968 A. Klopper; urinary oestrogens studies

1968 Sultan Karim; prostaglandins for termination; later induction of labour

1969 C. Wood; Apgar scores and foetal acidosis

1969 Robert Edwards and Patrick Steptoe; IVF achieved in vitro

1969 Stuart Campbell; foetal growth by ultrasound

1969 J. M. Morris and G. van Wagenen; morning after pill

1970 First neonatal intensive care unit opened

1970 Rubella immunisation in Britain

1971 R. B. Greenblatt; Danazol for endometriosis

1971 Bromocriptine for preventing lactation

1971 Wesselius de Caspari; ritodrine for premature labour

1971 A. L. Herbst; diethyl stilboestrol and vaginal clear cell adenocarcinoma

1971 Progesterone added to oestrogen for HRT

1972 A. T. Letchworth and T. Chard; HPL levels in preeclampsia for well being

1972 Joseph Meites; prolactin inhibition by hypothalamus

1972 N. A. Beischer and J. B. Brown; oetrogen assays and foetal well being

1972 N. R. Butler, H. Goldstein and E. M. Ross; smoking in pregnancy, small babies and perinatal loss

1972 G. C. Liggins and R. N. Howie; steroids to prevent RDS in premature babies

1973 H. P. Robinson, foetal crown rump measurements for foetal growth

1973 I. Kaplan; Laser in cervical lesions

1975 Edwards and Steptoe; gonadotrophins and clomiphene or HCG to produce ovulation

1976 W. N. Spellacy; Human placental lactogen from syncytiotrophoblast of placenta

1977 John Billing; Atlas of ovulation method for birth control

1977 Rosalyn Yalow; radioimmunoassay for hormones and enzymes

1977 C. M. Steer and R. H. Petrie confirmed Mag Sulph. better than ethanol for PET

1978 J. K. Todd; toxic shock syndrome

1978 Steptoe and Edwards; first test tube baby

1979 NIH study confirmed CTG lowered stillbirths, neonatal deaths, and low Apgar scores

1980 U. Ulstem; calcium antagonists inhibit preterm labour

1981 Alan Trounson; clomiphene boosted egg numbers in IVF

1981 P. M. Schlievert; Staph exotoxin produces toxic shock syndrome

1981 Laurence; proved folic acid prevented neural tube defects

1981 Computerised tomography in gynaecology

1982 Judy Chang and Yuet We Kan; diagnosed sickle cell anaemia in the foetus

1982 Intranasal GNRH Antagonist for endometriosis

1983 R. W. Smithells; multivitamins to mothers preventing neural tube defects

1983 Stuart Campbell; flow velocity wave forms introduced.

1986 L. Bailey; heart transplants in newborns successful

1986 M. Conant; condoms prevent HIV transmission

1987 Asim Kurjak; Colour flow Doppler

1987 C. P. West; GNRH to shrink fibroids confirmed

1989 Tamoxifen (yew tree bark) for ovarian cancer

1989 M. J, Oxtoby; transmission of HIV from mother to baby via breast milk proved

1989 M. H. Goldrath; laser ablation of endometrium

1990 J. S. Phipps; thermal ablation described

1994 Breast cancer gene, BRCA 1, identified

1996 Second Breast cancer gene, BRCA 2, identified

1996 PMF Boolell; Sildenafil (Viagra) for erectile dysfunction arrives.

1996 Mirena introduced (IUCD with progesterone)

1998 RCOG recommended aspirin for recurrent miscarriage patients with antiphospholipid antibodies

1999 Karen Nelson and Judith Grether provided evidence that inflammation during pregnancy and not anoxia can cause cerebral palsy in the newborn

1999 J. N. Walboomers and Michele Manor provided evidence that the Human Papilloma Virus is present in 99.75% of cases of cervical cancer

H5. Advances Over the Last Decade: 2000-2010

Reid J.N., J.E. Bisanz, and M. Monachese. “The Rationale for Probiotics Improving Reproductive Health and Pregnancy Outcome.” (2013).

Deshpande et al. “Probiotics in Neonatal Intensive Care.” (2015).

Romero, and Mahoney. “Non-invasive Antenatal Blood Screening for Foetal Abnormalities.” *JAMA* 314, (2015): 131-132.

“Antenatal Magnesium Sulphate for Foetal Neuroprotection.” NHMRC Guidelines, (2010).

Interventional Radiology;

Wee et al. “Management of Severe Post partum Haemorrhage by Uterine Artery Embolization.” *British Journal of Anaesthetics* 93, no. 4 (2004): 591-594;

Lynch, C. et al. “B Lynch Suture.” *Textbook of PPH.* Sapiens Publishing, Oct 2006, 287-307;

Duerr, Heiddi Ann. “Bakri Balloon for Postpartum Haemorrhage: Does it Work?” *Surgical Gynaecology, Pregnancy and Birth,* Oct 25, 2011, *ObGyn.net;*

- all designed to control PPH and preserve the uterus.

These later advances are in various stages of development and practical implementation.