INTRODUCTION

Introduction

In the period following World War II paediatrics first appeared to be viable medical specialty in Australia, and over the next twenty years became firmly established. The impetus for its development was the child. Children were individuals requiring special care for their own sakes and they were also objects of special scientific interest to aspiring paediatricians. Since early in the twentieth century the child had also been a social resource for the benefit of the nation, attracting the attention of governments, medical bodies and committees of inquiry. Their views on child health and welfare are exemplified by the findings of a Federal Government Committee, the Medical Planning Committee of the Joint Parliamentary Committee on Social Security in 1940:

In our present need the growing child is our most important asset; the foremost consideration in any plan for social security should be the adoption of measures to increase the birth of an increasing number of healthy children and to ensure the mental and physical health of the growing child.¹

Similarly the 1926 Commonwealth Royal Commission on Health repeated:

The health of the child determines the future health of the adult and on the health of the adult depends the obligations of citizenship including those of defence and parenthood.²

The reports emphasised that children were important for what they might become and what they might do for the State, reflecting the importance attributed to human capital, to the quest for national efficiency and to eugenics.³ What children were for themselves as individuals was of less relevance.

The reports did not initially stimulate the development of paediatrics, largely because many of their recommendations could be met by the public health services through such organisations as the infant welfare clinics and the school health services. Curative services could be provided by general practitioners and the children’s hospitals. However, by 1945 with improvements in the health of the population the needs for public health services declined. New knowledge and technology stimulated the development of specialization in the clinical disorders of childhood. At this time aspiring paediatricians faced questions about their potential professional roles. Were children sufficiently different from adults to warrant a separate subdivision within medicine? Was the study of the diseases of children sufficiently challenging intellectually to be of interest to the enterprising doctors who would be required for the successful development of a new specialty? Over the next twenty years these questions were increasingly answered in the affirmative as children were recognised to be in a separate medical category. This formed the basis for the rise of paediatrics, but paediatricians had to pursue various power and status indicators before the specialty could claim to be viable.

Paediatrics was relatively late in coming to Australia compared with countries such as France, Germany and the United States where it appeared in the late nineteenth century, and in United Kingdom where paediatrics began in the 1920s. The Australian children’s hospitals, which had always been centres for child health service development, were established in the late nineteenth century. The Royal Alexandra Hospital for Children (RAHC) in Sydney, for example, first admitted patients in 1880, but most of the doctors who worked there were not paediatricians in the sense that the term subsequently came to be used. Instead, they were general practitioners or specialists in other fields who had some interest in the disorders of children. There were only a few doctors in each State who could call themselves paediatricians. In 1945 there were probably fewer than twenty in the whole of Australia. Paediatrics came into prominence a long time after

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4 Public health has been defined as the formal collective practices undertaken by a community, usually through various levels of government, to prevent disease. It is largely concerned with groups of people rather than individuals. Curative or clinical medicine deals with individuals who are sick, in the traditional healing role. Douglas Gordon, Health Sickness and Society (Brisbane: University of Queensland Press, 1976), 10, 16, 17.

5 Lorimer Dods. Notes for an address, 7 August 1960, Dods papers, P172, Series 3, Item 1, University of Sydney Archives, Sydney. The figure of twenty is probably a rough estimate, as the definition of a paediatrician was often difficult.
the other major specialties in Australia; ophthalmology, surgery and gynaecology, for example, were established early in the twentieth century.

There were a number of forces which delayed paediatrics becoming a viable specialty in Australia until after World War II, and they had to be overcome before paediatrics could advance. Many related to prior possession of occupational space by other groups in medicine, the general practitioners and physicians who cared mainly for adults. Also, before 1945 doctors treating children were relatively powerless therapeutically. There were few forms of treatment which positively affected the outcome of childhood disease. The arrival of new scientific knowledge and technology in the post-war period provided valuable opportunities for the specialty to develop. Paediatricians were able to convince the medical profession and society generally that children were different to adults and warranted the provision of special medical care, which they were uniquely equipped to provide.

The development of a new specialty required an application of power and authority. As other professional groups had found, it was difficult for individuals alone to argue their case for specialty recognition; they needed to work together in an organized manner and establish a formal association to represent them and to negotiate on their behalf. This move, however, proved to be difficult and paediatricians were slow to establish their own independent association.

The thesis will examine the development of paediatrics in NSW between 1945 and 1965, and the forces responsible for that development. As members of a new specialty in Australia, paediatricians experienced particular difficulties in explaining who they were and what they did. This was partly because paediatrics was different to other specialties in looking after the members of a population group, whereas most other specialists were concerned with specific diseases or with particular body organs. The early paediatricians created other confusions amongst their colleagues; they did not always practise on children alone, as it was too difficult to make a living by doing so. They were often involved as physicians in adult internal medicine, or they were in part-time general practice. The development of the new specialty was also dependent on certain cultural, socio-economic and political circumstances. For example, there were cultural changes through which people perceived that medical specialists had more
skills to offer than general practitioners, who had in the past provided most of the care of sick children. The availability of effective health insurance schemes from governments and other sources allowed many more families to consult specialists. Financially, private practice for paediatricians became more feasible, and permitted a substantial growth in their numbers.

**Definitions**

Paediatrics has been defined as that sphere of medical practice which applies to infants and children. Sometimes the term is used in a broad context, implying both curative and preventive components of care, for which the term child health has also been used. At other times paediatrics is applied narrowly to the diagnostic and curative component. In Australia through the twentieth century paediatricians increasingly adopted the latter approach and progressively abandoned preventive services, which became the responsibility of the government public health departments. Between 1945 and 1965 paediatricians worked entirely or almost entirely with children. They were physicians and did not undertake surgery. During that time most paediatricians were generalists who treated the whole range of childhood disease. By the 1960s some of them began to embark on subspecialization, in for example, such areas as cardiology, neonatology and gastroenterology. This was some time after the development of subspecialization in other areas of medicine.

Paediatricians in NSW spent much of their time in their private consulting rooms seeing patients referred by general practitioners. They were not doctors of first contact or primary care doctors as they were in some other countries — in the US, for example. In their rooms the paediatricians diagnosed and treated a wide range of medical problems, including the feeding problems of infancy, which had been the mainstay of the few paediatricians who practised before the war. By the 1960s they were beginning to expand into new areas such as the treatment of children with behavioural and emotional problems, and learning disorders. Most paediatricians had appointments as honorary physicians to the Royal Alexandra Hospital for Children (RAHC), which was the only children’s hospital in Sydney until the establishment of the Prince of Wales Hospital’s

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children’s unit in 1964, the predecessor of the Prince of Wales Children’s Hospital. They regularly attended the outpatients department where they saw children who had problems similar to those who attended their rooms, but often aggravated by adverse socio-economic circumstances. The more senior honorary physicians also had obligations to provide care for in-patients. Many of the paediatricians had appointments to other hospitals in Sydney; they visited the children’s units in suburban hospitals and the nurseries in midwifery units around the city. Paediatricians had a number of different responsibilities, all competing for their time. Like other professionals, they experienced a conflict of interests in their work, because they had to try to balance their need to maintain their private practices (because there was no other source of remuneration) against the duty they owed to their patients in the public hospitals, who also were important for the development of their professional careers.

*Justifications for the Thesis*

The development of paediatrics provides valuable opportunities for historical analysis in a number of areas. It is a specialty directed at a particular section of the population and involves more than a single disease or a body system, unlike most other specialties. A history of paediatrics must involve a consideration of the place of children in the society of the time. It offers substantial challenges because it should seek to analyse two social phenomena; firstly, how a medical specialty developed at a particular time and in a particular environment; and secondly, how certain practitioners as a group sought to meet the needs of this special section of the population, the children.

There are published histories of all the Australian children’s hospitals that refer to the specialty, but they do not examine the full range of issues which affected paediatrics. In particular, they have not sought to examine the experiences of children in the professional development processes. Most are histories commissioned by the hospitals concerned and hence are celebratory in nature with little attempt at analysis. An exception is an account of the development of the Royal Children’s Hospital (RCH) Melbourne, which describes the enterprising role of the President of the Hospital, Lady Ella Latham. A more recent history of the same hospital examines its evolution in

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much more detail, including its approach to medical staffing that is relevant to the
development of paediatrics in Victoria and which provides valuable comparisons with
what happened in New South Wales.\textsuperscript{8} Both histories will be discussed in more detail in
Chapter Five.

Another recent history of an Australian children’s hospital is found in the thesis of
Bruce Storey, a paediatrician and historian. This covers the period from the
establishment of RAHC in 1880 to the 1930s, with a brief epilogue about the period
following World War II. It examines the socio-economic status of Sydney during the
course of the development of the hospital and the roles of the nursing and medical
professionals. Storey also discusses how doctors began to take an interest in the
disorders of children. Even then in the 1880s they were experiencing conflicts of
interests between their obligations to the hospital as honorary physicians and their
commitments to private practice.\textsuperscript{9} The same conflicts played an even greater part in the
later development of RAHC. Storey attempts to examine the role of the children and
their parents, but that is obviously difficult given the paucity of written and oral sources.

There have been numerous books written about the medical profession in general which
cover the period 1945 to 1965. One, by J.C.H. Dewdney, written in 1972, provides a
broad description of the organisation of the Australian health services. Children and
children’s hospitals are briefly mentioned, and the only reference to paediatrics is in a
table recording specialist numbers.\textsuperscript{10} There are other publications that examine the
changing relationships between the medical profession and the Federal and State
Governments. They do not discuss paediatrics directly, but provide useful information
about the medico-political scene against which the specialty developed. They help
explain the conflicts arising from proposals to change the way children’s hospitals were
staffed to meet the needs of scientific medicine, and the fears of doctors about a loss of
professional independence when threatened with increasing government involvement in
health matters. They explore the evolution of health insurance schemes which
eventually provided financial benefits enabling many more Australian families to

\textsuperscript{8} Peter Yule, \textit{The Royal Children's Hospital: A History of Faith, Science and Love}. (Sydney: Halstead
Press, 1999).

\textsuperscript{9} Bruce Storey, “The Emergence of Paediatrics as a Medical Specialty in Sydney 1870s through 1930s: A
Prolonged and Difficult Delivery,” (Master of Philosophy thesis, University of Sydney, 1997).

\textsuperscript{10} J.C.H. Dewdney, \textit{Australian Health Services} (Sydney: John Wiley and Sons Australasia, 1972), 279.
consult paediatricians in private practice about their sick children. 11 With that subsidy, paediatric practice became financially more secure, and the numbers of paediatricians could expand. The discussions, however, are of a general nature and only cover some aspects of medical specialization; the development of paediatrics is barely mentioned.

Historians and others have written much about one particular aspect of paediatrics — the development of infant welfare and infant feeding practices, which have produced fierce controversies in medical, nursing and public health circles. There have been lengthy debates about whether the infant welfare services were responsible for the improvement in infant mortality that was observed in the early part of the twentieth century, or whether it was due to changes in socio-economic circumstances. These debates and their relevance to the development of paediatrics are discussed in Chapter Three.

In their involvement in infant welfare, doctors were responsible for the development of milk formulae to feed both normal and sick babies. In the period when doctors working in child health had few effective remedies, the modification of cow’s milk and the prescription of additives to milk occupied much of their time and intellectual energy. This was the beginning of what, for the time, was scientific research in paediatrics, and the start of specialized medical work with children in Australia. The so-called science of infant nutrition had many interpretations, which contributed to the bitter arguments

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about the subject. During this period a number of doctors established reputations in the management of sick babies, such that they can be called the pioneer paediatricians in Australia.

After World War II infant feeding became much less important to paediatricians. There were other more interesting clinical challenges, better commercially prepared milk mixtures became available and mothers were better educated and were more likely to make their own decisions about baby care. Infant feeding, which before the War was a major part of the work of the few paediatricians in NSW, had little impact on the development of paediatrics after 1945.

There are few publications on medical specialization and professionalization in Australia comparable to the works of George Rosen and Eliot Freidson in the US, and Rosemary Stevens in Britain. British comparisons may have been useful to the thesis because Australian paediatrics was based at first on the UK pattern, but that changed with the establishment of the National Health Service in 1948, when paediatricians became part of the welfare state. In Australia, Evan Willis has written about a number of professions allied to medicine, namely midwifery, optometry and chiropractic. His remarks about professionalization can be applied in general terms to the development of paediatrics but there are no specific parallels. The same remarks might be applied to the thesis of Peter J. Lloyd, which discusses medical professionalization in NSW from a sociological viewpoint and devotes little attention to the separate problem of specialization.


14 Evan Willis, Medical Dominance: The Division of Labour in Australian Health Care. 2nd ed. (Sydney: Allen and Unwin, 1989).

Milton Lewis and Roy MacLeod have analysed early medical professionalization in NSW up to 1901. They argue that it was important for the profession to be well-organised if it wished to achieve recognition by the State and the people as the legitimate provider of medical services, against the competition of unorthodox practitioners. In NSW the medical profession lacked cohesion and was slow to develop an effective professional association. In comparison, doctors in Victoria were better organised; consequently they enjoyed a higher status and gained legislative endorsement of their profession earlier. The value of the organised group to the establishment of a profession has also been discussed in the general literature on professionalization. Two examples are works by Andrew Abbott and, particularly, Geoffrey Millerson. Chapter Two will show that paediatrics was slow in gaining acceptance as a specialty because it had difficulties in forming an effective association. Lewis and MacLeod make use of comparisons between circumstances in NSW and Victoria in arguing about professionalization. Comparisons of the patterns of development of paediatrics in the two states also help in understanding how the specialty developed in Australia.

D.G. Hamilton, a Sydney paediatrician, has written a brief history of the Australian Paediatric Association (APA), later called the Australian College of Paediatrics (ACP), which was the professional association created by paediatricians to further their claims for recognition. This work provides the best available account of paediatric development, but it is written for the Association about the Association and does not cover or analyse all the important issues, such as the conflicts between private and hospital practice engendered by the attempts to introduce scientific medicine to RAHC and other hospitals.

Paediatrics was firmly established in some other industrialised countries long before it was a viable specialty in Australia. There are certain aspects of its development in other places which help explain events in Australia, but much of what has been written

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emphasises that the evolution of a medical specialty is closely related to time and place and the political, economic and social environment. In other parts of the world, however, an earlier wave of knowledge in the late nineteenth century had stimulated an interest in the disorders of children and resulted in the establishment of paediatrics in a number of countries. The illnesses of childhood were included in the scientific medical research that began in France in the first part of the nineteenth century with structural or anatomico-pathological research and were followed by functional studies in Germany, particularly in biochemistry and physiology.\(^\text{19}\)

The real leader in the establishment of the paediatrics that was to influence the specialty in Australia, was the United States. The scientific medicine of France, and particularly that of Germany, was carried to the US by European doctors who settled there and by Americans who had studied in Europe. They established hospital departments of paediatrics that were closely associated with university medical schools.\(^\text{20}\) They enjoyed a high status in the international medical academic scene; American paediatrics led the world by the late nineteenth century and in 1880 it was designated a specialty by the American Medical Association.\(^\text{21}\) Sydney A. Halpern has examined in great detail the evolution of paediatrics in the US, which has a medical culture very different to Australia, and where a second, much larger, group of paediatricians became involved in primary care. The book provides a revealing picture of professional ambivalences — a specialty created to meet the health needs of children of all social classes moved its focus of attention to provide care for the children of mainly middle-class families, bringing considerable financial rewards to the paediatricians.\(^\text{22}\)

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21 Cone, 104.

A German paediatrician and historian, Edouard Seidler, remarked in 1990 that there had been no systematic analyses of the development of children’s hospitals or paediatrics in Europe. He noted that the first children’s hospitals were created during the nineteenth century for “society’s growing interests in its children as social resources, to be entrusted to medical care for individual and social survival,” but that they also owed much “to the interests of the medical profession in exploiting the children in the service of its new scientific orientation — the history of this institution (the children’s hospital) thus reflects both these competing factors.”23 Seidler’s brief analysis of the evolution of children’s hospitals is relevant to several aspects of paediatrics in NSW, particularly in his account of the opportunities created by scientific knowledge and the resultant pressures on paediatricians, and the conflict of interests between public hospital responsibilities and private practice.

The development of other specialties and their hospitals also provides some lessons for an historian of paediatrics. Janet McCalman has recently published a history of the Royal Women’s Hospital in Melbourne which discusses at length issues which are relevant, in principle, to my thesis, although her book is only marginally concerned with children. She adopts an approach different to previous Australian hospital histories, devoting much space to the patients, the women, and patterns of health care related to gender, as well as medical and surgical matters.24 There are very detailed and revealing discussions of the many issues which affected the development of the institution, and although the book does not focus specifically on the development of the specialty of obstetrics and gynaecology, it provides a very useful picture of a conservative section of the medical profession slowly evolving under the pressures of social change and the impact of new knowledge and technology.

A history of orthopaedics in Britain offers some useful analogies for a history of paediatrics. There, orthopaedics had a strong orientation to social issues, with a particular concern for children with crippling musculo-skeletal disorders, including

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congenital abnormalities, poliomyelitis and osteomyelitis. These were all diseases in which children’s hospitals and paediatricians had a serious interest, and over which there were sometimes arguments about occupational space. The book is also useful as a model because it discusses the development of orthopaedics against a background of the contemporary British society and professionalization.\textsuperscript{25} While there are considerable differences between medical practice in Australia and Britain, the organisation of Australian orthopaedics owes much to the British model. Comparisons with that country are more useful than comparisons with the US where fee-for-service arrangements determined, to a considerable extent, how specialties developed. In Australia there was a much greater commitment by orthopaedic surgeons and paediatricians to providing services to public hospitals in an honorary capacity, a commitment that endured in most hospitals for much of the period of the thesis.

Orthopaedic surgeons figured prominently in the work of RAHC and a number of their patients have told their stories in the oral histories in Chapter Eight. These patients were suffering from the effects of bone and joint infections, from poliomyelitis and from congenital abnormalities. They were often in hospital for months or years and had many opportunities to see the worst of life in hospital. Apart from a few isolated examples, paediatricians had surprisingly little to do with these patients who were nursed in orthopaedic wards or convalescent hospitals. Paediatricians concentrated on the acute disorders of childhood and had little to do with rehabilitation. Alfred White Franklin has described how orthopaedic surgeons in Britain took control of the hospital care of crippled children in the late 1880s because paediatricians did not want to be involved. He argues that this was the origin of the mistrust orthopaedic surgeons have held for paediatricians, which he believes persists in Britain to the present.\textsuperscript{26}

Similar conflicts about occupational space and the management of certain children’s conditions occurred through much of the twentieth century in Australia, where a prominent orthopaedic surgeon said in 1994: “Paediatricians stuffed orthopaedics.” He explained that they wanted to be involved in everything involving children, and

\textsuperscript{25} Roger Cooter, \textit{Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948} (Manchester: Centre for the History of Science Technology and Medicine University of Manchester, 1993).

disputed territory such as the management of bone infections which the orthopaedic surgeons believed was by right and custom theirs. In general, however, paediatricians had little to do with rehabilitation.

Philippa Martyr’s thesis on the history of rehabilitation in Australia is valuable for medical historians in describing a new type of specialty struggling to emerge in the middle of the twentieth century and, like paediatrics, dealing with a special, often neglected, section of the population. She also describes the development of physiotherapy, a major component of the rehabilitation services, as another professional group which also had problems of establishment. While paediatricians struggled against adult medicine to achieve independence and legitimation, physiotherapists were forced into an alliance with medicine to survive against the forces of unorthodox and quack practitioners who threatened its existence.

It is unclear why paediatricians generally did not become more involved in rehabilitation. Although there was much surgery involved in restoring disabled children to a functioning state, which accounted for the presence of the orthopaedic surgeons, many of the children had additional problems that would potentially have benefited from the expertise of a paediatrician. Paediatricians, however, were largely individual practitioners and rehabilitation involved working with other health professionals; it also involved frequent contact with government agencies. Both forms of association created anxieties for doctors who preferred to preserve their independence. The same fear made them suspicious of public health work.

There were a few paediatricians who were intensely concerned with rehabilitation. One, who achieved considerable prominence, was Dr Jean Macnamara (later Dame Jean), the Honorary Attending Medical Officer to the Physiotherapy Department at the Royal Children’s Hospital (RCH) in Melbourne from 1928 to 1959. She was closely involved in the many organisational and medico-political issues surrounding the rehabilitation of

disabled children, particularly those who had suffered from poliomyelitis. She was not however, involved in the mainstream of paediatric medicine in the hospital.

The published material relating to the processes of specialization in paediatrics in Australia that would help explain the pattern of its development is scattered and limited in extent. Its lack is a further incentive to write this thesis. There are also other reasons. An adequate history of paediatrics may fulfil a social purpose. Paediatrics, like all medical specialties, will continue to evolve and the lessons of the past may be of value to the future.

A Further Justification

I must also declare a personal interest in the writing of a history of paediatrics in NSW. I have been involved with the specialty for almost all of my working life, which includes the latter half of the thesis period. I graduated in medicine in 1953 and retired in 1996. Apart from two early years in adult hospitals my whole career has been spent in the medical care of children. I spent nine years in training posts in three different children’s hospitals, in Perth, Adelaide and Melbourne. In those positions I was associated with many of the paediatricians who contributed to the development of paediatrics in Australia. From 1964 to 1996 I was a staff specialist paediatrician in Newcastle, most of that period being spent in the Royal Newcastle Hospital, and the last few years in community paediatrics. Over this period I had a link with a fourth children’s hospital, with an appointment as an Associate Medical Officer to the Royal Alexandra Hospital for Children (RAHC) in Sydney. My interest in the development of medical organisations began with an involvement in Area Health Service committees planning paediatric services for the Hunter area of NSW. After reading a number of histories of children’s hospitals in Australia and overseas and other articles on medical historiography, I decided I wished to write a wider history of paediatrics and applied to do this as a postgraduate research student in the History Department at the University of Newcastle.

Retired doctors have often been accused of writing “medical histories,” that tell about the triumphal achievements of medicine and its institutions and that record the deeds of

their illustrious colleagues. Historians and sociologists write “histories of medicine.” They are concerned with the social, economic, political and cultural contexts in which ideas on health evolve and medical practice changes. They are interested in the views of patients and how they are affected by health processes; they accuse the doctors of leaving the patient out of their histories. Both groups are concerned with the power struggles of organised medicine with governments and the competition within the health services for occupational space.30

The writers of “the histories of medicine” have often been very disparaging of “medical histories,” describing these works as “simply chronicles devoid of explanation and interpretation.”31 On the other hand, the writing of “medical history without medicine,” history written without expert knowledge of scientific or technical matters, has been criticised for focussing excessively on social history and neglecting questions of clinical medicine and science, even when such technical information has a bearing on the subject, resulting in an “incomplete and sometimes distorted history.”32 I have attempted to present an argument about the evolution of a specialty that takes advantage of the possession of medical and scientific knowledge, while at the same time examining the broader issues. It is primarily a social history and will not deal with clinical issues unless they are relevant to the main theme.

My position has been something like that of a participant observer in anthropology, except that my observations have been in retrospect, but my previous positions have enabled me to participate in discussions with my interviewees which would not have been possible without a familiarity with the scene. A participant observer becomes an instrument for both data collection and for analysis through his own experience.33

I have tried to explain how a medical specialty developed, rather than a hospital or institution, the usual focus of medical histories. I have used technical information from primary and secondary sources in Australia and overseas. The interpretation of all this material has been assisted by my role as a participant observer, enabling the writing of “a history of medicine with medicine.”

As the history of the formative years of a medical specialty, this thesis concentrates on a distinctive approach to a relatively neglected topic in the history of medicine in Australia. As far as I am aware, there have been no similar approaches to writing such a history which has used a wide range of primary sources to provide as balanced a picture as possible, with a strong emphasis on oral sources, from both health professionals in various categories and from people who were patients.

Sources of Information

The main primary sources of information for the thesis were the official records of organisations concerned with both preventive and curative paediatrics. They included Federal and State Government records relating to public health services for children from early in the twentieth century. Later, in the period of post-war reconstruction there was much Federal Government planning in social welfare, which included many references to the health of children and their mothers, particularly in the reports of the Joint Parliamentary Committee on Social Security (JCSS) and its subcommittees, such as the Medical Planning Committee and the National Health and Medical Research Council (NHMRC). The official records of the children’s and other hospitals provided information particularly about the organisations associated with curative paediatrics. In the period covered by the thesis new knowledge and technology were shaping the care of children, and paediatricians and the hospitals were obliged to decide how best to cope with the changes. It was also a time of great medico-political change and turmoil. The hospital records, together with those from organisations such as the hospital medical staff associations and the British Medical Association (BMA) offered material on medico-political events that affected the development of paediatrics in NSW. From the records of the institution set up by the paediatricians, the Australian Paediatric Association (APA), one can appreciate the difficulties they experienced in trying to establish their own professional association and become independent from the adult
physicians and the longer-established Royal Australasian College of Physicians (RACP).

The *Medical Journal of Australia* provided much primary information. In the period under discussion it filled the purpose of a weekly newspaper for the members of the medical profession, as well as reporting on scientific and clinical medicine. There was much in it about medico-political matters. The *Journal* also published articles which described the contemporary clinical practices of paediatricians and revealed their perceptions of current knowledge. The *Lancet* and the *British Medical Journal* were also useful, but to a lesser extent because they did not so much reflect Australian events. Certain newspapers, including the *Sydney Morning Herald*, were useful for presenting a public view on health matters.

Some areas of great relevance to the development of paediatrics, however, have few written records. Doctors in private practice rarely kept information about how they organised their work. Their patients’ records are not available for use, if only for privacy reasons. The experiences of nurses in their work with children have rarely been documented. Children and their parents usually have no relevant documents, so I have employed oral history to obtain information from these people. This approach is recommended by Gwyn Prins who says contemporary history is incomplete without using all the sources, including oral sources.34 I have used oral history to provide factual information, to check written sources, to add depth to this information and for what Luisa Passerini says it can tell us “directly and indirectly, about the every day side of culture, and — the conflicts of power which take place.”35

Oral history has been labelled second-class history by some conventional historians. When compared with other historical sources it suffers from more serious problems associated with the bias, distortion and imprecise memory of informants, many of whom are elderly. Overall it is an imprecise vehicle for historical narrative compared


with history based on documents, with their greater veracity. In particular, the reliability of memory is often questioned. A detailed discussion on the physiology of memory is not pertinent to this thesis, but there is good evidence that long term memory in older individuals in the period of life review, when my oral histories were recorded, can be accurate. Some children’s memories may be particularly acute, and useful for the historian. David Lowenthal refers to the intense involuntary recollections from childhood when one sees and remembers what is there, while adults remember mainly what they think they ought to remember. Memory, however, is not just a passive reservoir of facts but is greatly influenced by subsequent life events, and the recollection of memories is conditioned by the need of people “to make sense of the past and to give form to their lives.” The memory of childhood events may have been coloured from early in life by the views of parents, and some of my sources admitted that they were uncertain whether certain views they expressed were their own or their parents.

From the manner in which my subjects became involved in their interviews, it was apparent they were anxious to tell their version of the past, and to vent their feelings about what they believed was unjust about the way they had been treated in hospital. This feeling was particularly strong in those who had spent long periods in hospital, one person comparing her situation to that of the lost generation of Australian Aboriginal children.

While oral history may reveal new facts or unknown aspects of previously known events, it has to be admitted that much of it is subjective, which has been considered a serious problem by some historians. In response to this criticism Alessandro Portelli argues that subjectivity can used in a positive way, providing a new dimension to history. He says that if the historical research is broadly based a cross section of the subjectivity of the people interviewed may emerge, which will provide an integrated

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36 Prins, 134.
37 Ibid., 133.
40 “Joan,” interview no.5 by author, 17 November 1999.
picture of events. Even from a small number of interviews conducted one can construct a useful cross section of experiences. I concede that those who came forward for my interviews might have been a biased group but they still produced valuable material and provided a different perspective to that of the health professionals. Their memories of hospitals differ markedly from those that have been included in previous publications about children’s hospitals.

It is not only what interviewees say that is important but the manner in which they organise and present their narratives is also revealing about how they see their past. Portelli says: “Oral sources may tell us not just what people did, but what they wanted to do, what they believed they were doing and what they now think they did.” These remarks are as relevant to an interpretation of the transcripts of interviews with doctors and others in positions of authority as they are to those of the people who were patients. The interviewee, however, is not the only person at risk of subjectivity. There is also the interviewer.

Oral history is different to conventional history, because two individuals are involved. It has been argued that documents also are “interviewed” in traditional history, but in oral history the interviewer plays a much more active role. While the interviewee provides the vital narrative that is the basis of the history, there is an unavoidable interaction between that person and the historian/interviewer and the final result is a product of both. The interviewer is responsible for selecting the interviewee, for organising and guiding the interview, for the background to the research which provides the questions, for asking the questions in a suitable way and for documenting the responses. The resultant historical discourse and the interpretation of the interviewee’s responses are in the hands of the historian. Portelli admits that taking sides is unavoidable in oral history; the historian may become either a protagonist or an antagonist. He recommends, however, that “on explicitly entering the story, the historian must allow the sources to enter the tale with their autonomous discourse.”

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41 Portelli, 67.
42 Ibid.
43 Ibid., 70-72. The position of the interviewer is also discussed in Anna Green and Kathleen Troup, *The Houses of History* (Manchester: Manchester University Press, 1999), 235, 236.
44 Portelli, 73.
Being part of the narrative confers on the oral historian a special political and personal responsibility which is more than that for the traditional historian, using written sources. The question of responsibility was of particular concern in the research for this thesis, because I had certain links with my subjects that were capable of producing distortions, because I had a past in paediatrics and children’s hospitals. My professional background may have made it easier for some people who were patients to tell their tale, because they would have appreciated that I understood hospitals and medical culture and terminology. To others I may have appeared intimidating, being identified with the authority figures that they encountered in hospital. Some of the interviewees who were professionals, paediatricians or nurses, for example, might have assumed that I was sympathetic to their views, given our common background. Others might have been suspicious of my motives in writing a history of their specialty, working from an academic department of history. I inevitably entered the resultant discourses to a greater degree than would an interviewer with no medical attachments. I also made use of professional contacts to facilitate recruiting people to interview and this raises the question of sampling in oral history, to be discussed in Chapter Eight.

The health professionals, paediatricians and other doctors, medical administrators and nurses did not present randomly for their interviews. I selected and invited them to participate in the oral history research for their anticipated capacity to provide information. Some responded to these requests in written form. In agreeing to be interviewed the professionals, like those who were patients, displayed a degree of self-selection, so that they also were likely to be people with strong views that they wished to relate. For example, two paediatricians from the RCH, Melbourne, were separately very eager to state that they believed that the existing histories of the hospital had not properly acknowledged the contributions of the visiting medical officers to the development of the hospital, compared with those of the full-time staff.

The interviews and letters have provided new information and have helped to expand and explain the official records, which are often merely records of decisions made by committees and boards of management. I have also used the methodology to find out what people who were children during the period of the thesis, and their parents, felt about their paediatricians and their experiences in hospital. Oral history is particularly appropriate to record the memories of non-literate people like children, who, in
addition, were marginalised as patients in hospital. They are examples of people for whom oral history was originally intended to provide empowerment. Paul Thompson has suggested that oral methodologies have made possible for the first time a history of childhood.

Thompson also says that all history depends ultimately on its social purposes in, for example, seeking to understand how political and social systems and other forces worked in the evolution of a town. In such an evolution people played vital parts: oral history is essentially built round people, enabling them to tell their story and to challenge the accepted myths of history. The same argument might be made to justify the use of oral history in the analysis of the evolution of a health system. The combination of oral history with history from written sources can be particularly valuable; one balances the perspectives of the other. The oral sources, of both the health professionals and those who were patients, have provided an immediacy to the thesis which is not available from official records.

The analysis of the data obtained has been in the style of qualitative research, a search for patterns and for ideas that explain that data. It has involved checking for consistencies and inconsistencies amongst the informants, and evaluating the evidence against more objective information. However, the very nature of the type of historical research I have undertaken means that the material one can obtain is patchy, being dependent of the availability of subjects, and dependent on what they remember or what they choose to remember. It would have been difficult to develop proformas or questionnaires to systematise the research because the subjects wished to tell their story in own their way.

The Organisation of the Thesis

This thesis is primarily about the development of a medical specialty as a segment of the profession of medicine. Following this introduction, Chapter One discusses some theoretical issues relating to professionalization which were relevant to paediatrics.

45 Green and Troup, 230.
47 Thompson, 28.
Much has been written on specialization as an aspect of medical professionalization, including discussions on the impact of new knowledge, the organisation of the work of the specialists and the competition for occupational space. The chapter argues that paediatricians were driven by a need to practise scientific medicine in a model which has been termed the scientific medicine paradigm, which had its origins in the United States at the beginning of the twentieth century.

Chapter Two examines the organisation of paediatrics, particularly the development of a professional association, which would permit a corporate approach to claims for occupational space. In the period from 1945 to 1965 paediatricians were unable to establish an association which fully met their needs, particularly one with which they could control the entry of new members to the specialty. They were forced to remain under the umbrella of an organisation controlled by physicians who treated adults, the Royal Australasian College of Physicians (RACP), the group from which they most wished to become independent.

Chapter Three discusses the embryonic phases of paediatrics in NSW. From the early 1900s there were a number of doctors who spent their whole time in child care, and who became well known to the medical profession and to parents. They can be described as the pioneer paediatricians and they worked in the field of infant welfare, which with other forms of preventive medicine had a high priority for doctors interested in the care of children. This phase did not last long and there was a gradual move towards curative work.

Chapter Four shows how new knowledge, technology and therapeutic agents drove the expansion of paediatrics in Australia that occurred after World War II, and which provided paediatricians with the authority that came with the possession of expert knowledge. There were four fields of special significance: growth, infectious disease and antimicrobial therapy, the metabolism of fluid and electrolytes and the care of the newborn.

Chapters Five and Six examine the roles of RAHC and certain general hospitals in NSW in the development of paediatrics. The children’s hospital provided a focus for the specialty, a workshop to develop skills and a place where paediatricians could organise
their specialty free from the scrutiny and competition of other specialties. They wished to adopt the scientific medicine paradigm to direct their work but were unwilling to give up their standing as honorary medical officers, knowing that there would be a conflict of interest between their hospital roles and their commitments to their other hospitals and particularly to private practice. They devised strategies such as advisory and consultative committees to help their hospital aspirations. In contrast, at the RCH in Melbourne, the honorary system was abolished and a salaried system installed. In Sydney paediatrics was dominated by private practice, in Melbourne paediatrics was centred more on the children’s hospital. The management structures of the two hospitals differed greatly and contributed to the way the specialty developed. In other hospitals in NSW, in the suburbs and country regions, paediatricians demonstrated to a wider circle of doctors the skills they had learnt in RAHC, which helped spread the influence of paediatrics.

In one hospital, the Royal North Shore Hospital (RNSH), a paediatrician showed that it was possible to develop a new paradigm in which preventive medicine figured much more prominently than it did in RAHC. In another institution, the Royal Newcastle Hospital, the first hospital in Australia to employ staff specialists, child care developed without a paediatrician, demonstrating that in an environment uninfluenced by traditional paediatric philosophies, useful services could arise. It also showed the dangers of doctors working in isolation, separated from the new knowledge that was radically changing paediatrics in the children’s hospitals.

Chapters Eight and Nine explore the role of children and their parents in the development of paediatrics. Logically, as the main reason for the existence of the specialty, children should appear at the beginning of this thesis but their role and experiences are more readily understood against the background of the hospitals and the professional aspects of paediatrics. Children in hospital were relatively powerless, and their position was maintained by the hierarchical nature of the hospital organisation, which enhanced the power and authority of the senior medical and nursing staff. Paediatricians believed that their status was important for the development of their specialty. However, the processes of maintaining that status disempowered their patients. Oral history is used to find out what children thought about a situation in
which they and their parents were denied power to influence the way they were treated.
The final chapter provides the conclusions of the thesis.
CHAPTER ONE
PROFESSIONALIZATION AND SPECIALIZATION

Introduction

The profession of medicine developed extensively in NSW and Australia during the nineteenth and early twentieth centuries and, by 1933, according to Willis, had achieved a solid professional status and authority.1 Specialization was a separate process in the evolution of medicine, and the specialties developed one by one through the twentieth century. Paediatrics was not firmly established until the 1950s. While the medical profession itself had to establish a place within society generally, the specialties had to negotiate with their colleagues within medicine for occupational space, taking advantage of the privileges gained by the broader group. This chapter discusses certain theoretical issues relating to medical professionalization and specialization. It will show that the establishment of paediatrics as a specialty depended on its intending practitioners clearly establishing their roles relative to other doctors, and demonstrating that they possessed certain esoteric scientific knowledge and skills. Before commencing that argument, however, a number of occupational terms need explanation and clarification because there has been considerable confusion about their meaning.

Definitions: Internal Medicine, Physicians and Paediatricians

Paediatrics began as a sub-division of internal medicine which was largely concerned with the illnesses of adults, and it was from adult medicine that paediatrics had to struggle to separate itself if it was to be a viable specialty. It is in this arena that there has been considerable confusion about definitions and roles. Certain terms such as “internal medicine,” “physician” and “paediatrician” have been confusing to many medical and non-medical observers, and the nature of the work associated with them has been unclear. In comparison, explaining the roles of say, ophthalmologists who work with eyes, or dermatologists who treat skin disorders, has been relatively easy because

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1 Evan Willis, Medical Dominance: The Division of Labour in Australian Health Care, 2nd ed. (Sydney: Allen and Unwin, 1989), 91.
their work is narrowly focussed. Internal medicine is a particularly difficult term to define. The professional body associated with this discipline in Australia, the Royal Australasian College of Physicians (RACP), could not provide a clear definition of either “physician” or “internal medicine,” when the College was founded in 1938, but chose to describe what activities they did not cover, in the following terms:

Internal medicine is difficult to define accurately, but it may be taken, in Osler’s words, as designating “the wide field of medical practice which remains after the separation of surgery, midwifery and gynaecology. Not itself a specialty (although it embraces at least half a dozen), its cultivators cannot be called specialists, but bear without reproach the old name physician.”

The author of the official history of the RACP, a distinguished Australian medical journalist, devoted a chapter in the book to attempting to define “physician.” He explains that the term may refer to any registered medical practitioner; it may mean a doctor who does not practise any surgery, or it may mean a doctor who is involved in internal medicine, which in itself is also difficult to define. While physicians might themselves have known their role it was important for the members of a new specialty seeking occupational space, like paediatrics, that other doctors and the public should know what they did.

In the 1940s and 1950s practitioners in both internal medicine and paediatrics could not clearly explain their roles to the public and to their professional colleagues. The field of internal medicine was occupied largely by physicians who practised on adults (called adult physicians by paediatricians) and to a smaller extent by paediatricians (sometimes called paediatric physicians), who practised internal medicine on children. What the elite consultant physicians did was well known to doctors because they had seen them at work in the teaching hospitals. Even then there were problems: some of them treated both adults and children and held honorary positions in both adult and children’s hospitals.

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The role of certain other doctors who were also called physicians was not so clear, nor were they always of such high status. In the late 1930s and the early post-war period, the medical staff in the district and regional hospitals, mostly general practitioners, began to be classified into categories of surgeons and physicians. There was strong competition for the surgical posts because they held the most prestige and promised the greatest financial rewards. Outside the teaching hospitals the posts of physician were not so valued. They often went to those who could not get a surgical appointment. One physician commented: “Men of inferior capacity or of little influence with hospital boards…swallowed hard and accepted the title of physician with ill-concealed disappointment.”

The term “paediatrician” was also confusing. A Scottish paediatrician wrote that the greatest handicap of his specialty was its name, because its role extended far beyond the etymologically derived interpretation, “therapeutics of children.” He declared that “the depth and breadth of paediatric study have never been strictly defined.” He questioned whether paediatrics should be called a specialty or whether it was general health care applied to a section of the population determined by age, which in itself implied a type of specialisation. Australian paediatrics had similar problems. It was difficult to define what was included in the internal medicine of childhood, particularly when general practitioners continued to treat most childhood illnesses. As well, Australian paediatricians professed that in addition to diagnosing and treating sick children they had an important role in preventive medicine, to which, in reality, they paid little attention, leaving that field largely to the public health services. The situation was particularly confusing when the specialty was first seeking to be recognised in the late 1930s and 1940s. A number of doctors practised what they called “paediatrics.” As well as those who specifically wished to be called paediatricians, there were other doctors who provided consultant medical services for children. They included adult physicians, surgeons who were beginning to specialise in paediatric surgery and general practitioners acting as part-time specialists. Just after the Second World War some doctors who wished to practise full-time in paediatrics, but who were uncertain that the

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6 Dr. D.G.Hamilton, letter to author, Sydney, April 1998.
specialty would materialise, believed they could not afford to sever their ties to adult medicine. For example, a Melbourne paediatrician, John Colebatch, who wished to pursue a career in paediatric haematology, had honorary positions in haematology at both the RCH and the Royal Melbourne Hospital until forced to relinquish the adult position when the rules of RCH forbade dual appointments.7

The concepts of specialization and generalization were also confusing. On one level in Australia the term “generalization” was applied to general practice or primary care and the term “specialization” to consultant practice, where patients were referred by another doctor for an expert opinion or treatment. In Australia paediatricians were always in the consultant category. On the other hand the terms have been used within the disciplines of internal medicine and paediatrics, with generalization implying a broad approach to the management of serious illness, and specialization meaning a narrow focus on specific diseases or organ systems. The latter has also been called subspecialization.

In Australia a clear division between general practice and specialty practice had long existed, based on British precedents. In England, throughout the nineteenth century, there was a rapid growth in the number of public general hospitals. They were intended for the poor, but with the increase in the efficiency and safety of the care they provided they attracted an aware middle class. That situation favoured the attending honorary specialists; on the other hand general practitioners were advantaged by increasing urbanisation and by the increasing affluence of the population. An informal agreement was reached by the late 1800s; it was never institutionalised but its influence has persisted to the present in both Britain and Australia. The doctors who called themselves specialists would be consultants; they would see only patients referred by general practitioners, who would be the doctor of first contact. In return, only specialists would have access to large general hospitals.8

There were other reasons for the persistence of generalization in Britain. Up to 1858 doctors had been bitterly divided into three groups; physicians, surgeons and apothecaries, but the intense negotiations which took place after that time resulted in a

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7 Dr. John Colebatch. interview by author, tape recording, Melbourne, 30 August 1999.
united, single medical profession. There was little wish to recreate the divisions which specialization would bring. Specialization might also result in a new professional body which was powerless, being too small to be effective or legitimate in the eyes of the State, the medical profession or the community.

The resistance to specialization was particularly strong among physicians, the Members and Fellows of the Royal College of Physicians (RCP), London. Although clinical science began to influence British medicine after the First World War there were persisting forces strongly opposed to specialization, because “specialization was a form of narrow-mindedness in the doctor himself. Gentlemen did not specialize, for it prevented breadth of vision.” Rosemary Stevens comments that the RCP continued its conservative historical role well into the twentieth century, to produce “a corps of generally cultured and widely experienced physicians,” that is, generalists in medicine, attached to the philosophy of the art of medicine as much as the science, at a time when specialization was well accepted in other fields. The same attitudes pervaded the physicians in the Australian counterpart of the RCP when it was established in 1938, and for some time after.

Many medical customs and practices came to Australia from Britain; they shaped the development of the profession and its specialties in this country. British legislation often extended to the Australian colonies. The pattern of training of medical students and junior doctors as residents and registrars, as well as the staffing of general hospital with honorary medical officers, came from Britain. Medical institutions like the British Medical Association (the Australian State branches) and the Australian Royal Colleges of Physicians and Surgeons were firmly based on British models. They all influenced the way doctors worked and the way medical labour was divided.

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9 Ibid., 22-25.
12 Stevens, Medical Practice, 370.
The situation was quite different in the US, where German medical science and technology was a powerful influence, and specialization began in the nineteenth century.\textsuperscript{14} However, comparisons between the ways medicine was organised in the US and in Australia are often inappropriate and confusing. In the discipline of internal medicine in the US some doctors chose to become (sub)specialists in cardiology, neurology and other organ or disease-related fields. Others, who called themselves internists, and who had trained in internal medicine, and some who described themselves as paediatricians, practised in primary care, which was called general practice here.

Paediatricians in Australia were never involved in primary care, but there were still problems of identity. To some doctors paediatrics was regarded as a subspecialty of internal medicine, by others it was seen as a separate occupational group. At first, in the 1940s and 1950s, senior paediatricians fostered a generalist attitude; they did not restrict their practices to any one organ system or disease. Subspecialization came later, in the late 1960s and 1970s.

\textit{Professionalization}

In the very extensive literature on professionalization there have been many debates about the nature of professions. They have formed a very diverse group of occupations, which has made a simple definition difficult. Ann Daniel, in her examination of the medical profession in Australia, states that the professions were differentiated from other occupational groups by certain characteristics. They claimed an authority derived from the possession of abstract, complex and specialist knowledge which they applied for human benefit. On these grounds, professionals believed they had a privileged position in society, and that they held autonomy in their particular fields of expertise.\textsuperscript{15}

The question of the role of knowledge in professionalization has also created much discussion, particularly about those professions, like medicine, in which science and

\textsuperscript{15} Daniel, 35.
technology have had such an impact. To doctors the possession of special knowledge has seemed particularly important and they have striven vigorously to monopolise its ownership. There are, however, other views. Willis, who has written about medicine and adjacent specialties in Australia from a Marxist position, believes that political and social issues were the main determining factors in the development of the dominating position of medicine in society, not knowledge and technology. He attributes the authority of medicine to its alliance with the capitalist state, and to issues of class and gender. He does not, however, deny the significance of the power associated with the possession of knowledge. He uses the term, the “legitimation of knowledge,” implying that certain kinds of knowledge have a greater truth value than others, and adds that the use of true knowledge leads to the development of “a set of practices which are accepted as authoritative and become hegemonic.”

Lloyd, an Australian who works in the field of health services policy, has extensively reviewed the origins of the professions from a sociological viewpoint. He acknowledges that while there are differing theoretical interpretations of how the professions have achieved their place in the hierarchical class structure there is a consensus that the possession of “esoteric and complex knowledge provides power and authority.” He also emphasises that any discussion about professionalization must relate the process to the particular population, to the historical era, and to its demographic, social, cultural, and economic environment. He says the principal factors that led to the development of the medical profession in Australia were increasing urbanization and industrialization, the rise of medical science and the changing organization of the hospitals.

Freidson has defined a profession as an occupational group that has achieved a dominant position in a particular division of labour, and has been granted autonomy in determining the scope of its own work. He says that what was unique and central to a profession was its status, which was the result of a value judgement of the society in which it was placed, based on the assumption that the occupational group possessed special skills and knowledge, that it embraced ethical standards and that its work had a

16 Ibid., 39.
17 Willis, 9.
18 Ibid., 21.
certain dignity and importance.\textsuperscript{20} Freidson has strongly emphasised the two-sided nature of medical professionalization; he says that it was dependent not only on the actions of doctors but also on forces outside medicine and needed to be sanctioned by the society in which it operated. \textsuperscript{21}

The main concern of this thesis is with the processes of specialization, but there are some issues in professionalization which are useful to an examination of the development of the segments of medicine. Aspiring specialists could take advantage of the high status medicine had achieved in Australian society by the middle of the twentieth century, and while their specialty also had to be acceptable to that society, specialization involved gaining control of an occupational space within medicine. While the place of knowledge in medical professionalization has been widely disputed, in specialization there has been a much stronger consensus that knowledge, particularly exclusive knowledge, played a central role.

\textit{Knowledge and Concepts of Disease}

Before the late eighteenth century human disease had been considered a generalized affliction of the body with disturbances of various humours manifested by certain symptoms, but with no specific structural localization. In the early nineteenth century, in France, doctors developed new concepts of disease derived from a correlation of clinical states with pathological lesions found in specific organs. The clinical information came from new technology and new approaches to physical examination. For example, Laennec related what he heard when he listened to the chest with the instrument he had invented, the stethoscope, to what pathologists found in the lungs and chest cavity at autopsy.\textsuperscript{22} On this foundation of anatomical knowledge of diseased bodily structures, medical scientists in Germany built another layer of understanding. This was about organ function and dysfunction resulting from work in biochemistry, physiology and microbiology in the late nineteenth century. \textsuperscript{23}

\textsuperscript{21} Ibid., 181.
\textsuperscript{23} Bynum, 95-103.
Bynum declares that the developments of the concepts relating disease to body organs laid the foundations for the scientific medicine of the twentieth century and fostered specialization in France and Germany and later in the USA.\textsuperscript{24} Specialization came much later to Britain and Australia for reasons that were more medico-political, social and cultural than related to knowledge.

\textit{Specialization}

The American medical historian, George Rosen, has strongly defended the central place of knowledge in specialization. He has defined a specialty as a field of medical activity organised around a focus of interest in a particular area of knowledge. In his writings he has provided a framework with which one may examine the development of medical specialties. He has argued that the development of specialization was associated with an increasing complexity and breadth of knowledge in medicine, which had occurred over several centuries. Within these greatly expanded fields of knowledge doctors developed interests in certain areas or foci, and they devised instruments and technology which added further information. In his main case study Rosen has described how ophthalmology, one of the earliest specialties, developed when certain doctors concentrated their attentions on diseases of the eye, using the newly-invented ophthalmoscope, a device for examining the interior of that organ.\textsuperscript{25} Certain foci of interest attracted sufficient numbers of doctors to form organised groups, the embryo specialties. With new knowledge and technology these practitioners gained advantages over other doctors in the care of their patients. Their increased knowledge gave them a higher status among their medical colleagues, who recognised them as specialists in the field. In turn the position of the specialty was legitimated by society and the state.\textsuperscript{26}

Rosen is careful to point out that successful specialization depended on other favourable circumstances. In particular, there needed to be a population large enough to provide sufficient affected patients to sustain the field of interest for the intending specialists.

\textsuperscript{24} Ibid., xi, 191-193.
Secondly, the specialty had to be viable financially whether from salaries or from private fees.\(^{27}\) The starting point, however, was a focus on certain knowledge, and for paediatrics in Australia, which largely evolved in the middle of the twentieth century, this implied scientific knowledge. This meant that paediatric practice would be founded on information resulting from experimental or laboratory research in the basic sciences of biochemistry, physiology, microbiology, pathology and pharmacology, and on clinical science. The medical meaning of the term, “science,” however, must be qualified.

*The Scientific Medicine Paradigm*

John Harley Warner has discussed the meaning of science in medicine in the US. His views are also applicable to Australian paediatrics, which progressively came under US influences through the 1950s and 1960s. He points out that from the time when science entered medicine in the nineteenth century, the term “scientific medicine” has never had a fixed meaning; it has meant different things to different people at different times. An interpretation of the term has depended on the matter being discussed, whether it was patient care, professionalization or science as a component of social control. Warner recognises that an identification with science has been very valuable for medicine. It has helped doctors understand and manage disease and enabled the development of useful clinical techniques. It has provided a source of cultural and clinical power, which has strengthened the authority of medical practitioners and legitimated medical practice. Science and the consequent technology reinforced the need to expand hospitals to provide patient care and to act as workshops where doctors could further develop clinical knowledge and add to their authority.\(^{28}\) He believes that the key to understanding the relationship between medical science and medical professionalization is in recognising the extent to which physicians used “not the content but the rhetoric of science.”\(^{29}\)

\(^{27}\) Ibid., 209, 210.


American doctors were able to convince much of the American public of the merits of medical science. Warner admits that he is unable to explain how this happened but it undoubtedly strengthened the acceptance by patients of what doctors had to offer, despite there being no simple correlation between increased scientific knowledge and better health care. Another American author, Paul Starr, in his account of the development of medicine in the US, has also discussed the intense interest which the American public had in medical science, which they perceived as a natural asset, and the consequent effect this had in enhancing medical authority.

There have been a number of theories proposed to account for the rise of science; a prominent one being what has been called the Whig or continuist model. Scientific knowledge developed by accretion. Facts were added rationally, and in a piecemeal fashion, to an ever-growing stockpile that constituted scientific technique and knowledge. This presumed an evolutionary process, in strong contrast to the revolutionary model proposed by Thomas S. Kuhn in his classic work, The Structure of Scientific Revolutions.

The historian, Richard J. Evans has noted that Kuhn’s views became dominant amongst philosophers of science in the 1970s. He explains that Kuhn argued that science was not necessarily progressive or rational. It was not always true to the experimental data, but the prevailing model, or what Kuhn called a paradigm, was maintained, often unconsciously and despite various anomalies, by an intellectual consensus so strong that the term “mob rule” had been applied by some detractors.

Kuhn wrote largely about the history and philosophy of the physical sciences, but his ideas have been applied by others to the development of knowledge in a number of disciplines. In Australia, Max Charlesworth and his colleagues have written about medical science based on an anthropological study of a medical research organisation, the Walter and Eliza Hall Institute in Melbourne. Referring to Kuhn, they have

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30 Warner, 52.
examined the scientific, cultural, economic and political pressures that have shaped the Institute’s research programmes. Charlesworth and his group note that Kuhn explained that science did not evolve in a continuous and cumulative linear flow, but developments occurred in discontinuous phases or “revolutions.” In each phase there evolved a dominant view of what was considered good and relevant science, which provided a model or paradigm which researchers could follow and against which research could be measured. What was good science at any one time was what the scientific community chose to accept as science. In his discussion of the recurrent revolutions in scientific knowledge Kuhn has also emphasised the transitory nature of “true” knowledge. Bynum agreed with him in remarking that “One generation’s science can be another generation’s prejudice.”

Charlesworth and his co-authors believe, with Warner and Kuhn, that medical science was both a social and a scientific construction. There was a naive assumption that science was autonomous, concerned with revealing absolute truths derived from the reliable observations of natural phenomena and experiments combined with a rational interpretation of the resulting data. In these processes, Charlesworth argues, scientists were often influenced by their preconceived ideas and expectations and by subjectivity and selectivity, and particularly in their individual interpretations of the data. He and his co-authors conclude that science, while revealing valuable new knowledge, was not autonomous, but was instead the product of human choices and actions, and influenced by external social and political factors. He acknowledges, however, that Kuhn has nothing to say about the political work necessary for the setting up and acceptance of a new paradigm, which he had witnessed in the intensive scientific politicking and propaganda in the Hall Institute.

David Armstrong has also commented on the significance of external influences on science. He has described how it was assumed, until Kuhn published his ideas, that while social factors might either slow or facilitate the emergence of discoveries, they

36 Kuhn 107.
37 Bynum, xii.
38 Charlesworth, 8, 9, 269.
39 Ibid., 270.
could not affect the content of knowledge. Kuhn, however, showed that the structure of scientific knowledge was also influenced by social circumstances, and was hence analysable by people such as sociologists, not just scientists.40

David A. Hollinger notes that Kuhn’s theory, originally applied to the history of science, has been employed by historians of art, religion and political and social thought.41 Some of the terms he has used, however, have caused confusion. Another writer, John Krige, says that Kuhn has used the word “revolutions” to indicate sudden destructive changes in beliefs that profoundly changed the theory and practice of science. When the transition to the new paradigm was complete the profession had radically altered its view of the field, its methods and its goals. Krige also notes that Kuhn sometimes implies that the revolutionary changes took place more slowly, and that there was some overlap between the old and the new paradigm.42 Whatever the rate of change, Kuhn has said that the transitions were not open to rational or intelligent analysis, suggesting that the nature and direction of scientific change could not be controlled. Krige has commented that this view has disturbed many scientists and historians who have believed in the rationality of science.43 Krige notes that French philosopher and historian Michel Foucault also believed that revolutionary transformations of the Khunian type have occurred in medicine, quoting him as saying, as an example, that at the end of the eighteenth century and the beginning of the nineteenth: “in forty or fifty years everything had changed…not just the maladies and their classification, but the outlook itself, a matter of a collective and complex transformation of medical understanding in its practice and its rules.”44

With some reservations, Kuhn’s ideas on the concept of “revolutionary change” can be applied to a history of the development of Australian internal medicine and paediatrics. After the Second World War Australian paediatrics was driven in a very different way to the prewar pattern, and a strong consensus had arisen that a certain form of medicine

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42 Krige, 23.
43 Ibid., 25, 26.
was the preferred course of development. There was no obvious violent revolution, and no “mob rule”, but paediatricians across Australia, with a few exceptions, agreed to follow much the same model, determined by a philosophy, to which one can usefully apply Kuhn’s term “the scientific medicine paradigm.”

Kuhn has been accused of having numerous and conflicting definitions of the term, “paradigm,” but the one most pertinent to this argument is that a paradigm is “an entire constellation of beliefs, values, techniques…shared by the members of a given community.”45 The scientific medicine paradigm provided a plan that directed the development of internal medicine, which included paediatrics, and which was believed to provide solutions to problems being tackled by the practitioners in that medical community.46 I will use the term “the scientific medicine paradigm” to indicate the model that paediatricians believed they needed to follow if they wished to see their specialty established. Those who determined the paradigm were largely the senior physicians in the field of internal medicine. They believed, and their views were reflected in the stated objectives of the RACP, that the practice of medicine should be based on scientific principles. They encouraged the development of research programmes to advance medical knowledge in the pattern of internal medicine in the US.47 A senior physician in Sydney, C.R.B. Blackburn, spoke of the need for science in medicine, emphasising that there should be close ties between universities and teaching hospitals. Both organisations were potentially very influential agents in the health system, he said, that could provide “scientific attitudes unobtainable in any other way.” He also spoke approvingly of the way scientific medicine had developed in the US, and particularly praised the work of the educationist, Abraham Flexner, in improving the quality of medical schools by encouraging their commitment to medical science.48

While the major influences on Australian medicine before, and shortly after, World War II came from the UK, the source of the paradigm that influenced Australian internal medicine, both adult and paediatric, after this time, was the United States. There were

45 Kuhn, 175.
46 Ibid., viii, 23.
48 C.R.B. Blackburn, “The University Teaching Hospital,” *Medical Journal of Australia* 2 (1965): 179-184. A history of scientific medicine in the US from the 1890s to the 1930s can be found in Howard S
no other tenable sources. In the 1940s and 1950s there was little scientific activity in paediatrics in Australia. In Britain, physicians were mainly interested in the development of clinical skills, and clinical science was only slowly developing.\textsuperscript{49} From the beginning of the twentieth century the US had led the world in medical science, which had been greatly strengthened by the changes that followed the publication of a report on medical education, commissioned by the Carnegie Foundation.

At the beginning of the twentieth century the medical schools in the US, which were mainly privately owned, were, with a few exceptions, of very poor quality. This was a cause of great concern for education and health authorities and prompted the Carnegie Foundation to fund an investigation by Abraham Flexner, a prominent educationalist. He inspected all the medical schools in the US and recommended major reforms, with a strong emphasis on the need for their undergraduate curricula to be founded on the basic sciences. Many of the substandard schools closed but those that remained greatly expanded their basic science departments and became increasingly selective in their entry standards, attracting only the brightest students, many of whom who would be more interested in research than in routine clinical practice. To support their teaching programmes the medical schools fostered a great expansion in medical research, supported by the enormous financial contributions of philanthropists such as Rockefeller, Carnegie and others. The granting of these funds was conditional on the adherence to a paradigm of scientific medicine, under an ideology that declared that scientific research could find a cure for all diseases, and lead to a happier and healthier society. There was also a political purpose as people like Rockefeller believed that philanthropy would make the US more stable.\textsuperscript{50}

In Australia the scientific medicine paradigm was seen by influential physicians as providing benefits for patients and for doctors, and for furthering the cause of internal medicine. It was adopted as a guiding policy, although there was never any formal institutionalised decision made. Paediatricians in their turn came to see that embracing

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scientific medicine was a logical solution and if they wished to be part of the elite scientific medical community and if they wanted their specialty to be legitimated. There was strong public support for this move. The Australian public also had great expectations of science as represented by the medical profession. However, as will be discussed later, paediatrics in Australia in 1945 and for some time after was considered to be unscientific.

One can speculate that paediatrics might have adopted a different sort of paradigm, and become involved with public health and social medicine that had occupied the attention of doctors interested in child health at the beginning of the twentieth century. On the other hand Australian paediatrics might have followed certain developments in the US where in the late 1950s, psychosocial paediatrics, “the new paediatrics,” began to appear. The interests of paediatricians moved from organic disease to developmental, behavioural and educational disorders, which had become of more significance with the decline in infectious disease. There were a number of other reasons for this change. Primary care paediatrics had became less challenging intellectually with the rise of hospital-based medicine and it was emotionally and physically exhausting. Further, an expanding specialty, family medicine, was competing for the same occupational space. Academic departments of psychosocial paediatrics arose to develop research programmes, to expand knowledge and to provide services for families with children suffering emotional and behavioural disorders. Those departments captured the interest of the trainee paediatricians who emerged in the 1970s much better skilled in the area and ready to incorporate their new knowledge in their practices. A new field or paradigm of paediatrics emerged.

A need for such services also existed in Australia, but paediatricians in the early post-war period largely elected to follow the scientific medicine paradigm and concentrate on organic disease and curative medicine, although there were some exceptions. At the Royal North Shore Hospital in Sydney Dr. Claire Isbister established in the 1950s and

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53 Ibid., 133, 134, 143-148.
1960s what might have been the beginnings of a new paradigm, which had a strong component of preventive care through health education. Dr. Isbister’s ideas, however, made little impact on her peers, because most paediatricians believed that they needed to concentrate of curative medicine to establish their specialty. For this they needed to possess sound scientific knowledge. There was, however, another form of knowledge that experienced paediatricians already held. This was called indeterminate knowledge and it also was useful for claiming occupational space.

**Indeterminate Knowledge**

Professional knowledge has been described in discussions on professionalization and specialization as existing in two forms. The first was determinate knowledge, which included scientific knowledge. It was developed by intellectual processes and had a high content of technicality. It could be acquired from teachers and from books, and could theoretically be learnt by anyone. Determinate knowledge obeyed specific rules, and for doctors it was the science of medicine.

The other form, indeterminate knowledge, was often referred to as the art of medicine. It was knowledge held by individuals and was based on experience and practice. It was not easily communicated to others and obeyed no rules. The possession of indeterminate knowledge was a valuable possession for a specialty’s claim for recognition because it was very difficult for critics or professional competitors to evaluate rationally or to dispute. It strongly supported the authority and autonomy of those who owned it.54

Paediatricians claimed that they possessed special indeterminate knowledge that gave them distinct advantages over other practitioners in the care of children. Paediatricians believed that they understood better than other doctors how children coped with illness and that they had special skills in handling them. They had “a way with children.”55 In this area one of their models was Sir George Frederick Still, who has been called the father of British paediatrics. He was, in the first quarter of the twentieth century, the

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55 For example, see P.L.Hipsley, Obituary of Dr.E.H.M. Stephen, Medical Journal of Australia 1(1954): 653, 654.
first doctor in Britain to practise exclusively in the field. Still was reputed to be able “to soothe a fractious child with the touch of his hand. He had a deep knowledge of children’s ailments, and had profound love for them and an almost uncanny understanding of their point of view. He had a strong and upright character, but showed his tenderness in his contact with children.”

Jamous and Peloille suggest that indeterminate knowledge gave a profession, and a specialty, a distinctive mystique, and an aura of competence and professional attitude that went beyond that provided by scientific determinate knowledge alone. However, on the evidence from the interviews with people who were patients in RAHC and other hospitals, there were deficiencies in certain aspects of indeterminate knowledge that paediatricians claimed they possessed.

The Work of Doctors

Both determinate and indeterminate knowledge provided a foundation for the practice of paediatricians. However, it was largely the work that they did which determined whether or not they were recognised as specialists both by the doctors who would refer them cases, and by the public. Abbott has called this link between a specialty and its work a jurisdiction. For the same concept others have used the term “occupational space” and Freidson has called it “a division of labour.” Specialties and their jurisdictions were in a dynamic state. New jurisdictions or occupational spaces were created when new knowledge and technology became available. Sometimes the boundaries of jurisdictions changed as specialties readjusted their patterns of work; occasionally social pressures brought change. Jurisdictions could disappear when diseases changed or were eliminated. One specialty’s jurisdiction or its boundaries might also be challenged by another specialty. Competition was an integral part of specialization.

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59 Freidson, 37, 48.
60 Halpern, 18.
61 Abbott, 21, 91.
As mentioned earlier, paediatrics was disadvantaged because it could not clearly define its role — the boundaries of its jurisdiction were unclear. Sociologists have shown that the more strongly focussed a specialty the more rapidly it evolved. Certain specialties with a narrow focus, like ophthalmology, developed rapidly early in the twentieth century. Paediatrics was much more broadly based. It was both science-based and a social-welfare-oriented specialty, and had to struggle much more vigorously for recognition.62

Production in Medicine

In an analysis of the development of French University-hospital system during the nineteenth century, Jamous and Peloille suggested that a useful way to examine the evolution of medicine was to analyse what the profession produced, which, they argued was in three areas: the production of medical knowledge, the production of medical care and the production of new doctors.63

Judy Sadler has used these concepts to look at more recent developments. She believes that the struggles for authority within medicine, the struggles of one group to gain advantages over another for occupational space, were determined by the relative strength of their possession of each of the systems of production. She agrees with many other sociologists that the production of new scientific knowledge provided the basis for specialisation. Initially knowledge was held by the doctors who first took up a special focus of interest, and new knowledge came from their own research and from that in the universities and the teaching hospitals, which were under the control of medical scientists and elite clinicians in the field. With scientification the basis of medical specialization, they were the authorities who came to have a very strong influence on the development of their respective specialties.64

The second system, the production of medical care, was the economic basis for medicine, and provided financial viability to the other two systems of production,

63 Jamous and Peloille, 120, 121.
64 Judy Sadler, “Ideologies of ‘Art’ and ‘Science’ in Medicine,” in The Dynamics of Science and Technology: Social Values, Technical Norms and Scientific Criteria in the Development of Knowledge,
whether the remuneration for care came from private practice or from salaried service. It was also the area where medicine came in contact with certain external social structures which helped shape specialties: the public and the patients, governments, and other funding sources.65

The real authority in medicine, Sadler believes, resided in those who produced the new practitioners because they regulated entry to the specialty. That production system was controlled by the formally-established medical associations, which in Australia were largely the Royal Colleges of Physicians or Surgeons, not organisations like the British or Australian Medical Association which were for medico-political purposes. The Colleges claimed that the doctors they trained would improve the care of patients and their possession of this authority gave the associations great power. They created monopolies in their particular field and ensured their members a source of income. The producers of new practitioners were linked with the elite who produced new knowledge, and the three systems of production were closely inter-related.66

The pattern of development of paediatrics was affected by all three production systems. Up to the 1950s the specialty lacked the authority to offer specialized medical care because the knowledge it needed was not yet available, meaning that it could not provide better care than others in medicine, such as general practitioners and general physicians. Further, the social environment was not yet ready for paediatrics. The financial rewards from paediatrics were insufficient to support a specialty of any size. Most significantly, until the 1960s paediatrics did not have the authority to control entry to the specialty.

Many explanations have been offered to account for specialization, but they leave many questions unanswered. Was it “an inevitable and desirable accompaniment of medical advances,” or was it “simply a device for professional advancement”?67 Or was the purpose, as Sadler suggests, to create a monopoly to ensure an adequate income for the

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65 Ibid., 178, 179.
66 Ibid., 179.
67 David Armstrong, Political Anatomy, 54.
members of the specialty?\textsuperscript{68} Were medical specialties created by altruistic doctors with a strong sense of responsibility, to bring to the sick the benefits of scientific medicine? Did the doctors really have a commitment to personal service and community welfare, and were they as motivated by ethical and moral principles as they wished to appear?

\textit{Conclusions}

I have argued that physicians, and in turn paediatricians, were disadvantaged in their moves to legitimate their specialty groups because they lacked a clear professional and public identity, much of which arose from conflicts between the concepts of generalization and specialization. Their work was not as finely focused as other specialties. A clear definition of the role of paediatricians only developed as the specialty separated itself from internal medicine.

In Australia during the 1940s and 1950s the paradigm of scientific medicine prevailed for those doctors who wished to be called specialists in internal medicine, including the paediatricians. The paradigm was a social and scientific construct, chosen by paediatricians and determined by the prevailing views of internal medicine and having its origins in the scientific medicine of the US. There was no valid rationality in this choice, because there was no reliable information on which to base such a decision. The eventual successful adoption of the paradigm was what would give paediatrics legitimacy in the arena of medical specialisation. This paradigm influenced the work of paediatricians, what they produced and how the specialty developed. In one important area of medical production, however, paediatrics was disadvantaged, namely in the control of the production of new specialists. The question of the development of a professional association to control this vital role in specialization, was thus a necessity.

\textsuperscript{68} Sadler, 183.
CHAPTER TWO
THE PROFESSIONAL ASSOCIATIONS

Introduction

Chapter One referred to Rosen’s discussions on medical specialization, and how doctors wishing to be considered specialists in particular fields of medicine created formally structured organizations to support their claims for occupational space. The associations controlled entry to the specialty by guiding the training of doctors aspiring to join and then certifying as suitable for membership those candidates who had satisfied certain entry criteria, usually by passing an examination. With this membership a doctor could be considered a specialist in the relevant discipline. Rosen has argued that these formally constituted organizations were valuable in furthering the growth and strength of specialties in the US. Observations suggest that the same was true in Australia, where the formal bodies were called associations or colleges.

An association strengthened the bonds between members and fostered communication and the sharing of knowledge. It established codes of ethics and professional behaviour; provided for sanctions for those who broke the rules, and offered rewards to members who made worthy contributions to the association. The development of a code of ethics and a means of ensuring conformity with that code was important for the specialty to be accepted as legitimate by potential patients and by other doctors. The association had to be able to reassure the public that its members were appropriately skilled in their tasks, that they would work in the interests of the people, and that they possessed integrity.

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2 Ibid., 209.
3 Ibid.
With these attributes the specialty association could claim that it should be independent and self-governing. In Australia, as elsewhere, full autonomy required State recognition which was facilitated if the association had high prestige and included members perceived as elite, and who had political and economic influence.\(^5\) For these purposes the association had to be large and well organised. The more strongly organized a specialty was the more effectively it could lay claim to a jurisdiction in the public realm and in the workplace.\(^6\) While the professional association aimed to establish its own credentials in the public arena, individuals gained prestige and status through membership. The system that controlled entry to the specialty, and the uniform codes of practice, helped control competition and improved the economic status of members.\(^7\)

Paediatricians experienced difficulties in establishing mechanisms that they controlled, that allowed the entry of new paediatricians to the specialty. The development of the specialty was hindered until the late 1960s when a sufficiency of control was acquired.

\(\textit{The Medical Associations and Paediatrics}\)

In Australia, between 1945 and 1965, most paediatricians were members of two professional associations, the larger and more powerful being the Royal Australasian College of Physicians (RACP). The College, established in 1938, aimed to provide its members with all the facilities of a typical professional association.\(^8\) Members of the RACP enjoyed high status and prestige. The letters indicating Membership or Fellowship of the RACP (MRACP, FRACP) could be added to the doctor’s formal title, facilitating recognition by other doctors and the public, although they did not distinguish between adult physicians and paediatricians. These links to the College gave paediatricians credentials, additional to their primary university degree, that were recognised by the State licensing bodies as qualifications that would be needed after the 1940s to apply for specialist positions in teaching hospitals and in many large district and regional hospitals. Later, after 1970, holders of the MRACP or FRACP would be able formally register as consultant physicians with the Commonwealth Department of

\(^7\) Millerson, 112-114.
\(^8\) Abbott, 82.
Health and be able to claim higher fees under the Health Benefits Plan of the National Health Scheme.9

Most paediatricians also belonged to a second body, which they had established in 1950. This was the Australian Paediatric Association (APA), known from 1978 as the Australian College of Paediatrics (ACP). Between them the RACP and the APA provided for paediatricians the functions usually offered by one comprehensive medical association, except that paediatricians were not in a position to regulate the entry of new members to the specialty; that was under the control of the RACP, which was constituted mainly for adult physicians.

There were other corporate structures for paediatricians but none filled the role of a professional corporate body. There were, for example, hospital departments which brought paediatricians together, but their role was limited to internal affairs. There were also groups established for social and educational purposes. The most successful of these was the Melbourne Paediatric Society, established in 1904. Later called the Paediatric Society of Victoria, it has held regular scientific and social meetings from early 1900s to the present. The long existence of this organisation is evidence of the duration of the special interest in Australia in the health and diseases of children, even before there were any specialist practitioners. It was not, however, a national body. In NSW a paediatric section of the British Medical Association (BMA), (NSW Branch), arranged regular clinical meetings for the medical profession generally, but it was not a professional association.10 Paediatricians belonged to the State branches of the BMA but they were medico-political organisations that represented the profession as a whole, and could not advance the interests of one particular specialty over another.

In Australia in the 1930s there were insufficient numbers of doctors with an exclusive or even a special interest in child health to contemplate the establishment of a corporate body large enough to be a credible and useful professional group. In each of the State capitals there were a few doctors who called themselves paediatricians. Very few had specific training in the discipline; they were general physicians interested

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in children or they were primarily general practitioners. In this period doctors were recognised as paediatricians by repute, because they were known for their skills in treating children’s illnesses, but increasingly the medical profession expected that specialists would have credentials derived from a period of formal training followed by the passing of a qualifying examination. There were no specific credentials available for paediatricians in Australia.\footnote{There was a paediatric qualification available in the USA from 1933, awarded by the American Board of Pediatrics, one of a number of specialty boards. Sydney Halpern, \textit{American Pediatrics; The Social Dynamics of Professionalisation 1880-1980} (Berkeley: University of California Press, 1988), 80, 81. It was not the custom for Australian doctors to go to the USA for training before the 1970s, nor were US Board qualifications recognised here.} An acceptable alternative was a diploma in internal medicine, but even that was not available until 1938.

In the absence of an Australian qualification many aspiring paediatricians went to Britain, some for training, others to sit for an examination in internal medicine to become a member of one of the Royal Colleges of Physicians, usually the Royal College of Physicians (RCP) London.\footnote{A.W. Holmes à Court, “The Structure and Function of the College,” \textit{Proceedings of the RACP} 5.2 (1950), 12.} On their return to Australia these doctors maintained the strong links between British and Australian internal medicine and paediatrics. The President of the RACP declared in 1959 that these overseas trips, to London or to Edinburgh, which he called “the Mecca of Australian physicians,” ended the isolation of Australian internal medicine.\footnote{J.G. Hayden, RACP, Presidential Address, \textit{The College Newsletter} 1, Sydney, 1959.} The Australian doctors who had experienced British medicine and who had been associated with its medical institutions and hospitals, returned favouring the philosophy of generalization over specialization, an attitude which was to have an effect on paediatrics for some years until US ideas began to predominate.

The British influences on Australian paediatrics persisted through the 1940s and the early 1950s, and they were reflected in clinical practices and in the ways in which doctors and hospitals were organised. Britain had little to offer in clinical science because that was late in becoming established in the UK. The major developments in science and technology were taking place in the US, and they progressively increased their impact on Australian paediatrics through the 1950s and 1960s. However, Australian physicians had been impressed with the British professional organisations
and they moved to develop a specialist association that was similar to those they had observed in the UK.

*The Royal Australasian College of Physicians (RACP)*

Senior physicians in Australia had agreed in the 1930s that training for internal medicine and a qualifying examination should be available in this country. To bring this about became one of the aims of the Association of Physicians, the direct predecessor of the RACP. Australian physicians wished to gain control of the entry of new candidates to the field of internal medicine, a vital step in the development of a specialty. The Association was established in 1930 by a group of elite physicians, most of whom were senior honorary medical officers in the teaching hospitals of Sydney and Melbourne. The question of having an Australian college was first raised in 1931, but a formal decision to establish one was not made until 1936. It was recognised that there was a need for “a body of some standing to organise and supervise the postgraduate study of Internal Medicine — a College would possess greater dignity and achieve a higher status in the eyes of the medical profession and lay public than an Association.”

The RACP was established in 1938 and paediatricians sought to become members, because they had no organisation of their own and because the distinction between adult and children’s medicine was still blurred. The College was modelled on the RCP, London, and held similar views on specialization. An early president declared:

> Fragmentation and segmentation (in internal medicine), and specialization which is premature or too narrow, may lead to failure to appreciate the perfect integration of function of the body, of which good health is a tangible expression…the aim of the College is to produce well-educated physicians…in the widest sense…who later may become specialists in narrower spheres.

In its attempts to emulate the RCP, the early College Council of the RACP was much concerned with status and prestige. Much of the time of its meetings was devoted to discussing the College motto, the armorial bearings (see Figure 2.1), the Royal Charter

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15 RACP, minutes of the first Council meeting, 29 April 1938. RACP Archives, Sydney.
16 Holmes à Court, 1950.
and the Presidential robes. The Inaugural Ceremony of the College was held in the Great Hall of the University of Sydney on 14 December 1938 in the presence of the Governor of NSW who read a message from King George VI. Representatives of the RCP, London, and the American College of Physicians were present. For a headquarters the College purchased one of the oldest mansions in Sydney, an imposing building in Macquarie Street built by John Fairfax in 1848. It later became the Warrigal Club for gentleman pastoralists. The building was adapted with great difficulty and expense, and not very successfully, for the various needs of the College (see Figure 2.1).17 The RACP acquired the equivalent of what Millerson calls the conventional (British) association status symbols, which included “a suitable London address in certain streets or squares (the Macquarie Street building was in an ideal position), a Georgian house with a sense of age and quiet dignity, the essential coat of arms, and a Royal Charter.” The Charter was a valuable symbol of high social status implying supremacy in a particular field, associated with a strong record of public service. It meant respectability and a strict control of entrance standards and professional conduct. It also meant that the College was obliged to abstain from selfish objectives, such as being involved in industrial negotiations or medico-political matters.18

The RACP was very concerned with its elite status and prestige in medicine and in Australian society. Internally, at first, it was also organised on elitist lines, with two levels of membership, Fellows and Members. The Foundation Fellows were mostly those who had been members of the Association of Physicians of Australia, or other physicians who had been nominated by the Association in its closing days. They were “physicians actively engaged in the teaching of medicine and men of distinction in medicine and the allied sciences.” Most were senior honorary physicians in the teaching hospitals, including the children’s hospitals.19 New Fellows were elected by the existing Fellows from the body of Members, taking into account “their standing in the College, their distinction in the literature or in science, academic honours, public appointments, the length of tenure of Membership, and their professional eminence.”20 At the lower level, Members were admitted to the College after gaining the approval of a Board of

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18 Millerson, 192, 89-91.
19 Association of Physicians; minutes of Council, 16 June 1937; Executive minutes, 16 June 1937. Discussion on proposed Articles of Association for the RACP.
20 RACP, Executive minutes, September 1945, date not given.
Censors which had satisfied itself of the applicant’s competence by an examination. (See Appendix One for a list of paediatricians who were Foundation Fellows and Members up to 1943.)

The College was governed by a Council elected largely by the Fellows. The Members could have a representative on the Council but their voting power was limited. For example, they could not participate in voting for new Fellows. The Council appointed the College President and other officers, and an Executive Committee. Although there was no distinction between adult and children’s doctors in the Constitution of the RACP, and there were significant numbers of paediatricians in the ranks of the Fellows and Members, few were elected to the Council or to be office bearers, so they had little opportunity to influence College policies from any position of power. Several doctors who practised in both adult and child fields were to be found in the early Councils, but it was not until 1955 that an undoubted paediatrician, one practising only with children, was elected. He was Lorimer Dods, and he remained the sole paediatrician on the Council for over ten years. Among the twenty or so other Councillors, all adult physicians, he was not in a strong position to further paediatric interests. Dods was nominated for President for 1964-1966 but received only one vote. There were seven other candidates nominated for this office, all of them adult physicians. It is unclear why Dods received such little support. He was Professor of Child Health in the University of Sydney, his clinical reputation was strong and he was skilful in medical diplomacy. He was described as the best-known figure in Australian paediatrics. The most likely explanation is that adult physicians believed that paediatricians were not their equal scientifically and hence it was inappropriate for one of them to head the RACP.

Although paediatricians were not amongst the elected officers of the RACP, they were not considered differently to other Members or Fellows in the College records; all were physicians in internal medicine. Of the 191 Foundation Fellows in Australia, twelve

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21 RACP, Articles Of Association, 32-37.
22 Ibid., 10-26.
23 RACP, Council minutes, 10,11 May 1955. It was not until 1984 that a paediatrician was elected to a senior office in the RACP, when Dr A.C.L. Clarke was elected Vice President.
24 RACP, Council minutes, 21 October 1963.
were undoubtedly paediatricians and they all held positions as senior honorary physicians in children’s hospitals. There were other Foundation Fellows who were both adult and children’s doctors. Paediatricians were also regularly elected as new Fellows.\textsuperscript{26} They also became Members in appreciable numbers from the time of the first examination in 1938. Of the forty-one candidates who passed that examination, six were paediatricians.\textsuperscript{27} Whether there was a numerically equitable representation of paediatricians among the Fellows and Members is difficult to assess, as their occupation was not recorded. Although there was an appearance of equality of status in the College, many of the paediatricians who were interviewed believed that that was not the case.

Eminent paediatricians in Australia have held, and still hold, perceptions that adult physicians thought them inferior in the broad discipline of internal medicine. These views were widespread, being held by paediatricians who came from different States and who had become members of the RACP at very different times. Dr Howard Williams, who gained his MRACP in 1946, and who was a senior physician and Director of the Clinical Research Unit in RCH, Melbourne recalled in 1995: “paediatrics at that time was regarded by all involved in adult medicine as being of lower status, carrying out minor and not very important work.”\textsuperscript{28} There was a strong perception that paediatrics was not up to the scientific standard of adult medicine. Dr Wallace Grigor, MRACP 1956, and an honorary physician in RAHC, Sydney, recollected in 1998:

I can’t speak for the time before 1956, but there was absolutely no doubt that for many years after 1956, like decades, the adult hospital world saw the paediatric world as just little adults who were looked after by doctors who were not all that scientific or important. So they were condescending and patronising, they didn’t rate us highly — I think the attitude has gradually died, but there are still elements of it around.\textsuperscript{29}

\textsuperscript{26} RACP, Lists of office bearers and Fellows and Members from foundation to 1943.
\textsuperscript{27} RACP, Council minutes, 13 December 1938. The lists of new members which appeared in the Council minutes were compared with lists of members of medical staffs of children’s hospitals.
\textsuperscript{28} Dr Howard Williams, letter to author, Melbourne, 14 January 1995.
\textsuperscript{29} Dr W. Grigor, interview by author, tape recording, Sydney, 13 August 1998.
Children’s hospitals were not places where most gifted young doctors would go to pursue a research or academic career; they were not scientific enough. Professor John Beveridge, MRACP 1952, Foundation Professor of Paediatrics at the University of New South Wales, declared in 1998: “Condescending is a mild term [for describing the attitude of adult physicians] I think it was much stronger than that. My colleagues regarded me as a failed internist when I went to the children’s hospital (RAHC) in 1950, and they made no bones about it.” 30 Another paediatric academic, Professor Ian Lewis, MRACP 1950, Senior Lecturer in Paediatrics at the University of Western Australia, and later Professor of Paediatrics at the University of Tasmania, believes that some adult physicians in the teaching hospitals turned medical students against a career in paediatrics. The place of paediatrics in the undergraduate curriculum was often undervalued by medical schools. Lewis recalled: “Adult physicians used to, and some still do, regard paediatrics as a specialty to be grouped with Eyes and ENT (ear, nose and throat disease). Paediatricians consider it should be rated equally with medicine, surgery, obstetrics and gynaecology.” 31 A report prepared by the APA also expressed the opinion that the Australian medical schools considered paediatrics of less importance than the other major specialties. It stated that insufficient time was given to undergraduate teaching, and it was often provided by adult physicians who considered paediatrics a minor specialty. The report recommended that paediatrics should be a major subject and that instruction should be provided by recognised paediatricians working full-time with children. 32

Other paediatricians have conceded that there was some truth in the criticism that paediatrics in the 1930s and early postwar period was unscientific. One, who began his paediatric career in 1937 and became a senior physician after the War, said in 1998:

In Sydney the general quality of the staff of the adult (teaching) hospitals, in terms of training and scientific attitudes and probably intelligence, exceeded that of the children’s hospital in the time that I knew them (from the 1930s onwards), although the Children’s Hospital had a few outstanding people who were undoubtedly scientific, for example, Dr Margaret Harper. 33

30 Prof. John Beveridge, interview by author, tape recording, Sydney, 19 May 1998.
31 Prof. Ian Lewis, letter to author, Hobart, 6 November 1998.
32 APA, Round table discussion on child health facilities in relation to the total needs of children. 2. The part to be played by paediatric teaching in the medical curriculum. 11 April 1953. File on child health services in Australia, Box 2. RACP Archives, Sydney.
33 Dr D.G. Hamilton, interview by author, Sydney, 24 February 1998.
Dr John Yu, MRACP 1967, and from 1979 Chief Executive Officer, RAHC, Sydney, believed that the unscientific image of RAHC extended to a later period:

I think that [being unscientific] is a true reflection of things. In fairness to the adult physicians paediatrics was not a very scientifically-based specialty. To adult medicine, which was blossoming into a very scientific phase, we must have seemed to be a very funny lot of people.\(^{34}\)

Yu said that when he was a junior resident in RAHC in 1961 some of the honoraries, such as Dr Kate Winning, were still heavily involved in developing infant feeding formulae. This had been a major research field for paediatricians before the war, but was no longer considered part of the modern scientific medicine paradigm.

The perceptions of the other side, those of adult physicians, have been difficult to obtain, which is not surprising given the expiry of time and the higher status that paediatrics has enjoyed more recently. Dr Stanley Goulston, an adult physician who had been President and Chief Censor of the RACP, pointed out that the period from 1947 to 1965 a golden age for adult internal medicine that saw the beginning of subspecialization at the Royal Prince Alfred Hospital, a major teaching hospital of the University of Sydney. He recollects that there was resistance and scepticism to the new patterns of medicine from some older doctors, and believes that this scepticism may have spilled over to the changes that were beginning to occur in the children’s hospital, that he asserts always had a great reputation.\(^{35}\) On the other hand, Dr Gaston Bauer, an adult cardiologist, cannot remember any sentiments of disrespect by physicians towards paediatricians.\(^{36}\)

Nevertheless, responsible paediatricians in clinical, research, academic and administrative positions and in private practice have held strong feelings about the adverse views of adult doctors on their specialty, whether those views were justified or not. It may have been that the members of a new and insecure specialty were unduly sensitive about any criticism, but there are frank admissions by paediatricians that they were not as scientific as adult physicians at a time when to be scientific was the

\(^{34}\) Dr John Yu, interview by author, tape recording, Sydney, 11 August 1998.
\(^{35}\) Dr Stanley Goulston, letter to author, Sydney, 2 July 1998.
\(^{36}\) Dr G. Bauer, letter to author, Sydney, 16 July 1998.
benchmark of progress in internal medicine. Paediatricians complained that the adult physicians did not know what was happening within paediatrics, nor did they understand the special needs of sick children. Whatever their views, paediatricians had to come to terms with the RACP, because Membership of the College was the most practical way of acquiring credentials with which they could claim to be specialists, although that meant passing an examination on terms set by adult physicians. There was no paediatric body willing or capable of holding such an examination. The UK diplomas, MRCP London or MRCP Edinburgh (which had a paediatric component) were still possibilities for some, but Australian doctors were being encouraged to obtain their qualifications in Australia. They were also urged to use any time overseas for research, and to acquire special skills and techniques which would be useful on their return, rather than wasting their time in attempting to pass an examination.³⁷

The Examination for MRACP

The MRACP examination aimed to test a candidate’s competence in the broad principles of internal medicine, and during the 1940s and 1950s it was accepted, without apparent serious complaint, as a general enough test to be appropriate for all physicians, whether they treated children or adults. The Australian examination was closely modelled on the MRCP examination held by the RCP London. That examination, on the principles of internal medicine, and taken mainly by intending adult physicians and paediatricians, was also used by trainees in a number of other specialties, including psychiatrists, pathologists, radiologists, and dermatologists, as their source of credentials.³⁸ Similarly, in Australia, ambitious doctors in these specialties studied for and attempted the MRACP examination. They believed that the possession of this diploma added to their prestige at a time when their own specialty qualifications did not exist or were of lower status.

The RCP London and the RACP both claimed that their Membership examinations were in general medicine, and that they were of equal standard. They negotiated certain reciprocal arrangements so that members of one College were exempted from the

³⁷ A.W. Holmes à Court, Presidential Address, Proceedings of the RACP, 5 July 1950.
³⁸ Rosemary Stevens, Medical Practice in Modern England: The Impact of Specialization and State Medicine (New Haven: Yale University Press, 1966), 339. The general MRCP examination was taken by all specialties up to 1964.
written examination if they wished to join the other College. However, despite the similarities and agreements about reciprocity, there were essential differences between the two that contributed to some confusion about the purpose and nature of the MRACP, a question which was often raised by the APA. In awarding the MRCP London, the RCP recognised only that a doctor had shown the potential to become a consultant specialist, whether in adult medicine or paediatrics. The London College recommended that the examination be taken early in the doctor’s career, two or three years after graduation. Then followed four to six years of vocational training: paediatric trainees would usually work in a children’s hospital as a registrar and senior registrar. After this training the doctor had to obtain a suitable appointment as a consultant in a hospital before being recognised as a specialist. In contrast to the situation in Australia, this approach to becoming a specialist was not a cause of concern to British paediatricians who saw the early examination in general medicine as a reasonable and not difficult hurdle. In Australia, on the other hand, the MRACP was usually gained at the end of training and its possession meant that the doctor was now considered a specialist. There was, however, only one form of examination for all candidates from 1938 to 1964. While it was appropriate for adult physicians, it was not suitable for paediatricians because it did not test sufficiently knowledge and skills in children’s disorders.

The examination for MRACP was conducted by a Board of Censors, which determined the standards required for entry to the College, but there were no paediatricians on this Board until 1970. There was one exception that illustrates both the ambiguous positions of some of the early paediatricians and the problems of identifying occupational preferences in the early College. The first Board of Censors included Sir Edmund Britten Jones, an Adelaide physician who was a Senior Honorary Physician in the Adelaide Children’s Hospital, but who spent most of his working time in adult medicine in private practice. For personal reasons he chose not to be an honorary physician on the staff of the Royal Adelaide Hospital, although he could have been, given his professional status in Adelaide. There were many physicians like Britten Jones who

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treated both children and adults. They are difficult to classify as either paediatricians or adult physicians, but their training and clinical experience often dated from the 1920s and 1930s when paediatrics was a very different discipline from that which developed after the Second World War. One assumes that these doctors were not paediatricians in the modern sense. They, and the other Censors who had had even less experience of children, would have had to be exceptional people to assess fairly the quality of candidates in the art and science of clinical paediatrics of the 1950s, compared with their ability as adult physicians to assess their adult-oriented candidates. Dr John Yu commented in 1998:

We (paediatricians) did the Membership in adult medicine and the first time I did the exam, and failed, my youngest patient was aged about eighty years. I could understand why the adult Censors might think that paediatricians weren’t all that good clinically — we were being measured by the wrong yardstick.42

The RACP did not have any specific requirements for candidates for training or experience before applying to sit for the examination, except that three years must have passed from graduation. While it might have been expected that a person wishing to be to be a paediatrician would have worked in a children’s hospital, there were no stated conditions. This contrasted with the explicit training and specific experience in operating theatres, wards and outpatient departments required by the Royal Australasian College of Surgeons (RACS) for intending surgical specialists. Physicians thought differently. The Chief Censor of the RACP declared: “the RACS prescribed a course of training with a vengeance.” For physicians, “experience is much less measurable and more subtly obtained.” The RACP had attempted to prescribe training in 1944 but had found it too difficult because of the many different types of posts held by physician trainees.43 It is more likely that these views reflected the importance that the RACP attached to the traditional philosophy that a good physician was a generalist, and that rigidity and narrowness in training was highly undesirable.

For similar reasons the Censors found it impossible to prescribe a curriculum for the examination, beyond stating some very broad principles. Candidates were required to have a much more detailed knowledge than that required for the undergraduate Bachelor

42 Yu, interview.
of Medicine examination. It was suggested that they read the recent most editions of certain general textbooks of medicine such as Price’s *Textbook of the Practice of Medicine* or Osler’s *Principles and Practice of Medicine* (these textbooks had many editions), as well as the standard medical periodicals for information about recent advances. Some knowledge of the history of medicine was also required. Candidates were expected to have a broad knowledge of medicine, but not that of a specialist in cardiology or neurology, for example. There was a reference to children in the advice given to candidates. “A broad general acquaintance with the medical diseases of children is also necessary, but an expert paediatrician’s familiarity with the rarer maladies of childhood and with the disease which only occur in infants, is not essential.”

The examination was in two parts. The first was a written examination with questions requiring answers in essay form. The second, undertaken by those who had passed the first part, was a clinical examination in which candidates assessed patients. The written section aimed to test the candidate’s knowledge of medical science and the principles of internal medicine, which a paediatrician might be expected to answer, but often the questions were too adult-oriented, particularly when the medical science of adults could no longer be validly applied to children. The clinical examinations were all held in adult hospitals, and while theoretically a candidate might have been given a child to examine, virtually all the cases were adults. The Censors expected that examinees, as well as showing their knowledge of medical science, would also demonstrate their skills in the art of medicine and show that “judgement and clinical sense which could only come from clinical experience under the guidance of a well-qualified physician.”

Although the Censors were expected to take into account the candidate’s training in a children’s hospital, the clinical section was more difficult for paediatric trainees than those trained in adult medicine. The examiners, being adult-oriented and not versed in pediatrics, were not in a position to fully assess the skills of the aspiring paediatricians,

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46 RACP, Reports of the Chief Censor. Almost every year, from 1943 to 1959, he emphasised that candidates must be able to demonstrate their good clinical judgement, if they wished to pass the examination.
particularly in their depth of indeterminate knowledge. Dr Howard Williams recalled in 1995 that the examination was unfair for paediatricians, from his own experience of being a candidate in 1948 and from his contacts with many candidates subsequently. He said that the Censors had no knowledge of the differences between adult and child patho-physiology and they had little awareness of what was going on in paediatrics. Many Censors did not like people who came up with only paediatric training. They were happier if candidates had done at least some adult work. They could not reasonably assess the quality of paediatric trainees, and perhaps they felt uncomfortable in trying to do so.

It was not easy for any candidates to pass the MRACP examination. Only about 30 percent of all those who sat passed, a small percentage considering that there was some preselection of candidates in the competition for employment in training posts in adult and children’s hospitals. Despite the difficulties, many aspiring paediatricians were successful in passing the examination. They accepted that this was the only way to join the exclusive and elite membership of the College, which gave them the essential credentials with which they could be identified as paediatricians. It is impossible to estimate how many would-be paediatricians were deterred by this hurdle, or how many were induced to follow an alternative course in adult medicine. Yu recalled:

I think a lot of people chose to do their Membership before they did paediatrics to get it out of the way, and the good ones then became seduced by the excitement of adult medicine, or by being offered jobs, and never came back to do paediatrics. There were quite a few people like that.49

An APA report supported these statements: the children’s hospitals sometimes had difficulty in recruiting suitable registrars because they were going to general hospitals to gain experience with adult patients to meet the high standard of knowledge expected of candidates to pass the MRACP. Others who chose to stay in paediatrics and work in the children’s hospitals were obliged to concentrate their studying time on adult medicine, reading about geriatrics and other subjects which had little relevance to their future careers. They should have been reading about child health, but it was of no help for the examination, that had the highest priority for most candidates. They also had to spend

48 Williams, letter.
49 Yu, interview.
time attending ward rounds and outpatient clinics in adult hospitals for the clinical experience they provided.\textsuperscript{50} It is not hard to see that these conditions were a deterrent to some doctors who otherwise would have liked to take up paediatrics, and for others it hindered their learning in paediatrics. The availability of a paediatric qualification would have avoided many of these problems and given the successful candidates a certificate of their competence, comparable to that obtained by trainees in adult medicine with their MRACP.

For doctors who wished to become adult physicians, attaining the MRACP was the hallmark of their standing as a competent practising consultant.\textsuperscript{51} The situation was quite different for paediatricians; it became progressively more apparent that passing this examination in general medicine did not test whether they possessed all the skills required of a consultant paediatrician. There were some benefits in having a broad general medical education, but aspiring paediatricians needed to show that they had a thorough grasp of the new scientific knowledge relating to children, in matters of growth and development, in the emotional and behavioural problems of childhood, and in new areas such as neonatology and genetics. There was a need for a hallmark for paediatricians and the MRACP as it stood was not appropriate for candidates or for the specialty. The authority of the specialty of paediatrics was diminished because the control of entry to the specialty was not held by its practitioners, but by adult physicians. To remedy the situation there appeared to be two options available to senior paediatricians. They could form their own association with its own qualifying examination, or they could try to persuade the RACP to provide a more suitable examination. The existing paediatric body, the APA, was forced to address these questions, with increasing urgency, through the late 1950s and early 1960s.

\textit{The Australian Paediatric Association (APA)}

The APA was established in 1950 as a national organisation, supported by paediatricians from all the Australian States. It began as a small informal body with quite modest aims: to promote contact and fellowship between paediatricians and to


\textsuperscript{51} RACP, Report of the Chief Censor, Council minutes, 10 October 1952.
hold regular clinical meetings. Like the RACP, the APA was strongly influenced by British medicine and used the British Paediatric Association (BPA) as a model. James Spence, a paediatrician from Newcastle upon Tyne and a prominent member of the BPA, visited Australia in 1948 on a lecture tour and strongly encouraged Australian paediatricians to create their own society. Membership of the APA was at first restricted to eighty to facilitate the active participation of all the members. Admission followed nomination by an existing member and the favourable vote of a membership committee. Most joined after they had become consultant paediatricians; that is, they had credentials from the RACP, or a British College, and they had entered paediatric practice. The Association also had members who were in other specialities associated with children’s hospitals, such as surgery, psychiatry, pathology and radiology. For many years the annual clinical meetings were held in Canberra, so that most attendees were away from the distractions of their practices and everyday work, and were free to attend the scientific proceedings and social functions. For the early meetings all were accommodated in one hotel to facilitate social interaction.

From a beginning as a modest social and scientific organisation, the APA then moved to have a wider role. The Association sought to influence the quality of paediatrics in Australia and to encourage research. It wished to be seen as an authoritative advisory body on child health to Federal and State governments and to other organisations. For this purpose a number of standing committees were established to consider matters such as the state of existing child health services, infant diets, children in hospital, and a pharmaceutical formulary.

The Association recognised early in its existence that paediatricians needed a strong professional organisation that they themselves controlled. A Brisbane paediatrician, reflecting on the position of paediatricians in the RACP, wrote in 1948 that “paediatricians can achieve little in the face of majority decisions of bodies where members may have only a mild interest in paediatrics and who are not and never will be

53 In 1958 the APA had 82 members, 36 were also Members or Fellows of the RACP, there were 13 surgeons and 6 pathologists. The rest came from various fields of medicine, including public health and general practice. APA, Note in historic papers file, Box 1, APA/RACP Archives, Sydney.
engaged in purely paediatric practice.”55 In 1954 the APA formally acknowledged that there was no satisfactory certificate of higher qualification in the specialty.56 It then voted “to establish an Australian Board of Paediatrics to examine the qualifications of men desiring to practise paediatrics as a specialty, and if necessary conduct examinations and grant certificates to those who meet the standards successfully.”57

Very little came from this decision, for reasons that are not clear, but were perhaps related to the inefficient organisational structure of the APA. After a considerable interval the APA decided to explore the second option and approach the RACP. Discussions were held in the early 1960s in the hope that the College might find a way of accommodating paediatric needs for a qualifying examination within the Membership system. The RACP Council was sympathetic to the APA requests and agreed to explore, with a joint committee, the issues involved. The Council could see eventually that the MRACP was not a hallmark for paediatrics, and was also concerned about the risks of a division in internal medicine should paediatricians establish their own college with an examining body, and take members away from the RACP. APA members were reluctant to leave the prestige and security of the RACP; and contrary to their previous decision, agreed that they would accept the MRACP examination provided it was shaped in a more suitable form.58

While most of the RACP Councillors were sympathetic to the APA requests for change, some had reservations. They felt that the anxieties of the paediatricians were exaggerated because many of them had successfully taken the examination which was considered to be a reasonable test for anyone involved in general internal medicine.59 Others argued that it was the duty of the RACP to have a special examination so that paediatrics could remain within the framework of the College.60

In response to the overtures from the APA, the RACP began to make changes that progressively accommodated the paediatricians. In the first move, in 1964, a section of

55 Dr David Jackson, letter to Dr Lorimer Dods, 9 April 1948, Historic papers, Box 1, APA/RACP Archives Sydney.
56 APA, Executive minutes, 8 April 1954. APA/RACP Archives, Sydney.
59 RACP Council minutes, November 1962.
60 RACP, Council minutes, 21 October 1963.
the written paper provided alternative questions for paediatric and adult candidates. A part of the clinical examination, the long case, involved a child as the patient. A paediatrician was invited to attend the examination as an acting Censor. The paediatric content of the examination progressively increased although always remaining under the control of the RACP. The APA played a major part in bringing about these changes, but there were other factors also operating. In the early 1960s the RCP, London, changed its examination to incorporate a paediatric component, which altered the previous reciprocal arrangements for a generalist examination and reduced the strength of arguments against changes to the MRACP.61 There were also pressures within the RACP from certain adult physicians who wished to engage more extensively in subspecialization in fields such as cardiology, renal diseases and endocrinology. There was a gradual acceptance of divisions within internal medicine and the abandonment of previous philosophies emphasising the importance of a generalist approach.62

Although the APA had written to the RACP in both 1961 and in 1963 threatening to form a separate college and to organise a paediatric examination, it was obviously not very enthusiastic about such a move.63 The major concerns were the costs and difficulties that would be experienced by a small organisation in running such an examination for a relatively small number of candidates. The APA had only 116 members in 1960, whereas the RACP had over 1000. As an indication of the work involved in organising a national examination, there were from sixty to eighty candidates sitting for each MRACP examination in the early 1960s. In 1965, in the second examination that had a paediatric component, when the candidate’s occupation could be established, there were fifteen aspiring paediatricians; in the next there were only nine.64 It would hardly have been cost-effective to run a separate national examination for such a small number of candidates with the limited funds available from their entry fees and considering the cost of transporting a number of Censors to the city in which the examination was held.65

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61 RACP, Examination changes noted, Council minutes, 7 August 1965.
62 RACP, Council minutes, October 1966.
63 RACP, Council minutes, 22/23 October 1961, which include a copy of a letter from the APA to RACP, informing the College of the progress of discussions within the APA on the subject of a qualifying examination for paediatrics. Also APA, copy of letter to RACP, 21 May 1963, File labelled “Higher degree,” Box 3, APA/RACP Archives, Sydney.
64 RACP, Council minutes, 16 September 1965, May 1966.
65 Dr John Colebatch, interview by author, tape recording, Melbourne, 30 August 1999.
Unlike the RACP, the APA remained a relatively modest organisation. It did not have a permanent secretariat or even rented premises until 1970.\(^{66}\) This was a cottage of very modest dimensions compared with the RACP building in Macquarie Street (see Figure 3.2). The operational structure of the APA was inefficient, according to one member, and its business meetings became more frustrating and inconclusive as it grew in size and its activities became more complex. The problem was partly due to the rules of the Association. Decisions for corporate action or on policy development could only be made by the whole body of members when they met once a year for the annual general meeting.\(^ {67}\) This lack of efficiency was reflected in the slowness of negotiations with the RACP. A professional association that was not well organised was disadvantaged in claiming the jurisdiction that it sought.\(^ {68}\)

The membership structure of the APA also created difficulties because, as well as paediatricians, there were other specialists who worked with children, such as surgeons, radiologists and pathologists, all of whom had their own professional organisations. The diverse membership added to the strength of the APA in clinical and scientific matters but would have created considerable difficulties had the APA tried to become a credential-granting organisation to only a section of the membership. This step was in the long run not necessary. The RACP progressively, if slowly, accommodated the needs of the paediatricians. The examination had become completely paediatric in content by the 1980s and there was a full complement of paediatric Censors. By then the category of Member had been discontinued; all in the College were Fellows, and the examination was for the Fellowship (FRACP).\(^ {69}\) The APA became the Australian College of Paediatrics, but paediatrics in Australia has not yet developed its own fully independent corporate professional body. The ACP was disbanded in 1998 and paediatricians joined a Paediatric Division of the RACP, with status equal to that of members of the Adult Medicine Division. Paediatricians are still placed in an

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\(^{67}\) Norman Wettenhall, “Some Thoughts on the APA,” The Wettenhall papers, Box 10, APA /RACP Archives, Sydney. The situation changed in 1977, when the management of the APA, to be known as the ACP from 1978, was vested in a management committee. Hamilton, *A History of the Australian College of Paediatrics*, 31,32.  
\(^{68}\) Abbot, 82.  
organisation dominated numerically by adult medicine physicians. It remains to be seen if the specialty of paediatrics is well served by the new arrangements.

Conclusions

The development of paediatrics was inhibited by an inability of the members of the specialty to construct a comprehensive professional association that they fully controlled. Instead, paediatricians had to rely on two organisations, the APA and the RACP, which neither separately nor together met all their needs. The APA was a relatively small organisation that did not have the power and prestige necessary for a specialty seeking legitimacy and occupational space, nor was it in a position to control entry to the specialty. The RACP was large, powerful and prestigious, and it conducted an examination which gave paediatricians their specialist status, but the paediatricians were not in control. Matters improved as the paediatricians gained a stronger influence on the entry examination and as they developed their scientific credentials.

The size and prestige of the RACP provided the member paediatricians with a professional authority that the small and modest paediatric association could never match. Although the RACP did not give them the power to admit new members to their own specialty, which most specialties would regard as critical, paediatricians were reluctant to leave the College to set up their own organisational equivalent, for reasons which that partly pragmatic and perhaps partly sentimental.

I have argued that because paediatricians did not have their own strong professional association or college the development of paediatrics was inhibited during a critical period of its growth. That absence of corporate power, however, only slowed the evolution of the specialty because there were other forces supporting the claims of paediatricians for their own jurisdiction, such as the authority that was coming with results of the adoption of scientific medicine. The children’s hospitals and the paediatricians had a mutual interest in this area, and it was in the hospitals’ interests to support the development of paediatrics. Paediatricians could also take advantage of the reputations of the small group of pioneer paediatricians who had been developing services in child health from early in the twentieth century.
CHAPTER THREE
THE PIONEER PAEDIATRICIANS

Introduction

The major developments in the specialty of paediatrics in NSW occurred in the two or three decades that followed the Second World War, when recent advances in medical science and technology were applied to the management of sick and injured children. While there were some doctors who wished to be called paediatricians before the war, they were few in number. Most sick children were treated by general practitioners, general physicians and other specialists who treated mainly adults. Even in the children’s hospitals most care was of a fairly general nature and there were few doctors who could be called children’s specialists. At best, paediatrics was a largely part-time specialty, incapable of supporting private practice, which was the only source of income at the time.

In the first part of the twentieth century, despite improvements in health in the era of sanitary reform with better water supplies and the construction of sewerage systems, the infant mortality rate (the number of deaths under one year of age per one thousand live births) in Australia remained high. Certain doctors focussed their attention on the care of babies and in doing so they developed special knowledge and skills, relative to the times, that enabled them to provide a higher standard of care than other practitioners. They began to claim occupational space that would eventually be filled by the medical specialty of paediatrics. These doctors were working mainly in preventive medicine, a field that was often neglected in Australia, despite much rhetoric to the contrary. Governments, medical associations, individual doctors and others expressed the view that preventive medicine had the highest priority and that the health of children, in particular, should be protected. Curative medicine, however, increasingly claimed the attention of most doctors as the century progressed.
This chapter will argue that paediatrics began, in a small way, in the early part of the twentieth century in NSW, originating in preventive medicine. In this public health arena the pioneer paediatricians established reputations as “baby doctors,” the first doctors in NSW to specialize in childcare.

The Rhetoric of Preventive Care

Outwardly, much energy was expended in investigating and planning the development of systems of preventive medicine in NSW from early in the twentieth century, with infant care being given a high priority. There were a number of official inquiries, Royal Commissions and formal investigations to try to find solutions to the high infant mortality rate that had existed from early in the nineteenth century. A great concern also was the declining population of the State. The first inquiry of relevance was the Royal Commission held by the NSW Government in 1904 on the declining birth rate, which had fallen 30 percent between 1886 and 1901. The Commission reported that the people of the State, particularly women, were responsible for voluntarily restricting the size of their families, but as that social change might be difficult to reverse other ways of increasing the population should be considered. The Commission recommended that immigration be increased and that the high infant mortality rate be examined.¹

Neville Hicks has questioned the quality of the statistical information used by the Commission, but more particularly he has criticised its interpretations, which he believes were biased by the conservative social and political views of the Commissioners. Much blame was laid on moral degeneracy and national decay, for which the Commission could offer few useful remedies. However, the high infant mortality rate could not be ignored (see Figure 3.1), and the rate for illegitimate babies was nearly three times that of the legitimate births. Poor nutrition, the quality of infant foods, and socio-economic issues seemed to be important factors to account for the deaths of the legitimate babies. Infanticide and baby farming were additional factors for illegitimate ones. Again, the mother was largely held to blame.²

¹ New South Wales, Royal Commission on the Decline of the Birth Rate and on the Mortality of Infants in New South Wales, Conclusions, 1904, Sydney.
² Neville Hicks, 'This Sin and Scandal': Australia's Population Debate 1891-1911 (Canberra, Australian National University Press, 1978), 28, 157,158.
During the course of the inquiry witnesses presented substantial evidence about the babies who had been born alive and well and who subsequently died: infant mortality in NSW was higher than all the other Australian states, with the exception of sparsely settled Western Australia. A large percentage of the deaths were caused by infantile diarrhoea, which health authorities considered was preventable. The Commission’s recommendations on infant health were based on the view that as most babies were born healthy, their health and survival depended on the quality of care provided by the mother. The best way to reduce infant mortality was by educating mothers in the hygienic nursing care and feeding of their infants, that is, in mothercraft.

The Commonwealth Government also engaged in the rhetoric of preventive health in holding a Royal Commission on Health in 1926. This Commission was outwardly much concerned with the low priority accorded to public health in Australia and made numerous references to child welfare, reiterating that the health of the child was vital to the nation and making detailed recommendations about mothercraft. The Royal Commission also considered proposals for a national health insurance scheme which, while not directly related to paediatrics, would have had consequences that would have considerably affected the pattern of medical practice in Australia. The matter of a scheme was deferred, but in the associated discussions, recommendations were formulated that preserved the prevailing situation whereby doctors in private practice remained free of any obligations to engage in preventive medicine and could continue to have access to the profitable section of the population with fee-for-service remuneration. The Commonwealth was left to provide care for the less affluent and to organise preventive services. The medical profession was able to define for itself a very valuable occupational space that favoured their continuing concentration on curative care. Milton Lewis states that these recommendations of the Commission were not surprising, given that it was conducted largely by the medical profession, taking

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3 NSW, Royal Commission. Division C, IX, X. Infantile mortality. The mean infant mortality for the period 1892 to 1901 in NSW was 110.6, in Victoria 109.1, in WA 146.1, in SA 106.0 and in NZ 81.4. The mortality rate for illegitimately-born infants was two and three-quarters times that of legitimate babies, largely reflecting adverse socio-economic factors. While about 40 per cent of infant deaths occurred in the first two months, due mainly to antenatal causes and hence not preventable, the majority of the rest of the deaths were due to preventable causes, particularly infantile diarrhoea or gastroenteritis.

4 Ibid., Division C, XII. Recommendations in regard to infant welfare.


evidence from other medical practitioners. The President was the Chairman of the Federal Committee of the British Medical Association (BMA).\(^7\)

The Royal Commission also proposed the establishment of a national public health scheme with the country divided into health districts that would be administered by salaried medical officers. Careful safeguards were included in the plans to prevent the scheme intruding into the occupational space of private medicine. However, it was hoped that private doctors would cooperate and hence have a greater input into preventive care. The scheme was never realised, partly because of costs, but also because it was feared that doctors would not cooperate, being reluctant to compromise their independence by getting involved in Government schemes.\(^8\)

In another exercise in the examination of maternal and infant morbidity and mortality, the Commonwealth Department of Health invited a British expert to visit urban and rural areas in all the Australian states. Dame Janet Campbell, Senior Medical Officer for Maternity and Child Welfare, Ministry of Health, London, came in 1930. She noted the improvement in the infant mortality rate which had almost halved since the beginning of the century. In NSW, for example, the infant mortality rate fell from 97.02 in 1901-05 to 54.77 in 1928 (see Figure 3.1), reflecting improvement in the prevention and treatment of conditions such as pneumonia and gastroenteritis. Campbell was concerned that the mortality in the first week of life had barely changed (21.32 in 1907, 22.19 in 1928), but little could be done about this until prematurity rates could be reduced and neonatal care improved. Dame Janet agreed with the approach already adopted — that the best way to improve infant health was to make the mother more efficient in baby care. She strongly recommended that there should be a much greater involvement of doctors in infant welfare services, because there was poor coordination between the preventive work of the clinics and the curative work of general practitioners. She believed that the medical profession should actively support the baby clinics, instead of viewing them with mistrust and suspicion. Doctors should be better trained in infant welfare work so that they could engage in a cooperative and mutually satisfying


\(^8\) Ibid., 12, 13.
approach to clinical problems.\textsuperscript{9} The Report was published in the \textit{Medical Journal of Australia} with an editorial comment that maternal and child welfare was largely a matter for the Government and the voluntary agencies. The recommendations about the roles of the doctors were ignored.\textsuperscript{10} General practitioners had little interest in the field if preventive care.

The next series of official recommendations on child health came in papers on post-war reconstruction, prepared by a Joint Committee on Social Security (JCSS), appointed by the Commonwealth Government “to inquire into and from time to time report on ways and means of improving social and living conditions in Australia and of rectifying anomalies in existing legislation.”\textsuperscript{11} The Committee was set up in 1941 to foster a new order in social reform and social security for the post-war period. Watts says that there was also a political purpose — to establish a consensus between the Menzies Government and the Australian Labor Party (ALP). The JCSS continued to exist until 1946, being supported for a time by the succeeding Labor Government. The Committee has been criticised for not having had any effect in shaping new social policies or legislation, but there is agreement that it focussed attention on many social issues, including health. Watts believes that the reports of the JCSS were influenced by the ideology of its public service administrator, Roy Rowe, and his research officer, Ronald Mendelsohn who favoured a socialist approach to Australia’s health problems, which would have made most doctors very suspicious of its motives. However, a major reason for the Committee’s lack of influence was that it lacked the support of the Treasury.\textsuperscript{12}

The Committee produced nine interim reports, which included many references to child health. They included a recognition of links between housing, unemployment and nutrition, and maternal and infant health. The reports advocated “positive health,” that a philosophy of prevention should permeate every component of health care, whether for

\textsuperscript{11} Commonwealth of Australia, Joint Committee on Social Security (JCSS) Sixth Interim Report, , 1943, pars. 72-86.
the individual or for the community. Vulnerable sections of the population required special protection. These included pregnant women, infants and preschool children.\textsuperscript{13}

The JCSS identified three essential principles in social welfare. The first was that the growing child was the most important asset of the nation and had to be foremost in any plan of social security. The second principle recognised that economic and environmental factors were the final determinants in the health status of the individual. The third stated that close cooperation between the Commonwealth and State Governments, the medical profession and the public would be necessary for the success of any comprehensive health scheme.\textsuperscript{14}

The Eighth Report of the JCSS in 1944 reiterated the official recommendations made earlier in the century about infant welfare and the promotion of mothercraft skills. It also proposed that the health of the preschool child and school children should be supervised with regular medical examinations for the early detection and treatment of abnormalities.\textsuperscript{15} These recommendations for infant and child welfare, about which there was little disagreement, were soon lost in the disputes between the Government and the organised medical profession over proposals for a national health service which were also included in the JCSS reports.\textsuperscript{16}

Like the Royal Commission of 1926 the JCSS reported on a national health insurance scheme, concluding that such a scheme was wanted by the public. It also found that the Commonwealth had limited constitutional powers to bring in any comprehensive scheme relating to health, which would prove to be a major deterrent to any national health planning. Paediatrics, as a social welfare oriented specialty, would have assumed a very different form had a national scheme developed. Instead, for most doctors, private practice was the only career option.

The reports of the JCSS had agreed on the importance of infant and child health to the individual, to the family and to the nation, but none of the recommendations were ever

\textsuperscript{13} JCSS, \textit{Sixth Interim Report}, 1943, pars.72-86
\textsuperscript{14} JCSS, \textit{Interim Report of the Medical Planning Committee}, 1944, pars. 3-8.
\textsuperscript{15} JCSS, \textit{Eighth Interim Report}, 1945, pars 22-34, 18c.
formally adopted. Despite the rhetoric governments were not strongly committed to advancing preventive work and few doctors in private practice in Australia chose to get involved in that field. It was left to the public health services to continue the preventive work they had already begun, and within those public health services certain pioneer paediatricians took advantage of the situation to advance their own professional careers and their specialty. The unacceptably high infant mortality rate provided a strong challenge. The problem of a high infant mortality rate and its consequences was not restricted to Australia but were found in most Western nations, which attempted to find their own solutions; these processes had a bearing on the Australian approaches to improving infant and child health.

**Infant Health in Other Countries**

A number of countries in Europe or of European origin became interested in child survival late in the nineteenth century. As well as the concern for the child as an individual, there were a variety of economic, social and military reasons. France was worried about a slow growth of the population and fears of consequent military weakness, particularly in the face of threats from Germany. Britain was concerned with its “international economic and political pre-eminence” and the United States sought economic efficiency.\(^{17}\)

In Western countries it had been recognised as early as the eighteenth century that the infant mortality rate was out of proportion to that of the rest of the population. However, it was not until later in the nineteenth century that serious efforts were made to seek causes and to try to reduce the death rate.\(^{18}\) Investigations revealed that the most common prenatal causes of deaths of maternal or foetal origin were congenital abnormalities and prematurity. They were considered unpreventable. Mortality of post-natal origin was due largely to gastrointestinal and respiratory infections, which were

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potentially preventable. These diseases were often associated with socio-economic
disadvantage, poor nutrition, poor housing and poor sanitation. Infant mortality rates
began falling in the Western world in the latter part of the nineteenth century due
largely to improvements in these postnatal factors, and not to any medical care or
expertise that was then available.\textsuperscript{19}

To a great extent breast feeding protected infants against infantile or epidemic
diarrhoea, so it was assumed that it was something in the substitute food, usually cows’
milk or cereal preparations, usually of wheat flour, that provided cheap alternatives to
milk, that were responsible for postnatal fatalities.\textsuperscript{20} Although knowledge about
bacteriology had increased enormously with the work of Pasteur, Lister and Koch in the
latter part of the nineteenth century, infantile diarrhoea was still associated with
“humours, miasmata or emanations from the ground, which somehow made the infant
food unsafe.”\textsuperscript{21} This explanation was still used by many doctors up to the early
twentieth century.\textsuperscript{22} Whatever the assumed cause of gastroenteritis, breast-feeding was
to be encouraged and strong efforts were made to provide pure milk for babies who
could not be breast-fed. The main approach to the problem of infantile diarrhoea was
through the mother in the belief that the health of the infant could be improved by
increasing her competence.

The development of the infant welfare movement in France set a pattern for the Western
world. The pioneering involvement of that country in maternal and infant welfare
reflected its urgent concern with what was seen as a “potential national catastrophe,” the
serious decline in the population.\textsuperscript{23} The first efforts began in 1865 when the Société
Protectrice de L’Enfance was founded to encourage breast feeding, to supervise the
health of infants being wet-nursed (a common practice of the time), and to educate
mothers of all social classes in infant and child care.\textsuperscript{24} The major contribution to infant
care came from Pierre Budin, an obstetrician and Chef De Service, Charité Hospital,
Paris. He set up the first \textit{Consultations de Nourrisson}s or child health clinic in 1892 to

\textsuperscript{19} Deborah Dwork, \textit{War is Good for Babies and Other Young Children: A History of the Infant and Child
\textsuperscript{20} Ibid., 94.
\textsuperscript{21} Ibid., 36.
\textsuperscript{22} Klaus, 50, 51.
\textsuperscript{23} Ibid., 5.
provide regular health supervision and to care for infants from his obstetric service, and to help mothers look after their babies. The clinic provided wholesome milk for mothers who could not breast-feed, the first of the *goutte de lait* or milk stations. They were directed particularly to preserving the life of infants of indigent families.\(^{25}\) Both the child health clinics and the milk stations were copied elsewhere in France and in other parts of the world.\(^{26}\)

The approach of the French clinics was authoritarian: mothers were refused help if they did not conform to the rules, which Klaus considers only possible in a country such as France where there was a close relationship between the State and the medical profession. French medicine was strongly influenced by the early development of centralised control of medical education and licensing, and the involvement of large hospitals in the national public health system. In France many doctors had an established role in public health as well as in their private practice. The French Government, in its efforts to protect the health of families and children for the sake of the State, relied heavily on the doctors, not only to provide expert medical care, but also to act as agents of the state in the surveillance of the population and policing of the preventive health laws. The medical profession was strongly dependent on the State for its political legitimacy.\(^{27}\)

It was, however, most unlikely that the French system would ever be introduced to Australia where the medical profession was fiercely independent. The central control of the medical profession and medical institutions did not exist in Australia, and most Australian doctors strongly resisted Government attempts to interfere with the relationships between doctor and patient or to introduce national health schemes.

Australian paediatrics had much more in common with the health services which developed in the UK, including the development of the preventive services in infant and child welfare. In Britain at the end of the nineteenth century, infant mortality was increasing.\(^{28}\) Many military recruits were found to suffer from poor physical health, for

\(^{25}\) Klaus, 62,63.  
\(^{26}\) Cone, 156.  
\(^{27}\) Klaus. 44, 45, 283, 284.  
\(^{28}\) Dwork, 5, 6.
which health authorities blamed poor nutrition, particularly in infancy.\textsuperscript{29} In an attempt to improve infant nutrition, milk stations were set up but were unsuccessful because they did not have medical supervision and could not reach a large section of the population.\textsuperscript{30} They were replaced from 1908 by a series of maternal and child welfare centres.\textsuperscript{31} This set a pattern of infant welfare work that lasted up to the start of the National Health Service in 1948. The British authorities considered a conservative approach, which lay in attempting to improve infant health through the voluntary education of mothers, the scheme most likely to succeed in the political and economic climate of England at the time.\textsuperscript{32} Jane Lewis states that the problems of infant welfare were seen largely as a medical problem, with the medical profession having a great influence on the management policies.\textsuperscript{33} The number of doctors involved, however, was relatively small: they were largely in the public services, as administrators in the national health services, in medical services associated with schools or in local government health services.\textsuperscript{34} Most of the day-to-day work was carried out by nurses.

The British service was directed primarily at working-class mothers as they were considered most in need of instruction in mothercraft. Middle-class mothers could attend the clinics but were believed to be not as amenable to the educational approach, or as needy of it, as the less-well educated mothers.\textsuperscript{35} The situation might be contrasted with that in the US where the middle class was responsible largely for the emergence of a new occupational group in infant welfare, the primary care paediatricians. The infant welfare services and the primary care paediatrics which evolved in the US were very different to anything that arose in Britain or Australia. They provide however, an example of how, in a different economic and political environment, a medical group seized an occupational space for their own professional and financial advantage and established a new specialty.

\textsuperscript{29} Ibid., 20, quoting an editorial in the \textit{British Medical Journal} of 1904.
\textsuperscript{30} Ibid., 103, 104.
\textsuperscript{31} Ibid., 137,139.
\textsuperscript{32} Ibid., 162,165.
\textsuperscript{33} Jane Lewis, \textit{The Politics of Motherhood} (London: Croom Helm,1980), 19.
\textsuperscript{34} For example, Arthur Newsholme, Principal Medical Officer to the Local Government Board from 1909 to 1919; George Newman, Chief Medical Officer to the Board of Education from 1908 to 1917, then Chief Medical Officer at the Ministry of Health. At the local government level were the Medical Officers of Health. Anna Davin, “Imperialism and Motherhood,” \textit{History Workshop} 5 (1978): 9-65.
\textsuperscript{35} Lewis, 19,73, 102.
In the US in the second half of the nineteenth century infant mortality was also high and for similar reasons to those pertaining in European countries. In response to the problem, groups of philanthropic women in many cities set up, after 1880, visiting nursing associations. They had at first an educational role, but later added an extensive network of milk stations or depots. In 1908 the New York Health Department established the Division (later Bureau) of Child Hygiene, the first of its kind in the world, with the objective of controlling all public health matters relating to infants, preschool and school age children. It set up infant welfare clinics and Little Mothers Leagues to teach schoolgirls infant hygiene and feeding and how to help mothers raise babies. This marked the beginning of an extensive and successful baby welfare and well-child-care system. However, in a culture that encouraged free enterprise and entrepreneurial health services outside Government control, the situation soon changed, and doctors in private practice, the primary care paediatricians, took over infant welfare from public and philanthropic providers.

Through the nineteenth century female physicians in the US had argued that they possessed special qualities of caring and nurturing that gave them grounds for claiming the right to care for women and children. From the 1850s they created roles for themselves in special hospitals in providing care for disadvantaged women and children, an otherwise neglected section of the population. Their domination of these hospitals did not last. With the rise of specialization in paediatrics the positions of the female doctors were gradually usurped by an increasing number of male paediatricians. As well, the women lacked professional representation in the field; they were excluded from the only national paediatric association, the American Paediatric Society. They were forced to find another career path and moved into the public health field where they joined the infant welfare clinics, amongst other services.

In the first decade of the twentieth century the women physicians were able to demonstrate considerable success in improving the health of infants and children of the poor. These results, as well as the effort of the Federal body, the US Children’s

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36 Cone, 106.
37 Klaus, 71,72.
38 Cone, 155.
Bureau, and other national, state and philanthropic organisations promoting child health, convinced middle-class mothers that they too should have regular health supervision of their own children, or “well-child care.” They began to attend the publicly funded clinics, which were at first run by both nurses and doctors. Their direction, however, became increasingly determined by doctors.40

A major component of the medicalization of the clinics was infant feeding, which doctors believed could be transformed into a science with benefit to babies and to their own status as physicians. They developed complicated feeding formulae, such as the percentage method of Rotch, which was said to be scientifically based and designed to meet the individual needs of each baby.41 Thomas Morgan Rotch was a paediatrician who was on the faculty of the Harvard Medical School. He devised what he described as a scientific method of feeding infants, which was in vogue from about 1850 to 1915. It set a pattern in infant feeding that stimulated others to find their own scientific methods of feeding babies in the US and Australia. Rotch devised an alkaline mixture of cow’s milk, lime water, lactose and cream, with the proportions of protein, carbohydrate and fat which closely resembled those in human breast milk. He believed that babies had individual nutritional needs to be ordered as carefully as a prescription for drugs. Minor variations in the constituents, as little as half a percent of one or more of the components, were recommended for individual babies. For sick babies the proportions were more critical. The formulae resembled complex mathematical tables. The milk mixture was preferably prepared by a commercial milk laboratory, but there was a modified method for use in the home. Other prominent paediatricians had similar approaches to infant feeding. One, L. Emmett Holt, for example, had nineteen different formulae to use between birth and one year of age.42 Their use obviously needed expert support and the formulae were impractical for a poorly educated mother, or one who was of low socio-economic status.

Another health surveillance procedure introduced by the newly arrived paediatricians was the use of growth charts. These were graphs on which, for example, the child’s

41 Ibid., 63.
length and weight could be recorded and compared with the range of growth of normal children. Because there was such a wide range of normal growth rates, the statistical technique of a percentile type of chart was necessary (see Figure 3.2). The charts recognised that normal children would grow along their natural percentile line, whether they were big, small or somewhere in between. These processes, which implied that infant care required a scientific approach and that only a physician with scientific training could interpret them, served to enhance the status of the doctors and their essential roles in the clinic. More paediatricians were recruited to work in these public clinics, but the demand for services continued to increase. The paediatricians seized the opportunity and moved into private fee-for-service rooms or offices, taking the middle class patients with them: the public clinics tended to lapse. What had been intended as a service for the poor became a service for the affluent. Halpern argues that the paediatricians were not primarily responsible for this situation, but that they took advantage of the developing enthusiasm of parents and the community for “well-child care,” which had been fostered by child health organisations. Furthermore, it became convenient for parents to attend the doctor who provided the “well-care” when their child was sick, further strengthening the doctors’ positions. The numbers of paediatricians in the US increased ten fold between 1914 and 1934. 43 By these steps paediatricians became the main providers of primary care for children.

Infant Health in Australia

Australia had the same concerns about maternal and infant care as France, the UK and the US at the beginning of the twentieth century. It was feared that a declining birth rate and an excessive infant mortality rate would lead to a fall in the population of the country, threatening national security and the future of White Australia. With the

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43 Halpern, 92. There were 138 paediatricians in full-time practice in the US in 1914, and 1734 in 1934. There are no figures for Australia because there was no occupational register, but the number in that time was very small, probably less then ten. Dods guessed there were less than twenty in 1945. Lorimer Dods, Notes for an address, 7 August 1960, Dods papers, P172, Series 3, Item 1. University of Sydney Archives, Sydney. V Comparisons however are irrelevant because US paediatricians were mostly equivalent to our general practitioners, but treating only children. Australian paediatricians were consultants.
growth of Russia and Japan, Australia was in a vulnerable state militarily in the Western Pacific.  

The problem of the high infant mortality rate was considered to be at least partly the responsibility of the State and Commonwealth health services. The manner in which they responded in NSW provided career opportunities for the pioneer paediatricians. The other states acted in similar ways to NSW, in principle if not in detail. Infant welfare centres were considered the best approach to improving infant mortality. Milk stations were not considered to be useful, in contrast to the US and French experience.

**Infant Welfare in NSW**

The first infant welfare service in NSW was established in 1904 by Dr W.G. Armstrong, the Medical Officer of the Metropolitan Combined Health District of Sydney. He was a public health practitioner, not a paediatrician. Armstrong had visited Budin in Paris and Newsholme, an infant welfare pioneer in Britain, and was highly impressed by the mothercraft education he saw, but was less enthusiastic about milk stations for Australia. He wrote a pamphlet of advice to distribute to new mothers and his department employed a health visitor to personally visit mothers of newborn babies and instruct them in baby care. The health visitor and the others who joined her strongly encouraged breast feeding as the best way of preventing infantile diarrhoea, but they also advised on safe artificial feeding if that was necessary. Armstrong demonstrated that there was an improvement in breast feeding rates in Sydney from 72 per cent in 1904 to 94 per cent in 1914, and an improvement in infant mortality from 116 in 1903 to 68 in 1914 (see Figure 3.1). Armstrong admitted that this success was partly due to the introduction of the baby bonus: the Government gave a sum of five pounds to mothers for early registration of the baby’s birth, which facilitated earlier contact by the health visitor. In a review of his work in 1939 Armstrong said that the infant welfare movement could not be the sole cause for improvement; other factors which he believed

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46 Ibid., 644.
contributed included the improvement in the water supply to Sydney, an improvement in the quality of milk, improved sanitation and a general “social betterment.”\textsuperscript{47}

The pattern of development of infant welfare services was strongly influenced by the decisions of the NSW Government and the Department of Public Health and its senior medical staff. In 1910 the Labor Party gained power in the State and set out to institute health services it believed were wanted by the community, particularly the less wealthy. With the increasing complexity and expense of medical treatment, the Labor Party believed that charity was no longer an appropriate way of financing these services, and that they should instead be supported by the Government as a community necessity. Fred Flowers, who had been closely involved in developing health policies, was appointed Minister of Health in 1914 and set about implementing his ambitious proposals for infant and child health. He wanted to nationalize medical services, but that was impossible from his position in the State Parliament, so instead he implemented a range of initiatives designed to improve child health care. He established the Lady Edeline Home for Babies for the treatment of cases of gastroenteritis and started school health services. He took over and then expanded Dr Armstrong’s municipal scheme for home visiting and established infant welfare centres in Sydney.\textsuperscript{48} Almost from the beginning the NSW Department of Public Health had a firm control over the infant welfare services in the State. Apart from the Royal Society for the Welfare of Mothers and Babies (RSWMB), which had a strong Government representation on its committee of management, voluntary agencies were excluded from the virtual monopoly of the State service, although they were active in some other States.\textsuperscript{49}

To facilitate this control, a new organisation was set up by Flowers. This was the Baby Clinics, Prematernity and Home Nursing Board, with wide responsibilities for maternal and child welfare. The bodies previously involved in this field, the Sydney Medical Mission, the District Nursing Association and the Alice Rawson School for Mothers

\textsuperscript{47} Ibid., 648.
\textsuperscript{49} Crichton, 31. See also Mira Crouch and Caroline Colton. \textit{The Course of Community Health in New South Wales 1958-1982}, \textit{Australian Studies in Health Service Administration} (Kensington NSW: School of Health Administration, University of New South Wales, 1983), 2.
were brought under one coordinating management. Flowers was concerned that the organisation of these philanthropic groups had been haphazard, that they did not cover adequately all the health problems that they should have been able to deal with and that there were unnecessary overlaps of function. He said his Government was prepared to contribute funds to maternal and infant welfare but too many bodies were seeking support. The Minister declared that he wanted a single body for coordination and management, but added that the Government had no sinister motives and did not seek direct control. He was, however, “specially anxious to take adequate measures to better protect infant life, that was the Government’s responsibility.”

Dr C.P.B. (later Sir Charles) Clubbe was appointed Chairman of the new Board, which created links between the preventive service and the Royal Alexandra Hospital for Children (RAHC) where he was an honorary surgeon and later Chairman of the Committee of Management. The Director General of Public Health was also a member of the Board, continuing the Government's strong influence. The Board established the first of its Baby Health Clinics in Alexandria, an industrial suburb of Sydney in 1914, with two nursing sisters and an honorary medical officer, Dr Margaret Harper, who spent an afternoon a week at the clinic. She saw difficult cases referred from the sisters in the centre and later from centres in nearby suburbs. An obstetrician also attended weekly for the pre-natal clinics.

Clubbe and the other members resigned from the Baby Clinics, Pre-maternity and Home Visiting Board when the Government restricted its financial powers, removing any executive function. A new Board with new members only increased Government influence. Later, the policy of Government control was modified a little; a number of interested voluntary agencies were invited to be represented on a new organisation for infant welfare, the Royal Society for the Welfare of Mothers and Babies (RSWMB), created in 1918. In the following year this society was given the responsibility of running the baby clinics, through a committee which included

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50 NSW Department of Public Health. Proceedings of a conference held on 17 June 1914 called by Mr. Flowers, Minister of Health 2/8566.2 NSW State Archives, Sydney.
members of the previous Baby Clinics Board, representatives of various charitable organisations including the Benevolent Society, the RAHC and the British Medical Association. Although government power was diluted on this committee it was still quite strong with Fred Flowers, the Minister of Health, his Under-Secretary and the Director General all being members.53

The Baby Health Committee of the RSWMB recommended in 1925 that the Centres should be under direct medical supervision and be part of a Division of Maternal and Baby Welfare under the Director of Public Health, because the work had greatly expanded and had become of vital importance to the State. The Committee noted that in 1915 the Centres had seen 18,000 babies and in 1924 165,000; the infant mortality rate had fallen from 68.1 to 59.9 deaths per 1000 live births for which it believed it could take some credit.54

Dr E.S. Morris was appointed to be the Director of this new Division. His career was in public health, but he had a particular interest in maternal and child welfare and had written a M.D. thesis on the subject.55 From his strong administrative position he had a major influence on the development of the Baby Clinics, both in this post and later when he became Director General of Public Health.56 The continuing strong support for the infant welfare system allowed it to expand in terms of the number of centres and staff, but even so, additional financial and public support was sought.

The Division of Maternal and Baby Welfare further strengthened the position of the Baby Health Centres in the community by allowing people in country towns to share in the responsibility for their operations. It offered a perception of part ownership and stimulated interest in the Centres. Although at first, in 1930, the move to local involvement was for financial reasons, it was valuable to have the support and loyalty of local people. The Director, Dr Morris, was able to enlist the support of the Country

53 NSW Department of Public Health, Minister of Health to Under-Secretary, 15 August 1919; Minister to the Executive Council, 18 August 1919; Copy of letter from RSWMB to Minister, 3 September 1919. 2/8564.3. NSW State Archives, Sydney.

54 NSW Department of Public Health, Director General to Under-Secretary, 29 October 1925, with information from the Baby Health Centre Committee. 2/8566.2 NSW State Archives, Sydney.

55 NSW Department of Public Health, Press cutting Sydney Morning Herald, 24 March 1926. 2/8566.2 NSW State Archives.

56 NSW Department of Public Health, Memorandum, 13 December 1926. 2/8566.2. NSW State Archives.
Women’s Association, which undertook to rent, or provide and maintain, premises and equipment for many Centres. The Department of Public Health provided the nurses and determined operational policy. Local Governments were also approached at this time to become involved in infant welfare, but refused. Later, in the 1940s, they changed their views and many municipalities and shires joined in supporting the Baby Health Centres, particularly when the Government greatly increased the subsidy for renting suitable premises.⁵⁷ In 1944 the Director spoke of the great progress since 1938 in public acceptance of the Baby Health Centres.⁵⁸ The reputation of the medical officers, as experts in infant care, was enhanced by their association with this successful system.

The RSWMB, and through it the State, acquired another important element in the control of the course of infant welfare in NSW by creating in 1921 a training school for nurses in mothercraft. The entry of new nurses to the system could be controlled and their knowledge and their attitudes to the system could be influenced to meet the requirements of the BHC. This new venture was prompted by the experience of New Zealand, which from the nineteenth century had the lowest infant mortality rate in the world. This achievement was claimed to be due to the care provided by the nurses of the Plunket Society, which had been established by Dr Truby King, a psychiatrist who had developed a special approach to infant care and feeding. This Society had a training school called Karitane.

The RSWMB sent their medical officer, Dr Margaret Harper, to New Zealand to inspect the Plunket system. On her return she recommended that a similar training school be set up in Sydney. Her recommendation was accepted and when the school, called Tresillian, was built, Dr Harper was appointed the Honorary Medical Director, a position she held until she retired in 1948.⁵⁹ She was in a very powerful position to influence infant welfare practices across the State because only Tresillian-trained nurses were permitted to work in the State’s Baby Centres. This strength was needed because the whole system soon came under a strong challenge.

Infant welfare and infant feeding practices were often controversial and generated considerable conflict. In NSW the policies of the State-sponsored RSWMB were strongly challenged by a rival organisation, the Australian Mothercraft Society (AMS) which had adopted the Plunket system. The AMS was established in Sydney in 1922 by a number of women who had benefited from Plunket care. It was organisationally separate from the its NZ counterpart but there were many informal ties, particularly through Truby King. Although the Plunket Society had similar broad aims to the RSWMB, namely to educate women in mothercraft and to train nurses to support that function, the processes of education and training of both mothers and nurses were markedly different.60

Experts on infant feeding in Australia agreed that breast milk was the most satisfactory feeding for babies, but when that was not possible the recommendations they made to mothers on the most suitable artificial feeding often differed markedly. Most artificial feeds were based on cows’ milk. Arguments raged as to how to make it suitable for human babies. How much protein did the baby need, how much could the baby tolerate? What should the energy and fat content be? What was the best form of fat to add, or the most appropriate carbohydrate?

Amongst the most prescriptive advice was that provided by Dr Truby King and his Plunket nurses. He said that cows’ milk should be modified to resemble breast milk as closely as possible, with a low protein content and the addition of special fat mixtures. He preached a very rigid approach to infant feeding and infant care with the baby (and the mother) being disciplined to carefully timed feeding and sleeping schedules. His approach gained considerable support from mothers, first in New Zealand and then in Australia and the UK. He was responsible for establishing groups of nurses trained in his methods, for example in the Karitane centre in Sydney. King’s dogmatic views, and his criticism of those who did not agree with him, provoked strong antagonism. In both Sydney and Melbourne there were rival schools of mothercraft training, each having its

60 NSW Department of Public Health. Secretary, Australian Mothercraft Society, Letter of information to the NSW Minister of Public Health, 30 September 1925. 2/8566.1. NSW State Archives, Sydney.
faithful adherents. Dr Margaret Harper, at first impressed by Truby King’s system, later advocated a much more flexible approach to infant care. An Adelaide paediatrician, Dr Helen Mayo, as a counter to King’s intense rigidity, said babies did well on almost any food.

King was a determined promoter of his ideas and made ten trips to Australia between 1919 and 1931 to support the AMS and to spread his ideology. The NSW Department of Public Health and the Director of Maternal and Baby Welfare were particularly disturbed by his activities. They said his letters to the press had caused considerable public anxiety and agitation about the State infant welfare services. King was accused of stating that the NSW infant welfare system was faulty, that the Tresillian nurses were not properly trained and that the only salvation for the State was the Plunket method. These accusations were made against King during the course of a deputation from the AMS to the Minister of Health. The AMS was seeking a subsidy for nurse training from the Government and wanted the Karitane nurses’ qualifications recognised so that they could work in the Government Baby Health Centres (BHC). Despite a number of attempts, up to at least 1958 the Department of Public Health repeatedly refused these requests. The Department believed that employing nurses trained under two different systems would be disastrous for the BHC because of the disagreements and conflicts that would arise. Besides, no additional nurses were needed. Tresillian could meet all the needs for new nurses. To subsidise the Karitane training program would indicate approval for their policies, which were considered unacceptable. The Department of Public Health could see that its controlling influence on infant welfare in the State

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64 NSW Department of Public Health, Under-Secretary to Cabinet, 21 November 1925. 2/8566.2, NSW State Archives, Sydney.
would be weakened if the AMS, and with it, Truby King, were allowed into their service.

Following a visit to Karitane, Morris reported his views on the Plunket system, and why he had such strong opinions against attempts to employ its nurses on his service. He said:

The devotees of the Plunket system, it seems to me, have aggrandised principles and methods almost into a religion. Activated by motives which to them seem the highest possible, they will naturally try to gain the ascendancy. The outcome will be division of the public mind concerning the merits and demerits of the rival organisations, and the mothers will be distracted and unable to decide what advice to follow.

Morris further emphasised the excessive rigidity of the Plunket system:

My personal experience is that the average Plunket nurse is extremely rigid and dogmatic in her views on infant feeding. Her conception appears to be based not so much on principles which are to be applied with ordinary reason, as on rules of procedure which are regarded almost as ritual. Any deviation from the Plunket principles is regarded almost as a heinous offence.67

There were other strong views expressed on both sides. During a deputation from the AMS to the Minister of Public Health, Dr Morris was accused by the AMS representatives of being antagonistic and very bitter towards that Society. He replied that the AMS was formed and remained in existence purely as a protest against the methods adopted by the State. An AMS delegate, Dr Green, having first stated that Karitane and Tresillian nurses were trained in exactly the same way, then contradicted himself: “One must be dogmatic in training mothers, they might get slipshod. Nurse training had to emphasise this. Methods were being taught at Tresillian which were entirely opposed to the Plunket system — there was a tendency to slackness.”68 In a later deputation the AMS accused the RSWMB of tolerating within its organisation a

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67 NSW Department of Public Health, Morris to Director General, 30 April 1926, 2/8566.1 NSW State Archives.
68 NSW Department of Public Health, Report of proceedings of a deputation from the AMS to the Minister, 16 May 1930, 2.8566.1 NSW State Archives, Sydney
group opposed to the AMS, and adding that the ring leader was Dr Harper who had become strongly prejudiced against the Plunket system.  

On the advice of the Department of Public Health, in which the voice of Morris was very apparent, the Minister of Public Health repeatedly refused to accept the AMS requests for public recognition. The Department retained control of the Baby Health Centres by controlling the entry of mothercraft nurses to the system. The potentially disruptive Karitane nurses were excluded, which was unfortunate for them, because there were very few alternative positions available, apart from a few positions in the small number of Karitane baby centres which had been opened, or in private practice. While it was understandable that the Division of Maternal and Baby wished to avoid internal dissension, the exclusion of staff from other systems made Tresillian a very inward looking organisation, which may have been to its disadvantage. There was a risk that outmoded views on infant care would prevail and that new ideas would not be accommodated. On the other hand, it increased the power of Tresillian, the Baby Health Centres and the medical administrator, Dr Harper, and enhanced her identification as a baby specialist in NSW by minimising competition in the field.

The recurrent appearances of Truby King in Australia, his outspoken statements and criticisms of the prevailing services may well have added to the status of Harper and others involved in the infant feeding debate who were perceived as being more conservative or belonging to the NSW medical establishment. While Truby King was supported by many people, including mothers who had experienced his form of infant care and influential people and politicians he had lobbied, his personality was sometimes to his disadvantage. He antagonised many people with his dogmatic views on infant feeding, which he insisted were based on scientific principles. His ideas were fundamental and not reconcilable with any other approaches to the feeding of infants. Others had different concepts of science, had seen feeding fashions come and go, and were suspicious of such dogmatism.

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69 NSW Department of Public Health, AMS depuation to Minister, 27 July 1932, 2/8566.1 NSW State Archives, Sydney.
Truby King also upset the conventional relationships between the two occupational groups in the health service. At a time when nurses were expected to be subservient to doctors, he was prepared to allow them full authority to manage the normal children in their care, whereas in the State system nurses were responsible to a medical officer, even when they were practising alone in their Centres. The nurses also had to be aware of the dominant role played by the baby’s general practitioner. The Director of the Department of Public health had agreed with the BMA that nurses would not offer any treatment to patients and that they would refer sick babies to their own doctor or the outpatients department of the children’s hospital. It is perhaps not surprising that many general practitioners did not support Truby King, preferring consultants who conformed with the prevailing professional etiquette.

King’s views were also likely to disturb the NSW doctors in other ways. E.S. Morris said, after a visit to Karitane (and it must be admitted that Morris was biased), that King had stated that unless a doctor was following the Plunket system any advice offered on infant feeding was unreliable. The general practitioners, however, had little interest in baby care. They were generally happy for mothers to go to the baby clinics, or if there were serious problems they sent the mother to one of the emerging paediatricians. They showed little interest in preventive work, except immunisation. Most general practitioners had sufficient work without the time consuming provision of advice on infant feeding to mothers. Another general practitioner commented that the baby clinics, at first bitterly criticised, had ceased to be a menace. They provided a valuable service and were not opposed by the medical profession. These attitudes of acceptance are not surprising given that experience had shown that the baby health nurses did not generally take patients from doctors. The complexities of infant feeding regimes and the associated controversies, and the problems the doctor might have in deciding which school to follow, made it simpler to let someone else handle the problem. In a survey of general practice it was found that while doctors supported in principle the routine preventive health care of infants and young children, only 2 percent actually provided

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72 NSW Department of Public Health, Morris to Director-General, 30 April 1926, 2/8566.1 NSW State Archives, Sydney.
this service, and 23 percent showed no practical interest or were hostile to infant welfare. In contrast 93 percent actively supported immunisation, a service which they often provided. It could be given quickly and they perceived it had positive benefits.\textsuperscript{75}

While the sample size was small, the survey confirmed that Australian general practitioners had little interest in preventive health activities.

It is doubtful that preventive work was financially viable for doctors in private practice in Australia. Many families were covered by friendly societies for general practitioner consultations, but the cover was limited to the treatment of illness.\textsuperscript{76} Most families found it difficult to afford specialist consultations, even if they could get to see the small number of paediatricians in practice in the 1920s and 1930s. The situation was in no way comparable to the US where the middle-class section of the population was sufficiently numerous and affluent to make preventive care paediatrics financially very attractive. Thus, in Australia, preventive health care for babies was left to the Baby Health Centres and the paediatricians associated with them, to their advantage professionally. General practitioners posed little competition for these paediatricians.

For the doctors, like Dr Harper, who worked in the baby health service in the 1920s and 1930s, their clinical work was comparable to the clinical work of their colleagues in the public hospitals, providing them with a workshop in which they could develop their clinical skills. They could see a large number of babies with a wide range of problems. Also, they had access to patients not otherwise available. Many of the babies were referred to them by the Centre nurses, a source of patients they could not take advantage of in private practice where, as specialists, they could only accept referrals from general practitioners.\textsuperscript{77} Hence, for paediatricians interested in infant problems, there were great benefits in an association with the BHC, even if it was in an honorary capacity (there were no salaried positions available).\textsuperscript{78} They could demonstrate their knowledge of the

\textsuperscript{75} Clifford Jungfer, “General Practice in Australia, A Report on a Survey,” 1961. Mimeographed copy, RACP Library, Sydney. This survey attempted to cover general practices in a wide range of geographic and socio-economic areas. While it was an admirable logistical effort, only 114 doctors were interviewed in detail, so that problems of sampling may have influenced the results There were about 6000 doctors in general practice in Australia at the time. Dewdney, 278.

\textsuperscript{76} T.S. Pensabene, \textit{The Rise of the Medical Practitioner in Victoria, Health Research Project}. (Canberra: Australian National University, 1980), 149.

\textsuperscript{77} See discussion in Chapter One. In Australia paediatricians were consultants and by convention only saw patients referred by general practitioners.

\textsuperscript{78} Cohen, 28.
science of infant feeding to their medical peers, to nurses, to parents and to the community in which they worked.

Halpern believes that in the US, in the 1880s and 1890s, when medical science was first applied to the health problems of children, infant feeding attracted doctors interested in research because the high infant mortality rate and its relationship to nutrition and infective diarrhoea posed problems that overshadowed all others. In the absence of intravenous fluid therapy, dietary manipulation was the only treatment for this serious condition. Proper nutrition was, in addition, protective against these problems. Paediatricians used the scientific information available at the time, interpreted in their individual ways, and developed special milk mixtures for feeding sick and well infants, such as the Rotch method.

The Rotch system had been tried in Australia in the same period but was found too complicated by many doctors who developed their own methods from their own modest research, stimulated by the prevalence of gastroenteritis. In a period when there were few effective therapeutic measures available, the manipulation of infant feeding provided the early paediatricians with a positive role and gave them an occupational space that was not disputed by other medical groups. The general practitioners were generally not interested and adult physicians who claimed a right to treat older children had no hesitation in letting the few paediatricians treat babies. Some general practitioners did develop an interest and skills in infant feeding in their practices, and for them it provided an entrée to a specialty at a period when there were no formal entry systems in place.

A medical position in the NSW Baby Welfare system gave status to the holder. As an administrator or director there was the potential to influence the policies of the service.

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79 Halpern, 46.
80 Ibid., 46.
82 Cohen, 28. Like many Australian paediatricians in the inter-war years Harper started her medical career in general practice, and later gave anaesthetics to make a living.
It offered exposure to health workers and parents across the State. Teaching nurses and medical students provided further opportunities to influence those who might later refer cases. It provided a forum for spreading one’s doctrine on infant feeding, and although few paediatricians were as dogmatic as Truby King, it was a field that attracted outspoken protagonists.83

Dr Harper is an excellent example of how certain doctors working in the infant welfare system became pioneer paediatricians. They demonstrated to the public and the medical profession their interest and skills in a particular section of medicine, in this case infant care as the first step in the formation of a specialty, at a time when there were insufficient colleagues to establish a formal organisation. Dr Harper possessed other attributes which gave her high status, particularly in medical circles. She was an honorary physician in the RAHC from 1914 to 1939 where she was regarded by her peers and by later observers as possessing credentials that entitled her to be described as a “scientific paediatrician” at a time when very few others were so regarded.84 She gained international recognition for separating two important childhood disorders, cystic fibrosis and coeliac disease. Although the causes of the two conditions would not be discovered for many years, she demonstrated in 1930 that coeliac disease was associated with a failure of the body to utilise or absorb fat even though digestive processes (the breaking down of food prior to absorption) were taking place. Cystic fibrosis, then known as pancreatic steatorrhoea (excess fat in the stools), was related to a failure of digestion of fat, and was associated with disease of the pancreas which post-mortem examination suggested was due to blockages of the flow of digestive secretions. Her long experience with children, in the period when the inspection of stools was an important diagnostic exercise, had made her aware that the stools of babies with coeliac disease were large and pale, while those with cystic fibrosis were accompanied by the passage of much free oily material.85

Margaret Harper lectured to medical students and trained nurses. She had consulting rooms in the specialists’ street, Macquarie Street (although earlier she had to practise

83 Mein Smith, “Truby King in Australia,” 36.
84 Dr. D.G. Hamilton, interview by author, Sydney, 24 February 1998.
part-time as an anaesthetist to make a living because paediatrics was not very remunerative). As confirmation of her status she was made a Foundation Fellow of the Royal Australasian College of Physicians (RACP) in 1938. Dr Harper earned her status as a paediatrician on many grounds, but primarily she was a “baby doctor” who had learnt her skills and derived her reputation from her association with the Baby Health system. She was fortunate that the Division of Maternal and Baby Welfare had been able to maintain a monopoly on infant welfare services, and build a strong and unified system in which she could operate.

There are other examples among the pioneer paediatricians of the valuable association between infant welfare and clinical paediatrics. In Sydney, Dr Kate Winning followed a similar career to Dr Harper and succeeded her as the Director of Tresillian School. In South Australia, Dr Helen Mayo’s career followed much the same course as Dr Harper’s. She was closely associated with the establishment of the Mothers and Babies Health Association, a voluntary organisation similar to the RSWMB. She was also a senior paediatrician at the Adelaide Children’s Hospital and another Foundation Fellow of the RACP. Dr Jefferis Turner founded the Maternal and Child Welfare Service in Queensland and became the State’s first paediatrician. In Melbourne, Dr Kate (later Dame Kate) Campbell was a highly respected paediatrician in the Queen Victoria Hospital and the Royal Women’s Hospital, and had a long association with the organised infant welfare services.

There has been a general perception that the infant welfare system in Australia was a valuable health resource, that it was well accepted by mothers and that it was responsible for the progressive fall in infant mortality. This view was regularly stated in the annual reports of the Division of Maternal and Baby Welfare of the NSW Department of Public Health. It was supported by Milton Lewis in his thesis written in 1976, in which he argued that improvements in infant mortality coincided with the

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86 Cohen, 28-39.
87 D.G. Hamilton, *Hand in Hand* (Sydney: John Ferguson, 1979), 148.
88 Neville Hicks and Elisabeth Leopold, “Mayo, Helen Mary ADB, 1891-1938, 466, 467.
establishment of infant welfare services, although he also believed that other factors contributed, such as a better milk supply.\textsuperscript{91}

Philippa Mein Smith has questioned the magnitude of the contributions that the infant welfare system made towards improving the infant mortality rates in the Australian states. She notes that the rates began to fall in the 1880s, well before the infant welfare movement was established. They improved uniformly across Australia in the early twentieth century although infant welfare services were patchy, and long before a significant proportion of the population of mothers and babies used the service. In Victoria, where infant welfare was best organised, only two thirds of babies attended clinics even in the late 1930s.\textsuperscript{92} Mein Smith has argued that other factors were more important in reducing infant mortality. The education of mothers improved and they developed higher ambitions as parents. They also had smaller families and were able to give more time to their children. The environment had improved considerably. She also questions the value of attendance figures in assessing the efficacy of the clinics and debates whether the advice given by the clinic sister was necessarily followed by the mothers.\textsuperscript{93} Selby has explored this question of compliance with advice given to mothers in Queensland, after also finding that many women did not use the baby clinics. The official figures indicated that only 30 percent of babies attended in 1927-28 and 54 percent in 1938-39. On the evidence gained from interviews it is apparent that mothers did not necessarily follow the advice given. However, Selby interviewed only fifty-five mothers who attended clinics, a very small sampling of the babies born in Queensland — 18,939 in 1930-31, and 20,412 in 1940-41.\textsuperscript{94}

In the presence of many potential factors that might have influenced infant mortality, many of them difficult to quantify, it is doubtful that any one factor satisfactorily explains the fall in the infant mortality rate, which showed a sharp dip around 1904, and a steady decline after that. The infant mortality rate was only one way of measuring the efficacy of the service and became less useful as the rate declined. There is considerable

\textsuperscript{92} Mein Smith, “Reformers, Mothers and Babies,” 365.
\textsuperscript{93} Ibid., 369.
anecdotal evidence that mothers found the infant welfare nurses helpful in raising their babies, but the type of service urgently needed to reduce deaths from gastroenteritis in 1915, for example, was not necessarily appropriate for 1940, when socio-economic and environmental circumstances were very different. By then mothers’ and babies’ needs had changed considerably. An official history of the Infant Welfare movement in NSW concludes by referring to perceptions that the infant welfare system changed little from 1914, shortly after it was established, to the time of writing in 1989. The author expressed concern that the baby clinic sisters had become isolated from other health professionals caring for children, and that little had been documented to justify the work of the service, although it had been well-accepted by a large number of parents.95

Mein Smith has argued that despite the difficulties of assessing the benefits of the infant welfare, an important outcome of the movement was to make mothers and babies visible to governments and to people in the community. These processes led to improved levels of professional education, which included doctors.96 One might reasonably presume that the Australian infant welfare system, assisted by the attitudes and support of educated middle-class women, created a medico-social climate that facilitated the development of paediatrics. Mein Smith has declared that the “raison d’être” of the new science of paediatrics was infant feeding, which might be interpreted as a marker for the services provided by the infant welfare system.97

The Australian situation has certain similarities to that in the US, where the origins of primary care paediatrics were to be found in infant welfare, with doctors there doing the work undertaken by nurses in Australia. In both countries infant welfare was fostered and largely utilised by the middle-class despite the original intentions to make it available to the less wealthy, whose children were most at-risk of ill health.98 Whatever its achievements, the Baby Health system in NSW provided a platform on which the early paediatricians could demonstrate their expertise and to show that paediatrics should be a valid medical specialty. The other areas of preventive health, however, in preschool and school health, were not so useful for paediatrics.

97 Ibid., “Reformers, Mothers and Babies,” 106, quoting Apple, 23.
98 Halpern, 84-88, 92. Mein Smith, Mothers and King Baby. 245.
The health supervision of children after infancy and at school was a logical progression from baby health care at a time when it was believed that regular medical examinations contributed to preventive health. There was nothing as dramatic in these age groups to benefit the paediatrician as there was in feeding for the infant group.

Preschool and School Health

In Australia, the health of school children, along with infant welfare, was given high priority in the official reports such as the 1926 Royal Commission on Health and the JCSS in the 1940s. Australia was to the fore in developing a school medical service. For example, in NSW, two part-time medical officers were appointed in 1907 to work in schools, one in Sydney, the other in Newcastle. The service aimed to provide regular medical examinations of children to detect abnormalities so that early treatment could be offered to prevent further illness or disability. It had no therapeutic role; children were referred to their own doctor for treatment. The service later expanded considerably with the appointment of additional doctors and nurses. Other sections were added: for dental health, for psychological care and for speech therapy.99 Similar services developed in other states.100

The School Medical Service in NSW was until 1953 a branch of the Department of Public Instruction, later called the Department of Education. The work of the medical staff was not entirely paediatric. As well as examining children they advised schools on hygiene and lectured teachers and pupils on health matters. They also medically examined student teachers and teachers who were on sick leave.101 The work of the Medical Branch was considered by the departmental authorities to be primarily educational and only secondarily a health service. The Education Department wanted its own source of medical advice. The school doctors were expected to work closely with the schools and to cooperate with teachers. For these reasons the Education Department

99 Cummins, 187-189.
100 J.C.H. Dewdney, Australian Health Services (Sydney: John Wiley and Sons Australasia, 1972), 163.
101 Cummins, 187, 188.
wanted the Medical Branch to be in their department rather than with the health services.\(^{102}\)

Organisationally the Medical Branch did not offer useful opportunities for paediatricians. The Principal Medical Officer’s role was mainly administrative, and in acting as a medical officer of health for the school system, a public health role. The medical officers had an onerous task. They were expected to offer three separate medical examinations to every child in the State during their school life, but the Branch was often short-staffed due to difficulties in recruiting suitable doctors. Conditions were poor, particularly for the women who made up most of the staff, and accommodation and transport in the rural areas were often very unsatisfactory.\(^{103}\)

For a perceptive medical officer the work of the Medical Branch had limited rewards. The service was inefficient and not very effective in the limited number of children seen and in the outcome of the medical examinations. For example, in 1939, only 36 percent of the NSW children who were scheduled to be examined were seen, 18 percent in SA and 3 percent in Queensland. A disappointing proportion of children actually received treatment for the abnormalities found. It was suggested that it might be more efficient for general practitioners to do the examinations rather than the school medical officers, but experienced school doctors said “the general practitioner as at present trained and with his present outlook has neither the training nor the aptitude to be given the responsibility for school medical examinations.”\(^{104}\) It is possible that the school doctors were merely trying to protect their occupational space, but it is more likely that they were correct, that general practitioners were not interested and not skilled in performing routine medical examinations, a procedure different to examining sick children.

There were considerable gaps in communication between school doctors and the general practitioner. There was little done to explain or justify the role of school health monitoring that Government policies declared so important. Jungfer found in his survey

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\(^{102}\) NSW Department of Public Health, Memorandum from Secretary, Medical Branch, 17 June 1931. 2/8566.4. NSW State Archives, Sydney.

\(^{103}\) NSW Department of Public Health, Letter from Mrs Thornhill, a Medical Branch employee, to Mrs Woodhill, 6 May 1965, enclosing a description of the work of the Branch written in April 1954. 2/8566.4, NSW State Archives, Sydney.

of child health that nearly 50 percent of general practitioners were indifferent or hostile to school medical services.¹⁰⁵ School medical officers were seen in a poor light and their professional status was low. There were rare exceptions, and it was possible to do rewarding work in the schools. Dr. Harvey Sutton, who was for a long period a school doctor and Chief Medical Officer from 1920 to 1925, became Professor of Preventive Medicine in the University of Sydney.¹⁰⁶ He was, however, a public health doctor. An association with a school medical service was not likely to advance a paediatrician’s career.

Despite their rhetoric about priorities for child health, governments were not prepared to contribute large sums of money to school health. At a meeting of the Directors of School Health of all the States in 1946 there was a consensus that that there were not sufficient funds to employ enough staff to provide satisfactory school medical services.¹⁰⁷ Moreover, the attitudes of the medical profession towards preventive medicine were not conducive to success. The Medical Survey Committee of the JCSS found in 1942-43 that most general practitioners across all the Australian states did little preventive work, or had little interest in preventive medicine, for which they seemed particularly untrained.¹⁰⁸

It was also apparent that parents were not very interested in having their children examined in school, or in having treatment for any abnormality found. In Victoria only 30 percent of children with defects had them attended to.¹⁰⁹ In its coverage of the school population, and in the remediation of abnormalities found, the school medical service was inefficient. The situation reflected an attitude on the part of governments, doctors and parents that routine preventive health care in schools had a low priority.

Supporters of preventive medicine believed that there was a critical period for the child between one and five years of age during which risks of damage might be reduced and

¹⁰⁵ Jungfer, 22.
¹⁰⁶ Cummins, 188.
¹⁰⁹ Pensabene, 53.
crippling disease prevented by routine health screening. From the commencement of the Baby Health Centres in NSW in 1914 mothers of toddlers had been encouraged to take them for regular checks on their growth and development, and to receive advice on nutrition and hygiene. From 1946 the Division of Maternal and Baby Health in NSW, in a pilot program, extended this service to provide medical examination of children in selected kindergartens, day nurseries and nursery schools in the Sydney area. The doctors planned to examine children under two every fortnight and older children every six months. The most common problems they found included carious teeth, enlarged tonsils and adenoids, knock knees and flat feet. However worthy the aims of this type of service, the considerable efforts required, the limited resources available and the uncertain benefits of regular examinations provided little challenge for a person intent on a paediatric career.

Conclusions

Some of the foundations of the specialty of paediatrics in NSW were laid down in the 1920s and 1930s by a small group of doctors who were experts in baby care. They had learnt their skills in baby health centres where they provided medical support for the nurses. The centres were run by the State Government with the support of voluntary agencies. In NSW the centres were strongly controlled by the Division of Maternal and Baby Welfare in the Department of Public Health and its predecessors. The centres were staffed by nurses trained in the State-sponsored Tresillian Mothercraft School and they offered a strong consistent policy on infant welfare across the State. Competing mothercraft services, such as the Plunket system of Dr Truby King, were largely excluded from infant welfare in the State by Government edict.

The pattern of organisation of infant welfare in NSW, with virtually a State monopoly, gave the Medical Director, Dr Harper, great power. She was able to influence the policies of the service and to benefit from the prestigious position from which she could project the image of a relatively new type of medical practitioner, the paediatrician. While she was predominantly a baby doctor, her other roles in the children’s hospital

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and the private practice further enhanced that image. She moved gradually from preventive to curative care.

Dr Harper is an example of a pioneer paediatrician who principally worked in preventive medicine. She and her colleagues had the field of baby care largely to themselves. Primary care doctors in Australia, the general practitioners, were not interested and financial constraints made it difficult for them to be involved in preventive medicine. Others, physicians and obstetricians, did not want to take on the complex baby care. Thus with a newly developed field of expertise, and no effective competition, these early paediatricians were able to claim an occupational space in the medical arena. The other areas of the preventive medicine of childhood did not offer the same opportunities for the development of paediatrics. The major growth, however, would be in curative medicine in hospitals, beginning in the children’s hospitals.
CHAPTER FOUR

SCIENTIFIC KNOWLEDGE AND MEDICAL AUTHORITY

Introduction

Chapter Three showed how pioneer paediatricians laid the foundations of paediatrics in NSW in the first half of the twentieth century. This chapter examines how, between 1945 and 1965, another group of paediatricians built on those foundations to firmly establish their specialty. They used their possession of certain newly available knowledge in scientific medicine to support their claims for occupational space. Much of this knowledge came from overseas; in the earlier years from the United Kingdom and later from the United States. The Australian system of medicine was based on British traditions and many Australian paediatricians received some or all of their training in children’s hospitals in the UK. After the 1960s the influence of US paediatrics increased as younger paediatricians were attracted by the opportunities for research in the US and went there to develop their skills. In the latter years of the decade more knowledge became available from Australian research.

British paediatrics developed as a subdivision of adult medicine and early paediatricians were often both general physicians and paediatricians at the one time. To create a new specialty meant establishing a demarcation between adult medicine and paediatrics. A simple way was to categorise children by age, but that in itself was insufficient because many practitioners had readily crossed that boundary line. David Armstrong has argued that specific knowledge provided criteria for demarcation, and that the strength of the boundary between internal medicine and paediatrics was based on “the essential differentness of the content of that knowledge.”

As well as the differentness of children from adults there was the question of differentness within childhood, a lengthy period usually considered to extend from birth

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to at least fourteen years. It raised the question of normality in childhood and the need to determine what was normal and, on the other hand, what was deviant and therefore requiring treatment? Normality was not a given state but one requiring value judgements that experienced paediatricians believed they were able to give. Their task was made easier and less arbitrary by their acquisition of scientific knowledge about childhood.

The early development of paediatrics in the UK was challenged by some in the medical profession who doubted that it was a valid specialty as it lacked that specificity of knowledge. The editor of the *British Medical Journal* discussed the future of paediatrics in 1931. He acknowledged that a study of the diseases of children was valuable, but questioned whether “the separation of paediatrics from general medicine was too artificial to be altogether good,” stating that “disease in children supplied rather a restricted field for the interests of a first class intelligence.” The editor recognised that the disorders of infants were in a different category from those of older children but implied that this was insufficient to warrant a new specialty.

There had been in Britain, from the late nineteenth century, a strong medical interest in one aspect of child health — the reduction of infant mortality through infant welfare. That, however, was in the field of preventive medicine and different doctors were involved. They were in the public health system and worked in government departments. The doctors who identified themselves as paediatricians centred their work around hospitals and private practice and had gained the lofty status of consultants in the diseases of children, following in the tradition of adult medicine. They considered the public health doctors of lower status.

In the US, where paediatrics was firmly established by the end of the nineteenth century doubts were also voiced about its validity. In the early part of the twentieth century many physicians and some paediatricians questioned whether paediatrics should be a separate specialty because its intellectual basis was not significantly different from other medical fields. There, two different streams of paediatrics had evolved. The first,

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established in the late nineteenth century was, like that in Britain, a derivative of adult or internal medicine. It was based in universities and teaching hospitals and was heavily concerned with research. There were fewer doubts about the validity of the second stream of paediatrics; it was not strongly knowledge-based, but engaged in providing primary care services to children. It was, in effect, a general practitioner service restricted to children. Sydney A. Halpern has stated that this stream was not as firmly dependent on science and technology as most other specialties, but was more influenced by societal ideology and the social reform movements that operated outside medicine in the US. It was concerned with the amelioration of health-related social problems, at least in the early stages. The idealism faded in the 1920s; the primary care paediatricians were swayed by market forces and moved to provide services for affluent middle-class families, for their own considerable financial rewards. Australian paediatricians did not seek access to primary care; that was firmly held by the general practitioners. The model of the other form of US paediatrics, the sophisticated paediatrics of medical schools and research institutions, did not reach Australia until the 1980s.

Like their colleagues in the UK and the US, Australian paediatricians had to establish that children were different from adults, and that their area of health care had sufficient intellectual depth to warrant a new specialty. In his discussions on the intellectual foundations of medical specialization, Rosen has emphasised the importance to an aspiring specialty of a focus of clinical interest. Certain doctors in NSW recognised that the scientific knowledge that became available after the Second World War provided a focus of interest of sufficient dimensions to justify an expansion of paediatrics.

The knowledge that had created paediatrics in France, Germany and the US in the nineteenth century, outlined in the Introduction, did not provoke paediatric specialization in NSW, although scientific information from those countries was

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4 Ibid., 9, 10.
5 Ibid., 93, 94.
available in textbooks and medical journals. For example, in the late nineteenth century a major Australian medical journal, the *Australasian Medical Gazette*, published editorials and letters from doctors which indicated that they were aware of recent research in infant feeding in Europe and the US. Doctors in Australia knew about and used diphtheria antitoxin to treat children in 1895 even though it had only been introduced in Germany in 1891. Despite the availability of appropriate knowledge, Australia and Australian medicine was not ready for any substantial paediatric specialization until after the Second World War. In his theoretical discussions on specialization, Freidson has conceded that while knowledge may be available, there may be obstructions which prevent it being utilised. There were substantial blocks to the development of paediatric knowledge in Australia before the Second World War.

There were few clinical scientists who were able to evaluate the scientific information from overseas and place it in a local context. There were few to push the cause of the new scientific medicine. Specialization generally was unpopular in Australia. Private practice in paediatrics was not financially feasible and salaried positions were not available. General practice and the children’s hospital appeared to provide all the services considered necessary. There were no community pressures to create an interest in child health, which Halpern believes was so important in the development of paediatrics in the US.

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11 Halpern, 90, 91. In the 1920s national child health organisations sponsored educational programmes, radio talk shows and magazines for parents. The American Child Health Association lobbied for a Child Health Day, “devoted to the promotion of every form of activity which protected the life and health of children.”
If NSW and Australia were not in a position to take up scientific knowledge before the Second World War, they were quite ready after it. Worldwide there was a major expansion of medical knowledge in most fields of medicine, including the diseases of children. This provoked a massive growth in paediatric research in the US. In Britain there was a similar, but slower, expansion of research associated with the growth of specialization and the emergence of the National Health Service in 1948.\textsuperscript{12} In NSW there were a number of domains of the new knowledge which were particularly useful for paediatricians in establishing their intellectual and technological credentials. The aim of this chapter is to examine those domains and consider how they supported the expansion of the new specialty. The key areas were in growth, in infectious diseases and antimicrobial drugs, in fluid and electrolyte metabolism, and in newborn care. The results of the application of scientific knowledge in these areas firmly supported arguments that children were different to adults and that paediatricians possessed the necessary skills to deal with medical problems dependent on that difference.

\textit{Growth}

The growth and development of an organism over the course of a lifetime is one of the central fields of inquiry in all the biological sciences. In humans, the potential for growth provided an essential “differentness” between children and adults. Children were still growing, adults had completed their growth period. In the late nineteenth century Abraham Jacobi, regarded as one of the leaders of paediatrics in the US, repeatedly told physicians and the public that “children were not miniature men and women.”\textsuperscript{13} Jacobi advised paediatricians to focus on growth and on the normal child. They should not restrict their interests to specific diseases, which was the approach of adult medicine.

British paediatricians “discovered” growth in the 1940s, both in their evaluation of the sick child and to use as evidence to support their claims for occupational space. One, Ronald McKeith, said that the most remarkable single change that he had seen in

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  \item \textsuperscript{12}Rosemary Stevens, \textit{Medical Practice in Modern England: The Impact of Specialization and State Medicine}. (New Haven: Yale University Press, 1966), 11.
\end{itemize}
paediatric practice between 1940 and 1964 was that paediatricians nearly always included some estimate of the child’s development in their routine examination.\(^{14}\) Another, John Apley, in arguing for an expansion of paediatrics in the undergraduate medical curriculum, said: “Growth is the quintessence of modern paediatrics. It is not dependent on empiricism, but science.”\(^{15}\) Both McKeith and Apley were talking about growth in its broadest sense; not just physical growth such as height and weight, but physiological and biochemical growth in conjunction with intellectual, emotional and social growth and development. The dimensions of all these aspects of growth were different to the adult, and they were different at different ages of the child. The stage of growth of children determined how they responded to disease and injury, and to therapy.

From scientific observations of growth in its various manifestations, paediatricians became aware of the ranges of normality, and in particular the significance of deviation from those ranges. The knowledge about the development of the normal child gave paediatricians the tools with which they could claim unique expertise in the care of children, against their competitors for occupational space who knew little about such matters.\(^{16}\) Knowledge about growth provided data to refute the arguments of adult physicians that: “It is the disease, not the age that matters,” a statement made in a Harveian Oration to the Royal College of Physicians in London.\(^{17}\) Paediatricians in Britain showed that age and growth did matter. Australian paediatricians followed.

In Australia in the late 1940s and early 1950s, as indications of an awareness of the significance of growth and childhood medicine, there were a number of references in the medical press about the subject. The editor of the *Medical Journal of Australia* urged the medical profession in Australia to adopt a broad approach to child health, to consider the needs of the growing individual and preventive care, rather than concentrating on the diseases of children. He stated that all doctors who treated children should have a thorough knowledge of child development, and that it should be


\(^{16}\) Halpern, 87-91.

taught to medical students and general practitioners in postgraduate courses.\textsuperscript{18} The Professor of Paediatrics in Melbourne, in a discussion on medical and paediatric education, referred to the need for doctors generally to be better educated about child growth and development. This knowledge was essential, he argued, if they were going to deal adequately with the emotional and behavioural disorders of children, as well as tend to their physical disorders.\textsuperscript{19} Another professor reminded the members of the Paediatric Society of Victoria in 1964 of the importance of growth, and reiterated that children were not just scaled down adults.\textsuperscript{20} In Australia, knowledge about growth had been used from the early 1900s in child welfare clinics and the school health service, but that was in a limited way, largely in measuring length and head size, and weighing babies and children. The doctors involved were in the public health services and their links with, and their influence on, clinical paediatrics were relatively small.\textsuperscript{21}

The importance of growth to children, and to paediatrics, was embodied in the concept of “failure to thrive,” a label applied by paediatricians to children who did not grow in height or weight at the expected rate, and where the cause was superficially not apparent. A consideration of the cause of this syndrome meant exploring a wide range of possibilities, including inadequate nutrition, emotional deprivation and mental disorders, occult infections and diseases of almost every organ in the body.\textsuperscript{22} Paediatricians could argue, not unreasonably, that only they, with their full comprehension of growth and thorough knowledge of children and their diseases, would be able to deal with a child failing to thrive. Adult physicians were not equipped for this task. It was a lengthy process for paediatricians to convince their medical colleagues that, on the grounds of growth, children were different to adults. Their next task was to show that they were the best equipped of doctors to deal with children’s diseases. A valuable opportunity arose around the management of infectious diseases.


Infectious diseases were common problems in childhood. Many were of a minor nature and resolved spontaneously. There were other infections, however, that were much more severe, being life-threatening or producing long-term disability. They tended to dominate paediatrics through the first half of the twentieth century because they occupied large numbers of beds in the children’s hospitals and claimed much of the attention of the visiting doctors. While the prevalence of infectious diseases of children progressively declined through this period, due largely to improved hygiene and nutrition and better standards of living, they remained the reason for many admissions to hospitals in the late 1930s and up to the introduction of antimicrobial therapy. Of the 13,000 admissions to RAHC in 1944-45 more than half were related to acute, chronic or previous infections. Doctors had no specific therapy to offer these children; all that could be provided was symptomatic and supportive treatment.

Antimicrobial therapy first became available in the late 1930s with the sulphonamide drugs, but for children more effective agents, beginning with penicillin, appeared towards the end of the Second World War. Paediatricians claimed that for the first time they could positively alter the outcome of many types of infectious disease in childhood. Paediatricians could be seen as doctors who could do something, as effective in their own way as the surgeons were. Their status thus increased, for it has been shown that doctors who actually do something to the patient enjoy a higher status than those who advise patients what to do or merely seek their cooperation in therapy in a type of partnership. Surgeons are thus said to hold a hierarchical pre-eminence over non-surgical practitioners in medicine.

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23 RAHC, Statistical Reports. Of the 13000 there were over 4000 admissions for the removal of enlarged tonsils and , caused by, supposedly, recurrent throat infections. There were about 1000 acute respiratory infections, 200 infections in bones and joints, 170 bowel infections and other miscellaneous infections.
The perception that it was possible to influence the outcome of infectious diseases with antibiotics was undoubtedly true; certain children with infections survived with the use of antibiotics when previously they almost certainly would have succumbed. It was difficult, however, to find clear statistical evidence that antibiotics made any difference overall, although some data is available. The annual reports of RAHC up to 1950 include figures on hospital admissions, diagnoses and deaths. Figures from later years were not collated for these reports, but Dr. D.G. Hamilton has extracted similar information from medical record index cards for his history of RAHC. He admits that it may not be very accurate, but is the best data available.26

It is certainly difficult to determine from these figures whether antibiotics had any effect. There were a number of problems in assessing the benefits of antimicrobial therapy. The diagnosis of the causative agent in childhood infections is not always clear; it is often difficult to separate potentially treatable bacterial disease from the viral diseases that did not respond to antibiotics. Infectious diseases are episodic so that prevalence figures and admission numbers are not very helpful. The severity of the infections varies considerably from year to year, so that comparisons of death rates do not reveal much of use. H.O.Lancaster, who has been responsible for most of the detailed statistical analyses of health in Australia, believes that antimicrobial therapy helped control certain infections, including those of the lungs, the skin and soft tissues, and non-tuberculous meningitis. Tuberculous meningitis and miliary tuberculosis could also be cured but they were both fading before chemotherapy was available. There were other circumstances that influenced infectious diseases and their severity. These included improved hygiene and water supplies and a general improvement in the standard of living. Immunisation and the capacity to isolate cases of infectious disease were also important.27 It was often many years before figures were available to show how the population was affected by infectious disease and its treatment, so that judgements about the effectiveness of antibiotics were based on the contemporary impressions of the observers, whether doctors, patients or their parents.

26 D.G.Hamilton, *Hand in Hand The Story of the Royal Alexandra Hospital for Children, Sydney* (Sydney: Ferguson, 1979), 327
The evidence available from RAHC on osteomyelitis illustrates the difficulties in trying to assess the effectiveness of antimicrobial treatment, particularly in the early stages of its use (see Table 4.1). Osteomyelitis (an infection in bone caused by streptococci or staphylococci) caused deaths, serious illness and disability in many children in the 1930s. The treatment was prolonged and included surgical drainage of abscesses in the bones, placing the limb at rest in a plaster cast, relief of pain, and attempting to improve nutrition. Often the infection did not clear completely and in the chronic state needed repeated drainage operations and removal of fragments of dead bone. The wounds were dressed frequently, which was very painful. Children were in hospital for months or years in chronic ill health and were left with disabilities caused by stiffened and shortened limbs.

The disease was relatively easy to diagnose, and the cause, bacterial, not viral, was usually clearly identified. The figures from over twenty-five years tell us that it was possible to reduce the death rate, which on these figures was quite small, but do not say anything about the important issues of how effective treatment was in reducing disability or other long-term effects of the illness.
Table 5.1  Osteomyelitis in RAHC, 1940 to 1965

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions</th>
<th>Deaths</th>
<th>Death rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940-41</td>
<td>120</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1941-42</td>
<td>94</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1942-43</td>
<td>89</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1943-44</td>
<td>108</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1944-45</td>
<td>145</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5 year total</td>
<td>556</td>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>1949-50</td>
<td>86</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1951-52</td>
<td>58</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1954</td>
<td>59</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1955</td>
<td>62</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1956</td>
<td>72</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5 year total</td>
<td>337</td>
<td>4</td>
<td>1.1</td>
</tr>
<tr>
<td>1960</td>
<td>93</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td>86</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td>69</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1963</td>
<td>75</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>71</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5 year total</td>
<td>394</td>
<td>1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source; D.G. Hamilton, *Hand in Hand The Story of the Royal Alexandra Hospital for Children, Sydney* (Sydney, John Ferguson, 1979) 333. Data from *Annual Reports* up to 1950, then extracted from diseases index cards by Hamilton.

The limitations of the objective evidence available stand in strong contrast to the subjective assessments of the benefits of antimicrobial therapy which could be found in articles in medical journals, particularly in the early days of the enthusiasm generated by the new forms of treatment. There were many reports on the treatment of infectious disease from children’s hospitals across Australia in the *Medical Journal of Australia*, which had a wide readership as the official journal of the British Medical Association in Australia. Shortly after penicillin first became available in 1945, reports appeared on its apparent effectiveness. An early report concluded: “Penicillin is of particular value in paediatrics, in which fulminating infections are not infrequently encountered: its rapid action in such cases makes it effectual when sulphonamides fail…children tolerate the drug extremely well.”

The public were also informed about the new treatment. The RAHC *Annual Report* of 1943-1944 drew attention to the first civilian use of penicillin.

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in Australia, on one of its patients. A child with meningitis, who had failed to respond to sulpha drugs, was treated successfully with penicillin specially obtained from the US. A newspaper report in 1946 told how the RAHC, “the only hospital in Sydney specialising exclusively in children’s diseases,” had been saving the lives of more children with respiratory diseases and preventing crippling complications in bone and joint infections since the introduction of the sulpha drugs and penicillin. (The death rate fell from 4.32 per 100 children admitted in 1943, to 2.9 in 1944 and 2.46 in 1945).

A report of the treatment of meningitis due to *Haemophilus influenzae* documented the effects of the various antimicrobial agents that had become available from the late 1930s. This was the commonest form of bacterial meningitis at the time, and it was almost always fatal. The first of the sulpha drugs was quite ineffective, but a later version, sulphadiazine produced a recovery rate of 22 percent. Penicillin led to an improvement in cure rates but streptomycin almost always controlled the infection. The author of the article said: “The various steps by which control over influenza bacillus meningitis has been established in recent years form one of the most striking advances in the treatment of children’s diseases.”

At a meeting of the paediatric section of the Australasian Medical Congress in 1948, a Sydney doctor discussed the results of the new treatment of osteomyelitis, which he said had had a mortality rate of 10 percent before the introduction of penicillin. In the 144 cases treated with the drug, there had been no deaths, the duration of stay in hospital had been much reduced, and almost all patients had ended up with normal function in their limbs. Another enthusiastically praised these results, saying: “The most depressing chapter of paediatrics is closed.” It was confidently predicted that osteomyelitis could be treated by antibiotics alone, that there would be no need for a surgeon, and that all the cases could be managed by the paediatrician. Unfortunately this phase lasted only a short time because the staphylococcus, the predominant organism, developed

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29 RAHC Annual Reports, 1943-44.
30 *Sydney Morning Herald*, 2 October 1946.
resistance to penicillin. Surgical treatment was reintroduced, but it was not as radical as before, and physicians continued to be involved in the care of osteomyelitis, jointly with surgeons.

The medical superintendent of an infectious diseases hospital wrote about the use of sulphonamides in the treatment of pneumonia following measles. He said the new antimicrobial drugs had saved many lives, the inflammation in the chest had almost always resolved more rapidly than previously and the stay in hospital had been shortened. A Melbourne doctor who treated many children said: “The introduction of the life-saving antibiotics has been an incalculable boon.” However, he warned that they should not be used indiscriminately, implying that the prescribing doctor should have a high level of knowledge and be, for example, a paediatrician.

The introduction of antibiotics gave paediatricians a new image — whether they were as successful in the treatment of infectious disease as they claimed to be at the time is less relevant. It was the perception of effectiveness which was important to the development of their specialty. On the evidence of reports in the Medical Journal of Australia and in publications available to the public, paediatricians were associated the cure of previously incurable infectious disease. The children were usually in the children’s hospital, the exclusive preserve of paediatricians, so that hospital, the paediatricians and their new specialty all benefited from the introduction of antimicrobial therapy.

There was another advantage for paediatrics with the introduction of antibiotics in that the pattern of admissions to children’s hospitals changed. Children spent less time in hospital. The average duration of stay in RAHC fell progressively from 12.99 days in 1940-41 to 9.0 days in 1964-65. There were probably a number of causes but a likely

contributing factor was the decline in duration of stay of children with infectious diseases.38 A third of the hospital’s beds became available for other purposes, and paediatricians could direct their attention to clinical problems which had previously been hidden under the overwhelming load of infectious disease.

Fluid and Electrolyte Therapy

The rate and pattern of the metabolism of the child is related to growth; it differs from the adult, and from child to child, depending on age. For example, the functions of the heart, the lungs and the kidneys all vary from age to age. The haemoglobin levels and the white cell count also alter. The levels of hormones and other chemicals change with increasing years. The child’s reactions to disease also alter over time, related to the immunological responses to infection and to metabolic changes. The effects of drug therapy also change from age to age.

A metabolic system of particular importance involves that of the fluid and electrolytes in the body, which are disturbed in many serious disorders of childhood, the most common problem being in gastroenteritis in which large quantities of both may be lost.39 These disturbances are in themselves life-threatening, often as much as the underlying disorder. Children are at greater risk than adults because their reserves of body fluid are much less and their metabolic needs are greater; the smaller the child the greater is the risk.

The high mortality rate of infantile gastroenteritis was a major factor in stimulating research. The development of rational therapy to correct these fluid and electrolyte disturbances was a major advance in paediatrics and was dependent on a thorough knowledge of the physiology and biochemistry of young children, and how they changed from infancy to adolescence. Paediatricians were the leaders in the medical profession in fluid and electrolyte therapy.

38RAHC. Annual Reports.
39The electrolytes in the blood of most concern were sodium, potassium, chloride and bicarbonate.
The first scientific knowledge about fluid and electrolyte metabolism in gastroenteritis came to Australia from the US. Marriot had shown in 1915 that the symptoms and signs of severe diarrhoea in children could be explained by the loss of water from the body and the accompanying metabolic disturbances, rather than being due to intestinal intoxication, which was previously a widely accepted explanation. In 1926 Powers devised a therapeutic plan to manage gastroenteritis that was used widely in the US for the next twenty years. By carefully administering fluid and electrolytes and withholding food, he claimed he could reduce the mortality of severe dehydration due to infective diarrhoea from 80 or 90 percent to 33 percent. There was obviously still room for the improvement, which came in 1946 when Darrow recognised the importance of potassium losses in gastroenteritis and developed safe ways of administering this sometimes dangerous electrolyte (high concentrations of potassium in the blood may affect the action of the heart muscle causing disturbances of rhythm and cardiac arrest).40

New technology improved the methods by which the fluids and electrolytes were administered. At first, in the 1920s, the rehydrating fluids were infused into the abdominal cavity, or under the skin. These were relatively easy technical procedures but they were superseded almost universally in the 1940s by intravenous infusions which offered direct access to the circulation. A considerable level of skill was necessary to insert a needle into a small vein of a young child, and expert nursing care was important to maintain the infusion over several days.41 In Australia, doctors began regularly using fluid therapy by the subcutaneous route in 1920s and some intravenous therapy in late 1930s.42 It was not until the late 1940s and early 1950s that comprehensive regimes for the management of fluid and electrolyte disturbances, based on physiological principles, were introduced, and paediatricians became familiar with their use.

The Australia Paediatric Association held a symposium on fluid and electrolytes at the annual meeting of the organisation in 1953, when papers were presented on new Australian research. It was apparent from remarks made in the course of the meeting that even for many paediatricians this was a new therapeutic field. Speakers expressed

41 Ibid.
the view that many of their colleagues did not have a sufficient understanding of the pathophysiological disturbances in severe gastroenteritis to treat it effectively and safely. The Professor of Child Health at Sydney University, Lorimer Dods, said that he believed that most of those present at the meeting would agree with him that, despite all the recent advances, they were relatively ignorant about chemical anatomy and that they should be very humble about their sketchy knowledge. He argued that it was important that all hospital units that cared for dehydrated children should have on the staff a senior clinician knowledgeable about fluid and electrolyte therapy, and that there be a full time resident member of staff competent to deal with such problems. An Adelaide paediatrician stated that the resources needed to provide this level of care could only be provided economically in a centralised children’s hospital: it was more appropriate to transport acutely ill patients to the children’s hospital than to provide special services in country hospitals.

Other technology was also coming into use. The treatment of severe gastroenteritis and other conditions associated with fluid and electrolyte loss became safer when the levels of the electrolytes could be measured on small samples of blood, and the results of the tests made rapidly available. The technology for this purpose became available in the mid-1950s, firstly with the development of the flame photometer for estimating sodium and potassium levels. Later tests measured, for example, chloride and bicarbonate levels. A clinician could have the results available within twenty to thirty minutes, when previously they had taken hours, and were of little practical value in treating a small child with a rapidly changing metabolic state.

The principles of fluid and electrolyte therapy, which became established for gastroenteritis, were used to support other forms of treatment in disorders such as bowel obstruction, severe infections, burns and shock. For example, the mortality associated with operating on pyloric stenosis, an obstruction at the lower end of the stomach, was

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45 John Beveridge. interview by author, tape recording, Sydney, 19 May 1998. Beveridge was closely associated with the introduction of these biochemical tests in RAHC in 1953-4.
reduced from 17 percent to 3 percent if the disturbed fluid and electrolyte metabolism of
the baby was corrected before the operation.46

Paediatricians came to be seen by their medical colleagues as pioneers and experts in
the use of fluid and electrolyte therapy, which was used in a large number of the serious
illnesses of childhood. From their training they also had the skills and experience to
diagnose the metabolic disturbances associated with severe illness, to interpret the
laboratory data, to insert and maintain an intravenous infusion and to prescribe the
appropriate quantities of water and electrolytes. They were dependent on the resources
of the hospital, particularly nursing staff trained to care for children, and the laboratory
and other investigative services oriented to children. In the area of fluid and electrolyte
therapy the paediatricians had few competitors. In some general hospitals clinical
pathologists administered fluid and electrolytes to children. These doctors could correct
the disturbed biochemistry, but their roles were limited because they did not have the
skills needed to assess the child’s clinical condition, which could only come from
paediatric training.47 The children’s hospitals themselves had few rivals before the time
when suburban and regional hospitals acquired paediatric staff. The situation fostered a
centralisation of services for severely ill children to the advantage of paediatricians and
children’s hospitals and enhanced the status of both.

Special Care of Newborn Infants

The acquisition of expert knowledge about premature and sick newborn infants gave
paediatricians an opportunity to claim occupational space that had not previously
existed. This space was not seriously contested by other specialists, and its occupancy in
the 1950s eventually led to the development of the subspecialty of neonatology.

Previously, obstetricians and general practitioners who delivered babies had not
attempted to treat anything more than the simple problems of neonatal life such as
feeding problems. Their main concern was with the mother. Maternal mortality was the

46 H.E. Williams, “The Surgical Treatment of Congenital Pyloric Stenosis of Infancy: a Review of 400
47 Dr P. Hendry. interview by author, Newcastle, January 1997.
benchmark of the obstetrician’s practice.\textsuperscript{48} Arney has stated that obstetricians only became interested in the foetus as a second patient in the 1950s because they were looking for scientific justifications for their involvement in the surveillance of pregnancies in the face of increasing competition from midwives.\textsuperscript{49} Perhaps their preoccupation with the welfare of the mother prevented them from looking more deeply into the problems of the baby, but the obstetricians were only one of several specialist groups unwilling to be involved with sick, small infants. The adult physicians, who believed they could look after older children, had never claimed knowledge or interest in this area. Australian paediatricians, up to the 1950s, had little involvement with the sick newborn. A major problem was that the causes of many neonatal disorders were not understood and there was little effective treatment available.\textsuperscript{50} A second reason was that paediatricians were rarely invited by the obstetricians to help in newborn care.

In the United States where paediatric specialization was much further advanced than in Australia, little attention was given to the problems of sick and premature infants until after the Second World War, although a few special care nurseries had existed from the 1920s. The Children’s Bureau, a US Federal Security Agency, noted in 1951 that although the infant mortality rate had fallen by two-thirds since 1915, to thirty-one deaths per thousand live births, it was still excessive. The Bureau recommended that a nationwide plan should be developed for the reduction of deaths in prematurely born infants. Paediatricians should aim to provide a level of care for the newborn equal to that which they provided for older children. A particular need was for better statistical data on neonatal deaths to try to determine why babies were dying. For ten years the city of New York had demonstrated the value of recording the birth weight on death certificates in investigating the causes of early neonatal deaths. The Bureau’s efforts resulted in a recommendation that the definition of prematurity be clarified and made uniform across the United States.\textsuperscript{51}

\textsuperscript{50} Beveridge, interview. Dr W. Grigor, interview by author, tape recording, Sydney, 30 June 1998.
In the UK the infant mortality rate was reported for the first time by the Registrar General in 1877, but was not analysed in any detail through most of the first half of the twentieth century. David Armstrong has stated that while the deaths of infants remained unexplained they were an invisible group in society. Increasing knowledge and a growing interest in the importance of the infant to the State helped identify the infant as a medico-social problem, but progress was slow. It was not until the mid-1950s that the statistical information could be usefully interpreted, initially with a subdivision of deaths into the categories of stillbirths, perinatal, neo-natal and infant deaths. More defining diagnostic labels based on pathological analysis replaced vague terms such as “atrophy”, “debility” and “prematurity” that had previously appeared on death certificates. Armstrong argues that while newborn deaths were assumed to be just the whim of natural forces such as regression and decay, infants could not be identified as discrete and essentially social creatures, nor would they be amenable to medical treatment. Without reliable data the premature infant was invisible to the analytical gaze. Infants were both the object and effect of these statistical frameworks and their status had to be established before any treatment could be contemplated.52

The situation was similar in Australia; infant mortality was higher than it should have been, and the causes were not clear, even in 1950 (see Figure 3.1). The Director of Maternal and Infant Welfare in the NSW Department of Public Health reported that while the infant mortality rate in the State had improved progressively from 110 in 1900 to thirty in 1945, the rate in the first week of life had not fallen, remaining constant at about twenty-three. While some of these deaths could not be prevented, being due, for example, to congenital malformations, others could have been avoided through better medical and nursing care. She said that babies were dying from chilling, from exhaustion and from careless handling received before they had got to mothercraft homes, where most premature babies were nursed. The report recommended the creation of special-care nurseries at large obstetric hospitals.53 The use of such vague...
terms as chilling and exhaustion reflected the state of knowledge of the time, the lack of useful treatment and the status in medicine of the sick newborn infant.

During a 1956 discussion on the infant mortality rate Lancaster recommended, following the advice of an Expert Committee of the World Health Organisation, that the statistical documentation of infant deaths should be improved. He urged that it should focus on deaths in the first week of life which would have the effect of revealing those that might be preventable by better medical care, and he challenged paediatricians and obstetricians to improve their performance. There were, however, a number of pervasive reasons why doctors had not been more active in the management of newborn infants.

Firstly, there were professional and societal attitudes that did not favour active medical intervention for sick and premature babies, based on the philosophy that it was better for a baby to die than to survive with a serious disability. It was “all for the best” and “the will of God” for those babies to die. These views promoted a passive, hands-off approach to the medical management of premature and sick infants. An Australian paediatrician who advocated active methods of resuscitation also expressed her strong anxieties about “the saving of a wrecked child.” These philosophies applied particularly to the resuscitation of the baby who did not breathe readily following birth, and was at risk of asphyxiation and dying, or surviving with brain damage, or who, on the other hand, might survive intact. It was very difficult to predict the outcome in such a situation. Those who favoured inactivity gave several reasons: it was better if the brain-damaged child did not survive, attempts at resuscitation might interfere with the baby’s own efforts to breathe and the resuscitation procedures might do more harm than good. It was widely thought that only simple ways should be used to try to help the baby breathe. If they did not work, nothing else would. The simple ways included mouth-to-mouth resuscitation, intermittent rocking of the baby to move the diaphragm to induce inspiration of air (including the use of an Eve’s Rocker), the insufflation of

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oxygen into the stomach, and the use of drugs to stimulate respiration. Some of these methods were far from safe.\textsuperscript{57}

It is difficult to dissociate these ideas on the care of the newborn from those of national efficiency and progressivism which, according to Powles, prevailed in Australia from the early 1900s to the late 1930s. Many Australians were concerned with the destiny of the nation, the white race and the empire, and particularly with the physical development and fitness of the young. Doctors were prominent in the eugenics movement, and one, Dr. J.W Springthorpe, a Melbourne physician, spoke of selective breeding, selective survival and the “careful elimination of everything that is of indifferent quality.”\textsuperscript{58} The fate of sick newborn infants was thus often dependent on the prevailing views on racial and physical fitness.

Another reason for the inability of paediatricians to influence the approach to the newborn in the early 1950s was that they were not able to do more for the baby than the obstetricians at this period of life. In a paper on the management of premature infants in 1949, Campbell said that the successful management of a premature baby depended fundamentally on meticulous nursing. Special equipment, with the most elaborate measures for humidification of the air, heat control and oxygenation, might be helpful but was only ancillary to nursing skills. She recommended only a few medical measures, oxygen, drugs for respiratory stimulation, Vitamin K, and antibiotics, and their application was relatively simple.\textsuperscript{59}

Childbirth was in the hands of the obstetricians and general practitioners, and they controlled access to the delivery rooms and the nurseries. Even in the US, where paediatricians were first invited into newborn nurseries in the 1920s, their advocacy of more active approaches to new born care and resuscitation had little effect in changing


conservative practices. They did not gain control of the nurseries until after World War Two.\textsuperscript{60}

In London in the 1940s paediatricians were not permitted in the midwifery units of the hospitals although they provided honorary services in the children’s wards of the same hospitals.\textsuperscript{61} In 1942 the editor of the \textit{Lancet} drew attention to the excessive infant mortality rate in Britain which he declared was due to serious defects in the nursing and medical control of the baby after birth. He said that first month of the child’s life should mean the beginning of paediatric care, yet it was apparent that few paediatricians had gained any clinical experience of that period.\textsuperscript{62}

Some obstetricians appeared to lack confidence in the capacity of paediatricians to help them and the baby. The Professor of Obstetrics and Gynaecology in Sydney University, Professor F.J. Browne, commented in 1952 that special nurseries for sick babies were not necessary, based on his experiences in the University College Hospital, London, during the war. He said that the premature babies who received simple minimal care had a mortality rate of 8 percent, but later “when paediatricians returned to complicate treatment” the mortality rate was 18 percent.\textsuperscript{63} He did not provide any documentation of his figures or his sample. His remarks were presumably just anecdotal and perhaps derived from selective memories. The comments reflect more the prejudices of one obstetrician than any valid statistical analysis, but unfortunately for paediatrics, Browne’s views were widely disseminated because he was very active in the postgraduate education of obstetricians and general practitioners in NSW.

If paediatricians wished to influence the care of the newborn then they had to gain the confidence of obstetricians to allow them access to all aspects of newborn care. Before the Second World War, a few paediatricians had been granted honorary appointments to the large public obstetrics units in a number of the State capitals. Some had University appointments to teach medical students about infant welfare. Dr. Margaret Harper was

\begin{thebibliography}{9}
\bibitem{60} Desmond, 317
\end{thebibliography}
appointed Lecturer in Mothercraft in the Department of Obstetrics and Gynaecology at the University of Sydney in 1921, and lectured in Mothercraft in the Royal Hospital for Women. Dr Kate Campbell held a similar post at the University of Melbourne from the inception of the Department of Obstetrics in 1929. They were mainly concerned with teaching students and nurses, and with some clinical work, but their role was limited because they were not involved in the care of the baby from the time of birth. Why the term “mothercraft” was applied to these positions is unclear. The term implies an art rather than a science, yet it was provided by women who had never been mothers. They had a vast experience in baby welfare clinics and were to the forefront of the science of infant feeding as it was at the time. Although some of the pioneer paediatricians were involved in large obstetric units from the 1920s they were not offered opportunities to contribute to the care of infants. Obstetricians retained the responsibility for the newborn.

Some basic principles for the care of sick and premature infants were laid down by the French obstetrician, Budin, in Paris at the end of the nineteenth century, which ranged from keeping the baby warm to offering appropriate nutrition and preventing or dealing with disorders to which the premature infant was prone. In the mid-twentieth century babies continued to be treated conservatively, with a great concern that any vigorous active treatment might be harmful. The baby was handled as little as possible because it was thought that it produced exhaustion and risked cross-infection. Warmth was provided by hot water bottles in a padded crib, and the baby was not fed for forty-eight hours because of a concern that milk might be inhaled into the lungs. Milk was then given very cautiously. Oxygen might also be administered, sometimes sparingly, but sometimes excessively under the false impression that it could do no harm.

A major point of contention concerned the resuscitation of the baby who did not breathe at birth, a relatively common situation. Up to 1961, no effective methods for the resuscitation of newborn infants had been instituted in NSW and there was strong

65 Desmond, 308-359.
opposition to any active measures. The situation in Australia then was similar to that described in Britain, where there were many dogmatic and contradictory opinions on what procedure was best, and the numerous drugs, methods, and machines that were recommended for resuscitation were evidence of the confusion surrounding infant resuscitation.

The knowledge which changed attitudes to new born care came mainly from research carried out in the United States in the 1950s; although there was some Australian work, by Dr. Eric Burnard of the Women’s Hospital, Crown Street, Sydney. The US and Australian research demonstrated that the only efficient way to resuscitate a baby who did not breathe adequately was by intubation and intermittent ventilation. Intubation involved passing a small tube directly into the upper airway, the trachea, under direct vision and inflating the lungs intermittently with air or oxygen using a small rubber bag. The procedure of intubation required a considerable degree of skill to perform safely. Some obstetricians were prepared to learn these skills but many sought help. In any case they were usually busy attending to the mother. The anaesthetist, present for the mother’s anaesthetic, was often asked to help, but increasingly a paediatrician was invited into the delivery room. Dr. D.G. Hamilton, a senior paediatrician in RAHC, believes this happened when the effectiveness of intubation in resuscitation became more widely known, partly through the efforts of the trainee paediatricians who had worked with Burnard in his research unit. They demonstrated the efficacy of intubation when they went to work in the large maternity units in the 1960s. Macbeth, an obstetrician from The Women’s Hospital, Sydney, acknowledged the influence of Burnard in changing his attitudes to infant resuscitation, and to accepting more active forms of infant treatment.

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69 The Australian research was undertaken by Dr Eric Burnard, in the Children’s Medical Research Foundation at the Women’s Hospital Crown St., Sydney. He had had extensive research experience in similar areas in the US and the UK. Children’s Medical Research Foundation, Reports, 30 June 1959 to 30 June 1962. RAHC Archives Sydney.
70 Macbeth, interview.
There were other reasons for paediatricians becoming increasingly involved with the newborn. The analytical gaze applied to infant mortality data had the effect of making babies visible. Professor John Beveridge, a paediatrician, believes it was the evidence arising from the expanded Australian infant mortality statistics data which brought the baby to the notice of obstetricians. They believed that they needed input from paediatricians before they could rationally discuss the causes of perinatal and neonatal deaths. From joint meetings the two groups reached a better understanding of the situation, and obstetricians became aware of what treatment the paediatricians could offer. They were then more frequently invited to help with the resuscitation of babies and other early neonatal care, including being asked to attend difficult deliveries.\footnote{Beveridge, interview.}

The opening of a dialogue between the two occupational groups offered further opportunities for useful collaboration. There were increasing numbers of clinical situations in which decisions about obstetric management had important implications for the baby, and the welfare of both the mother and the baby had to be considered. For example, an early induction of labour for maternal obstetric complications might result in a baby who was premature and therefore at risk of life-threatening respiratory problems. In another situation a baby might require a paediatrician to carry out an exchange transfusion shortly after birth for haemolytic disease of the newborn due to Rh incompatibility.

Invitations to paediatricians to provide care for the newborn infants enabled them to gain access to the nurseries and to eventually establish special care nurseries that they ultimately controlled. The early contact with the baby enabled paediatricians to meet parents, who became aware of paediatricians and their role, at the beginning of the child’s life. They would be likely to seek a paediatric consultation if the need for expert health care arose later. Many paediatricians in private practice established their links with obstetricians and parents by being readily available to see sick babies. Dr. Wallace Grigor recalled his work as a newly qualified paediatrician as including being available at all hours to see babies in maternity hospitals all around Sydney, a task that older, better-established paediatricians were reluctant to undertake.\footnote{Grigor, interview.} The American primary care paediatricians were very active in this field. They created their expert space by
becoming involved in well-child care, which extended to making contact with the pregnant woman and her partner before the birth of the baby, and being present at the birth, which was often normal. The institution of special care for newborn infants created a space in which the baby became progressively more visible and more exposed to heroic medical efforts which further enhanced that visibility. Newborn care provided a new occupational space for paediatricians.

Conclusions

This chapter has shown how the possession of expert knowledge helped paediatricians develop their specialty. It discusses four salient and strategic areas of scientific knowledge and the clinical practices which flowed from that knowledge. The first of the four areas, growth, established the essential differentness of the child from the adult. This was a key area in that it defined the main occupational space which paediatricians wished to occupy. It not only clearly separated them from adult physicians but also conveyed to the members of other specialties that paediatricians were concerned about the welfare of all sick children and had special skills in their care. This particularly applied to certain specialties, such as orthopaedics and ear, nose and throat disease, where occupational spaces might overlap. The next two areas, in infectious diseases and in fluid and electrolyte metabolism, demonstrated further aspects of children being different, and provided evidence that paediatricians possessed the knowledge and skills which would allow them to claim that they were the doctors best equipped to care for seriously-ill children. While other specialists might claim that they could adequately treat infections in children with antibiotics, in the management of metabolic disorders paediatricians had few competitors. Paediatricians could more effectively and safely manage conditions such as dehydration which often accompanied severe infections. They also had the advantage of controlling the admission of patients to the children’s hospital which most doctors accepted was the best place to nurse seriously ill children. Fourthly, paediatricians became involved in a new segment of occupational space, the special care of newborn infants, particularly sick and premature babies. This space was created not only by new scientific knowledge and technology but also by a general acceptance by doctors and people in NSW that each child was an individual needing

74 Halpern, 106-108.
vigorous efforts to ensure survival no matter what the outcome might otherwise be. Occupancy of this new space meant engaging in the difficult task of gaining the confidence and support of the obstetricians, but its possession provided many opportunities for paediatrics to enhance its status and authority.
George Rosen has pointed out that throughout history sick people have needed personal care and shelter as well as medical treatment. The communities in which they lived have accepted the responsibility for providing the accommodation needed for that care, including hospitals. These institutions have become an essential part of society. To understand their development one must take into consideration the prevailing cultural systems, the political and economic conditions, and the social changes relating to the health needs of the people in various historical periods.¹ Medical factors must also be taken into account. With the expansion of scientific knowledge through the twentieth century hospitals became larger and more complicated institutions and required more resources for patient care, including an increase in the numbers of doctors, nurses and technicians. Hospitals acquired additional roles; they became vital training institutions for medical and other professionals, and they were workshops where doctors could enhance their skills and personal reputations. They needed more and more funds, which increasingly were provided by governments rather than philanthropic organisations, and skilled staff were needed to control expenditure and consequently to manage the affairs of the hospital. These activities eventually involved not only professional administrators, but the doctors working in the hospital as clinicians also had to become involved in management.²

The governance of public hospitals in Australia also changed. During their formative years in the late nineteenth century and early twentieth century, they were primarily charitable institutions for the indigent; they were controlled by management committees representing the philanthropists who established them. Later the attending medical

² Ibid, 297-299.
officers, the honoraries, gained power because they possessed the authority associated with the possession of medical knowledge. The late 1940s saw the beginning of a return to control by the original governing body, greatly strengthened by the presence of a new force in the health system, the professional medical administrator. This form of management greatly increased its influence in hospitals through the 1970s and 1980s.

When hospitals were relatively simple institutions doctors could fulfile their obligations for the privileges of being appointed a member of the honorary staff by making occasional visits, often twice weekly, to see their patients. The modern hospital demanded much more of their time and energies, not only for clinical work but also for organisational matters. This created situations where there were conflicts of interests for those doctors who had responsibilities outside the hospital, particularly in private practice.

The next three chapters examine the changing roles of hospitals, and their relationships with their medical staff, and how those influenced the development of the specialty of paediatrics. I will discuss mainly the children’s hospitals, but will also refer to relevant events in children’s units in general hospitals. While the main stream of paediatrics in Australia developed in children’s hospitals, there was a later phase of growth which took place in the paediatric units in general hospitals, but this had to wait until the children’s hospitals themselves had demonstrated to the medical profession and the public the effectiveness of their philosophies of child care.

_Hospital Development_

In 1945 large Australian hospitals were staffed at a senior level by honorary medical officers who carried on a long tradition of service. Their numbers, particularly in the teaching hospitals in the capital cities, included very distinguished physicians and surgeons, and they and their organised groups, the medical staff associations, wielded considerable power. They were largely responsible, through their advice to the hospital boards of management, for determining hospital medical policies. Hospitals also had their own interests to look after. They had obligations to the governments, which provided funding, and to the public, which increasingly expected that the hospitals would offer services which reflected the new scientific medicine.
Most hospitals in Australia, except those in Queensland, continued to use the honorary system between 1945 to 1965. In NSW and Victoria there were two hospitals of particular significance to the development of paediatrics that moved to establish new relationships with their doctors and to pay them, either sessionally or as full-time employees to ensure that patients received their due care and attention and as a means of reducing the conflicts of interests which that unavoidable with an honorary system. This has been called the full-time system.

The situation in Queensland was different. The State Government took control of all the public hospitals in 1944 and honorary system was abandoned. The doctors who worked in the public hospitals were paid a salary. The changes were ideologically driven and followed the socialist policies of a State Labor Government. The moves ensured that even the State’s smaller hospitals were provided with doctors, but there were insufficient funds to provide the sophisticated level of staffing which was needed to fully develop scientific medicine, either generally or in paediatrics.3

The full-time system was not new and had been used in other countries to foster the development of the scientific medicine paradigm. Berliner has argued that in the US the financial support of the major philanthropic foundations was responsible for the successful adoption of the scientific medicine paradigm in research and clinical practice in medical schools and hospitals. Of the foundations the most powerful was the Rockefeller Foundation which was profoundly influenced by its philanthropic adviser, Frederick T. Gates, who had been given great responsibilities by the founder, John D. Rockefeller Sr. for determining the target of the donations.4 Gates believed that medical research would be able to find a cure for all diseases or be able to prevent them. He also believed that most doctors were charlatans and preyed on naive and unsuspecting patients. He said that medical scientists should concentrate on research

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and on training new scientists, and not engage in private practice because it seriously inhibited making new discoveries. He convinced the Foundation that funds should be given for medical research only on the condition that the staff of the research organisations and their related hospitals be full-time employees under what became known as the full-time plan. On these conditions, in the first decade of the twentieth century, the Rockefeller Foundation entered into a formal agreement with the first medical school in the US to adopt this system of medical staffing, the Johns Hopkins Medical School in Baltimore, under the Professor of Pathology, William H. Welch. The institution opened for patient care and research in 1910.5

Berliner believes that rapid rise of science in medicine in the US was facilitated by the employment of full-time medical officers, and that this influence persists to the present. However, the full-time plan was not without its problems, which were echoed when full-time salaried practice was introduced into Australia. In the US private fee-for-service medicine was strongly entrenched and a major condition for the philanthropic funding was that the clinical professors would be paid fixed salaries and their entire income would be derived from teaching and research. They might be allowed some private practice, because wealthy patients demanded access to the prestigious medical specialists, but any fees received had to be given to the Medical School. There was strong opposition to the plan from many doctors; in particular they resented what they described as the “proletarianisation” that was being forced on them.6 It is paradoxical that the philanthropic funds which had come from such energetic practitioners of capitalism were controlled by conditions which were labelled socialistic.

The experiment of the full-time plan threatened to split the medical profession in two. Opponents of the full-time scheme declared that it was impractical. They argued that the full-time doctors would be isolated and cut off from the local profession, they would be too scientific, and because only certain people would take up the work, they would possibly be too inward looking to be good clinicians.7

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5 Ibid., 141, 142.
6 Ibid., 157.
The distinguished physician, William Osler, who was then Professor of Medicine in Johns Hopkins Medical School, was bitterly opposed to the plan. He was highly regarded in the US for his research in internal medicine and for his warm, humane personality. He also had a large private practice that he asserted had never dominated his academic work. He said the new full-time positions were too doctrinaire in pure science. Full-time was:

A moral calamity, a disastrous impoverishment of the clinical man’s right and duty to be implicated in the whole community of physicians. A man who stood aside from the process of humanising and being humanised by the friction of personal contact might be a scientist but never a doctor — medicine must remain an art and distinctively the art of establishing personal rapport between the physician and the patient.8

Despite powerful opposition the funding proposals were too overwhelming to be refused; Gates had recommended that the Rockefeller Foundation offer a million and a half dollars to establish medical, surgical, obstetric and paediatric clinics on a full-time basis.9 The full-time scheme was adopted in Johns Hopkins Hospital and then spread to many other medical schools in the US, and still determines their staffing today.10

The US full-time plan influenced medicine in Australia, at first in a small way and then generally, so that by the 1980s most large hospitals employed staff specialists as well as specialists paid on a sessional basis. Of the two hospitals that were the pioneers of the salaried system in Australia, one was a children’s hospital, the Royal Children’s Hospital (RCH) Melbourne, and the other a general hospital with a large children’s service, the Royal Newcastle Hospital (RNH), in the provincial city of Newcastle. In different ways, both influenced the development of specialization in paediatrics. RCH demonstrated in the 1950s what could be achieved with the full-time system in developing research and hospital services new to Australian paediatrics. In RNH, from the late 1940s the full-time staff introduced a number of innovative and effective clinical services, but later serious problems developed due partly to a rigid style of management and partly to the hostility of Australian doctors to salaried systems. In child health RNH developed several unique programs but in attempting to develop

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8 Ibid., 169.
9 Ibid., 167.
10 Berliner, 139-161.
paediatrics without paediatricians revealed the intellectual hazards associated with an isolation from mainstream paediatrics.

Medical historian George Rosen has described how important hospitals were to medical specialization. While he makes few specific references to paediatrics, the general principles he expounded are applicable to that specialty. In particular, aspiring specialists needed a workshop where their knowledge could be expanded and their skills developed. The large hospitals were useful because they attracted many patients with a wide variety of disorders. The hospitals also provided a place where the doctors could meet to organise themselves and establish an efficient formal professional association so important to a developing specialty. Rosen emphasises that these events did not occur in isolation. The hospital was an organ of society, changing as that society changed and responding to its evolving demands. In turn, the hospital made visible the work of its specialist medical staff and influenced the way the community and other doctors perceived the medical care provided.11 Despite their mutual dependence there existed a tension between hospitals and medical staff over a number of issues, which affected the development of both. A major issue for all medical specialties, including paediatrics, concerned the conflict between the personal ambitions of the specialists and their role in serving their patients in the public hospitals. These hospital/doctor conflicts have been discussed in many studies of professionalization. They are also discussed in the analytical histories of Australian hospitals such as that of the Royal Melbourne Hospital and the Royal Women’s Hospital, Melbourne.12

Paediatric Hospital Development

Hospitals have played a vital role in the development of most medical specialties. For paediatrics in Australia the children’s hospitals were particularly important because they provided, at the favourable time in the 1940s and 1950s, the facilities needed for the

specialty to establish itself. Paediatricians had experienced difficulties in finding what they believed was their legitimate place among the other medical specialties. They had not established sufficiently well the scientific credentials of their specialty, and in 1945, in the view of many people and the medical profession generally, children formed a small section of the population with relatively insignificant health needs compared with adults. For paediatricians children’s hospitals provided a place where the members of new medical specialty could develop skills free from the competition of adult services. This independence was important to them because paediatricians had a perception that adult physicians thought them to be relatively unscientific, and hence inferior. In positions of mutual dependency the children’s hospitals and paediatricians could establish their claims to be providers of health services comparable to the adult hospitals and other specialist groups.

In Australia this was a late development compared with some other countries. In the US, for example, two different approaches to paediatrics developed. The first stream followed the German model, with the establishment of highly specialised and scientific paediatric hospitals in the late 1800s. However, by the early twentieth century most paediatricians were in primary care where they elected to provide routine health care to children in the community although they had been highly trained in scientific medicine in children’s hospitals. From their practices they had access only to small local hospitals, not the larger children’s hospitals. Halpern has examined critically how paediatricians claimed these two occupational spaces.13 The primary care stream has some relevance to the development of public health paediatrics in Australia, but little to hospital and private medical care because paediatricians here acted only as consultants. They were not doctors of first contact; general practitioners controlled primary care.

In one of the few critical articles published on the development of hospital services for children, a German paediatrician and historian, Edouard Seidler, has analysed the relative roles of paediatricians and their hospitals in Germany. His observations are in many ways relevant to circumstances in Australia. Seidler refers to the tension between the paediatricians on one side, with their aspirations for their professional careers and

for their specialty, and on the other side the hospital, with its responsibilities to the community for the proper care of children. He argues that children’s hospitals came into existence due both to a public wish to protect children and to the interest of a section of the medical profession in exploiting children for their scientific interest.\textsuperscript{14} The German paediatricians chose to provide their services in children’s hospitals rather than in children’s wards in general hospitals because it was best for both the children and for themselves. The relatively small scale of this children’s hospital system allowed Seidler to study more easily the effects of the sometimes congruent, sometimes conflicting needs of doctor and patient. In Australia the children’s hospitals were also small and the paediatricians relatively few compared with the number of other specialists, permitting a similar study, but in a geographic and socio-political environment very different to Germany, where paediatrics evolved as a specialty strongly based on clinical science.

\textit{Children’s Hospitals in Australia}

The early developments in child health services in Australia of significance for paediatrics were in public health, particularly in infant welfare, in the early 1900s. Out of these efforts came a group of doctors with special skills in dealing with the disorders of babies. They can be considered the first paediatricians. Many of them, as honorary medical officers, took their skills to public hospitals, mainly the children’s hospitals, although in NSW and SA special baby hospitals operated for a time when gastroenteritis was a serious problem.\textsuperscript{15} The preventive approaches were mostly abandoned, however, when doctors began to focus on the diseases of children, and it was then that the children’s hospitals became increasingly important to them.

It is not surprising that paediatricians chose to concentrate on diseases and hospitals in the period from 1945 to 1965. They could argue that the major public health tasks had been completed by the 1930s, though that might be disputed. Some had been resolved, but there were many others becoming apparent, particularly social, emotional and


behavioural problems that might have benefited from the intense study which doctors would later apply to hospital care. Douglas Gordon, Professor of Preventive and Social Medicine in the University of Queensland, has argued that with the diminution of infectious disease the public health services were suffering from “a dearth of the particular type of dragons they had been trained to kill.”\(^{16}\) The new problems of preventive medicine relating to dietary indiscretion, smoking and alcohol and other problems of individual self-care required a very different approach. Public health was also held in suspicion by many doctors for being too close to governments and their threatened intrusion into private medical practice.\(^{17}\) The paediatricians could also see that new knowledge and technology gave them therapeutic tools with which they could make, and be seen to make, an improvement in the outcome of many childhood illnesses. The ability to control infectious disease freed the children’s hospital and paediatricians from frustrating tasks which had occupied much of their time, enabling them to take on new clinical challenges. The opportunities to gain new skills in disease management were tempting for the majority of paediatricians in Australia because they were in private practice, where therapeutics, rather than preventive care, prevailed.

Paediatricians needed the hospital for a workshop and a meeting place where they, with their common interests in childcare, could come together to plan and organise their specialty. Here, in the training of new paediatricians, they exercised some control of the entry of new members to the specialty. In the children’s hospitals the senior medical staff could demonstrate their diagnostic and therapeutic expertise to students and junior staff, from whom they would later expect referrals. An appointment as an honorary physician to a prestigious children’s hospital also gave the doctor status in the community and medical world.

Paediatricians believed that the children’s hospital was a more efficient place for the care of sick children than a general hospital for a number of reasons. It provided an environment where they could treat children better, with the support of nurses skilled in the care of babies and young children. Other staff such as social workers,


\(^{17}\) Ibid., 810.
physiotherapists and occupational therapists were also attuned to the needs of children. The range of equipment available in children’s hospitals was appropriate for children from early life to adolescence, and the investigational services such as the pathology laboratories and radiology, were organised to meet the special requirements of children. Paediatricians maintained that children, for their own sake, were best cared for in the children’s hospital, which protected their physical and emotional welfare and kept them from the distressing sights of sick adults. Paediatricians believed that they possessed qualities which gave them special skills in caring for children and their parents, although these perceptions are challenged by the testimonies of patients.

Paediatricians also favoured the children’s hospitals for their own needs. It was more convenient and more comfortable to work in a setting that they controlled themselves. Children’s hospitals were believed to be different to adult hospitals. They were said to be more humane and more sympathetic to the needs of the staff as well as the patients. In her history of British children’s hospitals in the nineteenth century, on which Australian children’s hospitals were modelled, Lomax says they provided a more informal and unstructured atmosphere than adult hospitals, and were more suitable for children and their parents. As external and perhaps unbiased observers, medical students attending the RAHC appreciated its friendliness after the more formal atmosphere they had experienced in the large teaching hospitals. One medical student dramatically called the children’s hospital “a haven from the madding crowds of ignoble strife.” This view of the adult teaching hospitals and their internal professional conflicts has been echoed by a doctor who was training to be a physician in the late 1940s. He has described the tensions in the medical services in the large public hospitals in Sydney, which resulted from the intense competitiveness and gamesmanship prevailing between adult physicians flaunting their superior scientific knowledge. Doctors with the personalities that made them choose to be paediatricians were perhaps also more comfortable in the environment of a children’s hospital. In RAHC they were

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20 Senior Year Book, Faculty of Medicine, University of Sydney, 1939, 1949, 1953, 1955, 1956.
21 Ibid., 1939.
22 Dr R. M. Mills, interview with author, Newcastle, 24 June 1998. Mills had recently returned from military service. He had also worked for several years in RAHC on a research project on tuberculosis.
“a contented group” who feared that in the larger general hospital the needs of their child patients and their own needs would be submerged. Paediatricians feared they would be disadvantaged, if only because the number of children’s beds needed for Sydney’s population, for example, was only a tenth of those required for adults.

Whatever the relative merits of adult and children’s hospitals, both progressively improved the quality and range of services they provided through first half of the twentieth century. A NSW Government committee presented evidence in 1940 that members of the public of NSW had become “hospital minded.” People had much greater confidence in public hospitals than twenty years before because they knew that the standard of treatment available and the accommodation for patients had greatly improved. The committee reported that the public believed that better methods of saving life and alleviating suffering were being introduced regularly and that in this regard, the public hospitals were always in advance of private hospitals. In the words applied by Rosen to public hospitals generally in the industrialised world, they changed from being institutions for the sick poor to medical centres for everyone. The Australian children’s hospital shared in this public confidence. By 1945 they were attracting children from all social classes and had built reputations as competent providers of care. Paediatricians were also beginning to establish their identity, with their association with the children’s hospitals being of strategic importance.

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23 Dr D.G. Hamilton, interview by author, Sydney, 24 February 1998.
24 Herber H. Schlink, *The Hospital Problem of the Metropolitan and Suburban Area of Sydney* (Sydney: Australasian Medical Publishing Company, 1940). The pamphlet quotes international figures which recommended that there should be 5 general hospital beds per 1000 population, and 0.5 children’s beds.
The doctors who worked in the medical department of RAHC in 1945 came from a number of medical backgrounds. Some were from the infant welfare clinics of the public health services, with reputations as baby doctors. Others could devote only a part of their time to their special interest in child care; the rest of the time they were general practitioners or physicians in adult internal medicine. Yet others were surgeons who operated on children and also consulted on feeding and other non-surgical problems. Only a few were physicians who treated children only. However, after 1945 the medical staffing balance began swinging towards physicians who concentrated solely on the medical disorders of children — the dedicated paediatricians.

In 1945 aspiring paediatricians faced a number of challenges. How should they equip themselves to meet the demands of scientific medicine with its new knowledge, new therapeutic agents and technology? How might they use the situation to advance their own professional careers and their new specialty? How would they find the time to give to patient care in the children’s hospital in recognition of their honorary appointment? How would they earn their living, with private practice virtually the only source of income? How should they organise their time and energies to balance these conflicting commitments? The children’s hospitals were also challenged by contemporary events. They also had to cope with new science and technology and with their commitments to provide a modern children’s service for the children of the State. The new services, however, were expensive, so hospitals had to improve their management skills to ensure that their funds, which increasingly came from the State Government, were used effectively.

The development of paediatrics in two children’s hospitals illustrates how paediatricians and hospitals sought, in different ways, to come to terms with these challenges. Before the Second World War both the Royal Children’s Hospital (RCH) in Melbourne and the Royal Alexandra Hospital for Children (RAHC) in Sydney were large hospitals providing the major children’s services for their State, in a manner determined by the modest medical knowledge of the times. In the early 1950s RCH introduced a plan of development that was followed, in time, by all the other Australian children’s hospital. RCH radically changed the medical staffing of the hospital. The honorary system was abolished and salaried medical staff employed. The control of the hospital moved from the honorary paediatricians to hospital management. In contrast, RAHC, until the 1970s,
continued with honorary staff who were largely in control of the hospital’s policies. A comparison of the development of RCH with that of RAHC provides valuable insights to the evolution of paediatrics in Australia and NSW.

Royal Children’s Hospital, Melbourne

RCH was a large children’s hospital situated in the inner-city suburb of Carlton for most of the period between 1945 and 1965 (see Figure 5.1). It moved in 1963 to a new building in Parkville but the early development of paediatric services took place in the old building. In 1945 the hospital was staffed by honorary medical officers, few of whom had been trained specifically in paediatrics — most were otherwise suburban general practitioners. Paediatric specialization had been slow to develop compared with other specialties, including adult internal medicine. The senior honorary staff at the nearby major adult hospital, the Royal Melbourne Hospital, were all specialist physicians and surgeons.27 The children’s hospital doctors were conservative; they had not been influenced by those of their colleagues who had engaged in planning for post-war reconstruction in organisations such as the British Medical Association (BMA), the National Health and Medical Research Council (NHMRC) and in other government bodies. Just after the Second World War, when most people were looking to the future, the Committee of Management of RCH was told that the honorary medical staff wished to return to prewar conditions: “They did not sense the excitement of the new era in the same way as all other groups in the Hospital.”28

The Committee of Management of RCH had long had ambitious ideas for the hospital’s future. Dr John Colebatch, a junior resident medical officer in the hospital from 1935 and an honorary physician after the war, has described how the hospital was run by a group of powerful and influential Melbourne women, foremost among whom was Lady Ella Latham, President of the hospital from 1933. Lady Latham was an independently minded woman, but she was prepared to listen to expert advice about the development of elite hospitals and certainly had ample such advice available to her. She was associated with people prominent in the University of Melbourne as her husband, who

27 Dr John Colebatch, interview by author, tape recording, Melbourne, 30 August 1999.
28 Royal Children’s Hospital (RCH), Melbourne, Committee of Management minutes, 6 December 1945. RCH Archives, Melbourne.
was from 1935 the Chief Justice of the High Court of Australia, was Deputy Chancellor and then Chancellor of the University from 1935 to 1941. There were others such as Professor Peter MacCallum, Professor of Pathology, and Professor R. Douglas Wright, Professor of Physiology, who held very strongly that teaching hospitals should have a close association with the University. Colebatch believes that amongst Lady Latham’s associates were people who, in the late 1930s, were anxious that Australia should develop its own health services of the highest quality, and become independent of other countries like the UK in research and for training doctors in the specialties. Her advisers believed that the scientific links with other countries such as the UK would soon be dislocated because war with Germany and Japan was inevitable. \textsuperscript{29}

The paediatrician, Dr Howard Williams, has described how in 1940 Lady Latham formally declared that RCH should become a centre of knowledge, research and teaching in paediatrics with the highest academic standards. \textsuperscript{30} The first steps towards achieving that goal came with certain changes she initiated, believing that the power of the honorary medical staff had to be restricted if the hospital was to progress. \textsuperscript{31} In the past the honoraries had determined the course of the hospital but they were conservative and their attitudes to the hospital were influenced by their obligations to their private practices and their ties to organised medicine in the British Medical Association (BMA). Lady Latham believed that a more progressive presence was needed. She invited representatives of the University of Melbourne to become more closely involved in determining the future of the hospital. The Committee of Management of RCH created a new group, the Medical Advisory Board, to be the main advisory body to the Committee of Management, in place of the honorary medical officers through their Medical Staff Association, which traditionally had that privilege. The Medical Advisory Board had a crucial role in the hospital because it was the body which made recommendations to the Committee of Management on new senior medical staff appointments. \textsuperscript{32} Two University representatives, the Vice Chancellor and the Dean of  

\textsuperscript{29} Colebatch, interview.  
\textsuperscript{30} H.E. Williams, \textit{From Charity to Teaching Hospital: Ella Latham’s Presidency 1933-1954. The Royal Children’s Hospital, Melbourne} (Melbourne: by the author, 1989), xiii, 2, 3.  
\textsuperscript{31} Williams, 87-92.  
\textsuperscript{32} RCH Committee of Management minutes, 6 June 1940.
the Faculty of Medicine, were invited to be on the Advisory Board, despite the strong objections of the Medical Staff Association. 33 The Vice-Chancellor was Sir John Medley, who had unequivocally expressed the view that teaching hospitals should be aligned with modern scientific medicine. He maintained that medical schools should be part of the University and be actively involved in seeking new knowledge through research. 34 The influence of the University on the hospital, relative to the doctors, was further enhanced in 1946 when the RCH Advisory Board was reconstituted to include seven members of the Management Committee, four representative of the University and only three representatives of the honorary medical staff. 35

Professor Douglas Wright became a member of the Medical Advisory Board in 1947. 36 He had a powerful voice in negotiations on the development of Australian medical services in the period of postwar reconstruction. With Dr H.C. Coombs and Sir (later Lord) Howard Florey he argued for the establishment of a national institute of learning and research, including medical research. In his Halford Oration in 1950 he proposed the formation of research units in all the teaching hospitals of the University of Melbourne. 37 Wright, Colebatch believes, was a strong protagonist for the establishment of research programs in RCH, and was disappointed when the hospital elected to set up clinical rather than basic research. 38 Wright’s support and his advocacy of high academic standards in the hospital were particularly valuable for Lady Latham in realising her plans.

Howard Williams has explained how Lady Latham was also influenced to support research by Dr Reginald Webster, the hospital pathologist who advocated a balance of clinical study and laboratory method, that is, clinical research. Williams states that Webster held similar views to Sir William Osler, who, before moving to Oxford University as Regius Professor of Physic, had been Professor of Medicine in the Johns Hopkins Hospital in the US, and had been associated there with the beginnings of the

33 RCH, Committee of Management minutes, 6 June, 1940, 12 September 1940.
35 RCH Committee of Management minutes, 15 August 1946.
36 RCH House Committee minutes, 13 March 1947.
38 Colebatch, interview.
Osler, however, was vehemently opposed to the full-time plan, although he favoured strongly the alliance between clinical medicine and research. He was greatly concerned that laboratory research would dominate clinical work in University hospitals. This may help explain why RCH favoured clinical research, over basic research, despite pressures from the University of Melbourne. The focus on clinical research worked to the advantage of the hospital in helping gain the support of the medical staff for the radical changes being introduced because it provided new knowledge of immediate practical benefit for patient care.

With the power of the conservative section of the honorary medical staff considerably curbed, the Committee of Management was in a position to bring in the changes foreshadowed by Lady Latham. RCH set out to pursue a policy of hospital development that included new buildings, improved patient care and improved staffing. Clinical practices would be based on the paradigm of scientific medicine, supported by research units with strong links to the University. This implied that there would be increasing specialization within paediatrics, or in other words, subspecialization.

Honorary staff were not suited to these purposes. The proposed developments would only be possible with the appointment of medical staff as managers of key clinical departments. They would need to devote their whole professional time to the hospital, so full-time salaried posts would have to be created, a pioneering venture in Australian medicine. The hospital would need a chief executive officer who was powerful enough to implement the Committee’s policies, but sufficiently diplomatic to gain the cooperation of those members of the honorary senior medical staff who were strongly opposed to the changes, but whose services would still be needed. Formal research programs would also have to be initiated. The honoraries could see that with the creation of salaried positions they would lose their powerful position in controlling hospital policies. Previously they had been firmly entrenched and, as described by Abel Smith in Britain, for many “The hospital was a means to an end, the end being an adequately remunerated private practice.” The honoraries were supported by the

39 Williams, 78.
40 Berliner, 150-158. Fleming, 177-179.
organised medical profession, the BMA (Victorian Branch) which was a strongly opposed to the destruction of the honorary system.\textsuperscript{42}

The Committee of Management nonetheless pressed on with the plan despite the protests. A medical administrator and practising paediatrician, Dr Vernon Collins, was offered the position of hospital superintendent. He had been Medical Superintendent of the Hospital from 1937 to 1939, and during the War had worked in London as a physician in the North Middlesex Hospital. He served with the Emergency Medical Service where he had the opportunity to witness a new approach, for Britain, to medical staffing.\textsuperscript{43}

The Emergency Medical Service was set up shortly before the beginning of World War II in the expectation that there would be many civilian casualties from air raids. It recruited many doctors, including senior honorary physicians and surgeons, into a salaried service. For the first time in their careers they had an opportunity to take a broader view of health services. They become fully aware of the poor state of the hospitals and participated in planning better services in, for example, orthopaedics and rehabilitation, and in setting up national pathology and blood transfusion services. As frequently occurs in structures which include doctors, the question of private practice soon arose when they found that their incomes were greatly reduced and when the expected number of casualties did not eventuate. Many of the consultants went back to their private rooms and retained only a small commitment to the Emergency Medical Service. However, the experience helped pave the way for the National Health Service in which all consultants became salaried in 1948.\textsuperscript{44}

In Britain, Collins was able to observe the difficulties experienced by hospitals in attempting to improve patient care with only honorary staff available. He later witnessed the benefits of the employment of full-time salaried senior specialist medical officers and how they improved the quality and efficiency of medical planning, hospital

\textsuperscript{42} RCH Committee of Management minutes, 18 December 1945, containing a report of a meeting of representatives of the honorary staff of metropolitan hospitals and the BMA.
\textsuperscript{44} Abel-Smith, 436-446.
organisation and clinical work.\textsuperscript{45} Collins was also aware of events in medicine in the US. He had long had an interest in medical education and spoke approvingly of the work of Abraham Flexner and of the Johns Hopkins Medical School and its focus on medical science.\textsuperscript{46} His own ambitions for the hospital and those of Lady Latham coincided and he agreed to take on the new position in RCH, under certain conditions, which included holding a senior clinical role and being titled Medical Director.\textsuperscript{47}

A strong research facility was established with the formation in 1947 of the Clinical Research Unit, with Dr Howard Williams as Director. This unit established programs of clinical research in respiratory disorders (Williams), gastroenterology (C.M. Anderson) and fluid and electrolyte metabolism (W.B. McDonald) which had an immediate application to the clinical work of the other paediatricians.\textsuperscript{48} The Committee of Management believed it essential that the Director of Research should hold a position of high status, which implied, in the medical perceptions of the time, that he should participate in the regular clinical work of the hospital. Williams was therefore appointed a senior physician to inpatients.\textsuperscript{49} The granting of clinical appointments to salaried staff was made in the face of the opposition of the Honorary Medical Staff Association that had declared not long before, in 1947, that it was against their principles that a paid member of the medical staff should be allocated beds in the hospital.\textsuperscript{50}

Collins presented a report on the reorganisation of the medical staff to the Committee of Management in 1951. His recommendations were adopted and the Committee resolved that the honorary system should be abandoned, stating: “For the most efficient reorganisation of the Medical Staff, it is recommended that adequate payment be made for all professional services.”\textsuperscript{51} By early 1953 there were full-time or near full-time medical officers in charge of most of the key clinical departments of the hospital. The visiting staff, many of whom had been honoraries, were paid on a sessional basis.

\textsuperscript{47}RCH Committee of Management minutes, 4 November 1948.
\textsuperscript{48}RCH, Annual reports, 1948, 1950/51, 1952/53.
\textsuperscript{49}RCH Committee of Management minutes, 20 May 1948.
\textsuperscript{50}RCH Committee of Management minutes, 1 May 1947.
\textsuperscript{51}RCH Committee of Management minutes, 11 Oct 1951.
for the time that they spent in the hospital in clinical roles. They were now called “visiting medical officers.” The hospital could be assured that the medical staff would spend sufficient time within its walls to meet the goals that the Committee and Collins had set. The financial rewards for those working part-time were sufficient to ensure that their private practice was not a valid competitor for their time, and provided useful support for young paediatricians beginning in practice.52

To bring about these radical changes required clear planning and a committed Management Committee and administration. In a memorial oration a colleague spoke warmly of Collins’ strength and negotiating skills. He said that success came for the administration with “a rationality of development which disarmed resistance, in the lucid way in which Collins introduced change.”53 Collins’ diplomatic approach may be compared with that of William H. Welch and his introduction of the full-time system in Johns Hopkins Hospital in the US. Welch also adopted a mediatory technique in overcoming strong resistance to the scheme, and the full-time system soon spread to many other university hospitals in the US.54 Their approaches may be contrasted with the authoritarian introduction of the full-time system in the Royal Newcastle Hospital, which strongly antagonised many doctors in private practice in Newcastle and Sydney as well as the BMA (NSW Branch).

In the development of RCH it was significant that the holders of the key salaried posts in management and research enjoyed an undeniable high status as clinicians. This strengthened their positions in bringing about changed attitudes in their honorary medical colleagues. A measure of the acceptance of the new situation by the majority of senior medical staff was that the Director of Research was elected chairman of the Medical Staff Association in 1948, the first full-time staff member to hold this position, at a time when in other hospitals salaried staff were denied even membership of the staff association.55

52 RCH Annual Report, 1952/53. Williams, From Charity to Teaching Hospital, 96.
55 RCH Committee of Management minutes, 23 January 1958.
The task of the Committee of Management to bring in their changes was made easier by changes in the membership of the honorary medical staff just after the war. At the end of the Second World War many of the older honoraries in RCH retired. They had stayed on past their usual retirement age to provide clinical services in positions vacated by those doctors who had joined the military services. To replace them, six younger paediatric physicians were appointed to the honorary staff, which meant that they then constituted about half of the staff of senior physicians to inpatients and outpatients. The new doctors had trained in paediatrics before the war, in Australia and Britain. Many had previously held the position of Chief Resident in RCH, the most senior resident medical officer. They returned from the war full of enthusiasm, ready to establish a career in scientific paediatrics. They were a group of “young Turks” eager not only to establish successful practices, but to engage actively in research. They were ambitious for themselves and for RCH. They believe they played a very valuable role in the post-war development of RCH, but some of those who were amongst the “Turks” are concerned that their contributions have been underrated. They acknowledge the vital work of Lady Latham, Vernon Collins and Howard Williams, but believe that the account of the development of RCH by Williams, in From Charity to Teaching Hospital, which emphasises the roles of Latham and the salaried staff, is biased because of his views on private medical practice. One said that while the term “socialist” was too strong to apply to Williams, he had a strong social conscience and did not approve of people in private practice, maintaining that “they were a lesser breed.” The conflict provides an example of the long-standing divisions between honorary and salaried medical officers, even in a hospital where one might have expected such differences to have been resolved.

The newly appointed honoraries were of a new type; very different from their prewar counterparts. They were well trained in paediatrics and practised exclusively in the field. They were relatively mature from their war service. They engaged enthusiastically and productively in hospital work and in research. Their contributions in these areas were further enhanced when they accepted sessional payments. As an example, Dr John Colebatch was sufficiently well established in haematology by 1948 to request the

56 Colebatch, interview. Dr H.N.B. Wettenhall, interview by author, tape recording, Melbourne, 1 September 1999.
Medical Staff Association to support his application to management to set up a haematology research clinic. His request was refused then, but was granted in 1953. Colebatch successfully combined his research and hospital work with his private consulting practice in Collins Street, Melbourne.\(^57\) In contrast, the physicians in the RAHC Sydney had a much more difficult task in trying to develop their hospital.

RCH demonstrated, in a way new to Australian paediatrics, how to embark on the development of a hospital that was firmly aligned with the principles of scientific medicine. The vital elements were the vision of the Committee of Management, led by Lady Latham, the close association with the University of Melbourne and the enthusiasm of the doctors. The Committee developed a clear plan based on the appointment of a clinical administrator and a senior research worker, both of whom were established clinicians. The honorary system was abolished and medical staff were paid, some in full-time positions, others on sessional contracts. For both groups the hospital became a strong focus in their professional lives. The sessional paediatricians could also continue in private practice, which was for many of them important for their status in the community. Paediatrics and paediatricians in Victoria were therefore firmly centred on RCH between 1945 and 1965.

*Royal Alexandra Hospital for Children, Sydney*

The situation in Sydney was very different. RAHC lacked a Lady Latham and an administrator with “the rationality of development and the lucidity of exposition” attributed to Collins in RCH by one of his staff members.\(^58\) The Board of Management of RAHC had a plan for the future of the hospital, but it was not a visionary plan like that of RCH, nor did it recognise the crucial need of the time to examine the way medical staff worked in hospitals. The Board in 1945 merely acknowledged that RAHC had the responsibility for providing a complete paediatric service for NSW. It would continue to be a teaching hospital of the University of Sydney for medical students, and would train nurses and other health workers such as speech therapists and physiotherapists. The Hospital Board recognised that the hospital could make a very valuable contribution to postgraduate medical training as a workshop, because there

\(^{57}\) Colebatch, interview.

\(^{58}\) P.G. Jones, The Second Vernon Collins Memorial Oration, RCH Archives, Melbourne
were, in the wards and the outpatient department, a large number of patients with a wide variety of conditions.\(^{59}\) Although it was not directly stated, one might assume from these plans that the hospital wished to be seen as a modern institution, but there was no mention of research or that there was any need to look at whether the functions of the hospital should change to meet the needs of the postwar world. The hospital management did not take a leadership role. Instead, the pattern of development was determined by the members of the medical staff.

The paediatricians in RAHC wished to develop modern, scientific medical services and there was a wide scope to develop ambitious plans. The hospital itself had considerable latitude in determining its own future and there were no others forces in NSW to direct the planning of health services. RAHC might have built a hospital service similar to that in Melbourne or it might have chosen an equally innovative model. However, the paediatricians chose a course which restricted their capacity to pursue their desired object. They elected to give priority to private practice, to continue the prewar doctor/hospital relationship and to retain the honorary system.

*Planning of Hospital Services in NSW*

During the later stages of the Second World War and immediately after, there was much discussion in Federal Government and other circles about the future of social welfare in Australia, particularly concerning the health of women and children.\(^{60}\) The deliberations on post-war reconstruction included broad plans for hospitals. The Joint Committee on Social Security (JCSS) and the National Health and Medical Research Council (NHMRC) both recommended that there be an integrated national health system with balanced hospital and community services.\(^{61}\) These ambitious plans did not eventuate. Instead, the Commonwealth left the planning and control of hospital services to the States and the States left planning to individual hospitals.\(^{62}\)

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\(^{62}\) Ibid., 280.
In NSW under the Public Hospitals Act of 1929, the Hospitals Commission was responsible for ensuring that all persons needing hospital care should have access to an appropriately equipped and organised institution. The Commission, however, assumed a general supervisory responsibility only and left the development of planning to hospital boards of management. One might have expected that the State Government and the Hospitals Commission would have been concerned how the public hospital system developed, if only because they were being asked for more money to support it. The Committee of Inquiry on Hospitals of 1940 produced evidence that the public wanted the increasingly expensive hospital services provided free of cost to them, which would mean a greatly increased Government subsidy because charities could no longer provide sufficient funds. The Government subsidy for the maintenance of public hospitals as a percentage of total maintenance progressively increased from 47.4 percent in 1941-42 to 84.8 percent in 1950-51.

The Hospitals Commission began what appeared to be an exercise in planning in 1945 in ordering a survey to assess the health needs of the population of the metropolitan area of Sydney for the next twenty-five years. While the annual reports of the Commission contain minor items on planning, they do refer again to this survey. It is surprising that the Commission did not give planning a higher priority, given the financial pressures. Instead, much effort was directed to scrutinising hospital accounts and the efficiency of administration to see that its subsidy was not misspent. There is little evidence of an interest by the Hospitals Commission in clinical matters. Observers in RAHC can not recollect any Health Commission involvement in hospital planning. Perhaps the Commission was concerned that planning for clinical services would lead to conflict with doctors who in the past had been mainly responsible for taking initiatives in hospital development. Whatever the situation, there was little specific planning for hospital services undertaken by the State Government.

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64 NSW Government, Joint Committee on Hospitals — Progress Report, para 7.
The Hospitals Commission of NSW, however, showed that it was concerned about how public hospitals would be managed in the future. This was an indirect approach to planning, because hospital managers would be able to influence how resources were allocated within hospitals and therefore how they developed. With the increasing complexity of hospitals and their financing, considerable administrative expertise would be needed. The Commission strongly supported the training of both senior and junior hospital administrators, in the anticipation that chief executive officers, at least, would possess academic qualifications that would give them a status equivalent to that of senior clinicians. Their presence would bring a new force into hospital organisation to counter the power of the medical staff.

Dewdney has documented the emergence of hospital administrators and their growing responsibilities for the business management of hospitals. He has described the development of academic courses in the field in the University of NSW and the evolution of an Australian Institute of Medical Administrators and, later, a College. Medical administration was becoming a new specialty and the parallels with the development of clinical specialties are obvious. The RCH Melbourne had shown what a strong administrator could do in translating planning into effective action, but it was not so easy for most medical administrators in the 1940s and 1950s. The well-qualified CEO in RAHC, for example, was not able to bring in the changes he thought desirable because of the opposition of the honorary medical officers.

Until 1963 there was only one children’s hospital in NSW, the RAHC in the Sydney suburb of Camperdown. It played the key hospital role in the development of paediatrics in NSW during the eventful post-war period. The specialty of paediatrics was well established by the time the new children’s hospital, the Prince of Wales Children’s Hospital in Randwick began operating in 1963. Even at that time, however, there was no systemic planning for paediatric services based on an assessment of the health needs of the children of NSW and a consideration of the resources required. According to John Beveridge, who became the Clinical Director of the new hospital and also Professor of Paediatrics in the University of NSW, there was no analysis of such

matters as the child population or its geographic distribution, or illness patterns, either present or predicted. Later, as Adviser in Paediatrics to the Hospital Commission of NSW, he had access to official records which confirmed the lack of planning for child health in the State. Beveridge recalled in 1998:

I don’t really think I gave it (planning) any thought back in 1962 when I was appointed the second Professor in NSW. It seemed that the State Government had decided that it wanted a second faculty of medicine, the University had decided that one of the areas of importance for undergraduate teaching was paediatrics. There wasn’t any paediatrics. I therefore had to create (a children’s hospital).71

The NSW Hospitals Commission had no broad vision or policy for hospital service development, including the future of paediatric services in the State. There was no central health planning body, the Commission did not impose any pressures on hospitals, nor did it intervene in the development of hospital policy.72

The situation was not restricted to NSW. As late as 1972, Dewdney, in his survey of the Australian health systems, agreed that no comprehensive health planning units existed in Australia. There was “no one agency adequately staffed and equipped to formulate a comprehensive State-wide plan for health-service developments over the next ten years.” Planning may have been seen as futile, because of economic and political problems and the complexities of State-Federal funding arrangements.73 Gordon has quoted the health economist, Deeble, who in 1966 said about the Australian health services: “No hospital authority, commission or board has ever possessed sufficient objective data for planning. As a result, assessments of need have always been based on subjective judgements and impressions; and have thus been mainly local.”74 Thus planning was in the hands of hospitals, which meant that RAHC, as the only children’s hospital in NSW, would determine what hospital services would be provided for the seriously ill children of the State in the 1940s and 1950s. How RAHC responded to that challenge played a large part in how paediatrics developed in NSW.

71 Prof. John Beveridge. interview by author, tape recording, Sydney, 19 May 1998.
72 Mr Trevor Ward, interview by author, tape recording, Sydney, 12 May 1998.
73 Dewdney 339.
The paediatricians in NSW and their hospital, RAHC, both chose to concentrate on curative services within the hospital walls, despite the rhetoric of paediatricians that gave preventive care a high priority. There were some, such as Sir Robert Wade, who had advocated a broader role for children’s hospitals. He had been associated with RAHC as an Honorary Surgeon and paediatrician since 1901 and had been a President of the Hospital from 1933 to 1943. In a memorial oration dedicated to an earlier president, Sir Charles Clubbe, he declared in 1945 that teaching hospitals like RAHC had a particular responsibility for the general health of the community, and that a preventive service, based in the hospital, should be established. There is no indication that this advice was seriously considered; RAHC focussed its attention on increasing specialization in the diseases of children.

In Australia, the major hospital services for children were sited in freestanding children’s hospitals rather than in the large general teaching hospitals, which was the practice in some other countries. Most paediatricians in Australia strongly rejected this latter option, which in part reflected their self-interest and their anxieties about the ability of their emerging specialty to resist the competition of adult medicine. They were also concerned that children would not receive optimal care in a large adult hospital.

The question of where to site paediatric services had been debated at length in other countries and in international forums for some time. In 1928 participants at an international meeting in Hamburg discussed the future of children’s hospital services. While most paediatricians supported independent and separate children’s hospitals, a strong case was made for placing children’s services with general hospitals. It was more economical to do so because support services and facilities could be shared. More importantly, the separate development of the children’s hospital, previously thought necessary because of the problems of infection, was disadvantageous because it had isolated paediatrics from the intellectual stimulation of the mainstream of medical science.

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76 Seidler, 192, 193.
In the US these dangers were also recognised. In a brief history of hospital services for children in the US Samuel Radbill said that in the 1970s: “Separating children’s hospitals at a distance from the basic science centres has become a handicap to the quality and efficiency of highly tailored paediatric services. Children’s medical centres are moving into all-inclusive university general hospital centres.” Such an option was suggested for RAHC. There were several proposals to rebuild RAHC in the grounds of Royal Prince Alfred Hospital (RPAH), a major teaching hospital of the University of Sydney, but they were strongly opposed by RAHC, particularly by the medical staff, who feared being submerged in that very large medical institution. These concerns were understandable in the 1950s, before paediatrics had established its credentials. They were of less moment a decade later when the second children’s hospital in Sydney was established and paediatricians had a much greater confidence in their own identity. The Prince of Wales Children’s Hospital was built in the grounds of a large adult hospital, the Prince of Wales Hospital, in the 1960s. The Clinical Director of the new children’s hospital, John Beveridge, a powerful advocate for children and for paediatrics, was able to preserve successfully the independence of his section of the hospital while at the same time taking advantage of the economic and intellectual resources of the large general hospital. Thus in NSW, for most of the twenty years after the Second World War, when paediatrics became a legitimate specialty, the development of the specialty was largely isolated from the rest of medicine and closely bound to RAHC. Theoretically, an RAHC/RPAH alignment may have conferred some benefits to RAHC, given the delayed development of scientific medicine in the Children’s Hospital, but they would have been outweighed by the need for paediatricians and children’s hospitals to establish, separately, their own credentials. Whether the existence of comprehensive planning services for child health would have had an effect of the development of paediatrics in NSW is impossible to say, but in the absence of any direction paediatricians in NSW were free to follow their own choice of the scientific medicine paradigm and take their hospital, RAHC, with them. Their task was made easier because the hospital had access to considerable funds, separate to those

78 Beveridge, interview.
79 Ibid.
which came from the Government. This independence was valuable for a hospital because to a large extent the only way a Government could control a hospital was through funding.\textsuperscript{80}

RAHC, like the other children’s hospitals, as organisations dedicated to the care of helpless and powerless sick children, was able to create a favourable public image that was valuable in raising charitable funds that it could use for development, in addition to those obtained from the NSW Government. The Hospitals Commission provided subsidies from Treasury grants for public hospitals, including RAHC, and oversaw how the budget was spent. Like the other hospitals, RAHC had to get approval from the Hospitals Commission before any major projects were begun, because the Commission had to fund the staff for any new services; otherwise there was a considerable degree of independence. Public donations came to RAHC from appeals arranged by organisations and trade groups such as the Commercial Travellers’ Cot Fund and the Footwear, Leatherwear and Allied Trades Association, but a large amount came from bequests. The hospital cultivated a special relationship with the officers of organisations such as the Perpetual Trustees. The capital funds obtained from bequests provided a substantial income when carefully invested under the guidance of the successful businessmen who had been elected to the Board of Management and the Financial Committee.\textsuperscript{81}

Additionally, the requests from RAHC for Government funding were generally viewed sympathetically by the Hospitals Commission, because the Executive officers had gone to considerable effort to maintain cordial relationships with senior members of that body.\textsuperscript{82} With Government support and with the money available from its own fund-raising enterprises, the hospital had a great opportunity for flexible and adventurous planning if it had so wished. However, as Dewdney has commented, public hospitals did not always direct their often substantial donations appropriately, often failing to take into account the broader needs that might exist outside the hospital.\textsuperscript{83}

\textsuperscript{80} Crichton, 151.
\textsuperscript{81} Ward, interview. In 1957-8 there were bequests which totalled 40,000 pounds, in 1960-1 65,000 pounds. RAHC, \textit{Annual Reports}.
\textsuperscript{82} Ward, interview.
\textsuperscript{83} Dewdney, 32-4.
In 1945 RAHC had 491 beds, with 415 beds for mainly acute cases in the main hospital at Camperdown and 76 beds in the convalescent hospital at Collaroy. There was a large outpatient service with 102,378 attendances in the year. The hospital provided competent but modest medical services for the children of the whole State, in much the same way that it had done before the war (see Figure 5.2). The hospital was staffed by honorary medical officers. Few of them were full-time paediatricians and they spent the time not devoted to children in general practice or as consultant physicians for adults. Their private practices competed strongly for their time because it was very difficult for a paediatrician to make a living treating children only.

RAHC had made few moves towards scientific medicine compared with the adult teaching hospitals in Sydney. At the time the benchmark of medical progress, as perceived by the medical profession, was the application of newly available scientific principles to patient care and to the development of new approaches to solving clinical problems. The RAHC doctors were not scientific; in the words of a doctor who joined the honorary staff just after the war: “They had more patients than they could deal with and they believed they were treating them adequately. They didn’t know much about electrolytes or malignant disease. It was an uphill battle to change things.”

During World War II many of the male members of the honorary medical staff of RAHC were on military service. The hospital was staffed by women doctors and doctors who would otherwise have retired. From 1939 to 1945 the hospital was in a holding phase, but from 1945 new science, new drugs and new technology began to appear. The doctors who had been to the war reclaimed their old positions and new doctors were appointed to the honorary staff, ready to establish a position in the specialty of paediatrics. One, echoing similar statements made in Melbourne recalled: “We were a keen young bunch, ready to spread our wings.” A position on the staff of RAHC enabled them to develop their skills and knowledge, which could enhance their

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84 RAHC Annual Report 1945-46.
85 Hamilton, interview.
86 Ibid.
87 Ibid.
professional status and build their reputation so that they could compete in private practice.\textsuperscript{88} Such doctors were important to the hospital if it wished to continue to provide sophisticated services and to be, as one Hospital President said, “the final medical and surgical court of appeal” for the children of the State.\textsuperscript{89} The hospital had a responsibility to provide up-to-date services and the doctors sought new clinical fields to conquer, but in 1945 management did not have the same clearly defined aspirations for the future as its counterpart in Melbourne. Those members of the medical staff who saw a need for the development of new medical services had to take the initiative themselves to bring them about. They fostered, in their own way, the processes of subspecialization, but their approach to the scientific medicine paradigm was compromised by their attachment to the honorary system.

\textsuperscript{88}Ibid.

\textsuperscript{89}Lorimer Dods. Speech as guest of honour, venue not recorded, 7 August 1960, Dods Papers, P172, Series 3, Item 1, University of Sydney Archives, Sydney.
CHAPTER SIX

THE CHILDREN’S HOSPITALS-PART TWO

Introduction

Chapter Five discussed the role of children’s hospitals in the evolution of paediatrics and showed how one children’s hospital, the Royal Children’s Hospital (RCH), Melbourne, developed in a particular way to take advantage of new scientific knowledge and new therapeutics and technology. Another children’s hospital, the Royal Alexandra Hospital for Children (RAHC) in Sydney evolved in a different manner. The contrasting patterns of hospital development provide useful insights into a number of aspects of hospital and specialty growth, particularly in regard the power structures in hospitals and the attitudes of the medical staff to the hospital and their own professional careers.

Like their counterparts in Melbourne, paediatricians in Sydney began to take up new areas of clinical interest within paediatrics after 1945. Potentially they had considerable freedom to determine their own future and their hospital was well supplied with resources to expand. The doctors and the hospital chose a different approach to that adopted in Melbourne to deal with the pressures of modern scientific medicine. This chapter will discuss how RAHC expanded as a consequence of these decisions and how the specialty of paediatrics was affected. A critical decision made by the doctors after 1945 concerned the processes of increasing specialization, otherwise termed subspecialization.

Until the 1950s many members of the medical profession in Australia feared that the splitting off of specialties like paediatrics from general medicine was harmful to the integrity of the profession and the sense of equality of doctors. Subspecialization created further stresses. While some doctors believed that concentrating on a small area of expanding knowledge would enhance clinical skills and improve the outcome of treatment others held different views — that subspecialization implied overall a
restricted knowledge and resembled unorthodox or fringe medical practices like bone-setting. Within the relatively small specialty of paediatrics subspecialization created even greater tensions. It meant that certain doctors set themselves above their peers by proclaiming that they provided a superior form of treatment. It sometimes involved poaching patients from colleagues and aroused the hostility of general paediatricians. It also promoted further subspecialization as other doctors, for their own protection at least, sought to find their own field of special interest.¹

While subspecialization brought benefits to the patients, it has always to be understood in terms of the “political” choices that doctors made in the development of new services. In his discussions of innovation in medicine, John Pickstone has pointed out that attitudes to subspecialization were shaped by material interests and that new developments had to be considered in the context of their potential to strengthen or weaken an evolving specialty. The professional interests of individuals or of groups of doctors were central to those developments.² Pickstone added that proposed innovations in services were rarely subjected to any rigorous analysis of their benefits and ultimate costs.³ There is no evidence that any such analyses were carried out in RAHC between 1945 and 1965. Doctors learned of developments in other centres, usually overseas, and if they believed that they would be valuable for patients in the hospital or in their practices or for their own interests they might seek to have them introduced to RAHC.

The Beginning of Sub-Specialization in RAHC

In 1947 a senior physician at RAHC, Lorimer Dods, was awarded a Carnegie Foundation Fellowship to visit medical centres in Britain and the United States. He returned to Australia with information on the latest developments in paediatrics, which he shared with his colleagues.⁴ He persuaded a number of the younger ones that they should each take up a field of special interest; for example, in cardiology,

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³ Ibid.
cardiology, respiratory diseases, gastroenterology and epilepsy. They each selected a subspecialty they were interested in, convinced their colleagues that they had sufficient skills and knowledge, and organised facilities to see the cases that they hoped they would be referred. The new arrangements were formally supported by the Honorary Medical Staff Association, but with important restrictions. The subspecialists could act only as providers of advice. They could not take over the care of a patient. The restriction reflected a resistance to change on the part of the generalist paediatricians. They believed they had to protect their own interests, feared they would lose patients to the subspecialists and were concerned that their prestige would be lowered. Initially the generalists retained control and the role of the early subspecialists was limited.

The Hospital Board of Management and the administration played little part in planning these new ventures, but provided the necessary resources. At first the establishment of a subspecialty was relatively easy and inexpensive. The doctor needed a room with a desk and chairs in the outpatients department and access to patients in the wards. The earliest clinics were in cardiology, in the management of seizures and for bronchiectasis (a chronic chest infection). Patients potentially benefited from the more expert care that evolved because increased attention could be paid to the more difficult problems of diagnosis and treatment. The clinics added to the prestige of the Hospital by increasing the range of special services provided. Subspecialization was also an example of self-interest in raising the doctor’s status.

In the early stages these clinics were not unduly difficult for the honorary system to tolerate because they did not ask for a great deal of resources or threaten the dominant position of the generalists. This situation did not last long. To keep pace with expanding knowledge and technology new subspecialist services began to demand more resources, more time and increased professional skills. Cardiology provides an instructive example.

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5 Dr D.G. Hamilton, interview with author, Sydney, 24 February 1998.
Paediatric cardiology represented the Western tradition of progress in medicine, with a scientific and technological agenda that was continually advancing in new knowledge and the application of more and more powerful investigative and therapeutic processes. There developed “an awesome capacity” to operate on one of the patient’s most critical and emotive organ systems. 6 Cardiology also offered substantial challenges to the participating doctors, particularly the surgeons to whom, says Porter, it was like “a Himalayan peak.” 7

Cardiology was the first major subspecialty to be developed in RAHC. In the report that Lorimer Dods gave to his colleagues in 1948 on his study tour of paediatric centres in the US, he spoke enthusiastically about advances in the management of congenital heart disease, for which the first corrective operation had been performed in 1944. 8 The descriptions of new techniques in cardiac surgery, described in articles in contemporary medical journals, also made RAHC doctors aware of what could be achieved in special clinics and stimulated an interest in developing similar services in Sydney.

A child with congenital heart disease usually had multiple problems relating to the abnormal circulation of the blood in the heart and lungs, which often affected general health and delayed growth and development. Sometimes a diagnosis could be made by clinical examination alone, but usually special investigations were needed to make an accurate assessment of the anatomical abnormalities and the resulting functional disturbances to determine if they were treatable, and by what method. Sometimes the abnormal anatomy could be corrected completely by, for example, the tying of a patent ductus arteriosus, a persisting foetal connection between the main artery going to the lungs, and the aorta, which carries blood to the rest of the body. Sometimes, in more complex situations, the only possibility was a palliative procedure to try to improve the function of the heart and circulation. In the Tetralogy of Fallot, where there are a number of anatomical abnormalities, the main one being a constriction of the vessel

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taking blood to the lungs and preventing its oxygenation, an operation (Blalock’s operation) provided an artificial bypass of the narrowed vessel. Later there were operations that provided complete corrections of abnormalities.

The management of such complicated problems required a number of doctors, nurses and technicians working as a team. They could no longer, as in the past, be handled by one doctor. Pickstone has argued that there was an increasing need for corporate decision-making in technological medicine, particularly where common equipment was used and where organisational and administrative changes had to be made, and where careful account had to be taken of the “political” implications of an innovation. New services could not be created as simply as they had in the past. If RAHC was going to meet the needs of the children of NSW for cardiac services a comprehensive organisation was needed.

A physician was largely responsible for the diagnosis of the clinical problem, initially assisted by electrocardiography and conventional X-rays. More invasive investigations were often required which needed the skills of a specialist cardiologist. Catheters were inserted into the heart via peripheral blood vessels to measure the pressures and to sample the oxygen concentration in the various heart chambers. These procedures required special X-ray equipment as well as physical and chemical laboratories staffed by technicians. Later, angiocardiography, in which X-rays were taken following the injection of radio-opaque dyes into the heart, increased diagnostic accuracy. A surgeon performed the corrective surgery assisted by an experienced anaesthetist; and in the post-operative period the patient was supported by nursing staff in a special recovery ward. These resources needed were expensive and could only be provided in a large, modern hospital. However, parents in a socio-economically advanced state like NSW were coming to expect that the benefits of modern medicine would be available for their sick children.

The doctors in RAHC were faced with the decision of whether or not to embark on the establishment a cardiac clinic. They might have left this responsibility to the cardiac units in adult hospitals. The Royal Prince Alfred Hospital (RPAH) had previously

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9 Pickstone. 1-16.
carried out some cardiac surgery on children and appeared willing to continue. Cardiology, however, was a vital occupational space for paediatricians, and they could not allow it to be held by adult doctors if they were to establish their desired status in medicine. Paediatricians strongly believed that children were better cared for in the environment of a children’s hospital than in an adult hospital.\textsuperscript{10} They also maintained that they possessed the indeterminate knowledge that gave them a clear advantage in the management of seriously ill children. With the development of a comprehensive cardiology clinic paediatricians could show that they were as scientific as adult physicians. Supported by the Board of Management a group of doctors proceeded to establish a service for the management of congenital heart disease. There were no State initiatives in this field. The subspecialty provided the first example of a successful adoption of the scientific medicine paradigm in RAHC and benefited the patients, the doctors and the hospital.

In February 1948 the Honorary Medical Staff supported a proposal of Lorimer Dods for the formation of a Consultative Congenital Heart Clinic. A subcommittee was elected to investigate congenital anomalies of the heart and great vessels and the surgical treatment of suitable cases. This was one of the earliest of a number of medical staff committees created to organise new services. This approach to service development may be contrasted with the processes adopted by RCH, Melbourne, where new services were the responsibility of salaried specialists appointed by the Committee of Management. The subcommittee consisted of a physician (Lorimer Dods), a surgeon (T.Y. Nelson), an anaesthetist (A. Distin Morgan) and a radiologist (K.B.Voss).\textsuperscript{11} They were joined by additional surgeons and also a general physician (Douglas Stuckey) who was interested in cardiology and wanted to be a paediatric cardiologist. He later went to the UK for a year for training in cardiology, returning to a salaried part-time post in the cardiac clinic, as Physician-in-Charge, to carry out the special investigative procedures.\textsuperscript{12} The first cardiac surgeon (Nelson) was a resourceful general surgeon who had trained himself in cardiac surgery, having previously learned to be a neurosurgeon. These initiatives on the part of energetic and gifted honorary medical officers to meet

\textsuperscript{11}RAHC, Honorary Medical Staff (sometimes referred to as the Honorary Medical Staff Association or the Medical Board) minutes, 4 and 6 February 1948. RAHC Archives, Sydney.
\textsuperscript{12}RAHC, Honorary Medical Staff minutes, 4 Aug 1948: RAHC, House Committee minutes, 29 July 1953. Dr W. Grigor, interview by author, tape recording, Sydney, 30 June 1998.
what they perceived as the needs of the hospital, and their own ambitions, were not unusual in the era before formally-trained physicians and surgeons were available. A powerful driving force in the Cardiac Clinic was the surgeon, Douglas Cohen, who took up cardiology as his special surgical interest, in addition to his general surgery. Like Douglas Stuckey he later went to the UK for a year to train in paediatric cardiac surgery, returning in 1954. With increasing experience and influenced by developments in the US and UK, the Cardiology Clinic began to deal with more and more complex cardiac problems. This was only possible when the hospital acquired new X-ray and other investigative equipment.

Two chance encounters were important in advancing the work of the clinic. The first of these was with Mr John McDonald, an executive in the steel industry, whose son had been a patient of the Clinic. The child developed a staphylococcal infection following an operation for a congenital heart lesion, and unfortunately died. McDonald agreed to lend his considerable energies to helping the cardiac service. He organised the raising of funds that helped build a special cardiac ward and enabled the purchase of much essential equipment that would not otherwise have been available. The second encounter was with an engineer, Mr Viv Ebsary, an acquaintance of McDonald and a hydraulic pump manufacturer, who provided substantial technological skills to the cardiac service. Ebsary invented a device for hypothermia, a technique in which the patient was cooled during heart surgery. He later constructed a new type of heart-lung machine, a device for maintaining the circulation of the blood while the heart was being operated on. This machine was much better than those then available commercially and enabled the service to perform major operations which otherwise would not have been feasible in Sydney until much later.

Another important contributor to the growth of the clinic was the philanthropist, Alfred Basser, who, from 1956, provided funds for the investigational service, which was named the Adolph Basser Institute of Cardiology.

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14 Cohen, letter to author.
15 Mr John Jackson, interview by author, tape recording, Sydney, 5 October 1999. Mr Jackson was the Chief Technician to the Cardiac Unit, and was associated with it from its inception until 1977.
16 Cohen, letter to author.
The cardiac service grew rapidly. In its first year the clinic saw 31 new patients, in the next year there were 72 patients (102 attendances), and by 1965/66 there were 942 attendances.\(^1\) In 1959 the surgeons performed 1000 heart operations.\(^2\) The Basser Institute later employed a cardiologist, two part-time surgeons and one full-time staff surgeon (from 1965), two salaried anaesthetists, a salaried radiologist, and a Fellow, a cardiologist in training.\(^3\) The Clinic was sufficiently well established to perform its first open-heart operation in 1959. In the development of cardiology RAHC was equal to the hospital which was regarded as the yardstick for paediatric hospitals in Australia, the RCH, Melbourne. In most other areas of development RAHC was ten years behind RCH.\(^4\) A senior Sydney paediatrician reflected in 1998: “Cardiology was the jewel in the crown of RAHC.”\(^5\)

Cohen, describing himself as a fatalist, attributes the success of the cardiac service to a number of fortunate chance events, declaring: “It had something to do with being in the right place at the right time and associated with the right key personnel.”\(^6\) His remarks emphasise that certain individuals, at times, can play crucial roles in hospital service development. George Rosen has discussed the place of the “stranger” as an innovator in the development of specialised medical services. The “stranger” brings the special characteristics of mobility, objectivity, and freedom from convention to the task.\(^7\)

While not strictly a stranger to RAHC, Cohen can be seen as possessing similar qualities. In the development of cardiology there were highly competent, powerful personalities who were able to convince their colleagues, the hospital administration and Board of Management of the value of the work they proposed doing. Both Nelson and Cohen in particular were seen as very strong and persuasive people.\(^8\) A third factor was the chance contact with other enthusiastic people who were able to offer substantial technical and financial help. There was a team of highly competent people who worked

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2\(^{\text{Daily Telegraph, 30 January 1960.}}\)
3\(^{\text{RAHC, Annual Report 1965-66. RAHC, Board of Management minutes, 25 January 1965.}}\)
4\(^{\text{Prof. John Beveridge, interview by author, Sydney, 19 May 1998. Grigor, interview.}}\)
5\(^{\text{Grigor, interview}}\)
6\(^{\text{Cohen, letter to author.}}\)
7\(^{\text{George Rosen, The Specialization of Medicine with Particular Reference to Ophthalmology (New York: Froben Press, 1944), 39, 40.}}\)
8\(^{\text{Beveridge, interview. Hamilton, interview.}}\)
well together. The team included doctors, nurses and technicians, a great contrast to previous enterprises in medicine where most advances were achieved by doctors working alone. The clinic was also well supported by the CEO, John Fulton, who could provide a encouraging administrative climate and a link to the Board of Management. In RAHC cardiology was a specialty generated by enthusiastic clinicians. While it received substantial support from the Hospital, it was not a product of formal planning processes.

The establishment of a service such as cardiology, with standards of care equal to those in other advanced countries, added to the status of the hospital in the eyes of the Government and the public and generated further financial support. RAHC was skilled in obtaining publicity, and cardiac surgery was a spectacular way of gaining public sympathy for both the child and the hospital. An experimental heart-lung machine was often demonstrated to the press and to visiting dignitaries even though it was still only being used in animal experiments in preparation for its later use with children (see Figure 7.1). The hospital encouraged the approaches of the media for favourable news stories. A Sydney newspaper published a dramatic report of a young girl who had recently had a four-hour operation for congenital heart disease. She declared that she was now quite well. She was also pink, whereas before she was always blue and breathless, and unable to participate in ordinary childhood games. In another newspaper report a hospital spokesman stated that it would no longer be necessary for children with congenital heart disease to go overseas for their operations as they could now be treated successfully in the RAHC. These comments were intended to build public confidence in RAHC and to encourage donations. They also helped build the reputations of the members of the cardiac team. A team member later admitted, however, that at the time the success rate of the cardiac surgery was variable, as with most pioneering work. He remembered the distress of Cohen when three of the patients he had operated on died in the course of three weeks. The treatment of the simpler anomalies had a high rate of success, but there were a significant number of deaths with

25 Jackson, interview.
26 Hamilton, interview.
27 Jackson, interview.
the more complicated cardiac abnormalities, although these were in children who, without operation, had a very poor prognosis.\textsuperscript{30}

The development of cardiology demonstrated that if a hospital wished to develop highly sophisticated services it needed a substantial contribution of intellectual and physical effort and time from the medical staff involved. Children with congenital heart disease could present as an emergency at any hour of the day or night. There had to be senior staff available at all hours to carry out urgent investigations, which were often followed by surgical procedures of many hours’ duration. There were some full-time salaried specialists available in radiology and anaesthesia, but the physicians were only part-time salaried or honorary staff. Indeed, the surgeons were honoraries until 1965. The hospital was dependent on the good will of these doctors to provide cardiac services.\textsuperscript{31} Undoubtedly the individuals involved could use the situation to raise their own professional status. On the other hand, the same individuals had to make an enormous personal contribution to the service.

Cardiology provided an excellent example, for those wishing to use it, of the benefits of employing full-time salaried staff. It was the first of a number of specialist services that made inordinate demands on honorary staff. Despite this, the Honorary Medical Staff Association remained firmly opposed to the appointment of salaried staff. The suspicions they had about the inroads salaried staff might make into their work led to a careful framing of the conditions of employment of the cardiologist, Dr D.S. Stuckey, in 1953. He was allocated two paid sessions a week in which he carried out diagnostic work with cardiac catheters and other devices. In this area he was clearly not interfering with the rights of other paediatricians, none of whom had these skills or access to the intricate equipment. He had one session per week for consultations. This was in an honorary capacity, because in this clinic he was competing with his colleagues in general paediatrics.\textsuperscript{32}

The Honorary Medical Staff were ambivalent about the cardiac service. Its presence made the hospital appear up-to-date in a spectacular way, which reflected on all the

\textsuperscript{30}Jackson, interview.
\textsuperscript{31}Cohen, letter to author.
\textsuperscript{32}RAHC, House Committee minutes, 21 July, 14 December 1953.
medical staff. On the other hand, the service allowed salaried staff into the hospital, which many viewed as a dangerous precedent. However cardiology could be compartmentalized in the thinking of the honoraries. It was a new and highly specialized field, requiring complicated and expensive equipment and a great commitment of time. It involved a few highly trained paediatricians, largely sequestered in a special department. As a new clinical field it created a new jurisdiction, but took little work from the general paediatricians who made up the majority of the staff. Other forms of subspecialization in, for example, respiratory medicine, would pose a much greater threat to them.

*Respiratory Medicine*

Illnesses involving the respiratory system, the lungs and the airways, were the reason for the admission of many children to hospital. Most had relatively minor conditions, such as upper respiratory tract infections, while others had more serious and life threatening disorders. In the 1940s and 1950s general paediatricians felt confident of their ability to manage most of these conditions, but changing patterns of disease and new therapy and technology meant that new methods of respiratory care had to be adopted if RAHC wished to offer a modern clinical service to the children of NSW. The existing doctors on the staff would have to learn new skills or new doctors with the necessary skills would have to be employed. In the same way that paediatrics had to establish its jurisdiction in medicine as a whole, subspecialization meant individuals or groups within paediatrics would have to claim priority of access to newly created occupational territory, requiring that others be deprived of territory that they had previously controlled.

The respiratory disorders fell into two categories, acute and chronic. A chronic disorder, bronchiectasis, was one of the first conditions claiming attention. This disorder was associated with damage to the bronchi, the airways, in the lung, resulting from unresolved infection, often following measles or whooping cough. In the 1940s antimicrobial agents became more readily available and surgery, to excise the damaged segment (or segments) of the lung, seemed to be promising new treatment. Paediatricians in RAHC had had little experience of these new therapeutic approaches, so through the Honorary Medical Staff Association they set up a collaborative group to
improve their knowledge of the condition. The Bronchiectasis Consultative Committee was established in 1945 to provide advice on management and to coordinate the work of the several disciplines involved; the membership of the group included a physician, a surgeon and an ear, nose and throat specialist (there was often infection in the ears and sinuses). The Committee advised particularly on the question of whether surgical excision of the diseased section of the lung should be attempted. Newly available techniques in thoracic surgery and anaesthesia made this treatment much safer.33 Five years later, with better means of treating chest infections, bronchiectasis had become a much less common problem, but other chronic respiratory conditions demanded attention. In 1959 the Committee was asked to adopt a broader role and provide advice on the management of cystic fibrosis as well as other chronic chest diseases. It was renamed the Consultative Clinic in Thoracic Diseases.34 This committee system provided a mechanism that allowed certain honorary medical officers, otherwise generalist physicians or surgeons, to focus their attention on important clinical problems, to improve their diagnostic and therapeutic skills and to improve the outcome of patient care. It was a cautious approach to the beginning of sub-specialization in the hospital. While chronic conditions like bronchiectasis could be appropriately handled by a deliberative approach in a committee, the acute respiratory disorders could not be dealt with satisfactorily in this way. New methods of treating acute respiratory disorders would mean substantial changes to the work of paediatricians.

Advancing technology in the management of acute respiratory disorders revealed the need for new diagnostic and therapeutic skills. These conditions often presented to the children’s hospital as emergencies, requiring urgent treatment. They included conditions with obstruction of the airways, such as croup or diphtheria, or pneumonia or asthma with severely reduced lung function or states of the depression of breathing, which might be associated with head injury or poisoning. Patients with these problems often went to, or were referred to, RAHC because resident staff were always on duty to provide emergency treatment. These junior doctors did not always possess the required levels of skills to handle these situations appropriately, particularly in the new methods of management that were becoming available. These problems demonstrated the

33 RAHC, Honorary Medical Staff minutes, 30 November 1945, 8 February 1946, 2 August 1946.
34 RAHC, Honorary Medical Staff minutes, 9 November 1959, 9 May 1960, 7 November 1960.
deficiencies of the honorary system. While honorary medical officers may have possessed adequate skills they could not readily abandon their duties elsewhere to attend the RAHC within a very short time, nor could they spend long period at the hospital to provide the ongoing care which was often necessary. The advantages of having appropriately trained full-time salaried medical officer in the hospital at all times were readily apparent.

The honorary physicians in RAHC, however, wished to continue to be involved in the care of all the cases admitted on their allocated admitting day, and there was no other authority to decide otherwise. They believed they could find alternative means to provide the services expected in a modern children’s hospital like RAHC. They established advisory and consultative committees to pool knowledge, to develop new methods of managing acute respiratory disorders, and to write protocols of care to direct the resident junior medical staff. For these purposes the Inhalational Therapy Committee and the Respiratory Insufficiency Committee were created.35

In another set of pressures for change, the advent of the new science and technology of clinical measurement in respiratory disorders provided further incentives to examine how the hospital responded to these clinical challenges. In 1964 RAHC acquired a number of instruments for monitoring the management of lung function. They included an Astrup machine for measuring the carbon dioxide level and acid-base balance in the blood, and oxygen electrodes and oxygen monitors.36 In the same way that the ability to measure the electrolytes in the blood improved the understanding and treatment of metabolic disturbances like severe dehydration, so the measurement of the blood gases changed respiratory medicine. To take full advantage of the information from the new technology, to correlate it with clinical data and to develop an effective treatment plan ideally required the presence at the patient’s bedside of an expert in respiratory disorders. This meant that there needed to be better trained and more experienced staff available in the hospital at all times to cope with the emergencies. Visiting honoraries could not provide that service. One option to meet this need was to employ senior resident medical officers; another was to have full-time salaried staff as in Melbourne.

35RAHC, Honorary Medical Staff minutes, 7 August 1961.
RAHC was opposed to the appointment of salaried staff so the residents and honoraries had to work out the best approach to these acute problems, knowing that elsewhere other solutions had been found that produced better results.

The logistics and economics of managing seriously ill children had to be considered. Previously these patients had been looked after in the general wards, but in 1965 the Respiratory Insufficiency Committee recommended that their care be centralised in a special eight-bed ward. There, dedicated nursing staff could be provided and the special equipment deployed. This was the beginning of intensive care services, which would eventually bring great changes to the way paediatricians worked in the hospital. It meant that a limited number of doctors would have access to those patients requiring special care while others would be excluded and their traditional roles reduced.

RAHC was slow to make changes, however. In this acute respiratory ward the general paediatricians retained control for a number of years, even though they gradually delegated more work to the senior resident staff. The honorary staff were reluctant to give up their traditional role of being generalists and being responsible for all the clinical care in the hospital. It was not until 1976 that a staff specialist was placed in charge of the intensive care ward. Until then the development of new approaches to patient care was largely in the hands of committees established by the honorary medical staff.

**Committees and Advisory Groups**

Before 1945 the honorary doctors in RAHC, as in most other public hospitals, acted mostly as individuals, both as clinicians and in their relations with the hospital. For a long time, however, groups of doctors with common interests had met. For example, the physicians had regular meetings to discuss clinical and scientific matters. The whole senior medical staff met regularly as the Medical Staff Association, sometimes called Medical Staff or the Medical Board. The role of this

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37 RAHC, House Committee minutes, July 1965 (not dated), with Memorandum from the Respiratory Insufficiency Committee.

group was to provide corporate medical advice to the Board of Management. It arranged additional educational activities for its members and organized lectures for medical students and nurses. There were also social functions. These meetings, however, did not play any role in the organisation of medical work of the hospital.

With the increasing complexity of medical care, and the much greater use of shared resources, the individual approach was no longer appropriate. The work of the medical staff needed to be planned and coordinated and that required a management structure at the clinical level. There were two options available. The task could be carried out by salaried staff appointed by the Board of Management, as happened in RCH in Melbourne, or the honoraries themselves could attempt the task. The latter course was followed in RAHC until 1974. The honorary medical officers established committees and advisory groups to direct medical activity in the hospital.

RAHC’s cardiology service began in this way, and there were also groups established to deal with respiratory problems. There were numerous others that were set up to improve patient management and hospital services (the more important ones are listed in Appendix Two). These committees and the diversity of their tasks reflected attempts by the medical staff of RAHC to come to terms with the complexity of providing modern scientific hospital care. They were, in themselves, unprecedented moves for medical practitioners who were accustomed to working as individuals. The involvement of the honorary doctors in these corporate activities was evidence of their desire to improve patient care and of their good will and generous disposition towards the hospital, for committees were time consuming and took them away from their private practices. They preferred to be involved in these extra activities rather than face the alternative, in which specialised clinical care and organisational work would be largely the responsibility of salaried staff. It could be argued that they chose a relatively inefficient approach, compared with that which was developed in RCH. Their intention, on the one hand, was to try to make the honorary system work, while still being able to devote a considerable amount of time to private practice. On the other hand there was another, more self-oriented, motive. Using the Medical Staff Association committee system, they retained the power to control the clinical activities of the hospital. Staff specialists

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39 RAHC Honorary Medical Staff minutes.
would have been outside their control, being responsible to the Chief Executive Officer and the Board of Management.

Private Practice in Sydney

Medicine in Australia, up to the 1970s, was largely oriented towards private practice. At first most doctors were in general practice, but increasingly, through the twentieth century, various forms of specialization developed, particularly in the branches of surgery. Scotton has estimated that around 70 percent of doctors in NSW were practising privately through the period from 1945 to 1965, although the data is sometimes deficient and the definitions of occupation are sometimes unclear. Sir Theodore Fox, editor of the *Lancet*, after a tour of Australia, commented that all the Government and other health schemes which had evolved up to the 1960s strongly favoured private practice at the expense of the state.

The medical profession was well organised and politically sophisticated. Despite the increasing power of bureaucracies, doctors remained independent, and most were prepared to defend that status vigorously. Even though many doctors worked in state-supported public hospital, they protected their freedom by being honoraries. The paediatricians who practised clinically in RAHC were all in private practice. There were no clinical staff specialists until 1972, whereas the first was appointed in Melbourne in 1952.

To be a paediatrician in Sydney from the 1940s to the 1960s involved having at least two potentially competing roles, and sometimes more. First, most paediatricians believed they needed to have an honorary position in RAHC if they wished the public and the medical profession to recognise them as children’s specialists. With this position came considerable responsibilities, including attending the hospital for ward rounds and teaching medical students, outpatient sessions, committee work and educational meetings. Second, for financial reasons the doctor needed to be in private

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consultant practice. There were no salaried positions available. For many, their professional time was further divided. Most paediatricians had honorary positions on the staff of other hospitals, in the paediatric departments and the nurseries of midwifery units of suburban hospitals and in the large obstetric teaching hospitals. These positions were useful because it was in these other hospitals that they came in contact with doctors who would, hopefully, refer private patients. Contact with obstetricians and general practitioners was particularly valuable. The junior physicians benefited particularly from these outside opportunities to gain experience because inside RAHC they had limited access to consultant work, which was mostly undertaken by their seniors. The obstetric hospitals offered special opportunities. Dr Wallace Grigor, who became a senior physician in RAHC, recalled in 1998: “We [the young paediatricians] were called to see babies at all hours in district hospitals all round Sydney, mainly for acute problems that the older paediatricians didn’t want to get involved with. We also visited country towns.”

The minor problems of the newborn provided much of the routine work of young paediatricians and introduced them to parents who would be likely to consult them for subsequent illnesses in their children. The association between obstetricians and paediatricians paved the way for the development of the new specialty of neonatology. All these external activities, however, reduced the time available to the paediatricians in private practice to contribute to the development of services in RAHC.

Doctors have been accused of adopting practices that greatly enhanced their income, but this was perhaps less so for paediatricians. They often expressed their concerns about the capacity of young parents to pay for their specialist medical care, particularly before the advent of adequate health insurance schemes. Before the Second World War there were only a few paediatricians in Australia who could survive financially on paediatrics alone; they needed other sources of remuneration, such as giving anaesthetics or general practice. It was still a problem after the war. Dr D.G. Hamilton declared his interest in paediatrics in 1937; he passed his qualifying MRACP in 1948 and then gained a position as a junior honorary physician in RAHC. However, he decided he would have

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43 Grigor, interview.
44 Crichton has discussed criticisms of the entrepreneurial nature of many medical practices, their monopolies in health care and the fee-for-service principle as “an article of faith.” Crichton, 177,178.
to spend four years in part-time general practice before he believed he could survive financially doing only paediatrics. Other paediatricians had similar experiences.\(^{46}\)

Money, however, was a consideration that could not be ignored. Having entered private practice there were considerable pressures on the paediatrician to generate funds. The costs of consulting rooms, secretary’s salary, telephone, and a car were considerable and had to be covered, apart from providing for a personal income to support a family. The paediatrician had to view the duty owed to their honorary appointment at RAHC in the light of their other responsibilities.

Even for a conscientious doctor in private practice, with an intense interest in scientific hospital medicine and a serious dedication to the hospital, there were often unresolved conflicts of loyalty. One such person was John Beveridge, who, before becoming Professor of Paediatrics, was for a short time in private practice and an honorary physician. He soon became aware of the problem. He recalled: “Private practice will soon take over, particularly if you are successful at it, which I was.”\(^{47}\) Honorary medical officers could not provide sufficient time to their hospital for a successful development of the scientific medicine paradigm, however well motivated they might have been.

The financial situation of the paediatrician began to ease with the introduction of the pharmaceutical and medical benefits schemes of the Federal Government in the 1950s. Before that time there had been insurance schemes organised by friendly societies or industrial groups to provide financial support for families for illness and hospitalisation, but they were largely for general practitioner treatment and did not much help the paediatricians. The Pharmaceutical Benefits Act in 1950 made a number of life-saving drugs available free. The Medical Benefits Act of 1953 helped those patients who belonged to a voluntary health insurance organisation. The benefit that they paid plus a Government subsidy aimed to cover 90 percent of the doctor’s fee. This made it feasible for middle-class parents to take their child to a paediatrician. It was not until 1970 that treatment by a specialist brought a higher Government rebate and allowed a higher consultation fee.\(^{48}\) From 1945 to 1965 paediatrics in Sydney was strongly focussed

\(^{46}\) Hamilton, interview.
\(^{47}\) Beveridge, interview.
around private consultant practice as paediatricians could not afford to devote as much
time to their children’s hospital as their counterparts in Melbourne. Thus they were
always very dependent on the support of the hospital resident medical officers to care
for patients in hospital who were nominally their responsibility.

The Resident Medical Staff

The resident medical staff in RAHC provided most of the emergency care and the day-
to-day management of patients until the 1970s. The various levels of the junior staff
were part of a hierarchical structure; in the medical department they were responsible to
the honorary physicians or honorary assistant physicians. Every child admitted to
RAHC was placed under the care and responsibility of an honorary medical officer. The
honorary physicians visited the hospital several times each week to supervise the residents’ care
of their patients. They were also available at other times, in person or by telephone, to
advise their junior staff.

The junior staff in RAHC were salaried and usually on yearly appointments. Most of
them were in the category of resident medical officers. They had spent one or two years
in an adult hospital as the first part of their postgraduate training, and they then went to
the children’s hospital to gain experience for general practice, or to broaden their skills
before entering other specialties. A few residents were interested in becoming
paediatricians. For them their next step upwards was becoming a registrar. Access to
these positions was determined by the senior medical staff through the advice they
provided to the administration on the performance of candidates seeking appointment or
reappointment. In this way entry to the specialty was partly determined by the existing
members of the specialty, although as discussed in Chapter Two paediatricians did not
have full control because they did not have authority in the conduct of the MRACP
examination.

Registrars remained in their positions for a number of years, gaining experience and
knowledge and studying for and passing the qualifying examination for the specialty,
the Membership of the Royal Australasian College of Physicians. Some doctors went
overseas for training, obtaining an equivalent qualification, usually in the UK, and then
returned to RAHC. There were very few paediatric trainees immediately after the war,
but their numbers increased, encouraged by the example set by the younger paediatricians who had begun to demonstrate that their specialty could offer a challenging career. One who was very effective in this role was Lorimer Dods, a charismatic paediatric physician, who took a particular interest in the careers of the resident medical officers who worked for him. He convinced a number of young doctors who had performed well in their undergraduate studies, and who might otherwise have become adult physicians, that a career in paediatrics was professionally satisfying and could be of equal status, in terms of scientific medicine, to a career in internal medicine in an adult teaching hospital. The increasing numbers of resident medical officers coming to RAHC and staying on as registrars with the intention of becoming specialists added to the expertise available within the hospital walls.\(^{49}\)

The histories of the children’s hospitals make little mention of the work of residents and registrars, yet they played crucial roles in the early steps towards the development of scientific medicine when the hospitals were staffed largely by honoraries. Janet McCalman has discussed the roles of junior staff in the Royal Women’s Hospital (RWH), Melbourne, which one may assume reflects the prevailing attitudes to the training of junior doctors from the 1930s to the 1950s. They were handed opportunities to gain enormous experience in dealing with a wide range of critical illnesses, but often with little supervision. While nominally the honoraries were in charge of the situation, they were often very much in the background. The junior doctors were sometimes dealing with clinical problems beyond their skills and experience, with outcomes that were not always satisfactory. The situation persisted until more senior salaried full-time staff were employed.\(^{50}\) The circumstances were similar in RAHC. In two separate Coronial inquiries into deaths in the hospital caused by acute respiratory obstruction it was revealed that the doctors attempting to treat the patients, by tracheostomy or bronchoscopy, had only two or three years’ experience from their time of graduation, and the most experienced person resident in the hospital at the time had graduated only five years before.\(^{51}\)

\(^{49}\) Dr Graeme Morgan, interview by author, tape recording, Sydney, 13 October 1998.
\(^{50}\) Janet McCalman, Sex and Suffering Women's Health and a Women's Hospital (Melbourne: Melbourne University Press, 1998), 197, 198.
\(^{51}\) Sydney Morning Herald, 13 November 1950, 5 June 1957. In tracheostomy an incision is made through the skin of the neck into the trachea, the main airway, and a metal tube inserted to make an artificial airway, bypassing the obstruction. In bronchoscopy a long tube is passed through the throat into the airways of the lung, to look for and try to clear any blockage.
The more experienced members of the junior medical staff, the senior registrars, were often asked to act as quasi-specialists, performing clinical tasks otherwise carried out by honorary medical officers. Honoraries delegated considerable responsibility to them, particularly when acute emergency cases were admitted and the honoraries could not attend immediately because of other responsibilities. Registrars were also given wider roles in the hospital generally, not only in patient care, but also in assisting in the development of clinical policies. A position of senior registrar was valuable for the paediatrician-in-training as it afforded the holder of the position extensive experience and training. It was also convenient for the hospital administration because the registrar was readily available to provide advice and the registrars were often more knowledgeable about scientific medicine than some honoraries.\(^{52}\) The employment of senior registrars enabled the hospital to defer considering the need for salaried specialists.

The most senior registrar in RAHC was the Chief Resident Medical Officer (CRMO). The holders of this position usually stayed in the post for several years, and some became quite powerful in hospital organisation and in raising the standards of care. A particularly influential CRMO was John Beveridge. Apart from his major role in supervising the work of the residents and registrars, he developed a number of patient care protocols which were adopted by the hospital to, for example, standardise the management of the dehydration caused by gastroenteritis. He was involved in the development of biochemical tests which used very small samples of blood, facilitating the monitoring of serious metabolic disorders and opening up possibilities for research. He also initiated procedures for sending information to general practitioners about the patients they had referred to the hospital. The junior medical staff sought his help with difficult problems, reducing the need for the honorary to be consulted. Like other CRMOs, Beveridge acquired an enviable reputation for the quality of the help and advice he gave to junior staff, which was very valuable in encouraging referrals when he went into private practice.\(^{53}\)

\(^{52}\) Beveridge, interview. Morgan, interview.
\(^{53}\) Beveridge, interview.
As CRMO Beveridge was a quasi-specialist. The hospital had the use of his expertise but did not have to establish a formal staff specialist position, which was not possible in the medico-political climate at the time. The honoraries valued his support in managing clinical problems, but he was also a threat to them and their system, both in the post he held and personally. He demonstrated at first hand the benefits to the hospital that might come from employing salaried staff, but his energy and knowledge, his powerful personality and his abrasive manner antagonised many honoraries who were not as knowledgable as him. 54 Some of his colleagues believe that he was the person most responsible for taking RAHC into the modern scientific era, but he was not in a position in the management structure of the hospital to initiate fundamental changes in the organisation of the hospital. 55

**Medical Organisation**

The work of RAHC steadily expanded in the post-war period, which can be seen from Table 6.1.

Table 6.1. RAHC: Total bed numbers, yearly admissions, average duration of stay.

<table>
<thead>
<tr>
<th>Year</th>
<th>Beds</th>
<th>Admissions</th>
<th>Av. stay in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945/46</td>
<td>412</td>
<td>12,587</td>
<td>13.01</td>
</tr>
<tr>
<td>1950/51</td>
<td>439</td>
<td>11,057</td>
<td>12.11</td>
</tr>
<tr>
<td>1955/56</td>
<td>478</td>
<td>10,948</td>
<td>11.38</td>
</tr>
<tr>
<td>1960/61</td>
<td>488</td>
<td>12,124</td>
<td>9.52</td>
</tr>
<tr>
<td>1965/66</td>
<td>510</td>
<td>15,169</td>
<td>9.0</td>
</tr>
</tbody>
</table>

*Source: RAHC Annual Reports.*

The duration-of-stay figures partly reflect changing disease and treatment patterns and more efficient management, but whatever the cause, the fall and the increasing admissions indicated an increase in the intensity of work in the hospital. The honorary staff frequently looked at ways of making their work more efficient. One approach was to use the committee system. Another was to try to be more readily available for public hospital consultations by moving their private consulting rooms into the grounds of RAHC and by using the private section of the hospital, Wade House, for their private

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54 Ibid.  
55 Morgan, interview.
patients. In this way some of the honoraries attempted to be closer to the concept of “geographically full-time.”\textsuperscript{56} This term had previously been used in this sense in the early development of scientific medicine in the US at the beginning of the twentieth century.\textsuperscript{57} The difference here was that the honorary doctors in RAHC continued to have a major commitment to their private practices.

The clinical departments of the hospital were also reorganised in recognition of the need for more specialised care. The Surgical Department set an example. In 1950 it decided that each senior surgeon should be involved in both general surgery and a specialist area of surgery. The senior surgeon, Dr T.Y. Nelson, chose neurosurgery, and the others agreed that in order of seniority they would each select their preferred specialist area from thoracic, facio-maxillary, genito-urinary and rectal surgery.\textsuperscript{58}

The Medical Department, in which paediatricians were placed, had a number of different categories of staff — see Appendix Three. The Honorary Consultant Physicians played little active part in clinical work or in the organisation of the hospital. They had been granted an emeritus appointment on their retirement from the active staff, usually on account of age. The Honorary Physicians and the Assistant Physicians were directly responsible for the care of the medical patients admitted to the wards and in the outpatients department. The relieving physicians, permanent or temporary, were younger paediatricians waiting for a more senior appointment. In the relieving role they had little clinical work to do, but with the reorganisation of work they were encouraged to attend departmental meetings. In this department, in 1955, the physicians and assistant physicians agreed to form themselves into five teams and to share an allocation of duties in the wards, in outpatients, and in teaching.\textsuperscript{59} Previously, their responsibilities to the hospital were not clearly defined; the administration had allowed the senior medical staff to make decisions about their pattern of work in the long-held presumption that only clinicians could know what patients needed. They had inherited a tradition of independence, but with the increasing demands for more specialised and more intensive work in the hospital, they had to change if they wished to preserve the honorary system.

\textsuperscript{56} Grigor, interview. RAHC, House Committee minutes, 24 October 1960.
\textsuperscript{58}RAHC, Honorary Medical Staff minutes, 5 April 1950.
\textsuperscript{59}RAHC, Honorary Medical Staff minutes, 7 October 1955; House Committee, 24 October 1955.
Many of the honoraries were aware of what had happened in RCH Melbourne; they admired the progress in scientific medicine associated with the introduction of the salaried system, but they did not want it for RAHC.

Whether an honorary system or a salaried system was the best way to staff a hospital might be debated, and in RAHC and RCH there were strong views expressed by doctors for both approaches. In RAHC the honoraries were determined to maintain their status; in this they might be seen as looking to their own self-interest in maintaining a traditional system with which they felt comfortable and that they believed gave them protection against more government intervention in health care. From 1945 to 1965 the Board of Management of RAHC was actively involved in improving and expanding the physical resources of the hospital, but it did not seek to change the medical organisation in the way that the RCH Committee of Management had done. In this it was strongly influenced by the doctors who were prominent members of the Board.

The Board of Management

As a Schedule One hospital under its own Act of the NSW Parliament, RAHC was managed by a Board of Management. The first Board was elected in 1880 by the subscribers who had established the hospital. Its members then and later included influential businessmen, women prominent in Sydney society and doctors. Ostensibly the Board was elected annually, but in practice the candidates were chosen by the Board and their election never contested. Board members found a replacement following a resignation. Mr Trevor Ward, who was associated with the hospital from 1948, first as an accountant and later as the Director of Administrative Services, recalled:

The Board gave birth to itself and regenerated itself, but the highest principles were followed — we were lucky to have a happy balance of highly motivated people. The Board was really titular rather than active. The main work was done in the Finance Committee. The House Committee attended to the nitty-gritty

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60Royal Alexandra Hospital for Children Incorporation Act, No.8. Assented to 10 September, 1906. The Act provided for the annual election of a president, two vice-presidents (one female), treasurer, secretary, nine female and seven male members. Almost half the Board members retired annually but were eligible for re-election. The Board was elected by the benefactors and the members (those who had subscribed not less than one pound a year). There were also several life-members. There were two representatives of the senior medical staff on the Board, elected by the staff. Salaried staff were not entitled to a seat.
matters. The recommendations of both Committees went to the Board and was a rubber stamping process rather than anything else.61

Chapter Five referred to the strong University influence on the development of RCH, in which the University representatives on the Committee of Management and the Medical Advisory Board provided external standards, derived from their views on academic excellence, for guiding the hospital’s progress towards the paradigm of scientific medicine. While the Board of Management of RAHC included prominent citizens and businessmen, there were no representatives of the University of Sydney, of which RAHC was a teaching hospital. The Professor of Surgery was later on the Board, but he was there in his own right. There was a Conjoint Committee of the Hospital and the University to scrutinise appointments to the honorary staff, but many believed it provided only an endorsement of decisions made by the medical staff and the Board.62 The RAHC Board was, therefore, despite its worthy members, very inward looking and not open to external scrutiny. It is unclear how responsible it was to the people of NSW or to its patients. The legal responsibility of the Board was to the subscribers and to the benefactors, as described in the RAHC Act. Many believe that the doctors on the Board were the main determinants of hospital policy and that there were no effective balancing forces as there were in RCH.63

There was a very strong presence of doctors on the RAHC Board of Management and its committees. The Board had twenty-three members with, in 1945, three doctors who were members in their own right. They included the President and one of the two Vice-Presidents. In addition, there were two elected representatives of the Honorary Medical Staff. The Finance Committee of six had two doctors, the President and Vice President; the House Committee of fifteen had three doctors.64 A similar pattern of medical membership persisted for at least the next twenty years. Doctors were in key positions in the Board of Management and they had a strong influence in the decisions made by that Board. Those doctors had divided loyalties. While they had strong incentives to see RAHC flourish, they were members of other bodies that had interests that from

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61 Mr Trevor Ward, interview by author, tape recording, Sydney, 12 May 1998.
62 Mr Trevor Ward, telephone interview, Sydney, 16 December 1999.
64 RAHC, Annual Report, 1945-46.
time to time would conflict with the interests of RAHC. They were members of the Honorary Medical Staff Association, of their professional organisations, such as the Royal Colleges of Physicians or Surgeons, but most significantly many of them were prominent members of the body representing the organised medical profession, the BMA (NSW Branch). 65 John Fulton, during his tenure of the position of CEO from 1949 to 1965, frequently expressed his regrets that many honoraries had a greater loyalty and made a greater contribution to the BMA than to their own hospital. 66 The medical staff were strongly placed to determine the course RAHC followed in the twenty years following World War II, the period when paediatrics made its most spectacular advances. However, a number of the honoraries who made particularly strong contributions to the development of the hospital had competing agendas.

RAHC and the BMA (NSW Branch)

From the early 1940s through to the mid-1970s, there existed a medico-political climate in Australia in which doctors believed they were threatened with increasing government intervention in health and hospital matters, and even at times, when the Federal Labor Party was in power, nationalisation of the profession. 67 The doctors who worked in public hospitals believed their best protection against further interference was to maintain their independence by continuing the honorary system and by refusing to accept payment for their services in the public system. They were firmly supported by their medico-political organisation, the BMA, in the State branches. During a tour of Australia visiting health organisations, Sir Theodore Fox, the editor of the Lancet, was told that the BMA believed it was in a strong strategic position because “it should be able to anticipate and prevent the introduction of measures which, although seemingly of little consequence, would facilitate the introduction of a nationalised service at a later date.” 68

A number of the doctors who held prominent positions on the medical staff of RAHC and its Board of Management were also prominent in the British Medical Association

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65 Grigor, interview.
66 Ibid.
67 Dewdney, 21, 70, 34. Crichton, 74, 204.
68 Fox, 875-879.
Dr T.Y Nelson, a surgeon, was in a particularly powerful position and his influence on his colleagues and the hospital extended over a long period. He joined the honorary staff as a surgeon in 1923, became senior surgeon in 1944, and retired from the active staff in 1955, when he was appointed emeritus consultant. He represented the Honorary Medical Staff on the Board of Management twice, from 1937 to 1939 and from 1949 to 1955. He was elected to that Board in his own right in 1955, and was Vice President from 1959 until 1966, when he was elected President. Up to 1970 he strongly opposed the abolition of the honorary system and the establishment of salaried positions. So strong was his standing and power in the hospital that few were prepared to argue with him.

Nelson also held strategic positions in the BMA (NSW Branch). He was a Branch Councillor from 1947 to 1965, President from 1954 to 1955, and Secretary from 1957 to 1965. He was a member of two key committees of the BMA; the first being the Medical Politics Committee (from 1949 to 1965) which dealt with relationships between the medical profession and governments and public hospitals. The Committee’s attitudes were clearly stated when it became involved in a dispute between doctors in private practice in Newcastle and the Board of the Royal Newcastle Hospital, which employed a large complement of staff specialists. The Committee, of which Dr E.S Stuckey, also an Honorary Surgeon of RAHC, was the Chairman, reported: “it was agreed that there was an increasing and insidious trend towards socialization of the profession. The more we become involved with payment by the Government, the more likely it is to continue.” Nelson was also a member of the BMA Hospitals Committee from 1951, and Chairman from 1953 to 1965. The committee was concerned, amongst other matters, with the honorary system in public hospitals, the means test and medical representation on boards of management.

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69 The Presidents included W. Vickers, E.S Stuckey, .Lindsay Dey, D.G Hamilton and T.Y Nelson.
70 Beveridge, interview. Grigor, interview.
72 Beveridge, interview.
73 BMA (NSW Branch) Council, Committee Reports. Held in the Mitchell Library, Sydney.
74 BMA, Minutes of the Medical Politics Committee, 16 February 1960.
75 BMA, Medical Politics Committee minutes, 21 February 1961.
This BMA Committee repeatedly supported the retention of the honorary system. It was aware that some hospitals appointed staff specialists, but stated “the practice of employing full-time specialists should cease when honorary specialist services are available.”\textsuperscript{76} The Committee agreed that in some circumstances staff specialists could fill certain positions. They included those of pathologists, radiologists, radiotherapists, clinicians in thoracic departments (which were concerned with tuberculosis and not attractive to private practitioners), neuropsychiatry, and anaesthesia. Salaried staff could also have positions in certain fields of investigation, treatment and research where there was little opportunity for private practice, and where a full-time appointment was essential. They could also be in professorial departments where much time was spent in teaching as well as in patient care.\textsuperscript{77}

Even where staff specialist positions were tolerated by the BMA, candidates for employment were discouraged from applying because the Association disapproved of their having a right of private practice.\textsuperscript{78} The Hospitals Commission and the teaching hospitals allowed some staff specialists a limited right of private practice. It meant that their expertise was available to the whole community. It provided a small addition to their personal income and generated funds for study leave and research. The Commission believed that the availability of private practice assisted in the recruitment of staff specialists, but the BMA saw it as unfair competition. Until the mid-1960s at least, the BMA (NSW branch) was strongly opposed to the appointment of salaried medical staff in public hospitals when it disadvantaged doctors in private medical practice.

By the mid-1960s there were some indications that attitudes towards the remuneration of doctors in teaching hospitals were changing. Opposition to full-time salaried posts continued, but some honoraries considered that sessional payment was inevitable. Representatives of the RAHC told a BMA conference that the visiting staff should spend more time in the hospital, and that they favoured adequate payment for patient care and teaching. The representatives of the two largest teaching hospitals in Sydney, Royal Prince Alfred Hospital and Sydney Hospital, disagreed. They wanted the

\textsuperscript{76}\textit{BMA, Hospital Committee minutes, 1 November 1955.}
\textsuperscript{77}\textit{BMA, Hospital Committee minutes, 25 July 1956.}
\textsuperscript{78}\textit{BMA, Hospital Committee minutes, 25 July 1961, 25 August 1964.}
honorary system to continue.\textsuperscript{79} The honorary staff continued to hold a position of power in RAHC, but their privilege as the sole provider of medical advice to the Board was being challenged by a new authority in the hospital, the Chief Executive Officer, who held both medical and administrative qualifications.

\textit{Administration and the Chief Executive Officer (CEO)}

The period following World War II saw the rise of new positions of authority in the management of public hospitals in NSW — the professional medical administrators, usually called the Chief Executive Officers (CEOs). The doctors who held these positions were responsible to the boards of management for the complete superintendence of the hospitals. They could legitimately provide medical advice to the board because of their medical knowledge, and were therefore a threat to the medical staff associations that had previously held a monopoly in this area.\textsuperscript{80} Depending on their skills, their personalities and their relationships with the Board, the CEOs had the potential to influence the development of the medical components of their hospitals, including specialization. Previously, the hospital executives were responsible for only the efficient running of hospitals to ensure that the various health professionals could carry out their tasks. They might be assisted by a medical superintendent or chief resident medical officer, whose main role was in organising the junior medical staff, but with no authority over the senior staff, the honoraries.

In RAHC, between 1930 and 1949, the combined post of CEO and Medical Superintendent was held by Dr S.W.G. Ratcliffe. He was the first medical administrator of any standing in NSW, at a time when most medical administrators were relatively junior, but he was in the category of an executive with a limited role. The hospital chief accountant, Trevor Ward, recalled: “He was very autocratic. He basically controlled the Board — they sat there like mummies as he told them what to do. He was a very efficient business administrator, but he did not have a vision for the future for the

\textsuperscript{79}BMA, Hospital Committee minutes, 22 September 1964, 23 November 1965.
\textsuperscript{80}Crichton, 145-148.
children’s hospital.\(^{81}\) Nor did he participate much in the making of policy on medical matters, which was firmly in the hands of the Honorary Medical Staff.\(^{82}\)

Ratcliff was succeeded in 1949 by Dr John Fulton, who was an example of the new type of CEO, as was Vernon Collins in Melbourne. Fulton did not, however, possess the controlling authority held by Collins in Melbourne, nor, as discussed later, by McCaffrey in Newcastle. Dr Douglas Pettinger, the Assistant Medical Superintendent, recalled in 1998 that Fulton was a career medical administrator who came to Sydney from extensive administrative experience in Tasmanian hospitals. He was seeking a post as CEO in a teaching hospital. He applied for the RAHC position because he considered it to be of an appropriate status to match his qualifications, and it was the only one likely to be available for some time. He had no background in paediatrics and no specific interest in children’s hospitals.\(^{83}\) Compared with Collins, this put him at a disadvantage in his dealings with paediatricians.

Fulton was associated with a number of substantial developments in the hospital. They were largely in physical structures, the major one being the construction of the new outpatients department at the main hospital. Others included a special diet kitchen, the installation of piped oxygen to the wards (an innovative step), and a reorganisation of the medical record system.\(^{84}\) A Chairman of the Board of Management wrote that Fulton had “administrative ability of exceptional degree…possessing vision and initiative, (he) was able to look into the future, to see the need for improvements and how they could be effected.”\(^{85}\) On the evidence available these remarks over-estimate Fulton’s ability to change the medical organisation of RAHC. Fulton was seen by his colleagues on the medical staff as a competent administrator, but lacking the vision which was so apparent in Melbourne. He fostered an environment in which change could take place. He was ready to listen to new ideas and support them strongly if he

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\(^{81}\) Ward, interview.

\(^{82}\) RAHC, Honorary Medical Staff minutes. From a reading of the minutes the Staff made most of the decisions on medical matters without involving the administration, in contrast to the later situation where the CEO was often involved.

\(^{83}\) Pettinger, interview.

\(^{84}\) Ibid.

felt that they had merit, but he did not initiate or contribute himself to proposals which advanced paediatrics as such.  

The physical changes in RAHC were important but they did not alter the medical organisation of the hospital, which Fulton and certain other doctors on the staff considered essential if the hospital was to become a modern scientific children’s hospital. Fulton would have liked RAHC to follow the course set by RCH and have full-time salaried medical staff in key positions in the clinical departments of the hospital. Collins and Fulton were good friends and had frequent discussions about hospital organisation on visits to each other’s hospitals. Unlike Collins, Fulton was not able to bring about a change in the pattern of medical staffing. A friend and paediatrician, John Beveridge, later reflected: “Fulton did not have the power or the strength (to bring about these changes). The other fellows [the senior honorary medical officers] would just ignore him.”

Fulton was greatly concerned that the medical organisation at RAHC was inefficient and that it had not advanced in line with modern views on hospital management. He noted that there were 131 visiting honoraries whose lack of organisation caused enormous problems for the medical and nursing administration. While the honorary staff believed that the use of committees would improve patient care, Fulton thought that their large number provided an inefficient system that could be largely replaced by having “a good hard core of full-time clinicians on the staff with administrative roles.”

He was well aware of the difficulties he faced in trying to bring change to RAHC. He believed the honoraries were not able to weigh impartially the hospital’s priorities for patient care and, perhaps unconsciously, allowed their personal vested interests to intrude. He was also well aware that in most Australian hospitals the medical staff feared the appointment of full-time medical directors or chiefs of service.

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86 Pettinger, interview.
88 Beveridge, interview.
89 John Fulton, “Changing Patterns in Hospitals,” Lecture to the resident school in hospital administration, University of New South Wales, 12 August 1964. File A20, RAHC Archives, Sydney.
90 John Fulton, “Problems of Medical Staff Organisation and Relationships” Notes for a lecture to the School of Hospital Administration, University of NSW, 9 April 1963 File A20, RAHC Archives, Sydney.
Fulton accepted that the honorary medical officers had a place in the hospital. They performed useful work and were valuable in providing links between the hospital and the community, but he did not believe that they could adequately fill the key positions so essential for the progress of the hospital. He believed that honoraries also had serious shortcomings. They spent too little time in the hospital, they gave priority to their private work, and travelling to the hospital was time-consuming. They were often unpunctual in attending their hospital duties which disorganised the work of the operating theatres and wards. Many were so busy that they could not keep up with their reading of current medical literature, nor could they satisfactorily attend hospital educational and staff organisation meetings. The hospital expected a high quality of work from the medical staff, but there was no way of dealing with honoraries who did not do what was expected of them. They believed they were not subject to the ordinary disciplinary measures applying to employees. Honoraries were not “hospital minded.” Their main professional interests lay elsewhere.\textsuperscript{91} In the US, Frederick Gates had expressed the same sentiments at the beginning of the twentieth century. Modern hospitals and scientific medicine required that doctors give themselves full-time to the hospital.\textsuperscript{92}

The relationships between Fulton and many of the honoraries were often difficult. Pettinger said: “It may be that he would have preferred to get rid of all the older ones on the staff. He felt insecure with the older people, and could not implement his plans while they were around. (He) got on much better with the younger members of the medical staff because he could better mould them to his ideas and concepts.”\textsuperscript{93} It was the senior honoraries who held the power in the hospital and they also had a strong influence on the Board of Management. Fulton would have had to change the minds of both groups if the staffing structure of RAHC was to be changed, but he was not successful in this, unlike Collins in Melbourne.

The position of the CEO in RAHC was difficult. In most commercial organisations the CEO provided a link between a governing body and the employees, who were directly responsible to him. All communications went through the CEO. In RAHC the position

\textsuperscript{91}Ibid.
\textsuperscript{92}Berliner, 5.
\textsuperscript{93}Pettinger, interview.
of the honorary medical staff in this regard was unclear for they were not employees in
the usual sense. They had direct access to the Board through their elected
representatives and there were other doctors on the Board in their own right. They were
all free to express their opinions, which were influenced by their medico-political
connections. Fulton had no argument with his Board seeking information and advice
from the medical staff but he was greatly disturbed by the massive influence on the
Board of doctors who were actively working in the hospital. He believed, as an
experienced medical administrator, that the medical staff should have only an advisory
role to the Board of Management; as voting members of the Board their presence could
result in undue weight being given to the vested interests of the doctors.94 Fulton shared
these views with Dr Malcolm MacEachern, a prominent American authority on
hospitals and medical administration who visited Australia in 1926 and 1953 at the
invitation of several state governments. MacEachern stated that where medical staff had
voting rights on a governing board of a hospital, both sides were potentially
compromised. He strongly advised against having politicians of any category, including
medical politicians, on these boards.95

The Honorary Medical Staff

The honorary system dominated the staffing of most large public hospitals in Australia
up to the 1970s, except in Queensland. In RAHC, up to that time, the honoraries
indicated clearly that they considered that the honorary system was the best form of
staffing for their hospital. They believed they provided good patient care and that they
had made worthy efforts to meet the demands of scientific medicine. They were aware
of what had occurred in another children’s hospital in Australia, the RCH in Melbourne.
They acknowledged that this hospital, in scientific medicine and hospital organisation
and research, was “was light years ahead of us.”96 Their ambivalent position was

94 Fulton lecture, 1963.
95 Malcolm T. MacEachern, Hospital Organisation and Management (Chicago: Physicians’ Record Co.,
1935), 80. James A. Gillespie, The Price of Health: Australian Governments and Medical Politics 1910-
visited RAHC in 1953.
96 Beveridge, interview. Grigor, interview.
determined, however, by other more powerful forces operating in the medico-political arena.

The honorary staff at RAHC were not alone in Sydney in wanting to retain the traditional system. The staff of other teaching hospitals in NSW had similar views. The representatives of the honorary medical staff associations of all the Sydney teaching hospitals met in 1944 at a convention organised by the BMA (NSW Branch) to provide a response to Federal Government proposals on medical practice in hospitals. The delegates agreed with the Government’s proposals on preventive health measures but declared unacceptable the proposed free medical service, because the resulting contract between the Government and the doctor would interfere with the doctor-patient relationship, an argument often used by doctors in these circumstances. The convention recommended that honorary services should continue for indigent patients. This raised the question of defining the meaning of the term, “indigent” and the related problem of the introduction of a means test. The honorary doctors were angry because some patients who were not indigent were being admitted into public wards. Those in the children’s hospital were in an awkward position. They accepted that they should provide free care for poor people and they also felt that all children should have access to the best medical treatment. They were pleased that patients of all social classes chose to take their seriously ill children to RAHC, attracted by the reputation it had gained for expert care, but like their colleagues in adult hospitals, they did not want to provide free treatment for patients whose parents could afford private care. This was a vital issue for a specialty in which doctors in private practice had struggled financially for a long time.

On a number of separate occasions between 1945 and 1965 the Honorary Medical Staff Association of RAHC repeated its expression of support for the honorary system, but some occupational groups within the hospital were beginning to think differently. With the increasing complexity of surgery and with operations of longer duration, honorary anaesthetists were being asked to provide much more time to the hospital. As early as 1950 they requested that they be paid for their public work, but were not

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97 RAHC, Honorary Medical Staff minutes, 18 August 1944.
98 RAHC, Honorary Medical Staff minutes, 25 February 1945, 2 November 1945.
99 RAHC, Honorary Medical Staff minutes, 3 May 1952, 16 November 1953, 15 January 1962.
supported by the Honorary Medical Staff Association. Later, after further discussions the hospital agreed to pay them for their sessions. A staff specialist was appointed in 1954 and the full-time position of Director of the Department of Anaesthesia created in 1957. A staff radiologist was also appointed in 1954, largely for cardiac work.

The need for more general changes surfaced in the 1960s. The Professor of Child Health, Thomas Stapleton, suggested in 1961 that there should be a mix of full-time staff and honoraries. Honoraries were important for maintaining contact between the RAHC, the community and the suburban hospitals. He agreed that only a small number of salaried specialists were needed. For example, in medicine there should be a staff specialist in each of the five medical teams, to be involved in research and clinical investigations and to ensure continuity of patient care. His physician colleagues did not agree with Stapleton but, recognising the need of the hospital for more of their time, suggested again that their private rooms be located close to the hospital.

The next year at RAHC the senior medical staff held a special meeting on staffing. The participants acknowledged that they would have to spend more time in the hospital if it was going to provide high quality medical care. They reaffirmed the view that the honorary system was the best system for teaching hospitals, including RAHC, agreeing that “the use of full-time staff above registrar grade for general duties is not recommended and should be limited to specialised fields, research and professorial units.” However, there was some dissension within the group. A conjoint committee of physicians and surgeons, while opposed to full-time salaried appointments, recommended that visiting staff be paid; but the Honorary Medical Staff Association itself did not agree. Staffing was discussed again in 1965. At the request of the CEO

100 RAHC, Honorary Medical Staff minutes, 23 May 1950.
101 RAHC, Honorary Medical Staff minutes 31 May 1953, Annual Report 1954/55; House Committee minutes, 29 July 1957.
102 RAHC, House Committee minutes, 22 November 1954.
103 Thomas Stapleton, Letter to Honorary Medical Staff, May 1961. Copy in Honorary Medical Staff minutes.
104 RAHC, Honorary Medical Staff minutes, 7 August 1961.
105 RAHC, Honorary Medical Staff minutes, 15 January 1962.
106 RAHC, Honorary Medical Staff minutes, 15 January 1962.
the honoraries appointed a subcommittee to prepare a complete report on the medical staffing of the hospital, including payment. 107

This marked the beginning of serious considerations that the medical staffing system in RAHC should change, but it was not until 1971 that the first staff specialist paediatrician was appointed. 108 RCH had reached a similar stage in hospital development twenty years before. Nonetheless, RAHC had developed scientific medicine to some degree, to which the honorary paediatricians had made considerable contribution. However, progress towards the full adoption of the scientific medicine paradigm was hindered by the determination to retain the honorary system. Despite his aspirations as a medical administrator for the full-time system, the CEO was not powerful enough to change the views of the honoraries or the Board, which they controlled.

The Nursing Staff

Numerically the nursing staff far outnumbered the doctors, but there is little evidence that they had any significant part to play in the development of hospital policies up to 1965. The nursing service, under the Matron, was an autonomous division within RAHC, with its own budget. The Matron attended the meetings of the House Committee of the Board, by invitation but did not have a vote. Ward believes that in the times of both Ratcliff and Fulton she had little influence on hospital policies. He recollected: “Policy was announced to Matron, she was not consulted.” 109 There is no evidence that nurses were part of any of the numerous committees set up by the Honorary Medical Staff Association. The nursing staff had little power to influence the development of paediatrics in the evolutionary phase up to 1965.

107 RAHC, Honorary Medical Staff minutes, 3 May 1965.
109 Ward, telephone interview, 1999
Research

Crichton has argued that up to the 1970s there were insufficient resources in Australia to produce new scientific knowledge from fundamental research, or to produce major technological advances. Any new knowledge was brought in by doctors who had visited other countries, particularly the UK or the US, or by visitors who came from overseas. She says that during the 1940s and 1950s such new information became much more acceptable with cultural changes in what had been a narrow and provincial environment.\(^{110}\) These remarks are not entirely true for paediatrics. There was some research in both RCH and RAHC, but systematised research producing new knowledge was rare.

In paediatrics, knowledge came to Australia in medical journals and texts, although Hamilton recalled that the library at RAHC was of poor quality in the 1940s and he was uncertain how much his colleagues read what material was available.\(^{111}\) New medical knowledge and techniques also came in other ways. Some were brought in by Australian paediatricians who had been studying abroad, or by visitors who came from overseas to participate in educational forums and conferences. Some made a particularly strong impression. A senior physician in RAHC has remarked on the effects of a visit of an American paediatrician, Dr Ashley Weech, in 1957. He brought new information to the paediatricians of Sydney, but in particular he made the doctors in RAHC acutely aware how far behind the US they were in their pursuit of the scientific medicine paradigm. The connections established by the visit led to increasing numbers of young paediatricians going to the US to complete their training.\(^{112}\) The US was a leader internationally in medical research, in programs strongly reinforced in the 1930s by academic elites in universities, teaching hospitals and research institutes.\(^{113}\) By the late 1950s many young doctors in Australia were interested in acquiring research experience so it is not surprising that they were attracted to the US rather than to the UK.

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\(^{110}\) Crichton, 203, 204.

\(^{111}\) Hamilton, interview.

\(^{112}\) Ibid.

There was a recognition by some doctors in Australia of the benefits of the US approach to the development of medical science. Vernon Collins was an example. However, that recognition was often qualified. The Professor of Medicine at the University of Sydney in 1965 expressed his strong support for the development in Australia of the US system of fully integrated hospitals engaged in research, teaching and patient care, with full-time salaried staff. The medico-political climate forced him to modify his views, however. For the time being some compromise was necessary, as it had been in the UK, resulting in what he called “moderate integration.” The honorary medical officers had to be accommodated, and he felt that their role would not be lessened by having university professors as heads of clinical departments.\textsuperscript{114}

Organised paediatric research had begun in Australia in RCH, Melbourne, with the establishment of the Clinical Research Unit in 1948. In RAHC a small number of doctors had carried out successful research, with some achieving international recognition. For example, Clubbe gained recognition for his work on intussusception in the 1900s; Harper for hers on cystic fibrosis and Gregg for observations on rubella and its effects on the foetus. These research projects were carried out by practicing clinicians during the course of their everyday work. They were the result of individual efforts rather than corporate endeavours of the hospital or its staff.\textsuperscript{115}

The atmosphere in RAHC was in many ways not conducive to research, with most of the medical staff, as honoraries, spending only a small amount of time in the hospital. When the hospital was seeking to appoint a Professor of Child Health in 1949, with one option being to appoint a young academic paediatrician from overseas, a pathologist commented that the hospital had little to offer “a bright young whip from England.”\textsuperscript{116}

In the early post-war period the RAHC Board of Management showed little commitment to research, although the Honorary Medical Staff Association declared that


\textsuperscript{116}Stephen Williams, (Microbiologist) Letter to Dods congratulating him on his appointment as Professor, 12 December 1949. Dods papers. P172, Series 1, Item 1, University of Sydney Archives, Sydney.
it encouraged research and investigational work, and a clinical trials committee was set up in 1951.\textsuperscript{117}

RAHC was offered an opportunity to become involved in research early in the post-war period. In 1949 the Commonwealth Department of Health decided to establish an Institute of Child Health in the School of Public Health and Tropical Medicine. The University of Sydney agreed that the head of this unit be appointed Professor of Child Health and RAHC agreed to provide clinical facilities and accommodation. The stated role of the Institute was to provide advice on child health matters to the Commonwealth and to engage in teaching and research. It was anticipated that an institution would be created comparable to paediatric research institutions overseas, and that it would have a valuable influence on the development of the hospital services.\textsuperscript{118}

Lorimer Dods, who had been an honorary physician in RAHC since 1927, was appointed the first Director of the Institute, and Foundation Professor of Child Health, in 1950. At the opening ceremony he said that the Institute would concentrate on research in growth and development, nutrition, organic disease and psychological problems.\textsuperscript{119} From 1950 and 1965 the Institute produced 146 papers. While a few were related to clinical research in rheumatic fever, tuberculosis, cardiology and other topics, others were topic reviews, which did not always reflect original work. Dr F.W. Clements, Senior Lecturer in Child Health from 1952 to 1969, produced the most papers, totalling sixty-one. They were on social paediatrics and epidemiology, and while they were valuable scientific contributions to paediatrics in general, they did not have an application in a hospital trying to develop scientific medicine directed to the diagnosis and treatment of disease.\textsuperscript{120}

Observers in RAHC largely agreed about the Institute’s research record and its effects on the hospital. A senior honorary physician commented in 1998: “The Institute’s role was mainly clinical and teaching. The Institute could not have been seen to be a

\textsuperscript{117}RAHC, Honorary Medical Staff minutes, 5 May 1948, 8 August 1951, 7 February 1955.
\textsuperscript{118}RAHC, \textit{Annual Report}, 1948/49.
research institute in any way, even though Lorimer was keen on research and wanted young people to do it. It was not really an established research foundation. Another said Dods’ main contributions to the hospital were in areas other than research:

The Institute of Child Health had a seminal influence on the Hospital…Lorimer was such a charismatic figure and such a good clinician and such a good teacher that he spawned a lot of young doctors who wanted to be paediatricians…what Lorimer started was the groundswell of young people wanting to do paediatrics and going on into paediatric medicine and to a lesser extent into paediatric surgery.

Dods himself admitted that the Institute of Child Health was not an effective research organisation, saying in 1959: “RAHC is one of the largest and best equipped hospitals in the world, but there is no special research department.” There were moves in the late 1950s to establish another organisation. Dods and others, particularly John Fulton, the CEO, began to develop the Children’s Medical Research Foundation (CMRF).

In contrast, in RCH the members of the Clinical Research Unit were engaged in clinical and laboratory research from 1948. Some of the honorary medical staff, later known as the visiting staff, were also seriously involved in research in the early postwar period. Observers noted, and it was embarrassing to many from Sydney, that at the annual meetings of the Australian Paediatric Association papers reporting original research from RAHC were few compared with many from RCH. In RCH research had provided a stimulus to the development of new knowledge and techniques which had improved patient care and enhanced the status of the investigators involved, many of them practising paediatricians. The status of the hospital and the other paediatricians was also raised. RAHC did not benefit to the same degree because research there was limited and the capacity to follow the scientific medicine paradigm reduced.

Dods wished to foster research but admitted that he was not trained or skilled in that area. While there were mixed views on the influence of the Institute of Child Health on RAHC there are few dissenters about the positive influence of Dods on promoting

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121 Grigor, interview.
122 Morgan, interview.
125 Beveridge, interview. Grigor, interview.
paediatrics as a specialty in NSW and stimulating the aspiring young paediatricians who worked with him. His influence was Australia-wide. An Adelaide paediatrician, secretary of the Australian Paediatric Association, said of Dods in 1958: “You are our fountainhead.”

It is surprising that he did not have a greater influence on his colleagues in RAHC and that he did not challenge them to examine more critically the pattern of organisation of medical work in RAHC, for he strongly supported the principle of scientific medicine.

Dods saw his role as teaching medical students and postgraduates, in promoting RAHC in the community, and in developing networks of influential people to support the hospital. One can speculate that he believed that it would have been too difficult to build a research unit in RAHC like those that had been so successful in the US and in RCH. To be fully effective in clinical research the senior staff would have had to be employed full-time and hold clinical positions. The Medical Staff Association was firmly against such appointments and it would have been necessary to mount a very strong challenge to bring change. Dods believed that such action would have been divisive and destructive, and would have provoked serious conflicts between staff members and between the medical staff and the administration. A colleague noted that while Dods was usually very successful in influencing people he never wished to offend them. He promoted accord rather than discord and therefore did not challenge the honorary system in RAHC.

Conclusions

Chapters Five and Six have shown how a children’s hospital, RAHC, played a central role in determining the way in which paediatrics developed in NSW between 1945 to 1965. The evolution of that hospital has been contrasted with that of the RCH.

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127 Beveridge, interview.
Melbourne. At the time paediatricians accepted that the successful development of a specialty depended on how effectively it adopted the scientific medicine paradigm. For this purpose a children’s hospital supplied the workshop in which paediatricians learnt to apply the newly available scientific knowledge. It provided a sanctuary from the competitive gaze of adult physicians and a venue where they could build a corporate professional identity.

The successful creation of a new scientifically aligned specialty meant that the medical staff had to devote more time and energy to the hospital, for both clinical work and in the organisation of the delivery of services. This was difficult for the doctors in RAHC because they had determined to maintain the honorary system, an ideological decision for a professional group fearful of a loss of independence with increasing government intervention in health matters. They were then obliged to give private practice a high priority resulting in their having limited time to give to the hospital for scientific and service development. It was therefore a self-oriented decision, but not without precedent. The dilemma of choosing between public duty and professional self-interest had been faced by paediatricians in other countries such as Germany, the UK and the US.129

With ample good will the doctors tried to make the honorary system work by giving more of their time to the hospital and through the development of committees and advisory groups. These moves were also strategic concessions put in place while they were working to preserve what they saw as their long-term interests. In RAHC the doctors were free to make decisions about the future development of the hospital and its services. They directed the policies of the hospital through their influence on the Board of Management. The medical administrator, despite his aspirations for a full-time system, was unable to change the way the hospital worked in the face of the opposition of the doctors and the Board.

In contrast, in RCH, Melbourne, the honoraries were not in any position to make decisions on how they were employed. The Committee of Management was in control, with firmly laid plans for the development of the scientific medicine paradigm,

influenced by elite academic ideas of excellence in teaching hospitals. Working through a strong administrator the Committee abolished the honorary system and paid the doctors for their services, either in salaried or sessional arrangements. This allowed for the development of strong clinical and research departments. For their part, the doctors met the service needs of the hospital and found that the hospital supported their professional ambitions. Those who wished could still conduct their private practices, with their status enhanced by working in the prestigious RCH.

There were no objective means available for assessing the relative merits of the two children’s hospital in terms of the quality of care offered to their patients. The measure of hospital quality at the time was the capacity to provide services that conformed with the scientific medicine paradigm. On this criterion RCH was superior to RAHC. This opinion is supported by the testimonies of several experienced paediatricians in RAHC. There is also confirmation in the evidence that all the other children’s hospitals in Australia, including RAHC, eventually adopted the RCH pattern of medical organisation and research. The essential element in the new pattern was the replacement of honorary staff by salaried staff. In the one area in which RAHC matched RCH, cardiology, the honoraries worked more like staff specialists.

The merits of the full-time system for establishing scientific medicine had been confirmed elsewhere. In the late 1800s American paediatrics had followed the same course in establishing elite children’s hospitals and research departments during the first phase of scientific advances in the diseases of children. A critical factor then, as in Melbourne in the 1950s, was the employment of full-time clinicians able to devote their whole time to the hospital.130

The pattern of development of the two hospitals affected the way paediatrics developed in the respective states. In NSW paediatricians largely revolved around private practice. In Melbourne, while private paediatric also prospered, a more balanced approach evolved. The management of RCH ensured that the doctors fulfilled their obligations to the hospital, which was more readily able to offer comprehensive services to the public.

130Halpern, 57-61.
and to develop new ones. In their own ways both children’s hospitals provided bases from which paediatrics could expand.
CHAPTER SEVEN

THE PAEDIATRIC UNITS IN GENERAL HOSPITALS

Introduction

This chapter aims to analyse, through the study of the paediatric services in several different hospitals, how specialized health services for children developed outside of RAHC, and how they contributed to the development of paediatrics in NSW. While most of the new children’s services followed, as much as resources allowed, the pattern of RAHC, some attempted to approach children’s services in innovative ways.

Chapters Five and Six have shown how the earliest developments in paediatrics in NSW took place in RAHC. Geographically, this hospital was centrally placed in Camperdown, an inner suburb of Sydney. Not far away, in Macquarie Street, most of the paediatricians had their private consulting rooms. Over the twenty years following World War II paediatricians progressively established peripheral practices, distant from the centre, in the larger suburbs and major regional centres in NSW. They believed it would be easier to establish themselves away from their colleagues entrenched in central Sydney. In the 1940s and early 1950s, entering private practice in paediatrics was still a financially risky undertaking, and the competition with doctors returning from the war and newly qualified paediatricians all seeking places was fierce. Setting up a private practice was a business undertaking and the services offered were subject to market forces. In the suburbs and regional centres premises were less expensive than in Macquarie Street and the paediatricians were closer to their referring doctors. They believed that they could make their knowledge and skills in child care accessible to a larger number of children. The specialty itself stood to benefit as decentralisation had the potential to make more people aware of what paediatrics had to offer. The move from the centre, however, was not without difficulties for the paediatricians. They were exposed to increased competition for occupational space from other specialties, and were without the protective umbrella of the children’s hospital.
In the period when scientific medicine was the ruling paradigm most paediatricians believed that they needed to maintain contact with the centre of paediatrics in the State. Even those who practised in the suburbs of Sydney wished to have an appointment as an honorary paediatric physician at RAHC. At first this was in a relatively junior category that did not give them access to beds. Such access was granted only to the senior physicians. The new paediatricians believed, however, that the status associated with being on the staff of the children’s hospital was vital to their successful future as specialists.¹

There were paediatric beds that they could use in the larger public general hospitals in the suburbs and regional centres, often near to where they practised. The paediatricians sought or were offered posts as honorary paediatricians in these hospitals, which enabled them to look after their patients in the children’s wards, near the patient’s family home. Access to a suburban hospital provided opportunities for the new consultants to develop links with the local general practitioners and to gain their confidence by demonstrating their professional competence. The suburban hospitals did not have a full range of facilities for children, but the more difficult cases, such as those which required intensive care or special investigations, could be sent to RAHC.

Before the paediatricians went to the suburbs the children’s wards in the peripheral hospitals were used by general practitioners and by certain specialists such as general and orthopaedic surgeons, ophthalmologists and ear, nose and throat surgeons. In some, general physicians looked after children with medical problems. Occasionally they invited a paediatrician from Macquarie Street to consult about a sick child or a baby in difficulties. These then were the doctors who largely controlled the children’s wards and who held the occupational spaces the new paediatricians wished to enter.

¹ Some paediatricians who worked in the suburbs early in the post-war period included Dr. Kate Winning who was appointed honorary paediatrician at Ryde Hospital in 1939; her rooms were in Macquarie Street. Dr. Stanley Bradfield was appointed to Bankstown Hospital in the late 1940s, he was also in general practice in that area. Dr. John Alexander was a paediatrician in Canterbury Hospital and he had specialist consulting rooms in Campsie from 1950’s. Dr. D.G. Hamilton, interview by author, Sydney, 24 February 1998 and letters to author, Sydney, 24 February 1998 and April 1998.
One might expect that in the suburbs and rural areas there would have been a greater influence on the development of children’s services in the local hospital from people who lived in the area, but there is little evidence that citizens in NSW expressed formally any views on clinical services for children, although they were often involved in fund-raising. The parents of a child who had experienced a long acquaintance with the health system said that they believed it was a general view that if people thought they needed special medical services then they would lobby the Government rather than approach the local hospital. Shortly after they moved to Blacktown, a new outer suburb of Sydney, in 1963, Mr and Mrs “Clark” became members of the Blacktown Hospital auxiliary. They helped raise money for equipment for the hospital but were never asked to be part of any hospital planning system. There is no evidence that hospitals sought to involve the surrounding community in their planning for children’s services. Most developed adventitiously, without specific planning, but with some direction provided by the local doctors, who may have included paediatricians. The degree to which the children’s ward and other children’s services developed often depended on the enthusiasm of the paediatrician and the time he had to offer the peripheral unit, which was usually just one of his professional commitments.

**Paediatrics in Western Sydney**

From the late 1930s hospitals in the western parts of Sydney began appointing doctors to the positions of “honorary paediatrician.” They were primarily local general practitioners interested in children or were specialists who from time to time visited the hospitals for consultations from their rooms in Macquarie St. Sydney.

Dr D.G. Hamilton was probably the first paediatrician to establish a specialist practice in the suburbs of Sydney, in the 1940s, and his experiences illustrate the difficulties faced by paediatricians in creating their own occupational space distant from central Sydney and the children’s hospital. Hamilton began his paediatric training before the war, and on his return from military service in 1946 obtained an appointment as a junior

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2 Mr And Mrs ”Clark,” interview no.8 by author, tape recording, 12 October 1999. Mr and Mrs “Clark” were the parents of a child who had surgery for a congenital heart condition and they had had a long association with RAHC
3 Hamilton, interview.
honorary physician in RAHC. He believed he would not be able to make a living in paediatrics alone, as he explained in 1998:

I came back from the war with two children and no money. I did GP for four years at Carlingford and Epping, and was a visiting GP in Ryde Hospital, where I made many friends. In 1950 I restricted my work to paediatrics, partly in Macquarie Street, and partly in Parramatta. I think I was the first paediatrician to establish a practice there, and I was asked to join the staff of Parramatta Hospital shortly after.4

Hamilton said it was four years before he felt he was sufficiently well known for his paediatric skills, from his work in RAHC and from his contacts with local doctors, to give up general practice. He began consultant practice; one day each week in Macquarie Street, the rest of the time in Parramatta, while continuing his regular visits, as an honorary paediatrician, to public patients in RAHC and Ryde Hospital.

As a pioneer in a new phase of paediatric development, Hamilton faced numerous problems. One of the most serious was trying to allay the suspicions of the local general practitioners, his main source of referrals. They were worried that he might take patients from them because he was so readily accessible at his consulting rooms in the western suburbs. For that reason he was told he should not have his specialist practice in the Ryde area; it was not big enough, Parramatta was more suitable because it was a much larger centre. Many general practitioners supported his commencing consultant practice but others believed that they had had sufficient experience to deal with most of the problems of childhood. They welcomed specialists such as ophthalmologists and gynaecologists who had special technical skills but paediatricians would take over some of the occupational space they considered theirs. Child care had for a long time been a large part of Australian general practice. They were also concerned that if Hamilton saw a child in consultation he would want to go on seeing it and they would lose their patient.5

Dr Stanley Bradfield was another paediatrician whose medical career was centred in the western suburbs. His widow has described how he trained in paediatrics in Sydney and

4 Ibid.
5 Ibid.
in the UK and returned home in 1935 with a specialist qualification, the MRCP, London. He set up a general practice in Bankstown and became an honorary physician to RAHC, and also had consulting rooms in Macquarie St. He was on military service during the war and on his return hoped to practise paediatrics full-time. His plans were thwarted because he had difficulties in disposing of his general practice, which he was obliged to continue. It was a large and extremely busy practice and interfered with his paediatric work. However, despite the difficulties, he opened another set of specialist consulting rooms in Bankstown. 6 Mrs Bradfield wrote: “My husband’s life was a very busy one, having to travel between Bankstown, Macquarie Street and RAHC, but he was young then and able to cope. Needless to say Sydney traffic was not like it is today.” 7

These examples illustrate the difficulties encountered by some paediatricians in establishing their careers. There were financial constraints that necessitated a second source of income, sometimes from general practice, sometimes from practising as an adult physician. There were the difficulties associated with working in several places, and in the time spent in travel between them. The onerous duties of these paediatricians interfered with their capacity to contribute to the development of scientific medicine in RAHC. Despite the problems of working in the periphery, paediatricians established practices in other suburban areas. Some moved to centres outside Sydney, with one early example being Wollongong.

**Paediatrics in Wollongong**

The first paediatric practice in NSW outside Sydney was established in Wollongong in 1959. Child care in the city was always closely associated with Wollongong Hospital, which in 1950 had about 150 beds, including twenty-five to thirty children’s beds. The honorary medical staff were largely general practitioners, but there were some consulting specialists who regularly came from Sydney; it was practicable to do so because the two cities were relatively close. 8

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6 Mrs Bradfield, letter to author, written with the assistance of Mrs. Ros Osborne, her daughter, Canberra, 23 December 1999. Dr Bradfield was tragically killed in an accident at the age of 45.
7 Ibid.
8 Wollongong Hospital, *Annual Reports* 1949, 1950.
In district hospitals like Wollongong Hospital, most of the local general practitioners were able to join the staff as honorary medical officers. There was usually no set staff establishment and the appointment process was often a casual affair. It was a similar situation for specialists. A paediatrician from Sydney, Dr. S. P. Bellmaine, in 1953, began holding private consultations on one day a week in the city in the rooms of an eye specialist friend. From time to time he was invited to see sick children in Wollongong Hospital, but he cannot recall ever having applied for a position there, nor having any formal notification of appointment. His name, however, appeared in the list of consultant staff members in the hospital’s annual report. After several years his Sydney practice became more demanding and he arranged for a colleague, another Sydney paediatrician, Dr. R. H. Vines, to take over the Wollongong consulting sessions. Without any difficulties Vines was appointed to the hospital for the purpose of attending regular in-patient and out-patient sessions; although formal arrangements were made on this occasion. Wollongong Hospital recognised that he could only offer the paediatric service a small part of his time because he also practised privately in Sydney and had an appointment at RAHC.

Wollongong Hospital began to expand from the early 1950s to meet the demands of a rapidly increasing population. It changed from being a small district hospital and gradually acquired an organisational structure similar to that of a metropolitan hospital. The first steps towards the goal of becoming a specialist referral hospital only occurred in 1962 with the institution of a strict classification of the medical staff. This meant that the honorary medical officers could only hold positions for which they possessed appropriate training and experience, and there was a set number of posts in each specialty.

Before this occurred, a fully qualified paediatrician, Dr Ian Dunlop, went to live in Wollongong. He established a private consultant practice and was appointed as Honorary Paediatrician to the hospital in 1959. Vines then gave up his appointment because it would have been difficult to compete with a specialist who resided in the

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10 Dr. S. P. Bellmaine, telephone interview by author, Sydney, 22 August 1998.
city. Dunlop was the sole paediatrician in Wollongong and at Wollongong Hospital until 1968.12

In Wollongong there evolved a pattern for the development of a paediatric service in a regional centre, in what might be considered a relatively conventional process, with gradual steps to specialization. At first general practitioners provided all the care for children. Then came the occasional or regular visits by Sydney-based paediatricians for consultations. These visits enabled general practitioners in the region to evaluate the work of paediatricians and paved the way for one to reside and practise full-time in the area. Sometimes there was an intervening stage in which a general practitioner gained skills in paediatrics and opened a part-time specialist practice alongside a general practice. There were, however, some hospitals that elected not to follow the conventional pattern.

_Paediatrics in the Royal North Shore Hospital_

Paediatric services in the Royal North Shore Hospital (RNSH) followed a course which was different to the other suburban hospitals. RNSH was a very large public general hospital serving most of Sydney north of the harbour in the post-war period. From the 1940s the Chairman of the Hospital Board, Sir Norman Nock, had aspirations for the hospital to become one of the major specialist hospitals of Sydney. His planning was advanced when it became a teaching hospital of the University of Sydney in 1948. The management of RNSH originally planned to have a large children’s unit, with eighty beds, which one might have expected to develop a range of sophisticated, scientifically-oriented services, similar to those which were being developed for adults.13 That, however, did not occur. Paediatrics continued to function at a district hospital level, that is, it treated the common illnesses of childhood that required hospital admission, but did not develop special services such as intensive care or complex investigative facilities.14 There were a number of possible reasons for the modest level of development. Only about thirty or forty beds were available for children because the others were

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14 Dr Roger Vanderfield, interview by author, North Sydney, 12 November 1997.
appropriated for adults (the hospital had 500 beds). With only a small number of patients occupying less than 10 percent of the total beds, paediatrics would have had difficulty competing for funds against the larger, stronger and more ambitious adult services. There was not the infrastructure of resident staff, particularly registrars, to manage seriously ill children. It was uneconomic to try to duplicate the high-level technology services of the children’s hospital which was relatively close by at Camperdown. Some of paediatricians of RNSH also had appointments at RAHC and it was practical to transfer the more difficult cases. This was possible because paediatricians were not subject to the one-hospital one-doctor rule of the Sydney teaching hospitals, which restricted honorary appointments to one teaching hospital.\textsuperscript{15} The main reason that the hospital retained a modest in-patient service for children and did not become ensnared in high technology medicine was because the senior paediatrician, Dr Claire Isbister, had her own ideas on the role of a district hospital. She believed in a broad approach to child health, and she had a special interest in a particular facet of preventive paediatrics, patient and parent education.

The first paediatrician appointed to RNSH, however, in 1947, was Dr Lorimer Dods, a prominent physician in RAHC and later Professor of Child Health. Dods occasionally visited RNSH for consultations but did not play any part in the development of clinical services. The first active paediatrician on the honorary staff was Dr Claire Isbister. In the first instance she was appointed to teach medical students about infant care in the new clinical school. She had expected that she would also have clinical duties, but certain members of the honorary medical staff were concerned that the relatively new specialty would have an unfavourable impact on the hospital and they had her appointment restricted to teaching.

Isbister was appointed Honorary Assistant Paediatrician to the Obstetric Department in 1949; there was no paediatric department then. She was not welcomed by most of the obstetricians who wanted to continue to care for their own sick babies. Nor, at first, was she welcomed by the nurses who looked after those babies. They had established strong positions in the nursery and had been given considerable responsibility by the obstetricians, which Isbister’s appointment threatened. Eventually, despite the views of

\textsuperscript{15} Ibid.
the obstetricians, the Hospital Board granted her control of the babies classified as public patients. For a paediatrician to be given occupational territory previously jealously held by the obstetricians was a unique achievement in Sydney for the time.

Isbister was also in private practice; she had to earn her living. At first she struggled to survive because many obstetricians would not refer babies to her. Later, her financial situation improved when a few of the younger obstetricians who had recently returned from the war referred her private patients. She attributed this to the fact that her husband, a physician in the hospital, was also a returned serviceman. There were other restrictions on her work. In the children’s ward, where she had expected to have patients admitted under her care, she found the adult physicians who had always looked after the children in RNSH were unwilling to give up their places. She recalled:

I had no beds in the paediatric ward, as the physicians said that a paediatrician was not necessary, but they eventually admitted that they were not much good at looking after the under two-year-olds, and I got two beds (of the thirty) for the under twos. It was a long hard battle.  

These were irritating restrictions for a new paediatrician. They were also a considerable sleight on Isbister’s professional standing, because she was well qualified for paediatric practice. She had a distinguished undergraduate career, and then completed appropriate paediatric training at RAHC and in Britain, gaining her MRACP qualification in 1945.

Isbister believes that being a woman in a largely male environment affected the way in which she was accepted, although she admitted that she annoyed people because she spoke her mind and “laid down the rules fairly strongly.” McCalman has written about the problems women doctors experienced in the large public hospitals, where the medical staff was male-dominated, middle-class and highly conservative. To be successful in this environment women had to be strongly assertive, as Isbister was. Despite her strengths, her acceptance into the hospital came only slowly. She believes she was also disadvantaged in paediatric circles, such as the Australian Paediatric

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16 Dr Claire Isbister, letter to author, Blackheath, 10 February 1998.
17 Dr Claire Isbister, interview by author, Blackheath, 3 March 1998.
18 Janet Mc Calman, Sex and Suffering Women's Health and a Women's Hospital (Melbourne: Melbourne University Press, 1998), 199, 314.
Association, because she chose not to be on the staff of a children’s hospital; RNSH did not have the same status as RAHC in the emerging paediatric specialty.\textsuperscript{19}

Isbister developed a model of paediatrics that might have offered an alternative to the scientific medicine paradigm. While science was necessary to deal with complicated clinical disorders, a greater emphasis on preventive medicine might have been more beneficial to Australian children. While Isbister’s contribution to paediatrics was generally unappreciated by her colleagues, there were some who held similar views on the dangers of a too narrowly focussed specialty. An undoubtedly scientific paediatrician, Howard Williams, regretted in retrospect that his hospital, the RCH, Melbourne had an “achilles heel — it had been very productive in systemic medicine, but had been over-centralised…with a lack of understanding and of study of the social changes in the community and their effect on health.” He was disappointed that his hospital had not practised the wider medicine of his preferred model of social paediatrics, the hospital service created by James Spence in Newcastle upon Tyne.\textsuperscript{20}

Isbister was eventually permitted to care for babies and children in the hospital wards but her most noted activities were elsewhere, in preventive medicine, an area largely neglected by paediatricians in the children’s hospitals. In the outpatients department she had established a special asthma clinic because there were a large number of patients with the disease attending the hospital. This led to a strong involvement in asthma education for children and parents and later key roles in the Asthma Foundation of NSW. She developed a special interest in other areas of health education and set up what she believes were the first “Preparation for Parenthood” classes in Australia. Obstetricians initially opposed her actions because they considered that the education she offered interfered with their role, but she persisted and the classes expanded. Other educational projects were started in child development, in “Education for Living” classes and in learning disorders. Paediatricians who joined the staff later were encouraged to participate in health education.\textsuperscript{21} One in particular, Dr Michael Harris,

\textsuperscript{19} Isbister, letter.
\textsuperscript{20} H.E. Williams, letter to Lorimer Dods, undated, in correspondence file 1975, Dods papers, P172, Series 1, Item 6, University of Sydney Archives, Sydney.
\textsuperscript{21} Isbister, interview.
also developed a great enthusiasm for parent education and promoted it widely in other hospitals, such as the Royal Hospital for Women.22

In RNSH the paediatricians demonstrated that, as well as looking after sick patients in the wards, they could successfully engage in preventive programmes. They demonstrated that there were alternative paradigms for paediatrics other than the high technology and science of the children’s hospitals. Most paediatricians earnestly asserted that prevention was an essential part of their work, but in practice it was neglected in favour of high technology curative care.

Isbister encountered the same problems as other paediatricians in her efforts to claim from obstetricians and adult physicians’ occupational space she thought rightfully belonged to her. They held prior possession of the field and believed they should not give it up. The situation demonstrated the strongly competitive nature of medical practice that may not have always been in the best interests of the patients, if the views of paediatricians are accepted that they were the best equipped to treat sick children and babies.

The above examples illustrate how paediatricians began to move away from central Sydney and away from the protective umbrella of the children’s hospital. There was, however, a large general hospital in NSW where paediatrics was ignored, long after it was accepted elsewhere. The Royal Newcastle Hospital (RNH), one of the largest hospitals in NSW, in the State’s second largest city after Sydney, elected not to have a paediatrician on the staff until 1964. The reasons why this hospital decided that paediatrics was not of high priority, when it had a substantial number of other well-founded specialties, offers another perspective on specialization in childcare in NSW. RNH is of interest not only to paediatrics, but to medicine generally in Australia, because it set an example in hospital administration that was later followed by most of the other large public hospitals and which critically altered the relationship between doctors and the hospitals. This, in turn, had a major effect on medical specialization.

22Dr Michael Harris, tape recorded statement, Sydney, 8 April 1998.
Royal Newcastle Hospital (RNH) was a leader amongst Australian hospitals in the development of a radical new approach to hospital organisation and management, in which, primarily, the effective control of the hospital moved from the honorary medical staff to the administration and the board of management. The changes were introduced by the Medical Superintendent, Dr C.J. McCaffrey, in the period immediately after the Second World War. He also influenced clinical matters. He was highly critical of the quality of patient care provided by the traditional teaching hospitals and their doctors in Sydney; under his guidance the medical staff of RNH developed a number of innovative clinical services, including several new approaches to the provision of services for children.

These services were of considerable benefit to children and their parents, and their introduction challenged the assertions of paediatricians that they alone possessed the knowledge and skills necessary to care for seriously ill children. In due course, however, the claims of RNH that paediatricians were not necessary were found to have crucial flaws, which strengthened the case of the paediatricians for their specialty.

To understand how the RNH developed certain innovative children’s services it is necessary to understand how the hospital itself developed because it had possessed for a long time some unique characteristics. Newcastle Hospital, from 1949 Royal Newcastle Hospital, was a large hospital with about 250 beds in 1945, growing to 600 in 1965. It was comparable in size to the teaching hospitals in Sydney and far larger than any other hospital outside Sydney. Being 160 kilometres away it had developed remote from the conforming pressures and conventions of the medical establishment of the State capital.

The RNH Board of Management and the administration held high ambitions for the hospital. From the mid-1930s they set out to organise it in the style of a teaching institution, although that did not eventuate for another forty years. Among the first steps they took was to institute a formal medical staff establishment in a number of medical disciplines. Their aim was to have a staff of honorary medical officers who were all specialists; an appointee was expected to have completed a recognised training programme and to possess an appropriate specialist qualification. General practitioners
were excluded from the hospital. This was a very unusual step to take for a district hospital, and created great anger in medical circles in the city.\textsuperscript{23} This hostility between the hospital and the doctors in the city who were not on the staff, and the resultant isolation of RNH from the rest of the medical community in Newcastle, contributed partly to the way paediatrics evolved.

RNH embarked on its programs of physical expansion and medical specialization at the end of the Second World War. The Medical Superintendent, Dr C.J. McCaffrey, was a professional medical administrator and one of the first members in Australia of this new occupational group in medicine. Another was Dr V.L. Collins who played a crucial part in the development of RCH Melbourne. From personal contact McCaffrey and Collins were each aware of the other’s ideas on hospital organisation.\textsuperscript{24} From the precedents set by these two, medical administrators would have an increasing influence in public hospitals and would seriously challenge the medical staff for the control of the development of hospital policies.

McCaffrey had been closely involved in medical administration from the early 1930s in RNH. His knowledge of the subject came from his extensive reading and his work experience, for there were no training courses for medical administrators until the 1950s. He was an idealist in his views of the roles of large public hospitals and a pragmatist in his approach to hospital organisation. He declared forcefully that patient care was the focus of the work of the hospital, which should include preventive and curative care, and rehabilitation.\textsuperscript{25} The hospital was not just a workshop for the benefit of the doctors, merely providing them with tools and facilities to do their tasks unhampered by any restrictions. He recognised that in modern medicine doctors could no longer work alone; they needed the support of other experts who also possessed special skills including

\textsuperscript{23} Newcastle Hospital (NH) Board of Directors minutes, November 15, 1932, AB10766; June 16, 1936, AB 10770. University of Newcastle Archives, Newcastle.
\textsuperscript{25} C. J. McCaffrey, “Functional Management in a Hospital.” Paper presented to the Seminar on Administrative Studies, Australian National University, Canberra, 15 to 17 August 1963. RNH Library Historical material, Newcastle.
nurses, other health professionals and technicians. The hospital had a wide responsibility; both to the patients and to the community in which it was placed. Those who managed the hospital had to ensure that its resources were used wisely, because services were becoming increasingly expensive to provide. McCaffrey’s views were provocative to those doctors who used public hospitals to further their own professional ambitions and resented by those who had a genuine conflict of interests between their wish to serve the hospital responsibly and their commitments to their private practices. McCaffrey believed that these conflicts of interest were unavoidable with the honorary system and resulted in inefficient hospital services. It would be better, he resolved, to replace honorary medical officers with salaried staff specialists who could direct their whole professional time to the hospital. The influences of the US full-time system of medical staffing and of Johns Hopkins Hospital are quite apparent in McCaffrey’s plans. He was also aware of the way they would be interpreted by the medical profession. He told a medical administrator colleague that he was aware that his hospital “would be seen as socialistic, if not downright Red, but if the system which exists in Johns Hopkins at Baltimore is socialistic, then what they say must be true, for that is the system we are copying.”

McCaffrey announced his aims for Newcastle Hospital in 1943. He said that the hospital should have about 550 beds for medical, surgical and obstetric patients in public, intermediate and private areas (children were not mentioned). He predicted that the hospital would become the major hospital in the Newcastle area, as well as having a regional role in providing specialist services for the Hunter Valley and near North Coast. With the exception of one or two specialties, for which patients would have to go to Sydney, all specialist services should be available in Newcastle. The hospital would also undertake the training of resident medical staff and specialists.

His plans were adopted by the Board of Directors in 1946 and initially included provisions for a mixture of full-time, part-time and honorary medical officers, all of

28 C.J.McCaffrey, Comments on the Digby Report, filed with the NH Board of Directors minutes, 28 September 1943, AB10777.
whom had to be specialists. 29 It soon became obvious, however, that McCaffrey’s intention was to appoint mostly salaried medical staff and to have a full-time specialist in charge of every major clinical department, then a unique situation in Australian hospitals. 30 His innovative ideas were not restricted to medical staffing. He had plans for improving the efficiency of the hospital in many other areas, which included medical records, the operating theatres, resident medical officer training and anaesthetic, food, sterilising and geriatric services. 31 McCaffrey also wanted RNH to be the hospital base for a new Australian medical school, and at the request of the NSW Minister for Health he prepared a comprehensive case for such a school for Newcastle. 32 It was a mark of his stature amongst those involved in hospital planning and administration that his proposals were seriously considered at both State and Federal levels, but they were never adopted. 33

Over the next twenty years the hospital appointed salaried specialists in a wide range of specialties, but not in paediatrics. However, a broad range of services for children were instituted. The hospital had a children’s unit with fifty beds in two wards for patients up to fourteen years of age with medical and surgical disorders. There was also a convalescent unit for orthopaedic and other cases, such as rheumatic fever. The outpatients department was particularly busy, with families attracted by the low cost of the services made possible by a large hospital contribution fund. There were also some facilities for the sick and premature babies from the midwifery service. The medical care in all these areas was provided by physicians who practised primarily in adult medicine.

Besides these usual clinical services a number of innovative approaches to the care of children and their families were introduced, which reflected McCaffrey’s priorities for patient and parent welfare, with a particular emphasis on the avoidance of causing harm. Many of his innovations had another purpose; they often reflected his views on

29 Royal Newcastle Hospital (RNH) Board of Directors minutes, 7 May 1946. AB10780.
30 Ibid., 5 June 1951. AB10785.
32 Newcastle Morning Herald and Miners’ Advocate, 28, 29, 30 March, 4 April, 1961.
33 Ibid., 1 June 1962, and Leading article, 22 June, 1962. A medical school did not eventuate in Newcastle at that time; instead the second medical school in NSW was established at the University of New South Wales. Newcastle gained a medical school in 1974.
efficiency and cost-effectiveness in hospitals. He refused to slavishly follow the scientific medicine paradigm which was so evident in the development of many public hospitals at the time.

McCaffrey showed he was aware of the reports that were appearing in the 1950s on the emotional problems suffered by children in hospital, and how the problems could be reduced by allowing the mother to stay with the child. In 1955 he proposed to the Board of Directors that there should be additional beds in the children’s ward to allow mothers to come into hospital with their young children, to provide the ordinary nursing care and emotional support for the child while doctors and nurses would continue to provide the professional care. The Board asked the hospital architects to prepare sketch plans for six single rooms, but because there were no funds available the project lapsed.\textsuperscript{34} For similar reasons RNH adopted a policy allowing unlimited parental visiting in 1956, in place of the previous twice weekly visits.\textsuperscript{35} These moves occurred at much the same time as the children’s hospital was also beginning to modify its policies of parental visiting.

Another practice introduced by McCaffrey was also good for babies and their mothers. RNH had established a midwifery unit in 1951, which from the beginning had a new approach to infant care called “rooming-in.” Traditional nursing practices, in which infants were held in large nurseries, often very close together in banks of cots, were abolished. Instead, the newborn baby was kept in a basinet beside the mother’s bed, even in the larger wards. The mother was responsible for the routine care of the infant, which included feeding and bathing, greatly reducing the handling of babies by the medical and nursing staff. The main reason for the introduction of rooming-in was to reduce the risks to the baby of cross infection. At the time hospitals were having recurrent epidemics of infections by staphylococci, the “golden Staph,” which produced serious infections such as septicaemia, pneumonia and osteomyelitis in babies. Doctors and nurses were sometimes carriers of this organism, and the introduction of the policy greatly reduced the risk of their transferring infection to the baby. The hospital claimed that rooming-in virtually ended epidemics of cross infection in the nursery, while they

\textsuperscript{34} RNH Board of Directors minutes, 22 March, 20 December 1955. AB10789. 6 March 1956. AB10790.
\textsuperscript{35} Ibid., 7 February, 1956. AB10790.
continued to occur in large hospitals elsewhere, but no data was kept to support the claim. McCaffrey and the obstetricians recognised that the policy had valuable additional benefits for the baby in fostering what was later called “mother-baby bonding” and in helping the mother to learn the skills necessary to successfully care for her baby when she went home.\textsuperscript{36} The importance of bonding was not recognised widely until the publication of the work of Klaus in 1976, so McCaffrey was ahead of his time in that respect.\textsuperscript{37} This method for the safer care of mothers and babies was new to Australia and was later adopted by many other maternity hospitals.\textsuperscript{38}

Another area of infant welfare, feeding, also captured McCaffrey’s interest. Most of the approaches to infant care assumed that mothers possessed insufficient knowledge to be able to feed their baby properly, a problem which could only be corrected with expert advice from doctors or infant welfare nurses, reinforcing the authority of the professionals over the mothers. With McCaffrey’s encouragement, the physicians who treated children in RNH introduced a new approach to the care of infants which was designed to restore responsibility to the mother and raise her self-confidence.

The hospital established a well-baby clinic in 1951 as an exercise in preventive medicine. It was intended only for babies born in the hospital and the purpose was to monitor the growth and development of normal babies and help the mother with advice about the common minor problems of infancy, particularly about feeding. The Baby Health Clinics run by the Public Health Department of the NSW Health Department had similar aims, but they were strongly authoritarian and prescriptive of advice. The RNH clinics were different in that the advice given was intended to help the mother develop her own skills. It was provided by a dietitian instead of an infant welfare nurse. A medical officer was always in attendance to provide advice to the mothers if the baby was unwell. The RNH clinic strongly advocated breast feeding, but for those mothers who could not breast feed their babies a simplified approach to artificial feeding was developed which differed considerably from the conventional, relatively complex formulae of the Government clinics.

\textsuperscript{36} Ibid., 5 February, 1952. AB10786.
\textsuperscript{38} John Greenwell, telephone interview by author, Sydney, 11 December 1996.
The RNH clinic recommended feeding babies full-strength milk from birth, instead of the usual diluted milk and sugar mixtures. The doctors in charge recognised that their method had some problems, such as providing more protein and minerals than the baby needed, but overall the simpler approach benefited most mothers and did not significantly disadvantage the baby. To further help the mother it was recommended that the milk be provided at room temperature, not warmed. A trial of this system showed that the majority of babies progressed satisfactorily, and the method was much easier for most mothers. These infant-feeding policies reflected the originality of the proponents and a rejection of the generally accepted, so-called scientific evidence of the day in favour of a system that they believed empowered the mother. The approach also embraced pragmatism, a characteristic feature of many of the hospital’s policies. Despite its simplicity it was not widely taken up outside Newcastle where more conventional practices prevailed.39

Those conventional approaches to infant feeding had been well indoctrinated into the minds of many nurses and doctors, so it was not surprising that the presence of the RNH clinic should cause friction in the city. The RNH clinic provided advice that differed widely from that provided by the Government clinic nurses who saw it as a source of confusion for mothers and a criticism of their conventional approach. It was another source of irritation for many general practitioners for whom the presence of the medical officer in the RNH clinic was effectively unfair competition. The Government clinics had only been tolerated by the medical profession because official policies forbade them offering treatment and because they did not employ doctors.40 This divisive approach to the feeding of babies, which for those involved in infant care was a very important issue, worked against the interests of both sides in the controversy. Outside observers could see paediatrics as an immature specialty and infant welfare as ineffective because neither side was able to resolve the continuing controversies associated with infant feeding, which to many seemed a relatively simple task.

39R.M. Gibson, Joan M. Woodhill, R.A. MacMahon, Manual of Infant Feeding and Management Royal Newcastle Hospital, Newcastle, Undated but presumed 1950s.
RNH developed another policy on infant care that was controversial, and in this instance fundamentally different to contemporary practices. It was judged to be harmful by outsiders and provided paediatricians with an example that could be used to support their claims that only paediatricians should look after sick babies, and which confirmed their contention that doctors who were trained to treat adults did not possess the expert knowledge and skills required for children.

Keeping small babies warm had long been a widely accepted practice at home and in hospitals. Premature and sick babies needed special care. In conventional practice they were nursed in an environment which provided added heat to keep their body temperature at around the normal 37 degrees Celsius. This was most conveniently provided, after the early 1950s, by new technology in the form of the infant incubators or humidicribs, large perspex boxes which warmed the baby to a set, controlled temperature (see Figure 7.1).

McCaffrey firmly believed that the premature baby was disadvantaged by being kept warm, and the RNH nursery procedure manuals were written accordingly, stating that babies should be nursed at room temperature in what he called a state of suspended animation. Interestingly, the policy was sometimes disregarded by disbelieving nursing staff who adopted underhand approaches to warming babies, such as placing them in blanket warming cupboards. The source of the evidence on which McCaffrey based his policy is unknown. Some of his contemporaries believe it may have come from veterinary research on foals, others that it came from French or German sources. It is surprising that he did not provide his critics with the scientific references for such a controversial policy; in other circumstances he was adamant that his staff produce satisfactory data to back up their opinions.

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41Dr.J.Elliott, interview by author, Newcastle, 2 September, 1994. Dr Elliott was the staff obstetrician who established the RNH obstetric unit in 1951, and was later Director of Obstetrics. Dr.A.D.Hewson, obstetrician, interview by author, Newcastle, 22 December, 1994.

42Cyril Renwick, “Chris McCaffrey and His Hospital” in Chris McCaffrey A Great Administrator, A Memorial Recollection by His Colleagues, ed. Leo Butler (Newcastle: The Hunter Valley Research Foundation, 1985), 63-65. Prof. Cyril Renwick A.O. was Chairman of the Hunter Valley Research Foundation and a member of the Board of Directors of Royal Newcastle Hospital from 1960-1964. This book is an uncritical collection of reminiscences by admirers of McCaffrey.
McCaffrey read widely in the scientific medical literature, and had decided views on many subjects. Some of his colleagues believed that he was selective in the documentary evidence he chose to accept. There was considerable scientific evidence, readily accessible in reputable journals, that small babies should be kept warm. In a review of neonatal care, Sinclair points out that over the period 1957 to 1964 there were a number of well-controlled clinical trials that demonstrated conclusively that keeping babies warm by the careful control of the thermal environment improved the mortality rate in premature infants by 25 percent over the results achieved in earlier periods. There were many similar, but tentative, recommendations existent before the 1950s. McCaffrey may have had other reasons for opposing the use of incubators. He had a deep fear of hospital infections and described hospitals as one of the most microbiologically dangerous places that existed. There were serious problems of cross-infection in midwifery units and nurseries in the early 1950s in NSW. Incubators with their warm humid environment were believed to enhance the risk of infection. However, with good nursing care and attention to hygiene the risks of infection could be minimised.

There was another potential problem with incubators. In the 1950s a connection was established between the prescription of added oxygen for premature infants and subsequent blindness due to retinal damage, called retrolental fibroplasia. Incubators facilitated the use of oxygen. McCaffrey was strongly opposed to the use of this therapy, particularly if the gas was piped to the nurseries rather than being provided in portable cylinders. Piping was a practical way of delivering the large quantities required but encouraged its liberal and perhaps excessive use. This view on premature baby care was, in part, supported by an official publication of the NSW Department of Public Health that highlighted the dangers associated with incubators. The additional dangers of excessive oxygen, as a cause of permanent blindness, were also recognised. On the other hand, both incubators and oxygen were useful in helping small babies survive, but

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45 Dr Peter Hendry, “The Clinical Pathologist” in Chris McCaffrey, 137-149.
46 Thomas Cone, History of American Pediatrics (Boston; Little Brown and Company, 1979), 188.
47 Ibid., 221. Retrolental fibroplasia is a condition peculiar to premature infants which produces damage to the blood vessels of the retina, and may lead to permanent blindness.
48 C.J.McCaffrey, letter to the Manager, Mildura Hospital, July 27, 1959, University of Newcastle Archives, Newcastle.A7409(I).
extreme caution was necessary to prevent harm which required a high standard of medical and nursing care.49

RNH was strongly criticised by obstetricians and paediatricians outside the hospital for the way it treated small babies. A Sydney paediatrician, John Beveridge, was asked to visit Newcastle to consult on a sick premature baby in RNH. He said:

I drove up to Newcastle. It was winter and it was cold. I was taken to see this baby. The nursery was cold. The windows were open — there was a blizzard coming in. The baby’s temperature was unrecordable and they did not have an incubator. They didn’t regard them as necessary.[The baby was transferred to another hospital] Of course, the baby died — you can’t resuscitate a baby like that.50

McCaffrey was not unaware of the prevailing practices in the care of the newborn in at least one of the large midwifery hospitals in Sydney. He was associated with the Royal Hospital for Women, Paddington, from the mid-1950s, through the Medical Superintendent, Dr John Greenwell. Later, he was invited to join the Board of Management of that hospital to make available his skills in hospital administration. Greenwell asked McCaffrey for advice about the problems of cross-infection in his nurseries and was told that the use of the incubators should be discontinued. Greenwell could not accept this recommendation because he believed that, overall, incubators were valuable in the care of premature infants. The issue of humidicribs, in particular, and neonatal care in general, raised such an intensity of feeling between the two that they agreed not to raise it again.51

The real reasons for McCaffrey’s rejection of a well-accepted principle of infant care are unknown, but they are relevant to the development of paediatrics in Newcastle. McCaffrey was not opposed to the introduction of new technology as such, but needed to be convinced that it was useful, cost-effective and safe. RNH was the first hospital in Australia to purchase innovative equipment for the pathology department, which included an autoanalyser for automatically processing multiple samples of blood for

49NSW Department of Public Health, Division of Maternal and Baby Welfare, The Prevention and Control of Infection in the Newly Born and the Care of the Premature Baby (Sydney, Department of Public Health, 1958).
50Prof. John Beveridge, interview by author, tape recording, Sydney, 19 May 1998.
51Greenwell, telephone interview.
biochemical tests, and a flame photometer for rapidly estimating sodium and potassium levels on small quantities of blood. He accepted the need for the introduction of the procedure of exchange transfusions for jaundiced newborn infants, a radical new technology at the time.\(^{52}\) William A. Silverman, a pioneer American neonatologist who has written at length on the excessive and dangerous treatment of sick and small newborn infants, has declared how daring was this very invasive technique in the late 1940s.\(^{53}\) It is surprising that McCaffrey countenanced this procedure which seems so out of character with his other views on child care. In March 1949 he told his Board of Directors how the lives of two babies had been saved by exchange transfusion, and explained the organisation of the Blood Bank and the Pathology Department and their work that made it possible.\(^{54}\) For most aspects of baby care, however, he elected to follow a conservative non-interventionist approach. On balance he believed that incubators and oxygen were relatively unsafe and posed unnecessary risks to the baby. Whether he was right or wrong, his views prevailed in RNH for a number of years, until a paediatrician was eventually appointed in 1964.

McCaffrey had dogmatic views on many medical matters and was always ready to expound them. He created many enemies for himself and for RNH. One topic on which he created dissent was tonsillectomy. Many children in NSW were subjected to this operation in the late 1940s and early 1950s. McCaffrey was intensely opposed to tonsillectomy because he considered it mostly unnecessary and because it was relatively dangerous, with a number of serious complications, such as bleeding and infection.\(^{55}\) The operation was also very unpleasant for the child. Interviews with people who underwent tonsillectomies reveal how distressed they were by the operation, by the ether anaesthetic and the post-operative pain and bleeding, as well as their separation from their parents.\(^{56}\) McCaffrey vigorously criticised other doctors in Newcastle who

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\(^{52}\) Dr Peter Hendry, interview by author, Newcastle, 10 January 1995.


\(^{54}\) RNH Board of Directors minutes, 1 March 1949, AB 10783.

\(^{55}\) Separate figures for children are not available from RNH but in RAHC from 1945 to 1950, 18,912 children had their tonsils and adenoids removed. There were six deaths, 1 per 3000 operations, an appreciable mortality. From the evidence which came from an assessment of 681 children who had been on a waiting list for the operation for eighteen months or more, it was suggested that at least a third of children who had been recommended to have the operation did not really need it. David Dey, “A Survey of 681 Children Awaiting Tonsillectomy and the Indications for Operation in Childhood,” *Medical Journal of Australia* 1 (1952): 510-514.

\(^{56}\) Patient interviews, nos. 15, 18, 49, 53.
continued to perform the operation, which was yet another cause of conflict between RNH and doctors working outside the hospital. The intensity of these conflicts made it difficult for the doctors responsible for children’s services in the several hospitals in the city to cooperate, which otherwise might have been useful for the development of a fledgling specialty. The development of paediatrics in the city was therefore slowed.  

McCaffrey also contributed prominently to the development of clinical policies. In a celebratory book published by his admirers, McCaffrey is described by a colleague as being associated with:

Reform, innovation, development, conflict and its resolution — enormous growth in services, training, research and health — leadership of a kind that astonished Australia and the world. It was a most dynamic institution in which nothing that happened was not under constant medical, financial and administrative review, with McCaffrey involved at the centre of the action, on all fronts.  

McCaffrey provides an example of another force in hospital development, the powerful personality. He was the CEO and Medical Superintendent; in addition he had the power that comes from the possession of an extensive knowledge of medical matters, and he was a very powerful figure personally. He was able to influence profoundly the clinical practices of the medical staff who, in other situations, were the power brokers in hospitals.

He recruited a group of staff specialists who had similar ideas on medicine to his own, and who were disenchanted with what they had seen in the Sydney teaching hospitals. Many were of mature age, having returned from war service; all were interested in working in a new type of hospital. Under the leadership of McCaffrey a cohesive team of specialists developed in the late 1940s and early 1950s. In a number of specialties innovative clinical services were introduced. Some were highly successful, like the treatment of diabetes and geriatrics. Others were less so. Some, like aspects of neonatal care, were hazardous.

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57 Smyth, interview.
58 Renwick, 63, 64.
At first, McCaffrey’s ideas, when translated into services by a supportive and enthusiastic staff, were of considerable benefit to many patients, but later there were serious problems, with isolation from knowledge developing elsewhere being a serious difficulty. Sir Theodore Fox, editor of the *Lancet*, visited RNH in the course of a tour of Australian hospitals. He said that the hospital was a model of an efficient State institution, but added that it was also “an isolated professional enclave at great risk of persisting with obsolete and irrelevant policies.”

Certainly RNH was isolated from developments in the new (for Australia) specialty of paediatrics.

The hospital was also isolated from local medical influences by staffing policies that excluded general practitioners and those doctors who did not have specialist qualifications. Under the hospital by-laws even qualified specialists were not eligible to be appointed to RNH if they wanted to remain on the staff of another hospital. RNH was also isolated medico-politically. The employment of a large number of staff specialists antagonised the BMA (NSW branch) and many members of the medical profession generally, at a time when paying doctors a salary was perceived as one of the first steps towards the nationalisation of the medical profession. The isolation and the absence of a paediatrician contributed to an ignorance of what paediatrics might offer the hospital.

The lack of a paediatrician in RNH eventually drew public criticism in 1963. The NSW branch of the BMA complained that RNH, a large general hospital which served a major city, did not have a specialist paediatric service. Only one hospital in Newcastle, the Newcastle Mater Misericordiae Hospital (NMMH), had facilities for the specialized care of children. The matter was discussed by the NSW Government and RNH was obliged to create a position of staff specialist in paediatrics. Greenwell believes that McCaffrey was not against such an appointment. He would have appointed a paediatrician if he could have found one with similar views to his own, but was unwilling to have a staff member who might have radically different ideas, particularly

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60 Hendry, interview. Smyth, interview.
on neonatal care. McCaffrey had avoided the problem of dissent with his own ideas by favouring internal appointments, appointing staff specialists and other senior staff from candidates who had previously worked or trained in RNH. For the paediatric service there were no eligible candidates within the hospital so he was forced to look elsewhere for someone who would fit into the hospital organisation. This may have appeared risky to him because a paediatrician seeking an appointment at RNH at that time would have been trained in a children’s hospital and be orientated towards the prevailing scientific medicine and its attendant high technology.

McCaffrey’s role as Medical Superintendent came to an end in mid-1964 after a bitter dispute with the Board of Directors, allied with a section of the medical staff. The Minister of Health dismissed the Board and the hospital was placed under the control of an administrator. While the causes of the dispute were complex, McCaffrey’s inflexibility in the face of great changes in medicine elsewhere contributed to the problems. McCaffrey was at the forefront of hospital administration and organisation in Australia, and in providing safer and more humane hospital services for children and their parents. He may have had much more to offer paediatrics if he had been able to accept the inevitable rise of science and technology and to temper it with his own special perceptions of medical care. Instead, he would not seriously consider a paediatrician for his hospital until forced to by external agencies, and this delayed the development of paediatrics in the second largest city in NSW. There were, however, paediatricians in other hospitals in Newcastle, although they did not possess the full qualifications that were coming to be expected of specialists in the field.

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62 Greenwell, interview.
63 RNH Board of Directors minutes, 22 January 1958, B10793. The item refers to the appointment of a hospital matron.
64 RNH Board of Directors minutes, 3 March 1964. B13801.
65 RNH Board of Directors minutes, 19 August 1964, B13801. McCaffrey stayed at RNH for nearly another year, powerless under a Hospital Commission appointed administrator. He then resigned and resumed his previous occupation as a radiologist in various regional hospitals in New Zealand and Australia. He died in 1980. J.M. Duggan ADB 15, 1940 to 1980, 161.
In Newcastle, in private practice and in other hospitals, paediatrics evolved in a conventional pattern, similar to that described for Wollongong and the suburbs of Sydney. In the late 1940s a Newcastle general practitioner, Dr Dora Hoskinson of Mayfield, declared an interest in the problems of small babies arising from her involvement in obstetrics. She developed a reputation as a helpful consultant and was referred cases by other general practitioners in Newcastle, and from places as far away as Armidale and Tamworth. She was named as an honorary paediatrician on the staff of the Newcastle Mater Misericordiae Hospital (NMMH) in 1952. It is a comment on what the term “specialist” meant in the city in the period, outside RNH, that she was, at the same time, also named as an honorary obstetrician and as an honorary anaesthetist.

In 1954 Dr John Muller came to a general practice in Wallsend, a western suburb of Newcastle. He had undergone substantial training in paediatrics in Britain and held a Diploma in Child Health (London). This qualification was not sufficient for him to be recognised as a paediatrician in RAHC or RNH, but the NMMH did not have such rigid standards and Muller was appointed honorary paediatrician in a post newly created for him because he happened to be available. He was also appointed honorary physician at the third Newcastle hospital, Wallsend District Hospital (WDH) where he looked after both adults and children. This hospital did not have a position labelled “paediatrician” until 1969. Between 1958 and 1961 two more general practitioner/part-time consultant paediatricians were appointed to NMMH. They had similar qualifications to Muller and were not eligible to be on the staff of RNH. It was not until 1970 that a fully qualified paediatrician was appointed an honorary to NMMH. The differing criteria between RNH and NMMH for the appointment of specialist paediatricians added to the conflicts between the two hospitals and hindered any cooperative approach towards promoting the image of the specialty in the city.

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66Dr Jack Burgess, interview by author, Newcastle, 9 January 1997.
Between 1945 and 1965 there were children’s wards in three separate hospitals in Newcastle. RNH had fifty beds, NMMH about thirty, and WDH had twenty. Those in NMMH and WDH were poorly supported by resident medical staff and allied health professionals. Their laboratory and radiology services were also limited. They had no intensive care services, but they had people who were well trained in paediatrics, even if they did not have formal qualifications; the RNH paediatric service was well-supported by ancillary services but had no paediatricians. By the standards expected by paediatricians in children’s hospitals in the 1960s all the paediatric units in Newcastle were deficient in some ways. This situation persisted until the 1980s when a single paediatric unit was created by an area health service, at first in NMMH and later at the new John Hunter Hospital

Conclusions

There were few paediatricians in NSW in 1945 and they practised mostly in the central metropolitan area of Sydney. Occasionally they visited suburban hospitals for consultations. From the early post-war period new paediatricians began gradually to establish private practices in the suburbs and later in the larger regional centres in the country. The main reason for the outward move appears to have been the need to find a place for a private practice that offered financial security. Even then, the paediatricians sometimes had to engage in another income-producing activity, usually general practice, to make a living for themselves and their families.

These paediatricians, however, maintained strong ties to what they believed was the centre of paediatrics, holding positions on the honorary staff of RAHC. This, they judged, was essential for their careers in the specialty. Some also had a centrally situated private practice as well as their suburban consulting rooms. The peripheral movement of paediatricians meant that their expertise and skills were made available to a much larger number of children, and potentially more people became aware of what the specialty could offer, but it was at a considerable cost to the paediatricians themselves and to paediatrics. Working at a number of different sites, often a substantial distance apart, involved a considerable expenditure of time and energy. With all the demands on their time, the peripheral paediatricians experienced conflicts of interest and duty, with the result that they had limited time available to give to the development
of RAHC as a scientific hospital. If one accepts that RAHC was vital to the development of paediatrics in NSW, then the specialty in the State was disadvantaged by this situation because the hospital would not change the honorary system of staffing. The paediatricians who moved to peripheral areas lost the protective umbrella of the children’s hospital. They were working in places where other practitioners did not always agree that sick children had special needs and where the role of the paediatrician was still not clear.

The suburban and regional hospitals played a subsidiary role to RAHC. In these places paediatric services followed several patterns of development. In the first type they began with children’s services supplied by general practitioners, then by part-time specialists and finally by fully-qualified paediatricians resident in the area. Some hospitals followed a different course to the conventional one. In RNSH Dr. Claire Isbister showed how preventive medicine could be successfully combined with curative medicine. Given greater support she might have established a new paradigm in paediatrics in Australia. In RNH, the hospital that offered paediatrics without paediatricians, doctors showed that in an environment away from the conforming pressures of the conservative medicine of the state capitals and in a hospital that encouraged innovation they could develop useful clinical practices. Without paediatrics they became aware of the needs of children and their parents and established several valuable services. The same isolation, however, eventually exposed a critical lack of knowledge of certain unique physiological and pathological characteristics of small children. Paediatricians could use the example of this divergence from paediatric science to reinforce their arguments that only doctors specifically trained in the specialty should look after seriously ill children.

RNH also demonstrated a new approach to medical organisation, setting a pattern which would ultimately affect all the specialties of medicine, including paediatrics. Modern medicine required more of the time of medical staff than was possible with an honorary system, even in a hospital like RNH which did not slavishly follow the scientific medical paradigm of the teaching hospitals. A powerful hospital administration was needed to bring about important service changes, to abolish the honorary system and to install a salaried service. In RNH one can see the effects of an aggressive, inflexible application of power. In comparison, the changes which came in RCH, Melbourne,
were instituted with much less pain on all sides. The children’s hospitals and the children’s units in other hospitals, however, must also be examined to find out what they meant to their patients, the children and to the parents.
CHAPTER EIGHT
THE POWERLESS CHILD

Introduction

The next two chapters consider the role played by children and their parents in the development of paediatrics in NSW between 1945 and 1965. Despite the centrality of children in general to paediatrics they had little power to influence the development of the specialty. They were patients in a health system in which patients had little influence, and were further disadvantaged because children had little authority in Australian society.

There has been very little written about the role of patients, particularly children and the part they have played in the development of health services and hospitals. The primary sources of information are limited, so the methodology of oral history has been used to reveal the views of people who as children were patients in the Royal Alexandra Hospital for Children (RAHC) in Sydney and other hospitals in NSW. The two chapters consider the power relationships between doctors and hospitals on one side and children as patients on the other, and how they influenced the development of paediatrics.

Oral History

I sought to discover the “human face” of paediatrics and the children’s hospital using a selection of the recollections of people who had been in hospital as children to reveal the impact on them of various paediatric practices. It was decided to invite for interview people who had been in RAHC or in other hospitals in NSW between 1945 and 1965. Hospitals were chosen as the field for recruitment because it was believed they were the places where children would have experienced an intense association with the paediatrics and the health system, and with which they would have strongly identified. Most attention was focused on RAHC because that hospital was central to the development of the specialty in NSW.
In 1999 I interviewed fifty-four people who, as children, were in hospital in NSW between 1945 and 1965, or their parents, and in several instances I interviewed both child and parent. The subjects were recruited by issuing invitations to participate in the project in newspaper articles and in radio and television programs broadcast in NSW, Canberra and South Australia. A number also made contact through the web page established to support the project.¹ Some people were recruited through hospital staff members or through earlier interviewees. Of the fifty-four respondents twenty had been in the RAHC. Eight of these people were interviewed at length, using a tape recorder and formally transcribing the interview. The other twelve from the children’s hospital, and the thirty-four who had been in other hospitals, were interviewed over the telephone, partly to assess their suitability for more formal interviews, partly because their admission had been relatively short, often only for a few days, or because they had only a small amount of information to offer. The narratives of the interviewees were partly spontaneous and partly in response to questions. Pseudonyms are used to identify those who had long interviews. The short interviewees are identified by number. Not all the interviews undertaken are used here but the information from them provided valuable background material against which to judge the others. The interviewees are listed in Appendix Four, with brief details of their clinical problems. Copies of the interviewee recruitment notices and the permission form are found in Appendix Five.

There have been other oral history projects undertaken in children’s hospitals. About fifty children were interviewed by Julie Marshall for her commemorative history of the Princess Margaret Hospital for Children (PMH), Perth. There were only six children admitted between 1945 and 1965. Their memories of the PMH are different to those of the patients in RAHC and will be discussed later in this chapter.² Peter Yule also interviewed a number of children for his recent history of the Royal Children’s Hospital (RCH), Melbourne, but he has recorded mainly the clinical aspects of the patients’ stay in hospital.³ I also interviewed nurses, doctors and administrators from RAHC and RCH. The nurses were recruited through hospital contacts. While I approached the

doctors and administrators directly. They were chosen because I believed they would provide useful information about particular phases of paediatric development.

From the interviews of patients there are several categories of childhood experience that stand out in the frequency of their mention and the manner in which they were described. The sample is small and it was apparent that those who volunteered to be interviewed had a particular story that they were anxious to tell. On their evidence the institutions the children entered were strongly authoritarian and the patients, the children, were at the bottom of a hierarchical structure. To some of them the environment was fearful and they felt a loss of identity. As children they had little understanding of what was happening to them and they were offered little explanation of why they were sick. The most disturbing situation for the children was that of being alone and isolated from their parents. They were in strange surroundings where painful and unpleasant things happened to them, such as injections, enemas, anaesthetics and surgical operations. Many of the interviewees mentioned these clinical events but this analysis only deals with them briefly as they were, at the time, a probably unavoidable part of the management of their illness. The analysis will concentrate on those facets of the hospital stay which best demonstrate the power relationships between the patients and the hospital.

The Child in Postwar Australian Society

Chris Jenks, a sociologist, has pointed out that the child is not a natural phenomenon that can be defined by physical differences alone, such as age or size, but is a social construct. Many explanations have been put forward to explain childhood, with agreement only about a few matters; the most significant being that a child is different to an adult. In contemporary society the child is defined by being placed in a formal category relating to programs of care and education, or in institutional forms such as families, nurseries, schools, health clinics and hospitals. These programs and institutions are created by society, which determines what children are.
Linda Pollock has argued that from at least the sixteenth century there has been a concept of childhood. Children were seen as being different from adults, and the ways in which they differed were recognised. It was also appreciated that children went through a number of developmental stages. She suggests that for centuries the vast majority of parents have accepted the responsibility for the rearing of their children and for their protection and socialisation. Pollock disagrees strongly with Philippe Ariès who has stated that in the Middle Ages children were not seen as essentially different to anyone else, and that the modern concept of childhood dates only from the eighteenth century. Before that time children were not worthy of consideration, were treated harshly and exploited.\(^5\) Shulamita. Shahar recognises that Ariès has many supporters for his pessimistic conceptions of childhood in medieval society; that it was not a separate and distinct stage in human development. She believes, however, that there is ample evidence of the existence of a concept of childhood in that period, and that parents invested appropriate material and emotional resources in their young children.\(^6\)

Ludmilla Jordanova agrees that there is no easy way of defining childhood and that at the one time different parts of society may treat children and childhood differently. However, she acknowledges that in Western societies in the twentieth century children had several defining characteristics that they had not generally held in previous times. Those important in relation to their health care were that they were fully dependent on their parents, they were inactive economically and they lacked legal and political rights.\(^7\)

Viviana A. Zelizer has discussed how the image of children changed in the US between 1870 and 1930. With compulsory education and new labour laws the wage earning “non-child of the poor” became “the economically worthless child scholar” who was “emotionally priceless”. The “majority of children came to be appropriated into a neo-


\(^6\) S. Shahar, Childhood in the Middle Ages (London: Routledge, 1990), 1, 4.

romantic ideal of childhood.\(^8\) In Australia, child labour and education underwent similar changes, but their main effects were delayed by the depression.\(^9\)

European societies since the nineteenth century have considered that children, although innocent, were malleable, and were at risk of losing their innocence to evil forces. They needed to be trained to make them fit to enter the adult world with due respect for property and authority. They had to be taught to control their sexuality and to follow practices which did not damage their health. This training was as much for the benefit of the state as for the child. Similar ideas were held in Australia and there were numerous groups of experts who felt they were in a position to decide what was best for children and to give advice on how to rear them. Child rescue organisations flourished from the 1860s, and from the start of the twentieth century children came to the notice of other welfare organisations, run largely by altruistic middle-class women, and to eugenicists interested in the establishment of a superior race. Later, they became the objects of scientific medical interest. Jan Kociumbas explains how adults have been responsible for moulding children, so that childhood history must always be as much about adults as children.\(^10\) Children were not defined as individuals, but by what they meant to society. Their own particular health needs were usually interpreted by others, by their parents and health professionals, including paediatricians who saw it as their task to attempt to normalise children.

**Doctors and Patients**

The doctor-patient relationship in Western societies has been explored extensively by historians, sociologists and others. N.D. Jewson has provided an historical explanation of how patients came to possess such little power relative to the doctors. He has described the changes in the doctor-patient relationship from the eighteenth century to the late nineteenth century, which are relevant to the situation in the middle of the twentieth. In the 1770s, in the phase he calls “bedside medicine,” doctors had little

\(^10\) Ibid., xvi, xvii.
power. They were ignorant about the nature of most diseases and had few effective remedies. They served largely wealthy patients and were responsible to them for patronage. The techniques of the physical examination of patients had not yet entered medical practice, so the doctor relied on the patient’s words to make a diagnosis: the authoritative and autonomous patient was in control of the encounter. In the early nineteenth century medicine focussed on new knowledge about the pathology in body organs and the interpretation of the related physical signs. The history of the illness became less important, and the doctor’s close relationship with the patient diminished. The power of patients further lessened when their care was transferred from their homes to hospitals, which rapidly became larger as more and more people were admitted. Individual patients became relatively less significant in this phase, which Jewson calls “hospital medicine.” This was followed, in the 1870s, by the period of “laboratory medicine,” and one can argue that this phase persisted through most of the twentieth century. The focus was now on the cellular level and on physico-chemical processes that could only be measured in the laboratory. The doctor assumed even greater control and the patient as a person, and what Jewson called the “sick man,” disappeared from Western medicine.11

David Armstrong has also offered explanations for the changes that have taken place in the doctor-patient relationship. In the nineteenth century the medical gaze analysed in microscopic detail how illness was located within body organs “in the solid three-dimensional space of the human body.” By the middle of the twentieth century the gaze had moved to include the patient in a societal context “in the undifferentiated space between bodies.” This space included “the psycho-social determinants of attitudes, beliefs, and behaviour, which could only be elicited by listening to the patient’s views.” Until the 1950s paediatricians saw sick children largely as disordered body organs; they were in Jewson’s hospital and laboratory phases. After this time there were considerable changes and children came to be seen as a whole, which included a consideration of their intellectual, emotional and physical development. Armstrong argues that only then did paediatricians understand the developing mind of the child and the importance of the social milieu.12

Edward Shorter has argued that scientific medicine made drugs available in the 1940s and 1950s that actually cured disease, and that this seriously disturbed the doctor-patient relationship. The doctor lost interest in the whole patient-as-a-person approach that had existed before the war. Shorter has written:

> It must be emphasised that it was the appearance of caring which tended to be withdrawn. It would be ridiculous to argue that doctors actually somehow became less caring or less humane, since the character attributes of physicians have not changed over thousands of years. Merely the show of concern, the stage presence of a trained physician, came to seem less therapeutically important, simply because the doctor now handed out effective medications.\(^{13}\)

Paediatricians also were absorbed by their new capacity to deal with previously untreatable illnesses in children, particularly the infectious diseases. They appear to have forgotten the child as an individual.

**Professional Power**

The successful development of medical specialties depended on the aspiring practitioners possessing certain powers that have been described by Sadler and discussed in Chapter One.\(^{14}\) Paediatricians had to demonstrate to their colleagues in medicine that they possessed the power to control the production and application of medical knowledge relating to children and their disorders. They had to show that they were scientifically equal to the physicians in adult internal medicine. They also had to demonstrate their control of the production of medical care and the production of new paediatricians. The children’s hospital was central to all these aspects of professional development and was where the mechanisms of control could be most effectively applied.

For paediatricians, RAHC was particularly important for the control of the production of medical care because there were few other places to practise at the time when the major developments in paediatrics commenced in 1945. There was little private


practice, and the other hospitals in NSW had no special facilities for children. Paediatricians needed to control the children’s hospital to legitimate their specialty because, as Sadler has argued, control over hospitals provided the institutional basis for the control of medicine. Doctors had been at the top of the hierarchical structures in public hospitals in Australia from the end of the nineteenth century, and remained there until at least the 1960s. The new specialists in paediatrics had to maintain a dominant position in RAHC to establish their standing among the other specialties and among junior doctors, the nurses, the patients and their parents.

Medicalization and Foucauldian Interpretations

There have been a number of explanations to account for medical domination. The processes that led to the oppression of patients in the health system and hospitals have been described as “medicalization,” a term sometimes used by liberal humanists and sociologists writing from a Marxist perspective. In this sense medicalization has taken a negative view of doctors who attempted to enhance their position in society by presenting themselves as possessing expert knowledge that gave them the exclusive right to define and treat illness, and which subordinated the opinions and knowledge of lay people. The increasing power of scientific medicine further disempowered and exploited patients, limited their autonomy and encouraged their dependency. People who lacked knowledge, such as those in socio-economically disadvantaged groups and children, were further disadvantaged. This suggests that doctors and hospitals deliberately created a situation to subjugate their patients. This is contrary to the views of the philosopher and historian Michel Foucault, who has argued that institutional power did not emanate from groups such as doctors or hospital administrators. He has asserted that this form of authority was dispersed and lacked political rationale.

15 Ibid.
18 Ibid., 96.
Foucault has written extensively about power and discipline in institutions, including the military, prisons, schools and hospitals. Although his historical analyses have been strongly criticised he has put forward compelling ideas that have challenged existing institutional and cultural practices. He has questioned the Whiggish views of progressives who believe that in Western societies there has been a rise of “that humane emancipatory reason which was blueprinted by the Enlightenment, and constructed by bourgeois liberalism.” Instead, he argues, rationality and knowledge legitimised power, which then created disciplinary institutions such as hospitals, and entrenched administrative authority and bureaucratic regulations.20 He adds that certain individuals were under much greater pressures from a disciplinary regime than others. Those at highest risk were people who were “individualised,” those who differed most from what he calls the mainstream norm — the healthy adult. This included both children and patients.21

Foucault explains how power invested the space of an institution, such as a children’s hospital. It started in an insidious way with the target (in his terms, a docile body) in the form of the sick child. Power came through a multitude of often minor processes and from many different sources. The mechanisms of control were through discipline, in the broad sense of “training,” which was carried out in a closely detailed way with close attention to “the meticulousness of the regulations, the fussiness of the inspections and supervision of the smallest fragment of life and the body.”22

There were certain other techniques of “disciplinisation” described by Foucault that from the oral testimonies one can also see operating in RAHC. First, there was the control of the individual in space, by means of enclosures. The sick child was enclosed in the hospital, away from home and society, in a ward and in a bed, and sometimes in enveloping splints. Each individual was kept in his or her own cellular space, the bed.23 The second mechanism of discipline was through the control of activity and the timetable. Children were kept in bed, their play activities were severely restricted, and there were the regimes of hospital meals, treatment and washing. In the convalescent

22 Ibid., 140.
hospital there was the control of education and play activities, with rewards for compliance or punishment for breaking the rules.24

Another process of discipline was surveillance. The large, open hospital wards provided “the perfect disciplinary apparatus which made it possible for a single gaze to see everything constantly.”25 The ward sister’s desk was placed in a strategic position so that all the beds could be observed. The nurses were constantly watching the children. Surveillance included the techniques of routine medical observation, such as taking temperatures and pulse and respiration rates. In addition, there was indirect surveillance. The doctors and the matron on their regular rounds inspected the case notes with the carefully recorded observations of the nurses, and the noting of the giving of food and medication and the passage of urine and faeces.

Surveillance enhanced the power of the observer over the observed and emphasised their inequality. The traffic of surveillance was one way, towards the sick child. The process provided knowledge for the doctors that, when added to their already considerable expert knowledge, further enhanced their power over the observed patient.26 Lacking information, the child and the parents were unable to counter authority, even if they wished to, because they lacked a voice that was recognised as “legitimate.”

The powers of disciplinary space were enhanced by controlling communications with the subject of power, the child-patient. The presence of the parents interrupted the chain of authority in the ward and created potential conflicts with the governance of the nurses and doctors in their control of the child. Even communication between the patients was discouraged; it was a “dangerous coagulation” of individuals.27

Foucault’s word “docile” as applied to the children in hospital is appropriate. They were bodies to be “subjected, used, transformed and improved.”28 The coercion was constant,

23 Ibid., 141.
24 Ibid., 149.
25 Ibid., 173.
26 Foucault, Power/Knowledge, 104,105.
27 Foucault, Discipline and Punish, 143.
28 Ibid., 136.
and it was the processes of control that were supervised rather than the outcomes.\textsuperscript{29} Foucault points out that the disciplinary regimes often resulted from some rational medical need. Bed spacing and isolation improved ventilation in hospitals. At first, in the nineteenth century this was to stop the spread of evil humours that were believed to cause illness and later to prevent cross-infection. Strict bed rest was the mainstay in the treatment of certain chronic illnesses such as rheumatic fever and acute nephritis, both of which were common medical problems. The clinical observations were valuable for assessing the progress of the disease or its treatment. Foucault declares that out of discipline “a medically useful space was created.”\textsuperscript{30}

The reverse of Foucault’s statement was also true; medical practices were created which were in themselves useful for disciplinary control. Discipline was needed in the wards for social control to prevent children getting out of hand and it was easy to invent restrictions. While the patients might have accepted discipline as an instrument of medical action, it was its use in social control which worried the children. Former patients recall that they could not understand the reason for many of the restrictions placed on them, and no one tried to help them with explanations.

Foucault has declared that there was no point in asking who held the power that created this disciplined environment. Power installed itself and was located outside conscious or intentional decision. This form of power according to Foucault, was not the domination of one person or one group over another, not the power of a sovereign. This means that although there was a head person in the wards, the matron, and although there were the doctors, they were merely part of the apparatus which produced power. They were in an integrated system which functioned like a piece of machinery.\textsuperscript{31}

Some children in RAHC thought differently. All those who had long interviews, and many of the others, clearly identified a source of power in the matron or the ward sister. The use of the words “docile bodies” by Foucault also suggests submission and a pervasive coercive relationship in the hospital. Foucault has stated that disciplinary

\textsuperscript{29} Ibid., 137.
\textsuperscript{30} Ibid., 144.
\textsuperscript{31} Ibid., 176,177. Foucault, \textit{Power/Knowledge}, 97.
power to ensure social cohesion was one of the great inventions of bourgeois society.\textsuperscript{32} This implies that the attitudes that directed the system of oppression of children in hospital developed out of the prevailing social system, and provides a reason for this situation not being questioned by members of the public or by health professionals.

Foucault has provided useful theoretical explanations that are relevant to the plight of children in hospital, but they are not based on any observational or experimental data. Deborah Lupton explains that it is difficult to interpret some of Foucault’s views because of his shifts and inconsistencies and a certain lack of clarity when he describes power relationships.\textsuperscript{33} Hayden White relates how Foucault’s critics have questioned the truth of many of his statements, whether his interpretations are valid and whether his reconstruction of historical experiences are plausible. He notes that Foucault answers these criticisms by saying he sets the “free play of his own discourse against all authority,” which makes argument against his views difficult.\textsuperscript{34}

There are other explanations to account for the authoritarian environment of the children’s wards. Children's hospitals were created as separate institutions in the nineteenth century mainly to keep children away from sick adults because of the infections they might cause. Restricted visiting was introduced for the same reasons. The control of cross infection required a disciplined approach to the organisation of work in the ward, to the isolation of patients, to hand washing, and to the wearing of gowns and masks. Nursing staff could use the powerful argument of infectious disease control to further enhance their authority. Visiting was discouraged because the presence of parents diminished the nurses’ capacity to control the wards and interfered with what they saw as role to help sick children get better.\textsuperscript{35} Hospitals were conservative organisations and they were authoritarian, like schools and other institutions in the first part of the twentieth century. Power and authority were not easily given up.

\textsuperscript{32} Foucault, \textit{Discipline and Punish}, 105.
\textsuperscript{33} Lupton, 94-110.
\textsuperscript{34} Hayden White, \textit{The Content of the Form: Narrative Discourse and Historical Representation} (Baltimore: The Johns Hopkins University Press, 1987), 108, 130.
\textsuperscript{35} Irene Macadie, nursing sister, interview by author, tape recording, Sydney, 24 May 1999.
There are number of similarities between the doctor-patient relationships in RAHC and those in another hospital that, like the children’s hospital, provided care for a special section of the population whose needs were inadequately met. Janet McCalman has discussed in considerable detail how the women patients in the Royal Women’s Hospital (RWH) in Melbourne were disempowered and the victims of serious lapses of empathy and sensitivity. They were upset by a lack of privacy, by inappropriate remarks by the staff and by a lack of information. Many, like the children in RAHC, were just lonely or frightened. However, the male-female differential of the women’s hospital replaced the adult-child power differential of the children’s hospital. McCalman attributes the situation in the RWH to class and gender divisions. The gender explanations are not relevant for a hospital for children, but the explanations of class are more pertinent. Both RAHC and RWH were originally established by philanthropic bodies for destitute members of the community, and many patients came from socio-economically-deprived groups. One of the nurses in RAHC told of the different attitudes of doctors to private patients in RAHC. Private patients were visited more frequently, and their diagnoses, treatment and clinical progress were discussed readily with patients, in strong contrast to the way the patients in the public wards were treated.

The following testimonies of people who were patients in RAHC support many of Foucault’s concepts of institutional power and how it oppressed patients. What happened in the institution must also be related to what was happening in the evolution of the new specialty of paediatrics. Aspiring paediatricians were in the process of gaining power and authority to establish and their sustain their professional status. For this purpose their empowering position at the top of the hierarchy in RAHC was important, but this led to the relative disempowerment of those under them. They included the junior medical staff and the nurses, who had their own hierarchy. At the top was the matron, then the supervisory and the ward sisters, then came the junior nurses, their level in the system depending on the length of time they had been training. At the bottom were the child-patients, the most oppressed occupiers of the hospital environment.

The environment of the wards of RAHC was strongly authoritarian, as “Jill”’s experiences show. She was admitted to RAHC in 1948 when she was eight to investigate recurrent debilitating fevers. She recalled:

You knew that various uniforms on nurses meant they were sisters or nurses — the different colours and the different veil — just like school uniforms. You knew that that nurse was - and Matron, of course, made every one tremble. Matron was a dog. Matron frightened sisters, sisters frightened nurses and nurses frightened children. It was the pecking order — in those days the nurses were more concerned about whether the bloody crosses on the quilt lined up, because if they didn’t they got their heads pulled off. It was very military. They had mosquito nets which had to be gathered in a certain way, twisted in a certain way. The nurses had all this to contend with, so you didn’t really want a kid, who, after you had done all that, wet the bed. [“Jill” was a chronic bed-wetter]. It was a damn nuisance.

[The beds always had to be tidy] So we couldn’t do much anyway. You couldn’t colour in because the chalk might come off on your bed. You could read and you could hold your toys, but there wasn’t much else you could do. Total boredom. We just used to look at the ceiling — you could see all the kids lying there looking at the ceiling.38

“James,” with tuberculosis of the spine, had similar memories of the RAHC Convalescent Home, Collaroy Beach:

I remember for me it was a particular hellhole. The nurses for the most part were fairly good but some were absolute terrors. One could understand how they felt because they were under the thumb of the sisters. I can recall how in those days the beds had quilts with red crosses on them and those crosses had to be perfectly straight and the bed tucked in appropriately and the wheels of the cot or bed aligned just so, and when Matron or sister or doctor came around, the nurses would roll down their sleeves and put their cuffs on, and stand at attention. It was a very authoritarian atmosphere.39

Mrs Enid Bradfield was a nurse at RAHC in the 1930s. She explained that the quilts on the cots had a red cross on them, with RAHC embroidered on the cross stripe, which always had to be between the third and fourth bar of the cot, so that when standing at

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39 “James,” interview no.4. by author, 5 October 1999.
the end of the ward there was a straight line from one end to the other (see Figure 8.1). This disciplinary system which enforced the precise placing of the quilts was directed at the nurses, but indirectly the children felt the power of this regulation. Their play and other activities were severely limited to prevent the beds becoming untidy.

“Joan,” who had many admissions with rheumatoid arthritis from the age of three or four, said the children in hospital soon became aware of the system of authority. “You knew as a child who the head nurse was, who wielded the power.” There was little physical punishment, but “Jill” said that some nurses slapped children, although it was strictly forbidden by the administration. “Angela” remembers having her head put in a bucket of water because she wet the bed.

The system of authority in RAHC was daunting even for resourceful and relatively powerful parents. The popular novelist, Bryce Courtney, has written about his own son, Damon, who had severe haemophilia. He later developed AIDS from an infected blood transfusion. Damon was born in 1966 and died when he was twenty-four years old. As a child he had very many admissions to RAHC with manifestations of haemophilia, with external and internal bleeding, particularly bleeding into joints. He had numerous blood transfusions and intravenous infusions of Factor VII, the clotting factor in the blood that is greatly reduced in haemophilia. In his short adult life the problems of haemophilia continued, and he had numerous complications of AIDS; neurological, psychiatric, cardiac and others. Damon’s parents were articulate and vigorous in their efforts to try to help their child, and they were relatively powerful individuals in other spheres of society. “Sir Seymour Plutta,” their first paediatrician, whom they encountered after the baby had bled following circumcision, was pompous, patronising and impatient with them. He could not satisfy the parents’ needs for rational explanations of the child’s disorder and its future management.

Damon was admitted to hospital frequently for infusions of Factor VII. A fine needle was inserted in a vein and the clotting factor run in. It was a relatively simple procedure,

40 Mrs Enid Bradfield, with the support of Ruth Osborne. Letter to author, Canberra, 24 January 2000.  
41 “Joan,” interview no. 5 by author, 17 November 1999.  
42 “Jill,” interview no.6.  
43 “Angela,” interview no. 7 by author, 3 December 1999.  
and if it was given early following the first sign of bleeding usually prevented it getting much worse. The parents had great faith in the junior doctor who did these transfusions, but they soon realised that it would be more convenient for all concerned, and practicable, if they could learn to give the infusions at home. The Courtneys consulted other parents of children with haemophilia and found they also would like to do the same. They found out that haemophilia clinics in the USA used home treatment, and approached “Sir Seymour,” but he would not listen. He expressed the view that it was arrogant and preposterous of Courtney to suggest that the bleeding could be treated at home by a lay person. He alleged that Courtney was ungrateful for all the hospital’s efforts for their child and that it was wrong to lobby other parents. For parents to give such treatment at home would create an unfortunate precedent — soon patients might learn they did not always need the services of a highly qualified physician. The parents approached the Board of Management but it would do nothing as it was dominated by “Sir Seymour” and his colleagues. The Board members owed their positions on the Board to their Board colleagues, from mutual nominations, so they were reluctant to oppose the decision of one of their most important members.

The parents saw themselves as victims of an uncaring system. Courtney commented:

> The medical profession, as usual, was having it completely its own way. By the meek and mild patient standards of the time, we were making an impossible bloody nuisance of ourselves; doctors and hospital boards didn’t expect to be badgered.\(^{45}\)

Parents were overwhelmed by hospital authority. There were very few actions they could take to assert themselves, one being to remove the child from the institution. That might not always have been the best course medically, but was sometimes in the wider interests of the child. Based on a number of oral histories, Carol Mara has written a novel about a two-year-old child from a small country town who was admitted, paralysed by poliomyelitis, to RAHC. Her parents faced great difficulties in visiting her and getting any useful information about her treatment and progress. After a year of feeling helpless in the face of hospital intransigence they took their child home and treated her there, quite successfully.\(^{46}\)

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\(^{45}\) Ibid., 77...

The authority overwhelmed some children personally; their self-image was damaged. “Joan,” with exacerbations of rheumatoid arthritis, was sometimes admitted to hospital unexpectedly and unprepared, from an outpatient consultation, without personal belongings or clothes:

I was this faceless nameless thing — entering this tomb of a place again I was a no one — I was a nothing again. Doctors were talking over the top of my bed about me, as if I was a thing — no one talked directly to me. I was treated as a no one. I used to write notes to myself on small pieces of paper — “Julie I love you, and you are going to go home,” or something like that.47

“James” said: “I had the impression that I was the object in the bed that would most likely cause the nurses to come to grief with the sisters or the powers that be (he was naughty at times).”48 There were other remarks that provide additional evidence that children lost their identity on admission to hospital, further emphasising their powerlessness. These might have been evidence of a lack of awareness of the needs of children but they were certainly mechanisms of control. A girl, aged eleven years, who had a skin lesion removed in Royal Newcastle Hospital in 1958 said: “The adults were giants towering over the bed.” A boy aged nine remembered: “I was always treated as though I was pretty stupid,” while “Jill” added: “We were something that was moved in to be treated and moved out again. We didn’t have a say in the world, neither did our parents.”49

A few children learnt to deal with the authoritarian hospital system. “Angela” was first admitted to RAHC in 1949, and had repeated admissions for the next ten years for the treatment of congenital dislocated hips. She recalled:

[I coped] by becoming independent — I started to put my foot down about things. I suppose you could call it being cheeky at that age. I wanted to be treated differently, it was a way of asserting myself. Mum would sometimes bring eggs, a half a dozen eggs — so I could have an egg for breakfast. I knew how many eggs, and how many days, and if I missed out, I really let them know. I remember really letting them know I had not had my boiled egg.

47 “Joan,” interview no.5.
48 “James,” interview no.4.
49 Interviews no.46, no. 37 and “Jill”, interview no.6.
She added: “At about eight I learnt to handle doctors. I asked them what they were going to do.” She found out that there was a needle available instead of the unpleasant ether mask for her frequent anaesthetics. She demanded a needle and was allowed to have one.50

Some children who had been harshly treated recognised the prevailing culture in society which tolerated the hospital policies. “Jill” remembered:

Society was a lot harsher in the way children and adults were treated — stricter, tougher. Some of it, looking back, is appalling. Then it was the norm. I am sure the Children’s Hospital thought it was doing a good job — but I don’t think they realised how terrified we were. Children were something that were seen and not heard. You did what you were told, you went off to school and that was it — I think even as a kid we knew that the hospital [was bureaucratic]. You got to know the pyramids of authority. We were much more bound to authority than any child today. It was the same at school.51

Nurses confirm the strong authoritarian nature of RAHC and provide a picture of the children from a different angle. They confirm the atmosphere of authority and regimentation. If the children were at the bottom of this hierarchical structure of the hospital, the junior nurses were only a little further up. Ruth Burleigh, who nursed in RAHC from 1952 to 1957, remembered:

From the nurses’ point of view we lived in a very regimented situation. The wards were very regimented, our social life was regimented by the hospital into when you could go out and how many late nights you could have. So the regimentation we accepted as being normal. We had come out of the school system which was still pretty regimented, so we slotted into this formal hierarchical system where you kept your hands behind your back when you talked to the nurse who was a group ahead of you.52

Bette Thomas, who began nursing in RAHC in about 1947, also accepted the strict discipline and could see the reason for it. She worked in the hospital before antibiotics were readily available, when good nursing care was the only treatment available for many life-threatening conditions such as pneumonia and gastroenteritis. A vital part of

50 “Angela,” interview no.7.
51 “Jill,” interview no.6
this care was in the prevention of hospital-acquired infection, which could be life threatening in debilitated children. Its prevention required a disciplined approach to nursing and medical procedures. According to Thomas: “the discipline was strict but not oppressive — nurses who took pride in their work obeyed these rules no matter how irksome.”

The senior sisters held considerable power. One, who had been at RAHC from 1939 to 1980 as a ward and a supervising sister, expressed her fondness for children, and particularly for babies she had looked after, but also echoed the authoritarian attitudes of the hospital. She said few parents complained about the limited visiting hours. Some said that it was barbaric and cruel, but they were told that the nurses could do nothing about it and were invited to send their complaints in writing to the Board of Management. She said there were few formal complaints. Most parents, like nurses, dared not question the hospital and its doctors.

The honorary doctors, who were at the top of the hierarchical tree, took advantage of the authoritarian system, but chose not to question whether it was the most appropriate way to look after sick children. Ruth Burleigh recalled:

If you had Dr Stephens’ [a senior physician] patients, and he was coming to do a round, all his cots and beds had to be moved into the one position so that he did not have to walk all the way round the ward — and then move them all back afterwards. [The honoraries] were like God and they got enormously good treatment. That’s what they expected.

RAHC was not alone amongst children’s hospitals in its authoritarian approach. Another children’s hospital, the RCH in Melbourne, had a similar approach to children and nurses until the appointment of a new Matron in 1947. Some obstetric hospitals had even harsher environments. In her history of the Royal Women’s Hospital, Melbourne, which makes extensive use of patients’ and nurses’ testimonies, McCalman records that a nurse said: “The whole place was like the military — it was controlling — the whole atmosphere of the place was less than friendly — even up to the 1970s.”

References:
33 Bette Thomas, letter to author, Laguna, nd December 1999.
34 Christmann, interview.
35 Burleigh, interview.
36 H.E. Williams, From Charity to Teaching Hospital Ella Latham’s Presidency 1933-1954 The Royal Children’s Hospital Melbourne (Melbourne, Howard Williams,1989). 36,37. Yule, 341,351.
37 Mc Calman, 317.
The honorary medical officers appear to have been even more powerful than those in the children’s hospital: “Their medical authority was absolute and their dedication to healing and preserving life could, in extremis, exempt them from respect for a patient’s self-hood and autonomy.”

While the atmosphere of the RAHC was severe, it was consistent with the prevailing culture of authority in wider society, to which the institution added its own regimes of control. Some of these were necessary on medical grounds. There was the need, for example, to isolate or separate patients to prevent cross-infection. For similar reasons visiting was limited. Other regimes were more the product of a tradition-based organisation. Kociumbas has described similar conditions in schools in the 1950s which, despite the democratising changes in other areas, remained strongly conservative. Headmasters and teachers were mostly powerful authoritarian figures who were strict disciplinarians, and doctors were of the same ilk.

In RAHC the traditional practices of discipline and surveillance were embraced by those in the higher levels of the hierarchy. They were used by the matron and the senior sisters to exercise control over the junior nurses, and in turn over the children. The paediatricians accepted the existing system because it facilitated their quest for status. The power they gained was important for their professional authority and for the standing of their new specialty, but their empowerment was as the expense of the children.

*The Oral Histories - A Disparity of Knowledge*

Medicine, a serving profession, proclaimed that it developed to meet the needs of patients. In her history of medical specialization in Britain, Rosemary Stevens has declared that the sole justification for the practice of medicine should be patient care. However, people had little opportunity to say what they wanted from medicine. Their

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58 Ibid. 315.
59 Kociumbas, 212.
needs were largely determined by the doctors who possessed the authority of scientific knowledge and technology and were able to function relatively autonomously. For patients to know what they wanted from medicine meant they had to have an understanding of the available options, which were rapidly expanding with increasing scientific knowledge. The knowledge possessed by the patient was limited, and in the 1940s and 1950s doctors were largely unwilling to share their knowledge. This differential possession of knowledge enhanced the power of the hospital and the doctor and reduced that of the patient. Until the 1960s it was in the doctor’s interests of retaining power to limit the communication of information to the patient. This was especially so for the insecure doctors with their recently acquired knowledge in the new specialty of paediatrics.

The patients’ lack of knowledge made it difficult for them to engage with doctors in discussing health care. Most of what we know about the history of medicine has been written by doctors. The role of patients has rarely been considered in any depth, although at least two people, the doctor and the sufferer, are involved in any medical consultation. Sometimes there are more than two, as in paediatrics, with the family also involved. Porter recognises that “we remain profoundly ignorant of how ordinary people in the past have actually regarded health and sickness, and managed their encounters with medical men.”

People in Australia were becoming better informed about medical science after the Second World War. Sidney Sax notes that the media had brought health issues to the attention of consumers. He argues that in Australia in the 1940s and 1950s the public and various pressure groups were requesting better medical services because they were becoming more knowledgable about health. Consumers increasingly came to believe that health care was a basic human right. Even by the end of the 1930s in NSW the public had come to appreciate that as a result of scientific developments public hospitals had become safe and effective for them and their children. People had gained greater

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confidence in the ability of health professionals, but it was unlikely that they could ever possess sufficient knowledge for patients to be equal partners with doctors in making clinical decisions.

In an analysis of the rise of medicine in the USA, Paul Starr says that the American people believed that they received the sort of medicine that they themselves wanted, but that what they wanted was conditioned by a powerful and persuasive medical profession. Their own views, if they had them, were submerged. Doctors convinced their patients of the undoubted benefits of medical science and technology, and of their own skills, although often they promised much more than they could deliver.64 Vicente Navarro has disagreed with Starr, saying that the majority of Americans were dissatisfied with their medical care. There were more powerful forces than persuasion at work. The dominant socio-political groups, the medical profession and the capitalist system, shaped US medicine by the repression and coercion of the majority of the population, which was differentiated by class, gender, race and other power structures.65 There has been no similar analysis of Australian medicine and the American system is very different to Australia, but Evan Willis, in his book on the development of professional groups allied to medicine, suggests that the medical/capitalist system was dominant in determining health care here, implying that people had little say in the sort of health services they got.66 The evidence obtained for this thesis suggests strongly that the development of paediatric services was doctor-driven.

It was not until the 1960s in the US and later in Australia that people began to ask whether they should not have some say in the planning, management and delivery of their health services.67 Before this, patients lacked the power to influence their health care. When the patients were children they were even further lacking in authority.

66 Evan Willis, Medical Dominance: The Division of Labour in Australian Health Care. 2nd ed. (Sydney: Allen and Unwin, 1989), 216.
Kociumbas has discussed the difficulties of determining what children thought about their health and health care. Mostly one has to rely on the parent’s interpretation of what their child felt, or on the memories of their own childhood experiences, memories that are often influenced by later events and by romantic views of an ideal childhood.68

It would be unreasonable to expect young children to say what they wanted for their health, because their knowledge and experience was limited and they lacked the capacity to express themselves. However, the people interviewed were rarely given any opportunity, as children in hospital, to make decisions about the simplest matters like food and play preferences. One might have expected, however, that their parents would have been consulted. Parents did take the responsibility for the care of most of the ailments of their children, and almost without exception children had many illnesses, mostly minor infections. Parents managed these illnesses satisfactorily themselves without professional help, using a wide range of remedies kept at home.69 Sometimes they sought the reassurance of their general practitioner and occasionally they needed a specialist or a children’s hospital.

Parents of sick children seeking help often went through a number of consultants. Initially these were lay consultants in the form of relatives and friends, then a series of professional experts, each being more authoritative than the last. If parents in Australia wished to see a paediatrician they became involved in a professional referral system. They first approached their general practitioner who, if he thought it necessary, referred them to a paediatrician. As part of this system the knowledge and skills of the consultant were assumed to be so esoteric that they could only be evaluated by another doctor; parents were not capable of making that decision. In these processes the parents moved further and further from their own power bases, with reduced opportunities to make their own decisions.70 Parents could also take their child to the emergency department of a children’s hospital, but there they would only be able to see a specialist if referred by the resident medical officer. It was different in the USA where paediatricians were consulted directly. Many middle-class families had their own

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68 Kociumbas, xvi, xvii.
69 Helen Townsend, *Baby Boomers Growing up in Australia in the 1940s, 50s and 60s* (Sydney: Simon and Schuster, 1988), 57.
chosen paediatrician, which gave them a measure more of power than Australian parents.\textsuperscript{71} In Australia doctors took the responsibility for determining the health care the child received and the parent’s authority was limited. They were part of what has been called a collegiate form of client-professional relationship.

There is very little documented information about what parents wanted for their children, or what older children, with some ability to understand the issues, wanted. On the evidence from the interviews with parents, they were not greatly aware of the recent progress in medicine and surgery from the 1940s to the mid-1960s. For example, Mr and Mrs “Clark,” the parents of a child who had a heart operation in RAHC in 1960, said they could not remember reading about cardiac surgery around that time. The only information they had came from their doctors in the children’s hospital with whom they had been in contact since 1957. They said they were young parents and were not much aware about what was going on in medicine generally.\textsuperscript{72} Another child, “Peter,” remembered his parents watching an American television program on heart surgery before his big operation in 1963 when he was aged eleven years. He had experiences of hospitals, and several other operations, from his babyhood. He said: “I wasn’t specially interested, I vaguely remember it.”\textsuperscript{73} These remarks suggest that not all people shared the interest in health matters discussed by Sax, even if they had a personal involvement in the matter.

There was little effort to involve patients in discussions on the broader issues of health planning between 1945 and 1965. There is nothing to show that RAHC or the paediatricians sought the views of parents or the public on what sort of services they wanted their children’s hospital to provide. One hospital administrator admitted that the task was too difficult.\textsuperscript{74} Dewdney has pointed out that when energetic approaches were made to gauge the opinions of the consumers of health services, more critical views were uncovered, but these sort of surveys began only in the late 1960s.\textsuperscript{75} Except when it came to seeking donations, RAHC was remote from the public, although one might

\textsuperscript{72} Mr and Mrs “Clark,” interview 8 by author, tape recording, 12 October 1999.
\textsuperscript{73} “Peter,” interview no.2 by author, tape recording, 28 September 1999.
\textsuperscript{74} Mr Trevor Ward, interview by author, tape recording, 12 May 1998, Sydney.
\textsuperscript{75} J.C.H. Dewdney, \textit{Australian Health Services} (Sydney: John Wiley and Sons Australasia, 1972), 341-343.
interpret the widespread and generous charitable support received from individuals and from community, trade and other groups as an indirect mark of approval of the work of the hospital.  

There was a considerable gap in the level of knowledge possessed by doctors compared with lay people. Doctors and hospitals were unwilling to share their knowledge, or to take steps to find out the people’s views about their health needs. People seemed uninterested in challenging that situation. In RAHC, until the 1960s, doctors did little to bridge the knowledge gap. Children and parents were largely kept in ignorance, which enhanced the authority of the doctors and the hospital staff.

“Beryl” had an operation for hallux valgus (hammer toes) in RAHC in 1948, aged eleven years. She recalled:

I don’t remember whether my parents were involved in discussions about the operation. I think they were just told I had to have it, and that was it. My father, although he ended up as a superintendent at Nestlés and was there for fifty years, he didn’t say very much at all. My mother was very quiet. She was very meek and mild, so that if someone told her I needed an operation, that was it. In those days you did not question what the doctor told — they were on the top of the pinnacle — there was no discussion whether you wanted it or not or what was going to happen afterwards [she was immobilised in plasters in bed for four weeks].

Many of the interviewees complained that their hospital stay was made much worse for them because they were not told anything. Their problems of pain and discomfort were compounded by a lack of information pitched to their level of understanding. They were not told about immediate events like procedures, nor about their proposed treatment plans or their prognosis.

“William,” aged ten in 1952, suffered from polio. He was taken from home in an ambulance, without his parents, to RAHC. He recalled:

They bunged me into hospital, and I think I was in the isolation ward — the main thing I can remember first is being bundled up into a big ball and this big needle stuck into my back. It was most painful. I can still remember, real vivid. They were all — I can’t remember how many — were holding me down while this

76 RAHC Annual Reports. Each year the hospital published a very extensive list of donors.
77 “Beryl,” interview no.3 by author, 10 November 1999.
doctor was shoving this needle in my back, and it hurt. They didn’t tell me. I didn’t know what was going on — all I knew was that I had poliomyelitis. I didn’t even know what that was, and I never did find out until I grew up a bit more. I had the lumbar puncture in the first hour or so that I was there — it was my first experience of the hospital. Doctors and nurses holding me down and shoving this thing in my back. A good experience!78

“James” recalled:

I remember being in the double spica [a plaster cast], a real neck-to-ankle job. That was an unpleasant experience. The actual application of the plaster itself was unpleasant, because one was spread-eagled on the plaster table to have the plaster applied. Of course they needed to get under you, so the way they did it was to put your feet in foot splints with a bandage around them, and your shoulders were on a head piece, and then beneath the sacral spine they had a little, about four or five inches long by about an inch and a half wide, strip of metal on a pole that could be plastered right over and the whole thing could be pulled out at the end. They covered you in netting and wound the plaster around you. It was an exceedingly painful experience. I remember it so clearly. I was getting on to six or seven, I’m not really sure. This happened a number of times; plasters were taken off and reapplied to allow for growth. For a kid who had had no physical exercise to tighten muscles it was agony, with the weight of the plaster bearing down — you felt it all. I remember one occasion — I had several plasters applied. I was sent up just before three o’clock and put up on the frame and then — doctor always had his cup of tea at three o’clock, and so I was left there without any explanation. When the doctor came out I was in utter agony, and tears were flowing down and I remember the curt comment, “What are you blubbering about.” Dear, that fractured me, that’s well over fifty years ago. That’s the way it was.79

A girl, aged eleven, had suffered polio as a baby. She had many operations in Royal Newcastle Hospital for the resulting deformities. She was very fond of her orthopaedic surgeon, who she called Uncle Gordon. He talked to her a lot about her treatment but she remembers being distressed waking up after an operation in 1968 when she was eight to find large metal pins protruding from the bones in her leg, for splinting. She was not aware that this would happen.80

Some children received disconcerting messages. A girl aged six with osteomyelitis remembered that no one ever talked to her about her treatment, but she was upset to hear her doctors discussing taking off her leg. She was not meant to hear, but she was a

79 “James,” interview no.4.
80 Interview no.50.
perceptive and observant child: “I listen, I look, I don’t ask questions.” Sometimes information was obviously false. As a toddler in the private ward at RAHC, a girl remembers being told “It won’t hurt” just before a blood test. The doctor had difficulty finding a vein to take the blood and it took three nurses to hold her down.

A boy, aged nine, was in Canterbury Hospital with rheumatic fever for six months in 1949. The treatment of the time included strict bed rest. He had to lie flat and was not allowed to sit up. If he did he was promptly told to lie down. It was isolating and exceedingly boring. He had no clear idea of what was wrong with him. No one explained to him the reason for the bed rest treatment, and he was too timid to ask.

A boy who was in RAHC in the late 1930s with diphtheria found hospitalisation a terrifying experience that has stayed with him all his life. He said that men in suits came to visit him. They might have been doctors. He was not told anything and no one wanted to get close to him. He parents were not allowed to visit. He had another unpleasant experience when his tonsils were removed two years later. At the age of nine he remembers being carried, screaming, into the operating theatre, not knowing what was going on.

The lack of explanations made children fearful, not only of real events, but from those generated by the vivid imagination of childhood. “Jill” said it was:

The fear of the unknown, absolutely, not knowing. There was the fear that the procedures you saw other children having would happen to you. We were terrified — it was like being in a torture chamber. You did not know what you were going to get. Procedures, like blood transfusions, were turned into bogies. I used to watch this blood dripping down in the kid next to me — who died — so, I thought “That doesn’t work.” Because when you are eight, and maybe when you are feverish, maybe not, your mind gallops with terror. The fever makes it worse. Any child of eight is very imaginative in the worst possible way, and feels threatened if they don’t know what it means. The lumbar puncture thing, I thought if that happens to me I’ll die [a tray of instruments for a lumbar puncture for another child was mistakenly put on her bed]. That’s why when they came in and put his stuff on my table I was out. Everything went blank — I fainted.

81 Interview no.53.
82 Interview no. 20.
83 Interview no 37.
84 Interview no.9.
85 “Jill,” interview no.6.
Children in hospital were exposed to many distressing experiences for which they received no explanation. One of the most disturbing was the death of a child in a nearby cot. Deaths were rare, but more likely to be experienced by a child during a long admission. In response to a question about children dying in the ward, “James” recollected:

I remember the first death I came in contact with. Everything was quiet in the ward. One of the nurses was going round the ward and suddenly there was mad rush for the telephone, many running feet, screens were whipped out and put round the bed. The doctor came running, and then, well, there was the empty bed. The trolley whizzed out. From the ward we could see the morgue, we had an idea of what was going on — but you weren’t told anything, it was just hushed up.86

“Jill,” aged eight at the time, was in a cot next to a child who was so weak that she could not undo the wrapping on a doll that “Jill”’s mother had given her. No one thought to undo it so the child could play with it. “Jill” remembered:

The day that little girl died — She was taken out in the night. I remember the circles of torchlight. We knew she just died — I don’t know quite how, but we knew she was dead. The next day all these clowns came in and were jolly [to entertain and distract the children]. We found that really offensive. The hospital probably thought: “The kids are in a state, we’d better do something.” Because people always think that children can be snapped out of things by something silly. I remember we felt a terrible obligation, we felt we should respond and we did not want to. We felt, oh dear, its like going to a birthday party, and not liking it. We tried to laugh but it was very hollow. It would have been better if maybe they had explained to us, or even something solemn. It would have made us feel a whole lot better than clowns. Clowns were an insult. Probably some poor stressed doctor said, “God, Cheer them up.”87

In RAHC there were few opportunities provided for parents and children to have even simple information about the child’s illness from the doctor who was responsible for the medical care, much less to have any part in making clinical decisions. Many of the honorary medical officers were reluctant to talk to their patients or their parents. The attitudes of some of the honoraries became apparent when the hospital administration proposed to increase the visiting hours, as recalled by a senior nursing sister:

The people who disliked it most were the [senior] doctors. The specialists doing rounds, they loathed it, because they had to speak to the people. Otherwise they

86 “James,” interview no.4.
87 “Jill,” interview no. 6.
never had to speak to them. One of the senior physicians was so adamant that in her ward we had to change the visiting hours from the afternoon to the morning so there weren’t mothers and fathers there when she came around. She was a very good paediatrician, an excellent one. I was very fond of her, but she had that feeling that she should not have to deal with parents. It was a common attitude then. She was fine and she understood her patients, it’s just that she did not understand the parents.88

The only way that parents could get medical information about their child was to arrange to see the junior resident medical officer. He had a set time for such meetings, once a week, on a weekday, between 1 and 2 pm. He talked to the parents in the front hall of the hospital where there was no privacy. They rarely received any information from the senior honoraries.89

Very few of the interviewees could recollect the name of their doctor, even when they were specifically asked. “William,” who was in hospital for fifteen months with polio has little memory of his doctors, except that of fear because they always seemed to hurt him. He remembered: “They did rounds about once a week. No one told us their names and they never spoke to us.”90 “Angela” was one of the few who remembered her doctor’s name, but it was with strong reservations:

In those days you were children and you were spoken over, never to. You might get chucked under the chin — “How are you today?” — but then you were forgotten. I didn’t find them friendly. I think, to sit down and talk to you as a person would have been much nicer. But it never happened, not like it is today.91

Mostly the doctor was a vague distant character, but sometimes the memories are disturbing. “Jill” was upset because her doctor was patronising and paternalistic, illustrating that there was sometimes a gap between how some children saw their doctors and how paediatricians saw themselves as possessing special qualities that appealed to children. “Jill”’s doctor was considered by nurses to be the epitome of a paediatrician.92 One remembered: “[He] was just so charming, he never seemed to be in

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88 Christmann, interview.
89 Ibid.
90 “William,” interview no. 1.
91 “Angela,” interview no. 7.
92 Irene Macadie, interview.
a hurry, gentle and lovely with parents and children.”  

I hated him — he was my doctor, he was a phoney. Kids hate the jolly bonhomie — it’s very artificial. I hated him saying...because I had this thing about being so thin [from her recurrent bowel infection]. when he said “We don’t need to X-ray her, we’ll just hold her up to the light.” I never forgave him for that. I thought, “You pig.” I was very self-conscious about being this terrible little scarecrow with my cheeks all in and my eyes all out. To be just capped off by this jolly joke about being held up to the light, I thought: “I hate your guts.” Looking back on it, its quite funny, but when you are in the chair and you are that thin and a child, in front of others...The nurses all tittered and they all seemed to be the age of my teachers at school who sent me up as well. I thought “I just hate you” and so I hated him ever since — he lost me on that, absolutely. He probably thought he was being funny, but I also did notice, as a child, that he had two faces. Chatty chat to the kids, and he really treated those nurses like slaves and skivvies, very bossy, very “ha ha ha. Do that! Do that!” It was very rude, and the kids noticed it. Kids don’t miss much. We thought he was a phoney. It would have been better if he had been a cranky pig to us, because he was to everyone else. To deal with “I’m your buddy-buddy friend” and then to be rude to everyone else...it was a double standard that the kids picked like that.

In contrast, others who were patients in another children’s hospital, the Princess Margaret Hospital for Children (PMH), Perth, between 1945 and 1965, had different experiences of their doctor. On the evidence of a small number of interviews they had much warmer memories of their admissions, and of the medical and nursing staff. For example, “Roger” had acute nephritis at the age of twelve, and was in hospital in 1948. He was kept on strict bed rest for four months. He said his doctor was “a very nice person — quite frank.” The doctor who took out his tonsils later was “a smiling jovial sort of chap.” The nurses were also all very nice: “They gave you good attention. Whenever you wanted anything they were always there, and made you comfortable.” “Linda” was in hospital with severe burns, aged ten, in 1951. She remembers with considerable distress the pain and the itching, the dressings of the burns and the unpleasant medicine. Apart from that it was “just jolly good fun.” The nurses were “tremendous” and she remembers her doctor’s name clearly: “He was the nicest man.”

The oral sources were recruited by Julie Marshall for her commemorative history of the

93 Burleigh, interview. .These views were echoed by Phil Clifton, interview by author, tape recording, Sydney, 8 June 1999, and Joyce Christmann, interview.
94 Hamilton, interview.
95 “Jill,” interview no. 6
hospital which may have determined the sort of people who volunteered to be interviewed, with only people having positive views responding. It might also be that only positive experiences were included in the history.96 Another reason for the difference from RAHC may have because the hospital was much smaller. PMH had 250 beds in 1948, while RAHC had 440.

In Sydney things were generally not so satisfactory for the children but some doctors were judged very good at providing information at a time when this approach was unusual. The mother of a baby admitted with pyloric stenosis to the children’s ward at Royal Prince Alfred Hospital in 1951 said that her doctor, Dr Norman Cunningham, who was also a physician on the staff of RAHC, went to great lengths to explain the diagnosis and the operation that was needed.97 However, for many children and their parents the lack of information was a great problem contributing to their disempowerment.

Even if doctors in RAHC had been willing to talk to parents, the restricted visiting hours made it difficult for parents to meet them. The only visiting time for parents in the 1940s and for most of the 1950s was on Sunday, for a couple of hours. The honorary medical officers did not attend at that time and the regular resident medical officer was rarely there at the weekend. Many parents were from the outer suburbs of Sydney, or from the country, and taking public transport was usually difficult. “Angela”’s mother believed she had a very good doctor, but “he was not really very accessible — you would have to go to Macquarie Street to see him.” That was difficult because she lived in Newcastle. To get to Sydney to visit her child and back home meant enduring a very long day which lasted from 5 am until 10 pm.98

The negative attitudes to providing information to children and parents in the 1940s and 1950s stand out as extreme in contrast to those of a later period. Doctors from the 1960s onwards felt it important to talk to their patients and their parents who, in turn, appreciated having information directly from the doctor responsible for the care of the

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97 Interview no. 39.
98 “Angela,” interview no.7.
child. For children, however, providing appropriate information was sometimes difficult and some, even older ones, had problems in understanding all the implications of what they were told. An intelligent boy, “Peter” had major cardiac surgery in 1963 when he was eleven:

When they did the major operation [repair of a complicated congenital heart lesion, Fallot’s tetralogy] Dr. Gengos and Dr. Cohen [the cardiac surgeons] took the time out to explain this in great detail to me. Of course at the age of eleven it didn’t mean much, but they talked to me directly. They showed me diagrams and cut-away pictures of the human heart and all that sort of thing — so I can’t say I wasn’t informed. All I can say that at that age, that sort of information doesn’t mean much.99

Despite children being given extensive information about their treatment, they were always in the hands of a person with superior knowledge. “Peter” continued:

As it [the operation] was an absolute raving success, it’s very hard to criticise. Your judgement of conditions when one is eleven or twelve years — your judgement is not all that good or that refined. Maybe it is an era thing, but children of that time didn’t have the same expectations as young people now. You tended to go along with a lot of stuff whether it was right or wrong — a bit like being in the army.100

Some parents were highly impressed with their meetings with the cardiac surgeon who was going to operate on their child, but they always remained in the hands of the expert. Mr “Clark” recalled:

I find it hard to find words to describe this man, Cohen. He was gentle and friendly, he was an inspiration and I knew the man had skill and knowledge and he was the best one around. We didn’t know of him beforehand, but after my first talk with him I was sold. Sometimes these guys at the top of the tree tend to be a little bit “God” and don’t get out of the ivory tower. This guy was just the antithesis of that. We were in his hands all the way. The way he explained to us — he didn’t treat us like a couple of ning-nongs, saying: “This is what has to happen, just sign the paper and let’s get on with it.” It was: “Any questions?” A great man. I just had so much confidence in him. If he had said “Go and stand on your head in the corner,” I would have done it. So when he said “He has to have the operation, its time”, that was it. His natural manner [impressed me]. He was a quiet man, he spoke quietly, he was always friendly. That’s the impression I got straight away.101

99 “Peter,” interview no.2. by author, 28 September 1999
100 Ibid.
101 Mr. and Mrs. “Clark,” interview.
Some interviewees later experiences in hospitals that enabled the earlier experiences to be re-examined in a more informed light. “William,” who had such an unpleasant time with polio because he was not told what was happening to him, made some revealing observations. In 1992, forty years after his first admission to hospital, he and his wife had a child who was born prematurely. The child was admitted to the neonatal intensive care unit in RAHC. “William”’s experiences contrasted vividly with his expectations based on his childhood memories:

I went down there next morning and I was introduced to Dr. Barr. He said: “My name is not Dr Barr, I’m Peter. This is June; this is so and so. These are the nurses who will be looking after your son. Now this is what we are doing and this is what is happening, and this is why he has this [equipment] on him.” They explained everything: “If you want to know something just come and see me.” It was just so totally different to when I was in hospital — the same hospital. It was so different. We could be there at any time and sit with him. I couldn’t help thinking what it was like when I went into hospital. That first week — it was reassuring the way the doctors and nurses would talk to you. We knew exactly what was going on. When I went in [to hospital in the 1950s] I didn’t know and my parents did not know what they were trying to do, or doing.102

“Beryl,” who had an operation for hammer toes at the age of eleven in 1948, and who was told nothing about her impending operation, was invited in the 1980s to join a group of five cardiologists and other specialists who were developing a plan for the management of her child’s congenital heart problem.103 This was very different to her earlier experiences and typifies the changed attitudes to the sharing of knowledge between doctors and patients and their parents. The changes also point up the power that paediatricians gained by professionalizing child health knowledge, which gave them authority over other doctors who lacked that knowledge. It also enhanced their privileged positions as experts in their relationships with parents and children, who were denied any claims to information about what was happening to them.

Conclusions

This chapter has shown how through most of the 1940s and 1950s children who were patients in RAHC and their parents were seriously disempowered. Through various

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102 “William,” interview, no.1.
103 “Beryl,” interview no.3.
techniques of disciplination, the restriction of their activities, their isolation and their close surveillance they were made into docile bodies. Matters were made much worse because the children and their parents did not know what was happening, either in everyday matters or in their diagnosis, treatment and prognosis. The experiences of the children coincide closely with Foucault’s views on power and discipline in institutions.

Foucault has said that in hospitals such as RAHC the power which created the disciplined environment was an inevitable association of the institutional system. It was not controlled by any one person or group, but it allowed oppression to be installed and to persist. Foucault’s explanations may free the paediatricians from blame for inventing the power they held, and in any case, it was in place long before 1945. Also, it is difficult to accept that doctors and nurses had any malign intentions towards children.

However, the paediatricians chose to retain and exploit a situation that kept them at the top of the hierarchical tree in RAHC, over the junior medical staff, the nurses and the patients — the children. Their position provided them, as specialists in a new field in medicine, with authority and helped legitimate their specialty. The paediatricians could show that they were equal in status to their colleagues in the other teaching hospitals, particularly the physicians in adult internal medicine who had previously thought them inferior. The children at the bottom of the hierarchical order were placed at risk by this oppressive power. Administratively the paediatricians were in a strong position to change the system but they were very slow to act. It suited their professional purposes not to do so. As the specialty became more secure, and as social expectations began to change, the need to preserve status by enforcing the hierarchy weakened. This can be most clearly seen in the question of the separation of children from their parents, the subject of Chapter Nine.
Chapter Eight discussed the distressing experiences of children admitted to the Royal Alexandra Hospital for Children (RAHC) and other hospitals from 1945 to the 1960s. They were oppressed by the systems of disciplinage found in the hospital and their lack of knowledge of what was happening to them. Their most serious problem was the separation from their parents, the most disempowering feature of hospitalisation, which was made worse by the restricted visiting. This chapter examines the problems associated with the separation of children from their parents with admission to hospital. It discusses the improvements that occurred from the late 1950s and 1960s. They came partly from changes that reflected an increased awareness of the emotional needs of children. There were also changes in the power structures in the hospital which facilitated the adoption of a different approach to the care of children.

In RAHC, until the late 1950s, parents were only permitted to visit once a week, for two hours on Sunday afternoons, unless their child was dangerously ill when more frequent visiting was permitted. This was particularly distressing for young children who could not understand why they had been deserted and for children who were in hospital for long periods. Admissions for weeks or months, and sometimes years, were common until the 1960s.

The hospital, the doctors and the nurses had a number of reasons for keeping parents away from the children. They were worried that outsiders might bring infections into the wards and put the children at risk. This had been a real problem in the nineteenth century and the earlier part of the twentieth, but by the late 1940s it was no longer important. Parental visiting was thought to disturb the child and hinder recovery, based on the evidence that children were considered to cry excessively when their parents left. Parents often brought their children unsuitable food that might cause vomiting or upset
their appetite for hospital food, and their presence disturbed the routine work of the ward. Some nursing sisters feared that with unrestricted visiting they would lose control of their wards if too many parents came at the one time.¹

Children admitted to RAHC for medical treatment were separated from the love and security provided by the parents in the familiar environment of the home. They were among strangers in strange surroundings. “Joan” had a particularly difficult time in the children’s hospital. She had rheumatoid arthritis and experienced numerous admissions to hospital beginning in the 1940s when she was three. She recalled:

I had no mentor, no protector no guardian — at home I had Mum and Dad. Suddenly you are in this environment and people have all this power to do things to you and you are so conscious that no one is on your side. My parents, they were my backup, but they were miles away at home.²

“William” had polio in 1951 when he was aged ten years. He was sent off to hospital by ambulance, feeling very sick and with a paralysed right leg in which he had no sensation. He remembered:

My mother wasn’t allowed to be with me. I went off in the ambulance by myself. Mum and Dad weren’t allowed to come with me. They stayed home. I didn’t see them for ages. I didn’t see them at all the month I was in Royal Alexandra Hospital. I still don’t know why. Mum just said they weren’t allowed to. I never saw any of the family, any of them in that first month, that first frightening month of being in hospital. For a ten-year-old it was quite strange. This was the first time I had been away from home.³

Later he was at the Convalescent Hospital at Collaroy Beach, encased in a large splint, but contact with his parents was still restricted (see Figure 9.1). He added:

I couldn’t get out of bed, I couldn’t do anything. From being an active nine-year-old to suddenly being in bed in this frame — it knocks you about a bit. I was upset more than angry, because at this stage I was allowed visitors — Mum and Dad — but they used to wheel me out in my bed. There was a table like this. Mum and Dad sat on that side. I was on this side on my bed and that table stayed between us at all times. We weren’t allowed to touch each other — that was the closest I got to seeing them. They were allowed to come out once a week on a Sunday afternoon, that was visiting day. The rest of the time they weren’t allowed because

² “Joan,” interview no.5 by author, 17 November 1999.
they reckoned it disrupted the routines too much — upset the kids. We were only allowed to see them on a Sunday, so Sunday was a big day.4

“Jill,” aged eight, had a two-month admission to RAHC after being a patient in other hospitals:

Visiting was once a week and preferably just one parent, not two, and no younger siblings. So I didn’t see my sister who I was very close to — she was three years younger, so I missed her heaps. My mother had to come all the way from Gordon to Camperdown on Sunday public transport in 1948, which was about two buses a day. By the time she got there she was a rag. I remember there was this funny gap when she first came in. I was aching to see her, but until she smiled at me a lot I couldn’t get to her. I was pretty frozen off, which I did not want to be at all. It was almost like a shyness because I had not seen her for a week. I was not angry at all, or resentful. I was just a bit too sad, and I couldn’t cheer up, but if she kept smiling at me and hugging me up, suddenly I would melt, and just as I melted and it was really lovely, and I adored her being there, she had to go and you went back in. All the children used to howl like crazy when their parents went. The nurses would find it very difficult to settle us down on Sundays — they hated Sundays. My friend [a nurse] told me she hated Sundays. Once the parents went home, the kids were everywhere. They could not get them back into the regime. They had to go from one to another — tears and tantrums. My mother tried to explain that it was terribly hard to get there so she did not blame it all on the hospital, even if she could have come more often she may not have been able to. So she was quite fair about that. I did understand that it was hard to come.5

A small girl was in RAHC for several years from 1945 when she was three, with dislocated hips. Her parents visited infrequently because they lived in the country. When she went home she was surprised to find that she had two brothers she knew nothing about.6

Children with infectious diseases were, in the hospital practices of the time, not usually allowed to be visited by their parents. As a three-year-old, a boy was in a smaller hospital with polio in 1952. He believes he was there for four or five weeks, which to him was a very long time. He was allowed no visitors but can remember his parents peering into the ward through a window from the corridor. He was told his parents could not come into the ward because it might make his condition worse.7

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4 Ibid.
5 “Jill,” interview no. 6 by author. 16 November 1999.
6 Interview no.14.
7 Interview no.33.
A four-year-old was taken to RAHC with a broken nose. He remembers being placed in a cot and laid down on his back and tied down with wide sheeting straps. He can still see his mother crying and being dragged out of the ward by his father because they were told by the nurse that they had to leave. Another four-year-old was in a smaller hospital to have her tonsils removed. She had a strong feeling of abandonment and isolation: her most vivid memory is of her only familiar possession, her red dressing gown.

Children were not only isolated from their parents, but they felt isolated from other people in the hospital. “Joan” said the patients in RAHC were kept away from other children because of the need to keep the ward neat and tidy (see Figure 9.2):

I was in bed — in my little boat of a cot on a sea of polished wood with all the beds exactly in line, where we could not touch other. You could see other children through the bars but you couldn’t touch them. The cots were too far away, and the great thing for us to do was to tie the sheets in knots, and if Sister was absent from the ward, throw the sheet up to the next cot, and if the brake was off on the wheels, we could pull ourselves towards each other, and form a little life raft in this wooden sea and actually show some one else your toys or drawings, and have proximity to another child, and someone to talk to. But as soon as Sister or nurse came back, it was “Tut, tut, naughty girls, what are you doing?” Then we were moved apart again.

Toys were important for children because, as well as for play, they provided a link with their previous familiar, secure life, and their parents, but even they were removed in some wards. “Jill” recalled:

They took our toys away at night because there was something about them being unhygienic, and the kids hated that. We used to wail when they took the toys away. The nurses did not like doing it but they were told to do it — it was apparently unhygienic to sleep next to a furry toy, but you lay there with it all day, so why the night and not the day? Children at least couldn't understand and I still can't. I don’t know why night air and day air are so much different, or something — but away went the toys and night was when we were most frightened. So night was the time you needed your toys more than the day.

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8 Interview no. 16.
9 Interview no. 34.
10 “Joan,” interview no. 5.
11 “Jill,” interview no.6.
“Joan” has similar memories of the isolation of hospital life:

You weren’t allowed to have any toys — you couldn’t sleep with your arms under your head. If you had your arms under your head the nurses would make you take them down. The toys were taken off the bed. I think we had a pillowcase on the corner of the bed, where the toys were. The main thing was I couldn’t get the side of my cot down from inside the cot. I was effectively trapped in that bed, plus I couldn’t walk anyway.12

“Angela” has different memories of her toys. She said they were kept in a bag at the head of the bed and she cannot remember any restrictions.13 There must have been variations in practices from time to time and from ward to ward.

The isolation from parents and the other children extended to perceptions of isolation from the staff. “Joan” recalled:

It was as if I was in solitary confinement. The nurses — I am trying to remember whether they did anything other than give me food and bedpans. Some of them were trying to be a bit kind and did talk to me, I remember. Generally I had no companionship or camaraderie or feeling of being liked or wanted as me, from any person except the physiotherapist. The only person, in and out of hospital — because at Collaroy we had a physiotherapist called Jessie Ferguson, and I always remember Jessie Ferguson all my life, because she was kind to me. She made things a lot better for me. My recollection is of deprivation, of loneliness, as if I were in solitary confinement but I wasn’t. I was in an open ward, and I was with people but it was very lonely. It was dreadfully boring.14

A child in Royal Newcastle Hospital for removal of her adenoids in 1961 remembers, “It was a very cold experience…the nurses were not friendly. There were no cuddles, no one providing reassurances and no one saying, ‘It is all right.’”15 There were some children with mixed feelings about the staff, some of which may be the result of adult interpretations. A boy who was aged nine on his first admission, and fourteen on the second, said the nurses were extremely good. Some brought things for him from the hospital shop after they had gone off duty, another gave him some money after his tooth came out. Yet another was “a real bitch” who punched and pinched him, which he saw later as having sexual connotations.16

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12 “Joan,” interview no.5.
13 “Angela,” interview no.7 by author, 3 December 1999.
14 “Joan,” interview no.5.
15 Interview no.45.
16 Interview no. 12.
A girl had a favourite nurse in RAHC who combed her hair. Another girl who was a three-year-old in Ryde Hospital to have her tonsils out says that she vividly remembers that one nurse gave her some hot milk while the other nurses were at tea. This was against the regulations. Less positively, however, another stole her lolly.\textsuperscript{17} Children’s experiences and the memories that remained varied considerably for a number of reasons.

Some children were able to compare their experiences in RAHC with their time in other hospitals, which serves as a type of a control in the experimental sense. “Jill” remembers that the nurses she met in Gordon Hospital and the Sanitarium at Wahroonga were kinder to her. One made her baked beans at midnight, and another was very good at preparing her for a painful injection. But “Jill” was a private patient and those hospitals were much smaller: “I never had that sort of thing at RAHC. They [the nurses] were probably too busy, too many kids — big wards. The nurses were halfway between a nurse and a cleaner — always washing and polishing.”\textsuperscript{18}

The nurses presented a mixed picture to the children. While some were pleasant and others hurtful, in general they were remote. There were, however, some people in the hospital who were warm and friendly to the children. Members of the Salvation Army who regularly visited the Convalescent Home at Collaroy Beach were viewed very favourably by a number of children. They were people the children could talk to, in contrast to most of the others they met in hospital, and they also provided interesting diversions in an environment which was generally very boring.\textsuperscript{19}

Parental visiting was very limited up to the 1960s. Parents could see their child for two hours on Sunday afternoons. This period was very important to both, but in itself created problems which emphasised the emotional disturbances produced by family separation. There were also difficulties for the nurses. Irene Macadie, who nursed at RAHC from 1951 to 1955, recalled:

\begin{enumerate}
\item[17] Interviews no.14, no.47.
\item[18] “Jill,” interview no. 6.
\item[19] “Joan,” interview no. 5; “William,” interview no.1 and “James,” interview no.4, all have fond and strong memories of the Salvos.
\end{enumerate}
The parents came on Sundays and brought lollies, ice cream and chocolate and fed the children for two hours. When the parents left there would be dreadful screams until the last parent left, then it would be like switching off the light switch. Then the chucking started, and the children would be ill because they had been fed with everything the parents had given them for a week’s supply.\textsuperscript{20}

Ruth Burleigh confirmed this picture: “Sunday afternoon and evening duty was the worst shift of the week, everybody hated it. The children were upset — upset emotionally.”\textsuperscript{21}

One might have expected the nurses, particularly the younger ones, would have identified with the children and acted more as their mentors, but this does not appear to have happened. Burleigh added:

I don’t remember seeing myself as a parent substitute. Nurses couldn’t play with children. It was not encouraged. There was no time, and it was so busy, particularly where there were babies being fed three or four hourly. We sometimes had to feed two babies at once. We had a lot of cleaning — walls, beds etc. We were very occupied. We distributed food and fed children too. I didn’t see the children as being unhappy. There were some who were — more the toddlers. The older children — the orthopaedic children who knew they were going to be there for weeks and weeks — you didn’t get the feeling that this was an unhappy place, and they’re unhappy children. We had some fairly dragon-like senior nurses and ward sisters, some were quite severe, and some were caring and thoughtful.\textsuperscript{22}

Burleigh reflected on the changes which came with extended parental visiting, which made her more aware of the harmful nature of the previous restrictions:

The place became a much happier place, in a very short space of time. Along with daily visiting came these lovely new quilts, pale blue and pale pink, and they had some sort of embroidered design...instead of the Red Crosses which had to be so carefully aligned. That immediately changed the look of the ward, with its regimented appearance.\textsuperscript{23}

Another nurse has explained how some of the older sisters felt about changes in visiting and how this could affect their authority in the ward. Irene Mcaadie recalled:

One of the most caring sisters we had at the hospital was horrified. She had retired when twenty-four hour visiting came in. She said to us one night: “Do you mean

\textsuperscript{20} Irene Macadie, nursing sister, interview by author, Sydney, 24. May 1999.
\textsuperscript{21} Burleigh interview.
\textsuperscript{22} Ibid.
\textsuperscript{23} Ibid.
to tell me that parents can come any time, and that siblings can come? I never want to go back there again. What about the well-being of the child in the bed, with the siblings fighting underneath? There’s no peace.” She saw it as an intrusion on the child’s environment for becoming well again. She was probably one of the most caring sisters that we would have had at the hospital. A motherly soul, who considered the nurses were her daughters and the children were her children, but she was horrified because the visitors brought the germs in, and they upset the child’s peaceful time in the hospital…I could imagine older nursing sisters being horrified because they could see it as an open field for infection, because they had not had the benefit of antibiotics and what have you. They needed to nurse the child back to health. They didn’t have any real aids, as the staff have now.24

There was a widespread lack of understanding of the emotional needs of children at the time. Another nurse, in response to a question asking how she believed the children coped with hospital life, recollected:

You were young yourself and you were so busy trying to get through your work you didn’t stop to think. I think if you’d stopped to think about the psychological effect on them — visiting was only from two to four on Sundays — the doors opened and everybody just rushed in. It was chaos. I suppose it was archaic but we didn’t think of it being any other way. We just accepted it that way and I suppose the parents did. You hear some of the adults nowadays talk about how terrible it was for them. We got to know the children very well and became mothers to them. We got very involved with the children. You might be in the ward for three months and be the central figurehead, then you were gone — although you went back to see them. Then there would be someone else. It must have been very traumatic for them, really, which people did not realise in those days.25

The relationship between children and nurses took various forms, but in the strict discipline of the hospital, the situation may have been as difficult for the young nurses as it was for the children. Bette Thomas, who was at RAHC for several years up to 1948, wrote:

One of the most stressful situations for the young nurses was in looking after children with terminal conditions such as leukaemia or hydrocephalus. We could not avoid becoming fond of these patients, and of many long-term patients like the polio ones. Nurses were not good nurses if they did not become emotionally involved, but were useless if they could not control their emotions with situations in the ward. When John [a polio patient] died the whole hospital mourned, but

24 Macadie, interview.
25 Phil Clifton, nursing sister, interview by author, tape recording, Sydney, 8 June 1999.
nurses were not to show emotion in the ward. When you were upset you went out to the pan room and cleaned and sterilised the bedpans and cleaned the bath.26

Most of the people interviewed held negative views about their hospital stay. Some had positive or neutral experiences. A boy who had a number of admissions with nephritis between 1945, when he was three, and 1959 said he learnt a lot from just observing what went on; it helped a lot with his self-training.27 Another, admitted in 1967 for a heart operation, said it was good because he did not have to do any school work, talked a lot to other children and made some good pals.28 Some were not disturbed by the thought of medical care or operations. Some were envious of their peers who had had operations for tonsils, or stitches for a cut or a plaster for a fractured arm. They were badges of honour.29

Most of the people interviewed had been admitted to children’s wards, but five of the interviewees had spent time in adult wards. Their experiences were mixed. Some were distressed by being placed with sick adults, but for others it was not so. One child was upset by being in a bed near old ladies who were barely alive, and another by the death of a man in the bed next to him. A boy aged ten had rheumatic fever and was in an adult ward for several weeks. He said it felt strange but in some way it was a sort of comfort.30

The views of the interviewees provide some conflicting images but may be accepted as reasonably accurate memories of their experiences, even though they may have been coloured by subsequent life experiences, or the effects of a continuation of their childhood illness. The children who told the most disturbing stories had illnesses of long duration and were exposed to many members of a large nursing and medical staff. They had a higher risk of being exposed to potentially distressing circumstances, both in the main section of RAHC, and in its convalescent section at Collaroy. They also had very serious disorders, with often painful treatment, and suffered long periods of

26 Bette Thomas, letter to author, Laguna, January 2000.
27 Interview no.12.
28 Interview no.37
29 Helen Townsend, Baby Boomers Growing up in Australia in the 1940s, 50s and 60s. (Sydney: Simon and Schuster, 1988), 62.
30 Interviews no.44, no.12, no.37, no.35, no.31. The admissions took place between 1947 and 1967.
separations from home and parents. While the stories of children who had shorter stays in hospital are not so dramatic, they still tell of traumatic childhood experiences. The accounts of hospitalisation are in essence consistent with one another, and with what we know of other children’s hospitals in Australia and elsewhere.

The RCH, Melbourne, for example, had an even more rigorous attitude to visiting than RAHC during the 1940s, which the hospital said was based on overseas practices. Visitors were not allowed unless the child had been in hospital more than four weeks and then only on two Sundays each month, for one and a half hours. Dangerously ill patients could be visited frequently, but only if the doctor thought it necessary.31 The situation was no better in children’s hospitals in the US. Hunt says the child in hospital was considered “a biological unit, far better off without his parents who, in weekly or bi-weekly visiting hours were fundamentally toxic in their effect, causing noise, generally disorderly conduct and rejection of the hospital personnel to whom he had previously submitted with apparent willingness.”32

The stories that the people who were patients in RAHC have told are disturbing and do not coincide with the public images of children’s hospitals, which have been presented as friendly places. Hamilton, in his history of RAHC, talks of “the warm humanity that has always been part of the hospital and the love, which has motivated people who worked there.” There was a “love of people, love of children, love of their work and love of the hospital.”33 A recent history of another children’s hospital offers a similar image. The RCH, Melbourne was committed “to healing sick children with much love and tender care.”34

RAHC, on the evidence of its history and its acceptance and support by the people of NSW, might be seen to have been benign and well intentioned towards the patients.35

The hospital itself wished to project that image, and appropriated the view of childhood

31 RCH, Committee of Management minutes, 11 June 1942, RCH Archives, Melbourne.
35 Hamilton, Hand in Hand.
referred to by Zelizer, using romantic and sentimental images of childhood innocence and powerlessness to seek the financial support of the public. Each Christmas placards seeking funds were widely distributed (see Figure 9.3). A letter seeking donations for RAHC, written in 1961, indicates how the members of the Board of Management appealed to the people of NSW. It reads:

Dear…

If this letter had been written by a certain child, the response would have been instant and miraculous in its volume. The child we refer to, though nameless, is a symbol of the thousands of small patients who pass through the Royal Alexandra Hospital for Children each year. Most are too young to write, many are too sick. On their behalf we can at least try to convey to you how they feel, what they need, what prospects they have for subsequent return to health. Generally, they feel comfortable enough and have good chances of full recovery, mainly because of the wonderful work of the doctors and nurses, but their needs are tremendous — newer wards, additional modern equipment and laboratories. This is where you can help. This is where you can answer an unspoken plea of the small patient. Please send a donation — however small it may be — and on behalf of our children we do thank you.36

While the responses to this document might have produced better facilities for the treatment of the children, it did nothing to enhance the status of the children who were its patients, but emphasised their lack of power.

There were similar images propagated elsewhere that not only disempowered children, but sought to reinforce the position of the carers. In a history of the development of children’s hospitals in Britain in the late nineteenth century, which were models for the Australian children’s hospitals, Lomax describes how sick children came to have an image of blameless suffering, powerlessness and innocence, which was perpetuated by the hospital policies of not admitting children who were beyond the age of puberty. The hospitals used these images to attract public support and donations. Caring for children also provided benefits for the individuals concerned. The philanthropists who founded the children’s hospitals emphasised that protecting and providing care for sick children brought out the finer qualities in human nature.37 Alas, as these interviews show children’s experiences did not often correspond with the public images. In the

paediatricians’ quest for authority and status, they often hurt the people they professed to help.

Hospitals, Doctors and Children – Changing Attitudes

Paediatricians professed the importance of caring for the whole child. From the time of the foundation of the Australian Paediatric Association (APA) in 1950 members repeatedly discussed “the total needs of children” in both preventive and curative care. They expressed the need for paediatric services to have wide horizons. As well as providing for children with acute illnesses and physical disorders it was believed that there should be services for those with developmental delay and other handicaps, and that there should be provision made for the management of mental illnesses and emotional and behavioural disorders. The Association also declared that it was vital for paediatricians to understand the important role played by parents in the lives of their children.\(^38\) The rhetoric, as opposed to the practice, was benevolent and enlightened.

Why then did paediatricians subject the children they cared for in hospital to such a damaging oppressive environment? Why did they not take steps to hasten the liberalisation of parental visiting? This was a central factor in the minimisation of emotional harm, apart from avoiding admission altogether. It may have been that they were preoccupied by other matters. In the period following the Second World War paediatricians were confronted by a vast amount of new knowledge, new technology and new therapeutics. Their time and physical and intellectual energies were fully occupied and only when some inroads had been made could they start to think about the emotional aspects of child health. Their professional life was not centred on RAHC and they had many duties in other hospitals and in their consulting rooms. Paediatricians could also plead that in the 1940s and early 1950s they were unaware of the damaging impact of hospitalisation on children.

Why were there not more complaints from parents about the limited visiting? Lupton has argued that medical encounters have been strongly influenced by the interpersonal relations between doctors and patients. In any encounter both the doctor and the patient

benefited from the dominant position of the professional. Many patients were happy to give themselves over to the doctor, in trust and faith, as in a parent-child relationship. It was a collusive arrangement.\(^{39}\) In that situation the parents would not have wished to complain. Also, the authoritarian atmosphere of the wards made protest very difficult, as several interviewees and nurses have stated.

There are, however, stronger arguments to account for the long time it took to remove the restrictions on visiting in RAHC, when substantial changes had occurred in hospitals elsewhere. The paediatricians had the power to change the system in RAHC because they were in control of its policies. They were not malign, but it was to their advantage in retain the long-standing system in which they had very few contacts with parents and made little effort to explain matters to the children. Their differential possession of knowledge ensured their dominance over the patients and their parents. This reinforced their positions in RAHC, where as senior doctors they were at the top of the hierarchical tree. Their appointments to a large teaching hospital gave them status and prestige which was so important to the insecure members of a new specialty struggling to separate itself from the better-established field of adult internal medicine.

Matters eventually changed, however, and paediatricians found alternative means of ensuring their status that were less damaging to the children. In the late 1950s and 1960s attitudes to children in hospital began to change, brought about by new knowledge of the dangers of hospitalisation and separation from parents. This knowledge about the psychology of childhood came not from paediatricians or children’s hospitals, but from the mental health disciplines. In the 1940s in the US, child psychiatrists and psychologists began publishing evidence showing that young children suffered emotional damage when separated from their parents, but this information failed to attract the attention of paediatricians in Australia. In England another psychiatrist, John Bowlby, produced similar evidence which had a much greater effect. It was enhanced by the production in 1953 of a film _A Two Year Old Goes to Hospital_

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which dramatically showed the effects of hospitalisation on a child of very vulnerable age.  

The risks of emotional damage depended mainly on age, but also on the child’s personality and the stability of the parent-child relationship. The duration of admission was also a factor, with long admissions being more harmful. The children at most risk were those between one and four years of age who were capable of appreciating the need for parental care, but least able to understand separation.

Young children passed through several phases of behaviour following admission to hospital. In the first phase, children protested about the absence of their parents, calling out for their mothers and crying, sometimes with tantrums, sometimes with sad weeping depression or panic-like anxiety. The second phase was of despair. The children were subdued and withdrawn, quiet or irritable and fussy. They looked out anxiously for their parents through the doors and windows of the ward. The return of the parents in these two phases often brought tantrums and displays of anger. The final phase, that of denial and detachment, came after a more prolonged period of separation. The absence of parents was accepted and the child sought parental substitutes in nurses or others. Parents would be ignored if they returned. In the past this phase was seen by hospital staff as a positive development, for the child had settled in and was happy. It was, however, more likely to lead to long-term emotional damage. The disturbed behaviour, particularly in the denial phase, seemed to provide good reasons for excluding parents. Following discharge from hospital many young children had behavioural problems with regression in their sleeping patterns and in bladder and bowel control. Most of these disturbances, although unpleasant, were transitory. Some children had more serious problems, with severe behavioural disorders and psychological disturbances that could last into later childhood. However, not all children were damaged by admission to hospital. Some saw hospital as a positive experience in learning to deal with the world, and many children merely tolerated it.  

In the mid-1940s a paediatrician, James Spence, a leader in social paediatrics in the UK, began to allow mothers to stay with their young children at his children’s hospital in Newcastle upon Tyne. His main purpose was to use the mothers to relieve the nurses of routine tasks, allowing them to concentrate on the technical aspects of nursing, but he also appreciated the emotional benefits to the child of the mother’s presence. A government report, *The Welfare of Children in Hospital* (the “Platt Report”), published in Britain in 1959, was also influential in changing attitudes to the care of children in hospital. The report referred to earlier findings about the deleterious effects of parental separation on deprived children and children in institutions. It drew attention to the growing awareness of the individuality of children and their emotional needs and how it was important to preserve continuity with the home and parents during the hospital stay. Hospitals had changed and were no longer charitable institutions but increasingly provided scientific medical services to all sections of community. Advances in medicine and surgery reduced the need for confinement to bed and created pressures to provide for ambulant activities including education. The report emphasised that children should only be admitted to hospital if that was necessary for their medical care. It then included a large number of detailed recommendations about administrative, medical and nursing procedures designed to improve hospital care.

In Australia in the 1940s most children in hospital were treated in the time-honoured manner, but there was one example of a hospital which recognised the needs of its young patients. A large women’s and children’s hospital in Melbourne, the Queen Victoria Hospital, introduced unrestricted parental visiting to the children’s wards in 1947. The problems of children in hospital were clearly understood by the paediatricians and nurses who instigated the scheme. Their *Lancet* report of the new visiting arrangements stated:

The younger child feels only that he is taken from his mother and familiar surroundings and abandoned by his parents to strangers in a strange world. It is wrong to assume that the child who does not cry or make an outward showing

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does not mind being left. The young patient who frets inwardly is a real entity. He is forsaken and alone.\textsuperscript{44}

The report concluded that unrestricted visiting meant that the hospital could better meet the emotional needs of the child in hospital and reduce the risks of longer term psychological harm. The honorary doctors were able to demonstrate to the junior staff the correct way of communicating with parents and their children. In contrast to the situation in some other hospitals, the unrestricted visiting policy was not difficult to implement administratively. The authors of the article pointed out that the success of the regime depended on the personality, tact and understanding of the sister-in-charge.\textsuperscript{45}

The Queen Victoria Hospital was staffed entirely by women which may have accounted for its less authoritarian environment and its greater concern for the welfare of the patients.\textsuperscript{46}

In Australia the first formal public statement by the medical profession on mother-child separation was made not by paediatricians but by the Royal Australian and New Zealand College of Psychiatrists in a Position Statement in 1970. This document acknowledged the influence of the Platt Report and argued that the dangers of emotional deprivation associated with hospitalising small children and longer-term adverse effects could be reduced by admitting mothers and young children together.\textsuperscript{47}

A consumer’s body, the Association for the Welfare of Children in Hospital (AWCH) was established in 1974 and in the following year published a policy statement similar to the Platt Report.\textsuperscript{48} The document was officially recognised by the Australian Medical Association and the NSW Health Department in 1975.\textsuperscript{49} It was apparent that public demands for improvements for the care of children were changing in tandem with the

\textsuperscript{44} Marion Ievers, Kate Campbell and Mona Blanch, “Unrestricted Visiting in a Children's Ward. Eight Years Experience,” \textit{The Lancet} 1 (1955): 971-973.
\textsuperscript{45} Ibid.
\textsuperscript{46} Janet McCalman, \textit{Sex and Suffering: Women’s Health and a Women’s Hospital} (Melbourne: Melbourne University Press, 1998), 313.
changing ideas of the medical profession, as had occurred in the UK. The changing community attitudes that influenced hospitals and doctors were also acting elsewhere. Kociumbas has described how by the late 1950s the power of institutional authorities in Australian society had lessened; for children there was a relaxation of authority in relation to security, to protection and in education. There was a much greater recognition of the rights of the children.\(^{50}\)

The Princess Margaret Hospital for Children, Perth, was the first Australian children’s hospital to institute major visiting reforms in 1954.\(^{51}\) The others followed but the changes were only slowly adopted. In Sydney the medical staff in RAHC recommended a trial of daily visiting in 1954, and visiting hours slowly increased. However, unrestricted visiting was not introduced until 1962.\(^{52}\)

The moves to liberalise parental visiting in RAHC came from one of the ward sisters who aggressively pushed the idea that children needed to see their parents more often than once a week. One nurse later related: “it was the nurses, really, because we thought — you had this hullabaloo all Sunday afternoon, and it was dreadful — we thought if they saw them a bit more often....”\(^{53}\) The nurses were supported by some of the paediatricians who suggested in 1954 that there be a trial of “almost-daily” visiting in certain selected wards. Two years later the Hospital Medical Board recommended that the trial be extended, but changes were slow to take place.\(^{54}\) In contrast, children in the private section of RAHC, Wade House, had much more liberal visiting and the doctors spoke regularly to the parents.\(^{55}\)

Doris Hart, the Secretary of AWCH, had no doubts about where the blame lay for the way children were treated in hospital. She was very critical of the attitude of RAHC to its patients. She pointed out that during the 1960s and early 1970s the hospital encouraged the publication of newspaper stories about its medical and social successes,

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\(^{54}\) RAHC, Medical subcommittee minutes, 22 January 1954, 20 January 1956. RAHC Archives, Sydney.

\(^{55}\) Christmann, interview.
with references to the near miracles of cures taking place in the wards and operating theatres and “the visits of royalty, film stars and others of exalted social status.” There were stories about Christmas and Easter parties, and bundles of toys for the children. All these provided an impression of a hospital that was kind and caring towards its patients. There was, however, she said, “a very dark underside to the hospitalization of children and, long term, often devastating emotional trauma.” She blamed the paediatricians and the RAHC for the slow adoption of new policies of childcare. She said the body representing the Australian paediatricians, the Australian College of Paediatrics, was very reluctant to become involved with AWCH in the development of a policy about children in hospital, nor would RAHC help. The hospital was unwilling to make changes to its policies on visiting because the Board of Management lacked any accountability to the community and was strongly influenced by the senior medical staff. The Board was elitist and intransigent, and would not respond to a non-medical pressure group. In addition, she believed that the community was deeply ignorant of the emotional problems of hospitalisation and was unwilling to consider that their children’s hospital might cause harm to the patients. She gained the impression that parents handed over their rights to the hospital when their child was admitted. In her remarks Hart raised the question of medical status as an obstacle to change in the institution. In RAHC the Board of Management was largely controlled by doctors who resented being told how to look after children.

The Medical Superintendent of RAHC, John Fulton, made some revealing remarks in 1964 about the earlier attitudes of his hospital to parents and children. After the visiting times had been liberalised he admitted that, in retrospect, the hospital had been wrong in its policies and that it had been humanised by the introduction of unrestricted visiting. He implied that blame was attached to the nursing staff: “No longer do we have the old battle-axe sisters in charge of a ward, into whose domain you would fear to tread.” These remarks provoked a vigorous defence of the nurses from a previous Medical Superintendent and a nurse. Fulton did not, however, mention that the medical staff, the paediatricians, had not recognised or acknowledged the problem. Nor did he indicate

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56 Hart. 2-5.
57 Dr John Fulton, *Sydney Morning Herald*, 26 May 1964
that they controlled the policies of the hospital. Despite their concern for the whole child, paediatricians were slow to change.

In the 1960s other groups began to become involved in the welfare of children in hospital. The first of the parents’ organisations appeared in 1961. Mr and Mrs “Clark” have described how, as parents, of a child with congenital heart disease, they were foundation members of a cardiac support group:

We became part of a small family, a group. There was a guy named Jock Scougall. He had a child who was operated on at the same time as our boy. He was a bit of a goer. He whipped us into shape. He formed an auxiliary of parents who had had this heart operation in 1961. It was a happy association. We had formal meetings at the hospital, and we had a cricket match and other activities. We were more a social group. It was a good way of bringing in parents whose children had yet to have the operation: they could come and meet us and see our children, and see how well they were doing — it gave them confidence.59

Doctors and nurses from the cardiac unit attended the formal and social meetings of the support group and a free interchange of views was possible. The “Clark”s remember meeting Viv Ebsary, the engineer who developed the improved version of the heart lung machine, and Eddie Hulme and John Jackson who invented new cardiac pacemakers used in the unit. The group, which also raised funds for new equipment, was the beginning of a corporate consumer approach to influencing the policies of the hospital.60

There were also the forces of the market place which had not previously operated for children and paediatrics, whereas they had been in place for other specialties for many years. These forces, which gave the children and their parents greater power, began to exert their pressures in the 1960s. Through the 1950s there was increased affluence in Australia, while health insurance subsidies made private medical care affordable for a wider range of people. Before this time there were very few paediatricians in private practice because it was not financially viable. Most people had to go to the children’s hospital if they wished to consult a paediatrician. In 1945 there were probably fewer than twenty practising paediatricians in Australia, but by 1965 there were nearly 150.61

59 Mr and Mrs “Clark,” interview no.8 by author, tape recording, 12 October 1999.
60Ibid.
61Lorimer Dods, Notes for an address, 7 August 1960, Dods papers, P172, Series 3, Item 1. University of Sydney Archives, Sydney. There was no occupational register for the thesis period and the figure for 1965 has been estimated from the membership numbers of the Australian Paediatric Association. In that
Paediatricians became more accessible and parents had greater choice. Shorter has pointed out how choice of doctor empowers patients; they become less willing to be passive recipients of a doctor’s authoritarian recommendations. Parents were in a much stronger position to negotiate with a paediatrician about their child’s treatment once there were more practising. While scientific medical knowledge continued to give the paediatrician considerable power, the child and parent necessarily figured more prominently in his or her consciousness.

Paediatricians had also changed. They had established their scientific and clinical credentials and their specialty had matured. By the 1960s they had lost the insecurity they had experienced in their earlier years, particularly in their relationships with adult physicians. With their status and power confirmed there was no longer such an urgent need to use the hierarchical hospital system as their source of authority.

**Conclusions**

The last two chapters have examined the relationship between children (and their parents) and paediatricians and the institution so closely associated with paediatrics, RAHC, between 1945 and 1965. Our knowledge of the place of the patient in the doctor-patient relationship in the first half of the twentieth century suggests that patients had little power to determine the sort of medical or hospital care they received. Doctors were virtually autonomous and possessed overriding powers relative to patients because they possessed special knowledge. Children as patients had even less power than adults because they lacked any political or financial strength. Society chose to invest children with a romantic image, embracing innocence and helplessness, which strengthened the institutions which served them, but not children themselves. Lacking power, children could not effectively speak for themselves.

Children and their parents have left little documented information about what they would have liked for their health. It is likely that at the time few people formulated any ideas of what they wanted. The methodology of oral history has provided a useful
method of determining the views of people who, as children, had been patients in the children’s hospital and in the children’s wards of other hospitals. Although a relatively small number of people were interviewed, they have provided a picture of life in children’s wards which is consistent in substance, if not always in detail, with information from other sources. The interviewees told of their acute awareness of the overwhelming authority of the hospital where the smooth running of the hospital was more important than the personal comfort and concerns of the patient. The hospital provided efficient and safe medical care but the emotional needs of children were not met. In this environment children lived in fear and uncertainty because they were not informed about what was happening to them. The worst experience for the children was the separation from parents, who normally provided them with the love and security which was so important to their psychological development. Parents also lacked power because they possessed little information about their child’s illness; doctors would not or could not talk to them.

Paediatricians were no less humane than other people and did not lack concern for the welfare of their patients in hospital, but they did not, at first, understand children’s emotional needs. Paediatricians were in the process of legitimating their specialty. For this purpose the hospital was particularly important because private practice was limited. The paediatricians needed to maintain the position of doctors at the top of the hierarchical structure in the hospital, and while they were not responsible for establishing that structure it was in their own interests and that of their specialty to maintain it. In doing so they continued to hold their considerable authority over the nursing staff and the patients, and all the oppressive processes that entailed. They were slow to relinquish this authority and only changed in the face of undeniable evidence of the harm caused to children by the earlier policies. By then paediatrics was firmly established and the paediatricians had other ways of stamping their authority in medicine in, for example, their involvement in the high technology of cardiology and intensive care.

The liberalization of visiting was a key factor in changing the authority structure in the hospital, enabling the child and parents to acquire power they had not previously
possessed. The constant presence of parents in the ward ended the isolation of the child and restored the child-parent relationship. It diffused and reduced the authority of the nursing staff and the hospital administration. When the paediatricians conducted their ward rounds and examined the sick child the parents were by the bedside. The paediatricians could not avoid providing them with the information they needed to hear. The information barrier was eased. Eventually, both doctors and nurses came to appreciate the benefits of unrestricted visiting, as well as the child and parents.

From the 1970s there were further considerable improvements in the way children were cared for in hospital. Fewer children needed to be admitted, and those that came in had a shorter period of admission, which averaged two to three days. With different approaches to the management of chronic conditions, the long-term patients and their convalescent hospitals like Collaroy disappeared. Visiting was not limited at all, and parents were encouraged to stay in with their children, particularly the young patients. While hospitalisation was often still distressing, it could be much better endured than in earlier times when the institutional power of hospitals and the status-quest of paediatricians had resulted in tighter and more discriminating hierarchical structures.
CONCLUSIONS

This thesis has considered how paediatrics developed in NSW in the period from 1945 to 1965. The specialty, which barely existed at the beginning of that period, was well established by the end. The development of a medical specialty such as paediatrics involved the acquisition of authority, power and status by a group of doctors who shared a common focus of interest. Such a professional group sought to create a monopoly of the services it provided while maintaining self-regulation and autonomy. The successful development of a specialty required that it be accepted by patients and by people in the society in which it was placed. Government legitimation was also very valuable. It was, however, within the profession of medicine that the specialty first had to establish itself.

Paediatrics was a late developing specialty in Australia and the occupational space paediatricians wished to occupy was held by other medical groups. Paediatrics began as a division of internal medicine at a time when the medical view of childhood was not greatly different from that of adults. Paediatricians had ambivalent feelings about internal medicine. Adult physicians held most of the occupational space that paediatricians claimed, and the two groups were in competition for patients. On the other hand, from 1938 to the 1960s and beyond, paediatricians chose to join the RACP, even though that professional association was controlled by adult physicians. Over this period the RACP provided paediatricians with the professional credentials and status they needed to be deemed specialists.

Later, as paediatricians acquired their own identity as experts in the care of children, the relationship with the RACP became less meaningful. However, their own smaller organization, the APA was not powerful enough to act as a effective professional body, nor was it equipped to control the entry of new members to the specialty. For this, paediatricians remained dependent on the RACP. It was firmly oriented towards adult medicine and the entry examination did not properly test the competence of aspiring paediatrician. Eventually, a more suitable examination resulted, but the development of the specialty was hindered in a crucial period of development. Nonetheless in the twenty years after the Second World War, on foundations laid down by the pioneer
paediatricians, there was a rapid expansion of paediatrics stimulated by new knowledge and technology and the adoption of the scientific medicine paradigm.

For a workshop in which they could develop scientific medicine paediatricians in NSW had the RAHC. Their efforts were compromised because they elected to remain as honorary medical officers, with a strong commitment to private practice. This limited the amount of time they could give the hospital for service development and research and retarded the progress of paediatrics in the state.

Paediatrics in NSW was at first centred on RAHC but then expanded into the suburbs and regional centres and the local hospitals. In certain places services developed which challenged the scientific medicine paradigm and the style of paediatrics adopted by RAHC. In others unconventional and sometimes hazardous clinical practices developed that provided evidence supporting the arguments of paediatricians that only they, possessing unique knowledge, should care for seriously ill children.

The claims of the paediatricians for occupational space were well supported by the children’s hospital, for there were many interests in common. The close association with RAHC was essential for paediatrics, and the two were inextricably linked in their development. The association brought other benefits that also enhanced the status of the specialty and its members. The honorary paediatricians were at the top of the hierarchical staffing structure in the hospital. Their positions gave them power and authority. In the medical profession they were of equal standing to the honorary physicians in the other teaching hospitals, which was important for the members of a new and insecure specialty. It was vital for them that nothing happened to jeopardise their position. The hierarchical structure was intrinsic to the institution and it had consequences well described by Foucault. The differential power held by the senior medical staff was at the expense of other staff members and the patients, and some children were harmed by the system. Paediatricians had no evil intent towards children, but they were slow to allow changes to take place because the positions they had inherited in the hierarchy enhanced their professional status. In the circumstances the disempowered children and their parents could have little influence on the development of paediatrics or the children’s hospital. The situation changed largely when the information about harm became too strong to ignore. By then paediatricians had found
more positive measures to maintain authority with, for example, involvement in high technology medicine such as intensive care and cardiology and they were much more secure in their professional roles.

The purposes of professionalization in general and medical specialization in particular have often been questioned by sociologists and historians. Similar questions may be asked about paediatrics. Was specialization in paediatrics a system for offering improved health care to children, taking advantage of advances in knowledge and technology? Was the specialty established to meet the needs of children and their parents, or was it for the betterment of the state? Alternatively, was paediatrics developed for the benefit of paediatricians, to advance their professional careers in scientific medicine?

One must assume that paediatricians were well-intentioned towards children and were concerned for their health and welfare, although specific evidence of that intent is difficult to find in documentary form. On the other hand it is much easier to find evidence that specialization substantially benefited the professional development of paediatricians and to find examples where paediatricians adopted policies and practices that were self-serving. A prominent example was the decision to retain the honorary system in RAHC.

The thesis has shown how paediatricians experienced many conflicts of interest in the period between 1945 and 1965 when their specialty was rapidly developing. They had to balance their self-interest against the wider social responsibilities that came with the privileges society granted them as members of a specialty in the autonomous and self-regulating medical profession. They had obligations to their specialty group, to continuing their own professional development, and to maintaining their authority and status in the highly competitive arena of medicine. They owed a duty to their patients, both public and private, and to the children’s hospital which provided them with visiting privileges, a workshop and a showcase for their skills. Paediatricians had to engage in private practice, because there was no other way of earning a living. To attract patient referrals they had to go to the market place. They could promulgate their skills at clinical meetings and in medical journals, but a more effective way was to demonstrate the quality of work they performed. This could be done in the children’s hospital but
that venue was less useful to the junior doctors who did not have access to inpatients. Most paediatricians spent considerable amounts of time in the peripheral hospitals and midwifery units where they were visible to general practitioners and obstetricians, their potential referrers of patients. This work was time-consuming and interfered with their capacity to contribute to the development of RAHC as honorary medical officers.

In response to these many conflicts of interest the paediatricians in RAHC, conscious of the need to follow the scientific medicine paradigm, chose to adopt a compromise solution. They developed committees and groups structures to expand patient care and to improve the organization of clinical work. They also elected to retain the honorary system. This decision determined the pattern of paediatrics in NSW until the 1970. It meant that paediatricians were obliged to give high priority to private practice and so had less time to give to hospital development. The decision to retain the honorary system was based on a medico-political ideology which considered that the retention of the honorary system protected doctors against government interference in private medical practice. The paediatricians reflected the views of the wider medical profession, expressed through the BMA (NSW Branch), defending a system of medico-political control in hospitals that had existed from early in the twentieth century. The thesis has thus argued that development of paediatrics in NSW was largely shaped by medico-political issues. There were a number of other factors including the inevitable rise of specialization, the efforts of individuals and groups of paediatricians to develop new services and a growing awareness of the needs of the child. but the main factor was the retention of the honorary system.

In contrast, in RCH in Melbourne a different medico-political situation prevailed. There, the honorary doctors did not have the power to make such organizational decisions. The Committee of Management had gained control over the honoraries in the late 1940s. The honorary system was abolished and doctors paid for their hospital work. This shift in the seat of power in the hospital was a forerunner of similar changes across Australia.

By the 1950s a number of prominent medical administrators had argued that the honorary system was an inefficient way to staff a large scientific hospital. They had demonstrated the benefits which the “full-time system” of medical employment could
bring to hospital advancement. The administrators included William H. Welch in Johns Hopkins Hospital in the US who established his full-time system early in the twentieth century. In Australia Collins in Melbourne and McCaffrey in Newcastle, NSW showed in the 1940s and 1950s the value of staff specialists. The full-time system meant that the doctors had ample time to give to patient care, to research and to improving the organization of work in the hospital. Just as importantly, it reduced their conflicts of interests, particularly in private practice which was capable of distracting the most conscientious doctors from their hospital obligations. The payment of paediatric staff in Melbourne meant paediatrics was centred on the children’s hospital, with the conflicts of interest with private practice reduced. In Sydney the obligations to private practice held precedence.

From 1945 to 1965 paediatrics continued to expand in Sydney and Melbourne, although that in Melbourne was judged more scientific. By 1965 there were about 150 paediatricians in Australia with the majority in Sydney and Melbourne. The children’s hospitals were staffed by dedicated paediatricians and there was no place for physicians with only a part-time interest in the disorders of children. A number of subspecialties had been established and there were university departments of paediatrics in all of the medical schools. Private practice was becoming financially more viable reflecting an acceptance of the specialty by general practitioners and obstetricians, the main source of referrals. Physicians in internal medicine had also come to accept that paediatricians had earned their occupational space and they agreed that paediatricians should have increasing control of the entry of new members to the specialty. By 1965 paediatrics had become well-established and respected.

However, despite the advances in their status paediatricians were still dependent on the organizational structure of the RACP for their professional legitimacy, although many had hoped to establish a separate college. In 2000 the separation of paediatrics from adult medicine is still not complete. This may be seen as compromising the independence of paediatrics, or it may be seen as desirable by preserving integration in internal medicine. Paediatricians are still part of the RACP, the organization from which many of them earlier had sought to escape. The ACP has been disbanded and they now belong to the paediatric division of the RACP which, ostensibly, is of equal status to the adult medicine division. While the relationships between the two groups are currently
cordial, there is a great discrepancy in their membership numbers. The paediatric division has about 900 Fellows, and the adult division over 8000. It is possible that in the future the policies of the RACP may be determined by doctors who treat adults and the needs of the children’s doctors may again receive scant attention.

Increasing levels of specialization may also pose threats to the independence of paediatrics. With the great increase in scientific medical knowledge there has inevitably been an increase in subspecialization in both paediatrics and adult medicine, with a narrowing focus on organs and diseases. New professional organizations or associations are being formed around these new foci of interests. Child and adult organ-specific associations often share common interests and may elect to combine their activities. Again paediatricians will be outnumbered. While subspecialization should improve the outcome of patient care the situation may again arise where the special biological and emotional needs of children are submerged. The subspecialty groups are a threat to the future of the integrating function of the RACP and the smaller associations may be as largely ineffective in upholding their status as paediatrics was in the 1940s and 1950s.

In the 1940s and 50s paediatricians were well aware that relatively small professional organizations lacking political power were vulnerable to attacks on their professional freedom. It was a cogent reason for many of them to favour the retention of their links with the RACP rather than to seek to be part of a completely independent, but smaller, association. In the twenty-first century there are new threats. While the fears of government intervention in medicine have largely disappeared, there are threats from the private health corporations, as has been experienced in the US. Through the systems of health funding they have the potential to profoundly influence the way medicine is practised, and the small professional groups may be powerless to resist. For paediatrics, with children having relatively few health needs compared with, say, older people, and possessing limited political and economic power, corporatization may be particularly disadvantageous. Paediatricians fought hard to establish a level of independence, and may have to fight hard to defend it. The old fears of nationalization and at times, of socialism, may well be replaced by fears of control by institutional capitalism.

The children’s hospitals are also undergoing organizational changes which may threaten their separate identity, with implications for the independence of paediatricians. For
example, RAHC which existed independently at Camperdown from the 1880s, recently moved to western Sydney. While it is still an independent organization it is placed adjacent to the large Westmead Hospital that has 760 beds, and large ancillary and investigative services. RAHC has only 244 beds. A senior paediatrician remarked in 1998 that RAHC is only an administrative decision away from being subsumed by the adult hospital, although he suggested that course would be strongly resisted. Similarly the Prince of Wales Children’s Hospital is in a vulnerable situation, being situated in the grounds of the adult Prince of Wales Hospital. In Melbourne the RCH has become part of an administrative group with the Royal Women’s Hospital. Both could be taken over by an even larger organization.

With hospital development being controlled by governments strongly influenced by financial and political considerations, the nature and the quality of the care of children in hospital may be determined by people other than paediatricians. Children’s hospitals in Australia have enjoyed their independence for over a hundred years, and while it has been argued that they would benefit intellectually from an association with adult services, many paediatricians fear that paediatric philosophies of child care will be lost if children are forced to occupy a small section of a very large hospital. While paediatricians may not have always have had the best interests of children in mind, matters have changed greatly since the 1960s. It is better for sick children to be treated by paediatricians than by those who lack expert knowledge about their health needs.

The thesis has demonstrated the dangers of forgetting the patient in medicine, in this case, the child; a danger often discussed by sociologists, but ignored in “medical histories.” During the 1940s and 1950s, in the vigorous efforts of paediatricians to establish the authority of their specialty and to provide for the biological needs of their patients, the emotional needs of children were neglected. While client participation in health decision-making is now well-accepted and the psychological needs of children have been recognised, the increasing technology of hospitals and their reduced financial strength make it possible that the still vulnerable child might again be forgotten, unless the lessons of the past are kept in mind. We do not wish a child to say again after

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1 Dr W. Grigor, interview by author, tape recording, Sydney, 30 June 1998
encounters with paediatrics and a children’s hospital, “I was a faceless, nameless thing — I was a nobody.”

An historical study of the health professions and their institutions has a social purpose. It provides examples and lessons from the past which should enable paediatricians and other health professionals to provide better care in the future. However, with the continual changes and restructuring in the hospitals and health services the medico-political issues that played such a prominent part in the development of paediatrics between 1945 and 1965 may again predominate unless there is a continuing vigilance and a clear awareness of the needs of the child.

2 “Joan,” interview no.5. Joan was in RAHC for most of the 1940s.