RAPHAEL WEST CILENTO

MEDICAL ADMINISTRATOR, LEGISLATOR, AND VISIONARY

1893-1945

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SIR RAPHAEL CILENTO, Kt.,
Barrister-at-Law.
Raphael West Cilento graduated in medicine from the University of Adelaide in November 1918. This is an account of his professional activities and achievements from then until he left Australia in May 1945 to serve with the United Nations Relief and Rehabilitation Administration.

With the exception of a year spent in private practice in Adelaide between November 1919 and October 1920 Cilento was engaged in a variety of aspects of tropical medicine and/or public health during the period of this study. He served most of this time in Queensland, Mandated Territory of New Guinea or the southwest Pacific. His two principal employers were the Commonwealth government, December 1921 to September 1934, and the Queensland government, October 1934 to July 1946. (He was on leave during the last eighteen months of his Queensland government service).

This thesis claims to produce evidence which supports the following major propositions:

Cilento was a leading public health man in his time. He had exceptional talent as an administrator in the health field. Faced with a problem therein he could quickly discern its basic causes and devise administrative structures to bring about effective solutions. His quick grasp of essentials made him an excellent negotiator in a crisis.

When legislation was needed to effect reforms he produced Acts and Regulations that were innovative, practical and relevant. This legislation stood the test of time.

As a conceptual thinker, Cilento responded to the intellectual challenges of problem solving with originality and vision. Unlike his peers in the Anglo-Saxon tradition he perceived the difference between social medicine and the more specific, pragmatic programmes of preventive medicine.

In the latter sphere he was also practical and clearly saw the need to educate the public. As a speaker and writer he was both polished and popular.
Cilento played a major part in establishing a faculty of medicine within the University of Queensland. He established, in the English-speaking world, the first chair which in it title used 'Social Medicine', namely, Social and Tropical Medicine. He introduced social hygiene as a curriculum study for the first time in an Australian University.

He successfully promoted research. In the Department of Health and Home Affairs he built up an excellent laboratory which rapidly produced results in that the micro-organisms that caused two separate disease entities, 'Q' fever and 'Pomona fever', were discovered in the 1930's. The laboratory was also a centre for forensic medicine.

Through his membership, first of the Federal Health Council and then of its successor, the National Health and Medical Research Council, Cilento influenced health policy and bio-medical research on an Australia wide basis.

Cilento recognised the injustice that had been done to Aborigines. Within the limits of his powers (which in this area were tightly restricted) he strove constantly to improve their health and to preserve their culture.

As Director General of Health and Medical Services he was believed by the organised medical profession to be involved in the destruction of the powers of the honorary doctors in the public hospital system. As a public servant advising the Commonwealth government he produced an administrative structure for one of the earliest attempts to introduce national sickness insurance into Australia. The profession's resentment of the government's intrusion into this area was directed at Cilento personally. Reasons are given why this was both odious and unjust.

Cilento's major fault was an inability to discern what was feasible at a given time, be it in medico-politics, politics or public service life. In his determination to achieve results quickly, he was intolerant of the views and difficulties of his opponents. This could adversely affect his working relationships with superiors. He was ambitious and had a propensity to centralise power. His insatiable curiosity and vitality were fuelled by a constant stream of new ideas. He loved to institute reforms but lacked the patience to consolidate these by routine. He was always looking for fresh fields to conquer.
ABBREVIATIONS

AA     AUSTRALIAN ARCHIVES
AITEM  AUSTRALIAN INSTITUTE OF TROPICAL MEDICINE
BMA    BRITISH MEDICAL ASSOCIATION
BSCHB  BRISBANE AND SOUTH COAST HOSPITALS BOARD
CDH    COMMONWEALTH DEPARTMENT OF HEALTH
CHL    COMMONWEALTH HEALTH LABORATORY
DTM&H  DIPLOMA OF TROPICAL MEDICINE AND HYGIENE
DDTH   DIRECTOR, DIVISION OF TROPICAL HYGIENE (CDH)
DG     DIRECTOR GENERAL OF HEALTH AND MEDICAL SERVICES
FHC    FEDERAL HEALTH COUNCIL
LMP    LABORATORY OF MICROBIOLOGY AND PATHOLOGY
MED.J.AUST  MEDICAL JOURNAL OF AUSTRALIA
NH&MRC NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL
PMO    PRINCIPAL MEDICAL OFFICER
QIMR   QUEENSLAND INSTITUTE OF MEDICAL RESEARCH
QPD    QUEENSLAND PARLIAMENTARY DEBATES
QPP    QUEENSLAND PARLIAMENTARY PAPERS
QSA    QUEENSLAND STATE ARCHIVES
RWC-PDC RAPHAEL CILENTO to PHYLLIS CILENTO
TNG    TERRITORY OF NEW GUINEA
UNRRA  UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION
ACKNOWLEDGEMENTS

This thesis has had a very long gestation and many people have helped along the way. It is a pleasure to record my lasting gratitude to those already mentioned. I owe particular thanks to Emeritus Professor Douglas Gordon who provided many insights and patiently read preceding drafts. Without his help this work could not have been completed although responsibility is mine for any errors that may have occurred. Professor Malcolm Thomis of the History Department, Mr Don Munro of Administration, and the staff of the Fryer Library all gave invaluable assistance on behalf of the University of Queensland. For reading the final drafts I am indebted to Sandy Yarwood and Susan Pechey and to Helene Marsh and Warwick Gould who offered incisive criticism with the candour their mother has come to expect of them. There are no words to express in full measure the depth of my appreciation for the support and encouragement of my husband, Len Fisher.
DECLARATION

I declare that this thesis is my own work, and has not been submitted in any form for another degree or diploma at any university or other institute of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

[Signature]

30 April 1984.
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INTRODUCTION

The civilisation of ants is written in their chromosomes, that of man resides not in men but in libraries, museums and in legal codes. A French biologist.

This is a study of the role of Raphael Cilento as a career medical administrator in Australasia; it is part of the life story which he himself was writing in the cool basement of his typical Queensland home on the banks of the Brisbane River when the flood of 1974 occurred. Events associated with that catastrophe indirectly led to the presentation of this thesis.

The river raged through Sir Raphael's bookrooms taking a heavy toll of a lifetime collection of his public and private papers and rare books. In the tragic confusion of the flood's aftermath everyone rushed to help his neighbour and, in an indiscriminate way, took perhaps an even greater toll. Although I had not met them prior to the flood, the Cilentos were my neighbours. I saw a one ton truck full of silt laden debris make seemingly countless trips to the dump. The desperate mood of the moment was to shovel it out; no-one thought to search the stinking silt for priceless first editions or imagined that any such treasure might be redeemable.

Devastating as was this loss to Sir Raphael personally, it was also a significant loss to the sources of history both in Australia and in various international spheres in which he had been active. In the past, the Fryer Library of the University of Queensland had sought to acquire the Cilento papers as had most other scholarly libraries in Australia. Sir Raphael, however, had deferred his decision on their final disposition until he had finished writing. (He was in his eighty first year when the flood interrupted his work; obviously he intended writing his way right up to the pearly gates).

For some years I have been one of many field workers actively collecting books and documents for Fryer. Aware of this interest, Dr John Tonge, who was working heroically in the Cilento silt, suggested that I might be of more use upstairs helping to sort books, snatched from the path of the flood, which now littered the house.

I discovered, a few days later, lying around in the basement, abandoned alike by river and shovel, numerous small rocks set in a sea of residual mud. Excavated, they often proved to be bundles of documents and the nose of a dedicated Fryer forager began to twitch. Book sorting was postponed and the urgent task of salvaging papers was begun. Where duplicates were found, Sir Raphael agreed to give them to the Fryer Library and, in time, as though aware that the loss of his library was a blow from which he could never recover, he offered all that remained. Much of this remainder was undamaged in the house upstairs. This was the nucleus of the Sir Raphael Cilento Collection which is still growing, even after a decade, as material is discovered in odd corners, old trunks and boxes full of odds and ends. The collection also includes rare books, memorabilia, photographs and Melanesian artifacts. These last supplement earlier gifts to the University and are housed in its Museum of Anthropology. So wide were Sir Raphael's interests that the collection supports research in many different fields of scholarship: it is a handsome contribution from one who was a founding father of the University's Faculty of Medicine, its first Professor of Social and Tropical Medicine, and a long serving Senate member, a gift that only he could have made. In 1981 Lady Cilento also gave her papers to Fryer, in their own right a rich source of social history. The University is an honoured and grateful recipient.

She who washes muddy papers has no friends. Working alone, I took many months to prepare these documents for Fryer's professional conservators. Soaking, washing, drying, sorting, listing and, of course, reading as I went, I became increasingly fascinated with this material, with its geographical, historical and sociological range and the perception of relationships between these factors. Herein lay very early insights into such social questions as the mutual influences operating between medicine and its socio-cultural environment and between medicine and economics as a factor in politics.
My decision to make use of this material was encouraged by Dr Denis Murphy, Reader in History at the University of Queensland, under whose guidance the task was begun. The objective was to illuminate the role of Sir Raphael Cilento in the reorganisation of health and medical services in Queensland between 1934-1945. Before this could be done two things had to be explained: why Cilento had been chosen for the task and why he had accepted it.

That trail led back to his childhood and the formative influences of his student years. His father, the stationmaster at Jamestown, a small railhead in the wheatbelt north of Adelaide, was the son of migrant parents; an able, ambitious, and highly intelligent man who required and expected his children to succeed. He was a superb organiser with strong community interests and commitments particularly in matters of education and cultural activities. He had a flair for showmanship and encouraged his talented children to perform publicly almost as a way of life. This, coupled with the necessity to earn his living from the age of thirteen, was an unusual background for a student at the Adelaide Medical School; attitudes and values fixed in childhood together with his family's relative poverty of means did much to inculcate in the young Cilento ambitions and aspirations that could not be satisfied in the traditional clinical practice for which he and his peers were trained. From their viewpoint the choice of a career in public health, especially on the part of the year's equal top graduate, was nothing short of aberration.

A survey is given of his introduction to tropical medicine which led to a career in medical administration begun on the outer marches of colonial medicine and pursued for twelve years in tropical Australasia. Two lengthy chapters have been devoted to the Commonwealth Department of Health's expansion into New Guinea and the South West Pacific which virtually began and ended with Cilento. Here he performed with distinction. It was his brilliance as a planner and organiser, together with his insights into the socio-cultural causes of morbidity both among Melanesians and north Queenslanders that earned him a knighthood in 1935.

There is ample evidence that his appointment to Queensland was influenced by the reputation thus earned; newspaper and parliamentary reports attest to this. The second part of this thesis describes Cilento's activities and achievements as Queensland's first Director General of Health and Medical Services; the duties of the incumbent had, in fact, been drawn up by Cilento himself with the reform in mind.
The focus is on Cilento's contribution to the legislative and administrative changes which enabled government to intrude in various ways into clinical medicine: into hospitals, mental health services, medical education, registration and the like. In these areas and in the reorganisation and rationalisation of public health services Cilento's innovations frequently led the rest of the nation. Set against the background of conflict between the government and the BMA, it is a most complex area of study.

An unforeseen difficulty for the historian was that, apart from some unpublished theses then being written, there existed no body of literature which might have led to primary sources, most of which had to be discovered ab initio. Professional historians, sociologists, geobiologists, economists, and political scientists have almost totally neglected the health history of Queensland during Cilento's period and contemporary public figures such as Forgan Smith, E M Hanlon and J D Story have so far failed to attract biographers. This meant that Cilento's few remaining contemporaries had to be identified and where possible consulted. Mr Patrick Hanlon, Sir David Muir, and Sir Allan Sewell gave helpful interviews on Hanlon, Forgan Smith and Charles Chuter respectively. For introductions to medical men: Drs A D D Pye, Cecil Cook, the late E H Derrick, Owen Powell, Sir Abraham Fryberg and Professor D H K Lee, I am indebted to Emeritus Professor Douglas Gordon, on whose knowledge and wisdom as a leading medical administrator and educator I also relied constantly for guidance on medical, technological and statutory matters and their interpretation. Together we concluded that a third section should be written, illuminating Cilento's role as a constituent member of the successive national health councils. His exploitation of this policy resource at bipartite government levels is described in the last four chapters. (The epilogue must stand alone).

It was from the vantage point in Canberra that Cilento was able to obtain money to effect reforms in Queensland and to design and implement measures to investigate the problems of Aboriginal health, public hospitals on a nation-wide basis, and the health of coal miners, all matters in which he personally did much of the survey work.

Research in the National Archives and the library of the Commonwealth Department of Health brought evidence of Cilento's seminal role at the beginning of the national medical insurance debate about who shall decide how medical service
will be paid for, the consumer (the government and the individual patient) or the provider (the BMA and the individual doctor). This wrangle is still unresolved.

Through the aegis of the NH&MRC Cilento was required to advise both conservative and labor governments in his capacity as a public servant; therefore his contribution is not recognised in most published sources. He offered an alternative to outright nationalisation: a salaried medical service in competition with private practice. The transcript of his evidence before the relevant parliamentary committee reveals the true Cilento for he is speaking in camera. It is a remarkable document in its lucidity, perspicacity and sheer commonsense. A critique of this, interwoven with an examination of the same topic, entitled *Blueprint for the Health of a Nation*, provides insights into the early development of welfare in the medical field in Australia. *Blueprint* was Cilento's plan to accommodate these changes administratively, and was offered as a basis for discussion. The BMA, however, saw him as an agent, rather than as an interpreter, of social changes threatening their profession, and in 1945, when he left Australia to assume urgent international responsibilities of vast scale and complexity, Cilento, like most precursors, was a prophet without honour in his own land.
PART ONE

CHAPTER ONE

Father to the Man

The grandfather of the subject of this study was the first to bring to Australia the name of the Italian province Il Cilento. He was Salvator born in Naples in 1831 into a prosperous shipping family.

As a boy he watched eagerly the attempts of the King of Sardinia to break the Austrian hold on northern Italy. At seventeen he joined insurgents dashing northwards through the Papal States. The rebel band was routed by the Austrians at Custozza and King Ferdinand of Naples decreed the death penalty for anyone proved to have taken part in the uprising. Salvator was saved only by the affluence of his family and smuggled out of the country. He fled to England and signed on as a crewman aboard the English trader Telegraph. While this ship was quarantined in Port Adelaide because of typhoid fever aboard Salvator, in a delirium, escaped ashore; when he regained consciousness in hospital his ship had sailed and he was listed as an absconder, or so the story goes. This was in January 1855.

He remained in South Australia and became a good colonist. He married a Scotswoman and they reared seven children. Embittered by the deprivation of family, fortune and citizenship for fighting his country's cause, Salvator never spoke of Italy to his children who naturally absorbed the South Australian ethos characterised by values of self help, personal achievement and the proud allegiance of a free Crown colony to England's Queen Victoria. Salvator rapidly established a successful lightering business in St Vincent Gulf and educated his four sons at a Marist Brothers College until economic difficulties forced him to cut short the education of his third and most ambitious son Raphael Ambrose in 1880 at the age of fifteen. Raphael Ambrose, father of our man, turned in frustration to the South
Australian Railways in search of a career that offered both security and advancement. He had had a longer and broader education than had most of his peers and the expanding railway system held career opportunities. Within seven years he had become the state's youngest stationmaster, a feat described with some understatement by the Railways Commissioner of the day as 'fairly rapid promotion'.

Raphael Ambrose cultivated people in high places. Among the signatories to a number of impressive character testimonials are the Anglican Archbishop of Adelaide and the Premier of South Australia. He was described as a 'keen, clean businessman' capable of filling any position in the traffic department of any railway where 'brains, sound commonsense and organising ability are required'. Unsolicited letters survive to attest his courtesy and capability.

Raphael's was undoubtedly the stronger parental influence on his elder son in his formative years. The values and attitudes absorbed by the youth remained so constant throughout his life that it is revealing to study their origins in the ambitions, commitments, interests and talents of his father.

In the days when everyone and everything travelled by train, the local stationmaster was a well-known and influential person in his town. Cilento saw himself as a career railway officer and eventually rose to the rank of Senior Inspector in the service. He made strong commitments to any community where he happened to be living throughout his peripatetic life. At the age of sixteen he founded South Australia's first Catholic Men's Literary Society and with it, an associated drama group where he loved to act or direct as appropriate. He went on to found and foster interest groups of various sorts to bring people together in newly

1. A G Pendleton to R A Cilento, 31 January 1916; Cilento Collection, Fryer Library University of Queensland, Collection 44/142. Note: All future references to the above collection will be annotated thus: Fryer coll. 44/

2. F W Holder to R A Cilento, 28 August 1897; Fryer coll. 44/142

3. Ben Hunt, Manager Elder Smith P/Ltd to R A Cilento 18 January 1916 Fryer coll. 44/142

4. Charles Ely, General Manager Silverton Tramway Co. to R A Cilento, 26 January 1916 Fryer coll. 44/142
developing railhead townships. As a churchman, first a Catholic, later an Anglican who achieved the status of Synod member, he always supported the social activities of the church. Politics interested him. In 1901 he was unanimously selected as Liberal Party candidate for the Legislative Council, Central District No. 1 (itself an interesting comment on his bearing). He declined the honour as he planned to be in London for the coronation of King George V and Queen Mary in August 1902. Over the ensuing forty years he attempted many times to enter politics at state and municipal levels but although he campaigned well, he was never elected. His most spectacular involvement was as chief organiser of the Protestant Party of South Australia in 1927. He wrote:

No member at a Federal, State, Municipal, Union or other election shall vote for any Roman Catholic candidate. This State, at least must be kept free from Popery and Priestcraft.

Clearly, by age 62, the one-time patriot had become a zealot.

Throughout his career, stationmaster Cilento did his best to promote educational opportunities for community benefit. In 1912, at Gladstone, he chaired a meeting to found the first Railways Institute in South Australia because there were no evening classes available 'to instruct those unfortunates who flounder around in an office with no chance of being taught station work for advancement'. There were many in this predicament; eager for promotion but without the means to gain the necessary qualifications. Some years earlier, he had arranged first-aid courses to help railwaymen qualify for proficiency allowances and had included interested citizens in the classes. This initiative earned him a special medal awarded by the Railways Commission. Concerned as well, that children's education was often interrupted by the need to help on the farm, Cilento sought to encourage interest in learning by awarding silver medals for attendance and general proficiency; he collected money for their purchase from the business community and had them made by the town's

5. F J Cleland, Pres. Port Adelaide District Federal Union and B D Mason, Sec. to R A Cilento, 26 January 1916 Fryer coll. 44/142
7. R A Cilento, Letter to the Editor, S A R Officers' Magazine, November 1916 Fryer coll. 44/142
leading silversmith. For the benefit of his own children, money was somehow spared for the purchase of regular instalments of the Encyclopaedia Britannica.

Cilento senior had a true Italian flair for showmanship. As a way of life, his family learned to display their talents in the public arena: the concert hall, the speaker’s platform, the committee room, the sport’s contest, published word or drawing competition. It was the stationmaster’s business to know his customers and their needs. For the extroverted Cilento this presented no problem. He gave service and, with the eye of a martinet, saw that his well-turned-out staff did the same. He was never above carrying luggage for the elderly and performing other small acts of courtesy and kindness. Gardens he loved; on assuming an incumbency, he immediately set about beautifying the station surroundings with bright shrubs and flowers and planted shade trees for the future. The well-kept premises reflected both managerial pride and a high standard of efficiency. Italian operatic flair took over whenever an important visitor or civic occasion was to be honoured. The station would be gaily decorated, the staff a gleaming guard of honour, bands playing if possible, reporters certainly. With an unerring sense of occasion the stationmaster would add his special welcome to that of visiting dignitaries.

In February 1891 just after he was appointed stationmaster at Jamestown, Raphael Ambrose Cilento married Francis Elizabeth West, daughter of the Mayor of Burra and great, great granddaughter of Benjamin West an eminent neo-classical painter who in 1792 because President of the Royal Academy. The couple lived in the well-built limestone station house at Jamestown for the next seventeen years.

8. Review (Jamestown) 27 February, 1905 Fryer coll. 44/142

9. On 10 October 1971 the Jamestown railway station became a National Trust Museum. Sir Raphael Cilento had the honour of giving the occasional address both as a founder of the National Trust in Queensland and in honour of his father. R W Cilento, 'National Trust Museum Jamestown', 10 October 1971, holograph Fryer coll. 44/. Nancy Robinson, Change on Change, (Investigator Press, Adelaide 1972) pp.250, 251

10. 'State visit Governor General' (Murray Bridge). 'French Trade Mission led by General Pau', are examples of such occasions in R A Cilento Cutting Book (disintegrated; to be microfilmed, Fryer coll. 44/)
On 2 December 1893 their second child and elder son was born. He was baptised Raphael West. All five children of the marriage were to bear their mother's family name both to honour their famous forbear and to emphasise their English blood though, interestingly, Benjamin West was American. Of the four grandparents only Salvatore was Italian, the others came from various parts of the British Isles; the family was more Gaelic than garlic as the young Raphael, called Ray by his family, was wont to remark.

Nevertheless, he was curious to learn something of his Italian background anathema to his mother and ignored by his father whose patriotic sentiments were seethingly British. Cilento was the only Italian name in Jamestown and despite his very fair colouring and the family's standing in the town, Ray was not immune to the taunt of 'Dago'. His father taught him to treat the jibe as jealousy among those with ordinary names. This bolstered pride and he began to feel that a name linked with a principality must be important. There is irony here; ordinary Italian people customarily took their district name as their own. Raphael did not know this and in any case what follows is family folklore.

In young manhood, when the two had become firm friends, Raphael persuaded his grandfather to tell him the history of the family. Legend, truth, or a colourful blend of both, it was a source of inspiration to the willing listener.

Il Cilento, from its shoreline along the Gulf of Policastro, stretches back into the wild, mountainous regions of southern Italy that for centuries were havens for political refugees. It had spawned many revolutionary movements: the Carboniere (or Black Hand), the Mafia (originally founded to drive the French from Italy) and the Filadelfi (or Friends of Mankind) which according to Salvatore was established by the Cilentos and espoused the aspirations of the French Revolutionaries: Liberty, Equality, Fraternity. After a series of confrontations with the Papacy the Filadelfi were proscribed but maintained their ideals and their identity in Italy.¹¹

¹¹. R W Cilento, 'The World my Oyster', Fryer coll. 44/ (Ch. 17) p. 6. Unfinished autobiography divided through collection, annotated thus: Cilento, 'The World...', (first twelve chapters 44/4)
His interest thoroughly aroused, Raphael sought to establish an illustrious background, if one existed, as an inner shield against those fellow medical students who, in his first year of medicine in 1914 were 'gradually imbibing the idea that my company is not select enough and treating me rather as parvenu'.\footnote{R W Cilento, diary, 1914, Fryer coll. 44/16, p. 5} Reading from Dennis’ Cities and Cemeteries in Etruria, he traced his family’s descent from Marcus Cilenius, ancient Etruscan ruler, to the Cilento dei Cilenti, (as translated from the Etruscan) his immediate forebears. Final proof for him, lay in the exciting discovery that his family crest was identical with that of King Marcus Cilenius. Tenuous evidence perhaps, but good enough for one who so fervently embraced pride of name as a focus for high ambition and paradoxically, as the guarantee of his rightful place in the social milieu of preferment and privilege at the medical school.

It was a very private possession, confided only to his diary, where he wrote that ‘... it is our name that shall be important’ adding prayerfully, 'Mine let it be to hand it on to my children ... resplendent with honours'.\footnote{Ibid}

These considerations were of no importance to the family in Jamestown in 1893, a crisis year in Australia in which thousands of small businesses failed, banks crashed and unemployment was endemic. Fortunately, the line had to stay open, so that the stationmaster’s job was safe. Within three years two more daughters were born. A latecomer to the family was Alan, a second son who was to have a distinguished banking career in South Australia.

The children were all exceptionally talented. They were good students, but it was in the wider activities encouraged by their father that they began to attract attention. Ray was athletic, so much so that his headmaster saw him as a future Rhodes scholar. He and his elder sister Gladys frequently won state-wide essay and drawing competitions. In 1930, their father won first prize for a prepared speech on How to provide work for the unemployed. The girls had splendid singing voices. Two of them won their way to the Elder Conservatorium of Music from which they graduated; surely a tribute to parental support. A scrap-book of family activities in war-time South Australia survives and provides a miscellany of patriotic concert
programmes in which father and daughters feature constantly. Their mother, a competent pianist and talented mimic, disliked public appearances but enjoyed music-making in the family circle. Until 1906 when he left home, Ray took part in concert performances, reciting and acting.\textsuperscript{14}

Thus was the pattern of family life set in the mould of the Australian bush, in a secure and lively home where the limitations of the breadwinner's wage were transcended by hard work and the enjoyment of shared activities. For Ray this pattern changed when he failed by two marks to win a secondary scholarship. This placed his further schooling, necessarily away from home, beyond his father's means. Without consulting him, Cilento senior approached the local solicitor, Frederick Young, (later Sir Frederick, the state's Attorney General), with a request for articles for his son. Young agreed with alacrity and volunteered to waive the usual premium. To the father this seemed a perfect solution. To the son, who had to refuse the generous offer, it was an acute embarrassment. He wanted a medical career, a secret he now confessed to his father:

\begin{quote}
I stood a little in awe of my handsome, peremptory father and I knew I must displease him. But I had determined to become a doctor and intended to see it through.\textsuperscript{15}
\end{quote}

This was the first independent step of his life. To the youth of thirteen already longing to escape the confines of small town life and the anxious scrutiny of his father that would inevitably follow any attempt at a local career, the hurdles that lay between him and the medical school seemed to beckon rather than daunt. To earn his secondary education he joined the Education Department as a cadet teacher; a seven year course which he began at Jamestown school as a monitor in 1906. He was paid 12/6 per week, which when he left home the following year to enter the Teachers' Training College (Adelaide High School), barely provided subsistence. By passing Junior and Senior Public examinations in consecutive years (1908-09) he reduced his course by one year and in 1910 was posted to Port Pirie school for two

\textsuperscript{14} R A Cilento, Cutting Book, 44/- held Fryer Library

\textsuperscript{15} Cilento, 'The World ...', holograph notes for Ch.1 Fryer coll. 44/4
years final training. Academic hurdles he took in his stride but the need to supplement his departmental allowance placed a heavy burden upon him. Yet he never lost sight of his goal. Recalling Port Pirie days, he wrote of 'shabby clothes and no girls, of trundling ore in banana carts (long barrows) at the smelters and burning the midnight oil writing for newspapers to extend meagre funds and pave the way for matriculation into medicine. For recreation he formed a Scout Troop and took up boxing, wrestling and public speaking, none of which required money'.

Since his teaching course had precluded the science subjects pre-requisite, graduation as a teacher at the end of 1911 brought him no closer to medical matriculation. In all the circumstances, his only hope was to win a government bursary, rare and coveted, which would pay his university fees. To become eligible the student had to attempt successfully the English essay and all subjects appropriate to the degree course chosen. To miss one was to lose the bursary. Resolve and rebellion strengthened within him as almost everyone scoffed at the idea; everyone, that is, but his father who at some personal sacrifice, helped him financially at this time. He entered Prince Alfred College as a boarder to attempt in ten months, three years work in subjects quite new to him. After a gruelling year, he failed chemistry and therefore lost his entitlement to the bursary which had been awarded on his high aggregate.

Bloody but unbowed, he worked frenziedly for the posts, supporting himself by farm work. He not only passed but had saved enough money to pay for his 'pre-med' year and put a deposit on his medical course. This was begun in 1914 with a loan of fifty pounds from Dr William Aitken, described by a historian as the last of the Jamestown giants. This colourful frontier doctor had brought Raphael into the world and inspired within him the ambition to become a doctor.

16. Advertiser (Adelaide) Cutting Book - ibid
17. Cilento, holograph notes for 'The World ...' Fryer coll. 44/- I think I may well be the oldest surviving South Australian District Scoutmaster as I set up the first troop outside Adelaide at Port Pirie and Solomon Town and gained its confirmation on May 20 1910
18. Cilento, 'The World ...' (Ch.2) p.3) Fryer coll. 44/4
Raphael Cilento accepted the need to earn his way; his colleagues did not. Most were from well-to-do families and took their status for granted. The proud young man who had won his way by sheer hard work and ability, felt humiliated:

My life was geared to grinding frugality and the rejection of anything but essentials. Inability to afford equipment kept me out of sports clubs ... I found opportunity only in boxing, wrestling and outdoor activities. I could not afford the luxury of intimate friendships. They meant obligations I would not have been able to meet. In later life as I established and consolidated myself I remained a loner. 20

At university this was far from the case; student years were a time of fulfilment and expansion of the skills that his hard life had taught him. Two 'bone poor students', contemporaries from Prince Alfred, shared his outdoor interests. They formed the 'Bubonian*(Night Owl) Club of seven members for week-end exploratory expeditions. Paul Hossfeld was their geologist; T D Campbell the expert on teeth found in human and animal skulls while Cilento was the group's anatomist and authority on Aboriginal remains. 21 They became life-long friends and it would be ludicrous to suggest that they hankered after conventional club life. They were most fortunate having the guidance of teachers such as Professor Frederic Wood-Jones of Anatomy who, in 1919, was appointed honorary curator of Anthropology at the South Australian Museum. Others with whom they worked on these expeditions included Dr (later Sir Joseph) Verco an eminent conchologist and dominant figure in the medical profession and Dr Ramsay Smith who, with the famed anatomist Archibald Watson, built up a collection of Aboriginal remains now in Edinburgh University. The broadened knowledge and competence gained from working with these men was an invaluable adjunct to formal training.

At the end of his first year in medicine, Cilento won a scholarship that paid his fees for the rest of his course. On the way through he won many prizes and on graduation, the Everard Scholarship for equal first place. This had been most

20. Cilento, 'The World ...' (Ch 1) p.12 Fryer coll. 44/4
21. Ibid (Ch 2) pp. 7, 8
worthwhile. Instead of a sizeable debt, he finished his course with thirty pounds in the bank.22

Wartime conditions both telescoped and extended training in clinical years. Shortage of doctors presented unusual opportunities for surgical and senior medical work normally reserved for more experienced practitioners. Withheld from active service to complete their course, Cilento and his contemporaries had opportunity to serve during vacation in hospitals or in Army Camps. Cilento, who all his life maintained that hospitals were for patients, made straight for the Army. At one stage, when conscripts were being trained, his elitist attitude shows in distinctly 'holier than thou' diary comments; he wrote that some conscripts were less than patriotic and was contemptuous of the trivia that made up ninety per cent of the complaints on sick parade and intrigued with the ingenuity of their excuses. Of administrative procedures he was bitingly critical.23 However, as he wrote:

> Small things determine big issues. It was in War Service Camp that I first recognised sanitation and hygiene as sciences worth studying and realised, by default, that organised efficiency was the key to successful administration.24

His life-long political stance was taken at this stage. In 1916 he was elected Liberal Party Organiser for the Barossa Valley. He was a supporter (and sharp critic) of Billy Hughes, pro-conscription and fiercely opposed to the Miners' Strike. Yet, while standing conspicuously on the right of the political spectrum, Cilento has puzzled friend and foe by his apparently paradoxical determination to nationalise medical services in conjunction with reformist Labor governments. (In this he was to a large extent misconstrued as will be demonstrated).

From the beginning of his course Cilento edited the Faculty Journal MSS Review, often contributing caricatures both written and drawn of public and faculty figures assisted by another adept artist, Miss Phyllis McGlew, the only woman in the

22. Ibid, (Ch.1) p. 13
23. Ibid, (Ch.3) p. 3
24. Cilento diary, November 1916, in 'The World ...' (Ch.3) p. 4
course. Near the end of their training, at his thirteenth time of asking, she finally agreed to marry him.

The opportunity to do locums came early in those war-time years and brought to Cilento an experience that was a key factor in his future, although he did not recognise this at the time. Here is an abridged extract from his diary note:

My Aboriginal patient was in a meanly built cottage about the middle of the street. As the car drove down it was greeted by scores of mongrel dogs of every canine colour and shape. Their furious barking brought natives old, young and middle-aged, black, yellow and almost white to every door and window ... The home of the sick woman was floored with mud and stamped hard with bits of wood and an old door to help flatness. The living room was crowded with wailing gins who, like children, seemed terrified to see a stranger. The bedroom was smaller, dirtier and similarly floored and roofed with bags that bulged with many a hint of vermin and dirt.

The woman was a half-blood, about twenty-five, married to a portly, scowling buck of about sixty and had aborted at about six months from violence. I had been called because the afterbirth would not come away ... a dreaded complication among ill-fed and anaemic women ... I had little difficulty in removing the afterbirth successfully, watched by half a dozen Aboriginal women who refused to leave but lay or sat on the floor and watched my every movement ... A few questions - no answers but a desperate shyness. I left the room, running the gauntlet of staring eyes and so the car and home.25

Some fifty years later, Cilento recalled the incident vividly, saying that although he had often been in contact with Aborigines as a child, he had never realised their physical, mental and sociological problems.

That one experience set me on the road to a lifelong interest in their complex situation in relation to our after-coming race that had dispossessed them.26

25. Cilento diary, 17 December 1917 in 'The World...' (Ch.3) p. 10. Fryer coll. 44/4
One flash of insight had shown the student doctor two phenomena of overlapping complexity: that contact with the white man had tragically depleted the total health of the Australian Aborigines and, by extension, that poor health and social conditions were factors in the human condition so interwoven that amelioration could be achieved only by special understanding and treatment. The maturity of understanding demonstrated so early in life would seem to have developed from his father's examples of concern for his neighbours and his own hard life.

Immediately upon graduation in November 1918, Cilento volunteered for overseas military service and left for New Guinea with the Australian Naval and Military Forces, destined to serve in a hospital in Rabaul. Reflecting on this episode he wrote in his memoirs:

> The long period of probation had passed: I was a qualified medical practitioner; a captain of the AAMC; engaged to be married and about to leave, almost by accident for a tropical area, where peace, in due course might provide exciting opportunities in a new but exciting field of medicine.²⁷

Circumstances had streamlined and linked his life-time interests. These were the study of public health and administration and as a major concern Australian and other aboriginal races: both were reinforced by active general medical practice with particular emphasis on endemic and epidemic diseases of the tropics. In addition, that year in Rabaul about to begin showed him that there were administrative aspects of an outpost assignment existing in embryo anywhere.²⁸

Chance, and the pre-dominant influence of his father in his formative years, had set a pattern that was to govern his whole later life.

²⁷. Ibid, p. 16

²⁸. Ibid
CHAPTER TWO

(a) Training in the Tropics

Hygiene is the corruption of medicine by morality.
H L Mencken, Prejudices, 3rd series

Mencken's aphorism establishes the perceived role of hygiene (public health) in the human health syndrome. The practising clinician sees himself as a healer; the hygienist is trained to ensure that healthy people stay fit. His armamentarium includes quarantine procedures and prophylaxes to control the introduction and spread of transmissible diseases. He is interested in health education, maternal and child welfare, national fitness, clean air, ground and water supply, good housing, nutrition and a host of related subjects concerned with the maintenance of positive health. He depends on organised facilities and programmes provided and supervised by health agencies and government authorities broadly known as public health.

The growing acceptance of public health as a role of government created the need for the modern public health administrator with his cadre of trained personnel to carry out its specialised functions. It is a coincidence of history that the growth of this phenomenon and that of the Australian nation occurred in the same era. Australia was not far behind the leaders in public health development and not least because the colonies had evolved a strong tradition of government initiative, with the state assuming responsibilities far beyond those of 'laissez faire' societies in Europe and America.

Standing on the threshold of his career, pondering upon the direction he should take, Cilento saw in this new field opportunities for professional and personal fulfilment in challenges he could not resist. Australia's response to public health progress; the establishment of its first institute of medical research; the late flowering of a federal health department with its weighty responsibilities for health care in the Mandated Territory of New Guinea and Cilento's self-motivated
preparation for what he saw as his future career in tropical health as part of this development provide the main themes of this chapter. It falls naturally into two parts, the first of which sets the scene for Cilento's eventual appointment as Director of Health in the Mandated Territory of New Guinea.

Upon his enlistment in November 1918, Cilento had been drafted into a specially organised tropical military force being trained in Sydney for service in German New Guinea. A few weeks later, he sailed with a small group of reinforcements for the British Occupation Force there, arriving at Rabaul late in January 1919.

The occupying force, now gradually being relieved and displaced by civilians had evolved from the 1st Battalion Australian Naval and Military Expeditionary Force which, after a short passage of arms, had secured the surrender of German New Guinea on behalf of Great Britain on 13 September 1914. As it was necessary to occupy the conquered territory until the end of hostilities, the military contingent found that its role was not to fight but to govern. After four months, these combat troops were replaced by a tropical force intended to meet the administrative and military duties of an occupying power. Although wholly inexperienced and poorly equipped for the circumstances they had to control, this tropical force steadily evolved through a number of adaptations to circumstances, into the civil administration which, under mandate from the League of Nations and later under the United Nations Trustees Council governed the country until it achieved independence in 1973.\(^1\)

By the time Cilento arrived, the Australian Army Medical Service in New Guinea (as distinct from Papua) had gradually expanded their role to embrace a wide range of civil responsibilities never before covered by a single authority in that area. The metamorphosis could be clearly seen.

On 4 October 1914, the Principal Medical Officer of the Occupying Force Colonel N. Howse returned to Sydney to enlist in the Australian Imperial Forces and

1. F A Maguire, Principal Medical Officer, 1st Battalion, AN&MEF, 4 September 1914 to 17 December 1914, quoted in: A G Butler (ed.) The Official History of the Australian Army Medical Services (Australian War Memorial: Melbourne, 1930), pp. 781 et seq.
was replaced by Capt. F A Maguire. During this phase of the occupation two major factors affected his authority: first, the provision in the terms of surrender that civil conditions were to remain unchanged as far as possible, and second, the medical system that had been evolved by the Germans to meet the requirements of the industrial system built up to develop her Pacific possessions.\(^2\) He therefore decided not to interfere with the civil health authorities unless, through their fault, the health of the troops was being menaced. But it soon became necessary to impose upon them an ordinance compelling compliance with fundamental standards of hygiene and sanitation to control the spread of certain prevalent diseases. Administration of this ordinance gave the Principal Medical Officer (P M O) some right of interference.

Maguire's replacement, Major C L Strang, P M O of Tropical Force which arrived on 17 December 1914, had the inestimable advantage of being a specialist in tropical medicine. He had a staff of seven medical officers. By the end of December, a major outbreak of malaria among the troops brought a candid admission from the medical staff in general that lack of experience in tropical hygiene was a serious handicap.\(^3\)

It was in recognition of the special difficulties of this phase of the occupation, that the Australian government had appointed its former Secretary for Defence, Colonel Pethebridge, as commander of Tropical Force. This capable civil administrator (given military rank for the purpose) and the forceful Dr Strang soon made a positive impact on the medical situation. The Tropical Force had to provide medical facilities and sanitation for troops in barracks and camps, a public health service for the relatively large white population, mostly foreign, and approximately a quarter of a million free natives living in scattered villages. Another element under control was the Asian and other coloured alien population but indentured natives, under the terms of the surrender, remained the responsibility of the German planters who employed them.\(^4\) For the same reason, German hospitals at Rabaul, Herbertshoe and Madang had been turned into military establishments with provision

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2. Ibid
3. Ibid
4. Cilento in Butler, The Official History of the AAMC ...ibid, pp. 799 et seq
for civilians while German doctors in the three towns were engaged for attendance upon the natives. With such a small establishment, the medical detachment could do little but try to control the main problems of malaria and dysentery affecting the troops. This they did very well. The problem of the native had two main elements that worried Cilento so much that he took steps to remedy them. The first of these was the health of the free natives, which, as under German control, was still left to the missionaries and the second, the health of indentured natives whose recruitment had become the subject of several enactments during the occupation. They were subject to various disorders that not only might affect the troops but also reduce their own capacity for work. Australia was morally obliged to care for the health of the indigenous people and Cilento, in time, wrote to the Administrator, General Johnston, with suggestions for more effective measures when civil rule began. The Administrator's reply to this letter is quoted below as a pointer to Cilento's future career. Cilento had written from Kavieng, where, from 25 March 1919 until he left New Guinea in the following October, he was in medical charge. Here his love affair with tropical medicine began to flower. His diaries brim with excitement aroused by strange and interesting diseases; the human problems of the polyglot coloured population and the wonders of the physical surroundings he explored at every opportunity. 5

The large district under his immediate care for health extended over the entire island of New Ireland with its administrative centre at Kavieng, to New Hanover above it and the Northern Solomon Islands below it, and included hundreds of smaller islands. Although the native hospital housed 'over-numerous' patients suffering from a variety of tropical diseases, Cilento made special mention of deficiency conditions such as beri-beri, a preventible malady, which he attributed to devitaminized plantation rations. Here is an early indication of a medical interest in nutrition which was to become dominant in his career. 6 Another developing characteristic was the imperative inner drive to explore and observe at first hand. Now he surveyed his new district, visiting outlying villages and island settlements to study the health and living conditions of indigenous peoples. To satisfy his anthropological curiosity he penetrated into untouched areas where head-hunting and cannibalism had but recently been a way of life.

5. Cilento, New Guinea Diary, Fryer coll. 44/17
6. Cilento, 'The World ...' (Ch.6) p. 12 et seq Fryer coll. 44/4
At Namatamai in the far south, the capable medical assistant in charge had used his convalescent labourers to cultivate the fertile soil to such good effect that there were profuse crops of fruit, vegetables and nuts to supplement the inadequate diet of polished rice and tinned meat or fish provided by the government. Cilento was so impressed by this that on his return to Kavieng he tried to emulate it by having some ten acres cleared by his convalescent patients and planted with suitable crops as diet supplements for the hospital inmates. To his dismay, the highly successful crops were claimed by the District Officer on the grounds that they had been grown on government land by native labour and therefore were his to do with as he thought best. Cilento saw this as an example of the callous disregard for native peoples that too often discreditably characterised the Australian wartime administration.

It was this incident, intensified by my interest in diet as a problem in the tropics for both white and black, which resulted, some years later, in my introducing there one of the first dietaries for native labourers in the world.

After the war, Cilento applied for demobilisation on the grounds that he planned to marry and needed to secure a payable practice in civil life. Inasmuch as there was intense competition for suitable practices in the immediate post war period he considered it vital that he be on the spot to protect his own interests and those of his fiancée who at that time was studying in London.

Yet he could not resist taking steps to remedy two aspects of conditions in New Guinea that worried him deeply; the haphazard quarantine controls and the ad hoc fashion in which the changeover from military to civil control was being conducted by Australia. As Australia was shortly to receive the League of Nations mandate for the good government of the Territory of New Guinea (with all that implied for the welfare of natives), he devised a plan of management to be put before the Government Commission that was soon to come to the Territory.

7. Ibid, p. 29
8. "Dr (later Lord) Boyd-Orr, in East Africa, reached a similar stage at the same time and by coincidence it was one of the factors that led to a knighthood for each of us on 20 February 1935", Ibid, p. 28
The influenza pandemic that had killed more people than had died in the war, highlighted the need for efficient quarantine as a matter of urgency. Accordingly Cilento wrote to Dr J H L Cumpston then head of the Quarantine Department in Australia and suggested to him that he should be ready when the mandate came to impose uniform quarantine regulations on the whole of Australasia. By then the Territory of New Guinea, hereafter TNG, would be governed as an integral part of the Commonwealth. This was to be the key to Australia's becoming the leading health authority in the area which Cilento hoped would be brought into being as the South West Pacific Region, and also strengthen Cumpston's bid for the formation of a Commonwealth Department of Health. The outworking of important aspects of this plan belong to the next chapter.

The plan with regard to the problems of the indigenes was outlined in a report to General Johnston as mentioned above. Cilento's report has not been discovered but here is the Administrator's reply:

My dear Cilento,

I have read and re-read with considerable interest the most excellent report on the health of natives made by you on the 9th inst. in respect of New Ireland. I am most heartily in accord with all your deductions and with practically all your suggestions.

I have on many occasions given this subject considerable thought but found it impossible to introduce effective measures while we were labouring under such feelings of uncertainty.

Defence has granted me short leave to Australia, and I am afraid your relief will be arranged before I return. If you have an opportunity to look me up when passing through Melbourne, I shall be delighted to see you and if possible discuss this subject more fully.

A Commission from Australia will be sent at an early date to make enquiries and submit a report as to the most suitable means of Government under the Mandatory powers granted to Australia. I hope to have an opportunity of referring some of the matters you have


10 G R Johnston to R W Cilento, 28 July 1919 Fryer coll. 44/
touched on to this Commission, and assure you that I will do everything in my power to effect the improvements on the lines your report has indicated.\textsuperscript{11}

I value your report very much, and intend taking it to Australia, where I may, if opportunity offers, quote several of your paragraphs in support of statements I may make on the subject.

If the fortunes of War prevent our meeting again within the next few months I would like you to know how sincerely I regret the necessity which compels the termination of your appointment with this Force, but I thoroughly understand your position, inclinations and ambitions. I am quite sure you will succeed in life, and wish the future Mrs Cilento and yourself the very best of luck and good fortune.

Yours faithfully


The Administrator's strong and approving response has been quoted in full because it indicates the quality of Cilento's report to him which had demonstrated his ability to recognise the problems of the indigenous peoples, to synthesize solutions and articulate them in administrative form; obviously he had a social conscience, political insight, the courage to put his views before the decision makers and the power to influence them. This was a remarkable development in a young man barely out of a conservative medical school which had in no way trained him to originate social change.

Much encouraged by Johnston's commendation and stimulated by the challenges he had met, Cilento left New Guinea in October 1919 and was demobilised in Sydney. He had spent approximately ten months in New Guinea.

On his return to Adelaide the search for a living began. The city was flooded with doctors as returning men and new graduates converged on the scene. Practices were at a premium. Cilento, who could not afford to buy was forced to 'squat' in a

\textsuperscript{11} The members of the Commission were: Sir Hubert Murray (Lieutenant Governor of Papua), W H Lucas (a man of wide experience in Island commerce) and Atlee Hunt (at that time Secretary of the Home and Territories Department of the Commonwealth). Cilento, 'Official History ...' ibid, p. 807
new suburb called Tranmere, having first obtained the consent of the established doctor further in.

He had some months to wait until his fiancee returned from London where she was studying maternal and child health. With their wedding date set for the following March, Cilento supplemented income from his meagre practice by working as a demonstrator in anatomy at the medical school. Based on knowledge gained in New Guinea, he submitted a successful MD thesis on the subject of native nutrition and published an anthropological study on the practice of head-shrinking. In collaboration with F A Maguire, formerly of Tropical Force, he began to write the official history of the Australian Army Medical Services in New Guinea. For pastime, Cilento resumed an old interest. Frederic Wood-Jones, Professor of Anatomy at the University of Adelaide had been appointed honorary Curator of Anthropology at the Museum of South Australia in 1919. He immediately commenced a study of Aboriginal skulls and other human bones in the Museum collection. Associated with him were Cilento and his "Bubonian" friend, T D Campbell, who together described and drew many of the specimens.

The Cilentos were married on 18 March 1920. Phyllis, much inspired by her London training, was keen to continue her work. Raphael appreciated her need and each promised the other the right to pursue independent careers insofar as this was compatible with married life, a remarkably enlightened agreement for those times. Raphael had acquired a taste for the tropics and found Tranmere raw and arid. Earlier, he had sought re-appointment to New Guinea but, unknown to him, this move was blocked by his father in law, a close friend of the Minister for Defence who, at his request deflected the appointment which had virtually been promised to Raphael;

12. R W Cilento, 'A Study of Nutrition of Native Populations', MD thesis, University of Adelaide, 1921 (degree awarded 1922). This is probably one of the earliest theses on this subject. Observations on a Series of Artificially Distorted Skulls, by R W Cilento appears in the bibliography of the Adelaide Museum, 1921. He had collected those skulls while on war service in New Guinea. They are now in the Anthropology Museum, University of Queensland.

13. Maguire and Cilento, Part III (V.1) The Occupation of German New Guinea, in Butler The Official History of the Australian Army Medical Services, ibid

he had no intention of allowing his only daughter to go to an area where his sister had died in childbirth.

When the established doctor put a young partner in Tranmere, Cilento immediately changed tack.

He wrote to Port Moresby (Papua) and to the authorities in the Northern Territory of Australia and was assured by both that a position was available if he cared to apply for it. Neither was really attractive to him; what he really wanted was to be Director of Health in the TNG. Years later he recalled:

My basis for action in medicine or in life generally, has always been to choose an unusual career which you know will be essential and wait for the opportunity. I knew that we were to receive the Mandate for former German New Guinea, a responsibility upon which we should have to report; that there was virtually nobody in Australia who knew anything about tropical medicine and they would need someone who did...

Keen now for more tropical training, Cilento took a gamble. Noticing advertisements in the then current BMA Journal inviting applications for six physicianships in the Federated Malay States, (now Malaysia), he consolidated his few assets, bought steamer tickets for himself, his wife and her mother (who insisted on coming too), and set sail. They arrived while applications were still being considered in London, secured an interview with the local Director of Colonial Health Services, convinced him that they had saved him the cost of fares and training and presented themselves in situ. Their point was taken. Cilento was appointed a physician to the Sultanate and also for the State of Lower Perak with headquarters at the Port of Teluk Anson, while his wife was gazetted 'the first lady medical officer ...in the British Colonial Service'. Their appointment was for twelve months beginning in November 1920. Here their first child, Raphael Frederic, was born.

Teluk Anson provided rich experience in tropical medicine. Cilento initiated here the first mass campaign for the treatment of framboesia (yaws) by the injection

15. R W Cilento to Mel Pratt. Transcript of interview as part of oral history programme, Australian National Library, 7 March 1971, p. 12. Fryer coll. 44/1, p. 71. It is a measure of Cilento's ambition that he was attracted by a position in which his reports would go through the Commonwealth authorities to Geneva.
of the newly discovered organic arsenic which proved dramatically successful medically and effective in persuading the natives to accept western medicine. Here also, he introduced the new Rogers and Muir treatment for leprosy. His work at Teluk Anson included the usual port duties concerned with quarantine and he was able to visit both Ceylon and Java for the purpose of studying closely their advanced methods. In Batavia, in August 1921, he represented Australia at the Congress of the Far Eastern Association of Tropical Medicine. This came about in a very interesting way that had decisive consequences for Cilento's career.\textsuperscript{16}

On 10 January 1920, the day on which the Treaty of Versailles was ratified by Germany, the League of Nations came into being and on 9 May of that year Australia accepted the Mandate for the Territory of New Guinea under which it was responsible for providing the people with good government in the industrial, economic and domestic fields with due co-ordination of administrative, educative and health provision.\textsuperscript{17} In March 1921 the Commonwealth Department of Health was instituted. This was the situation Cilento had been working towards and here, in far away Teluk Anson, opportunity literally came knocking at his door. Dr J S C Elkington, Director of Quarantine in the new department, while on a tour of duty in the region, called on Cilento to persuade him that if he were determined to make a career in tropical medicine his first duty was to Australia and to offer him a post in the tropical section of the Commonwealth Department of Health. This occurred in mid-1921.

Since the offer carried the added bonus of twelve months preliminary training as a tropical hygienist in various parts of the world, Cilento accepted the offer with

\textsuperscript{16} The existence of Well's disease, a rare and specific form of leptospirosis among the labourers in Java's rice paddies, was a theme of the conference. Named for its discoverer who had isolated its causative organism in Europe in 1875, it was originally found in urban sewer workers and known to be rat borne. It was a dread disease, often fatal. The parallel, in Java, was the working environment; low-lying stagnant water producing lush rat harborage and loose rice for their food. Similarity of environmental conditions for workers in Queensland's sugar cane fields had aroused suspicions that epidemics of so-called 'cane fever' recorded in 1870 and 1900, could have been Well's disease.

\textsuperscript{17} Cilento, The World ...' (Ch.8) pp.10 et seq
enthusiasm.\textsuperscript{18} A letter from Cumpston confirming the agreement read, in part:

The position will be, for the present, styled 'The Medical Officer for Tropical Hygiene' and the duties will be those allotted by myself as Director General of Health in connection with tropical hygiene in tropical portions of Australia and British and German New Guinea. This work will be done in connection with the Australian Institute of Tropical Medicine at Townsville.\textsuperscript{19}

In a firm and detailed letter, Cumpston directed Cilento to extract himself as soon as feasible from his present post and proceed to London via the great quarantine stations of Ceylon and El Tor (Egypt). In London he was to attend the course of tropical laboratory work at the London School of Tropical Medicine concluding with the May examinations for the Diploma of Tropical Medicine and Hygiene. He was directed to return via New York, journey to the Caribbean to survey public health education in the region and then spend some time in the Panama Canal Zone studying the methods of the late General Gorgas whose success in the sanitation of the Isthmus was still exciting hygienists. And finally, home across the Pacific for a familiarisation course under Elkington before taking up his duties in Townsville late in 1922.

Cilento could scarcely believe his good fortune; twelve months in which to study his chosen subjects in the best academic and field situations in the world.

Before leaving the Malay States, he sent his wife and baby back to Australia and, wearing appropriate Malayan dress, travelled exhaustively through towns and villages 'studying the details of mosquito control' as directed by Cumpston and learning the customs and habits of the people. He spoke fluent Malay and was at pains always to win the confidence of the villagers and try to persuade them to accept the benefits of western medicine.

\textsuperscript{18} This course of training was provided by the International Board of Health (Rockefeller Foundation, U S A ) by arrangement with the Commonwealth Government.

\textsuperscript{19} J H L Cumpston to R W Cilento, quoted in 'The World ...' (Ch.8) p. 12
The effort he put into the London course is attested by his having won both the Duncan Medal for first place in the course from among fifty four students from many lands, and the Lalcaca Medal for the highest achievement in the three courses held during that year. He was the first Australian to do this. An exciting academic experience for him was that here at London University for the first time he had access to a world class library in which he could fully explore his interest in what is now called social medicine. In the writings of Johann Pieter Franck (1745-1821), a very early exponent of the relationship between man's health and his social environment, Cilento confirmed ideas, nascent since his experience in the Aboriginal humpy three years earlier, that living conditions cannot be separated from individual or community health. This was to become one of the guiding principles of his career and the impetus for his more important contributions to the service of his fellow man.

With the exception of that one year of private practice immediately after the war, Cilento had spent the four years following his graduation in situations that provided intensive training in tropical medicine and hygiene in varying conditions and environments. In addition, he had enjoyed the benefit of academic laboratory training; inspected areas of important development in this discipline, travelled widely and observed deeply. He had learned the languages of native peoples well enough to be able to relate to them and gain insights into their beliefs, their diseases and their social conditions. This blend of practical and academic training had been a very thorough postgraduate preparation for his principal objective, the post of Director of Health in the Mandated Territory of New Guinea. In September 1922, however, when he returned to Australia to take up his appointment with the Commonwealth Health Department, there was no role for him or his department in the Mandated Territory. In May 1921, under the aegis of the Department of Home and Territories, a specially formed administrative cadre under Brigadier General G E Wisdom had replaced the occupying military forces there. The post of Director of Health was occupied by Colonel F Honman former personal physician to Prime Minister W M Hughes. The Commonwealth Health Department was still in embryo, its expansion into the Mandated Territory solidly blocked by a senior department.

20. The Duncan Medal was awarded in April 1922 at the completion of the course; the Lalcaca Medal in October of that year. Advertiser (Adelaide) 17 October 1922
The second part of this chapter provides the historical background to Cilento’s role in Queensland, both in the shorter and longer terms of his service in that state. The main personalities, themes and events concerned are presented as Cilento would have seen, understood and been affected by them when he returned to Australia to take up his appointment and formalise his relationship with the two men most important to his office, Cumpston and Elkington, at the headquarters of the Commonwealth Health Department in Melbourne early in September 1922.

The mixture of hope and fear with which Cilento embarked on his career still coloured his recollections some fifty years later when he wrote in his memoirs:

With some trepidation I reported for duty with the Commonwealth Health Department as its newly appointed Medical Officer for Tropical Hygiene ... The Department itself was in a similar state of lusty infancy and, moreover, there were doubts as to its legitimacy! The Constitution Act of 1901 which defined the respective fields of State and Commonwealth responsibilities had by Section 51 limited the Commonwealth power in health by one word - "Quarantine". Until the pandemic of influenza in 1918-20 the potential department was merely the health section of the Department of Customs. That pandemic however, provided a logical basis for the claim that when a health problem passed the boundaries of a state or was a risk to one or to all, Commonwealth assistance... might be demanded. Cumpston, blessing the name of Panic, the handmaid of Hygiene, seized and never relinquished the initiative and in March 1921, his section reached departmental status and the Commonwealth Health Department was proclaimed... Cumpston was the administrative genius who co-ordinated earlier, isolated efforts of others and was the founder of the department, as such, and its first Director General. 21
Into those words may be read Cilento's admiration for Cumpston's achievement and his personal pride in the new venture. Yet, he was concerned about the doubtful legitimacy of the department by which he meant that it had no constitutional endorsement; public health was apathetically regarded by government and unless Cumpston could get his department accepted on a broader footing after the emergency had been forgotten, it might well be left to die of inanition. It would be disingenuous to conclude that the health ministry had been procured solely by the force of public terror even though, as it happened, this had been considerably heightened by a short-lived outbreak of bubonic plague that followed in 1921-22. For at least a decade before, Cumpston had striven steadily to build a national health consciousness from his base in the Quarantine Service. The other basic component was the Australian Institute of Tropical Medicine. The role of these two instrumentalities will be discussed later.

Cumpston's ideal of service was to provide Australia with an efficient health organisation which, at federal level, would provide subsidised research and other aids to public health progress for the states which usually could not afford them. He was a true federalist, an intellectual who believed in the concept of co-operation with the states, while respecting their sovereignty in matters of routine hospital and medical care, could provide the benefits of science and technology which he foresaw would become increasingly relevant to health care delivery. These ideas were too new to stimulate demand pressures on the Commonwealth government from the public or the profession, while the states were extremely wary of Commonwealth intrusion into any of their activities, health included. The Director General had a hen and egg problem: with such a small establishment he could not expand until he could attract an appropriate share of government funds and vice versa. The only possible opening was the Territory of New Guinea, now not only an integral part of the Commonwealth but also under scrutiny from the League of Nations. Health and welfare of the indigenous people had been emphasised in a very special way under the terms of the Mandate. Here was an untrammeled field in which to demonstrate the many public benefits of a well-run health department. Cilento's plan for reciprocal

22. In August 1919, the Royal National Association of Queensland cancelled its annual exhibition to allow the showgrounds to be used for emergency hospital accommodation for influenza victims; the only time in the Association's long history that cancellation of this feature of Queensland life has occurred.

quarantine measures in the whole southwest Pacific area co-ordinated and managed by Australia which he had formulated and put before Cumpston in a letter from Kavieng in 1919, might also be implemented in connection with New Guinea responsibilities and as a logical extension of them. In the interests of the Commonwealth and its health department, Cumpston and Cilento both extremely ambitious men, had their sights set on the Territory of New Guinea. Independently, they had recognised very early that it offered a unique set of conditions favouring professional expansion. Acknowledging Cumpston's foresight Cilento wrote:

> With remarkable vision he formulated plans that not only included all Australia and adjacent islands, but extended to international fields and the possibilities of cooperative work with bodies like the Rockefeller Foundation.24

With the benefit of hindsight, it becomes clear at this point, that Cumpston had prepared to exploit the New Guinea situation as soon as opportunity offered using the eminently suitable Cilento as his spearhead. The overtones of opportunism conveyed by this metaphor, whilst certainly reflecting Cumpston's strategy, should not be allowed to obscure the honest desire of both men to make a notable contribution to the cause of public health in the Mandated Territory and perform a service to the reputation of Australia in so doing. The appointment of Honman had foreclosed this opportunity for the time being at least. Cilento returned to Australia fully equipped to grasp the great challenge of his life only to find it tantalisingly out of reach. The trepidation he felt on joining the department was undoubtedly stimulated by anxieties about his future. Meanwhile there was a great deal to be done closer to home.

One of the first of several ambitious projects delegated to Cilento was the control of the hookworm campaign set up in Australia in 1918 by the Rockefeller Foundation of New York which was richly endowed from the Rockefeller fortune as a centre for public health research and social amelioration. A universal hookworm survey of Australia was contemplated and offered the opportunity to check the incidence of malaria and filariasis while the coastal fever which obviously included several types of disease was also an untouched but essential field for study. Cilento's assignment therefore, was to guide these surveys and to lay down a research programme for the Australian Institute of Tropical Medicine with emphasis on the

24. Cilento, 'The World ...' (Ch.9) p.2
fevers. 25

As the incoming director of the AITM (as the Australian Institute of Tropical Medicine was known), Cilento reported directly to Elkington who was Chief Quarantine Officer for Tropical Australia and exercised general surveillance over the AITM. He was second in charge of the Commonwealth Department of Health and Cilento's personal link with Cumpston. His ideal was to provide a satisfactory health service to tropical Australia and her dependencies. 26

He was professionally and ideologically committed to the task, and was as well, an affable, likeable man; attributes of supreme value in an area of endeavour where, in default of powers conferred by law, success depended upon the ability to influence people. The nature and orientation of Cilento's assignments described above show a strong bias toward tropical problems in the allocation of Rockefeller money for field and laboratory research - Elkington's chief objective. There is no doubt that Elkington's personal persuasiveness had much to do with this outcome. 27

The formation by the Commonwealth of a national health bureau was a logical and inevitable consequence of Australian circumstances and experiences. However the timing of this development was decided by a number of advantitious factors: the epidemics of 1918-21 (of which the intercurrent plague visitation was a strong reinforcing element); the resolution on tropical health of the Australasian Medical Congress of 1920; the acceptance of the League of Nations mandate for former German New Guinea; and the visit of V G Heiser, head of the International Health Bureau (Rockefeller Foundation of New York), who persuaded the Australian Prime Minister that the nation needed a ministry of health. 28 It was Cumpston's exploitation of the Commonwealth Health Department for which he had been striving.

25. Ibid p.2
27. V G Heiser, An American Doctor's Odyssey (New York: Grossat and Dunlap, 1936) p. 352
28. Ibid, pp.353 et seq
for the past decade. Cilento's appointment was an important element in the next stage of this strategy. These factors will now be looked at in greater detail in order that their true nature and effectiveness may be assessed.

The episodes which cause populations to be panicked into accepting health controls are usually crises; epidemics, natural disasters, wars. In Australia, the movement for environmental sanitation that had been promoted by doctors and concerned citizens from early times, progressed very slowly as is the way of public health until, in the first decade of this century, it was accelerated by a plague cycle. Eight raging epidemics between 1900 and 1909 scourged towns along the eastern seaboard. In Sydney in 1900, where 100 plague deaths sent richer citizens to seek sanctuary in the mountains like the Florentines of old, a further outbreak occurred in the rat-infested wharf-side slums in 1903. Chinese residents were blamed for these outbreaks. This, the verdict of guilt by association, was one of the enduring themes of white Australians' hostility to coloured people linking them with dread diseases and fanning the flames of racial hatred lit by fear and ignorance; a prejudice which also injected bitterness and confusion into the Black Labour question in North Queensland, an important element in this story.

In Cilento's view, it was in response to plague that the Commonwealth government finally assumed its quarantine responsibilities under the Constitution Act of 1901 and established in 1909, the tiny health section of Trades and Customs it called the Department of Quarantine. Cumpston saw the potential of this service as the basis for a full Commonwealth Department of Health and laboured determinedly for ten years to bring about this culmination which he knew could be achieved only as a result of public demand. And so it proved! The brief but widespread outbreak of bubonic plague that followed the influenza pandemic had, of course, the greater force because of its timing, sustaining and heightening the level of public panic created by the pandemic and playing right into Cumpston's hands.


31. Cilento and Lack, Triumph in the Tropics, ibid p. 433
Bubonic plague, the legendary 'Black Death', is a theme of horror in our race memory; its periodic visitations over the centuries assisted the 'vastly complex process of social defence' in Australia no less than in Europe. In Cilento's opinion the cycle of plague epidemics in the first decade of this century caused an upsurge of interest in public health in Australia which influenced the following events. In 1901 Queensland instituted a Department of Public Health; the outbreak of 1906 coincided with the repatriation of the Kanakas; in 1909 the Quarantine Service of Australia and the Australian Institute of Tropical Medicine were approved; in 1911, Cumpston and Elkington elaborated an effective system for maritime quarantine protection. The next big step forward occurred in 1921 with the formation of the Commonwealth health department, immediately following the post war epidemics. In all these cases plague played a catalytic role.

The Australasian Medical Congress which began in the nineteenth century as the Intercolonial Congress, sponsored and conducted solely by the medical profession, was an authoritative voice which mobilized concerned opinion about Australia's health problems. This body played a seminal part in the establishment of the AITM. In 1920, at its meeting in Brisbane, the plenary topic was Tropical Health. By then it had been demonstrated by research at the Institute that the tropics did not harm white man physiologically, findings reinforced by actuarial evidence that north Queensland did not have an excessive death rate. What was agreed was that living conditions in the north were comparatively uncongenial and that many diseases called tropical would occur anywhere in conditions of dirty living and poor sanitation. Consequently in a resolution that meant 'Clean up the North', the Congress stated:

The whole question of successful development and settlement by white races is fundamentally a question of public health in the modern sense. ...The Congress desires to emphasise that any extension of population and settlement under existing loose sanitary conditions and sanitary practices which

32. R W Cilento, Australia's Orientation. Repr, Health, July-December, 1933
Cilento and Lack, Triumph in the Tropics, ibid, p. 433

prevail at the present time in tropical Australia cannot fail to result in ultimate disaster.  

Here indeed was the new health priority of the White Australia Policy, which was to have a determining effect on the future of the AITM. Research would be directed towards diseases actually affecting the population while public health education would motivate both public health authorities and private individuals towards a personal and environmental hygiene, by convincing them that it was necessary. Devising and directing this programme was to be Cilento's task.

Mutatis mutandis, Australia's responsibility under the New Guinea Mandate, called for the introduction and application of similar public health principles in what would now be called a Third World country. If Australia were to earn credibility as a Mandatory, a national health bureau supported by a credible research institute with relevant capabilities was a minimal requirement.

At this point the influence of Dr V G Heiser, a forceful American who, since 1918 had been representing the Rockefeller Foundation in Australia, became decisive. His original involvement had been with both Commonwealth and State governments on the question of Hookworm disease known to be endemic in the tropics but to occur also in the temperate zones in environments such as mines and tunnels. The Foundation, which spent vast fortunes on the amelioration of social conditions in undeveloped countries, preferred to negotiate with national authorities. Heiser had discussed with Elkington and others, the desirability of a federal health ministry, but all agreed that short of public panic, the jealousies of local and state governments could obstruct such a move. On his return visit in 1921

35. Heiser, An American Doctor's Odyssey, ibid, p. 355
37. Cilento, 'The World ...', (Ch 9) p. 3
he found a change of heart. The epidemics had revealed the inability of the states to deal with national health problems and as hookworm was in this category, Heiser argued he needed full Commonwealth support. Cumpston agreed to increase his involvement on condition that American funds and expertise were extended to cover simultaneous checks on filaria, malaria and various types of coastal fevers.\(^{38}\)

The moment was ripe for the creation of the federal health ministry. The obstacle now was the stubborn resistance of Prime Minister Hughes who cavilled at the cost. Cumpston and Heiser joined forces for the coup d'etat. At a meeting with Hughes arranged by Cumpston, Heiser stated a case for the Ministry of Health. At first he met with vociferous opposition but in a lively interchange described in Heiser's account of the interview, he shoutingly convinced the deaf and diminutive statesman that without such an organ the country would rightly be considered backward. To reduce the initial costs of the ministry, he offered substantial American help, including the loan for a year of three American public health specialists, an industrial hygienist, a sanitary engineer and a tropical hygienist, while at the same time paying for the training of three Australian replacements. (Cilento was the tropical hygienist). In a bizarre twist, Heiser persuaded Hughes to base the national programme of public health education designed to stimulate popular health consciousness, on the hookworm campaign.\(^{39}\) Hughes consented to the general terms of Heiser's plan and as the Bubonic plague was gaining strength just then, public demand for government action ensured that the Labour Opposition gave consent to the Order in Council, by which, on 7 March 1921, the Commonwealth Department of Health was gazetted. Cumpston was appointed Director General (CDH) and his empire subsumed quarantine. Elkington, his second in command, became Chief Quarantine Officer (General) for Queensland and the Northern Territory and overall supervisor of the AITM which came fully under the aegis of the Commonwealth authorities at that time. Cilento, unaware of his destiny as its future director, was working in Malaya.

\(^{38}\) Ibid.

\(^{39}\) Heiser, An American Doctor's Odyssey, ibid, p. 355. As Heiser tells the story Hughes did not think much of hookworm disease as a national health issue; tuberculosis was more like it. But Heiser, committed to the Hookworm Campaign, insisted that people would become interested in the projected survey and Hughes would get the thing Australia needed most, support for a central health bureau. In the Australian context, even at that time, this sounds like the right result for the wrong reason.
Cumpston’s achievement, wrote Cilento in his memoirs, crowned eleven years of effort by the former who had hung the whole edifice on that one word - ‘quarantine’. This becomes self-evident even in the light of the combination of circumstances just discussed, in which Cumpston’s catalytic performance is manifest. Not only did he get the department he aimed for but distilled from those issues a new programme for the AITM designed to make it a credible institute, not primarily for research as formerly, but as a central laboratory and administrative centre for dealing with the principal health problems of tropical Australia, Papua, and (former) German New Guinea; a programme that exactly expressed his new policy aims that he had chosen Cilento to implement. Cumpston’s only base had been the quarantine service.

With Cilento now overseas studying for his new responsibilities, it would be as well to look at the origins of the AITM. Many of the problems to which he would be required to address himself were still as potent in their more modern form as they had been when the Institute had been founded to investigate them. This was because, like the health questions surrounding the sugar workers, they were fundamental to the politico-economic complex of Australian society.

The Australian Institute of Tropical Medicine founded in Townsville, on 1 January 1910, proclaimed by its name and situation that tropical medicine was seen as an entity that was important to influential and informed people. Like the Commonwealth Quarantine Health Service, the Institute was established near the end of the plague cycle mentioned earlier and was also a forerunner of the Commonwealth Health Department. The roots of the AITM might be illustrated in colour; the Yellow Peril Syndrome, the Black Labour debate and the White Australia Policy and traced to the latter half of the nineteenth century. This trio of issues which had heavy political overtones, brought to public recognition the importance of tropical health and sickness in relation to the national concern to populate Australia’s northern frontier as a defence measure. For this reason, the Institute

40. Cilento, 'The World ...', (Ch 9) p. 1
may be described as originally the scientific policy base of the White Australia Policy.

The almost universal fear that Australia would one day be overrun by land hungry Asian hordes ensured widespread acceptance of government measures to promote the permanent white settlement of the north east coastal tropics. The most important influence favouring this development was the establishment of industries viable within the Australian economy.42

Until comparatively recent times the theory that white man could as much as survive in the tropics only while he avoided physical exertion, was held as an article of faith by European colonists, including reputable medical men. This was at least one reason why Australia had not been able to attract enough settlers to support agricultural expansion into the 'wet tropics' where the sugar industry had tentative beginnings in the 1860s.43

There were two elements of the sugar industry towards the end of the century whose interests were in conflict; plantation interests that regarded coloured labour only as economically affordable and physically suitable to plantation conditions and economic structures, and a rising tide of free settlers, ex-miners and so on who, as federation approached, were quietly demonstrating that it could be grown with white labour.

In the early days of the sugar industry in Queensland, Pacific Islanders had been recruited as the labour force of the great plantations there much as indentured Indian labourers were used in Fiji and Natal. They were called Kanakas, the Melanesian word for man. Criticism of the Kanaka trade had many grounds:


43. Cilento, Review of the Position of Tropical Medicine in Australia (Canberra: Federal Health Council Report, 1931), App 11, pp. 22 et seq. In the 16th, 17th and 18th centuries only 10-15% of Europeans returned from tropical service. In the latter half of the nineteenth century most returned home after sojourn in India, for example. It was Queensland's good fortune to emerge in the last mentioned period, but the bad reputation of the tropics persisted until at least the Second World War.
revulsion against the cruelty of the recruitment methods; the callousness of their exploitation in the canefields and a concern for the effects on the white workers of competitive, low-paid coloured labour.\textsuperscript{44}

When gold was exhausted on the Palmer River and elsewhere in the north, tough, determined, fortune-seeking European men flocked to the coast to find work. Times were grim at the end of the century and ugly racial struggles ensued. Gross prejudice against the coloured man was inflamed by the prevalence of serious disease conditions, a situation for which the white man blamed the Kanakas as he had the Chinese for the chaotic health disasters of the goldfields, shown by Gordon to have been the most sustained in Queensland's history.\textsuperscript{45} The justice of this accusation is doubtful; while there is some disagreement between them about the levels of morbidity, Gordon, Cilento and Cumpston all agree that death rates among Kanakas far exceeded that of Europeans and that they died of white man's diseases such as measles, tuberculosis and dysentery.\textsuperscript{46} There is, of course, a qualitative difference between objective study and emotional public response. At the time, the Kanakas were seen as undesirables who bred and spread sickness through their dirty living habits and conditions. They were blamed for introducing malaria, filariasis and leprosy. But at the core of the agitation against the Kanakas was the belief of the emerging nation that its strength would depend on the purity of its bloodlines. Therefore the first non-machinery legislation of the new parliament included two Acts that aimed at making Australia white. The Immigration Act excluded virtually all non-European migrants by means of a dictation test and the Pacific Island Labourers' Act provided for the cessation of Melanesian importations and the repatriation of those islanders who could not prove domicile. As Humphrey McQueen has persuasively argued, race consciousness was central to Australian nationalism because it performed the classic function of providing an external threat in the form

\textsuperscript{44} Yarwood and Knowling, Race Relations in Australia, ibid, p. 208 et seq


\textsuperscript{45} Gordon, 'Mad Dogs...'. ibid, p. 15

of the Yellow Peril.\textsuperscript{47} With the legislation of 1901, White Australia became the settled policy of the new nation,\textsuperscript{48} a symbol of its safety as the Monroe Doctrine was to America.

The White Australia Policy made it necessary that we populate the north; that we demonstrate that white Australians could survive in a social group that called north Queensland home. Health was a common factor in the complex of economic, social and political questions now to be determined in that light.

By the time of federation the economy of Queensland's coastal tropics depended on the continued viability of the sugar industry and in turn on the success of its transition to white labour. Confronted by the legislation that phased out black labour, the Queensland sugar growers were offered compensation in three main forms; tariff protection from imported sugar which at the same time gave them access to the Australia wide market; encouragement to dismiss non-white labourers by the Commonwealth's Sugar Bounty Act of 1903 which gave rewards to growers using white labour only and finally a range of economic, scientific and medical supports, ranging from the pre-existing colonial legislation that gave a financial basis for co-operatively owned cane crushing mills, to the setting up of state funded research into tropical agriculture and the provision of medical research facilities.

Between 1903-13, the sugar bounty was solely provided by a refund to sugar producers of an excise duty which they themselves paid. To prevent producers employing those Melanesians who had settled in Queensland from undercutting those who employed white labour, the excise duty was refunded to those whose sugar was grown by white labour. Naturally, this stimulated demands on the government by those employing Melanesians for reasons of economy, to prove that in the long run, white workers would have the health to sustain the industry.\textsuperscript{49}

\textsuperscript{47} Humphrey McQueen quoted in Yarwood and Knowling, \textit{Race Relations in Australia}, ibid, p. 227
Health considerations were a deterrent to permanent settlement here in the first decade of the century, for the 'low tropics had a special degree of morbidity, if not of death. Perceptive people feared yellow fever after the Panama Canal opened infected areas of America to an increased volume of shipping to Australia and Asia, the more so because the relevant mosquito vector was present all along the Queensland coast. The incidence of fever was high ... its effects continuing; hookworm was a massive menace'. The plague cycle had not missed the northern towns and the dread diseases attributed to the Melanesians contributed to a pervasive wariness among Europeans contemplating settling in the tropics.

Greatly assisted by this general public attitude, Bishop G E Frodsham of North Queensland, whose five year incumbency had convinced him that health risks in the north were substantial, began to lobby the Australian Medical Congress for a medical research station. He was ably supported by Professor Anderson Stuart, Dean of Medicine at Sydney University and by faculty men from Melbourne and Adelaide medical schools. In 1908 the Congress agreed to support the Institute in principle. Anderson Stuart wanted it to be within the University of Sydney but Frodsham, who knew a great many influential people, supported by the medical staff of the Townsville Hospital, won the day for Townsville on geographical, epidemiological and other grounds.

The resulting Australian Institute of Tropical Medicine, or AITM, had the aim of scientifically probing many aspects of tropical disease and tropical living with special emphasis on 'the acquisition of such knowledge and the determination of such facts as will indicate methods of maintaining or improving the health of a working white race in Australia'.

An important objective was to test the validity of so-called 'climatic determinism', the very widely held assumption that tropical climates per se

50. Gordon, 'Mad Dogs ...', ibid, pp. 55, 61, 62, 69
51. Bolton, A Thousand Miles Away, ibid, p. 75
53. Ibid, p. 26
physically changed the blood structures of Europeans; a belief carefully fostered by those with vested interests in maintaining a black labour force in the canefield.54

To direct the Institute, Dr Anton Breinl, Head of the Runcorn (Tropical) Institute of Liverpool, England, was appointed in London by a committee on which Professor Anderson Stuart was represented. Born and educated in Vienna, Breinl was a scientist of highest international repute. As his laboratory assistant he chose a Runcorn colleague, John Fielding, who was to be paid 2 pounds per week. Together they began original research into a wide variety of problems, but the most important of these, from a political point of view, was directed to human physiology and metabolism under tropical conditions.

Sir William Macgregor, Queensland's first medical governor, who was experienced in tropical medicine, persuaded the Queensland government to accept some financial responsibility for the new Institute on its soil and it was thereupon recognised as a Queensland agency. The administrative management was originally accepted by the University of Sydney and a committee of Queensland and Commonwealth government representatives, one of whom, Elkington, represented the Director of Quarantine, an activity which he made an important function of the Institute. Although each body contributed to its expenses the Institute commenced life extremely short of resources.55

On 1 January 1910 its work began in an iron-roofed, wooden annexe of Townsville Hospital where a ward had been allotted for clinical work. On the same day Elkington became Commissioner of Public Health in Queensland and sought to co-ordinate the work of the Institute with that of his department.56 He established there a northern quarantine office to defend the country against plague, cholera and


55. Cilento, The Australian Institute of Tropical Medicine', Health, 1928, (No 16) p. 106

56. Cilento, The Versatility ..., ibid, p. 21
smallpox then endemic in Indonesia and the spread of malaria from Papua.57

While hard pressed to make a research institute from one assistant and a shed, Breinl immediately set about his task. He made a survey of the most prevalent diseases in the north and listed them as filaria (underestimated), sprue, dengue fever, hookworm disease, eye diseases, indefinite fevers and leprosy; a formidable list which must be taken seriously from so reliable a witness. A man of vision, he saw that the question of whether white man was capable of living and propagating under tropical conditions, if satisfactorily solved, would have beneficial economic and social consequences not only for Australia but for the whole world. Encouraged by Anderson Stuart, Breinl also aimed to provide a course of post-graduate study in tropical medicine at the Institute.58

In 1911, largely due to Elkington's persistence, the Commonwealth government increased its annual grant to the AITM to 4,000 pounds, making it by far the largest contributor. Thereupon, Atlee Hunt, Secretary of the Department of External Affairs was added to the committee and de facto control of the Institute passed to that department from the Queensland Government which could afford but a fraction of the input of her more affluent partner. The university representatives were retained as scientific advisers and it was decided to build a new laboratory and engage five new scientists.59

Opening the new building in June 1913, Sir William Macgregor said:

The policy of preserving tropical Australia for a purely white race is one of the most interesting problems of modern statesmanship. A final proof of whether this is practical, time alone will furnish, for history does not supply the experience to settle the question.60

57. Cilento, The Versatility ....' ibid, p. 25

58. Anton Breinl, Annual Report of Australian Institute Tropical Medicine, 1910, (pp. 5, 6) quoted Cilento, The Versatility ...', p. 21

59. Cilento, 'The Australian Institute ...' ibid, p. 106

60. W Maegregor, Townsville Bulletin (Townsville), 30 June 1913
The outbreak of World War 1 deflected Breinl's attention increasingly from research to the management of Townsville hospital and quarantine duties. His work with intractable malaria cases from the war zones made him one of the most important officers of the Service, as Cilento has recognised. Despite this, he and his team of scientists proved, mainly by negative results, that white man's capacity to work and thrive in the tropics was a matter of health and not of climate. Gordon's tribute to Breinl said:

... I understand that in the fields of general parasitology and entomology quite a number of original findings were recorded. At the beginning all was dubiety and obscurity in respect to the effects of tropical climate. At the end, all these doubts had been resolved.

Attempts to establish the postgraduate course were frustrated by war and, with the successive resignations of his scientists for the same reason, the Institute languished. In October 1920, Breinl resigned as well. This was a bitter decision for one who had given so much. It was commonly held that xenophobia had weakened his will to carry on. Had that been so, he would surely have felt more secure within the Institute than in private practice in Townsville, where, in fact, he proved to be popular and successful. His scientific career, alas, was at an end; a tragic outcome for Australia and for the scientist at the height of his powers.

Dr Robert Douglas who researched Breinl's history and talked with his family and colleagues, has concluded that he was forced out by Cumpston. Sir Edward Ford, head of the School of Public Health and Tropical Medicine (successor to the AITM) stated that in his opinion such an action would almost inevitably follow should a staff member persist in a stand Cumpston saw as threatening some plan he saw as important. P A Maplestone, a helminthologist of world standing who was Cilento's predecessor, resigned from the Institute due to interference from Cumpston. Douglas sought Cilento's view on the matter and here is his reply:

61. Cilento to Mel Pratt, 'Transcript of interview...', p. 14
62. Gordon, 'Mad Dogs ...', ibid, p. 106. To a man such as Breinl, nurtured in the autocracy of Teutonic universities and the autonomy of English ones, Cumpston with his inability to delegate ... would have proved insufferable, ibid, p. 117
63. R A Douglas quoting Sir Edward Ford, _Anton Breinl_, ibid, p. 24
64. P A Maplestone, 'Research in Australia', _Med. J. Aust_: 682, 1922
Breinl was brilliant, but as you have obviously guessed, the AITM was only one important side issue in a much greater plan ... to establish the Commonwealth Health Department as an independent body ... with far reaching potentialities in New Guinea as an integral part of the Commonwealth. Breinl had no experience in the field of diplomacy, (especially where there was military and control) and as a German speaking alien would have no chance to capture and supplant the military administrators.\textsuperscript{65}

From the pen of Cilento, fifty five years on, this might be dismissed as special pleading were it not for some published statements by Breinl which support it in principle. At a meeting in Melbourne of the Public Works Committee in May 1928, Cumpston, in reply to questions, reportedly stated that Breinl's nationality had prejudiced the Institute and that he could not work in harmony with his colleagues. In reply, Breinl publicly addressed and refuted these allegations with convincing evidence to the contrary. In turn, he condemned Cumpston's insistence on censoring his work before publication and claimed that he had resigned in 1920 because Cumpston had appointed two assistants to his staff without even consulting him as director. Finally, he deplored the down-grading of the Institute during Cumpston's regime.\textsuperscript{66}

Cilento, caught in the crossfire, then published a statement attributing Cumpston's apparent denigration of Breinl to bad reporting and hastened to the defence of the Institute saying that since it had been taken over by the Commonwealth and run by the taxpayers' money, every effort had been made to make its programme one of the utmost value to the public.\textsuperscript{67}

This statement of the new role of the Institute seems to hit the nail on the head. In 1920, preparing for his position as Australia's leading public health administrator, Cumpston had to give careful consideration to what was required of his only field base. Even Breinl's achievement in settling the physiology question, at

\textsuperscript{65} Cilento, quoted by Douglas, Anton Breinl, ibid, p. 24

\textsuperscript{66} The Brisbane Courier (Brisbane), Research Work, Townsville Institute, 31 May 1928

\textsuperscript{67} The Brisbane Courier (Brisbane), 'The Townsville Institute, Dr. Cilento in Reply', 5 June 1928
least in part, was no longer relevant, nor was high level research into white ants and other enquiries conducted by his men. These rightly belonged in a university, as Anderson Stuart had foreseen. Cumpston possibly felt threatened by world class scientists like Breinl and Maplestone, since he insisted on censoring their work. At bottom, however, he did not want scientists to direct his Institute because their goals and his were in conflict. The political and socio-economic priorities of both Queensland and the Commonwealth were to make the north a healthier place to live. The White Australia policy justified this in the national interest. It was now known that white man could live, work and thrive in the tropics because he had demonstrated this. It was the presence of disease that threatened industry and supported the popular belief that tropical climate was unhealthy and medical science had now proved that most of this disease was preventible.68

In 1921, the circumstances of history directed public interest to the coastlands of the northern tropics and to its tropical dependencies. Cumpston, anchored in Melbourne, needed an officer in Townsville with a blend of professional and diplomatic skills who was an effective communicator. 'Public education', said Heiser to Hughes, is the key to public health.

The Institute was necessary to the department's performance and credibility if it were to direct what was essentially a public health reform programme in the Mandated Territory of New Guinea as Cumpston (and Cilento) devoutly hoped would be the case. Here, in the glare of international spotlights, Cumpston needed a good performance to bring his department into political recognition. He wanted a man with the inherent ability to devise suitable programmes of preventive medicine in administrative and legislative form and the force of personality to address them to the decision makers with confidence and clarity. Cilento was in Malaya preparing himself for just that opportunity. In all the circumstances outlined in this chapter, it is clear why Cumpston sent Elkington to Teluk Anson to recruit Cilento and why Cilento accepted the challenge with alacrity.

68. J W Gregory, The Menace of Colour, ibid, pp. 174, 175
CHAPTER THREE

Astride the Coral Sea: 1922-1929

Unless the administration of tropical countries makes health everything disease will make them nothing.

Cilento's dictum on the importance of administration in the prevention of disease in tropical countries introduces the guiding principle of what was to become a brilliant period in an outstanding career. This chapter offers a survey of the underlying forces and events which gave these years their special significance.

During most of this time, Cilento simultaneously directed two inter-related yet essentially different areas of responsibility as an officer of the Commonwealth Health Department. He was the director of the Australian Institute of Tropical Medicine in control of policy direction between October 1922 and March 1930 when that institution was absorbed into the new School of Public Health and Tropical Medicine at Sydney University. In March 1924 he was seconded to the Administration of the Mandated Territory of New Guinea and subsequently appointed Director of Health and Quarantine Services there. In his absence from Townsville, Dr Alec Baldwin was Acting Director of the AITM. At state level, the Institute was supervised by Dr John Elkington, director of the newly formed Division of Tropical Hygiene (CDH) based in Brisbane.


2. Whereas the AITM was still an agent of the White Australia Policy and seen as such, the welfare of the indigenous people of New Guinea was Australia's first responsibility under the conditions of the Mandate for that country.

3. Now the Commonwealth Institute of Health; reconstituted 3 March 1980, the fiftieth anniversary of its founding.
It was in the discharge of these duties in Townsville and Rabaul that Cilento first attracted world attention through his initiatives, reports and publications. He now had important forums in which to be heard; his major New Guinea reports were addressed through the Commonwealth Government to the Mandates Commission of the League of Nations in Geneva and circulated through the Health Committee of that body to its many member nations.

From March 1924 until the latter part of 1928, Cilento's headquarters were in Rabaul. From this time the focus of the narrative changes to provide a survey of his management of a complex of public health and related political problems in the Mandated Territory.

In a wider frame of reference, Cilento's role in two ambitious conferences that sought to establish Australia as the dominant health power in the Austral Pacific Zone, is examined.

His performance in all these activities so impressed authorities at Geneva that, together with Dr Paul Hermant of France, Cilento was chosen to carry out the first survey of health conditions in the above named zone, under the aegis of the League of Nations. This was an honour for the Commonwealth and Cilento was seconded to the League from November 1928 to May 1929 in order to make the survey and prepare a report.

However, as Elkington had resigned following a clash with Cumpston in 1927 and named Cilento as his successor, it was as Director of the Division of Tropical Hygiene (CDH) that Cilento embarked on his assignment for the League. Elkington's influence on Cilento as guide, philosopher and friend is an underlying theme in this chapter.
Following his briefing in Melbourne, which could have left him in no doubt that Cumpston was in charge of the Commonwealth Health Department, Cilento was launched into Queensland by his immediate senior John Elkington, with whom he was to enjoy a very different relationship. Together they used the five weeks or so remaining in Cilento’s year long study tour as a period of familiarisation during which Elkington introduced Cilento to the people and circumstances important to the incoming Director of the Institute of Tropical Medicine. They travelled together by boat from Melbourne and arrived in Brisbane in mid-September 1922.

Cilento soon wrote to his wife describing his first few days; the tours of inspection, the meeting with the Rockefeller Foundation officers who, their responsibility at an end, handed over the management of the Hookworm campaign to him, and his overall pleasure in the company of Elkington. In his words:

Elkington was a very good cabin companion and full of historical, geographical and topical anecdotes. He has many activities outside medicine and seems to have dabbled in almost all hobbies. Most of all he seems to delight in getting into an old suit of dungarees and pottering about in his workshop.

First spare day Elkington and I met Dr Sawyer and Dr Sweet (his assistant) and held a conference. We arranged that I should teach the near-at-hand the essentials of hookworm and the malarial and filarial routines. This I am proceeding to do... Sawyer placed the whole establishment under my direct control and I am free to go my own way. This is therefore ideal. The State authorities are cautious...

Cilento could scarcely have had a more suitable mentor. Compatibility based on shared interests and mutual goals eventually deepened into warm and lasting friendship. Elkington, who was twenty-two years older than Cilento, exerted strong influence on his career. In time, Cilento came to regard the older man as his father in public health and affectionately called him Tuan, the Malay word for master. Certainly Elkington had much to teach him.

4. Cilento, The World ..., (Ch 9) p. 4, quoted from his diary. Fryer coll. 44/4
Tropical medicine is largely preventive medicine. It is non-clinical in nature and at the turn of the century when Elkington graduated in medicine from Melbourne University, it attracted few practitioners. Elkington's independent and enquiring mind led him to Asia, especially India and later Japan for post-graduate study. While on leave in Australia, his experience of plague and smallpox, both virtually unknown to medical men in Australia, led him to volunteer his services during a time of need in Tasmania. As early as 1903, as a member of the health service of that state, he was striving to make people more aware of health hazards by providing sanitary education. He argued that exotic diseases such as cholera and endemic ones such as typhoid could be prevented in the same way and that efforts to prevent cholera, plague and smallpox should not be separated from efforts to control diphtheria and scarlet fever. That is, there should be no quarantine service as a separate entity.

To discover how it was that the Queensland government allowed federal authorities to introduce what amounted to internal quarantine controls within the state, one need look no further than Elkington's reports as Queensland Health Commissioner (1910-1912). At that time, the Commonwealth carried out its quarantine function by using the state heads of health as federal officers for that purpose. In this capacity, Elkington took full advantage of his responsibility as Quarantine Officer for the tropical coast of Australia, to co-ordinate his department's activities with those of Breinl at the AITM. For example, he established depots of calf lymph at strategic points along the coast; vaccinated the Torres Strait Islanders; set up a voluntary service of vaccinated nurses, inspectors and other helpers (at call) in case of emergency; and intensified his campaign for sanitation of the tropics. Taken together with his public health education campaign which sought to inform the people and the profession about the prevention of most common communicable diseases and the appropriate administrative safeguards he introduced, Elkington's regime produced a degree of integration of State and Commonwealth services that was remarkable for its time. Breinl's statement in his first report that the sanitation of the tropics was the key to a new era in tropical colonisation probably reflects

5. Cilento, 'The Versatility ...' p. 16
7. Cilento, 'The Versatility ...', p. 26
Elkington's influence on the research-orientated scientist.\(^8\) As Commissioner of Health he took preliminary steps at that time for administrative control of diseases and promoted field work to provide material for research units at Townsville in order that together he and Breinl might establish the requirements for successful white colonisation of the tropics.\(^9\)

In 1913, convinced that the Queensland Government had neither the money nor the political will to support his project, Elkington transferred to the Commonwealth Quarantine Health Service. Here, as second in command to Cumpston, he had control of coastal quarantine in the whole of tropical Australia, a position from which he felt he could exert more influence on the preservation of health in North Queensland. According to Cilento, the two quarantinists fought back to back against great odds in those early days, but by virtue of that fact faced different opponents and different aspects of the complex field. While both men initially wanted to free the Quarantine Service from the Customs Department, Elkington fought to win the tropics and recognition of the capacity of white man to live and thrive in those areas and Cumpston, his health department secured, fought to increase its prestige with Melbourne and Adelaide first and later Canberra as his strongholds.\(^10\) In this matter, Cilento became a disciple of Elkington; in time it was to be the rock on which their relationships with Cumpston were, in each case, to founder.

To a degree, Elkington had laid the foundation of the Queensland public health service in the modern sense when, as Commissioner, he had formulated the Health Act (Amendment) Act of 1911. But he emphasised that such Acts are not 'legislative thunderbolts'; preventive medicine is a dynamic, requiring not only regulations, but a broad level of public, professional and political understanding of its aims before compliance can be achieved. To this end he had exercised his wit and will to involve people from all walks of life in what he saw as a public relations exercise.\(^11\) This approach was to be the key to the new Commonwealth presence in Queensland.

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8. A Breinl quoted in Cilento, *The Versatility ...*, p. 21
9. Cilento, *ibid*
10. Cilento, *The World ...*, (Ch 9) p. 21
11. Cilento, *The Versatility ...*, p. 22
Cilento was an apt pupil. Apart from involving doctors, health inspectors and others in his hookworm programme immediately he arrived in Brisbane, he approached state authorities through doors opened for him by Elkington. This may have been when he met Forgan Smith and began an association that had far reaching consequences for them both. Fresh from the Java conference of the previous year at which Weil's disease among agricultural workers in the tropics had been discussed Cilento was alert to the possibility that rare but severe outbreaks of unidentified 'canefever' in Queensland may have been Weil's disease. Forgan Smith, then MHR for Mackay, Queensland's sugar capital, would have been the obvious person with whom to discuss the matter of obtaining permission, as a commonwealth officer, to maintain a watching brief on future outbreaks of canefever; permission which Cilento obtained in 1922. Forgan Smith's concern was with the industrial implications of any proven link between canefever and working conditions in the sugar industry. Weil's disease became an issue in which both men were heavily involved during much of the next decade.

For the first fortnight or so after his arrival in Townsville, Cilento toured the main centres of the north with Elkington who introduced him to the people and groups who were interested in their campaign for tropical sanitation, or who needed to be. 'Publish or perish' seemed to be the watchword of the reorganised institute and the pair were widely reported in the current news media. As well, Cilento was under instructions to publish all research findings, survey reports, educational programmes and any other items emanating from the Institute that could enhance public enlightenment on public health.

How then did he perform as Director of the Institute of Tropical Medicine? The folklore of the cognoscenti is that not much went on at the AITM after Breinl's time. This may be because, as J E Claffey the Institute's historian has confirmed, annual reports were not published after Breinl's resignation in 1920. In reply to Breinl's criticism in 1928 referred to above, Cilento, after five and a half years as Director, was able to reply that quantitatively more had been published in the post-

12. Cilento, Weil's Disease and Rat Control (Queensland Department of Public Health Publication, 1934), p. 1

Breinl era than during it. Qualitatively, as will be demonstrated, he had several original papers to the credit of his staff and himself. What he stated publicly on that occasion was that the policy of the Institute had changed: one cannot compare different things.

Fortunately John Fielding, Breinl’s original research assistant, returned from long service leave in England shortly after Cilento’s installation and wrote the following:

The constitution has changed somewhat... There was obvious evidence of a thorough reorganisation and there seems every prospect that work will now proceed along normal lines. Evidence of this was forthcoming in the publications put forth by Cilento and his staff. Health laboratory—practical pathology and much serological work proceeding. Lancelot Cooling, entomologist with previous experience working with Baldwin in hookworm, malaria and filariasis in Queensland. New director agreed to my re-opening eye worm in poultry and rat leprosy work. Cilento controlled my work during the year and wrote the following - oouchueuca iritis chrochitis with unusual features...

The final esoteric phrase is included to illustrate Cilento’s capacity to describe research phenomena and to supervise tropical laboratory research work which had been part of his London course. In another place, Fielding related that the laboratory had been refitted to provide excellent laboratory and educational facilities; media rooms, one of the most extensive libraries on tropical and other subjects in Australia; museum and pathological material and facilities for private research which were available to any private practitioner wishing to use them.

The post graduate course was also sporadically and successfully re-introduced in

14. Brisbane Courier, 5 June 1928, Research Work, Townsville Institute, ibid

15. Posterity is indebted to John Fielding who, at Claffey’s suggestion, compiled a journal covering his 30 years’ service with the Institute. Included is the name of every member of staff who worked there together with short, biographical comment and a complete list of all publications emanating from the Institute. A copy of this journal is in the Fryer Library under the title: J A Fielding, The Australian Institute of Tropical Medicine, Townsville, North Queensland. Reminiscences of Staff and Work. (undated)


17. Ibid
Cilento's time: it would seem from Fielding's first hand account that facilities favouring specialised study there may have been better than is usually supposed. The tension and immediacy of his account suggest that the Institute had indeed been revitalised.

The activities of the Institute fell into three divisions: educational, investigational and diagnostic.

The educational aim was to mirror the relationship between health and hygiene and for that purpose, the Hookworm Campaign provided the ideal medium. The life cycle of the parasite which debilitated and in extreme cases killed its victims, was easily demonstrated. Ova in the faeces, confirming the presence of the worm in the host can be seen through a microscope. When hatched, the worm enters the skin particularly through bare feet, pervades the body and completes the disease perpetuating cycle. Once it was understood that the disease could be prevented by the use of latrines, it could be eradicated and its recurrence prevented by personal and community alimentary hygiene.18

The provision or improvement of sanitary facilities in schools, on farms, in cane barracks and fringe communities was urgently needed. Aborigines were especially difficult to help for they failed to see the need for latrines. Random defecation, a natural, safe practice for nomads, became a health menace in a static situation. Their poor diet lowered their resistance to the effect of the parasites and compounded the community problems by creating foci of endemic filth diseases.

A bilingual programme of illustrated talks, pamphlets and press articles was prepared by Cilento.19 He devised and delivered a training course for hookworm microscopists, many of whom were lay people and volunteers. Practising doctors,

18. Dr S M Lambert of the Rockefeller Hookworm Campaign reported on the horrendous sanitary conditions in north Queensland in 1919 when, between January and October he had supervised the building of 4,000 model latrines and the repair of 4,000 more. S M Lambert, A Doctor in Paradise (Dent and Son, Fourth Australian Edition, 1946), p. 12

19. Una Piaga del Nord Queensland, La Malattai dei vermi ad uncino (Hookworm). Siamo debitori del deguente articolo Dottor R W Cilento, undated fragment Cilento Cutting Book, Fryer Library, 44/
health inspectors, teachers, hookworm nurses, aides and public spirited citizens were pressed into service in an organised way to encourage people to be cleaner. In the laboratory, apart from routine testing, Cilento reported that:

Outstanding work has been done upon the life history of the hookworm, methods of differentiation, relative values of various drugs in treatment, the preponderance of one or other type of worm, and the corresponding clinical significance etc., while local epidemiological observations have been made over a wide area to determine disputed or unknown points in etiology, methods of spread and related matters.20

This was the new method of research at the institute; sociologically directed research, education and environmental cleansing which characterised the revised Hookworm Campaign which ended in 1927.21

Investigational programmes at the Institute at this time, though by no means limited to common diseases as Fielding has shown, emphasised prevention. It was Cilento’s unique contribution to the AITM that changed its research orientation from physiology to implementation in practical public health.

Like hookworm disease, northern fevers had socio-political implications for the continuing climatic argument; hence overall enquiry into these illnesses in general and malaria and filaria in particular was recommended by the 1920 Medical Congress.22

Whereas former observations of these two pathological entities had been uncoordinated, Cilento had the whole field surveyed, insofar as this was possible, with complete mosquito surveys of Brisbane and partial investigations of Innisfail.

   Also relevant: 'Some Problems of Hookworm Disease at the State Orphanage Townsville'. Med. J. Aust., v.11, 1923

21. J H C Elkington to Dr Richards, Rockhampton, 28 July 1927, Fryer coll. 44/8

22. Transactions of the Eleventh Session..., ibid
Mourilyan and Cairns.\textsuperscript{23} He then looked at the relationships between populations of disease vectors and the hygiene conditions of each area studied as variables affecting health. The distribution pictures were further set against related data from many parts of the world such as China, India, Egypt and Balkan countries, for Cilento always placed his observations in global perspective. Derrick, whose later work on 'Q Fever' made him famous, stated, in a tribute to those who had helped him, that it was Cilento whose vision set the northern fevers in their world-wide relationship.\textsuperscript{24} This first Australian survey of malaria and filaria formed the basis of future research and publications emanating from the AITM.\textsuperscript{25}

The \textit{White Man in the Tropics} was Cilento's most original and enduring publication as director of the AITM; a work in which he demonstrated, perhaps for the first time in Australia, that social medicine is a science in its own right. Both underlying and amplifying the thrust of the hookworm and fever investigations carried out at this time, this sociological study supported the evidence of three generations of white Australians who had successfully colonised the tropics.\textsuperscript{26}

The criticism that north Queensland's population comprised almost no old or young people but consisted of healthy individuals in their prime who, at the end of a short working life, were but wrecks of their former selves was so persistently repeated as a deterrent to those who could work in the cane fields that Elkington ordered Cilento to investigate the whole question.\textsuperscript{27}

This was a challenge much to his liking. Employing Miss A Gorman, a trained nurse, to make a detailed survey of children's growth, development and living

\textsuperscript{23} Cilento, \textit{Health}, ibid, p. 110

\textsuperscript{24} E H Derrick, \textit{The Challenge of North Queensland Fevers}, \textit{Annals of Medicine}, v.6 N. 3, 1957


\textsuperscript{26} Cilento, \textit{White Man in the Tropics}, \textit{Commonwealth Department of Health}, 1925

\textsuperscript{27} Cilento, \textit{The World ...}, (Ch 9) p. 21
conditions in diverse areas of the region and to collect relevant factors affecting the life and work of women in those same areas, Cilento set guidelines, deliberately skewed towards the poorer sections of the society. It was a masterly study assessed by the authoritative and often sceptical pen of Gordon as follows:

One might predict that of all the papers written on the subject of north Queensland settlement, a future historian might well place the highest value on the account provided by this social investigation. And elsewhere gives as his reasons:

Cilento's report on this socio-medical survey provides a commendable amount of detail about the way the ordinary person lived. It will in time become an important historical source. From this it is possible to connect the meagre manner of living even as late as 50 years ago with the prevailing patterns of communicable disease (Cilento 1926) ... Present-day morbidity surveys, though broader in scope and more comprehensive in detail, almost of necessity neglect the environment which influences the diseases being recorded. This is a pity. These two earlier surveys, particularly Cilento's, remind one of Charles Booth's Life and Labour of the People in London. It is to be hoped that, as the record of more of our ills is entrusted to the care of computers, the investigators will record from time to time, as well, the manner in which we love, work, play, and sorrow, because in many cases the two are causally associated.

Cilento's conclusions were that provided people lived appropriately, there was no basis to support the theory of climatic determinism; that despite the worst conditions of domestic comfort and hygiene a high standard of health is still maintained. He was critical of the unnecessary lack of fresh fruit and vegetables which people simply would not trouble to grow. Apart from proving that north Queensland was not comprised of a selected population, Cilento's study revealed a whole new concept in social medicine.

The new diagnostic role at the AITM was developed as a result of Cumpston's vision. About this time, realising that most public hospitals could not afford pathology departments and as a service to those doctors who were aware of their usefulness, he gradually established a chain of Commonwealth Health Laboratories.

28. Gordon, 'Mad Dogs ...', p. 38
across the nation. Centres with a common need were mining towns such as Wollongong, Port Pirie and Kalgoorlie. This was a form of Commonwealth subsidy to needy states; an application of Cumpston's ideal of public health as well as a thoughtful extension of Commonwealth Department of Health activity.

A chain of these routine health laboratories was commenced in Rabaul in 1921 (with a branch that had been set up by the Germans) and soon stretched from Cairns to Townsville to Rockhampton, thence Toowoomba and to Lismore in New South Wales, although they did not occur in that order. They provided diagnostic facilities for laboratories of all kinds as well as stocking and selling sera and vaccines produced by the Commonwealth Serum Laboratories, soon also to fall into Cumpston's enterprising hands. As a referral centre for the tropical network, the AITM gained a significant new function.30

Although it did not fit into any of the three categories just discussed, the Inland and Island Tropical Health Service plan belongs chronologically and strategically to this stage of development of the AITM. Cilento, who had observed the workings of the Island and Highland Health and Medical Service in Scotland, suggested to Elkington that it might be adapted to provide a reliable health cover for outback settlers by correlating the fragmentary services of the Northern Territory and the island groups represented at the Australasian Medical Congress with those of far-west Queensland. With perhaps seven related postings leading from arid and isolated stations to those in more congenial and larger coastal centres, doctors would be attracted to a service that offered the opportunity to accumulate experience and seniority and hence gain a wider control over their futures.31 Implementation required the consent of the authorities concerned. Elkington seized on the idea and made it his main objective. He presented the plan first to the 1922 meeting of the Australasian Medical Congress which applauded the idea of mutual co-operation but failed to support its implementation. This was a set-back, not only for the AITM which would have administered the scheme and thereby entrenched itself the more firmly but, for unstated reasons that had to do with the future strategy of neo-colonial expansion, the rejection undermined the substratum of Cumpston's empire.

30. According to Claffey, Commonwealth Health Laboratories were established at Rabaul 1921, Townsville 1922, Toowoomba 1923, Rockhampton 1924, and Cairns 1928. J E Claffey to F G Fisher, Fryer coll. 44/11

31. Cilento, 'The World ...', (Ch 11) pp. 30, 31 precis
building ambitions which Elkington and Cilento heartily supported.\(^\text{32}\) This strategic element ensures that the Inland and Island scheme is a recurring theme in this account of Cilento's career, although it failed to be accepted at the time.

Cilento's summary of the activities of the Institute in his time indicates their variety and extent. Taken seriatim they include: the increased numerical significance of clinical diagnoses; the introduction of the first full post-graduate course in 1925 and provided each year until 1928 which attracted a small number of students from mainland Australia, Papua, the Mandated Territory and the Solomon Islands Protectorate; examinations into local epidemic diseases which numbered twenty two and included amongst the most valuable results the discovery of 'Ratbite fever' and paragonomiasis in the Mandated Territory; work done on 'X' disease in Townsville and leprosy in Tropical Australia; research into fevers and hookworm have been noted; papers published since the Commonwealth Health Department took control of the Institute in 1921 totalled eighty six, of which ten were issued as service publications and one, *White Man in the Tropics*, became a university textbook; routine examination services of practical and statistical value ranged from human post-mortems to the quality of imported meat. The Museum of the Institute then contained several thousand entomological and other specimens though it lacked the means to display them.\(^\text{33}\)

It would seem from this summary that the one important laboratory in north Queensland was a thoroughly vital institution providing not only the routine services essential to public health and adequate medical practice but also pragmatic research related to the needs of the vast region it covered. Cross fertilisation with the Mandated Territory also produced good scientific results. Creeping eruption of the skin observed in New Guinea led to a useful study of the Queensland sandworm. Detailed studies of malaria and correlation of data on food deficiencies with the cause of depopulation in the Western Pacific Islands all provided Cilento with ammunition for his health programmes. Men like Heydon and Backhouse worked independently on research interests arising out of their own enthusiasms in Rabaul:

\(^\text{32}\) Ibid. While the scheme (a forerunner of the Flying Doctor Service in a sense) had much to commend it, local jealousies probably prevented the surrender of such a significant service to the Commonwealth.

\(^\text{33}\) Cilento, *Health*, pp. 110, 111
As Gordon has noted, the achievements of the Townsville Institute are recorded in some 150 papers published from the Institute during the twenty years of its existence. Of the people who at various times worked in Townsville, at least six subsequently obtained professorships. These were: Young, Priestly, Maplestone, Baldwin, Lee, Sunstroem and Cilento (part time professorship). A number of others distinguished themselves in other ways in scientific and academic fields. Its research record was certainly meritorious.34a
Baldwin, with the help of Sydney University, ran the post-graduate course in tropical medicine. Despite this creditable performance, research necessarily remained ad hoc as Cilento had no way of influencing policy: some of its effectiveness was consequently dissipated. Policy changes brought a deterioration of the Institute by the end of the decade but these were beyond Cilento's control and do not discredit his performance as director.

By the end of 1923 Cilento, an impatient man, was chafing to get to New Guinea. Jamestown had made him sensitive to the constraints of small town life and with the Institute back on its feet, though in Cilento's view with little future prospect, Townsville began to pall. Service in New Guinea was the mainspring of his ambition and he eagerly seized the opportunity which came soon after with the resignation of Colonel Honman following criticism from the League of Nations. Cilento at once volunteered to go to Rabaul and report on the situation and Cumpston readily seconded him to the Administration there for twelve months. He arrived in March 1924 and by January of the next year had compiled a detailed report on existing health conditions and made recommendations for their improvement.

This report so impressed the decision makers that J G McLaren, Secretary for Home and Territories in the Commonwealth Government, recommended that Cilento be appointed Director of Health and Quarantine in the Mandated Territory of New Guinea for three years to implement it. The Administrator sought to limit him to advisory status, but in the knowledge that there was no other available tropical

34. Cilento, personal interview, August 1978
34a. Gordon, 'Mad Dogs ....', ibid, p. 92.
35. R W Cilento to P D Cilento: 18 September 1923, and 21 January 1924 Fryer coll. 44/. Cilento's correspondence with his wife was frequently in the form of letter-diaries from which he later compiled his reports. Such material will be cited in future thus: R W C to P D C ... A news item (datelined New York 20 May 1922) stated that Cilento was in the Panama Canal Zone studying the methods of Gorgas before going to New Guinea to take charge of medical and hygiene administration. Sydney Morning Herald, Cilento cutting book, Fryer Library, coll. 44/. This seems to indicate that Cilento had understood from the start that his appointment carried the promise of the New Guinea post. The Institute job had formerly been held by scientists. Unless otherwise stated, New Guinea, in this text, means the Mandated Territory and does not include Papua.

36. Cilento, Medical Policy and Progress in the Territory of New Guinea, Rabaul, 1925. Author's copy, Fryer coll. 44/
health administrator capable of meeting the League's requirements, Cumpston and Cilento resisted this arrangement. McLaren took the point and Cilento thereupon carried the flag of the Commonwealth Department of Health into the coveted territory. At the age of thirty two he had achieved the first major goal in his planned 'summer of aggressive achievement'. He now had immeasurable scope for impressive service, a stage on which to perform a complex of difficult tasks under the scrutiny of Geneva and Canberra with Cumpston anxiously watching from the wings.

Cilento's report of January 1925 was both comprehensive and critical; it said bluntly that little if any progress was being made in medicine or sanitation throughout the Territory and broadly attributed this state of affairs to the following causes: (a) lack of trained personnel; (b) lack of attention to the more important aspect (preventive medicine); (c) lack of fund for progressive works; (d) lack of cooperation between departments in the Territory; (e) lack of departmental 'esprit de corps' and efficient supervision; (f) lack of any continuous medical policy.

It is proposed to elaborate these deficiencies using supporting evidence from other authorities and to show how Cilento met the major challenges to his task (which he saw as a trust) of making provision for the improvement of health in the Mandated Territory.

During his military service, Cilento had been less than impressed by Australia's management in New Guinea, especially in respect of the natives. In this context he had written his crié de coeur:

Heaven help New Guinea if we get the ruling of it.
Everyone here prays that any nation from Greenland
to Timbuctoo shall get it rather than Australia shall
add it to her museum of wasted opportunities.

A man of experience who later expressed similar sentiments was Dr S M Lambert, whose experience in Papua had impressed him with Sir Hubert Murray's humane attitude to native peoples, especially when he contrasted this with north Queensland

37. Cilento, 'The World ...', quoting from his Medical Progress and Policy ..., (Ch 9), p. 22
38. R W Cilento, New Guinea Diary, April 1919, Fryer coll. 44/17, p. 40
where he found that Aborigines were medically untreated. He described Australia's six year military occupation as 'an evil regime', nor did he expect the new civil cadre to improve matters. Virtually none of the seventy officers was trained in the management of native peoples; Wisdom would have had to personify his name to remain sane under the conditions of colonial politics then obtaining. Scornfully he wrote:

The white population was more of a problem than the black; this new government was in the grab-bag period... every hand feeling out for a prize. The public health men were inexperienced. All that their director, Colonel Honman knew of the subject, he had learned as private physician to Prime Minister Hughes.

Historian, C D Rowley, while conceding that the Occupation Forces had carried out their duties to the natives along German lines but with less efficiency, was severely critical of the regime that had replaced them. As substitute rule began in 1919, he claimed, native policy which should have been the first preoccupation if the mandate were to be discharged in good faith, had been overshadowed by the affairs of the Expropriation Board and the seizure of German property.

Lack of trained personnel with associated failure to appreciate the nature of the health responsibility had been Honman's downfall. From the beginning Cilento sought to remedy this vital defect but it was obviously a long term project. For example, the revival of the post-graduate course at the AITM was an attempt to train men for New Guinea, which while laudable as far as it went, could not provide the numbers necessary to affect the situation even in the long term.

39. S M Lambert, Doctor in Paradise, ibid, pp. 77 et seq. Dr Strong, International Pacific Health Council Report, 1926, stated in Papua, the aim was to treat all people alike and almost every European had some responsibility for the medical care of the natives. Fryer col.

40. The term native is here used as it was in the literature of the period.

41. Lambert, ibid

Cilento’s frugal upbringing together with his experience in Malaya in the handling of coloured people helped him to a solution which made use of the resources at hand and involved the natives in the management of their own health affairs in a co-operative manner which is only now being employed in Australia. His system, based on the residual German framework, began with an organisation of thirteen areas staffed with eleven medical officers, thirty white medical assistants (trained to diagnose and treat a limited number of common complaints), a sufficiency of nurses and 2098 native medical orderlies, called tultuls, who could apply bandages, dressings and first aid. This was an extension of the German Dokta-Boi system and had the obvious advantage of involving native assistants with the ‘white medicine man’. All missionary activities (previously working independently), were brought into relation with the government, standardised and subsidised with grants of drugs and dressings. Apart from the occasional purloining of iodine and cotton wool for war-paint and the confusion of the Dokta-Boi with the native medicine man, the system, both imaginative and practical, worked very well. A member of the Mandate Commission of the League of Nations, the Commissioner for France, F. Andrade, commented upon the evidence of co-operation with medical missionary work and noted with approval that:

Use was made of native assistance in carrying on the medical service... The Chief Medical Officer, Dr Cilento, pursued the wise policy of mobilising auxiliary forces which, up to the present had been working independently... the great increase in numbers of natives assisted medically during the year was an astonishingly fine record.43

Lack of attention to preventive medicine was emphasised in Cilento’s report and linked with the third of his assigned causes for the lack of progress in health care. His paragraphs 14, 15 and 16 read:

Preventive medicine is generally recognised to be the main problem in a native tropical country. All well-established tropical administrations recognise in fact, that all other problems are subservient to health, since if a country can be made healthy it can survive even poor administration while if it remains unhealthy, no government however conscientious or well intentioned in other respects can secure

permanent progress...

In old established countries, such as Ceylon, it has been recognised that a mere striving towards economic development irrespective of the health of the native population means disaster.

It is noted in this connection that the Ceylon Budget for 1924/1925 allots 27% of the revenue to medical purposes. 44

Satisfied that the strategic requirements were met when Australia secured the Mandate, Australia's Acting Prime Minister Joseph Cook announced that the Territory must pay for itself. This proposition was ridiculed by Colonel Ainsworth, an expert on native administration who had been invited to report on the state of affairs there. He said it was impossible that so young and undeveloped a country with so many urgent and absolutely necessary requirements could do so. 45 In the view of Colonel J K Murray, former Administrator of Papua-New Guinea, Canberra failed in some important respects to give aid and support to those who were working for the advancement of both Australian and native interests. 46

This failure became embarrassing to Cilento when studies into the causes of death and disease among indentured labourers correlated highly with their poor nutrition. The supply of plantation labour was inadequate for copra production, posing an acute social and economic problem. Despite recent gold discoveries at Bulolo the country's chief export earnings were from copra produced by native labour. Production costs were cut to the bone in the 1920's due to low export prices.

Good nutrition is basic to the prevention of illness. German planters had kept their labourers fit by insisting that every plantation must have some acres set aside for native food crops. These tubers, roots and fruits provided minerals and vitamins for a precariously balanced diet. Their Australian successors, in their ignorance,

44. Cilento, 'The World...', quoting his Medical Progress and Policy..., (Ch 9) p. 23
45. Commonwealth Parliamentary Paper, 109, 1923-24
insisted that every inch be planted with coconut trees and fed their labourers on polished rice and tinned meats which, by contract, they were obliged to purchase from the owner-traders for whose copra vessels the system provided profitable return cargoes.

When severe berri-berri decimated the work force, Cilento devised several combinations of scientifically balanced diets based on their traditional food and asked General Wisdom to decree that the planters must supply them. They refused on the grounds of the (minimal) costs involved; the Administrator bowed to their presence and declined to take action. Cilento was aghast. Australia was failing in her obligations under the mandate and he was officially responsible. When Lady Wisdom obliged by sending him a Women's journal containing helpful hints on diet, Cilento was heard to mutter that what was needed was less 'general wisdom' and more specific knowledge.

Called to Canberra soon after on another matter he laid the matter before Secretary J G McLaren who was also unmoved. Cilento asked for an enquiry, even a royal commission and finally threatened to resign. McLaren persuaded him that enquiries could be counter-productive and that his resignation would harm Australia's reputation in the eyes of the League. It was his first lesson in Real Politik; an area in which when principle was at stake, he proved to be a chronically slow learner. This time, however, he and Wisdom compromised: the diets were introduced gradually and at the expense of the indentured labourers.47

Cilento's stand on native health attracted powerful support. Sir James Barrett, an eminent medical man and an influential spokesman on Australia's handling of the mandate, wrote:

If these people die out in a fertile country, other people will certainly take their place and circumstances can be imagined in which the Mandated Territory might become a menace of the first order. The resources of Australia in men, money and above all in applied science must be

R W Cilento, 'Food Deficiencies in the Mandated Territories' Med.J.Aust, 4 September 1926
These powerful words were not ignored. If Australia were less than sensitive to her moral obligations in the Mandated Territory, it still cringed with fear of the 'Yellow Peril'. This was the likely reason why, in February 1927, the Commonwealth government announced that it would defray the cost of an investigation by Dr Cilento into the causes of depopulation in isolated groups of the Territory of New Guinea collectively known as the Western Islands. The study looked at the history of population shifts, hostile invasions, introduced fauna and diseases, native familial relationships, land-holding customs and health status at varying levels, all carefully matched for comparison. Cilento's conclusion was that most groups were doomed to extinction unless their health and nutrition were improved. This study, sophisticated for its time, still supports high level, overseas research. In both these areas, diets for indentured natives and depopulation studies, Cilento was in the forefront of world thinking.

Lack of co-operation between departments and of departmental esprit de corps and supervision manifested itself particularly insofar as Cilento was concerned in the rivalry between the parallel controlling bodies represented by the Administration and the Expropriation Board. The latter authority had taken over German hospitals and other medical facilities which complicated Cilento's attempts to provide an organisational framework for the Commonwealth Health Commission to which he had been seconded. In his pursuit of power he secured his own appointment to the Administrator's first Advisory Council which consisted of five members. His objective was to capture and supplant the Expropriation Board by bringing about the amalgamation of the two services, abolishing costly and confusing dual control and


49. Cilento, Causes of the Depopulation of the Western Islands of New Guinea (Canberra: Government Printer, 1928)

50. In 1980 an article on an entomological survey of Wuvulu and the Hermit Islands was published in the Bulletin de la Societe de Pathologie Exotique. The author, Dr Philippe Gaxotte of the Paris University, wrote to Cilento that the above-named study was his only source of 'previous informations' and that his statistical data were particularly useful..., P Gaxotte to Sir Raphael Cilento, 15 June 1980, Fryer coll. 44/10
centralising management in his own hands. When this amalgamation was secured, Cilento was able to address the remaining deficiency, the lack of a progressive medical policy.

Of the endemic diseases of highest incidence in the Territory, he chose to concentrate on the eradication of the pitiful yaws; he had proven in Malaya that this widespread disease was suitable for campaign methods of treatment and that results were spectacular. In addition smallpox vaccination, epidemiological surveys of hookworm disease, and the introduced tuberculosis and gonorrhea together absorbed the department's capacity to provide field programmes.51

Between 1925 and 1928 the new director travelled widely by every means available carrying out inspections while observing the intricate structures of native life, the beliefs and customs upon which their culture depended. Insights so gained enabled him to overcome much of the native fear and distrust of the foreign medicine man. The oldest trick was to effect the magic cure on the chieftain or his son; after that the confidence of the villagers could be reinforced by combining treatment with a native ritual, such as the sunrise dance described by Cilento:

I persuaded the natives suffering from yaws that the (organic arsenic) injections in their veins was magic and covered each lesion with a bandage giving strict instructions that no light must fall on the lesion for nine days. Meanwhile, the drug did its work and the scab, protected by the bandage, separated. On the ninth day, before sunrise, the patients paraded on the men's side of the creek where most villages are set, the bandages were loosened but not removed until sunrise when, at a signal, they were ripped off taking the scabs with them. The former sites of yaws showed pink against the brown skin... the delighted natives believed they had seen the scabs fly away like butterflies as the No 1 doctor had promised.52

Besides winning the confidence of the natives, the success of the yaws campaign boosted the reputation of the Health Department, as did the cleaning up of Chinatown Rabaul. This task, which took two years to complete, was highly praised

51. Cilento, 'The World ...', (Ch 10) pp. 20, 21
52. Cilento, New Guinea Diary, 1924 Fryer coll. 44/9
in the local press. The editor completed a lengthy eulogy in purple prose:

While the Administration ... appears to be sunk in the arms of Morpheus ... there is one department which is very much awake... the Department of Public Health under the able direction of Dr. R.W. Cilento and his assistants... Where once the cesspools and middens of oriental depravity... held triumphant sway, new roads have appeared, drains constructed and decent sanitary conditions imposed. Two small parks... are being formed to keep the Chinese children out of the unsavoury gutters ... The new roads cut through the heart of Chinatown besides letting in light and air ... will prove a boon to the police and enable that much maligned body to more effectively control the area.

As early as mid-1924 Cilento had gazetted regulations to control mosquitoes in Rabaul while at the same time taking what steps he could towards providing the town with a pure water supply. (This was an area of control claimed by the Public Works Department). Apart from depopulation studies, Cilento carried out investigations into malaria and published his findings in conjunction with Baldwin.54

It is worth mentioning that Cilento set up the first medical register in the Mandated Territory, concerned as he was by the number of 'doubtful doctors' there, particularly following the Bulolo gold rush of 1925.55 One of the first practitioners registered was Phyllis Cilento, M B B S who, as the first woman doctor in the Territory, conducted an obstetric practice, mainly for Chinese women. Meanwhile, her own two daughters, like most European children, had been born on the mainland. With her husband away a good deal of the time, this busy medical mother had little opportunity to enjoy the pleasant seignurial life-style, reminiscent of Malaya, which the Germans had introduced into the well-planned European section of the town.

53. The Rabaul Times (Rabaul), 9 September, 1927 in Cilento cutting book, Fryer coll. 44/7
54. R W Cilento and A H Baldwin, Malaria in Australia, (Canberra: CDH Service Publication), 1930
55. Experience in the Mandated Territory made Cilento very wary of possible charlatans among so-called 'refugee doctors' entering Queensland in the 1930's; accordingly he built safeguards into his Medical Act of 1939 to protect both genuine doctors and the public.
The laxity of quarantine regulations in German New Guinea had prompted Cilento's initial letter to Cumpston in 1919 and in his report of January 1925, he stated that the establishment of reciprocity with the Commonwealth, the Territory of Papua and the British Solomon Islands Protectorate had been suggested and approved in principle. This was the basis of Cilento's 1919 plan which found favour with Cumpston and Elkington who for years, had been trying to formulate reciprocal quarantine regulations with what were called the Austral Pacific Zone powers, with control centralised in Australia. Cilento also wanted to see Australia first in the field and his opportunity to grasp the initiative came in 1925 with the lifting of the Australian Navigation Act (1921). Contact with the East was re-established, and vessels began to arrive in New Guinea from ports declared for cholera, plague and smallpox, within the normal incubation period of these diseases.

The Commonwealth Government, which in this respect saw Australia as a neo-colonial Pacific power, consented to Cumpston's request for a special Pacific Quarantine Conference, involving the powers set out above. This meeting, held in November 1925, focussed on the wider aspects of threatened epidemics and decided, inter alia, that the Commonwealth Quarantine Act should be the basis for reciprocal procedures in the area. Cilento's original report, which had stressed the vital defects of quarantine in New Guinea insofar as they posed a threat not only to that country but also to Australia, had given Cumpston valuable support both as a quarantinist and as director of the CDH. The agreement setting up the South West Pacific (Quarantine) Zone was ratified in 1928.

The Pan-Pacific Science Congress at Melbourne in 1923 adopted the following resolution:

That the scientific problem of the Pacific which stands first in order of urgency is the preservation of the health and life of the native races by the

56. Cilento, Medical Progress and Policy ..., ibid, Recommendation No 26
58. Ibid
application of the principles of preventive medicine and anthropology.⁵⁹

The Commonwealth Government, in recognition of its responsibilities in Northern Melanesia, had considered the possible benefits of a conference of the various countries having interests in the Pacific at which action might be taken for the improvement of the standard of health, not only of the natives but also of all those resident in the islands. One of the features of the Quarantine Conference of November 1925 had been consideration of international action and co-operation to prevent the introduction of exotic diseases to these islands to the danger of their non-immune populations. (Cilento's survey of the Western Islands of New Guinea in 1927 looked at the causes of depopulation there from an anthropological and public health viewpoint).

Influenced by these considerations, the Commonwealth Government in August 1925 requested the British Government (for whom Australia exercised the Mandate of the Territory of New Guinea) to invite the governments concerned to send delegates to a conference in Melbourne. A formal invitation was also sent to the League of Nations.

This conference was held in Melbourne from 15-22 December 1926 with delegates from Great Britain, France, Japan, the United States of America, Australia, Papua, New Guinea, New Zealand, Samoa, Fiji, British Solomon Islands, Federated Malay States and Straits Settlements. Dr Norman White, of the Health Section, represented the League of Nations.⁶⁰

Opened by the Acting Prime Minister Earle Page, himself a medical man, Australia's first international health conference, an occasion of considerable éclat, had far-reaching sequelae for the Commonwealth, its health department, and for the administrators who organised it, Cumpston, Elkington and Cilento.

⁵⁹. Report of the Pan-Pacific Science Congress (Melbourne: Government Printer, 1923)

⁶⁰. Health, January 1927
Cilento wrote in words ringing with patriotic pride that, due to the brilliant chairmanship of Cumpston, the important resolutions of the Conference, drafted in detail by Cilento and Elkington, were accepted. Subject to ratification, Australia became the central administrative power in the Austral Pacific Zone for the exchange between members, of health intelligence, the management of reciprocal quarantine procedures, and research programmes. The agreement in no way interfered with members' sovereign rights. The Commonwealth Department of Health, entrusted with co-ordinating a system of health intelligence between administrations of the Zone, was also henceforth to maintain liaison with analogous bodies in Singapore, Paris and Washington.\(^61\)

For the Bruce-Page Government, the value of the Conference in polishing Australia's tarnished image as a Mandatory would have been significant. Feed-back from Geneva was gratifying; a resolution adopted by the Eighth Ordinary Session on 30 September 1927, stated:\(^62\)

> The Assembly, noting the recommendations which have been made by the International Pacific Health Organisation in Melbourne in December 1926, in relation to the work which might be undertaken by the Health Organisation for the study of health problems in the Pacific area, expresses the hope that the possibilities of action in this sense will receive full and early consideration by the Health Committee.\(^63\)

The Health Committee, having studied this resolution, announced that

A survey of health conditions in Papua, New Guinea, the New Hebrides, New Caledonia, the Solomon Islands and Fiji would yield results of international interest and importance.\(^64\)

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61. Cilento, 'The World ...', (Part 11 Ch 4) pp. 11, 12

62. McCallum, International Hygiene..., Austral Pacific Zone', unpaginated, Fryer coll. 44/

63. Ibid

This survey was entrusted to a French and an Australian representative, Dr Paul Hermant, a member of the French Colonial Medical Service and on the recommendation of Cumpston, Dr R W Cilento. A very valuable report was published by these investigators. A follow-up entomological survey was recommended by the Malaria Commission of the Health Committee, but with the reduced budgets and call for economy that reached Geneva by 1931, co-operative investigations through the League of Nations were shelved.

The conference urged as a matter of priority that a modern laboratory in association with the central health administration should be established and if possible a vessel equipped as a mobile laboratory for investigation and patrol work at different points within the territory. Elkington was ready with the Inland and Island Plan to secure a foothold for the Commonwealth Health Department in Papua and the Mandated Territory under this scheme, the possibility of which he had foreseen in 1923. Confidently he asked Cumpston to put the Plan on the agenda of the Australasian Medical Congress of 1927 for reconsideration.

To Elkington’s dismay and disbelief, Cumpston disclosed that policy changes adumbrated in the Royal Commission on Health (1925) were about to preclude the implementation of his cherished plan, the key to the consolidation of the tropical programme, as incompatible with future Commonwealth Health Department policy. In fact, the tropical phase was about to end. The programme had been threatened by moves put forward at the Commission hearing, to transfer the Australian Institute of Tropical Medicine to a new School of Public Health and Tropical Medicine being built within the University of Sydney as a joint Commonwealth/State instrumentality; a move which had been stoutly resisted in sworn evidence by Cumpston, Elkington and Cilento and shelved as a long term objective. But all now was changed.


The specific allocation of funds available for public health in the Commonwealth sphere, the focus of the Commission's enquiries, was finally Cumpston's decision and a matter of high policy. Australia had become an urban society with a large percentage of its population clustered about the southeastern seaboard. War pensions, rehabilitation services, migrant assimilation and its special health problems were pressing matters of Commonwealth responsibility compounding urban social conditions of great complexity. Therefore, Cumpston tacitly had decided he must prune expenditure in the tropics in order to provide, as was his task, a balanced scheme of public health service as an underlying factor of national welfare. Far ahead of his time, Cumpston had seen the way medicine was going in Australia and that he had to be in the vanguard of the trend if his department were to survive: he was continually looking for a fiefdom.

Elkington saw this as betrayal by the very man whose career he had both promoted and supported. Bitterly watching the gradual dismantling of his tropical programme, abandoning the national public health care of 170,000 Australians who happened to be living in the tropics where there were still sizeable health problems, he decided to resign, for he could no longer work with Cumpston. He was just fifty seven years old. He named as his successor his friend, ally and protegee, Raphael Cilento. Thus it was that Cilento made his survey of Melanesia on behalf of the League of Nations, as Director of the Division of Tropical Hygiene (CDH) based in Brisbane.

At the 1926 International Conference Lord and Lady Stonehaven gave a Vice-Regal reception to enable visiting dignitaries to meet notable Australians. This proved a social disaster. According to Melbourne's leading paper:

Their Excellencies remained on the dias and only Drs Strong (of Papua) and Cilento seemed able to effect pleasant introductions and appear to be at home. The party resolved itself into an evening for Melbourne socialites: the opportunity for useful social interchange was lost.


68. Cilento, 'The World ...', (Ch 11) p. 32. Fryer coll. 44/4

69. The Age (Melbourne), 23 December 1926
At this time too, New Guinea was topical and Cilento was invited to address an invited audience on the subject: Cumpston's lot was to pass the vote of thanks.\textsuperscript{70} Whereas the reserved Director General would have melted from the limelight glaring upon his junior officer, Cumpston was never again to invite public comparison with Cilento.

Yet Cilento had earned the success that brought opportunities for growth and favourable attention to Cumpston's department both at home and abroad. He had been loyal and phenomenally hard-working. They worked in different ways. Cumpston's forte was continuity of direction from headquarters, a captain on the bridge of his ship; he was not a tropical man, nor was he possessed of Cilento's compulsive drive to see for himself, assessing a problem and all its parameters before attempting to synthesize a solution, that so often had the magic touch of vision. Their respective strengths were complementary; each had need of the other.

Since October 1922 when he became Director of the Townsville Institute until March 1928 when the Melanesian report was complete, Cilento had worked almost without respite. The AITM had been translated into a public health agency in line with public policy but the research baby had not been thrown out with the bathwater; applied work was continuing, where possible in connection with the New Guinea team. As he had no means of influencing policy, however, research remained ad hoc.

Cilento's work in the Mandated Territory and beyond, during this period, was of greater scope and magnitude than may be described here, but it seems appropriate to re-emphasise some of the more important of his achievements. Ridding Rabaul of the malaria carrying anopheles (mosquitoes), cleansing and rehabilitating the Chinese quarter of the town were projects begun as early as 1924: the introduction of the first enforceable ration scale to prevent berri-berri among indentured workers despite political opposition; the provision of an organisational framework for the medical treatment of free natives that linked them and their missionaries with the government health agency in the reduction of yaws and the prevention of small-pox; all were active educative and preventive health measures.

\textsuperscript{70} Cilento, Negroids of New Guinea, reported in \textit{The Age} (Melbourne), 25 November 1926. Cilento cutting book, Fryer coll. 44/
From his first field investigation into Malaria and Filariasis in 1923, followed by the report on Medical Policy and Progress in New Guinea in 1925, and the contemporary social study of White Man in the Tropics; the depopulation studies in the following year in the Western Islands and finally the report on the six month's survey in Melanesia with Hermant, Cilento's reports had been respected and useful. And there was a quality that gave his work a special touch, a blend of practicality and inspiration.

Two authorities most concerned with Australia's performance as a Mandatory sum this up very well. At home, Sir James Barrett, famous ophthalmologist and publicist, wrote that:

On the one hand an honest and expensive attempt is being made to deal with a most difficult situation, on the other hand, the dominant note will be dismay at the enormous scope of necessary activities and the almost insuperable difficulties of applying the principles of preventive medicine to a backward race. Real progress seems to have been made in the organisation of health work. It is the best feature of the Administration. 71

At Geneva, Sir Joseph Cook expressed the consensus, saying of the Report of the Public Health of the people of New Guinea (1927), that it was a most able document and showed that the right man was in the right place. 72

71. James Barrett, The health problems in the Mandated Territories in The Mandate and the Australian People, ibid, p. 85

72. Sir Joseph Cook, Minutes of the Eleventh Session of the League of Nations, 7 July 1927, C 348, M122 (V 1) Fryer coll.
CHAPTER FOUR

(a) Director of the Division of Tropical Hygiene (CDH) July 1928-September 1933; Senior Medical Officer (CDH) September 1933-October 1934.

What is there to do at a dying man's bedside?
Cilento, July 1929 diary

This chapter deals specifically with the period from May 1929 when Cilento returned from overseas duty to take up his appointment in Brisbane and falls thematically into two main areas with overlap in time and space.¹

In September 1933, upon the abolition of his division, he was promoted to Senior Medical Officer (CDH) ranking next in seniority to the Director General. However, he remained in Queensland for several months winding down Commonwealth affairs before transferring to Canberra in February 1934. In October 1934 he resigned from the federal service to take the position of Director General of Health and Medical Services in Queensland and returned with his family to live once again in Brisbane.

The melancholy quotation above, written on the occasion of Cilento's final inspection of the Australian Institute of Tropical Medicine, sets the tone of the first thematic area underlying this discussion and is concerned with his adaptation to the phased withdrawal of the Commonwealth Health Department from most of its commitments in Queensland.

The second looks at Cilento's role in studying and advising the state government on those diseases and subjects which the state had tacitly handed over to the federal government in circumstances related in the previous chapter. Examples of these were leprosy, northern fevers, hookworm and aboriginal health.

1. Courier Mail (Brisbane) 31 July 1928 noted the appointment of Dr R W Cilento as Chief Quarantine Officer and Director of Tropical Hygiene in Queensland, announced in the Commonwealth Gazette from 30 July 1928 with a salary of 1,250 p.a.
Cilento had returned to mainland Australia with an outstanding reputation as an administrator with expertise in tropical diseases (traditionally topical in Queensland), native health and political negotiation. Consequently his advice was sought by community, medical and government leaders in times of public debate about medical and/or public health issues. An example was the Sister Kenny question in 1933.

For the first three years of Cilento's incumbency, the depression years, Queensland was governed by the Country-Liberal Regime under Arthur Moore, while from June 1932 a Labor Government led by William Forgan Smith had been elected to lead the state back to prosperity.

A long running battle between former Labor administrations and the BMA over the control of medical policy within government hospitals had led to the appointment by the Moore Government of a Royal Commission in 1930 to consider the best method of financing these hospitals and to settle the issue of lay versus medical control of hospital policy. The depression had highlighted the plight of the sick, poor and the needy to streamline the state's health services in the interests of efficiency and economy. Both major political parties therefore needed a clear policy of health reform to take to the electorate in 1932 and both sides unofficially consulted Cilento who, encouraged by his successes in New Guinea, already had ideas about organising medical services at home.

As soon as he had seen the writing on the wall spelling the eventual doom of the tropical programme Cilento, after his fashion, had begun to look for an unusual job which he knew would become necessary and prepare himself for it. Many years later he told a friend that he had seen Queensland as a colonial empire ripe for a takeover. He might have added that he meant to be its emperor.

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2. R W Cilento to D Gordon, personal communication, 1980
Drs Raphael and Phyllis Cilento arrived in Brisbane in May 1929, shortly before the birth of their second son and fourth child, and settled in Clayfield. The busy mother set up professional rooms beneath the high-set home so that both medical practice and family care could be managed, and the family resumed its unique brand of normality. Brisbane has been the family headquarters ever since.

Immediately, the two doctors began to identify themselves with the problems of the community with which they shared the depression years. Brisbane was then a 'pan and tank city', where uncomfortable, unhygienic living conditions were common and frequently exacerbated by poverty. As a port city, far from the centres of production, Queensland's capital was hard hit by unemployment and low wages. Ignorance was a factor compounding uncongenial and in some cases distressing living conditions and one which could be offset by public enlightenment. To the Cilentos, this was a familiar situation and one in which they were willing and able to help.

Under the pseudonym Hygiea Raphael began to write regularly for the daily papers short, commonsense articles to advise people how to live, eat and dress appropriately for the climate. He alerted the people and authorities to the need for mosquito eradication as dengue fever was common in Brisbane; through his articles on diet and nutrition also urged government to provide animal protein in the diet of Aborigines under care; founded a committee among business and professional men to promote dress reform with the slogan: Be Australian, think Australian, look Australian! Cilento was actively involved in the Bush Children's health scheme during this period.

3. Raphael's enforced anonymity as a public servant was partly overcome by using his wife's name. Soon she began publishing in her own right and for more than fifty years has contributed to daily papers and women's journals topical and universal articles on health and related subjects that can be understood by the lay reader. Her articles provide a chronological guide to the trend to alternate medicine and, as collected in the Fryer Library, a rich source of social history.

4. Daily Mail (Brisbane), 11 November 1930. Other well-known committee members were Brisbane business men, Messrs E Pike, E Molesworth and H Marshall.)
Dr Jefferis Turner, famed pioneer of infant and maternal welfare in Queensland, was appalled by high morbidity and mortality levels in this group which he saw largely a function of ignorance; he wrote, for example, of the needless deprivation of Queensland's milk-starved children.\(^5\) In an attempt to enlist the help of influential people, he approached Dr Phyllis, then Chairman of the Health Committee of the National Council of Women (Queensland Branch). She responded at once by founding the Mothercraft Association of Queensland. With her London training, personal experience and enthusiasm to guide her, she soon had an efficient, voluntary organisation to train young mothers, mothers and infant welfare nurses in the proper nutrition, dressing and care of babies and mothers in Queensland conditions. For too long had the unsuitable English tradition of woollen clothing and heavy diet been the unquestioned norm. This Association, founded in October 1931, dissolved exactly thirty years later after it had promoted the establishment of Mothercraft Homes and child care centres throughout the State.\(^6\)

In support of Raphael's series of broadcasts on nutrition, Phyllis compiled a cookery book designed to encourage the use of cheaper cuts of meat by demonstrating their nutritional value.\(^7\) Although roundly condemned by some Labor spokesmen for suggesting that the poor should eat offal, she was also hoping to enlighten the rich; ignorance of dietary values causes malnutrition, especially among children, at every economic level. She lectured at the University of Queensland on this group of subjects for many years.

Raphael, a much sought public speaker, never hesitated to give a lead, however controversial. As President of the Queensland Branch of the Royal Society (1933-34), he looked at Australia as an Asian country in a series of lectures later published under the title *Australia's Orientation*.\(^8\)

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8. R W Cilento, Australia's Orientation, Repr. from Health, Commonwealth Health
Addressing the city's leading business and professional men half a century ago, he told them that Asia was Australia's natural market. While government efforts were being directed towards revival of the chilled beef market in Europe, the controversial Cilento was advocating tropically grown beef for Japan! Speaking from his Malayan experience, he criticised the inappropriate labelling of Australian products as both self-defeating and discourteous. Weights and contents described in English were unintelligible to bazaar buyers. If the brilliantly coloured bird on the jam tin suggested 'potted parrot', greater still were the fears that the contents of the Glaxo tin picturing a beautiful baby might be true to label, while the wallowing pig on the dried milk pack was a complete affront to Muslim buyers. For these reasons, Australian products were all too often left to rust untried in the market place. He urged all exporters to visit their markets, get to know local people, their requirements and customs. Commonplace as this sounds today, fifty years back these concepts in marketing startled the Queensland merchant.

In connection with Health Week of 1932, Cilento promoted a National Fitness Campaign to stimulate physical and mental vigour, which may well have been the first of its type. At a time when the community in general needed a lift and a lead, most of these initiatives were forward-looking and morale boosting, designed to help people take control of their own lives as much as possible; involvement which made the Cilentos respected public figures in Brisbane.

With the same blend of energy and determination, Cilento set about stimulating the activities of his flagging department. Hitherto there had not been much for the Divisional Director of Tropical Hygiene to do in Queensland. Elkington, the first incumbent in 1922, had been doing the duties of Chief Quarantine Officer and a kind of de facto survey of tropical diseases which might invade the north. He had general oversight of the AITM, the Hookworm Campaign and the Commonwealth Health Laboratories, but in the main he had been a king looking for a kingdom. He had pinned his hopes for expansion on the adoption of the Inland and Island Health Scheme which he and Cilento believed could be justified in the national interest.

9. R W Cilento, Address to the Constitutional Club (Brisbane), Brisbane Courier, 2 September 1930

Cumpston saw the total plan as a means of consolidating departmental extension into public hospitals of outback Queensland and New South Wales and, of course, into the key bases of the new Austral-Pacific Health Zone but tacitly doubted if, in the long run, it could be afforded. He was proved right when explicit changes of policy both in Canberra and Geneva stalled the machinery almost at the moment of its activation. When this happened, Cilento's hopes for an extended extra-territorial term were also dashed.

The economic depression (1929-33) was a disaster whose fierce onslaught accelerated the rate of change and, in the health field, tilted the balance of power in favour of the Commonwealth. The slow rate of integration decreed by the Royal Commissioners in 1925 could not be afforded in 1929.

Australian credit in London had collapsed. There were no loan moneys coming forward to settle some 33 million pounds of overseas debts;... the world prices for primary produce and for most metal commodities had commenced to tumble... shrinking Commonwealth and State revenues, industrial strife, rising unemployment all added to the general misery.11

Cumpston was fighting for the survival of his department. The 'last to come, first to go' public service retrenchment rule had ominous portents for the nation's youngest ministry. In advance of the Financial Emergency Act, 1931 he had pared his lean establishment to the bone. In 1928, he loftily informed his staff that in order to save the department they must be prepared to make sacrifices for the people of the Commonwealth. He retrenched his divisional heads progressively and thereby attained pre-eminent power within the department.12

The implications of these moves were not lost in Cilento; it was crystal clear to him that unless he took matters into his own hands, his future lay in Canberra where the top job was solidly occupied by a most capable officer only twelve years his senior. Moreover, he was deeply committed to the Australian tropics. The three main areas of the programme which he felt must be safeguarded were Aboriginal health, residual Hookworm infestation and research into undifferentiated northern fevers.

Immediately he arrived in Brisbane in 1929, Cilento took steps to save these important activities from official obliteration. First he considered the hookworm problem. Inevitably there would have been some backsliding since the last programme ended in 1927; cessation of control now would soon render useless thirteen years of effort and the expenditure of a great deal of money. He knew that in very wet areas such as Cardwell, a resurgence of the parasite population had raised the level of infestation among the people. A new plan of action was needed. Cilento now sought to involve Drs Coffey, the State Health Commissioner and St Vincent Welch, Chief Medical Officer for Schools in the hope that when the Commonwealth pulled out, they would support his plea that the Queensland Government should assume responsibility for hookworm control.

Electoral pressure, which kept the government honest, stemmed from the pervasive belief in the White Australia Policy as the watchdog of the north. Lobbyists representing farmers, sugar industry workers, and their vigilant unions, together with the ambient 'yellow peril' syndrome, ensured that Cilento's statement that hookworm was the only great, devitalising disease threatening white settlement in north Queensland could not lightly be dismissed.  

When Cilento spoke of a 'devitalising disease threatening white settlement' he meant precisely what he said. In the same statement he stressed that:

Many diseases called tropical are merely diseases which have their greatest distribution where social and sanitary conditions are grossly defective or

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primitive and nowhere is this the case more than in
the tropics.\textsuperscript{14}

This was the gospel of preventive medicine which all public health men knew and
which Cilento tirelessly preached; the causal connection between environmental
conditions and community and individual health. There was still a gamut of
disease conditions, lurking or flourishing wherever conditions favoured them; in
Aboriginal settlements in towns, shanty dwellings, cane barracks and the like.
Gordon notes that there were still a number of matters of medical interest to
investigate in tropical Queensland in 1930; it so happened that as an epidemiologist,
he was involved in this investigation more than thirty years later.\textsuperscript{15} Professor
Helmore, first Dean of Dentistry at the University of Queensland, was of the opinion
that medical research must begin in the tropical north.\textsuperscript{16} As late as 1966, no less an
authority than E H Derrick was still wary of tropical diseases and echoing Cilento's
plea for vigilance in their prevention and control:

The disappearance of typhoid, malaria from the
mainland is a public health victory. The means to
prevent dengue and to prevent scrub typhus are at
hand, but the prevention of leptospirosis (Weil's
Disease) is an unsolved problem. ... although there
has not been one case of malaria acquired on the
mainland since 1946, we are still vulnerable while
the disease is unconquered in New Guinea and
Indonesia.\textsuperscript{17}

Whereas over time, Cilento's main concern about tropical diseases were
addressed by reputable scientists, his 1930 edict linking hookworm to the health of
white settlers was calculated to win continuing support for its eradication in a
society still wedded to the White Australia policy.

Conversely, it was the deep-seated social attitudes underlying this policy that
precluded any hope of government or popular support for Aboriginal health and

\textsuperscript{14} Ibid. Also in Cilento, The Future of Tropical Medicine, 1929-30’ Fryer coll. 44/
\textsuperscript{15} Gordon, Mad Dogs ..., ibid, p. 89
\textsuperscript{16} Courier Mail (Brisbane), 8 January 1935
\textsuperscript{17} E H Derrick, 'The Challenge of North Queensland Fevers', Annals of Medicine
Vol. 6, No. 2 1957, pp. 182-187
welfare. At the level of poverty and ignorance where conditions made hookworm infestation endemic, the only difference between Aborigines and the poor whites of the north was the colour of their skin. Hookworm, rats, mosquitoes and disease vectors generally are known to be colour-blind and foci of disease in Aboriginal groups had therefore to be eradicated before the white man was safe.

Cilento’s work for the improvement of native health and living conditions - the two were inseparable - had been notably successful. Having recently made a careful survey of conditions in Melanesia, he was anxious to make comparisons in Queensland where lived the greatest number of Aborigines under control and therefore accessible. He wrote that leprosy, tuberculosis, V.D. and hookworm diseases had been introduced by white and coloured invaders to the non-immune indigenes and therefore a moral obligation existed to treat them medically. Australia should do as much for her Aborigines as for the coloured populations of her dependencies. Anything less would be shameful.

The Federal Health Council offered the best forum for making known Queensland’s need for continued research into undifferentiated fevers and those pathologies listed above which were so closely bound up with the living conditions of the Aborigines that the two could not be separated. Not only was it an advisory body to both levels of government within Australia, but its role extended, through the Federal Director General, to the various health organisations of the League of Nations.

For Cilento, the first step was to collect evidence upon which to state a case for continuation of these elements of the tropical programme. This meant getting permission from Cumpston to make a field survey of the tropical coast.

Cumpston was in an awkward position. Negotiations were in progress for the transfer of the Institute and he could not afford to associate himself officially with policy he was committed to abandon. Yet, he knew that Cilento’s international reputation would ensure that his data were accepted as proof that the

18. Cilento to Dr J W Walker, London, 21 February 1935 Fryer coll. 44/11
Commonwealth was shouldering its international obligations and provide necessary information for this new activity within the Sydney School. He therefore permitted Cilento to undertake the first departmental inspection of this magnitude, 'as a self-appointed, unofficial task'.

Accordingly, in June 1929 Cilento set off alone on his long journey. Routine inspection of the Institute at Townsville he described as perfunctory. 'What is there to do at a dying man's bedside?' he asked. He was unable to tell his very anxious staff what their future would be; he their Director, had not been told. Cumpston played his cards close to his chest and the result for his senior men was often demeaning.

In Ingham he was joined by Coffey, St Vincent Welch, and local hookworm staff for a study of the area. High endemicity persisted here and a new system was being tried whereby a travelling unit cleaned a district thoroughly and left a trained nurse to follow up every case until a cure was effected. The persistent difficulty was to get people, employers and schools to provide and maintain adequate sanitary conveniences. Public sympathy with their objectives waned when obdurate insanitation continued to nullify their work. Using methods of his own, Cilento had found impressive subjects to demonstrate that a tightening of local controls was imperative. Vividly he described what they saw:

We wanted to see the method of taking the census, obtaining specimens, educating people, examining privies - preferably in both English and Italian-speaking families. We first visited a galvanised humpy where lived a Scottish farmer, his wife and numerous children. They dosed everywhere... on beds of dingy clothing bulging through broken sacks. All had hookworm except the baby who couldn't yet walk and the seven months foetus on its way to individuality. They go nowhere, see no-one - do nothing but hard manual work. One is hare-

21. R W C to P D C, letter diaries (Cilento to his wife, 1929 tour, 22 June 1929 to 21 July 1929) Fryer coll. 44/21
22. Ibid
23. Ibid
lipped.

From this dismal home we went to an Italian family whose better built humpy was also swarming with children and had the most frightful privy. We were well received, the medicine was taken politely... they understood not one word of the patter spoken to them by the local inspector. 24

Cilento's descriptions of conditions at the Ingham and Trebonne schools are in the same vein. Privies were appalling; hookworm infected children were identified and photographed with the 'normal huskies' for comparison. Dr Welch made gloomy notes while Coffey used his weight to smarten up local government officers. 25 In Cairns, a day or so later, these men met as a committee and accepted the plan of action prepared in advance by Cilento and agreed to refer it to the government as a basis for renewed co-operation.26

The final outcome of this strategy was the appointment of a joint Commonwealth/State Health Committee, headed by Cilento, whose purpose was to organise an up-dated hookworm campaign along lines indicated by him. Later he won support for the scheme from the New South Wales Government and involved health officials and medical practitioners from Lismore to Cairns in a fight against this filthy disease.27 In 1931 the Moore Government gave one thousand pounds to the campaign despite the economic stringencies of the times. When abandoned by the Commonwealth in 1933, Queensland had assumed this responsibility and even set up the Hookworm Inspectorate recommended by Cilento.

24. Ibid, 3 July 1929
25. Ibid
26. Ibid, 8 July 1929
27. This was negotiated by Cilento with officers of the BMA in Sydney as a private initiative as both an eradication and educational exercise. Cilento diary, 18 February 1932, Fryer coll. 44/. Cilento to Dr Dick, Lismore, 4 November 1930, Fryer coll. 44/10. Cilento, Hookworm Disease and Hookworm Control, Commonwealth Dept. of Health pamphlet, 1939, Fryer coll. 44/54
On reaching his northernmost destination, he noted with disgust the depressed and filthy conditions of the so-called self-supporting Torres Straits Islanders. The health picture was deplorable. Children of twelve had horrible granuloma lesions; fever raging on one island had already caused ten deaths and was unrecognised until Cilento diagnosed malaria and had it confirmed by the Institute. As Thursday Island was a quarantine station, the Commonwealth Health Department could have been involved, but Cumpston refused to be drawn. No help was sent to Dr Vernon at the ill-equipped and undermanned hospital, despite Cilento's urgent request.

Nor was the state authority obliged to act when Cilento reported an active case of leprosy on the northern mainland. He took slides that were positive and informed the Protector in the hope 'that she was not left to infect others'. Each intrusion into the domain of the Queensland Protector of Aborigines had to start ab initio.

Cilento's comprehensive report of this survey was placed on the agenda of the 5th Session of the Federal Health Council in March 1931. His data provided a commendable amount of material for Cumpston's review of the international and Commonwealth activities of his department during the previous year. The presence of leprosy among both European and Aborigines featured in both sections; the international because since becoming a member of the International Hygiene Bureau in 1926, Australia had agreed to provide intelligence, inter alia, on this subject to the branch bureau at Singapore, and to the Commonwealth because of the very nature of the disease and the fact that Europeans were affected. The Federal Health Council proposed that Cilento should be authorised to make an official study of this problem on behalf of the Commonwealth. Cumpston, wary of again becoming involved in

28. R W C to P D C letter diary, July 1929, Fryer coll. 44/21
29. J H L Cumpston to R W Cilento, 12 August 1929, Fryer coll. 44/10
30. R W C to P D C, letter diary, 14 July 1929, Fryer coll. 44/21. Referring to Thursday Island he also wrote: 'I am more interested in this place than any other quarantine station; it is the native element and native diseases that attract me', ibid
Queensland, successfully recommended the adoption of a less contentious position. Cilento was thereby authorised to compile reports from time to time on the position of leprosy in the various states as epidemiological information provided by them accumulated; a vague situation which placed no obligation on member states to cooperate. Naturally this displeased Cilento. The Council did authorise him to make a joint attempt in Queensland with the Protector of Aborigines to put native sanitation on a satisfactory basis, a seemingly impossible task.

In 1932 Cilento began a systematic survey of the health of Aborigines under care and in the following year made tours of inspection, always combining routine and ad hoc purposes, that reach heroic proportions. In July he commenced, in Rockhampton, an inspection of quarantine stations, laboratories and Aboriginal settlements south of Townsville. From Darwin, in August, he combined these activities with the survey of a mosquito-free air route for aircraft entering Australia from Singapore and bound for southern capitals. This responsibility excited Cilento. The purpose was to prevent Yellow Fever and other mosquito borne diseases from entering Australia. The survey took him overland as far as Toowoomba: the resulting report was the basis of Australia’s commitment to the International Air Convention on this matter. At Roper River, Cecil Cook, the Territory’s Chief Medical Officer, joined him and together they covered vast distances examining Aborigines and European settlers. In mid-September Cumpton sent Cilento to Townsville to assess the work of Sister Kenny and in October he trekked overland from there to the tip of Cape York examining Aborigines. His findings, policy making documents, are studied in a later chapter devoted to this subject.

From 1931 onwards, as a member of the Federal Health Council and later the National Health and Medical Research Council (NH & MRC), Cilento was in a position to talk to both levels of government. As his influence in Canberra was to become dominant after 1939 on the National Health Insurance question, its progressive development will be discussed in a separate section. However, to maintain continuity, the series of resolutions of the 1933 FHC meeting should be mentioned here.

32. Review of Tropical Medicine and Hygiene in Australia - Leprosy - Resolution 17.
Accepting as a resolution Cilento's persistent position that Aboriginal living conditions and social organisation were inextricably bound up with their health, the Council further resolved that leprosy should be placed on the Council agenda and Cilento delegated to organise and supervise epidemiological work in this connection for the next five years. This was a most important victory; he now had access to the Aborigines which opened up opportunities for more organised and detailed studies. His fight for continued government involvement in the tropical programme had not been in vain.

Turning now to the Brisbane scene, Cilento's interest in tidying up the State's public health administration was signalled very early. In an address to the League of Nations he gave this clue to his thinking:

The importance of tropical Australia has been obscured during every period of financial panic... but progress in an administrative sense might be made if other activities were in abeyance.

Here he was underlining the role of administration in policy procedures and development.

Evidence that he had pondered the crucial question of lay versus medical control in public hospitals came early in 1931 when the BMA put to the government a model scheme of health reform. The intent was to embody those recommendations of the Royal Commissioners which had been favourable to the BMA while there was a sympathetic government in power and so influence the projected Hospitals Act to the advantage of the profession. This did not eventuate for a complex of reasons given in a later chapter.

33. Report of the Federal Health Council, 1933, Minutes, p. 7. R W C to P D C letter diary March 1933, describes an epic battle between Cumpston and Cilento over these resolutions. Fraser coll. 44/21

34. R W Cilento, Tropical Destiny, Australia and Melanesia' Brisbane Courier, 14 November 1930

35. The Moore Government informed the deputation led by Dr P J Kerwin, MLA, that Cabinet had not yet considered the Hospitals Bill. When it had decided upon the cast of legislation a draft measure would be made... In fact, the matter was shelved and as the Moore Government lost office in 1932 the hopes of the doctors were not realised. Brisbane Courier and Daily Mail (Brisbane), 8 March 1931
Although as a public servant Cilento could not reveal his authorship, there are indications that the scheme had been worked out by him in co-operation with two leading members of the BMA, Drs E S Meyers and T E Price, (then president of the local branch of the Association). These men were friends and confidantes as indicated in their correspondence.\(^{36}\) Across the relevant press notice in his cutting book, Cilento has written: 'badly detailed account of scheme put up for me by E S Meyers'.\(^{37}\)

Meanwhile he had been working on a plan much nearer and dearer to his heart. In 1930 with the transfer to Sydney of the AITM Cilento lost his field base and Queensland its only public health and research institution. Identifying his own interests with those of the state, he designed a complete and logically structured paradigm for the re-organisation and co-ordination of health and medical services in Queensland. It was a hierarchical plan headed by a director general. From the job description, it is clear that Cilento saw himself in this position. In consequence, he made a private, personal commitment to fit himself for the task, as is revealed in his own account of what motivated him to undertake the formal study of law.

Medical reform in Queensland was a key issue in the elections of May 1932. The leaders of the BMA had, with advice from Cilento, formulated a plan which would have suited the electoral propaganda of the Country/Liberal Regime as has been shown. The Labor Opposition, determined to retain control of hospital expenditure as central to their policy, needed an electoral plank with widely based health and welfare commitments to appeal to the electorate whose health worries had been compounded by the depression.

Their leader, William Forgan Smith, valued central control. His machinery for the rationalisation of primary industry marketing had been designed on hierarchical lines stretching from the government at the top to the farmer at the bottom and had been put into legislative form in 1926 when he was Minister for Agriculture.\(^{38}\) The

\(^{36}\) Correspondence, Cilento collection, Fryer Library coll. 44/11

\(^{37}\) Cilento, Cutting Book, Fryer coll. 44/. Cilento to W M Hughes, 19 January 1938 also refers. Fryer coll. 44/11

\(^{38}\) Primary Producers Organisaton and Marketing Act, 1926
same organising principle was the foundation of Cilento's plan, based on the establishment of a Ministry of Health in Queensland, promised to the electorate by Labor. Whether Forgan Smith invited Cilento to structure this model for him or was presented by him with a fait accompli is not known but what has become clear from Supreme Court documents is that Cilento had already drafted his scheme well before 1932. Although this fact does not emerge in his anecdote here briefly quoted, he had mentally assumed the responsibilities of the Director General at the time of conceptualising the office. He wrote:

I drew in draft the enabling legislation that ultimately established the first Director Generalship of Health and Medical Services... and the corresponding department under Mr E M Hanlon. I took this draft down to the Solicitor General (Mr H Henchman) who begged me not to go on with it as I was not a lawyer. It was essential that I get this legislation through and I immediately arranged with the Registrar of the University to commence a study of law. I was permitted to commence at Intermediate level as it was considered that I already had all the primary subjects except logic and as the Registrar remarked, 'No lawyer needs any logic at all'.

Cilento thereupon enrolled with the Barrister's Admission Board (there was no Law School in Queensland). The date was February 1932, four months before the elections. Hanlon was then an opposition backbencher with no obvious lien on the health portfolio, Cilento was still a Commonwealth officer. Forgan Smith was the only man likely to have encouraged him to originate such a radical and ambitious undertaking on behalf of the Labor Party.

Yet Cilento does not appear to have been politically motivated; in important respects such as his advocacy of a medical as opposed to a lay inspectorate of hospitals, his position is much closer to the BMA.

39. Cilento, Correspondence file, Supreme Court of Queensland and Commonwealth Practitioners Board, Fryer coll. 44/. Cilento, Barrister-at-Law, Fryer coll. 44/, pp. 1-6, emphasis added.

40. Director General to Minister, Memorandum, 4 May 1935, HHA 11, A48/2315, (QSA)
The thirties produced much intellectual debate on social issues. Dr H C Coombes' response to the depression was to study economics and the banking system; Cilento's was to improve health services 'through organised efficiency, the key to social progress' as he had said in another context. This essay in statecraft was entirely consistent with his character and performance throughout his career.

Faced with the certainty of an unacceptable future in Canberra, Cilento had taken two major courses of action to preserve his independence; undertaken academic study of the Law to improve his administrative skills and status, and demonstrated to thinking men such as Forgan Smith and later Hanlon, the advantages of organisational reform as a step towards economic and social progress in the health and medical services of Queensland.

Cilento could not have refrained from making a personal contribution to the national debate; that was his nature. Undoubtedly too, any altruism was reinforced by a strong element of enlightened self-interest.

Forgan Smith's electoral victory in 1932 had been narrow. Labor's 2.5 million pounds Revival Plan, based on public works as unemployment relief, had been an urban vote winner and his most urgent task was to get people back to work. In Brisbane, where there was little industry, relief money had to be seen to be spent. As Treasurer he had sought to limit the deficit in his first budget to 1,485,000 pounds but found that draft estimates of budget deficits in the Revenue Account stood at almost twice that figure. As the Premiers' Plan for relief of unemployment in Queensland had to be implemented, Forgan Smith declined to establish a Ministry of

41. Cilento, 'The World ...', (Ch 1) p. 2
42. Clem Lack, Queensland Political History (Brisbane: Government Printer, 1962), p. 128
Health at that stage. Edward Michael Hanlon, Home Secretary in the new Ministry, whose responsibilities included health, was anxious to get on with the job of re-organisation as a preliminary to the sweeping changes envisaged; plans predicated on a separate Ministry of Health. Yet, as the only Minister representing an urban electorate (itself an interesting comment on the political and demographic patterns of the times), he could have no quarrel with the priorities of his leader.

Crucial to the economy of the State was the sugar industry where, directly or otherwise, four out of every five Queensland agricultural workers were employed. The Federal Government had struck a heavy blow in 1932 by exercising its right to set the domestic price of sugar and reducing it from 4½d to 4d per lb. This was seen to reduce the employers' capacity to meet demands that might arise for improvement in workers' pay and conditions; always a possibility in that volatile industry where Communist sympathisers, refugees from fascist Italy, Spain and Yugoslavia had stiffened the militant attitudes of its unionists. The Australian Workers' Union and Labor's Central Executive were seen more and more as too remote politically and geographically to serve the interests of the north; an ominous portent for Forgan Smith whose personal and party political base was essentially in these electorates.

In September 1933 however, there occurred a number of politico-medical events which interacted with exquisite irony to demonstrate that there is nothing so political as a social question with a health problem at its centre. A spokesman for the Commonwealth Health Department, thought to be Cumpston, took the entire edition of its house journal, Health, to announce the end of the tropical programme and to justify the move by emphasising all that had been done for Queensland under

43. Courier Mail, 14 July 1932. Measures implemented included the introduction of Queensland's first statutory working week (44 hours), a law to reduce the price of gas and electricity, and a Mortgagees and Debtors Relief Bill. Address in Reply, Queensland Parliament, 1932. QPP

44. Queensland Year Book, 1932

its aegis. In place of the AITM he pledged that an ambulatory unit would be available to the State in case of need; there had, after all, been no epidemic in Queensland for ten years.\textsuperscript{46} He crowned his record by concluding:

The White Australia problem may now be considered to be a problem no longer... The Commonwealth Government has thus shouldered the obligation of this, the greatest medicine problem of Australia and has fully discharged its obligations.\textsuperscript{47}

In connection with Cilento's Presidential Address to the 1932 ANZAAS Congress a few months earlier he explicitly instructed him to stress:

... the great importance of Australia's tropical areas and possessions and that this is one of the great major health problems of Australia.\textsuperscript{48}

That was gratuitous advice to Cilento of course, but it is significant that Cumpston said 'is' and not 'was' (a great major health problem). It would seem that he spoke with two voices and certainly failed to convince the medical profession which took a large spread in a metropolitan paper to publish a stinging rejoinder. Cumpston's apologia was demolished as political casuistry. Far from cost saving, the transmogrification of the Townsville Institute for the aggrandisement of the Sydney University had been at enormous cost. The writer poured scorn on the research priorities of the Sydney School as totally trivial and claimed that Australia still had an obligation to safeguard the health of settlers on her northern frontiers. This was a late and futile outcry; the horse had galloped off to Sydney three years earlier.\textsuperscript{49}

\textsuperscript{46} An outbreak of plague in Townsville on that occasion had caused 7 deaths but also helped to save the life of the Institute.

\textsuperscript{47} \textit{Health}, Commonwealth Health Services publication, September 1933

\textsuperscript{48} J H L Cumpston to R W Cilento, official communication, 18 July 1932, Fryer coll. 44/15

\textsuperscript{49} 'Tropical Health Still a Problem', \textit{The Telegraph} (Brisbane), 16 September 1933
As though to prove the doctors' point, a catastrophic outbreak of fever, believed to be Weil's disease, occurred at the same time in the canefields of Ingham.  

Dr John Morrissey, the physician treating these cases, concluded from circumstantial evidence supported by educated guesswork by his colleague Tim Cotter of the Commonwealth Health Laboratory in Townsville, that the disorder was that specific form of leptospirosis, Weil's disease. To confirm this, investigation by a specialist pathologist was required but the only diagnostic service available was blood and urine testing at the CHL in Townsville. These proved negative, possibly due to time taken for transit.

Cilento, who had been waiting ten years for this outbreak to occur, was asked not to intervene. Forgan Smith, who by now had the Sister Kenny imbroglio on his hands, possibly feeling that the government could handle only one health crisis at a time, told Cilento to 'turn a blind eye' on the canefields. As Director of Tropical Hygiene he may have had some room for independent manoeuvre but now, as Senior Medical Officer, his movements were a matter for Cumpston. It is impossible to believe that Cilento would not have asked to be sent, but in all the circumstances, Cumpston appears to have decided to wait and see.

This was a calculated risk, particularly on Forgan Smith's part. Outbreaks of Weil's disease were rare and this one followed an abnormal weather pattern of torrential rains followed by short, dry spells. These conditions created the ideal medium in which the disease-carrying rats built up a powerful strain of leptospirae with which they contaminated low-lying canefields onto which the cane cutters moved as soon as the sun shone. With their bare feet and cane-scratched limbs, they offered ideal access to invading leptospirae. Forgan Smith's gamble was that the weather would return to normal before the next crushing season and the problem would go away.

50. Menghetti, ibid. Menghetti records that between October 1933 and the following February, forty patients were affected, sixteen showed classic jaundice and internal haemorrhage and four died. All were healthy males working in the sugar industry, p. 29

51. G C Morrissey, Med.J.Aust (V.2) 1934, p. 496

52. R W Cilento, personal interview, 1978
It was believed, though not by Cilento, that burning cane before it was cut sterilised the ground. Certainly it offered a degree of protection by ridding the fields of vermin and reducing cane spikes etc. Cane burning also had economic implications that set up a chain reaction in the industry; millers' profits were reduced because the sugar content of burned cane was more costly to recover and unless harvested immediately after burning the stand deteriorated rapidly. The miller compensated by paying less for burned cane and the farmer, in turn, docked the cutters' wages. The exception was in cases where the burn had been ordered by the cane inspector. The normal twenty percent wage reduction was unacceptable to the cutters and was seminal to long and continuing industrial disputation in an industry not noted for its all-round reasonableness, as Murphy has mildly remarked.53

A proven link between fever outbreaks and the sugar industry in 1933 would certainly have sparked off industrial trouble and jeopardised the valuable harvest. Forgan Smith, his eye on the depleted Treasury, probably saw an uncomfortable historic parallel with the dilemma that had faced Sir Samuel Griffith in 1892 when, in order to save the sugar industry, he had been forced to retract his promise to end indentured labour. Otherwise, 'there would not have been one single shilling to pay the salary of any civil servant in Queensland on the following pay day'.54 Under similar compulsion, Forgan Smith had made the decision to ignore the crisis and thereby guaranteed a severe backlash when the abnormal weather pattern continued into the next crushing season and the concomitant fever outbreaks extended to the industrial flashpoint of Innisfail. This was to bring Cilento back into the picture.

The intercurrent Kenny crisis was inescapable because the government was caught in the cross-fire between strident public opinion demanding official recognition, and support for an unregistered therapist whose muscle re-education skills had caught the popular imagination, and the BMA which officially stated that such a move would be criminally irresponsible and argued fiercely that as Sister Kenny had no knowledge of anatomy, physiology or the pathology of the disease, her

53. D J Murphy, T J Ryan (St Lucia: University of Queensland Press, 1975), p. 171

treatment might well be harmful in the longer term. Her image as a faith healer would attract patients away from trained therapists and therefore was doubly dangerous.

'Sister' Kenny, whose courtesy title stemmed from her World War 1 service, had a long history of success in muscle re-education. In the wake of the everpresent cycle of epidemic poliomyelitis, with its pathetic overtones, parents of victims, usually educated and articulate (since polio is a disease of affluence) were demanding that Sister Kenny, commonly said to obtain cures faster and more often than did the medical profession, should be given a chance to teach her skills to others.

Health Minister Hanlon was in a cleft stick. He was a most compassionate man and the plight of cripples touched him deeply. He was, as well, suspicious of the self-interest of the organised profession on the one hand and highly sensitive to political pressure on the other. Yet he dared not sanction unorthodox treatment without the support of reputable and impartial medical opinion and asked Cumpston to second Cilento to act as honest broker in the dispute.

Cilento was well prepared. He had been acquainted with Kenny's work much earlier by Charles Chuter, Assistant Undersecretary of the Home Department, a most ardent supporter, and had made it his business to look at her work unofficially in July 1933, as he passed through Townsville, where she was working unaided and unpaid. He described her as a powerful woman with a commanding presence and direct gaze, and was genuinely impressed by her dedication to her patients and her belief in herself. She was supported only by her Army pension and royalties from appliances she had devised. On Chuter's invitation he had attended a demonstration of her work at the Brisbane General Hospital on 5 September 1933.

Following instructions by Cumpston to examine and evaluate Kenny's treatment, Cilento at once began an intensive study of the small, ill-assorted sample of patients being treated by Sister Kenny in makeshift premises in Townsville, rented for the purpose. Lack of established criteria of assessment and of objective case histories was an obvious bar to reliable appraisal. To overcome this difficulty in the future,

55. Cilento, letter diary, July 1933, Fryer coll. 44/22
two local doctors, Guinane and Taylor, were appointed as recorders to the clinic, and Dr Alan Lee of Brisbane retained to examine the same patients at regular intervals to provide dependable records of progress. Before compiling his report, Cilento interviewed as many parents, patients, doctors and masseurs as possible seeking information and opinions relevant to his inquiry.

In default of evidence to the contrary and bearing in mind that it was impossible to determine how much recovery was due to treatment and how much to natural process, Cilento concluded that Sister Kenny had produced results remarkable enough to attract the surprise and inspire the confidence of both medical and lay witnesses. He was particularly impressed with two features of her treatment, apart from which, he stated, he could find nothing new in her method.

These features were the use of suggestion to instil confidence in the patient at the outset (thus countering the expectation of defeat which attends so much routine therapy), and the technique of provoking reaction in affected limbs. Whereas Sister Kenny saw this as a God-given power to transfer stimuli directly from herself to her patient, Cilento saw it as a function of her personality and did not believe it could be taught with ease to anyone else. Nor did he believe that anyone could regenerate a nerve once dead.

With a blend of hope and caution, Cilento concluded his report by saying:

... if this early provocation of volitional response could be coupled with adequate massage and other stimulation in selected cases... a progressive step might be made in the treatment of cases of paralysis, and their re-education materially accelerated.

His findings as a whole indicated that, in his opinion, Kenny may have stumbled upon a method of treatment that could be of value in muscle re-education and he

58. Ibid
59. Ibid, p. 15
60. Ibid, p. 16
recommended that this be given a trial under supervision and critical eye of the medical profession, a proviso which angered Kenny.  

The report was sufficiently positive to enable Hanlon to advise the Prime Minister on 2 November 1933 that a clinic would be set up in Townsville, to function until June of the following year, for the treatment by Sister Kenny of poliomyelitis victims under the supervision of Dr Dungan in connection with Drs Taylor and Guinane. Dr Alan Lee and Dr J V O'Neill were to assess progress. Dr Cilento would examine and report again on Sister Kenny's work at the end of that period. During that time, she was to instruct others in the use of her method. Hanlon too, had been cautious. Only under medical supervision with a wide range of checks and balances, would her treatment be investigated and evaluated.

Cilento's adjudication had won a welcome respite for Hanlon although the Kenny question was later to bedevil their relationship.

During his four years in Queensland he had done much that was innovative and beneficial for the cause of public health. Long term policies of planned health reforms in Queensland and, by extension, in Canberra, had been put into logically designed form by an administrator of experience and acuity. The Hookworm campaign had been re-started and extended into New South Wales. Support for epidemiological research into Aboriginal health had been won in the Federal Health Council. A keen observer of life with a knowledge of indigenous peoples and of the Italian language and customs, he had moved about among the people of north Queensland and based on first hand observation and personal records several official

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61. In her words: 'I do not want medical men to discuss whether or not my work is valuable because I know what it will do. It has taken numbers of cases over a period of ten years which were regarded as incurable by doctors ... and it has restored them to the community as citizens able to earn their own living. I do not want, therefore, medical men to tell me whether or not my method is possible, because that is no longer in question: I want them to tell me how best this new knowledge of rapidly restoring paralysed people to health and strength can be applied where it is needed'. Quoted in Cilento, ibid, p. 11
accounts of their health and social needs, enlightening to the community as well as to medical men and governments. He had not been able to change social attitudes and values, but had shed light on those areas where he saw such change as desirable. He had assisted both the government and the profession with expert advice on special matters.

(b) Senior Medical Officer (CDH) 1933-1934

Since his first appointment as Director of the Institute at Townsville in 1922, he had always been king of his own castle, free to create a sphere of influence and exercise the prerogatives of an innovative officer supported by both Elkington and Cumpston and later, as well, by authorities in Canberra and Geneva. Gradually, by a process of attrition, his professional freedom had been strangled. In February 1934, he took up duty in Canberra, surely the most unwilling and unwelcome of promotees. A tropical man in all respect, he detested 'that dreary, detached public service mortuary chapel called Canberra'. But as he now had five children to support, he had little choice but to stay there until he obtained another post. He dreaded being under the thumb of Cumpston who, he believed, was constitutionally unable to delegate responsibility. Cumpston had designated Cilento 'Senior Medical Officer', not Deputy Director General. The implication was clear; his role was to be as nebulous as his title and he was to have no power of initiative. Of their first conference in Canberra Cilento wrote:

Cumpston told me that he wanted me to take off his shoulders the whole burden of the tropics... that he must rely on me for the elaboration of his ideas, gave me Heiser's visit (to-day) ... the Territorial Conference in a few days' time etc. etc., ... I was not going to slip on it... Matters are too delicately poised here for me to lose one point even.

The tension in this letter needs no underlining; the distribution of duties reveals Cumpston's realistic appraisal of those areas which he could leave to Cilento (subject

62. R W C to P D C, letter diary, March 1934, Fryer coll. 44/21
63. R W C to P D C, letter diary, 19 February 1934, Fryer coll. 44/21
to his supervision). He saw fit to repose in him the diplomatic handling of Heiser, who held the key to Rockefeller funds necessary to hold Australia's position in the Pacific (now being challenged by America). He excluded Cilento from the Territorial Conference for which he had prepared the agenda but required him to be on tap during the discussions; this was humiliating in the extreme, particularly as it was attended by his former associates.

Writing letters for Cumpston to sign, elaborating another's ideas, was a form of professional obliteration Cilento was too proud to accept, and he soon told his Chief that he intended looking for another post. In July he was a favoured contender for the position of Administrator in New Guinea; a 'ginger group', opposed to the custom of appointing retired armed services' officers to this post as a sinecure, supported his candidature in principle. He was shortlisted. However, tradition held and the coveted job went to Sir Walter McNicoll, a retired General and prominent Victorian Liberal Party man. Cilento believed that Cumpston had worked against him in this matter and thereafter his position in Canberra became untenable. He thought of standing for the Federal seat of Lilley. 'If only we had that 2,000 to spare!' he wrote to his wife.

Cumpston and Cilento had been born into an era which admirably suited their abilities, but also in a particular state of world development in applied hygiene. Their mutual difficulty was that they were decades ahead of their time in their perception of the relationship between medicine and society. It was not their fundamental attitudes to public health that were at variance but rather their respective orientations. In time they were bound to polarise. The evidence of history (and of Cilento's diaries) is that the two men had been friendly and mutually supportive while their career interests had coincided. What made them finally

64. Hermant and Cilento, 'Report of the Health Mission to the Pacific ...', Fryer coll. 44/112
65. R W C to P D C, ibid. (Cilento's letters to his wife at this time are full of despair) Fryer coll. 44/21
66. 'Will Australia Lose New Guinea?' Canberra Times, 20 June 1934
67. R W Cilento to W M Hughes, 19 January 1938, Fryer coll. 44/15
68. R W C to P D C, letter diary, July 1934, Fryer coll. 44/21
irreconcilable once these interests were set in conflict was admitted by Cilento:

He and I were both aspirants for power and sometimes our power desires clashed. It was this that led me ultimately to take up service with the Queensland Government... on the basis of my own proposals for the re-organisation completely of that State's health service. 69

In his memoirs Cilento paid Cumpston a very high tribute in saying that Australia is a healthier place to live because of the work of this man who would brook no competitors. 70

Clearly there was no room for both these men in Canberra. Cilento had another compelling reason for making a move which he could not then state; this was the knowledge that he was in line for a knighthood which could not be issued while he was junior to Cumpston.

On 18 September 1934, there came a telegram from Hanlon offering him the position for which he had so long prepared himself. With enthusiasm and no doubt with great relief he accepted the post of the first Director General of Health and Medical Services in Queensland. As a preliminary he was instructed to spend a few weeks looking at health services in southern capitals, but the Weil's disease time bomb exploded in the north and he was recalled to deal with the emergency.

69. Cilento, 'The World...', (Ch 15) p. 1 Fryer coll. 44/1
70. Ibid
PART TWO
1934-1946 Queensland Government Service

(a) The Decade of the First Director General Health and Medical Services

Preamble

The stage has been set for the central purpose of this monograph; to describe the role and influence of Raphael West Cilento in the re-organisation and extension of Queensland government health services in the 'thirties' under E M Hanlon as Minister.

As with most colonial beginnings, regulations governing health in Queensland had been introduced ad hoc and had accumulated into a haphazard collection of duties and responsibilities with much confusion and overlapping within and between government authorities and departments. The State had now matured to the point where it was necessary to rationalise and co-ordinate these activities for greater economy and efficiency. Reorganisation mostly concerned the Home Office, a vast unwieldy department where most health and medical responsibilities were divided indiscriminately between the desks of the Undersecretary and the Assistant Undersecretary as part of a multitude of disparate duties.

In the wider sphere there was urgent need to regulate relationships between the government and the practising medical profession and to establish a medical school and medical research facilities then wholly lacking in Queensland.

These aims required wide-ranging enabling legislation and far-sighted policy changes which Cilento had tentatively put in administrative form as far back as 1931, as has been noted. In designating him Director General of Health (that is public health, preventive activities) and Medical Services (treatment of the sick
insofar as this concerns government, the most obvious examples being public hospitals), the government recognised both his administrative and medical qualifications to mastermind the reform.

This chapter looks at the important changes in government health policy and management under Cilento as Director General and is, in effect, a summary of the material contained in subsequent chapters of this section, each of which develops a separate aim of the comprehensive plan of reform in the light of its special application. In this way, Cilento's contribution to the progress of Hanlon's comprehensive health reforms is demonstrated in the working model of his suggested paradigm.¹

1. R W Cilento, Preliminary Report to the Minister on the Re-Organization of the Home Department to provide for a separate or co-existent Ministry of Health. HHA 1, 10 December 1934, (QSA). This is a landmark document and will be noted hereafter as Preliminary Report to the Minister...
CHAPTER FIVE

(b) Themes and Issues

Alexander himself expressed astonishment at those who thought that the hardest thing was to win an empire; the greatest task is to set it in order.

Plutarch, Mor. 207 D

Health as a subject touches most areas of public usefulness. There are formidable barriers to its ordering; the more so since it is invariably complicated by social, economic and political factors and emotionally charged issues. This dissertation rests on just such a complex and pause is taken here to set the stage and bring the dramatis personae of this turbulent phase into sharper focus.

Raphael Cilento was nearing his forty-first birthday when he was commissioned as Queensland's first Director General of Health and Medical Services in October 1934. He knew both the people and the problems connected with his new office, and his influence on the Premier, Forgan Smith, had been such that the government was now prepared to base massive health reforms on his proposals of which the Premier had long been aware. He had been advising Hanlon both officially and unofficially since the latter assumed the health portfolio in 1932 and was well-known to Charles Chuter, who was about to become Head of the Home Department. He and his wife were both highly regarded public figures in Queensland.

Cilento's plan had been predicated upon the establishment of a Ministry of Health headed by himself as Director General.2 The government had accepted this but in the event Forgan Smith could not afford to enlarge his cabinet and the compromise solution was the division of the Home Office into the Department of Health and Home Affairs in January 1935.3 Cilento, by virtue of his title, expected to be in charge of the health moiety at least and, at his insistence, health was put

2. R W Cilento, Preliminary Report, introduction, p. 7, Table 111
3. Courier Mail (Brisbane), 23 November 1935
first in the name of the dual ministry. He had the privilege of allocating the internal spaces in the department's new premises in William Street and the connecting door between him and his minister was a political statement. His predecessor as Commissioner of Health had a restricted range of public health duties and reported to the Assistant Undersecretary. Cilento, whose duties and responsibilities were yet to be defined, could not operate under subordinate constraints. To accomplish his task, he had stipulated as a condition of his employment that he have access to the Minister. Hanlon honoured this agreement when he introduced into the parliament a short but significant Bill especially 'to instal Dr Cilento as Director General of Health and Medical Services in charge of the Department of Health'. There could be no plainer statement of intent. However, until a new Health Act established the legal basis for the projected Health Department, Cilento's powers were uncertain; for example, he had no budget allocation of his own and was beholden to the Undersecretary to fund his initiatives. Inherent seeds of conflict between Cilento and Chuter inevitably sprouted vigorously.

Cilento's non-pensionable contract was for seven years and was renegotiable. The salary of 1500 pounds per year with annual increments of 100 pounds to a ceiling of 2000 pounds was, in raw terms, slightly higher than the Premier's. It was also free of normal public service charges. This was a very high salary and indicates that the government was prepared to pay for what it considered to be the best service available. Nevertheless, Cilento had left a permanent and pensionable position in Canberra and was the wrong man to have forsaken security and the status of second in charge in the Commonwealth service unless he had been promised the top job in Queensland implied in his title. What happened eventually makes enlightening reading.

It is now possible to introduce the main themes of Cilento's term as Director General of Health and Medical Services (hereafter Director General).

4. E M Hanlon, Health Acts Amendment Bill, 21 November 1934 QPD VCLXXV, p. 1580. During the second reading both sides of the House paid high tribute to Dr Cilento. Moore, leader of the Opposition, queried the principle of Cilento's salary being exempt from normal public service charges but did not question the amount of it. His other reservation, clearly indicating that he assumed Cilento would have his own budget, was that doctors are not, as a rule, expert financiers. Hanlon disagreed strongly on that point.
First, there was the breakdown of the system in which local charities had built, managed and maintained public general hospitals through a committee network. For reasons outside this discussion the system became unworkable first in Queensland and again in its major hospital, the Brisbane General. The task of revitalising a body which, financially, was scarcely breathing fell to a very able officer in the Home Department named Charles Chuter. In 1917 the hospital had been incorporated as a sub-division of that department to prevent its closure through lack of funds. In 1922, Chuter rose to the position of Assistant Undersecretary, thereby assuming responsibility for the administration of the Hospitals Act. From that time until almost the end of the next decade, he was engaged in devising a legislative structure that would enable the state government to administer the Brisbane General and other major public hospitals in Queensland; a method of paying for them was needed which would involve both the local and state government authorities. The state government took the view that if it was to pay sixty percent of the shortfall of projected hospital budgets and the local authorities forty percent, it was going to call the tune. This last point provoked a bitter struggle with the honorary medical staff at the Brisbane General Hospital, who had hitherto made the important decisions in the running of the hospital. In 1936 the government finally assumed financial responsibility for public hospitals in Queensland apart from one or two run by the churches. This fight, though not of Cilento's making, was of enormous importance in shaping his relations with the medical profession.

A landmark policy change, enunciated in the Hospitals Act 1923, had created the Brisbane and South Coast Hospitals District by amalgamating five major hospitals and constituting the Board of the same name to manage the entity so formed. The Board came into being in 1924 under the chairmanship of its architect Chuter; he remained chairman until 1930, after which he served nine years continuously in the executive capacity of Deputy Chairman and Finance member.

5. Through their Medical Advisory Board whose recommendations were usually accepted by the Brisbane and South Coast Hospital Board controlling the hospital; wanting more than advisory status, the doctors were fighting for representation on this Board.

6. Most notably, the privately funded Mater Misericordiae General Hospital.
The City of Brisbane Act 1924 was, in a health sense, complementary to the above-named Hospitals Act. It was a charter of self-government under which the city fathers became custodians of the public health of the metropolitan community. In effect, the two statutes combined to place one third of the population of Queensland and its five major hospitals outside the control of the State government health authorities, except during epidemics.

The status of public health administration is the next theme. A Commissioner of Public Health had been appointed at the beginning of 1901 at a time when his responsibilities covered mainly environmental sanitation (water and wastes), control of infectious diseases and some rudimentary supervision of 'pure food'. During the next three decades public health gradually progressed to embrace preventive clinical activities such as school health services, venereal disease services, health of the railway workers and so on. A number of medical officers engaged in such work reported directly to the Home Secretary or were employed in other departments. In addition there were the activities of the various local authorities such as health inspectors. Each of these responsibilities, including hospitals, contributed to the cost of health control. To reduce what was seen as an enormous total expenditure it was necessary to co-ordinate the activities of all these authorities as closely as possible.

Cilento put these aims for centralised control in an unambiguous form, the legal expression of which was the Health Act Amendment Act of 1936. Complementary statutes enacted at the same time, were its mirror image, the Local Government Act and the Hospitals Act. Paramount over other laws in this subject area, was the Health Act, 1937, under which all three 1936 statutes were condensed and consolidated. This was a logical, exemplary document, an indication of administrative expertise of high order in its authorship. (The Health Act Amendment Act of 1936 was subsumed under the Health Act of 1937 and thereupon repealed).

The third sphere was mental health. Queensland's mental hospitals had functioned previously as an entity engaged in clinical activities; their superintendents reported to the Home Secretary. This service was brought under the Director General's control. Two perceptive and exhaustive pieces of legislation, the Mental Hygiene Act and the Backward Persons Act, 1938 were designed to improve the treatment and status of the mentally afflicted.
The fourth of Cilento's interests in which he led government thinking concerned the official legal relationship between practising doctors and the governing authorities of the community in which they resided. Ever since the English Medical Act of 1858 defined the 'registered medical practitioner', the legal bases of such relationships have by convention been termed 'medical acts.' The need to review the medical profession's legal status in Queensland had become pressing. Since the original Medical Act of 1867, the only amendments (in 1925, 1932 and 1935) had been of a piecemeal nature. Cilento wrote a completely revised set of registration requirements for medical practitioners and for those doctors who claimed specialist status. He made the Director General Chairman of the Medical Board, delineated negligence and malpractice, set up a Fees Tribunal and a judicial body to hear appeals against decisions made by the Medical Board. This was Cilento at his best. The Medical Act of 1939, incorporating his innovative ideas, placed Queensland years ahead of the rest of the country in this sphere.

Together, these laws provided Queensland with a modern, efficient structure for the administration of public health. They are a lasting testimony to Cilento's major skills in conceptual and administrative thinking. This was a fertile period for Queensland's health and welfare services. Hanlon's massive hospital building programme was completed at this time. Cilento was also successful in many related fields: reorganising the Laboratory of Microbiology and Pathology, introducing research and statistics services, upgrading medical services, establishing the Radium Institute, and introducing the Queensland branches of the Health Education Council, Nutrition Advisory Board, and National Fitness Council. He set the foundations upon which Edward Derrick was later to build the Queensland Institute of Medical Research. Cilento was a most active agent in the founding of the Queensland University Medical School, where he became its first Professor of Social and Tropical Medicine, a discipline of his own devising. He brought under the control of the Director General both the Government Health Laboratories and the physical and medical supervision of private hospital standards.

Public hospitals, curative institutions, were traditionally outside the purview of public health departments. Cilento, denying any dichotomy between prevention and cure as legitimate concerns of medicine, argued that the medical, as distinct from the clerical, side of hospital control should come under the surveillance of the health department. These ideas are developed in the context of the Hospital Act in a later
From acts to action, the story can now be carried by events following upon Cilento's widely acclaimed appointment. The leading Brisbane editorial comment of the day summed up popular and indeed professional sentiment enthusiastically:

If the government contemplates setting up a distinct Ministerial Directory of Health to take control of all public health activities it is acting wisely in having the whole ground surveyed by an experienced medical officer who is fully seized with the importance to Australia and to Queensland of tropical hygiene and for the carrying out of this work the State will heartily welcome back Dr. Cilento.

Naturally, Cilento was delighted by the warmth and acclaim that greeted his appointment but this was not the time to take a bow. With all eyes upon him he was required to establish the credibility of the government's public health commitments, especially in relation to tropical diseases, which at that time were still uppermost in the public mind. Panic arising from continued Weil's disease outbreaks in Ingham had been building up since the 1934 crushing season opened in June:

Thirty-six new cases appeared within a month, two of them proving fatal... In August eighty cases were reported in ten days and a further six cases in September. All the patients were healthy males and all were working in the sugar cane.

Forgan Smith's gamble of the previous year had failed. The abnormal wet had continued its sporadic pattern with consequential disease outbreaks menacing the community.

7. Cilento, Report to Minister, p. 22
8. Courier Mail (Brisbane) Editorial, 19 September 1934.
   Charles Wassell, President BMA Queensland to R W Cilento, 17 May 1935, Fryer coll. 44/11
9. Menghetti, The Red North, ibid, p. 30. Cilento's version is that in 1933 and 1934 Morrissey clinically diagnosed 158 cases with 21 cases of jaundice and 7 deaths. R W Cilento, Tropical Diseases in Australasia (Brisbane, 1940), p. 112
Dr Morrissey, the Ingham practitioner who had been valiantly coping with the epidemic since it began in 1933, immediately appealed to the Commissioner for Public Health in Brisbane but as he had neither research facilities nor an appropriately trained 'bench man' he was unable to help. Not until 7 August 1934 was Dr Sawers, a specialist pathologist formerly of the AITM, despatched from the Sydney School of Tropical Health. Within a week, he and an assistant had identified the Weil's disease, leptospira, in a human sample while almost simultaneously Dr Tim Cotter confirmed these findings in a laboratory animal.\textsuperscript{10}

This outbreak precipitated a short but effective strike in Ingham which generated some violence and community antagonisms.\textsuperscript{11} The Australian Workers' Union (AWU) won from the industrial magistrate an order to burn cane before cutting it in the Ingham district while the cutters agreed to accept a ten percent reduction for handling it. This became known as the Ingham rate.

The real industrial stimulus began when the disease broke out at Innisfail which, for reasons beyond this discussion, had become a stronghold of the Australian Communist Party. Government concern was to contain the industrial backlash which threatened the traditional leadership of the AWU in the area.\textsuperscript{12}

The outbreak here was reported on 5 October 1934. Immediately a local committee was formed to instigate anti-rat control measures, using poison baits and insisting that all cane be burned before it was cut. This latter measure was favoured by the cutters, who believed that it sterilised the ground which had been contaminated by the rat urine that carried the disease organism.\textsuperscript{13} It soon became

\textsuperscript{10} G Morrissey, The Occurrence of Leptospirosis in Australia Med.J.Aust V.2 1934, p. 496 et seq.
T J P Cotter and W S Sawers, A Laboratory and Epidemiological Investigation of an Outbreak of Weil's Disease in North Queensland, ibid, p. 597

\textsuperscript{11} Menghetti, ibid

\textsuperscript{12} For an extended study of the rise of Communism in north Queensland see D Menghetti, The Red North, ibid. A useful oral source was recorded by Fred Paterson, Australia's only ACP representative (MLA for Bowen). Interview with Fedora G Fisher, Fryer Library

\textsuperscript{13} Courier Mail (Brisbane), 6 October 1934
obvious, however, that many farmers were ignoring the order to burn.\textsuperscript{14} On 10 October the government set up a Weil's referral centre at Innsfail under Dr Mathew while the local committee pressed for the enforcement of burning orders. On 16 October a big anti-rat offensive was mounted on the orders of the industrial magistrate. The costs of this were to be borne equally by the industry, the growers, and the Local Authority. The industry, resenting both the order to burn and the cost of the clean-up operation, retaliated by reducing the cane cutters' pay.\textsuperscript{15} Thereupon four hundred men went on strike at Mourilyan, demanding that all cane be burned and the penalty for handling it be reduced to the Ingham rate.\textsuperscript{16} On the next day, 17 October, Cilento arrived in Ingham after a forty-four hour journey, having been despatched by the Premier on the first train after he had arrived in Brisbane.

In departing from the usual processes of industrial arbitration because of the health problem at the heart of the crisis, Forgan Smith laid a heavy burden on his new chief health executive. To the Premier and sugar industry leader now facing an election here was a portentous situation fraught with political and economic menaces. The problems were compounded by the community confusions and antipathies which flowed from the government's cavalier treatment of the epidemic of the previous crushing season. To a public health man the epidemic always posed the chief professional challenge; in this case, however, Cilento's first task was to settle the strike.

\begin{enumerate}[\textsuperscript{14}]
  \item Ibid, 8 October 1934
  \item Ibid, 16 October 1934
  \item Although he valued the process for other reasons, Cilento doubted that burning cane sterilised the ground. He saw Weil's as a typically urban disease affecting sewer workers and, by extension, those who came into contact with rat-infested slime in an agrarian environment, not necessarily canefields. Before the mechanical harvester lifted men above this danger zone J I Tonge had shown that leptospiroae survived cane fires while researchers in the fifties proved, inter alia, that Cilento's earlier assumptions about environmental as distinct from industrial links with leptospirosis were correct. R W Cilento, Weil's Disease and Rat Control, Health Service Publication, Queensland 1933. J I Tonge and D J W Smith, Leptospirosis Acquired from Soil, Med.J.Aust, V. 11, 1961, pp. 711 et seq. E H Derrick, D Gordon, C J Ross, R L Doherty, C Sinnamon, V Maclonald and J M Kennedy, Epidemiological Observations on Leptospirosis in North Queensland, Australasian Annals of Medicine, V. 111, No. 2, May 1954
\end{enumerate}
On 22 October a Weil's death occurred at Innisfail and the mood of the men became ugly. Pay rises granted to the Mourilyan men during the previous week were being demanded elsewhere on the canefields. Two days later the Industrial Court decreed that the burning of all cane was mandatory under law.

Cilento saw this as a chance for compromise. Not all farms, he stated, were rat farms, nor was burning clean cane helpful in controlling the epidemic. He ordered therefore, that a qualified State Health Department inspector be retained by each mill during the crushing season. No cane whatever was to be cut until the inspector had issued a certificate stating whether it was to be burned or might be cut green. This was the basis for negotiations which settled the strike and saved the sugar harvest. The AWU, whose membership included not only the mill workers but also their parliamentary representatives, all members of Labour Caucus, had for the present, withstood the Communist Party's challenge for the control of the sugar workers.

The government moved swiftly to consolidate its position. Weil's disease was declared an infectious disease within the meaning of the Health Act (it had already

17. Courier Mail (Brisbane), 22 October 1934
18. North Queensland Register (Townsville), 25 October 1934
19. Pencilled minutely in his pocket diary are instructions to be formulated as a guide to these State Health Department inspectors. While clearly not written for the historian, they provide insights into Cilento the public health doctor and precursor of modern industrial medicine. Consider the following extracts:
'Don't discuss burning with the men. They will come to a field already examined and decided on as to its health risks... The decision is final. ...Wherever there is a reasonable doubt resolve it in favour of the men; they are taking the risk... Do not allow yourself to be stampeded by the cutters or the cane inspectors. Do not tie your hands by accepting refreshment or entertainment from the farmers. Explain that you do this to avoid charges of collusion by the men. In the same way remember that the use of mill facilities for transport and the company of their Chief Inspector is merely for aid in the identification of the fields... not for assistance in determining their condition from the viewpoint of burning or cutting green. Idea is to give men the greatest degree of protection with least upset to industry.

R W Cilento, pocket diary, Fryer coll. 44/25, emphasis added.
been added to the table of diseases compensable under the Workers' Compensation Act)\textsuperscript{20} levies for a fund to combat the disease were imposed and provision for research was made. In this manner, the campaign burden was spread throughout the industry. The long scientific pre-occupation with Weil's disease in Queensland had entered a new phase.

Once again an epidemic proved to be the health reformer's best friend. In the exploitation of this one, Cilento gained important ground. Forgan Smith announced that, if re-elected, he would give priority to the establishment of a Ministry of Health.\textsuperscript{21} The demonstration that such a ministry would strengthen government covertly because of its inherently moral force must have made him reconsider the

\textbf{20. Courier Mail (Brisbane), 17 November 1934. By Order in Council, 10 October 1934, Queensland Industrial Gazette.}

In April 1937, in a leading case, Cardillo v the State Insurance Commissioner, Mr Justice F W Webb, President of the State Industrial Court, handed down an important decision relating to the question of whether or not Weil's disease led to permanent disablement. The case was an appeal by Cardillo against a decision by the Ingham Magistrate who ruled that he was not incapacitated in January 1936 in consequence of having contracted Weil's disease in 1934. This was on the evidence of Dr H J Taylor, government medical referee, who examined him and found him fit for work; an opinion counter to that of Dr Morrissey who had supported his claims for compensation since 1934. The magistrate had also been impressed by the evidence of Dr Cilento, who as a medical witness for the crown, had been examined on the nature of the disease. Webb stated, obiter, that intense local interest in the standing of the medical witnesses and in the allegations that malingering by some cutters who had contracted the disease might be encouraged by one of the medical witnesses (a clear reference to Morrissey) had at times obscured the issue. He dismissed the appeal on the evidence of Drs Cilento and Taylor. \textit{Queensland Industrial Gazette, 30 June 1937, p. 442 (present author's precis).}

Into that summing up may be read the political overtones intruded into the case. From evidence elsewhere, it seems certain that while his evidence was valid, Cilento let his right wing politics get the better of him and in effect implied that Morrissey's sympathies with his patients blinded him to their tendency in some cases to manipulate him for their own ends (as Webb had also observed). Morrissey's stand endeared him more than ever to the community and to the AWU members who distanced themselves politically from their party bosses in Brisbane. Cilento, who had not earned the affection of the communities involved as had Morrissey who had treated the victims medically, and Cotter who had supported him in the laboratory, was seen by many of those involved as a doctrinaire Devil's advocate.

The decision set a precedent for the Crown to argue that Weil's was not a permanently disabling disease in the generality of cases.
question of its cost. Regulations gazetted in an emergency tend to remain in force long after their original purpose has been forgotten and Cilento's official arm had been lengthened and strengthened into the vexed area of rat control which is the key to the question of Weil's disease mitigation. Forgan Smith had declared his support for a medical school in Queensland and, to Cilento's intense satisfaction, the need for research into tropical fevers had been underlined by the serious consequences of this outbreak. A further bonus, which Cilento was to spell out later when stating a case for the inclusion of a section of Industrial Hygiene as a function of his new health department and its introduction into the curriculum of the projected medical school, was the opportunity to demonstrate that 'the medical negotiator, trained in industrial medicine is not only of great use to the parties but may be the determining factor in achieving settlement'.

This is so because workers, while remarkably impervious to industrial accidents, panic when their workmates begin to die from disease. Black magic assails them. The sugar workers, many of them linguistically handicapped, had known mounting terror over the preceding twelve months caused by the lurking threat of an industrially linked disease which they saw as inescapable and incurable. Doctors fight magic with magic. That is their mystique. Cilento had an additional advantage; he could write and converse in Italian. He had the knowledge and force of personality to show that it was not black magic; to explain in simple, rational terms just what had happened. By means of communication, he 'laid on hands' to calm people down. He had access to important people: leaders in the Italian community, union representatives, mill managers and growers' delegates. He was used to addressing audiences, was lucid, and could describe simple methods by which such frightening episodes could be avoided.

22. The magnitude of this force was commented upon by leading Q C, Mr Rex King, who noted that despite many attempts to change this, the only power of search without warrant in Queensland (in 1979) existed under the Health Act. Courier Mail (Brisbane) 4 November 1979

23. Ibid, 21 November 1934, leader

24. Cilento to Minister. 'Report on the need for a Department of Industrial Hygiene', HHA 11, Re-Org., undated (QSA)
Outbreaks of industrial disease are the more readily understood because the hazards are caused by human processes. The impact of this epidemic was of more use in demonstrating Cilento's dictum that 'habits make the environment' than had been years of formal hookworm education. The province of the public health man starts at the wharves with the battle to keep out rats. In sugar country wet, overgrown harborage provides breeding ground for them, while cane provides food. For that reason, poison baits had limited use because rats would take them only when hungry; they were too smart to be caught by the same poison routinely. At the same time, their predators such as dogs and owls were at risk from the poison. Cilento insisted that harborage be burned and later personally introduced flame throwers into the clean-up campaign. He emphasised the danger of letting men work in slimy water; of the 134 cases reported in Ingham, those tested could in every case be shown to have been working in such conditions. Twenty years later, scientists agreed that the transmission of the disease is linked to occupation where it brings the patient into contact with infected water; i.e. it is an environmental as distinct from an industrial hazard as such. This point had been vital to Cilento when advising on government responsibility for compensating victims.

Finally, Cilento was in a position to have necessary legislative measures quickly enacted and an inspectorate established to enforce regulations. These conditions favoured his handling of the labour relations crisis while personal qualities fitted him to deal authoritatively with public hysteria.

As he made his long journey back to Brisbane, pausing en route to inspect the Kenny Clinic at Townsville, Cilento must have been pre-occupied with his future.

25. R W Cilento, North Queensland Register (Townsville), 20 October 1934, and in local Italian language newspapers and pamphlets
26. Cilento, Weil's Disease ..., ibid, p. 4
27. Derrick, et al, Leptospirosis in North Queensland, ibid, p. 96
28. 'Rat Prevention and Destruction Regulations'. Queensland Government Gazette, 15 November 1934. Although overturned by the industry, these regulations were reinstated successfully; for example, no approach was made to the Industrial Court for burning orders at least until the end of 1935. Each Inspector decided on such orders only when justified. Annual Report of Health and Medical Services, Queensland, QPP, 1937, p. 1063
His former status of unofficial adviser to Forgan Smith and Hanlon had now become that of subordinate officer, particularly in relation to his minister. Whereas he and the Premier had much in common, Cilento and Hanlon seemed on the face of it to be an unlikely team, so much so that the writer ventured to ask Cilento why it was that Hanlon had chosen him. 'Other way round' came the cryptic reply. He was a very old man of very few words when he made this statement but it came so promptly that it bears consideration. Just as Hanlon would have been looking for a capable administrator so too would Cilento have been assessing ministers likely to be in contention for the health portfolio; as he had been discussing the new health ministry well in advance of Hanlon's appointment, he may well have influenced Forgan Smith in this matter.

There is no evidence that Cilento ever lost his personal relationship with Forgan Smith. They shared an intellectual mean and thought as leaders think. From 1934 onwards they were close neighbours who occasionally strolled together in Annerley Park, no doubt talking things over. They had a common approach to organisation based on long term rationalisation and assessments. Both men appreciated higher learning and the value of scientific research. It was in respect of these matters that Cilento relied for support on the Premier rather than the minister, and conversely had his greatest influence on the former.

Hanlon was precisely the opposite; manifestly he did not like doctors as a class although he genuinely wished to have amicable relations with them in a professional sense, while keeping the honoraries under control. Nor was he receptive to long term academic considerations. He was a political pragmatist with a fund of

29. R W Cilento, personal interview, March 1982
30. Members of the Cilento family remember this association very well.
31. David (now Sir David) Muir, who was official secretary to the Premier between 1939 and 1942, affirms that Forgan Smith valued Cilento's advice and judgement. He relied on four close friends, J D Story and senior doctors Jarvis Nye, John Bostock and Cilento as a think tank, especially regarding the development of the university. Cilento was particularly influential in the establishment of the medical school. Fedora Fisher: recorded interview with Sir David Muir, Brisbane, 5 July 1983, Fryer coll. 44/
32. Example of Hanlon's suspicion and indeed distrust of doctors collectively pervades his parliamentary speeches during his term as Health Minister.
commonsense and a humane approach to life. Fairly obviously Hanlon did not think highly of Cilento's assessment of political feasibility, while Cilento was not impressed with Hanlon when he ventured into medical planning. Hanlon's main interest was in hospitals; Cilento was a public health man. Naturally they had their differences but they complemented and understood each other. Both had great zest for their task as reformers and proved to be a dynamic combination. Although Hanlon unceasingly reminded the parliament and, in his own lively press articles, the public, that Cilento was a man of outstanding capabilities, there is no evidence that their personal relationship was ever other than formal.

In the beginning Hanlon actively sought the advice and later the services of Cilento, whom he probably saw as the strong doctor he needed to support the government in its contests with the honoraries.33

Cilento and Chuter were bound to clash. There was, as has been said, an inbuilt conflict of interests in the re-organisation and division between them of Chuter's territory, the Home Department, which developed into an enduring power struggle.

Chuter's position was understandable. He had not enjoyed amicable relationships with Undersecretary (Sir) William Gall who retired a little early to make room for Cilento. With the top job now within his grasp, Chuter was not about to have his territory arbitrarily carved up by the Young Pretender, MD, who had been appointed to do just that. Whereas he appreciated the need for the rationalisation of his department he was not prepared to yield one iota of control of hospital policy to the medical profession as represented by the Director General. The principle of medical versus lay control was the departmental battle line between Chuter and Cilento from the beginning.34

33. As demonstrated in his handling of the first confrontation between Sister Kenny and the BMA in 1933.

34. In his Preliminary Report to the Minister, Cilento suggested that the position of Undersecretary be left vacant until re-arrangement of intra-departmental responsibilities had been decided; a suggestion with ominous portents for Chuter, ibid, p. 18.
Cilento for his part had always started at the top and had not been house-trained in the unwritten rules of public service procedures. According to Allan (later Sir Allan) Sewell, then personal assistant to Chuter, Cilento got off to a bad start by 'poking about below stairs' so to speak. Cilento always based his judgements on personal observation. He was under instructions to study staff performances and duties with a view to rationalisation. By not sitting decently at his desk and calling for reports down the line he almost brought the department to a standstill.\(^{35}\)

Usually three main Acts, viz, the Hospitals Act, the Health Act and the Medical Act controlled this whole area of government responsibility. The Hospitals Act was, to Cilento's chagrin, kept firmly beyond his surveillance. It was Chuter's embattled territory and the legislation which he had laboured so long and skilfully to bring to fruition could not, in any case, be altered to fit Cilento's new-fangled ideas; this was particularly so given the advanced stage of its development and the set of Queensland's political and public expectations of hospital service to the community.

With his pen dipped in gall, Cilento wrote of his involvement in the operation of the new hospitals legislation:

> Under the Hospitals Act 1936 my own association with the hospitals was limited to the selection, or rather a report on the selection of medical officers for hospitals, so that the curious position has arisen that the professional head of this department has no association with the actual treatment of sickness or of provision for that treatment, but controls the welfare only of the leprous, the insane and the dead.\(^{36}\)

Yet, ironically, it had been Cilento's proposal that the Director General should advise on hospital medical appointees, that gave the Act its sharpest teeth.

Cilento's appointment to Queensland was well regarded by the organised medical profession who, for the first time, felt that a voice of medical authority might put forward plans to co-ordinate medical services with a lean to the professional viewpoint. The knighthood which had been conferred upon him in January 1935 was seen by his peers as a distinction that strengthened the voice of medical men vis a vis a

\(^{35}\) Fedora Fisher personal interview with Sir Allan Sewell, Brisbane, May 1981

\(^{36}\) Cilento to Dr P Grieve, Dirranbandi, undated, Pryer coll. 44/11
vis the government and they honoured him with a dinner at which these hopes were expressed. He learned with some dismay that he was expected to champion the BMA in its continuing conflict with Charles Chuter. Whatever his private convictions, as the 'taker of the King's shilling' he was bound in loyalty to the government. To most senior medical men, loyalty to a Labor Government on the part of a colleague, and he a knight, was sheer apostasy.

Hanlon saw to it that his chief health executive retained an arm's length relationship with the BMA while at the same time expecting him to heal the breach between them. Cilento described it as a very lonely post.

Personality factors reinforced Cilento's inner isolation. Unable to accept hospitality during his student days because he could not afford to reciprocate, he never became gregarious; never made time to enjoy the simple human pleasures of rubbing shoulders in the tea room or at the club. Nevertheless, as with his fellow students, Hossfeld and Campbell, he formed life long friendships with colleagues such as Elkington, Meyers, Price, Derrick, Jarvis Nye and others; friendships which were nourished by shared intellectual interests and professional concerns.

This chapter has sought to introduce the main problems that Cilento had been appointed to solve. Organisationally these may be seen as the need to rationalise and co-ordinate public health services within and between government departments, with particular reference to the Home Office.

The terms of his contract with the Queensland Government have been noted; was the Undersecretary or the Director General to become de jure head of the projected health ministry?

Ambivalence surrounding his status is reflected in the fact that although he had the task of drafting important changes to the Health, Medical and Mental Hygiene Acts which reflected the philosophy of and provided the machinery for Hanlon's

37. Cilento, The World ..., holograph notes, (Ch 32) Fryer coll. 44/

38. Cilento to Dr Charles Wassell, President of BMA (Queensland), 24 April 1935, expresses this dilemma with tact and says that, as far as lies within his power, the interests of the profession will be fully protected. Fryer coll. 44/
reform programme, he was virtually excluded from the formulation of the vital Hospitals Act about which he had many innovative ideas.

As soon as Cilento arrived in Queensland in October 1934, he was called upon to settle the strike that followed an outbreak of Weil's disease among sugar workers in north Queensland. This had major political connotations. So successful was his mediation that he was able to convince Forgan Smith that Queensland had special tropical health problems that necessitated a state medical school and research institutions; this focussed attention on the justification for a department of social and tropical medicine in the new medical school and opened the way for Cilento to introduce industrial medicine as an academic discipline and a legitimate extension of the health department.

Space has been devoted to discussing the important people with whom Cilento had to interact; Forgan Smith, the Premier; Hanlon, the minister and Chuter, the Undersecretary and there is a brief word on Cilento's personality.

Nevertheless the reader will fail to advert to the significance of certain points made in this thesis unless he realises the rigid division made between public health and clinical medicine as defined in the preamble to this chapter. This difference exists at a theoretical, practising and emotional level which is why Cilento's title was so unusual; he was presumably intended to be director of two essentially independent branches of state health care.
CHAPTER SIX

The Hospitals Act - 1936- Charles Chuter's Act

Announcing the opening of the new hospital complex consisting of the Royal Brisbane, Royal Women's, Wattlebrae Infectious Diseases Hospitals, and the University Medical School, Hanlon proudly told the people:

Old English systems of pauperdom were transplanted here, with placards over patients' beds to remind them. These have long since gone. The Brisbane and South Coast Hospitals Board planned to build new hospitals from its inception. These hospitals will have a big district base. When complete there will be 1,250 beds. ... Hospitals are now conducted in a spirit of service to the community, not only in settled areas, but in every part of the State. 

As Minister for Health, Edward Michael Hanlon carried out the Queensland health reforms for which his public life is best remembered. Due to his compassion and commonsense, he perceived much sooner than most that the real economic problem in sickness is the hospital. Other reformers had concentrated upon access to a private doctor and a bottle of medicine. Only in the seventies was it forced upon everyone that the hospital is the huge heavy tail that wags the health care dog. To Hanlon, the provision of standard hospital care in case of need was a duty of government; therefore it was imperative to contain costs in what is now called the public sector in order to afford accommodation and treatment on the scale required. Time honoured methods of financing hospitals through charity funds were not only inadequate and increasingly unreliable, but carried overtones that were an offence to dignity, a point on which Hanlon was extremely sensitive. His messianic vision was of the Brisbane General becoming the largest hospital in the southern hemisphere, servicing the entire Greater Brisbane area and, in some specialties such as cancer treatment, the whole state of Queensland. He aimed to provide maternity accommodation in every hospital, base hospitals in regional centres, and a flying

1. The Telegraph (Brisbane), 1 August 1936
doctor service for the isolated.2

In 1938, Cumpston, one of the nation's most eminent medical administrators, paid a handsome tribute to Hanlon's vision, that statesmanlike quality that informed much of his judgement, when he said:

It has always been my experience that Mr Hanlon has shown vision well ahead of our concepts... You have developed a hospital system ... in this State which must excite the admiration of all who see it.3

Since the very survival of public hospitals depended on a reliable system of financial provision, Hanlon owed a great deal to his far-sighted Undersecretary, Chuter, who step by step, had adapted the funding structure to the forces of change that inexorably eroded the sources of voluntary finance upon which they had been founded. To that extent, Hanlon's hospitals were built on Chuter's foundations.

Chuter's personal assistant during that era, Allan Sewell, considered him a great public servant, high principled and extremely competent.4 In a leading study, Chuter had looked closely at the role of local government, measured by the test of its finance.5 A disciple of Sir Samuel Griffith, he believed in the devolution of control of local affairs to involve people in their management at the parish pump level. Practising the art of the possible, he periodically amended the 1923 Hospitals Act (1928, 1929 and 1932) bringing hospital areas under the umbrella of government

2. Hanlon's provision of a maternity hospital in practically every Queensland town continued the work of previous Labor administrations. Since the introduction of the Maternity Act (13 Geo. V, No. 22. October 1922), sixty four buildings for maternity and ante-natal clinics had been opened in country districts in Queensland. 'Labor Government in Queensland 1915-1928', Queensland Parliamentary Papers, V.1 1930, p. 676. By comparison, in Newcastle General Hospital in 1928, there was only one obstetric bed in a total of 268. Dr A D D Pye, personal interview, ibid

3. J H L Cumpston, Official Report National Health and Medical Research Council, Brisbane, 1938, Chairman's Address

4. Sir Allan Sewell, personal interview, ibid

5. Charles Chuter, Local Government, Law and Finance (Brisbane: Smith Paterson, 1921), pp. 60, 61
financial regulations as the failure of the voluntary system spread.\(^6\)

Cilento had no policy influence on the formulation of the 1936 Hospitals Act, the culmination of Chuter's progressive legislation just described. As Director of Medical Services, Cilento had proposed in his preliminary report to Hanlon, that medical as distinct from lay control of hospitals should be transferred to him under this Act, which given their respective qualifications, seemed a reasonable division of administrative responsibility between him and Chuter.\(^7\) For reasons to be discussed, this did not occur; a failure of expectation which not only disappointed Cilento, but was a source of continuing friction between him and Chuter. However, there are more positive aspects of this Act, such as the implications for medical education in its provision for the replacement of the honorary system, which are essential to any evaluation of Cilento's role as Director General.

The organised medical profession and, in particular, honorary specialists resented state intrusion into their professional affairs while rural landholders objected to paying disproportionately high costs for hospital maintenance under Chuter's scheme. The main stimulus for the 1930 Royal Commission into Public Hospitals may well have been the complaints of the powerful rural lobby rather than the quarrel between Chuter and the honoraries as is generally supposed. Bureaucratic changes wrought by the Act were also considered in this discussion which may now be continued along chronological lines.

The government first assumed responsibility for the Brisbane General Hospital, the only one of any size and consequence in the State, when due to patriotic claims on monies raised for war charity, it collapsed financially and was then maintained by the Home Department under the surveillance of Charles Chuter. This occurred in 1917.

In 1922, when Chuter became Assistant Undersecretary of this department, the hospital was still in financial extremis. Demographic patterns were changing. Everywhere the drift to the cities was gaining momentum. In Brisbane, in line with this trend, the proportion of wage earners to property owning taxpayers was

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7. Cilento, 'Preliminary Report to the Minister ...', ibid, Health, HHA/1 10 December 1934, p. 15 QSA
The account given here covers the detail of the local situation but there was a more basic happening which applied to all hospitals after the turn of the century. Surgery became effective and the infections which used to be acquired in hospitals, "hospitalism", were overcome by asepsis and antisepsis. As a result a much greater number of the population now had to use hospitals and their stay therein was much longer than it is at the present day.

This also implied that surgeons with special skills became much more valued and consequently powerful.
increasing. The voluntary and contributory method of hospital funding had insufficient support; it was a principle, moreover that had never been freely accepted in Australian society. Chuter, whose studies had given him an intrinsic understanding of the cause and effect relationship of these phenomena, set about devising a method of paying for both hospitals and public health services in the city, to take progressive account of them.8

As an alternative to outright nationalisation of hospitals, a plank in Labor's platform since 1905,9 the government decided to keep the voluntary system alive where possible by introducing districting, a scheme whereby small, scattered hospitals were replaced by one centrally situated in a designated district. The voluntary system was still integral to the new formula of management; people were encouraged to continue to support their hospitals through shared activity on boards and fund raising.

The 1923 Hospitals Act, which established a mechanism to accommodate districts as they became non-viable, applied only to ordinary hospitals in what was about to become the Greater Brisbane area. The Brisbane and South Coast Hospitals Board (hereafter BSCHB) was constituted to service the hospital district of that name. This was a nine member board with equal representation of subscribers, the local authorities and the Home Office. None of these nominated a medical practitioner to the Board. This Act set the principle that hospital revenue should, as necessary, be provided by the government and the component local authority in the proportion of sixty to forty percent of the shortfall of contributions to the budget estimates of a Board at the beginning of its financial year.10 This was a disincentive to private funding and, as contributions ceased, so government representation on boards was increased. This occurred early in the life of the BSCHB, which administered the district's five main hospitals (including Wattlebrae Infectious Diseases Hospital, which it managed on behalf of the City Council and excluding the privately funded Mater Misericordiae Hospital). All told, this agglomeration serviced

8. C Chuter, Local Government..., ibid, gives an extended discussion of this.

9. Labor in Politics Convention, 1905. In 1913 the Convention extended this policy to include dentistry and optometry and in 1916, to include national health. The 1917 crisis was thus a precipitant rather than cause of the government take-over of public hospitals in Queensland.
about 310,000 people or about one third of the total population of the State. The BSCHB, like the Brisbane City Council as constituted under the City of Brisbane Act 1924 had complete autonomy within its own jurisdiction. When conflated, the health provisions of the two Acts placed this vast proportion of the population of Queensland beyond the surveillance of the state government health authorities, except during epidemics, a situation trenchantly criticised in the parliament and deplored by Cilento and his predecessor, John Coffey.  

The BMA was a long-standing adversary of Labor Government in Queensland. Running battles over lodges, pharmacies, quacks and the nationalisation of public hospitals had been going on for decades. Conscription of doctors in World War 1 had made them apprehensive about government controls over the profession and, even after conceding in the early twenties that nationalisation was the fairest method of financing community medical care, the BMA ruled out any system based on hospitals.

The profession had a proud history of voluntary contributions to the care of the sick, help during epidemics, private investigations into prevalent disease conditions and, most notably, specialist treatment of the poor by honorary specialists at the Brisbane General Hospital, the training ground of the specialists of the future. This elite body of medical men was affronted when a committee of Labor lay appointees to a board on which they had no statutory representation threatened their right to make the important decisions at the hospital, and the old battle intensified around a new epicentre personified by Charles Chuter.

As the administrator of the Hospital Act, Board chairman Chuter wielded considerable power in the sphere of controversy. The aim of the districting scheme was essentially to reduce the number of hospitals in existence and prevent

11. J Peterson, QPD (V) 157, November 1930, p. 2152. Coffey's report on the Health Administration of the Brisbane City Council, following an enquiry he made on the direction of the Governor in Council in June 1933, is a very seathing document. Fryer coll. 44/

Cilento saw this as the most important third of the population, since it was here that organisational provision for epidemics would, in the nature of things, be needed. Preliminary Report, ibid, p. 5

overlapping of expenditure occurring with the proliferation of hospital machinery; such as X-Ray equipment. Since, in most cases, these purchases would have been made on the advice of medical men, the government reasoned that doctors would always dominate laymen on the unassailable grounds that they alone were qualified to judge the needs of patients. Consequently, if doctors were allowed an executive say on hospital boards, government control of funding would be extremely difficult. Chuter, therefore, obdurately resisted all attempts by the honoraries to gain statutory representation on the BSCHB through their own Medical Advisory Board. In fact, that body's recommendations regarding staff appointments were always accepted. Conversely, due to an ancient anomaly, the government could not dismiss a member of the medical staff, although it could be held responsible for his mistakes. As matters stood, moreover, nobody had authority to change from the voluntary system to a salaried medical service at the Brisbane General Hospital. Tact was not Chuter's besetting sin. He believed in the accountability of specialists and said so; he considered honorary service as a means to professional advancement that could not be gained in any other way.

The fervour of the struggle between Chuter and the honoraries reflected personal antipathies, mutually exclusive priorities and, on the part of the honoraries, a perceived threat to their power base in the government's plan to nationalise hospitals.

13. Hanlon, QPD (V) CLXX, November 1936, p. 1752

14. Nationalisation means all things to all men. In its various connotations it bedevils much of the argument in this study. Loosely applied, and as interpreted by the organised profession, it is tantamount to state acquisition of medical practice as an undertaking. This lifts the concept into a highly emotive and contentious area. In fact, as spelled out by Hanlon, Chuter and Cilento in various contexts, the Queensland government sought to 'nationalise' only those activities for which it had to pay, such as the provision of public hospitals and their associated medical services insofar as these were not provided by the users. Government did not intrude into the internal medical management of hospitals and there was never any question of its taking over private medical practice. Queensland public hospitals had never been free enterprise institutions. Chuter had reason to oppose the honorary system. There had been some very bad appointments on the medical side and some irregularities in the letting of contracts for such things as nurses' uniforms by the elite Voluntary Subscribers' Committee. Chuter knew nepotism when he saw it and had the courage to be openly critical of these things. Source: A D D Pye, personal interview, ibid. Editorial opinion, Med. J. Aust. 1938, 1:2 queried the suitability of the system to hospital practice in Brisbane.
Peripheral, but based on the same principle, were the organised efforts of the BMA representing country doctors as a group, to have government lay down conditions of work in public hospitals to protect them from exploitation by those who could afford to consult them privately.

A third issue was the alleged plight of the rural landowners who objected strongly to paying for the cost of their local hospitals in the guise of additional land tax and were pressing for a hospital tax on wages spread over the entire electorate.

In 1930, the Conservative government, led by Arthur Moore, appointed a Royal Commission to look into all these questions. On the subject of hostilities between Chuter and the honoraries, the findings supported the contentions of the BMA. The Commissioners found that Charles Chuter was an unsuitable officer to be Chairman of the BSCHB and ought not to continue in that position. Accordingly, he was replaced as Chairman by T L Jones, later in that year.

From the doctors' point of view, the most momentous recommendation of the Royal Commission was that the administration of the Hospitals Act should be placed under a permanent Commission of three members on which the medical profession would be represented. This was designed to give a certain amount of independence to the hospital administration and free it from political influence.

During the struggles of the twenties which culminated in this Royal Commission, leading members of the BMA looked at possible solutions to the problem of lay versus medical control both at home and abroad. For this reason their progressive ideas for a permanent commission appear curiously at odds with some other recommendations put forward in the same report, which even then were contra-indicated by observable social trends in the society. Addressing the question:

15. Report of the Royal Commission to enquire into certain matters relating to Public Hospitals in Queensland 1930, p. 61 (9)

16. C A C Leggett, The Organisation and Development of Queensland Hospitals, ibid, p. 54. This recommendation was later incorporated in the submission to the Moore Government on behalf of the BMA, prepared by Cilento, Meyers and Price in 1931.
Whether under present conditions the facilities for the training of nurses in public hospitals is satisfactory \(^{17}\) the Commissioners resolved that their working hours should be raised from eighty eight to ninety six hours per fortnight, excluding meal times and recreation, because the existing frequent changes of shift prevented the nurse becoming familiar with her duties to the detriment of her patients. \(^{18}\)

Another recommendation concerning the working conditions of nurses on whose backs the public hospitals of Australia had long been carried, appears in the light of to-day's social attitudes to indicate outrageous elitism and insensitivity on the part of senior medical men. As a gulf between them and Hanlon, it is worth quoting:

> The Sisters, conjointly with the resident medical staff, are allowed a more liberal scale of diets than that allotted to other grades. While offering no objection to the menu granted to doctors, the Commission considers it unwise to differentiate between the several grades of nurses. Such a course tends to create dissatisfaction, but the present dietary for nurses could be slightly improved. \(^{19}\)

Chairman W Harris, dissenting from the findings of the majority report, rejected the principle that Honorary medical staff be represented on the governing board of the hospital. This would exclude the Medical Advisory Board from direct access to the BSCHB. He supported the creation of an independent Inspectorate of Hospitals. For Hanlon, Harris's key statements read:

> Your Commissioner reiterates the view that it is the community as a whole and not any particular section of it that it represents upon Boards in whom the Act vests the responsibility for the administration of hospitals and therefore does not recommend any change from the present system. \(^{20}\)

17. Report Royal Commission on Public Hospitals ..., ibid, p. 8
18. Ibid, p. 30
19. Ibid, p. 34
20. W Harris, ibid, p. 52
But this was a minority view. By and large, the terms of reference set by the Moore government had ensured a victory for the doctors, and in its financial recommendations giving the government the option of paying the hospital deficit by a tax levied on all citizens, a victory also for the landholders. Either way, it was a pyrrhic victory. The hopes of the doctors ended with the defeat of the Moore government soon afterwards, while a closer look at the taxation question revealed that under a hospital deficit tax, landholders would be required to pay more than they were paying under their hospital rate levy. The proposal was therefore dropped like a hot brick.

With the doctors' strategy laid bare in the Commissioners' Report, Hanlon moved to implement its best features in reverse, that is, to government advantage, as soon as he was empowered to do so. Rejecting the hospital deficit tax, he secured the 'power of the purse' by re-introducing Golden Casket funds to subsidise hospital beds at the rate of 10 pounds per annum. This restored cut-backs in hospital funding introduced during the depression by Arthur Moore. At this time as well, Hanlon paid tribute to the honoraries and lay assistants who gave their services freely in order to keep the hospitals going and to provide relief for those who could not afford private medical treatment.

Chuter then took his legislation a step further by providing under the 1932 Hospitals Act, Amendment Act, that hospital boards would consist of an uneven number of two-tier government members whose chairman was elected by the board (this last vestige of democratic pretence was removed in the 1936 Act when the government took power to appoint a chairman who in future would be one of the department's representatives).

21. Ibid, p. 61
22. Hanlon, QPD (V) CLXX, 1936, p. 1489. The pastoral industry in the 1920's had been prosperous and graziers' incomes high.
23. Hanlon, QPD (V) 162, 1932, p. 1225
24. Ibid, p. 1801
25. Hanlon, QPD (V) CLXX, 1936, p. 1749. (He noted that the Moore government removed all Labor representatives from all hospital boards, ibid.)
Hanlon's version of a Hospitals' Inspectorate was that it be composed of laymen. The Royal Commissioners' recommendation that a Hospitals' Commission be established was ignored and Chuter's legislation thereafter omitted all reference to the Medical Advisory Board of the Brisbane General. Officially it had ceased to exist.

The Commission's vicious denigration of Chuter would have withered a lesser man and a lesser public servant. Chuter must have been deeply hurt but was not one whit chastened by their criticism. He was a tough survivor but his antipathy to those members and those features of the BMA which he found objectionable grew to obsessive dimensions as his vendetta against the honoraries continued.

Hanlon stacked the BSCHB with government nominees; a practice he and Forgan Smith had unctuously deplored in their predecessors.

In his preliminary report to the Minister, Cilento stated a powerful case for the formation of a Ministerial Executive Committee along the organisational lines suggested by the BMA, not only as a means of regulating relationships between opposing factions in the government and the profession (as he had been specifically appointed to do) but to provide himself with a power base until the new Health Act was gazetted. It had the further purpose of instituting a basis for mutual

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26. Hanlon, QPD, (V) CLXX, 1936, p. 1748. The Lay Inspectorate was vociferously opposed by Cilento, who in his annual report to parliament entered a strong plea for a medical inspectorate, saying:

There exists no arrangement by which this department can satisfy itself upon the way in which hospital boards are served by their staff in a medical sense; the adequacy of treatment; medical and surgical equipment; operating theatres, numbers of staff; staff conditions. It is impossible for a layman to perform a comprehensive inspection of this type. Their role is to scrutinise expenditure and efficient service in hospitals'.

Queensland Parliamentary Papers (1940-41), pp. 7, 8. To an unusual degree this diatribe transcends the usual bland criticism of one's political masters in official reports and is an example of Cilento's willingness to incur official displeasure in support of medical principles.

27. QPD (V) 162, p. 1228, 1932. Dr W N Robertson, Vice Chancellor of the University of Queensland who, as president of the BMA in 1915, had asked doctors to use their influence with politicians individually to block nationalisation of hospitals, was somewhat vengefully removed from the BSCHB. P D Robin, 'The BMA in Queensland', ibid, p. 127
consideration between himself and Chuter on matters of hospital design, financial management and the like as they affected their respective responsibilities. He stressed that there should be power to co-opt experts as appropriate. Since control must always remain in the hands of the Minister, Cilento proposed that the latter should be Chairman and Executive member of this triumvirate body with himself in charge of medical services and Chuter 'whose experience and knowledge of local government was probably greater than that of any other available officer' advising in his area of expertise. 28

Hanlon did not consent. The immediate reason for this is suggested in a later chapter, but political instinct probably warned him off. He had to get his legislation through. He had been elected to do so. It would in any case have been an unusual role for a Minister. 29 Hanlon was wary of the medical profession and would have been unlikely to expose his powerful reforming arm to the coils of Aesclepius insinuated through his chief health executive. Cilento's role as a mediator was obstructed on all sides. It did not endear him to Chuter or to the medical profession once they realised he was there to beat them, not to join them. In trying to do both, he was attempting the impossible.

'Hanlon did not follow Labor policy, he led it', declared Cilento who knew him as a polite and careful listener who could change his mind but, when unconvinced, did

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28. Cilento, Preliminary Report to the Minister ..., ibid, p. 14. OPD, ibid, p. 1095, 6 provides a good example of inco-ordination between those responsible for hospital design and those for financial provision.

Powers are asked for in respect of Brisbane and South Coast Hospitals Board to raise money for nurses' quarters not provided and lack of which means that a large wing on the verge of completion cannot be used'.

Cilento aimed to prevent future blunders of this type.

29. Cilento may have thought this would be a tactful device whereby both the professional and the administrative head of the same department could receive equal ministerial recognition.
things his way as was his prerogative. He was inordinately sensitive to implications of pauperism or patronage inherent in the benefactions of the rich and classicly expressed to his mind, by the honorary system of specialist treatment at the Brisbane Hospital. Such social attitudes, to him an obnoxious remnant of the English class system, offended his Irish pride and were an offence to the human spirit. In his political wisdom, he identified goals in terms that the electorate could see, use, and understand. This applied a fortiori to the frenetic spate of hospital building which brought the General Hospital to dominate the Brisbane skyline. Even people of means saw in this burgeoning edifice a symbol of sanctuary like the cathedrals of mediaeval towns; concrete guarantees against ruin by illness to the family man earning some 4 pounds per week at a time when a hysterectomy operation cost about 70 pounds and hospital fees likewise; reassurance to a community shaken by the depression and threatened by war.

Prevailing community attitudes of indifference to the sick aged drifting into the city forced them into the General. The public had so much faith in it that they travelled miles to take their cuts and coughs to 'cas' (casualty ward), which was overburdened, while the suburban doctor lost valuable patients. Despite criticism, Hanlon held fast to his purpose of free hospital and institutional service to all who needed it without the humiliation of a means test. (The Means Test was abolished in 1946). As will be demonstrated, Cilento also deplored means testing as an indignity, but he regarded Hanlon's new 'General' as obsolescent from the start.

With its function as a teaching hospital in mind, Cilento entered many a plea for community hospitals. No modern teaching hospital could function as a sort of comprehensive; it must show its students acute and serious illnesses, rare diseases, maternity and surgical techniques. It has no place for the convalescent, the infirm or the sick aged. It cost three times as much as a nursing home, he explained, to keep such patients in a teaching hospital, to the exclusion of the patients it should

30. R W Cilento, personal interview 1980. In a letter to R H Robinson in 1949, Prime Minister Chifley made a similar observation on the character of Hanlon, saying that he was sorry that Hanlon had not agreed some years before to let the Commonwealth join with the Queensland Government in developing Blair Athol and Callide coal fields. Chifley hoped that the developments of Queensland coal deposits on a large scale would provide Australia with ample power in the years ahead. L F Crisp, Ben Chifley (Sydney: Angus & Robertson Paperback ed., 1977) p. 353
attract. Hanlon was unmoved. Like his people, he still believed that the place for sick people was the hospital and the role of the medical profession was to care for them all.\(^{31}\) This placed an enormous burden on the staff.

Chuter, Cilento and the Assistant Undersecretary Robinson, assisted by the parliamentary draftsman Broadbent, began as soon as Cilento arrived to draft the provisions of the Hospitals, Health and Local Government Bills which were reciprocal measures, intermeshed for procedural purposes. Matters such as revenue, budgeting, council debts and borrowing powers (health responsibilities of local authorities) were all reflectively integrated in the core legislation. Given the advanced stages of the Hospitals Bill, Cilento did well to interpolate three provisions, one of which was never implemented. This was the innovation which Leggett, later a noted surgeon and medical historian of the period, saw as so far-sighted: the proposal that the country be subdivided into health units based on a central office. Powers to control the health activities of the local authorities were a necessary conflation. Cilento, anxious to avoid a reform based on outmoded lay control, proposed that medical units so constituted should be operated under divisional health inspectors, but freed from the fear of dismissal by the local authority; a fear 'which at present reduces their work to a non-progressive routine'.\(^{32}\) This revolutionary centralist heresy shocked Chuter's local government sensibilities and was far too hot for Hanlon.\(^{33}\)

About forty years later, Leggett was to write:

There was one provision in the Act, which with a far seeing administration could have provided community health centres in Queensland a quarter of a century before the reforms of the Whitlam Government led to their establishment. The Boards were given authority to provide satellite medical centres with facilities approved by Cabinet .... one

\(^{31}\) Cilento expressed these opinions frequently and publicly, even as early as his preliminary report to Hanlon. But the Minister stuck to his principles: during World War 2, despite a critical shortage of staff, the 'General' housed 1500 patients at times in accommodation designed for half that number. No-one was turned away because of inability to pay.

\(^{32}\) Cilento, Memo to Minister, HHA 11, Re.Org. undated (QSA)

\(^{33}\) Cilento did not perceive the political implications of this proposal; or if he did, he did not recognise the strong rural influence which has always been of paramount importance with all Queensland political parties.
portion of the Act which promised local boards some chance of ... progressive achievement.\textsuperscript{34}

There is historical irony here. It was resistance to change, that caused the government to bury this provision upon which its author had pinned his hopes for progressive reform in that sphere of administration. Time and again his innovative ideas were to be crushed between the upper and nether millstones of political and medical conservatism.

Two other suggestions in an early memorandum from Cilento to the Minister were incorporated into the Act. These read:

a) With reference to the Minister's own remarks that medical officers at hospitals in remote centres should be possessed of proper qualifications and ability, it appears that this can only be done by making all such appointments from Head Office. This will also give a very necessary control to medical policy throughout the State.

b) The question of private hospitals I have endeavoured to cover by a new section in the Bill by putting the licensing in the hands of the Minister as suggested.\textsuperscript{35}

From context, it is clear that Hanlon had asked Cilento to put these policy matters into administrative form, and that Cilento had seized the opportunity to gain ascendancy over local hospital boards by usurping their traditional authority in these two areas of control. Although it did not initiate policy, the form of Cilento's first proposal had far reaching implications which will be examined in a later chapter.

Initiating the Bill in committee, Hanlon paid lip service to the democratic virtues of local control with all the Irish blarney at his command. Hospitals controlled by the people whom they served would be better managed than they would if controlled from Brisbane. Local boards would be responsible for the care of the sick including the prevention and mitigation of illness. Prevention was a new duty as were maternal and child welfare, dentistry services, optometry and, where

\textsuperscript{34} C A C Leggett, The Organisation and Development..., ibid, p. 63

\textsuperscript{35} Director General to Minister, Memorandum, 12 November 1935, HHA/11 (QSA). Copy Fryer coll. 44/11
necessary, the provision of ambulance services.\textsuperscript{36} Despite strong Opposition objections to the broadened definition of hospital board duties, Hanlon insisted that these were reasonable functions of hospitals in the service of their communities, even to the inclusion of research and investigation in the case of Base Hospitals, all of which seems ludicrous when the composition of most country hospital boards is considered. Most were political non-entities who had to be given some status reward for party service. The boards did have power to make decisions where the expenditure of money was not involved but this obviously was a severely limiting factor. Real power was exercised by the central authority; the lay inspectorate of hospitals and control of the purse strings ensured that, although on paper the 1936 Act appeared to give power to the boards to control hospitals (except where the Director General’s veto on medical appointments applied), in fact it did everything possible to circumvent the use of this power. This was Chuter’s hidden strategy, the illusion of local control.

Opposition Leader Arthur Moore bluntly exposed this double standard:

It would be infinitely better for the government to nationalise hospitals and assume full control. It is no use putting limited responsibility on the shoulders of local people and then taking away their power (to do the job as they see fit).\textsuperscript{37}

\textsuperscript{36} E M Hanlon, The Telegraph (Brisbane), 29 August 1936. To appreciate Hanlon’s motivation for including dental and eye care on the list of local government health responsibilities it is necessary to recall the effects of isolation and of the depression on the Queensland community. The incidence of trachoma in outback areas had long concerned government medical authorities. The first attempt to provide dental services to the poor was made in 1908 with the establishment of a Dental Hospital in Brisbane; a function taken over by the BSCHB in 1926. In 1935 the Faculty of Dentistry was created within the University of Queensland. Just prior to this the government decided that it was essential to spread dental services to the people in centres of population outside Brisbane. By arrangement with hospital boards, dental clinics were established in association with Public Hospitals. E M Hanlon, Healthy Teeth, State Health Department Publication, 6 July 1941, Fryer Library

\textsuperscript{37} Moore, QPD (V) CLXX, 1936, p. 1755. For an extended discussion on the provisions of the Hospitals Act 1936 see Supply Debate QPD (V) CLXX, November 1936, pp. 1747 et seq.
The Bill also included a clause giving power to the BSCHB to change from the honorary system to a salaried medical system, which sounded the death knell of the honorary tradition in Queensland.

Cilento did not scruple to criticise those aspects of the Hospitals Bill that were repugnant to him; the exclusion of the medical profession from medical and managerial decision making on hospital boards; the lay inspectorate and the use of local council facilities for preventive work. He did not advocate that doctors should have executive positions on boards, but recommended instead that each medical superintendent be a permanent member of the Health Department responsible through the permanent head to the minister. He should be seconded to the board of his hospital where, within policy guidelines, he could bring professional knowledge and judgement to bear where applicable. Only in this way, combined with a professional inspectorate and local medical service units, could a first class comprehensive health service be maintained. This mechanism too, was manifestly centralist. A centralised paradigm is probably the most efficient that can be devised and the treasurer required that of the Director General. But it had the advantage of making medical men responsible for medical services while leaving the clerical and financial side to those appropriately trained in those fields. Cilento explained to Hanlon that despite the wonderful amount of hospital building that had been done:

Bricks and mortar cannot supply services, they only house them; services themselves need co-ordination and co-operation at all levels between service and expenditure, between ministration and administration. 38 (emphasis added)

But Hanlon was not interested in semantic subtleties. While he publicly acknowledged the sacrifice and the contribution of the honoraries to the welfare of the sick he, like Chuter, saw their motives as at least tinged with enlightened self interest, declaring that it was upon the poor that they must learn their profession. 39

38. Director General to Minister, Memorandum, 4 May 1935, HHA 11 (QSA)
39. Hanlon, QPD (V) CLXX, 1936, p. 1813
Late in 1937, with too few honoraries left at the General Hospital, those remaining were working impossibly long hours. When a surgeon with a bad hand failed to report for duty he was castigated in Parliament. This was too much. The honoraries threatened to walk out.

The lines of battle shifted from the hospital to the Health Department as Hanlon directed Cilento to settle the dispute which had brought the hospital to a state of crisis. Cilento chaired the ad hoc committee which had representatives from the University, the Hospitals, the BMA and the BSCHB, which met to resolve the impasse and find a basis for mutual co-operation between the honoraries and the government. Recalling that emergency meeting forty years on, Dr Pye gave this vignette of Cilento's performance:

As chairman, he had little to say, but I shall never forget how skilled he was at putting together what five other people had said in a fairly long and heated discussion. He called in his typist and in less than two pages of dictation summarised the debate. Not one word had to be altered.

A few days later, Hanlon presided at the conference of representatives of the BSCHB and the honorary medical staff, to agree a joint plan for reorganising the Brisbane Hospital in conjunction with the Queensland University Medical School. Here, Cilento appears to have played the mediator's role, stating 'the medical case for the medical men against the expressed prior instruction of the Minister'.

It was agreed that the honorary system would be phased out and replaced by salaried staff. At issue was whether organisation should be by a system of departments under full-time professors appointed by the Board, or by a unitary

40. There was a shortage of genuine honoraries, such as Ear Nose and Throat specialists but one of the problems with which the Superintendent had to contend was the hordes of general practitioners who came and went at all hours of the day and night to see one or two patients only. Pye, personal interview, ibid.

41. Pye, personal interview, ibid

42. Cilento to T A Price (President Queensland Branch BMA), 8 December 1937, Fryer coll 44/11
system within the Department with the honoraries continuing as departmental heads. Professor H J Wilkinson, by arrangement with Chuter, stated the Board's case for full-time staff and made a powerful appeal on the theoretical side. Cilento on the other hand opposed these appointments on the grounds that it was inopportune to make these changes just as the medical course was beginning and disruption would be inevitable; when men would have to be selected 'blind' and given permanent positions, and so on.43

A compromise position was reached in which it was decided that there should be from two to four departmental appointments at professorial level, with a staff of at least forty-five part-time salaried staff. Consideration was to be given to the appointment of present honoraries, in view of their service to the Board.44 This displeased Chuter, since it left his old antagonists firmly entrenched. On the other hand, with the abolition of the honorary system in November 1938, he won the bitterly contested principle. In helping to establish dialogue between the honoraries and the Board, Cilento restored some harmony to the negotiations and the crisis was defused.

Apart from routine visits to Sister Kenny's patients, the emergency meeting described above was the only occasion on which Cilento entered the General Hospital officially. But whereas he had little to do with hospitals, he came to have a great deal to do with doctors and although unsuccessful in his bid to wrest from Chuter the medical surveillance of these institutions, he eventually exerted considerable influence in this direction by virtually by-passing the boards.

Cilento's power to advise on the appointment and reappointment of all medical officers in government hospitals put teeth into the Act of 1938, so far as these doctors were concerned, for it affected each one of them from the most senior to the newest intern. Technically, his power of appointment was not absolute; on the contrary it was restricted to advising the hospital board concerned as to the fitness of the applicant, but re-appointment was at his discretion and no explanation needed to be given. This awesome power, known as the 'D.G.'s veto', placed a heavy burden

43. Ibid

44. Courier Mail (Brisbane), 8 December 1937
on the Director General, as Leggett observed. Cilento evidently realised the peril in this position and, under a later amendment, a committee was set up to advise him where senior appointments to hospital medical staff were concerned.\textsuperscript{45}

Two other points dear to Cilento's heart were won by his advocacy at the official planning meeting; one was the decision that the Board should move as quickly as possible to establish outpatients' clinics in certain suburbs to take the pressure off the General Hospital;\textsuperscript{46} the other that hours of attendance of part-time honorary staff should be regulated.\textsuperscript{47}

From the skeleton of the most important Hospitals Act in Queensland's history, seen against the background of historical forces that shaped and coloured it, it is clear that Chuter succeeded brilliantly in placing public hospitals on a sound financial footing through central lay control while retaining the facade of devolution necessary to involve people at the local level in some responsibility for their management.

In particular the government's dominant position under the new statute was safeguarded in four ways. The first was the power of the purse by means of general taxation reinforced by budgetary requirements placed upon boards and the power of the lay inspectorate to police expenditure within hospitals. The second was the authority of the central government to appoint the majority of board members, including the chairman who had a deliberative and a casting vote. This ensured that, where finance was a necessary consideration, government policy would prevail. The third mechanism of government strategy was the virtual conversion of the Brisbane and South Coast Hospitals Board into an instrument of government policy vis à vis the organised medical profession. The Medical Advisory Board, traditional voice of the honoraries at the General Hospital, was now silenced; the Board could receive relevant advice only from the hospital's superintendent who had no executive say and

\textsuperscript{45} Leggett, 'The Organisation and Development...' ibid, p. 80. 9 Geo VI, No. 25, 29 September 1943 QPD (V) CLXXXIII, p. 1906

\textsuperscript{46} Courier Mail (Brisbane), 8 December 1935, ibid

\textsuperscript{47} Sir Raphael Cilento, personal interview, June 1975. He recalled the disruption caused by irregular visits of specialists in his student days; he now sought to correct this.
was, in any case, one of its employees. The change in Board structure under the Act had paved the way for government intrusion into the field of medical education, formerly the exclusive preserve of the medical profession. Finally the Undersecretary did not have to consult the Director General on medical matters except the appointment and re-appointment of hospital medical staff.

In spite of all this, the Boards were finally responsible to the Minister and until recent times members were blamed when things went wrong. Ironically, this had been the position of the BSCHB so fiercely resented by Chuter in the days when the honoraries made mistakes. This situation no longer exists; the public does not believe such nonsense.

The Hospitals Act 1936, by establishing the mechanism for financial and political control of public hospital policy, laid the foundation for Queensland's 'free hospital system'; it was to be a decade before this came to fruition. In 1941, Chuter transferred to the Department of Local Government as its permanent Head and in 1944 Hanlon became Treasurer. He was succeeded as Health Minister by Thomas Foley who introduced the 1944 Health Act Amendment Act by which the Department of Health and Home Affairs became the sole source of hospital funding, and all board members, excepting one representing local authorities, became government nominees. The centralisation of government control, like the exclusion of the medical profession, was now complete. In January 1946, with financial help from the Commonwealth Government, treatment at Queensland's public hospitals became free without a means test. (As will become evident, Cilento played a significant role in the early debates at the national level, which led to this development). This above all Hanlon's achievements in a long and successful political career, is his memorial.

While it is certainly true to say that the Hospitals Act 1936 was Chuter's individual achievement and the abolition of the honorary system was a necessary concomitant, this was in no way Cilento's doing. Caught in a collision of social, economic and political forces, the high priests of the profession sold their birthright for the biblical reward to ensure their very survival.

Cilento could not have saved them from this humiliating position; he was obliged to plan to implement government policy. Certainly, he believed that a salaried medical service under professional direction was the best way of guaranteeing that
medical standards could be maintained in a system which was designed for institutionalised care and relied on the efficacy of a hospital bed to provide the sort of hospital treatment that the electorate knew and expected. To that end, he had tried to gain control of the medical side of hospital administration under the Act. This was precisely what Hanlon and Chuter were determined to prevent: collusion between Cilento with his innovative ideas about raising medical standards in hospitals and the doctors who were also deeply concerned by this question. Such collusion would have wrecked the Act.

A paradox in the BMA’s judgement is apparent in McGrath’s discussion of this point. She notes that Cilento’s prediction that salaried medical staffing of public hospitals was inevitable alarmed members of the practising profession who feared exclusion from practice therein.48 In their view, this aligned Cilento with repugnant Labor principles. Her thesis concludes, however, that after 1937, peace between the government and the BMA was achieved by liberal exercise of the very great powers of the Director General and dialogue between his office and the BMA Council in Queensland.49 Cilento, as architect of the system that made this rapport possible was, in its exercise, the original mediator between these traditional antagonists but McGrath fails to recognise the connection.

Similarly, the profession has long forgotten the ancient quarrels, while Cilento’s role as conciliator was probably never really known to the great bulk of the practising profession; therefore the legend persists that he was somehow guilty of professional apostasy. This is both ironical and unjust.

49. Ibid, p. 384
CHAPTER SEVEN

The Re-Organisation of Public Health Services in Queensland -
the Health Acts - 1936 and 1937

Good order is the foundation of all good things.\(^1\)

Editorial comment upon Cilento’s appointment as Director General of Health and Medical Services in Queensland had a positive and enthusiastic ring:

If the government contemplates setting up a distinct Ministerial Directory of Health to take control of all public health activities in the State it is acting wisely in having the ground surveyed by an experienced medical administrator who is fully seized with the importance to Australia and to Queensland of tropical hygiene, and for the carrying out of this work the State will heartily welcome back Dr Cilento.\(^2\)

Public health activities were recognised as important functions of the nation and the State. This was most unusual; such matters were, as a rule, apathetically regarded alike by politicians, practitioners and people. From the tangled roots of their colonial beginnings, these services had sprouted randomly and were now in a state of utter confusion. It was Cilento’s appointed task to rationalise and coordinate them into an efficient, workable system. In addition there were innovations planned which would upgrade Queensland’s public health service and which lay outside the Act being studied in this chapter.

2. Courier Mail (Brisbane), 19 September 1934
Hanlon stated in the parliament that the disparate state health activities would be brought under the control of the Director General and that special emphasis would be placed on prevention: this implied official recognition of the importance of preventive medicine as an aspect of public health and that Cilento would be head of a health department. For a complex of reasons, this did not occur. Cilento found a way to circumvent this bureaucratic disability and instituted a well structured administrative system to carry out government reforms as outlined by Hanlon. Outstanding innovations were in the fields of industrial hygiene, the establishment of the Health Education Council, Nutrition Advisory Board, National Fitness Council and improved supervision of local authorities' health activities. Cilento upgraded the state Laboratory of Microbiology and Pathology and encouraged its research activities very successfully. He achieved an expanded and co-ordinated department with qualified medical men as heads of its special sections.

These alterations were codified at first in the Health Act Amendment Act 1936 which was completely subsumed in corporate legislation proclaimed, not as an amended statute, but as the Health Act 1937, implying a watershed and a new beginning.

In most important respects, this was Cilento's Act. Its contents and its development will now be studied in the context of the man and the times.
Cilentto now entered upon a fresh period of 'aggressive achievement' to recall his phrase of long ago. In bringing to fruition this most pervasive, yet least controversial of Hanlon's health objectives, a new Health Act, Cilentto laid the groundwork of the public health reform.

The central problem was the inherently ad hoc nature of medical administration associated with Queensland's colonial beginnings; the State was now ready for effective and efficient machinery which could streamline these services. Cilentto defined public health as 'those health activities in which the state interests itself as a duty', meaning public hospitals and measures to prevent illness or, as he preferred to say, preserve good health. There was no question of the State's taking over private medical practice.

The year 1935 began auspiciously for Cilentto when he was named Knight Bachelor in the Commonwealth Honours List. He was indeed a happy man; just forty-two years old, he had made his name in the way he would most have wished. The national award was fitting, for although he was known as a great North Queensland man, he always maintained a national stance. He was a proud Australian; no cultural cringe, no sectionalism ever demeaned his discourse or his bearing. He was knighted for distinguished service to Australia, in the mainland tropics, the Mandated Territory of New Guinea and the South Pacific sphere. By his efforts and initiatives he had been seen to earn credit for his country in the eyes of Geneva, London and Canberra.

Imperial honours grace both the recipient and his cause. Prime Minister Bruce was an imperialist and presumably recommended Cilentto's knighthood at the end of his overseas tour of duty early in 1929. His government fell in October that year to the Scullin Labor Ministry and this forestalled the award. Once Cilentto was back in Australia, visibly junior to Cumpston, so high a civil honour was interdicted by protocol. This situation was resolved when he resigned from the Commonwealth service. The knighthood was in recognition of colonial service and Cumpston was in no way eligible on those grounds.

3. Cilentto, Courier Mail (Brisbane), 6 April 1937
4. Citation of Knighthood: possession Dr David Cilentto.
This explanation of the timing of the award is conjectural. What is not in doubt is that Cilento knew that he was in line for the honour and would have been deprived of it had he remained in Canberra. To Cilento it was more than an accolade; it was a vindication of his personal worth and the family origins which he felt had been called into question in his youth and which he had privately vowed would one day be demonstrated by his efforts and attainments. Like most achievers he was ambitious. There can be few men in his position who would have shrugged off a knighthood.

The supreme irony was that Cilento was serving under a markedly egalitarian Labor government when his name appeared on the Honours List. Nevertheless, he has related that Forgan Smith was secretly pleased that his chief health executive had been so honoured. History does not relate Hanlon's reaction, but it is known that he had a very high regard for Cilento.

Friends and reporters calling to congratulate the new knight and his lady found that it was a hectic working day in the home. While scantily clad children shinned up tall palms or hosed everyone in sight, their desperate parents were trying to settle into their new home. Schools had to be found, preparations made for the resumption of the father's legal studies, and before long the mother's medical practice. The demands of Cilento's work left little time for family life and, inescapably, his indomitable wife did most of the parental duties. Community involvement continued. Neither, throughout their long lives, ever found time to rest on the laurels of knighthood.

About this time Cilento endowed a fund to provide for a medal and, in time, an Oration to commemorate outstanding achievement in the fields of native welfare and tropical medicine in Australasia. Designed by him and given in tribute to his migrant forbears and those who had pioneered the tropical north, it was called, predictably,

5. Cilento diary, 1914, p. 5 Fryer coll. 44/16
6. Apart from ample published evidence, Hanlon's son Patrick told the writer this and added that his father had been anxious to secure Cilento's appointment. Personal communication, 1981
the Cilento Medal. Cumpston was less than delighted; he had been omitted from the medal selection committee and wrote rebuking Cilento for perpetuating his name in this fashion. Unabashed, Cilento replied, in effect, better he than the stonemason and clearly implied that one of his reasons for leaving Cumpston's service was to allow his knighthood to issue.8

The Cilento Medal was originally presented at the Institute of Anatomy in Canberra in conjunction with the Ann Mackenzie Oration (also named for its founder, Sir Colin Mackenzie). The disruption of war years, the metamorphosis of the Institute and the ravages of inflation have made the award of the medal erratic. Though relatively few in number, the recipients have all been distinguished men. The most recent award was in 1982 when the recipient was Professor R L Doherty whose research into the problems it recognised is known world wide.

The Inaugural Sir Raphael Cilento Oration was given in Brisbane in 1981 by Dr Trevor Wood under the auspices of the Queensland Branch of the Royal Australian College of Medical Administrators. His title, FOREVER AMBER was a reference to the fact that many of Cilento's far-sighted recommendations of forty years earlier were still stalled at the yellow lights of political expediency.9

In late 1934, however, the powerhouse combination of Hanlon and Cilento had most systems at 'go'. Graphically Hanlon told the parliament:

> We have local authorities all over Queensland who have local medical officers and health inspectors; we have departmental health inspectors. We have all our insanity services in which we have eight doctors... and they have nothing to do with the medical officers of the Aboriginal Department. The Department of Public Instruction employs one doctor; the State Government Insurance Office does likewise. Our Sanatoria and Homes have either full or part-time doctors. We have a host of government officers on salaries - more or less... There is no cohesion, no co-ordination and no direction. In the

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7. W M Hughes to R W Cilento, Letter of approval, Cilento Medal Fryer coll. 44/5
8. Cilento to Cumpston, 27 May 1937, Fryer coll. 44/5
last analysis there is no responsibility but inefficiency and waste.

It is to increase the efficiency of the various medical services that Dr Cilento has been engaged. It has been realised that the public health services of Queensland have been considerably starved and have neither the equipment nor the staff to do really preventive work. I do not value any public health service that is not preventive... the public health service needs re-organisation. We also need a better health consciousness among our people... a service that will prevent epidemics... We have obtained the services of the best medical man available in the Commonwealth to take charge of our services. When he makes his suggestions and if they involve extra expense... and it should be necessary for the government to tax the people to obtain the money, the responsibility will rest on the government of deciding how far they will be justified in carrying out his suggestions.  

Hanlon and Cilento were clearly in accord about the purposes and priorities of public health and about the problems of administering the Health Act as things stood. Hanlon's enthusiastic endorsement of Cilento as Head of the future Health Department was echoed by speakers on both sides of the House. Hanlon had a realistic anticipation of the increased costs of the projected programme and committed his government to support these where necessary. Cilento, too, was cost conscious and resourceful as will be shown.

In this part of the discussion of the new Health Act, the parameters of responsibility envisaged and their correlation and co-ordination as spelled out in Cilento's plan may now be looked at and his performance evaluated in the context of prevailing circumstances.  

Reorganisation required by Hanlon was to be achieved by grouping public health and public hospital medical matters under one Head and servicing health care delivery to the community through the machinery of co-ordination between a

10. Hanlon, QPD (V) CLXVI, pp. 1584, 5 October 1934

11. Cilento, Preliminary Report to the Minister ... ibid, HHA/1 (QSA), 10 December 1934, pp. 9-12
cohesive medical staff responsible to that Head. Public health education and an extension of existing services were seen as a necessary extension of departmental responsibilities underlined in Hanlon's statement. Cilento envisaged a health department consisting of ten sections, seven of which already existed in an uncoordinated and sketchy fashion. Outside departmental range were School Hygiene and Industrial Hygiene, which he planned to bring within it and to these add Sanitary Engineering, a section which at that time did not exist.

There was a powerful case for a separate Ministry of Health not least to allow concentration of the Minister's attention on the expansive and intricate programme envisaged. Had this been financially possible, Cilento would certainly have been head of his own department and the division of duties between him and Chuter, essentially between intrinsic health and local government, matters would have been less contentious. He was aware that the ideal of a separate ministry was not considered financially feasible at the time he drew his preliminary plan and on the basis of that awareness and in deference to the wishes of the Minister had predicated it upon a compromise, dual ministry of Health and Local Affairs. To ensure that he would have the authority to match his responsibility, he devised a form of Ministerial Executive to permit him to function as first among equals in a divided department. His submission to Hanlon in support of this idea has already been adverted to in the previous chapter. The strongest arguments for the concept were these: firstly the question of the re-organisation of the Home Department, which necessarily involved some delicate handling in areas where medical matters were organically intertwined with local government activities (public hospitals being the most sensitive case in point), called for some neutral ground for decision making. Secondly, and flowing from this to the impasse between the government and the BMA.

12. R H Robinson, For my Country pp. 192, 193
13. Cilento, Preliminary Report ..., ibid, p. 6 and p. 27
14. By special enactment, (25 Geo.V No 29, 6 December 1934) a Director General of Health and Medical Services for the State of Queensland, had been appointed by the Governor in Council. By the same enactment, the former Public Health Commission was transferred from the surveillance of the Acting Undersecretary of the Home Department to that of the Director General. This very limited segment of the total health responsibility was all that Cilento could legally administer in his own right until the new Health Act became law more than two years later.
in which Chuter was a principal protagonist, there was Cilento's special responsibility in this matter. To correct the stalemate the government had appointed him as Director General of Health and Medical Services in order that his standing as a medical administrator might have weight with both the profession and the public service at the negotiating table.  

Cilento's third important proposal for the formation of this special consultative committee was that there should be power to add and authority to co-opt persons skilled in either the public service or medical aspects of special policy situations (such as architects or doctors) or qualified to express opinions on behalf of local groups, provided always that their role should be purely advisory. Cilento summed up his submission in these words (the emphasis is his):

... the Ministerial Committee has been so constituted as to provide the fullest expression of both medical and public service viewpoint on every matter affecting funds, new works, new policy, or relationships with voluntary organisations or associations and practitioners registered in any medical or allied subject.

He concluded by saying that it was his belief that only in this way could a situation of stalemate be avoided, a situation which would impede the reform. On the other hand opportunities for co-operation created by such a mechanism would attract the support of the great body of the medical profession.

Cilento's immediate objective was to obtain a policy instrument whereby he could influence decisions within the department untrammeled by his present lack of authority and weighted by ministerial and, if necessary, outside support. As things stood, he was working with both hands tied behind his back.

Chuter, while second in command of the Home Department was not de jure heir to the top job within it. Cabinet could have appointed Cilento permanent head had it so wished. There seem to be three discernible reasons why this did not happen:

15. All Hanlon's public statements at this time and Cilento's various draft proposals for the re-organisation of the Home Department, assumed that Cilento would become permanent head.

16. Cilento, Preliminary Report ..., ibid, pp. 15,16
Cilento's knighthood did not find favour with Labor politicians as a whole, the separate Ministry of Health could not be afforded and Cilento's injudicious stand on the Sister Kenny issue, which surfaced again in 1935 just when the distribution of responsibilities was being considered by Cabinet.

It will be recalled that it was due to Cilento's favourable appraisal that the Kenny Clinic had been set up in Townsville to allow Sister Kenny to demonstrate her techniques and instruct other therapists in their use. The official time limit set for this experiment was about six months, a period too short to allow of any credible assessment outside this frame of reference. Popular belief, strongly promoted by the press, was that Sister Kenny had been given an unrestricted license to practise. When, in August 1934, Cilento reported his findings after several months' periodic observation, he expressed strong reservations about some aspects of her work and was emphatic that, until more was known, she must work under medical supervision. He still praised Sister Kenny's psychotherapy but doubted that she could transmit her techniques to others because, lacking a rational understanding herself, she could not explain them. He was worried about the early discarding of splints and the use of 'graduated load' to rehabilitate affected muscles. In his opinion at least two years continuous assessment of the same patients by the same doctors would be necessary to decide whether these procedures were safe.18 (This was the foundation of the Royal Commission on Poliomyelitis 1936-37 which found against Kenny and, incidentally, exonerated Cilento).19 In sum, Cilento recommended that Kenny continue her work strictly in conjunction with the medical profession; always Cilento's position.20 Kenny saw this as betrayal by the man who had originally supported her and became bitterly hostile towards him. She still imperiously rejected the need for medical men to evaluate her work; their role was to take it at face value and help her to make it available to as many sufferers as possible. At this stage, Cilento was still a Commonwealth officer.

18. R W Cilento, Final Kenny Report, undated, Frver coll. 44/109
20. Cilento, Report on Sister Kenny's after treatment ... ibid, p. 11 Frver coll. 44/109
Throughout his health ministry, Hanlon made exhaustive journeys to remote places to study the health and living conditions of the people. In October 1934 he went to Townsville to see Sister Kenny at work and shortly thereafter announced that a clinic using her methods would be opened in Brisbane for the treatment of paralytic children.21

Cilento, now Director General of Health in Queensland, was deeply troubled. The press was making increasingly exaggerated claims for the success of the Kenny method and the public clamoured for its wholesale adoption. Hanlon's announcement had implied government, and therefore his own, approval of procedures which had not been evaluated reliably and which in important respects were contra-indicated by received medical wisdom and experience. The controversy between the government and the profession gained momentum until on 10 March 1935 Cilento stated publicly:

The Queensland Government neither approves nor disapproves of Sister Kenny's method, nor do I. The government opened a clinic in Townsville to give Sister Kenny every opportunity to demonstrate her method.22

Whether Hanlon had been consulted prior to Cilento's statement is not known but he was quick to check the government's position vis a vis Sister Kenny.23

Kenny reacted imperiously to Cilento's expression of dissociation and wired Hanlon:

... AM PERSONALLY MAKING ARRANGEMENTS FOR CHILDREN OWING TO DISHONEST ATTITUDES OF DR CILENTO IT IS NECESSARY FOR ME EITHER TO DO THIS OR TO CLOSE THE CLINIC WHICH WOULD BE DISASTROUS FOR YOU AND YOUR GOVERNMENT.24

21. Hanlon, Courier Mail (Brisbane), 27 October 1934
22. Cilento, The Daily Mail (Brisbane), 10 March 1935
23. Crown Solicitor to Undersecretary, 5 April 1935; letter states that 'I am of opinion that Nurse Kenny was appointed as an honorary nurse of the Crown by Cabinet (solely to supervise a clinic at Townsville). Government has met all clinic expenses ... her services may be dispensed with by same authority'. (QSA) 30 A B C A/31750, 1935
Kenny then sought to prevent the opening of the Brisbane clinic by refusing to cede to Hanlon, as Minister, the international copyright of her methods 'until there was complete government approval of them'.\textsuperscript{25} In the eyes of Cilento (and the BMA) this was a preposterous and irresponsible suggestion. Hanlon had a tiger by the tail. It was again an election year and, committed to the electorate, he opened the clinic under the supervision of Dr Jean Rountree and a team of nurses, all of whom were familiar with the Kenny method.

Shortly afterwards, W M Hughes, the Commonwealth Health Minister, announced his government's approval of the Kenny treatment; thereupon Cilento again challenged official opinion in the widely read \textit{Sunday Mail}:

\begin{quote}
If the money which will be devoted to this more spectacular endeavour were devoted to the enlargement of existing massage and re-education centres in the great public hospitals and funds were provided for the continuance of orthodox treatment in hundreds of cases which now remain crippled for lack of funds to continue, a progressive step would be taken which both public and scientific opinion would applaud. ... no method known to science can restore nerve tissue that has been destroyed.\textsuperscript{26}
\end{quote}

This, of course, was exactly the position of the BMA and the physiotherapists, (to use modern terminology). Given the staff/patient ratio and facilities available to Sister Kenny, they believed they too could effect cures to the same extent and by far more dependable methods.

Once again, as on the issue of native diets in New Guinea, Cilento had refused to sacrifice professional responsibility to political expediency, but there were few who paused to weigh his chosen words. He attracted belligerent criticism and every effort was made to coerce him into acquiescence.\textsuperscript{27} Kenny, in April 1935, instructed

\begin{flushleft}
\textsuperscript{25} Elizabeth Kenny to E M Hanlon, A/31750, 30 (QSA)
\textsuperscript{26} Ibid. It had been stated in the \textit{Labour Daily} (Brisbane), 27 March 1935, that Sister Kenny claimed to be able to cure all cases within two months of onset of the disease. She may have been misquoted but Cilento was anxious to correct widely published misinformation of this kind.
\textsuperscript{27} Cilento to J R S Lahz, official communication, 15 May 1935, Fryer coll. 44/11
\end{flushleft}
Hanlon to order Cilento to have nothing more to do with her work.\textsuperscript{28} This is supported in evidence in the report of the Kenny Commission that Hanlon instructed Cilento in the following month to have nothing further to do with the Kenny clinic 'in my interests and in order not to hamper government business'.\textsuperscript{29} It was a very strong rebuke. The minister had every right to demand tacit support from his chief health executive. In the trial of strength between the government and the BMA which underlay this controversy, Cilento had publicly lent the weight of his reputation to the profession. However wise his opinions (and it should be remembered that he consistently supported Sister Kenny on condition that she worked under medical supervision), he had been arrogant in his expression of them. Was Hanlon's rebuke a portent that Cilento's expectations would not be realised? It would seem so.

Redistribution of responsibilities within the Home Department was being considered by Caucus during this period and the Director General's antagonism to official opinion would not have prospered his cause: conventional Labor' opinion of doctors in general, knights in general and therefore medical knights in particular, was abysmal. Nor would Cilento's advocacy of centralised administrative control of health matters have found favour with what was a rural governing party.

In November 1935 Forgan Smith announced that he could not afford to enlarge his cabinet to provide for a separate Minister of Health.\textsuperscript{30} On 5 December 1935 the Ministry of Health and Home Affairs was established by Order in Council. Hanlon resigned as Home Secretary to become its first Minister, while Chuter, who had been Acting Undersecretary of the Home Department since Gall retired on 31 December 1934 was, in March 1936, confirmed as Undersecretary and thus Permanent Head of the dual department. The metropolitan press correctly foretold this outcome saying that as postponement of the promised legislation had been forced on the government by the extent of prior statutory changes necessary, a Ministry of Health would be set up forthwith to allow dissection of the Home Department to proceed. Chuter and Cilento would have clearly defined duties, the one clerical and administrative, the

\textsuperscript{28} Elizabeth Kenny to E M Hanlon, 11 April 1935 A/31750 30 (QSA)

\textsuperscript{29} Report of the Royal Commission into Poliomyelitis..., ibid p.60 (QSA)

\textsuperscript{30} Courier Mail (Brisbane), 23 November 1935
other professional and inspectorial.  

By these executive decisions, Cilento lost three major advantages which he considered necessary to the effective performance of the tasks he had been appointed to carry out as Director General: the senior departmental position, control of his budget and the auxiliary power provided by a Ministerial Executive Committee. Presumably, while Hanlon had accepted in principle the proposal for this committee as set out in Cilento's preliminary report, he had been alerted by Cilento's stance on the Kenny issue to the dangers of allowing him direct official contact with the organised medical profession and the right to speak for the Minister of Health. Hanlon did not trust doctors. They were seldom Labor men and Cilento was no exception.

Chuter, on the other hand, although of fiery temperament, was a reliable supporter of official policy. He had a genuine commitment to Sister Kenny (who treated his daughter) and used his authority with the BSCHB to have a ward set aside for her to treat her patients in Brisbane's most important teaching hospital, the General, in the year following the 1937 Royal Commission which found against her. Here she and the practising profession learned from each other and modified methods accordingly. Kenny's patients recovered sooner and their limbs were more subtle and better nourished than the doctors' patients. The therapist of 1933 who, knowing nothing of the anatomy, physiology or pathology of the diseases she was treating, described her healing act as God given, by 1939 could explain her method in clinical terms. Despite this, she was still shunned by the profession. In refusing to allow the medical profession to drive Sister Kenny out, Chuter had performed a great service.
to the community.\(^{32}\) Cilento, by Ministerial direction, retained general surveillance of these patients.

Cilento's direct access to the Minister still guaranteed that Hanlon alone was privy to his confidential reports and communications and that only he could rebuff Cilento's initiatives, except on financial grounds. And there was the rub! Forty-six years later, one of Australia's most distinguished medical administrators deplored this still-existing situation:

> Cilento's desire was for a unified medical service under one Chief Executive; a co-ordinated health service embracing all institutional and community activities. He achieved this in the professional sense by vesting all these powers in the role of Director-General... but not in the administrative sense. It is futile for the professional head to set his objectives and plan to achieve goals if he is beholden to another equal head for the resources. Let it be his total responsibility to his Minister to ensure that his objectives are achieved within the available resources.\(^{33}\)

Interestingly, the 1980 Queensland Government sought to unify professional and administrative chains of command under a singularly accountable officer, preferably a medical administrator. It was proposed that financial authority would be vested in the position held and not in the administrative background.\(^{34}\) The report containing these recommendations was originally accepted by Cabinet but subsequently shelved.

\(^{32}\) In the opinion of Dr A D D Pye who as General Superintendent of the 'General' at the time had a great deal to do with both Sister Kenny and Charles Chuter. Personal interview, ibid. Poliomyelitis was the one communicable disease of numerical consequence active and increasing in the 1920s and onwards. Unlike other communicable diseases, such as TB., it is a disease of affluence and therefore noticeable among the articulate middle classes. In America, polio therapists received much publicity because of this. From his wheelchair, Franklin D Roosevelt promised that if re-elected he would establish Kenny clinics. (A/31751 QSA). As demonstrated by her threat to Hanlon, Kenny was aware of the political potency of her cause. Although initially rebuffed in America, she went on to become a national (and international) heroine. In 1947 the Queensland Government sent its Director General of Health and Medical Services, Abraham Fryberg and a prominent orthopaedic surgeon, Stubbs Brown, to America to study and report on her methods. The report was favourable although Stubbs Brown did express certain reservations.

\(^{33}\) Trevor Wood, Forever Amber, ibid, p. 15

Cilento built his health ministry on precisely this organising principle; authority under the Minister flowed directly from the Director General to his sectional heads without the interposition of an undersecretary. This refers to the health moiety of the Health and Home Department, an entity called the Health Department of which Cilento was the professional head. To clarify his position, he had written to Hanlon in July 1935 suggesting that as he had very little power, his contract should be re-written expressing his role as advisory. This would take up no more than one third of his time and the remaining two thirds could be spent on drawing tighter the threads between government and the university. (This was clear evidence that he had been promised a university role as Director General). He concluded that they should together discuss the whole matter with the Premier.  

They must have reached a mutual understanding at this point; Hanlon certainly gave Cilento strong public support and room to manoeuvre above departmental level. Whatever their differences, they achieved a great deal as a team, although initially there was no money for expansion.  

Like Trident's spear, Cilento's re-organisational approach was three-pronged, aiming at:
1. Co-ordination of all medical services within the Health and Home Department with consequential transfers from other departments.
2. Rationalisation of staff.
3. Legislation to provide for the extension of the variety and depth of health services.

The overall objective was to promote and protect positive health from pre-birth throughout the whole of life, through education and the provision of preventive facilities. Education for personal fitness through nutrition, exercise, leisure activities and in the utilisation of facilities such as baby clinics for example, were considered to be a duty of government if social attitudes were to mature to meet social needs. The various activities involved must be brought into direct relationship with the Minister and so extended as to express trends in social thought in

35. Director General to Minister, memo 13 July 1935 HHA/11/(1934-36) File 4 A/482315 (QSA)
36. Minister to Director General, 21 February 1936, HHA/11 A/482315 (QSA)
administrative provisions.\textsuperscript{37}

The newly created Health Department was to include those health activities previously administered by the Home Department, including the services formerly under the charge of the Commissioner of Public Health, and health related responsibilities located in other departments or yet to be formulated.

In administrative terms, Cilento's objective was a department of ten sections incorporating the responsibilities and based on the organisational principles described. As a total concept it envisaged considerable expansion in depth and range of the original Health Commission. The most radical changes in this area will now be looked at seriatim:\textsuperscript{38}

1) Section of General Health and Hospitals.

Drs Cilento and Coffey were in charge of this section from which general administration and co-ordination were directed. As pre-existed, the four traditional interests of public health: environmental sanitation, supervision of food and drugs, communicable diseases (including Hookworm), and the publication of vital statistics provided by the Government Statistician, came under this section. Control of the physical standards of private hospitals was brought under the Health Act as was the Wilson Ophthalmic Hostel, formerly under the supervision of the BSCHB.\textsuperscript{39}

Cilento had sought oversight of general treatment in all dispensaries and hospitals (public, private, specialised, convalescent and chronic) which involved the administrative control of the medical work of local authorities and all medical, nursing staff and inspectors. As described in the previous chapter, most of these duties were retained by Chuter under the Hospitals Act 1936.

\textsuperscript{37} Director General to Minister, memo - Procedure for creation of Department of Health and Medical Services, undated, HHA/11, A/482315 (QSA)

\textsuperscript{38} Cilento, Preliminary Report ..., ibid, pp. 7, 8 Table III

\textsuperscript{39} Annual Report of the Director General of Health and Medical Services, 1940. (Hereafter Director General's Report, year) QPP, Appendix.
2) Section of Maternal and Infant Welfare.

This activity was formerly under the Maternity Act 1922, in charge of Dr Jefferis Turner who pioneered the whole concept. Although he reported to the Assistant Undersecretary, he enjoyed a great deal of autonomy. This he declined to surrender and resigned when this section was incorporated under the Health Act 1936.

Due to its excellent foundations, Maternal and Child Welfare thrived under new management. Turner had shown that with co-ordinated motherhood education under trained field workers, the health of mothers and babes could be improved. From his gloomy report about Queensland’s milk-starved children in 1935 an impressive improvement in child health statistics could be demonstrated five years later. Several innovations had been introduced. A Child Centre railway car, making itinerant visits along set routes added to the 60 per cent increase in Child Care Centres which, in three and a half years, brought the total number to 144. Following Dr Turner’s scheme and with the cooperation of medical staffs, welfare nurses were able to visit mothers and babes in hospitals; residential provision for premature babes was made and domiciliary service provided to advise mothers about the care and feeding of poorly nourished children.

Health education expanded noticeably. A correspondence section had to be opened to meet the demand for information coming from as far away as Korea; this involved the medical director in giving personal advice and there was a gradual increase in the number of mothers who corresponded regularly with the department about the progress of their infants. Publications of the service, Care of Mother and Child, and The Expectant Mother, were also widely sought in Queensland and beyond. The University’s medical curriculum included a course in mothercraft (initially devised and given by Lady Cilento), and demonstration classes on the

40. In his Preliminary Report to the Minister ..., ibid, p. 9, Cilento wrote: ‘This is a branch of medicine now attracting the gravest attention owing to the falling birthrate and the (stationary) high death rate for mothers. In 1933 Queensland had the worst figures in Australia... As a genuine activity of preventive medicine it should be under the control of the (health) department’.

41. R W Cilento, personal interview, 1978
feeding and care of infants were provided by Departmental medical officers at the request of the BMA. The co-operation of the University and the BMA in this enterprise was a breakthrough for Cilento. By 1939 he was able to report that a department had been built covering child health from pre-birth to school age. In fact pre-school provisions were very limited but the machinery for its expansion was in place. Liaison with the sections of School Hygiene and of Special Diseases was effected.

3) Section of School Hygiene.

Under the new Health Act this service was transferred from the Education Department to the Health Department and with it, its chief officer, Dr St Vincent Welsh. In contrast to Jefferis Turner, he welcomed the change which he had advocated as far back as 1929-30. Fervently he wrote:

The creation of a Ministry of Health... devoutly to be wished, has been brought about with the happiest results. The details of the plan... have now taken complete form; the future is bright with the promise of expansion, greater efforts and a greater scope for health work which must be the foundation upon which to build a sound education, with vigorous bodily health.42

The movement of this service to the Health Department had been one of the strongest recommendations made by Cilento. He advocated that this section should have surveillance of the pre-school child through to school leaving age in matters of medical, mental and dental health and that these services should be co-ordinated with those of maternal and infant welfare and of special diseases.43 In time, he was able to report that Hookworm nurses were integrated into the school hygiene system and that positive cases were hospitalised until cured. Cilento was well in the forefront of official thinking in these matters, especially where the pre-school child

42. Director General's Report, 1939. QPP, pp. 73, 77. Director General's Report, 1941. QPP, p. 8

43. Cilento, Preliminary Report to the Minister... ibid, p. 19
was concerned. 44

Under the same Act dentistry for schools became an activity of the Health Department after more than a century with the Education Department (then Department of Public Instruction). At the same time, the passing of a new Dental Act had further implications for the upgrading of the service.

4) Section of Social and Industrial Hygiene.

This was a new section, initially under the control of Dr Noel Lane. Here again Cilento's advocacy was cogently developed along social lines:

*Work is the life blood of a nation's vitality... and productive work is more and more a matter of individual efficiency - that is, health;* (not based in hospitalisation), nor the provision of palliative treatment for the sick, but essentially in the positive development to the full of every individual's mental and physical powers... 45

Under the Health Act 1936 the Department took power to make regulations governing all aspects of social and industrial hygiene previously divided between the Department of Labour and Industry and the State Government Insurance Office. This co-ordinated preventive matters of industrial safety and workers' insurance. War-time conditions (including the enlistment of its Director, Dr Abraham Fryberg) delayed the implementation of powers under the Act, although departmental records show that health officers advised on war time problems arising from increases in the range and type of industrial operations.

As Cilento pointed out at the time of the Weil's Disease dispute, officers trained in industrial hygiene had an important role to play and may even determine issues. Largely due to his special pleading, Industrial Hygiene as an important branch of preventive medicine was introduced into the routine medical course at the University

44. Director General's Report, ... ibid.

45. Cilento, Preliminary Report ..., ibid. p. 24. Cilento to Minister, 12 November 1935: Suggests strategy to wrest control of this matter from another ministry. Fryer coll. 44/11
of Queensland (alone among Australian universities) in 1938. Cilento concluded his report of that year, with this typical piece of logic:

From the medical viewpoint there is no justification for increasing rates of pay as compensation for (uncomfortable conditions or dangerous conditions of work... unless they are not capable of improvement.) It is foolish to pay a worker a few more pence an hour if his health may be impaired or his life endangered by submitting to conditions involving hazard.

Promotion of physical exercise both for work and leisure and the introduction of a contributory insurance scheme were also proposed; the former idea was one of Cilento's original concepts in that it looked at the worker as a fit man in an industrial environment, not as a sick one. Systematic examination of those engaged in injurious trades, the policing of lead levels in industry, safety factors and such matters as ventilation in ship building were carried out by officers in this section. This is a very good example of what was achieved by combining the activities of two outside departments under Health and then developing and co-ordinating all projections of the entity so formed.

5) Section of Special Diseases.

6) Section of Mental Hygiene.

7) Section of State Wards.

These three sections which in certain respects were closely correlated cannot be effectively described until it is possible to consider them in the light of the two Mental Hygiene Acts which came later. The section of State Wards, for instance, as proposed by Cilento, embraced problems common to all three sections. The Tuberculosis Bureau proposed for section 5 (Special Diseases) did not materialise.

46. Director General's Report, 1943-44. QPP, p. 10

47. Ibid, p. 11
8) Section of Research and Laboratories.

In his preliminary report, Cilento had pointed out that the Minister had power to authorize inter-departmental changes, after taking advice from the Public Service Commissioner; and further, that inter-department transfers might be the subject of special arrangements not affecting their statutory status. In this way control of the Laboratory of Microbiology and Pathology had been gained at the outset, even though it was administered under the Anatomy Act, while the Government Chemical Laboratories had been won similarly from Treasury.

Cilento wanted to upgrade the medical analytical work, post mortem examinations and general medical jurisprudence for which the Laboratory was responsible. As things stood the section was very poorly represented, according to Cilento's preliminary assessment. No research was done and the government was dependent for the carrying out of its own regulations upon an outside officer, (the Government Analyst) or, except for minor examinations performed by a laboratory staff incompletely qualified, upon the various Commonwealth Health Laboratories.\footnote{Cilento, Preliminary Report..., ibid. p. 11}

Provision of a research facility and its associated capability for statistical records was considered by Cilento to be central to a workable health service. Recent embarrassments had brought this home to the government and it was agreed that this should be a primary objective of the reform. Obliged to maximise existing facilities, Cilento decided to upgrade the run-down, routine diagnostic laboratory, long in the hands of a short-staffed lay director operating in makeshift premises in the Old Court House. The first move had been to bring the laboratory into the Department's new premises and consequently into close relationship with the rest of the staff.

To raise the status of this the Laboratory of Microbiology and Pathology (hereafter LMP) and increase its potential for other uses, it was desirable that its director be a qualified scientist. As there was no money, Cilento ingeniously suggested that the salary to attract a good man could be saved if medico-legal autopsies, now done by private practitioners, be included in his duties. Moreover, a
forensic autopsy service with appropriate records for retrospective study could be initiated at no extra cost.49

Hanlon accepted the force of this argument and Cilento, with commendable perspicacity, appointed Edward Holbrook Derrick, a pathologist whose promising career had been cut short by serious illness. He had spent a decade or so in far north Queensland in search of a curative climate and at his interview displayed an insight into tropical diseases that impressed Cilento. Theirs proved to be a close and fruitful partnership. Derrick, whose writings reveal a man of great humility, was to endow medical knowledge with a rich legacy of brilliant research.50

Only weeks after Derrick's appointment, Ernest Sunners, Chairman of the Meat Industry Board, requested an investigation 'into this abattoir fever the men are getting'.51 This was a most sensitive industrial issue. Aware that he was short of staff and equipment, Cilento nevertheless approached Derrick who responded to the challenge like the true scientist he was and, in collaboration with (Sir) Macfarlane Burnet, in time was able to explain the cause and spread of the disease. This discovery brought world fame to Derrick and his humble Brisbane laboratory.52

51. E Sunners to Director General, official communication, HHA/J1 (QSA) 17 May 1935. Appointment E H Derrick, Director on Probation, Laboratory Section, Department of Public Health... with salary rate of 900 per annum... The appointment of Dr J V Duhig to carry out post mortem examinations required by the Coroner was terminated from 31 May 1935 by the same ECM.
52. The 1939 Cilento Medal was awarded to Drs Derrick and Burnet as co-discoverers of the etiology and epidemiology of 'Q' Fever. In recognition Derrick wrote to Cilento expressing gratitude for the latter's support of his work 'especially as that support involved you at times in difficulties'. E H Derrick to R W Cilento, 1 January 1939, Fryer coll. 44/11. In his monograph, A Mystery Fever Invades Brisbane, Derrick gratefully recalled how Raphael Cilento offered him the chance of a lifetime.
Not the least remarkable aspect of the 'Q' fever discovery was the contribution of three observant members of the practising profession, Drs Little, St Ledger and Delaney. Together they had been observing the pattern of the disease; pure serendipity, romantic as the discovery of penicillin, led them to call it "abattoir fever", an important clue to the scientists.

Cilento and Derrick between them expanded a minimal testing laboratory into a facility for forensic enquiry, a teaching resource, a mobile field research unit and a world famous research centre. It became the major diagnostic laboratory for the Queensland Institute of Medical Research which grew from its foundations. This world class institution, now operating in conjunction with the University of Queensland, was planned by Derrick at the invitation of a grateful Health Minister, Hanlon. In many published statements, Derrick acknowledged Cilento's role in fostering this period of distinguished productivity.

9) Section of Sanitary Engineering.

This concept was too new for Queensland and the government failed to appoint the Chief Sanitary Engineer on whom Cilento had intended to base what he saw as a most important function of a modern Health Department. Its basic purpose was to regulate health provisions governing housing, hospitals construction, quality of water supplies, pest control, sewerage and other sanitary schemes; the section was to have special liaison with Section 1) Health and Hospitals. A special problem was to impose the provisions of the Health Act upon the Brisbane City Council. Although Cilento had strongly recommended to the Minister that the Council be compelled to provide a qualified man who was also a sanitarian and that he be an officer of the (then) Health Commission, the State could not override the Council which, under the City of Brisbane Act, had autonomy in health matters. The best Cilento could achieve under the new Health Act was the appointment of two senior and eight junior

53. The City of Brisbane Act was Chuter's brainchild. Home Secretary Stopford who had piloted it through parliament in 1924, stated in 1932, that 'it would stand to our shame before the whole civilised world that any community the size of Brisbane should be dependent upon a part-time medical officer'. OPD (V162), October 1932, p. 957 et seq. In his official report as Health Commissioner in 1933-34, Coffey stated that he had been directed by Governor in Council to inquire into the health administration of the Brisbane City Council and had reported his findings to Hanlon 22 August 1933. The unsigned report quoted above, however, although contemporary with Coffey's, appears to be by Cilento. Fryer mss 44/
health inspectors to ensure that the Council complied with State health regulations.

Incorporated in the Act was Cilento's proposal that departmental health inspectors have authority over their local authority counterparts who, under a provision of the 1922 Act, could neither be demoted nor dismissed. Time has proved the value of this measure.

In general the matching provisions of the Local Government, Health and Hospitals Act of 1936 worked to the advantage of the Director General much as Cilento deplored the basing of medical responsibilities on local authorities.

10) Section of Finance

Control of this activity remained with the Undersecretary of the Department.

New responsibilities created or acquired under the Health Act.

(a) The section of Medical Services Supervision was created under both the Hospitals Act and the Health Act to provide for supervision by the Director General of the medical and physical standards of private hospitals. In practice, medical services continued to be supervised by the Undersecretary because the standards laid down could not be controlled without substantial inputs from the medical section of the service.

(b) Control of the Government Chemical Laboratories was won by Cilento from the Treasury, with the support of Forgan Smith, on the somewhat specious grounds that 60 per cent of its work was medical. This coup cast the Director General in the role of purveyor of a wide variety of services to a range of departments, an enterprise with countless ramifications under the centralised system being developed.

As from January 1935 the Government Analyst reported to the Director General. He acted for Commonwealth (Customs) and State Government.

54. Cilento, Preliminary Report..., ibid, holograph note, p. 11
Departments ranging from Health, Geological Survey, Main Roads, Mines, Police, Railways, and State Stores, as well as private practitioners and even on occasions, John Citizen. For the Health Department alone, testing included food sampling, drugs, pathological specimens, water, sewerage, bakeries, butcheries, dairies and poisons.⁵⁵

In 1937, when this Laboratory came under the Health Act, specified requirements were laid down for the registration of medical officers, analysts and inspectors. Local authorities were obliged to appoint or join in appointing such officers as the Director General recommended. Following former Director, J. Brownlie Henderson, Cilento actively co-operated with other states and the Commonwealth in obtaining uniform standards of food and drug control. The move also eliminated gross overlapping of responsibilities notably by the Department of Agriculture and Stock; rationalisation which Hanlon described as an essential goal of the re-organisation.

Under the section of the new Health Act providing for the inspection, removal and sampling of dangerous drugs, powers conferred on the Director General included the right of entry of any of his officers to inspect any suspect place. In this way the right of police (and health officers) to enter and search without warrant premises suspected of housing illegal drugs was vested in the Health Act and not in the Police Act. The Director General's powers in this matter were enhanced by his subsuming the role of Chief Customs Officer on behalf of the Commonwealth.⁵⁶

By grasping the initiative, and with the support of Hanlon and Forgan Smith, Cilento had gained in the Laboratory of Microbiology and Pathology and the Government Chemical Laboratories well in advance of the Health Act, two professional services that provided enormous potential for the overall achievement of his aims.

(c) Nutrition as a crucial factor governing health had been recognised and hammered by Cilento throughout his career. In Queensland, he had been very vocal

⁵⁵. Health Act 1937, S.24
⁵⁶. Health Act 1937, Division 4, SS. 130, 131
on this subject for years and soon after his appointment wrote in strong terms to Hanlon pointing out that there was no reference to nutrition in the existing Health Acts:

The Director of Labour and Industry is concerned with the dietary of the relief workers and the unemployed; State Children's Department is concerned with children in orphanages; former Home Department with institutions such as Dunwich... all entirely unco-ordinated... The question of nutrition is one of the most important aspects of medical work and becomes increasingly so as world opinion follows science.57

Cilento, who was among those who had actively promoted the Commonwealth Advisory Council on Nutrition (1936), immediately set up the State Nutritional Advisory Board and successfully sought its recognition by the Commonwealth as its representative in Queensland.58 To get this general activity into the Health portfolio had been one of his greatest desires. Like the Health Education Council of Queensland (constituted under S.1641 of the Health Act, 1937) it was duly incorporated. Both these bodies had been strongly canvassed under the aegis of the National Health and Research Council and will be referred to again in the national section of this study.

The Health Act Amendment Act of 1936 was repealed when it was incorporated into the Health Act 1937. It had served as a device for the restructuring of a discrete Health Department from the inchoate Home Department. Additional activities such as School Health and Maternal and Child Welfare which had not been surrendered voluntarily were legislated into the new department under the aegis of the 1937 Act.

To gauge the effectiveness of this statute as an instrument of policy, comparison may be made between the status of three of the four original sections


58. The State Nutrition Advisory Board consisted of: Sir Raphael Cilento, Chairman, Dr A D D Pye, representing Brisbane Hospitals, Professor D H K Lee, University of Queensland, Dr St Vincent Welsh, School Hygiene and Mr Leon Meston, State Analyst. Director General's Report, 1937/38 App. A. OPP, p. 1001

The section of Environmental Sanitation had gained mosquito control and surveillance over Weil's disease. A Chief Sanitary Inspector was added to coordinate and supervise local sanitary inspectors including those of the Brisbane City Council.

The section of Food and Drug Supervision had expanded into other secretariats, other states and the Commonwealth. Links with industry, private medical practitioners and individuals were forged. State and Commonwealth Nutrition Boards and the section of Industrial Hygiene, the Health Education Council, School Hygiene, and Infant Welfare were inter-related. Cohesion was achieved through unilateral appointment and supervision of medical and laboratory staff.

Communicable Diseases was another section with a growth story. Research led by Derrick and his teams was having notable success; immunisation of school children and extension of trachoma and hookworm surveys included pre-school children, Aboriginal as well as European. Enthetic diseases received special attention. Regulations gazetted in 1939 required all medical practitioners to report cases of venereal disease to the Director General and two extra doctors were appointed for follow-up treatment. Negotiations were in progress to set up a "Tuberculosis Bureau in conjunction with the Brisbane and South Coast Hospitals Board."59

On the adverse side, Cilento had failed to win approval for his strongly argued section of sanitary engineering, a concept regarded in Queensland with extreme apathy. Nor did he achieve his own budget; overall financial control was the prerogative of the Permanent Head and not the Director General.

The report paraphrased above should also be read with certain reservations in mind. Much of the expansion was provisional at that stage. War time commitments controlled the direction of research and inhibited the growth of a viable industrial

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59. Enthetic Diseases File, HHA/4 No. 48/2312 (QSA). Control of Tuberculosis, Director General's Report, 1939, QPP, p. 116
hygiene section; facilities for the pre-school child were deplorable in Queensland as in Australia as a whole until in comparatively recent times, university studies were devoted to their improvement. In this area, as in that of geriatric homes, Cilento's concepts were well ahead of society's understanding and expectations. The problems of tropical fevers, of dangerous and unhealthy working conditions and of the pre-school child were solved piecemeal by many workers in many fields over time. This is the way of social and preventive medicine.

Cilento's enduring contributions were first of all to recognise and state the need and then to provide a logically integrated framework within which the solutions of his successors could be applied and developed. In his time, using the means at hand, he fostered the processes of amelioration through organisation.
CHAPTER EIGHT

From Microcosm to Macrocosm - Public Health Expanded.

With the passing of the Health Act 1937 the blueprint for public health practice in Queensland (the practice of prevention collectively by central government and local authority) was in place. In designing this machinery, Cilento had played the role of administrative technician, albeit with an unusual degree of imagination and resourcefulness. His grand plan, however, was much more ambitious; the concept of a Ministry of Health in which the activities of preventive and curative medicine were mutually supportive organisationally and the interests of professional and lay management given each their due weight in public hospitals in the interests of harmony and of healing; an ideal governed, as he recognised, by the costs involved. This was Cilento’s credo of public health as a social responsibility.

In this chapter, the study of his plan will be extended to cover these generalities in some detail; in the account of his successes and failures the influence on the reform of Queensland’s first Director General of Health and Medical Services may be further evaluated.

In spite of his special pleading in his preliminary report to Hanlon, Cilento had failed to achieve any significant influence on public hospitals. To solve the impasse between medical and non-medical administrators in the Department he proposed a Health Executive consisting of the Minister, the Undersecretary and the Director General of Health. This was certainly unconventional and probably impractical.

Cilento moved into other clinical areas (outside hospitals); Mental Health was brought under his control and upgraded by two important pieces of legislation; geriatrics, where his initiatives had little success; and the control of the purchase of X-Ray and other electro-medical equipment for public hospitals.
Due to his influence on Premier Forgan Smith, Cilento was able to stimulate the founding of the medical faculty in 1936. In some respects the new medical school had innovative and unconventional attitudes not found elsewhere in Australia. This was due to Cilento.

Thinking as a public health man, the Director General intruded vigorously into the faculty curriculum by providing both laboratory facilities and teachers from his own department.

Within the framework of this brief synopsis, Cilento's plan and his performance may be studied in greater detail.
In a review of the essentials of state medicine, Cilento concluded that:

Every State is charged with the necessity for appropriate action to co-ordinate the whole of its medical services in their range and efficiency, and to render them universally available.¹

The uncertain powers which stemmed from lack of legislative endorsement and his own ambivalent position within the dual ministry in the early years, did not prevent Cilento from taking initiatives once he had convinced Hanlon - or Forgan Smith - that they were medically and financially valid.

This special relationship with executive ministers had been devised by Cilento to overcome historical situations in Queensland where inertia was the main barrier to any progress in the reform.

Cilento’s cogent argument for a Ministerial Executive was, at base, subtler and more pervasive than has been indicated. The hidden strategy was to ensure the supremacy of professional over lay opinion in medical planning. (The term ‘medical’ is here used in its widest sense). In Cilento’s words, a trained doctor could learn the clerical skills necessary to an administrator, but the process was not reversible.²

Only a medically trained mind could appreciate the relationships between medical education, research and private practice, and a comprehensive plan for high quality health care. These relationships were crucial to his long range plans for innovative departmental intrusion into areas formerly outside the territory of government. Conditions at the time of the reform favoured their inclusion in a co-ordinated plan and Cilento, seeing the potential, seized the opportunity. Into his long ex-parte plea for the establishment of a Ministerial Executive, may be read the desire to extend the scope of the medical and social programme as widely as possible as an integral part of the general plan.³

1. Cilento, Preliminary Report on Reorganisation of Home Department to provide for a separate or co-existent ministry of health, ibid, p. 6
2. Cilento, Blueprint for the Health of a Nation, 1945, p. 134
3. Cilento, Preliminary Report ..., ibid, p. 16
Certainly, in proposing to make the Minister de facto head of the Department, he was fighting for time to establish himself in the vacuum produced by the early retirement of the former Undersecretary, William Gall. The document demonstrates his overwhelming desire for central power (which attitude he shared with his Premier) and for a tight administrative ship. This is still a moot point; in times of financial difficulty, centralised control is probably mandatory. The major weakness in Cilento's preliminary report was its ambivalence about hospitals. This may have been intentional, since he knew that lay control of hospitals was fast becoming an obsession with the Labor Party. He had the courage to say that this was unwise but avoided saying what should be done about it. Perhaps it was due to lack of insight into the essence of clinical medicine. (Owen Powell believes that pre-occupation with public health narrows the vision of its practitioners). Yet Cilento did acknowledge that doctors cannot be excluded from a reasonable amount of influence in a workable health service:

In all countries there is an overwhelming urge towards institutionalisation of treatment, but unless this is co-ordinated with the patient-practitioner problem, it is likely to involve the government in increasing expenditure at an accelerated rate.

And who, fifty years on, has an answer to that dilemma? His stress on the pre-school child was about fifteen years ahead of its time, and the blunt warning that buildings do not make medical services, they only house them, were outstanding extra-mural comments in a very challenging document.

Consideration of the supplementary activities mentioned above begins with the section of Mental Hygiene. Cilento and Hanlon were in complete agreement with each other and with concerned members of the community on the need for reform in this area.


5. Cilento, Preliminary Report..., ibid. p. 22

6. Ibid, p. 19

7. Ibid, p. 9
The origins of social attitudes to mental illness in Queensland were rooted in the
determination of early colonists to sever all connections with its squalid beginnings
as a convict settlement. The preferred social image was of the hard working, God
fearing citizen of stern and uncompromising morality.

Evans has demonstrated that this Calvinistic attitude created a ferocious
attitude towards the mentally ill and a callous rejection of the infirm and incurably
ill on the grounds that they were humanly useless and, therefore somehow
blameworthy in the work-worshiping society of the late 19th century. Believing it
should purge itself of parasites, the society isolated them, as Britain had her
convicts, by banishing them to offshore islands. This human flotsam included
'paupers', the undeserving poor, who could not work.

Early attempts to humanise attitudes towards the insane were made by Dr B
Ellerton when he wrote that care of the weak was a human duty - while advocating
that they be sterilised to prevent future propagation of their kind.\(^8\) His solution was
the oldest known to man.

Twenty years later, despite the Ryan government's Royal Commission into the
Management of Hospitals for the Insane and many public outcries over the years,
Queensland's attitudes remained appallingly ignorant and punitive. In 1937 Donnelly
stated in the parliament:

... the whole cause of congenital insanity is the
misdeeds of the people. Venereal disease has played
a part in increasing the numbers of imbeciles born as
a result of parental misdeeds.\(^9\)

Not only did the speaker advocate enforced sterilisation but castigated the churches
for preaching compassion for the victims, instead of the gospel of pure living, and
deplored the pensionable provision for imbecile children and their parents. Loud
"hear! hears!" from the chamber greeted this speech.

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9. QPD (V) CLXXI, 1937, p. 891
The Mental Health Act and the Backward Persons Act 1938 were not and are not part of public health, that is, preventive medicine. Care by governments for mental patients is a historic responsibility, a legacy from our English past. Doctors employed in our mental health services were a part of the Home Department which Cilentó acquired when Dr H B Ellerton resigned as Inspector of the Insane in 1935 and the post passed to Dr John Coffey, Cilentó's deputy. This activity then became part of the consolidated health scheme, although not under the Health Act.

There is no better illustration than this of the courage and compassion of Hanlon as he tackled the tragic confusion of social attitudes and maladministration that had placed the helpless beyond the pale in Queensland. Drop the word Insanity was the heading of his moving plea for humane attitudes towards these unfortunate people incarcerated in mental hospitals and institutions for the incurable.10

Hanlon's prejudices showed when he blamed the medical profession for post-natal derangement in women, but his proposed psychiatric clinic in conjunction with the Women's Hospital was enlightened and medically acceptable.

Jordan credits the BMA with the first progressive steps in psychiatric services in Queensland and notes the ignorance of politicians about this complex subject.11 What Hanlon lacked in clinical insight, a scant enough commodity even among the cognoscenti, he relied upon two experts to supply. One of these was Dr Basil Stafford, new general manager of the Asylum complex; he sent Stafford to Paris for the World Mental Hygiene Conference in 1937 to be followed by an extended study tour in Europe and America. Then, it would be up to Dr Cilentó to co-ordinate the changes to be made in the new legislation. Cilentó, in turn, has affirmed that Hanlon himself compiled the basic policy report in conjunction with Stafford.12

Long before the term 'geriatric' had escaped from the universities, Cilentó saw the need for separate institutions for the aged to take the pressure off general

10. E M Hanlon, *The Telegraph* (Brisbane), 13 March 1937
12. Director General's Report, QPP, 1939, p. 1266
hospitals. After visiting the Dunwich Benevolent Institute for the Aged, Hanlon described it as a human dumping ground for helpless people; the island barrier intended to keep them free from communicable diseases had been flattened by sheer weight of numbers. Before the days of pensions, Dunwich became known as purgatory. Trachoma sufferers, TB patients with nowhere else to go, alcoholics, sick aged, mental patients (including children, for whom there was no special provision in the State) swelled the tide of human flotsam washed up and virtually abandoned on Stradbroke Island. Even married couples were segregated.

Hanlon promised that Havens for the Aged would be built saying:

We have an honour and a duty to care for them without a trace of patronage remaining.\(^{14}\)

Cilento, after an inspection of the Peel Island Leprosarium which lasted some days, compiled a tragic report on the hopeless conditions there.\(^{15}\)

Shortage of asylums for the insane and the 'custodial and primitive' care that still involved gross restraint, long since abandoned in more enlightened societies, also attracted Hanlon's pen. Committal procedures for mental affliction and criminal insanity were the same for both categories; the role of the police in committal to asylums had been the subject of High Court litigation in 1933.

Accepting that there was need to distinguish between causes and degrees of mental incapacity, Hanlon wanted provision for caring institutions where backward people could be helped to achieve a sense of personal worth through the mastery of simple skills and duties; provisions for the temporarily deranged, modern treatment for the permanently ill, and an overhaul of committal and removal procedures under law.\(^{16}\) He had a feeling for what is now called 'occupational therapy' but, like the society he served, such a professional approach to treatment was conceptually

\(^{13}\) Cilento, Preliminary Report..., ibid. p. 5. *Blueprint for the Health of a Nation* (Sydney: Scotow Press, 1944), p. 97

\(^{14}\) E M Hanlon, *The Telegraph* (Brisbane), 13 March 1937

\(^{15}\) R W Cilento, *A Visit to Peel Island Leprosarium*, August 1931, Fryer coll. 44/uncal

\(^{16}\) E-M Hanlon, *The Telegraph* (Brisbane), 3 October 1936
beyond him and, moreover, he was forced to consider costs scrupulously. Despite this, or because of it, he had sent Stafford overseas to make a careful study of relevant advances to ensure that the new mental health legislation would be both enlightened and cost-effective.

Two long and searching Bills, the Backward Persons Act and the Mental Hygiene Act, became law in 1938. So great was the impact of these statutes that Coffey was obliged to report that proclamation had had to be delayed until revised regulations could be prepared.

Cilento, in his annual report of 1939, summed up the essentials of the two Acts as follows:

The Mental Hygiene Act of 1938 inaugurates a new outlook and is essentially a treatment Act. It repeals the Insanity Act of 1884. It provides a new nomenclature, as a therapeutic approach made many of the previous names and terms not only ineffective but meaningless. It provides the machinery to facilitate the treatment of incipient psychoses by the sections relating to voluntary, temporary and private patients. It lays the foundation for the expansion of clinical activities, the co-ordination of state facilities and private practice, by permitting medical practitioners to visit State Mental Hospitals as consultants to their patients. The internal administration of mental hospitals required a considerable amount of internal re-organisation to fully comply with the purposes of the Act...

The Backward Persons Act of 1938 should supply a much felt want for there was not legislation to deal with mental deficiency. This approaches the problem from a psychiatric angle and establishes, in the first place, a Survey Board to evaluate the extent of the problem and co-ordinate existing and proposed facilities. It also establishes a psychiatric clinic for investigation and research and the training of teachers and officers in the field of psychiatry.

17. Backward Persons Act, 1938 (2 Geo. VI, No. 30). The Mental Hygiene Act, 1938 (2 Geo. VI, No. 21)

18. Leggett, Organisation and Development of Queensland Hospitals..., ibid, p. 289

19. Director General's Report, QPP, 1939, p. 1267
He added that it was hoped to appoint part time specialist medical officers to his department without delay, on the grounds that it is impossible to separate mental from physical sickness and that the efficiency of treatment in mental hospitals would be, therefore, largely proportional to the efficiency of the physical treatment. Control of this section of the Health Department was exercised by the Director of Psychiatric Services, subject to the Director General under the Minister.

Cilento has related in his memoirs that the attempt to establish institutions for the frail and sick aged failed, and with it the expression of the new trend towards geriatric medicine. He advocated removing these patients from general hospitals where their care and attention were a heavy drain on resources and placing them in nursing homes of a superior kind, the running costs of which were relatively low. Modern readers will recognise that it is on the same cost-benefit basis that to-day's Health Insurance Funds are constantly seeking to remove geriatric patients to nursing homes. In his day Cilento's idea was too new and at the critical moment, World War II began.  

Nevertheless, by 1945 there was an expanded and appropriately staffed department in which four medically qualified specialists supervised the mental hospitals of Brisbane, Toowoomba and Ipswich; Dr Coffey remained Inspector of Asylums and in his report that year, as Acting Director General, was able to claim some of the progress the legislation had been designed to promote:

The advantage of recent mental medical legislation is now becoming apparent through the increased numbers of voluntary patients who are seeking admission to the mental hospitals for the benefit of skilled treatment; and for the implementation of this legislation a Psychiatric Clinic has been established in Brisbane.

One of Cilento's very early initiatives, that had Hanlon's full support, was designed to study all aspects of electro-medical equipment purchased for public hospitals in Queensland. Demonstrating his faith in the efficacy of the well-chosen consultative committee, he established the X-Ray and other Electro-Medical

20. Cilento, 'The World...', ibid, (Ch 16) p. 6
21. Director General's Report, 1945, QPP, p. 00
Equipment Advisory Board with the following members:22

Sir Raphael Cilento, Director General, Chairman
Undersecretary W Watson, of the Chief Secretary's Department
Dr Arthur Boyd, M.E, D.Sc. (University Engineering faculty)
Dr Valentine McDowall, radiologist and expert X-Ray technologist.

The objectives of this impressive Board were to control the medical use, distribution, and standards of expensive electro-medical equipment in public hospitals. They were breaking new ground; X-Ray apparatus was the first intrusion of costly technology into medical equipment into medical services.

There was much to undo in Queensland. X-Ray machines were a new medical fad; succumbing to plausible salesmen without any understanding of what they were buying or how it was to be used or serviced, hospital boards too often bought unsuitable, unnecessary and even unusable material. In time, anaesthetic machines, fluoroscopes, and other products of advancing technology compounded government costs and concern for public safety. Immediately the Board was in being, Hanlon sent Cilento to Sydney to study all aspects of the subject at one of the city's leading public hospitals.23

Henceforward responsibility vested in the boards to decide just where and how public funds should be spent on electro-medical equipment for public hospitals. The distribution was rationalised by Cilento, the cost structure by Watson, while Boyd and McDowall laid down stringent standards for safety of operators and equipment. Owing to the danger of unskilled work, including radiotherapy, treatment centres were restricted. The aim was to district the entire state providing a series of interdependent, but locally complete, units working up to the main centre. Private practitioners' needs for service within convenient range were considered. Board members designed standard radiography rooms for hospitals and upon request, interpreted films sent to them. This activity was much in demand.24

22. Queensland Government Gazette, No. 110, (4 May 1935)
In 1944, when the Radium Institute was established at the Brisbane General Hospital's cancer treatment centre, the Board was absorbed by the new facility. Its records, covering ten years of study and investigation, were made available for background guidance; Cilento's detailed infrastructure was designed to implement Hanlon's promise to every cancer sufferer in Queensland; facilities for patients to be seen by travelling specialists at their nearest centre, transport to Brisbane, suitable housing, treatment at the Institute for as long and as often as necessary at no cost to themselves, provided a service worthy of departmental co-ordination at its very best.

Whereas the Medical School within the University of Queensland could not be claimed as a Health Department agency, Cilento played a precipitating role in its establishment.

Forgan Smith was anxious that both medical and veterinary faculties should be founded during his term as Premier. To represent the government in the founding stages, he needed an eminent, articulate doctor with negotiating skill and an insight into the medical problems besetting the tropical electorate. Immediately after the Weil's strike settlement he had announced that plans for these faculties would go ahead. However, there is circumstantial evidence that one of the conditions of Cilento's appointment had been the inclusion of a chair of Tropical and Social Medicine and Cilento's professorial status.

25. Director General's Report, 1943-44
26. The Queensland Radium Institute was set up on the recommendation of Drs Ralston and Edith Paterson, two recognised specialists in the organisation and application of radio-therapeutic treatment for cancer. Dr R Paterson was Director of the Holt Radium Institute of Manchester. Director General's Report, 1943/44, p. 15. The relevant report of the Radium Institute states that Hanlon brought in a wide range of experts to consider the type of deep-therapy machine to be purchased. This represented an enormous outlay for the government. Hanlon's handling of this matter, which included inviting the Ralston's, as with his sending Stafford overseas, does much to counter Leggett's criticism that as Minister for Health, he did not travel abroad for personal enlightenment.
Forgan Smith had many strengths; his dedication to the future of Queensland was expressed by outstanding personal contributions in public life; the young University of Queensland owed much to his reliable support. A great sugar industry leader, he probably had this responsibility very much in mind when, as Minister for Agriculture, he had promoted the faculty of that name. Stressing the relationship between higher learning and the progress of the state, he said at the inauguration of the Faculty of Agriculture that he looked to it to serve the community as well as the teaching and research interests of the community. This was in line with tradition. Premier Kidston, in the keynote address at the founding of the University, had said:

Queensland is a university of the people and I trust that when ... the Senate, when they start to manage this institution will remember that it is also to be for the people.  

It had also been emphasised as highly desirable that the University evolve an individuality of its own and that it concern itself with the particular requirements of the State which it served.

Every respectable academy seeks to make an original contribution to the sum of knowledge both to justify itself and to enhance its reputation; only in this way can it hope to attract a high order of funding and scholarship. Finding a vacant field where there was need and opportunity to make a notable contribution was, for Cilento, a familiar exercise easily to be translated from the personal to the institutional context. No-one familiar with his priorities as a public health man can fail to see his fine Italian hand in the proposals put forward for the new medical school or doubt the extent of his influence on Forgan Smith.

During a Senate meeting in the late forties, Chancellor Forgan Smith firmly told the Director General of Health, Abraham Fryberg, that two men were responsible for the founding of the medical school, Sir Raphael Cilento and himself.


30. E Stirling, ibid, p. 257

31. Sir Abraham Fryberg, personal interview, May 1980
Historians relate that in April 1935, Forgan Smith appointed the Advisory Committee to report on the proposed Faculties of Medicine and Veterinary Science to be established within the University of Queensland. The Committee, chaired by the Vice Chancellor, Dr W N Robertson, consisted of three members representing the University of Queensland, two representatives of the BMA and two of the Brisbane and South Coast Hospitals Board. The agenda and proposals of the meeting appear to have been prepared by Cilento and were unanimously accepted without modification. The Committee found that there was need for both faculties. Limiting comment to the medical school, the first finding was:

"... That the scope of this faculty should include particularly tropical medicine and public health as parts of routine medical education and should be based on recognition of the practical and clinical side of the subject."  

Amplifying that finding and developing a rationale for the school, the argument continued:

"Queensland affords opportunities and facilities greater than those of any other state at present in respect of anthropological studies with all that implies for the successful solution to the Aboriginal and coloured problem in the State, in tropical Australia elsewhere and in the tropical dependencies. These opportunities are wasting and are rapidly diminishing."  

Pointing to the increasing development of aviation, the report underlined the consequential erosion of Queensland’s traditional isolation as a safeguard against exotic diseases and warned that without medical education and co-ordinated research, the present organisation of health and medical services will be incomplete and to that extent, ineffective.

32. These findings, as proposals, are in Cilento's handwriting. A/3780, 36/8048, 10 June 1935 (QSA) p. 3. Members of the Advisory Committee were: Dr W N Robertson, Chairman, Vice Chancellor (President of the BMA); Professor E J Goddard, Physiology Department; Sir Raphael Cilento, MD, Director General - Representing the University. Dr L Jarvis Nye, Dr T A Price - Representing the Medical Profession. Mr T L Jones, Hospital Board Chairman; Dr A D D Pye, General Superintendent Brisbane Hospitals - Representing the Hospitals Board. Report to the Honourable the Premier (W Forgan Smith Esq) upon the proposed establishment of a Faculty of Medicine and a Faculty of Veterinary Science within the University of Queensland, 10 June 1935, Fryer coll. 44/ 153

33. Ibid, p. 3
Tropical medicine, social medicine, Aboriginal studies and co-ordinated research: Cilento's leit motiv sought to ensure a uniquely Queensland Medical School as surely as he led the Advisory Council to say, on the subject of curriculum:

In regard to the establishment of a Professorship of Tropical Medicine it was thought by members that specialisation in this branch of medicine would be a definite asset to the proposed medical school and was one of the justifications for its establishment.\(^\text{34}\)

Documentary evidence therefore supports Forgan Smith's affirmation of Cilento's role in the founding of the medical school and the direction of its emphasis. Conversely, Cilento is on record as saying:

I realised that the decision could be taken at any time ... and the man who had full power in the matter was Forgan Smith. I approached him.\(^\text{35}\)

He also said that the battle to establish the School had been going on for forty years; this refers to those predecessors whose valiant attempts to secure the academy is a story of high drama, one could almost say, melodrama. Especially he was thinking of E Sandford Jackson, E S Meyers, J V Duhig, and Ernest Goddard, who spearheaded the drive and who made a working academy with little more than bare hands and the ability to deceive politicians about the costs involved.

Cilento's role was more than catalytic, in the accepted sense of that term. Professor Ralph Doherty's succinct analogy strikingly illustrates the difference:

The good medical administrator, like the catalyst present in undiminished quantity at the end of an experiment, demonstrates dynamic homeostasis and not inert stability.\(^\text{36}\)

He was speaking of Cilento's influence on the founding of the Medical School. His attempt to have Aboriginal studies incorporated as the basis for human anthropology within the course failed. Otherwise, in relating the curriculum to Queensland's tropical problems as its distinguishing feature and occupying its honorary foundation

34. Ibid, p. 9
35. Cilento, 'The World ...', (Ch. 6) pp. 14-15
36. R L Doherty, Funding, Structures and Academic Function - Crises in Australian Medical Education, Cilento Oration (Brisbane), 1982, Fryer coll.
Chair of Tropical and Social Medicine was only the beginning of Cilento's long and notable association with the University.³⁷

Naturally he wrote his own course; encapsulating his holistic view of social medicine, he defined it in public health terms as:

... not only those activities in which the State interests itself as a duty; not only the care of the individual, but the study of medicine in terms of community welfare.³⁸

Thinking globally, Cilento was mindful that, in breaking ground at the workface of socio-medical knowledge, Queensland would be giving a lead to the world. The Weil's disease epidemic had played right into his hands and reinforced his argument to the Advisory Committee that tropical medicine was not only a natural concomitant of social medicine, but a raison d'être for the Medical School. Gordon, who argues convincingly that the tropical proposal produced the right result for the wrong reason, nevertheless concedes that research into an area of tropical physiology led by Douglas H K Lee, brought some international repute to the embryo school.³⁹

Gordon was right in that students were not seeing so-called tropical diseases in hospitals any more. The challenge of undiagnosed, undifferentiated fevers still existed, but at the level of scientific research which was vigorously pursued into the sixties.

In 1956 the title of the Chair was changed to Social and Preventive Medicine, and in terms of 'community welfare' has assumed an ever-growing importance in the curriculum of the Medical School.

³⁷. Bryan's tribute to the founding fathers of the medical school is recalled here: Since the inception of the Faculty, the major subjects ... had been handled by honorary or part-time staff. The University owes a considerable debt to these men. Without them the Faculty could not have functioned. H Bryan, The University of Queensland, 1910-1960, unpublished history of the University's first half-century, Fryer Library, p. 157. In May 1935 Forgan Smith was admitted to the degree LLD (honoris causa, the highest honour the University could bestow). Cilento received an honorary MD.

³⁸. R W Cilento, Courier Mail, 6 April 1947

³⁹. Douglas Gordon, Health Sickness and Society, ibid, p. 307
From 1935 onwards Cilento was, by virtue of his office, a member of the University Senate. Without pre-empting the discussion on the wider implications of his position on both Faculty and Senate under the provisions of the Medical Act 1939, the nature of his influence on medical studies should be mentioned. The innovation of Industrial Hygiene into the curriculum for the first time in an Australian University, designation of Hanlon's psychiatric clinic as a specialised training school, introduction of Maternal and Infant Welfare as a discipline and involvement of the Laboratory of Microbiology and Pathology in the teaching of entomology and pathology, forged new dynamic links between university, the department, and the medical profession.

In 1941 Cilento's submission to Cabinet for State Social Service Fellowships in Medicine and Dentistry, tenable simultaneously within the University of Queensland and the Department of Health and Home Affairs, was accepted. This was the forerunner of the medical cadet system that brought to fruition the concept of a government medical career first postulated in the Inland and Island plan of 1923.

Though various practitioners had laboured long and hard to establish the medical school, Cilento, through his personal influence on Forgan Smith and greatly assisted by the Weil's disease outbreaks, had provided the final impetus that won over a reluctant cabinet. This situation had not pertained in southern universities where the founding stimulus had come from the doctors and grass roots influence. As a result of what happened in Queensland there was a unique link established between the Medical Faculty and the Director General of Health and Medical Services, the strength of which will be demonstrated in the following discussion on the Medical Act 1939.

40. Cilento, Proposed Industrial Hygiene Division, c. 1939. Fryer coll. 44/. The introduction of this discipline into an Australian University was another first for Cilento. As defined it dealt with the health, welfare and human rights of workers and addressed medical, sociological and economic problems.

Cilentò had made three remarkable contributions to medical education in Queensland: he was the driving force which finally established the Medical School; he introduced the concept of social medicine to Australian medical education, and had created the unique influence which the Director General had on the Faculty.

Impressive as is this summary statement, it does scant justice to Cilentò's greatest achievement as the creator of an academic discipline in its own right. An extended discussion of social medicine is given here to throw it into thought provoking relief.

Social Medicine in our time

As a medical educator, Raphael Cilentò has the distinction of reviving the concept underlying social medicine and introducing it to medical curricula in Australia. In the eighteenth century Johan Pieter Franck and Ramazzini had preceded the great pathologist, Virchow, of the mid-nineteenth century, as ardent advocates of this concept on the European continent. The more pragmatic Anglo-Saxons, both in the Empire and in North America, had shown little interest in environmental factors, social or economic, as agents of health or of disease. Their health reforms relied on the enforcement of preventive measures.

Preventive medicine takes a specific problem such as gastro-enteritis in infants, diphtheria in children, lung cancer or chronic bronchitis, and endeavours to promote the practice of specific preventive procedures appropriate to each disease; public health is an aspect of preventive medicine which deals with clear-cut goals.

Social medicine, by contrast, is an all-embracing discipline. The underlying principle is simple; the study of health in (social) groups of people may produce useful information. For instance, it may be determined that there is a low incidence of skin cancer in Victoria and a high incidence in north Queensland or that miners
and Aborigines are susceptible to lung diseases - though obviously for different reasons. It has been shown, to take another example, that as the Australian population became more affluent and better educated, they lived more cleanly and had fewer children. This, in turn, led to more desirable child-rearing practices and so to a lower infant mortality rate.

On the adverse side, it became apparent that from the 1920's onward more people, particularly males, were dying from heart disease in the form now known as coronary occlusion; smokers tended to have worse health and shorter lives than non-smokers.

This kind of study of the social group also showed that the poor sections of the population suffered more ill-health than their more fortunate fellow citizens. As a fledgling doctor, Cilento had attended an Aboriginal woman who had aborted in late pregnancy from malnutrition and ill-treatment. With a flash of insight, he saw in this episode a possible relationship between the social conditions and health of Aboriginal people. In his early publications and continuously in his travel diaries and professional reports, recurring references to unsuitable housing, poor diet, the psychological problems of the isolated; the early ageing and infertility of the women; the pervasiveness of parasitic diseases in conditions of ignorance, poverty, and dirt and, therefore, preventible, all emphasise Cilento's preoccupation with this phenomenon. He wrote around many aspects of the subject and lectured on it to all levels of society. This task of enlightenment, then as now, was undertaken to stimulate reforming zeal for socio-economic conditions while pointing to specific problems which might be alleviated by the process of preventive medicine. The anti-smoking campaign is a classic, contemporary example.

In promoting attitudes derived from its basic concepts, social medicine has shown not only the effects on health of individual behaviour, but also created an awareness among medical practitioners of the pressures which society uses to promote its value systems, encouraging the individual to think and act in certain ways, some of which, for good or ill, affect his health. Cilento aimed to inculcate in the student an awareness of the dual responsibilities of the medical practitioner, namely, to the community as well as to the individual.42
It was Cilento's achievement to draw attention in Australian medical education to these holistic, more widely oriented ways of looking at health and medicine. Ryle, who established the Chair of Social Medicine at Oxford University in 1946, received world acclaim for his innovative outlook, but Cilento of the University of Queensland had preceded him by a decade.43

43. Cilento served the University as a Senator from 1935 continuously until he resigned as Director General in 1946. After he had returned from overseas service, Vice Chancellor J D Story invited him back on to the Senate saying he valued his knowledge, experience and judgement, 3 February 1953, Fryer coll. 44/11. He accepted and served a further three years, this time in his own right. His lifelong interest in anthropology and education led him to donate his collection of relics and artifacts from many sources, to the University Museum of Anthropology.
CHAPTER NINE

The Medical and Pharmacy Act - 1939

Cilento's authorship of the above-named Act is attested in his handwritten letter to Hanlon which begins:

In accordance with your instructions I have prepared a Medical Bill covering the points raised during the last two years in connection with the deficiencies of the Act.

I attach, accordingly, a rough draft of the Bill - 1939 - two copies of which were passed to the Undersecretary some time ago by Parliamentary draftsmen. The attempt to alter the old Act affected so many sections that a new Bill was necessary.¹

This statute was regarded by Cilento as perhaps his greatest single contribution to the advancement of medical (as distinct from public health) administration and is the central concern of this chapter.

With the introduction of a Medical Act, Cilento was not being original. The oldest known Code of Laws, The Code, promulgated by Hammurabi, King of Babylon in 2080 BC, prescribed fees patients were to pay and punishment for negligent treatment.

If a doctor has treated a gentleman for a severe wound with a bronze lancet and has cured the man, he shall take ten shekels of silver ... if he has caused the gentleman to die, one shall cut off his hands.²

In those days, as in the times of the Hebrews and Egyptians, distinction was made between the work or status of the surgeon and of the physician. In the Middle

1. Director General to Minister A/3780, 28 June 1939 (QSA)

2. W Ramsay Smith, 'Medical Treatment by Unqualified Persons' (Federal Health Council Report, 1931), Appendix 11
Ages, the days of chivalry, ladies were educated to the practice of the healing art. The clergy exercised this function as well. Later efforts were made to restrict the practice of the art of healing. In 1422 a Bill to restrain women and all persons who did not have an MB degree from Oxford or Cambridge from practising physic was introduced into the English parliament; but it remained a Bill.

In Britain up to the reign of Henry VIII, all who practised medicine were called physicians. They were usually clergy assisted by apothecaries, who made up drugs, and barber surgeons, who were authorised to perform operations by the use of hands and instruments. Both surgeons and apothecaries became part of the Guild system but later also formed companies. In 1518, Henry VIII gave a charter to the Physicians of London (later the Royal College of Physicians of England). The Barber Company and Guild of Surgeons united to form the United Barber-Surgeon Company. In 1540, Henry VIII gave them also a charter. In 1843 their much-changed professional descendants became the Royal College of Surgeons of England.  

Meanwhile, the question of malpraxis had attracted special legislation. In 1511, because of the great injury done to many of the King's people by irregular practitioners of all sorts, conditions and trades, an Act had been passed forbidding anyone to practise in London and seven miles around, unless approved by the Bishop of London and four doctors of physic.

As a result of this measure it was found that many who were skilful and who attended the sick from motives of charity were being persecuted by practitioners who attended merely for money and who would not attend the poor. Consequently, in 1542 an Act was passed permitting herbalists etc., to administer ointments, baths, or drinks; for the stone, strangury or ague.

The legislature of the day thought that many practitioners were so unskilled that it was better to admit quacks at the portal.


4. Ramsay Smith, ibid.
By the beginning of the nineteenth century both apothecaries and surgeons had improved their status and were in fact doing most of the medical practice in England.

Physicians were comparatively rare as a University degree was a prerequisite. They looked after the rich and usually occupied many of the 'honorary medical posts' in the large voluntary hospitals which became teaching hospitals. The difficulty was that no one knew how much practice or theoretical training any individual healer had had. For example, had a surgeon had any obstetrical training? Had an apothecary any skills in simple surgery? Much of their work was the same - what today is called general practice, with some surgery and obstetrics included. But when it came to assessing individuals there were no criteria which guaranteed minimal standards of training.

After bitter debate, the (British) Medical Act of 1858 was enacted, in order to solve this problem. It laid down (eventually) minimal standards for medical training. When a student surmounted the examinations set by a variety of bodies, which were used to enforce the standards, he was registered by the State as a 'medical practitioner'. This person was deemed to be capable of performing any of the healing arts from the moment of registration. He was, by custom, given the courtesy title of 'Doctor'. The Act was administered by the General Medical Council; that august body of medical men was mainly concerned to ensure that the complement of examining bodies supplied training programmes of which it approved and that the examinations enforced a minimum standard of competence.

In the latter half of the nineteenth century, very few doctors wished to specialise after obtaining registration and their qualifications to do so were no concern of the General Medical Council which, in effect, legally determined who was a general medical practitioner.5

The Australian colonies in due course passed rather similar Medical Acts. Their counterparts of the General Medical Council were called Medical Boards. Since a doctor trained at, for example, Melbourne University, might wish to practice in

5. As will be demonstrated, Cilento took this process a step further in 1939 and described in legal terms the qualifications necessary in a specialist.
Brisbane, South Africa, or England, it became necessary for all Australian medical schools to have their training programmes and examinations approved by the General Medical Council to provide the much valued 'reciprocity of medical registration'.

So that attempts by superior authority to regulate the medical professions are of great antiquity; distinctions between surgeons, physicians, and apothecaries were there from the beginning, with their corresponding responsibilities, rewards, and punishments. The general outline shows by its historical conformity that 'the physicians position is never determined by physicians ... but is limited sharply by the framework of the times'.

The 1858 Medical Act of the English parliament went some way towards making medical practice a monopoly. This was an early partnership of power which protected the public and the profession and 'guaranteed that doctors would be of uniform and acceptable standard'.

Four years later, the first piece of similar health legislation was debated in the parliament of the new Colony of Queensland. This became the Medical Act of 1867 and remained unchanged on the Statute Book for the next fifty-eight years.

In the intervening years much bitterness characterised the inter-personal relationships of those who claimed to have the right to treat sick people. Arguments about the worth and validity of qualifications possessed by individual 'doctors' determined that the thrust of colonial medical acts was to decide who should become medical practitioners. In this century, they came generally to lay down laws and regulations dealing inter alia with:

1) the composition of the Medical Board which administered the relevant Act

6. Cilento 'An Open Letter to Medical Men', (insert Telegraph (Brisbane), March 1938), Fryer coll. 44/124
7. Gordon, Health, Sickness and Society, ibid, p. 864
   P D Robin, The BMA in Queensland, ibid, p. 162
2) minimum requirements needed by a 'doctor' to become a registered medical practitioner
3) professional negligence on the part of a doctor
4) inhibition of competition and disputation between medical practitioners (laws about advertising and criticism of other doctors)
5) sundry clauses designed to protect patients in areas not covered by negligence clauses. Examples might include sexual seduction of patients and various efforts to protect patients against grossly excessive fees.

Public understanding of this subject has been complicated by the existence of various bodies all exercising regulatory powers. Contrary to popular belief, the BMA/AMA has not the power to deregister a doctor; that comes within the jurisdiction of a state government instrumentality, the Medical Board.

State branches of the BMA/AMA do have special committees which advise the elected council of each state branch on that branch's ethical rules, which in the main regulate relationships between only those doctors who are its members. They cover competition between doctors in finer detail; for example, a consultant's retaining a patient who has been referred to him, or one doctor using undue influence to attract the patients of another. Membership of the BMA/AMA is not obligatory; registration by the Medical Board is the sine qua non of the legally qualified medical person who wishes to practice the profession. A doctor in his professional conduct may commit offences against the criminal law, such as performing illegal abortions or defrauding Medical Insurance Funds; usually when a doctor is found guilty of a criminal offence the Medical Board removes his name from the register of medical practitioners for that particular state. Unless he is re-registered, he may not practice his profession and some scarring of his personal and professional reputation is, in any case, unavoidable. Thus the general area covered by the medical acts of the various states is a complex one. Except in federal territories, the federal government does not enter into this matter in any substantial way.

In Queensland a state Medical Board was founded in 1860; its function was clearly expressed in the composition of the Queensland Medical Board set up a few years later under the Medical Act of 1867. This Board was to consist of no fewer than three legally qualified members of the medical profession, one of whom was to be nominated president. There was also to be a secretary. The precedent was that,
in the case of this Board, the government nominated all the members including the president. None was a civil servant; none was paid. As the instrument for registering medical practitioners whose qualifications in colonial days varied widely and included chemists and druggists, the Board was unacceptable to many of the more highly qualified men. Lack of sanctions and powers to deregister those whom they considered to be quacks and charlatans convinced the orthodox practitioners that their status and livelihood were being degraded by the inflexibility of the Board's constitution. There were many disputes which finally came to a head with the debate over the right of optometrists to test sight. Robin has written of the outcome:

In 1925, the Medical Act was finally amended, thanks to the sympathy of Mr Stopford (the Minister concerned). The Medical Board was empowered to deregister practitioners and to levy a registration fee to provide it with funds to organise the prosecution of illegal and infamous practitioners.\(^9\)

Relations between the government and the profession at this time were so amicable that the latter seems to have been unconcerned with the implications of the change in the composition of the Medical Board from professional to lay membership enacted at the same time. It would seem that the profession saw the Medical Board as its own tool rather than that of the government: a power to cleanse the Augean stable and in general to do very much as it liked. (This applied later to medical education as well, even though the state government supplied the money for the medical school).\(^10\) Stopford noted that although the Opposition advocated that the Board should be elected by the profession the BMA was satisfied with a Board, all of whose members were still nominated by the Governor in Council.\(^11\) The profession did not challenge Stopford's statement that the BMA had nothing to do with the Board. It was a union ... similar to the lawyers union which looked after


10. As a result of BMA pressure at this time the Medical Act 1925 legalised the practice of Anatomy, the first step towards a Queensland medical school. When this was achieved more than a decade later, the profession fiercely resented government intrusion into areas that had been the sole preserve of those members at the top of the BMA pyramid. Cilento, seen as architect of this heretical change, naturally incurred the censure of the official body.

11. J Stopford, QPD (V) CXLV; p. 1455, 1925
members of its profession.\textsuperscript{12}

The Board was used by the profession to keep out undesirables such as Continentals and Indians whose \textit{bona fides} were regarded as suspect, and to clamp down on those who attempted personal advertising. To obliterate the nineteenth century image of venom and brawling over professional skills the BMA dealt severely with those factions or individuals causing interpersonal conflict. In this sense the BMA had a great deal to do with the Board.

Chuter saw fit to change the composition of the Medical Board in the 1925 Act as a step in his long term strategy to gain financial control of hospitals. It was to be reconstructed to consist of not less than five members appointed by the Governor in Council who would choose one as president; there was no requirement that any member be medically qualified. The other radical change was that, in place of the traditional honorary secretary (a medical man), a (paid) registrar would be appointed.\textsuperscript{13} The changeover was rendered less contentious by allowing the existing Board to remain in office as though appointed under the Act.\textsuperscript{14}

On paper this looked portentous, yet the profession did not seem unduly agitated, probably because in practical, political terms, government interference in the esoteric area of determining the standards of doctors would not have been approved by the electorate. Chuter, with his long-term goals, would not have made so daring and potentially provocative a change without good reason. The most likely explanation would seem to be that, whereas he was not interested in controlling the profession, he was concerned to control its members who would work in public hospitals, and in this way sought to provide a reserve of power for future use. In parliament in 1939 Dr Watson Brown labelled the Medical Board as the ‘internal machine of the profession’.\textsuperscript{15} Chuter was seemingly aware in 1925, despite the assurances of Stopford and the complacency of the BMA, that whoever controlled the

\begin{itemize}
\item \textsuperscript{12} J Stopford, QPD ... ibid.
\item \textsuperscript{13} Vide Queensland Medical Act 1925: Geo. V: No. 1, 24 (ss 4 Part 11)
\item \textsuperscript{14} Ibid
\item \textsuperscript{15} Courier Mail (Brisbane) Press Gallery Notes, ‘Cynicus’, 10 December 1939
\end{itemize}
Board, effectively controlled the profession.

The absurdity of a potential Medical Board without doctors was removed when the Medical Act was amended again in 1933. In the terms of the amendment, a majority of four members, including the traditionally appointed Chairman, was appointed by the Governor in Council, as were the three representatives of the BMA nominated by this body. This meant that the profession was in a minority position on the Medical Board. The registrar was to be a member of the public service, a layman, who could provide a useful link between Board and Department. The profession, although in a minority, was now for the first time able to nominate some members of its own. This was a gain over the 1867 and the 1925 Acts.

There were no more important changes to the structure of the Medical Board until the introduction of the legislation which superseded all former, related statutes, the Medical and Pharmacy Act, 1939 (hereinafter called the Medical Act). This act was directed towards the implementation of the final stages of Cilento's re-organisational plan, which had to wait the enactment of pre-requisite legislation now encapsulated in the Health Acts 1937.

Unlike those statutes and the Mental Hygiene Acts that together provided the legal basis for Hanlon's reform, the Medical Act was solely concerned with medical practitioners, as such and on all levels. It set acceptable standards of education and training for registration and the legal position of practitioners vis-à-vis the state and the patient. Whereas the power base for a Director General is usually in the Health Act, it is clear that in the Medical Act, Cilento extended this base in breadth and depth in five key areas that interactively and individually provided a new blueprint for the future legal position of medical practitioners. The Act stipulated that these

16. Chuter understood that the Australian community is resistant to institutional change and introduced it gradually. The manner in which he metamorphosed the position of the 'amateur secretary' of the Medical Board to that of public service registrar, over two separate Acts, eight years apart, is a good example of this approach.

17. According to Dr P G Livingstone, the present Director General, there is a change of policy here. More recently, as the legislation dealing with the various Boards comes up for review, the Health Department is altering it to stipulate that all members must be chosen from the appropriate profession.
(radical) changes would be:

1) a further alteration in the composition of the Medical Board under which the Director General would hold the position of chairman (ex-officio),

2) a medical graduate seeking full registration would be required to produce evidence of having served as a resident medical officer for twelve months in a hospital approved by the Medical Board of Queensland in addition to existing requirements for registration,

3) in future a registered medical practitioner could not claim that he was a 'specialist' unless he was registered as such by the Medical Board of Queensland; he had to produce evidence of having passed appropriate post-graduate examinations and, as well, of having undertaken specialist training for a substantial number of years in a hospital approved by the Medical Board of Queensland: there were amnesty clauses,

4) the legal framework of a doctor's relationship with the Board were as defined under the Act and covered a doctor's right of appeal against the Board's decisions and the conditions under which a patient might obtain redress,

5) the provision of a Medical Assessment Tribunal under judicial surveillance which was an innovation of the statute.

As will now be told, these four alterations to the old Act and the introduction of the principle of impartial judicial surveillance in conflicts involving medical assessment of fees, all largely determined by Cilento, changed the status and management structures of the organised profession in the most profound and extensive manner.

1) The new constitution of the Medical Board had many implications; the power of the Minister was institutionalised by providing that the Director General be chairman (ex-officio): the Minister also had the right to remove or replace any Board member at his discretion. The cardinal point here is the authority exercised by the full time public servant as chairman. The rest of the Board are amateurs. From his base in the department, the Director General is in a strong position to influence government policy. He makes a logical submission, the Minister agrees, and the Chairman tells
the Board what the Minister has determined.\textsuperscript{18} By making the Director General Chairman of the Medical Board, other Board members were influenced to look at matters as the government desired. This was a logical strategy: part of the organisational change which reflected the centralist policy of Forgan Smith in government generally\textsuperscript{19} and the increased government control of medical services for which Hanlon had electoral approval. The appointing of the Director General, a very highly placed civil servant, as Chairman of the Medical Board in place of a respected elder statesman of the profession was, in terms of its consequences, to be one of the most radical changes wrought by the 1939 Medical Act. Yet the profession seemed unperturbed, probably because they did not foresee the consequences.

2) Mandatory Internship for Registration of Medical Graduates in the terms proposed by Cilento had been accepted by the Advisory Board of the projected medical school, a body heavily weighted with senior medical men. Two major innovations concerning the training of doctors were recommended for inclusion in the new Medical Act which was being discussed for at least three years before it could be enacted. The first of these requirements was intended to control a minority: in support of the relevant proposal Cilento wrote in the original draft submission:

\begin{quote}
The best students of any graduating class are offered one year’s experience in established public hospitals and these positions are eagerly sought because of their extraordinary value. On the other hand, those who by the weakness of their passes are too far down the list to hope for such posts are turned loose at once to practice their profession on the public. This is precisely the reverse of what should happen... and it is very gratifying to find that the BMA in England \textsuperscript{30} should so strongly have advocated this provision.
\end{quote}

18. There is ample archival evidence that many ideas attributed by Cilento to the appropriate political authority, usually the Minister, originated in his own mind, and were couched in terms to persuade or influence official opinion. Hanlon, however, was no pliant cypher, but his own man.


20. Director General to Minister, A/3780 (QSA) ibid.
For the reason given and, importantly, as a means of providing a captive, cheap staff for future teaching hospitals, it had been agreed by the government, the university, and the local branch of the British Medical Association, that this innovative measure be written into the new Act. It appears to have been the first official consideration of this concept within the general penumbra of the Association. However, certain disaffected senior doctors in Queensland covertly persuaded the Federal Council of the British Medical Association (Australia) to protest formally, through the Federal Government, to the British Minister of the Crown responsible for the General Medical Council, that the move would disadvantage British medical graduates who may wish to practice in Queensland. In response, the General Medical Council, through Mr Anthony Eden, threatened to refuse reciprocal rights of practice to Queensland medical graduates. Other parts of the Empire would automatically have adopted the same restriction.

To have taken such an unseemly step the august body of the federal branch of the Association and local influential doctors must have been outraged by projected state interference in what had always been its own area of decision, namely the standards set in medical education.

Interference by an Imperial body in Queensland's domestic affairs enraged Hanlon. Choosing the inaugural dinner of the Faculty of Medicine, of all stately occasions, he stated bluntly that he was not concerned whether Queensland graduates were recognised overseas. Their duty was to serve Queensland. This injudicious and untenable threat was excruciatingly embarrassing to Cilento, who was forced temporarily to withdraw the offending provision to save both Hanlon's face and the infant medical school.

The volte face of the General Medical Council in England, soon afterwards and its conniving at the introduction of the measure in New South Wales in the following

21. Cilento did not introduce inexpensive junior medical staff for public hospitals; he offered, it is believed, 4 pounds per week, 400 per cent above the going rate in the south. Moreover, the graduates a year or two later took the government to Court and as a result became the highest paid hospital doctors in Australia for two decades at least.

year would appear to support the notion that the principle at stake in the Queensland episode had been the territorial rights of the profession rather than the intrinsic merit of the idea. In the event there was time to reinstate the clause (19) in the Medical Act, but the competitive Cilento was wounded by the fact that Queensland, first in the field, was last in the race.23

There is folklore still current that a major objection to a compulsory year of medical service was the feeling that it might be the 'thin edge of the wedge', the first insidious step towards the control of the profession. It was in fact the first instance of a government directing the place of practice of medical graduates and immediately heightened fears of 'nationalisation of medicine'. When war came in 1939 the profession agreed to be conscripted on condition that its own nominees and not the public health authorities would supervise the operation. Nevertheless, it was on the organisational basis of Cilento's original Inland and Island plan that the coordinating committees operated, an irony much resented by Cilento.24

By then the problem of doctors fleeing from Hitler's Reich and seeking employment in Queensland had to be considered. To provide suitable employment for any capable foreign doctor, and for his registration when he proved his capacity to reach required standards, Cilento recommended an obligatory period of hospital work which would also act as a ready means of providing junior staff in the larger hospitals.25 Experience in New Guinea after the first war, when the absence of a system to check their bona fides allowed many dubious 'doctors' to practise there, had alerted Cilento to the need to exercise strict control over registration of foreign doctors as medical practitioners in Queensland.

23. Cilento and Lack, Triumph in the Tropics, ibid, p. 444. Lack (Cynicus) Press Gallery Notes, Courier Mail, 12 October 1939 reported that Hanlon, defending Clause 19 of the Medical Act in parliament, emphasised the need for fledgling doctors to have more obstetric training and backed his assertions with startling figures on infantile mortality in Queensland's public hospitals. Although medicine and surgery were included in the clause, Hanlon's priorities were unequivocal. In the same debate, Hanlon rejected the proposed amendment of Dr Watson Brown that there should be statutory medical representation on the Medical Board, arguing that it would cripple the Act.

24. Cilento, Social Services Advisory Committee - Medical Planning Sub-Committee transcript of evidence, EEE 18 et seq Fryer coll. 44/108

25. Director General to Minister, 28 June 1939 A/3780 (QSA)
3) The third innovation, also in connection with medical training, was precipitated by the phasing out of the 'honorary' system of specialist service, signalled in the 1936 Hospitals' Act. In future part-time hospital medical staff would be paid and it was expected that eventually they would all be specialists. Cilento foresaw that some legal statement had to be made to define the qualifications necessary for specialist practice. It was resolved by the provision of a Registry of Specialists, in future, higher academic qualifications in their speciality, together with a substantial period of approved hospital experience, would be required of candidates for registration as specialists. In this connection Cilento's most distinguished innovation was insistence on a period of apprenticeship. Only recently has this been done in the United Kingdom. By contrast, the Royal Colleges in Australia, Physicians, Surgeons, and the like, have a tendency to insist on a stipulated period of training in an approved hospital as well as the usual examination requirements. Cilento's insistence on an approved apprenticeship in the main was a precursor to this trend. There are still Australian states without a Registry of Specialists but, according to Gordon, in the seventies the Commonwealth Government had, with great difficulty, to make its own registry to decide how medical insurance rebates should be differentiated.\(^{27}\)

The introduction of this registry may also be said to have crystallised an observable trend. There was an urge among members of the profession to see standards raised. Dr Jarvis Nye, friend and physician of Forgan Smith, was a leader in this field, and would have lost no opportunity to influence the Premier. The standard of surgery in some hospitals, especially where performed by general practitioners, was causing concern.\(^{28}\)

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26. The Medical Act 1939, ibid (Part IV S 3)

27. D Gordon, private communication, 1982

28. Leggett, 'The Organisation and Development...', ibid, p. 88. Most members of the profession who performed major surgery were general practitioners; in 1928 when the Royal College of Surgeons was founded that very question created an uproar in the BMA.
An added complication at that time was the intransigent attitude of some foreign specialists who refused to undergo the required registration training.\(^{29}\)

Of paramount importance as well, as Cifento’s experience had shown him, was the protection of the seniority of doctors serving in the armed forces. The supreme objective, therefore, of the relevant section of the Medical Act was to lay down criteria which must be met by all who aspired to practise medicine in Queensland, whatever their place of origin.\(^{30}\)

An ameliorating factor in this section of the Act was the provision of generous amnesty clauses that allowed general practitioners to be registered in a variety of specialities; anaesthetics, obstetrics and surgery for example. Some saw this as the rather asinine antics of the doctor turned lawyer.\(^{31}\) But Sir Raphael Cifento had the last laugh. A decade or so later most of these practitioners were dead and the specialist register contained only those practitioners who had met the requirements of the 1939 Act.

So much for those clauses which, through registration requirements, endeavoured to lay down training standards of doctors.

4) The fourth area under discussion concerns the legal framework governing the doctors’ relationship with the Medical Board. The government recognised the duty to provide legal sanctions against malfeasance, gross professional negligence, and exhorbitant fees, to protect the vast majority of ethical practitioners and the public at large. Herein lay some nice questions of definition.

Apart from recurring cases of badly performed surgery in Brisbane’s hospitals, for which the surgeon could neither be held accountable nor dismissed, there were cases of quite shameful malpraxis in which the medical profession closed ranks to

\(^{29}\) Courier Mail (Brisbane), 14 January 1937: ‘Foreign Specialists... Ban’. The Age (Melbourne), 1 December 1939: ‘Refugee Doctors...’

\(^{30}\) Cifento to Captain A Fryberg, AIF Abroad, personal letter, Fryer coll. 44/11

\(^{31}\) Queensland Division BMA to Director General. Undated. Comments and suggestions re foreign doctors. Fryer coll. 44/
protect its members. One example was a cruel and crudely worded attempt to 'rip some quids' from a wealthy patient who happened to read the referral letter; another, a fatal, criminal abortion involved collusion by three doctors to provide false evidence of the cause of death. An autopsy by Dr Derrick disproved the doctors' statements, but the ensuing coronial enquiry failed to recommend any action against any person concerned. Then there was the 'tear in the eye' approach to the soft-hearted Hanlon by those who claimed they were being overcharged by doctors; complaints Hanlon took seriously enough to ask Cilento to investigate them. These factors alone created strong feelings in government and professional circles that standards must be set to put the status of doctors above reproach and to preserve public confidence in their profession. Cilento worded the relevant clauses in the Act to the following effect:

According to the Medical Act of 1939 it is infamous conduct for a doctor to show negligence. The section (35: xii) is as follows: ... a medical practitioner (including a specialist) shall be guilty of misconduct who ... omits through negligence to do something which any reasonable man guided by these considerations which ordinarily regulate the conduct of human affairs would do, or does something which a reasonable man claiming such general or specialist qualifications would not do, or shows in any other way the absence of such reasonable skill and attention as shall have endangered the health of the patient or prolonged his illness or period of convalescence.

32. HHA/5, A/428310 (Doctors named in this file are not identified in this thesis). File in general shows government's profound concern with practice of abortion: Director General claims potential loss of 5000 lives a year to Queensland must be prevented. In the case mentioned above, the cremation of the victim was secretly aborted on instructions of the Police Commissioner and the body conveyed to the Pathology Institute for post mortem examination by Derrick who found that the cause of death from pneumonia as stated on the death certificate was false: septicaemia following abortion had been the cause.

33. Report of death of Hazel Lorraine Smith. Fryer Library 44/. This interpretation of reasonable care and skill was taken by Cilento from a leading Common Law case, Lamphier and Phipps (1838, 8.c and p. 475) in England. In thus expanding the field for negligence in a medical practitioner, he brought indignant protest from the profession. Source: Med IV, Medical Ethics: 'The Legal Responsibilities of Medical Practitioners', University of Queensland.
As an example, it is suggested that 'infamous conduct' would be demonstrated if a medical practitioner refused to go to a case when he had been told that it was urgent and that he was the only available medical practitioner.

The mandatory requirement under the Act that practitioners should report to the police as soon as possible suspected illegal operations, bullet wounds, or any kind of injury that might indicate that a police offence had been committed, was fiercely resented by the profession and hotly debated in the parliament on the grounds that it required doctors to breach traditional confidentiality between practitioner and patient.\(^\text{34}\)

5) The Medical Assessment Tribunal as outlined by Cilento was a logical corollary to his legal definition of malpraxis; a means of legal process by which doctors could be charged with an offence and conversely, appeal against decisions of the Medical Board. Cilento wrote to Hanlon:

> The proposed Tribunal will have special powers for special cases - worked out as carefully as possible from British precedents. Because of the inclusion of the judge as the central figure, a borrowed legal subtlety, the decisions of the tribunal can be seen to be based on matters of law and they materially increase the powers and control of the Minister under whom the Bill is administered.\(^\text{35}\)

The Tribunal was to be a Superior Court of Record, comprised of a Supreme Court judge and two medically qualified assessors. The Chief Justice was to nominate the Tribunal judge; the government and the profession, one assessor each. All were to be appointed by Cabinet; appeal of matters of law was to the Full Court.

Reference to the increased powers of the Minister was Cilento's less than subtle technique for appealing to the Minister when he particularly wanted his way. He must have seen the need to protect the office of Medical Board Chairman; as a medical man and a public servant the Director General was in an ambivalent position.

34. Director General to Minister A/3780 (QSA) ibid, codified in Medical Acts, 1939 to 1966, ss, 34, 35 Queensland Statutes, p. 589

35. Ibid
position. Therefore, in areas of conflict between government, citizen and/or medical practitioner, the right of the judiciary to decide the issue must let justice be seen to be done. The Tribunal was also a court of referral from magisterial to other courts on matters having a medical element.

The Board now controlled conditions for registration and professional conduct, including that of specialists; the Tribunal judged matters of legal accountability also including that of specialists.

Teased apart, the legal provisions of the Act provided that a doctor could be declared negligent or charged with other offences specified. He could be professionally involved in matters before a magisterial or other court, or in unfavourable decision by the Medical Board. In all these cases he had the right of appeal to the Medical Assessments Tribunal. Disputed rights in the recovery of fees might also be referred to the Tribunal.

Patients could complain of excessive fees or negligent treatment and have their cases decided on matters of law by an impartial court of law. Formerly, as has been told, the profession was able to close ranks to protect its members from legal action by the public or to render civil action highly unlikely to succeed.

Other areas into which the Director General's power base was extended by the Medical and Pharmacy Act, 1939 (to revert at this stage to its full title) may now be introduced.

The Pharmacy Board required the power to police its own ethical standards; the situation as to apprentices was unclear and the question of patent medicines appeared to need tighter control. Insofar as was applicable, Cilento adopted the ethical procedure laid down by the General Medical Council (of Britain) in all cases where ethics were required to be defined. Amendment of the Pharmacy Act 1917-1933 was achieved by its bodily replacement with the corresponding provisions of the British Pharmacopoeia.

36. Deputation from the Pharmacy Board to the Director General, 27 September 1938, Fryer coll. 44/. With regard to the question of patent medicines, Cilento drew attention to limitations under Section 92 of the Constitution Act, 1901 prohibiting interference with interstate trade.
The contemporary Dental Acts and Opticians Acts carried their own amendments in line with reform policy, as did the Nurses' and Masseuses' Acts of 1938. The principle guiding the 1939 Medical Act that specified qualifications and stipulated a professional code of conduct for medical practitioners was adapted to include para-medical and related boards already in existence, and to pre-caste the framework to accommodate and regulate those ancillary specialities such as speech, occupational and physiotherapy which were to develop with new knowledge and technology. Schematically, these boards were drawn into a uniform pattern of control in which the Director General was to be Chairman with a deliberative and a casting vote; as with the X-Ray and Nutrition Advisory Boards, those cognate medical subjects which had avoided clerical domination in devious ways had been brought under the surveillance of the Director General, under the Minister, unimpeded by public service procedural requirements.

The Medical Act, completed Cilento's grand plan of re-organisation and co-ordination of Health and Medical Services in Queensland. It solved problems created by the displacement of the honorary system and led to the (eventual) acceptance by the profession of government control in some areas formerly regarded as sacrosanct, such as the nice consensus that medical education was solely a matter for the profession. Both of these were formidable goals, set by Cilento himself, when he had been appointed as administrator and mediator just five years previously. With his capacity for analysis and powers of legal creativity, he had crystallised solutions to complex problems in simple, lucid words. The administrator had been conspicuous; the intercessor had been obliged to work with senior colleagues of the profession, on a personal basis unofficially, secretly at times, to achieve mutual understanding. It was not strange that the architect of the new laws that told doctors what they may and may not do was fiercely denounced by them; yet an eminent successor, at times most critical of Cilento's judgement, has stated:

Time has proved all these enactments to be wise and practical. Nevertheless at the time, these changes attracted much unwarranted obloquy and bitter criticism.  

Sir Clarence Leggett, eminent surgeon and most trenchant critic of public service intervention into hospital management in the thirties, described this Act as 'a purely

reformist piece of legislation of great social significance' adding that it did not appear to be politically motivated. Cilento records that with its enactment, the profession's image of him as

a knight in shining armour fighting for its ideals was instantly obliterated, to be replaced by something from the African jungles... a form it has not entirely lost over the subsequent thirty years, though successive generations of medical men have forgotten, or never knew, the origin of the stigma.

This was a bruising experience for Cilento who saw this statute as perhaps his most significant personal contribution to Medicine, in its wider sense.

What then was its origin within the Act? According to those who can remember, the matter which caused most bitterness was the stipulation that graduates must serve an internship in an approved hospital before receiving full registration. It will be recalled that the original opposition to the scheme had come from 'the old guard' of local doctors trained in Sydney, Melbourne or Adelaide faculties which had determined the standard required of an Australian medical graduate. This was always accepted automatically by the Medical Boards in the various states, and governments had never before intruded into this area. Yet the Australian University Medical Curricula had to be approved by the General Medical Council; the conservative wing of the BMA would accept the prestige and political nature of that body but would fear that politicians (particularly Labor ones) might debase medical education by choosing medical board members amenable to political pressure.

On the legal side, doctors resented to being obliged to report such matters as suspicious knife wounds, illegal operations and other statutory conditions which they saw as a breach of doctor/patient confidentiality. In expanding the definition of negligence in a medical practitioner, Cilento heaped coals of fire upon his head. Yet his stand on anti-wounding and back-yard abortion and his insistence on the highest standards of professional care and responsibility reveals an exemplary aspect of his character and a strict adherence to the professional values and ideals of medicine which most of his colleagues were also anxious to uphold and see upheld. Cilento never hesitated to be controversial where principles were at stake, as he

38. Leggett, The Organisation and Development ...', ibid, p. 88
39. Cilento, 'The World ...', (Ch 16) p. 10
demonstrated in his stand on Sister Kenny. He came to see her essentially as a quack and took the view that most doctors take of quacks, although his administrative career paid dearly for this.

Some light might be shed on the controversial Act by asking, in what ways did it differ from those in other states? Four main areas are discernible. First, it set up a specialists registry and described in legal terms the qualifications needed to gain entry to that registry. At the time of writing not all states have such registries and the Federal Government has had to make good their deficiencies. The British took a quarter of a century to determine legally the qualifications necessary for a recognised medical practitioner. Cilento in a very brief space laid down the qualifications needed in a specialist. So far as is known, that had not been done anywhere else. Doctors greatly fear civil actions for negligence. In such legal action what could be more damaging to a doctor than having to admit that he had no specialist training in the procedures that were the subject of the action? The specialist registry has proved invaluable to those making hospital appointments and the public has come to realise that major surgery should be performed by qualified surgeons.

The second difference is that the Act in Queensland had, and still has, certain democratic features. Medical practitioners, particularly those on serious charges, are judged by a judicial tribunal and not by members of the Board.

The third special feature is that in Queensland the Director General is, ex-officio, Chairman of the Medical Board. In most other states there is not even a salaried officer from the Health Department or its equivalent on the Board.

Finally the Medical Act in Queensland had major strengths in the procedures it laid down to implement its aims; for example the Tribunal. The Act has withstood the test of time, in that the amendments required over a span of years have been minimal. Moreover, there has been no professional clamour for alterations. In short, the Act demonstrates the talents of a competent medico-legal administrator who was far ahead of his times.

In spite of criticism at the time, the Act does not have a decalogue of professional sins not to be found in other states. Incidence of negligence, self-
advertisement and the like, is much the same in Queensland as elsewhere. The procedures for handling them differ somewhat here, as has been shown.

It is a more subtle outworking of the Medical Act, 1939, however, that distinguishes the Queensland scene. This is particularly evident in the power and influence of the Director General but it is beyond the resources of the lay observer to evaluate its full effect in operation. Douglas Gordon, at times A/Director General and later Deputy Chairman of the North Brisbane Hospital Board and Professor of Social and Preventive Medicine has, upon request, and in the light of hindsight and experience, written an opinion, a primary interpretation which is quoted here in full:

Looking at what has subsequently happened, two seemingly minor clauses in the Hospitals Act, 1936 and one in the Medical Act, 1939 have in practice succeeded in conferring substantial power and influence on the office of the Director General of Health and Medical Services. The Hospitals Act, 1936 stated that the Director General had to approve all appointments of medical officers to public hospitals. In the Act, however, the Hospitals' Boards still made the appointments. The clause in the Medical Act, 1939 relevant to this discussion made the Director General ex-officio President of the Medical Board.

When these two powers were used in conjunction in the circumstances prevailing in Queensland some unexpected results transpired. It is a moot point, however, whether or not Cilento had visualised these. During his incumbency in Queensland he certainly took no steps to develop the potential of the situation. His absorbing interests lay in public health (prevention) and in devising medical administrative structures. He was not particularly concerned about the details of clinical work carried out in hospitals.

Directors General who followed him, however, willy nilly were caught up in hospital administration in a substantial way. Hospitals expanded rapidly in both size and technology after the War. As Chairman of the Medical Board, the Director General raised a file on any doctor who applied for medical registration. This contained details of his qualifications and professional experience. It was natural, while wearing the 'hospital hat' to add to this, records of subsequent hospital appointments.
The special circumstances in Queensland were: all medical staff in the state were paid, there were no honoraries; the hospitals did not have Medical Advisory Boards. The Director General, therefore, had to approve the appointment to hospitals of first year residents on partial registration and, for purposes of dealing with subsequent application for full registration at the end of the first year, to take note of any adverse report; note here that both 'hats' are being worn. He had to approve applications for registrarships (the only way to obtain specialist training is to hold a registrarship), approve of other full time medical staff such as directors of pathology and radiology, of part-time specialist staff (the former honoraries) and finally, wearing his other 'hat' he chaired the Medical Board which admitted applicants to the Specialist Registry. Unsatisfactory officers were not reappointed after the expiry of their given term. The decision lay with the Director General. No reason had to be given. This provision provided the Act with a very sharp cutting edge.

Cilento saw the inherent risks in this and in 1944 had the Hospitals Act, 1936 amended so that henceforth when deciding upon applications for medical jobs in teaching hospitals, the Director General would have a committee to advise him. This consisted of Hospital Board representatives, university representatives and representatives from the medical staff of hospitals. Since the Director General, with or without a committee, in practice made the final decision anyway, the custom grew of sending all medical applications to the Director General without consideration by hospital boards. His recommendations were usually accepted by the Boards concerned, without further discussion.

Not surprisingly, the central site of power became gradually known in the medical world and medical practitioners who were seeking appointment as often as not phoned the Director General rather than the appropriate Board. Thus is power accumulated.

Though, in the Hospitals Act, 1936, apart from medical staff appointments, the Director General had no power, in practice after World War II, he gradually came to be consulted about all medical changes of any importance in public hospitals: new specialist clinics, new equipment of major kinds, etc. Here again, the custom grew up of hospital superintendents ringing the Director General directly to ascertain his probable decision before putting proposals to their boards.
In the 1960's or thereabouts, an expert medical administrator came from the United Kingdom and after surveying the local scene, remarked that the Director General in Queensland exercised more power than any other medical administrator in the world! Cilento was a committed seeker after power but I doubt if he foresaw how successful his efforts would be.  

40. Douglas Gordon, personal communication, December 1982
PART THREE

1929-1945 Bi-partite Government Service

In the Upper Echelons of Power

Preamble

The aim of the final part of this dissertation is to demonstrate, by examples of his commitment to the cause of public health as an organic whole, Cilento's effectiveness as an Australian medical administrator. Three topics have been chosen which were of primary concern to him throughout his career and which were pursued as vigorously at national as at state levels, or even earlier in New Guinea. The themes of these topics are respectively medical research, Aboriginal health, and medical organisation. The scene is Canberra, headquarters of the Federal Health Council and its successor the National Health and Medical Research Council and locus of the many national committees set up by the federal government to grapple with the problems of social security of which health was an important component.

The annual reports and discussion papers of the national councils reveal Cilento's dominant role as a constituent member. From 1937 and, increasingly from about 1940 until 1944, he can be seen as the single most prominent thinker, planner and polemicist in the great health insurance debates of that era. He is still remembered by some as the man who tried to nationalise medicine and, by extension, enslave the doctors. So distorted is this view that a long and searching critique of his treatise on medical provision for the future, as he saw it and which he wrote at government request, has been attempted. Only through historical analysis and quiet assessment of the facts may his thesis be fairly judged and the accuracy or otherwise of its long term predictions be seen. It is hoped that by going back to the origins of the long and complex debate on national health insurance, it will be possible to strip away the rhetoric and see it as it really was.
The previous section was devoted to the central thesis of this monograph: the role of Sir Raphael Cilento in the reorganisation of health and medical services in Queensland. A brief summary of their content will show that there is a focus on Queensland which distorts the account by doing scant justice to Cilento's simultaneous work at Commonwealth level; work which had beneficial results that flowed up and down between these levels. This focus restricts the reader's view of Cilento. He emerges primarily as an organiser, planner and innovator of exceptional capacity but there is a great deal more to Cilento than that. At the conceptual level his contribution to health care thinking in Australia was outstanding. To demonstrate this quality it is proposed to summarise the Queensland section and establish its essential link with Canberra.

With the passing of the Medical and Pharmacy Act 1939, the complex of tasks for which Cilento had been appointed to Queensland was essentially complete. From the amorphous Home Department, a discrete Health Ministry had been carved out; adjuncts of intrinsically medical concern had been retrieved from other ministries, or, as in the case of Nutrition, National Fitness and Industrial Hygiene, introduced ab initio to the department.

The University of Queensland Medical School was brought into being; limited research facilities had been introduced and medical education linked formally with them and with the newly-created teaching hospitals.

The consummation of Chuter's Hospitals Act in 1936 had underpinned Hanlon's extensive hospital building and extended treatment programme. With the abolition of the honorary system in 1938, the impasse between the government and the powerful coterie of 'specialists' within the BMA had been removed.

The question of country doctors' incomes had been addressed. The central government had paid the salaries of full-time public hospital superintendents and subsidised part-time medical attendants on a scale related to the size of a local population. No longer were doctors subjected to the vagaries of local authority variations in this matter.1

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1. The Health Act Amendment Act, 1944 removed the responsibility for funding local hospitals from the constituent local authorities.
A body of law had been created to give statutory expression to the new paradigm which, once activated, became a dynamic which has proved remarkably serviceable. Under the corporeal Health Act 1937 power was provided for present management and future change.

In this way many former complexities had been ironed out and the structures created for a limited nationalised health service in Queensland. One large stumbling block to the achievement of Hanlon's reform programme remained; there was still no guarantee that Queenslanders would be able to afford the cost of standard hospital accommodation should it become necessary for the breadwinner or members of his family. To provide this guarantee to all who needed it had been Hanlon's strongest personal and public commitment as Minister for Health. From 1937 onwards the whole question of the collection and apportionment of income tax as a responsibility of state and federal governments respectively had been clouded with uncertainty and Hanlon was unable to reach his goal of free hospitalisation in Queensland until he had the means of paying for it. Not until 1945 did the Commonwealth Hospitals Benefit Act appear on the Statute book and provide the means whereby he could negotiate the necessary federal subsidy. On 1 January 1946 he was able to introduce the free hospital scheme that no Queensland government since has dared to abandon. Ironically, he was no longer Minister for Health and Cilento was no longer effectively Director General in Queensland.

In the capacity of adviser and advocate, Cilento had a great deal to do with the genesis of this and related legislation and, although he remained a Queensland officer, it was in Canberra that the last act in his role as Hanlon's reform administrator was played out.

Though treatment within the following chapters is ordered chronologically, the interrelatedness of the subject matter occasions some overlapping between sections and some repetition of facts is unavoidable, although it is hoped to keep these to a minimum. It is to this end that the discussion has been limited to three subject areas, the first of which is medical research.
CHAPTER TEN

Guiding the direction of bio-medical research

The establishment of the National Health and Medical Research Council, generally referred to as the NH&MRC, which held its inaugural meeting at Hobart in February 1937, changed the face of medical research in Australia. Its predecessor, the Federal Health Council, had been a meeting of public health officers of the Commonwealth and various states, mainly to advise and persuade governments about public health policy. It was a discussion between public servants about the activities of governments; focussing narrowly on public health, only one part of medical activity, it was a somewhat introspective council of expert crown employees.¹

By contrast, the NH&MRC was to embrace as well, certain research matters. Ever since World War I, in both the United States of America and the United Kingdom, science had been penetrating in ever increasing depth, the theory and practice of medicine. A flow-on had been the setting-up of research units in teaching hospitals and, increasingly, the presence of full-time university staff members (clinical) in such hospitals. Without discussing the reasons why this scientific intrusion had lagged behind in Australia, it was apparent as early as the 1926 Royal Commission on Health that more medical research should be done in this country and a recommendation to that effect was incorporated in the Report.² The federal government, therefore, had a commitment to research at least a decade before the requisite instrument was brought into being. When it was decided to provide money for research, the NH&MRC was given the responsibility of allocating

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¹ O W Powell, Medical Research and Public Policy, Thesis M.Pub.Ad., Department of Government, University of Queensland, 1975, p. 101

² Ibid. The work and status of the AITM were separate considerations at that time. Through the formative years medical research in Queensland was directed research, dictated by public policy; it began by solving problems ad hoc and was only done by people who had the urge to do it.
resource to potential investigators in addition to continuing its advisory role in public health. Cilento's exploitation of this expanded facility, to involve the Commonwealth once again in the support of tropical research while actively promoting positive health as a desirable goal of national health, is the main theme of this chapter.

In a tribute to the new national council, Sir George Ritchie stated in his opening address at the 1939 meeting:

> By linking in its functions the two areas of public health and medical research the National Health and Medical Research Council illustrates the dual aspects of a worthy ideal.\(^3\)

According to Cilento the NH&MRC was Cumpston's brainchild. It was obvious to him that no worthwhile national policy or political clout could be achieved without representative input from the organised profession, the universities, and informed lay opinion. Hence the national council was expanded to include, as well as the states' representatives that made up the former council, a representative of each of the medical organisations, the BMA, the Royal Colleges of Physicians and of Surgeons, and the universities with medical schools and two distinguished lay members (one a woman). No longer could Cumpston be thwarted by the states voting en bloc. The federal council had become a national council designed to cover a much wider field than had its predecessor. The great majority of its members were authorities in one field and that field was medicine. As Chairman, Cumpston showed his mental stature and historic vision when he stated at the outset his belief that the newly constituted Council should concern itself with the full range of research-laboratory, clinical and social.\(^4\) The instrumentality has gone from strength to strength. When it speaks, governments listen. The introduction of seat-belt legislation is but one example of the force of argument marshalled by this body. It is, nonetheless, a purely advisory council and may not of itself prohibit dangerous preparations or practices. This is the prerogative of government.

3. Report of the National Health and Medical Research Council, 1939. From its inception, interested bodies have argued whether or not the NH&MRC should include both public health and research responsibilities. The debate still flourishes. On the positive side, it does provide a forum where medical administrators and those determining research policy at least talk to each other to the benefit of their mutual understanding.

4. Powell, 'Medical Research...' ibid. p. 104
Prime Minister Lyons, delivering the keynote address to the inaugural meeting of the NH&MRC, announced that the Commonwealth government had increased maternity allowances and assistance to infant welfare programmes. Linking this to national nutrition, the theme of the meeting, Lyons proudly stated that it had been Australia's S M Bruce who had first drawn world attention to the connection between nutrition and health at Geneva. In fact, as has been shown, Cilento had done so a decade earlier in his reports on native diets to the League of Nations. Lyons committed his government to follow up whatever were the recommendations of the National Nutrition Advisory Council and its matching states' committees when its projected survey into all aspects of the nation's nutrition was completed. A survey in this depth involved matters of concern in both national health and medical research areas covered by the NH&MRC, and this is an appropriate stage at which to introduce the beginnings of research activities.

In 1936 considerable sums became available from the King George V Memorial Fund and it was resolved to make annual research grants to the states under the auspices of the NH&MRC. This was the Commonwealth's first move into the university to nominate its own research programme. With its share of 4,200 pounds Queensland University began its commitment to medical research which has been a feature of its policy ever since.

As Professor of Social Medicine, Cilento had represented the University on the newly formed Federal Nutrition Council when an extended survey of the dietaries of families in all mainland cities was begun. Professor D H K Lee of the Physiology Department, who shared Cilento's interest in tropical phenomena, was placed in charge of the investigation which at first included an inland survey of child nutrition

5. J A Lyons, NH&MRC Report, February 1937

6. NH&MRC Resolution 1 (Session 2, September 1937) observed that: 'despite paramount defence needs the Medical Research Endowment Bill was passed in Federal Parliament, July 1937'. NH&MRC Report, No. 2, 1937

7. H Bryan, The University of Queensland, ibid, p. 85
and a study of the mineral content of common Queensland foods. This research was expanded under the auspices of the Tropical Committee (NH&MRC) which began work in 1938.

In 1937 an all-states committee had been formed to determine the policy of the national council on research priorities and related matters, such as support for institutions and nominated research workers on designated projects. Cilento, assisted by Dr J V Duhig, represented Queensland and set predictable parameters by forming the Tropical Committee mentioned above. With the exception of its convenor, Dr F McCallum, its members were all to some degree, tropical men. They were:

Dr E H Derrick  
Professor D H K Lee  
Dr A H Baldwin  
Dr Paul Mitchell  
Dr F McCallum (convenor)  
Sir Raphael Cilento (chairman)

In March 1938 this group met in Brisbane to institute a plan of enquiry into problems involved in the permanent establishment of a healthy virile population in northern Australia. Modesty of aim was certainly not to be its limiting factor.

The committee decided that these problems lay broadly within three major fields: climatic physiology, public health, and medicine. It further considered that because of the interdependence of problems in tropical medicine and hygiene, each individual subject area would, in general, have to be viewed in relation to all three headings. Three separate teams were formed to match their specialised areas; where applicable combined research work was to be carried out between teams. For example, as Cumpston observed:

Opportunities exist under well-controlled conditions for combined nutritional and physiological research.

8. D H K Lee, 'Report of Nutrition Survey' (undated) (HHA/11 bundle 7, QSA). Lee found unsatisfactory levels of nutrition in both country and city children varying from 14 per cent to 23 per cent of basic requirements of protective foods such as cheese, milk, fruit, vegetables and offal. ibid.

9. NH&MRC Preliminary Report, March 1938: also Health: 504 (AA)
work on all newcomers to the tropics and older residents at Darwin, including not only the civil population but under conditions of military and naval service in that area.\textsuperscript{10}

The physiology team led by Lee was looking into human adaptation to cooling systems in the tropics; a piece of original research which brought outside acclaim for the new medical school as Gordon has noted and which prefigured the use of air conditioning in Australia's tropics.

The public health committee was looking at housing, nutrition, and sociological conditions in the tropics of the Australian continent and its territories.\textsuperscript{11} The study of ventilation, heat regulation and heat orientation in tropical houses had obvious implications for Lee's investigations.

Nutrition centred around comparisons between European groups and between those Aboriginal groups whose diets varied according to their degree of exposure to European food. Apart from its immediate application this information had relevance for the inter-current national survey on nutrition.

Sociological conditions and individual psychology focussed the attentions of researchers on medical problems although their correction might involve economic and socio-environmental adjustments.

In his reports to the League of Nations in the middle to late twenties, Cilento had demonstrated that a high correlation existed between deficiency diets and disease. Another early worker in the field, Boyd-Orr, had also emphasised this relationship at Geneva in 1931. At the League of Nations Assembly meeting in 1936, one of the most important items on the agenda was the question of agricultural surplus and its co-existence with disease due to hunger. For Australia, S M Bruce

\textsuperscript{10} Cumpston, NH&MRC Report, ibid

\textsuperscript{11} As noted in Chapter Three of this work, Cilento had planned and supervised a classic study of living conditions and housing in north Queensland between 1923 and '25. It was an important piece of original research published as The White Working Population of Tropical Queensland, Health 4:5 (1926). In later publications it was entitled: White Man in the Tropics
informed the delegates that nutrition was the spearpoint in the movement to substitute a policy of agricultural production for one of restriction.12

At home, the public health response was the formation of the Commonwealth Advisory Council on Nutrition. On the founding committee, Cilento represented the University of Queensland by virtue of the fact that, in the previous year, his first initiative as a Senate member had been to establish the Nutrition Council of Queensland, (an unofficial body), to study aspects of the state's nutrition. This was replaced early in 1937 when Cilento formed the State Nutritional Advisory Board which was then formally linked with the parent body to correlate scientific investigations and public education programmes on this subject. Thus Cilento's influence in stimulating widespread awareness of nutrition as both a social and a physiological factor in health was both early and sustained.

Apart from its intrinsic worth as a social health activity, this is an example of Cilento's enterprise at its best.13

Under Medicine, the major interest was in the study of tropical fevers. In addition, further work was done on established research interest; the effect of lead paint in causing chronic kidney diseases. From the beginning of this century the swallowing of exfoliated paint by young children had been a talking point among medical men. In 1932 a Commonwealth-assisted investigation led by Cilento resulted in the finding by Drs Jarvis Nye, Gifford Croll and Lockhart Gibson, that lead paint not only caused acute lead poisoning in children but was probably the causal factor in Queensland's high death-rate from Bright's Disease in adults. This discovery was one of the original contributions to medical science made by Queensland medical practitioners. On this question, Cilento held a dissenting view. In introducing

Cilento was Chairman of the State Nutritional Advisory Board; membership is listed on page 164 above. Its terms of reference were wide: its aims to correlate enquiries into defined aspects of human nutrition and to co-ordinate findings at federal level. It looked beyond staple foods to special needs for special groups, Aboriginals, the aged, nursing mothers, school children, with the aim of providing dietary guides for professional and public guidance.

legislation outlawing the use of lead in paint, Hanlon accepted the majority finding.\footnote{Graham Croll, 'Histology of Lead Poisoning'. Report on work carried out by Cilento, Nye, Gifford Croll et al under Commonwealth Department of Health, 1932 HHA/6 (QSA)} This work was taken up by the university's physiology school and continued by Dr David Henderson after World War II. He was a physician in private practice working on a specific grant.

In 1935 Cilento, who never ceased to promote the study of tropical fevers by whatever means he could, set Derrick up with minimal financial help to investigate a strange fever in the Brisbane abattoir's area. He and Burnet had discovered 'Q' fever. Once again, a similar complaint from the Sunshine Coast, as it is now called, led to the description of yet another fever, Pomerua fever, a form of Weill's disease. Neither of these ventures was supported by the NH&MRC, since the research predated it, but as a result of Derrick's work, the Council declared the Laboratory of Microbiology and Pathology an approved research centre and funded both Derrick and Burnet separately to continue work into 'Q' fever.\footnote{J H L Cumpston, NH&MRC Report, 1939, ibid.} Gordon Heaslip began work on the vectors of scrub typhus, while Cilento, aided first by David Johnson and then by Graham Croll, carried out a general survey into the health of the Aborigines of the Kuranda tribe as part of a long-term leprosy study to be discussed more fully later.

Leptospirosis has already been mentioned in connection with the virulent outbreaks of 1933 and 1934 and was an important research interest in Queensland until the sixties.

The genesis of these research projects (with the exception of lead paint which was later) can be traced to Cilento's earliest writings and work. He always argued strongly for the principle of scientific enquiry, albeit with a special tropical application, at that stage of Australia's tropical development. Both Forgan Smith and Hanlon had come under his influence and fully supported the NH&MRC's Tropical Committee with the resources of the State Health Department and the University of Queensland.
Cilento was not a researcher in the accepted sense of that term; as Director General he encouraged Derrick and Lee, both excellent scientists and several others as well, within Queensland. At the same time, as a member of the NH&MRC he drew attention to problems which needed investigation and persuaded the Council to provide some financial support for what became a series of continuing scientific enquiries.

Meanwhile the Federal Nutrition Survey had been completed and, as the Prime Minister had undertaken to implement its findings, the public health side of the NH&MRC coin will now be looked at in order to see the developments that flowed. In May 1939 Cumpston told the meeting:

In 1938 the final report of the Advisory Council on Nutrition was presented indicating the need for considerable research and considerable education and study of certain problems in relation to nutrition... the Commonwealth government therefore decided to give special attention to:

(a) the period of rapid growth and development (the pre-school child)
(b) the cultivation of national fitness generally. 16

It was resolved that the study of the pre-school child and of national physical fitness education were obvious extensions of the nutrition survey and that public education in these matters was essential to the success of any health programme. Only through public awareness could the leading edge of disease prevention be pushed toward the attainment of the positive health of the community.

(a) The problem of the pre-school child.

Although each state representative of the NH&MRC had been requested to report on this activity, Cilento's was the only paper presented for discussion at the next meeting. Perhaps Queensland only had the genesis, and it could not be described as more than that, of a system for including the pre-school child in the general public health care plan. Summarising these beginnings, he touched on the work of the Mothercraft Association, Creche and Kindergarten, Baby Clinics,

including the mobile train service, and other agencies. The pre-school child was regarded officially in Queensland as the two-to-five age group and the general activities available to parents at that stage were almost entirely restricted to advice on diet and general medical management. Cîlento stressed the need for education at all levels and welcomed the formation by the Commonwealth of the projected system of Lady Gowrie centres.\textsuperscript{17}

(b) National physical fitness

Hippocrates asserted, over two thousand years ago, that a doctor must teach his patients to care for their own health. Physical fitness, consciously striven for by both individuals and communities, had long been advocated by Cîlento. In 1932 in Queensland he promoted a national fitness programme as an antidote to depression neurasthenia; probably the first of its kind in Australia. In 1937 he spearheaded a National Health and Fitness Campaign in Queensland to promote the concept of positive health as a possession which each man must win and keep for himself. Addressing the 1940 meeting of the NH\&MRC on the same subject he affirmed:

\begin{quote}
The purpose of a Health and Fitness Campaign is to teach the community the knowledge and practical application of how a man can live a healthy life in the everyday environment of his existence. The remedy for ill-health is correct living and conduct.\textsuperscript{18}
\end{quote}

This expresses the innovative attitude that underlay his introduction of sport and exercise programmes among factory workers; avoiding sickness by promoting health. In Canberra, his advocacy of university lectureships on this subject was successful.

Hanlon was less than impressed by his Director General's achievement:

\begin{quote}
17. Cîlento, The Problem of the Pre-School Child, NH\&MRC Report, ibid, App.1. Maternal and child welfare (dealing mainly with babies in their first year) so dominated public health as it related to the young child that little was done in any state for the pre-school child until after World War II. Hence this interest in Queensland anticipated a movement still to come throughout Australia.

18. Cîlento, Health, Food and Fitness, Department of Health and Home Affairs, Queensland, 1937: Commonwealth Health Department pamphlet, 1940 (AA)
\end{quote}
'What a lot of hooey', he snorted. 'Whoever got fit sitting in a lecture room for three years? And you still have to pay for it. But, as the Commonwealth is footing the bill, Queensland with all other states will establish a university lectureship.'

Here again was a classic case of the Hanlon/Cilento syndrome. About ten days later Hanlon supported the project in his own way when, launching the Queensland Council for Physical Fitness, he took as his slogan 'More players and fewer onlookers at the playing fields' and announced that his government would provide the sum of 58,000 for extended recreation facilities. No-one was more delighted than the exercise-conscious Cilento.

It is fitting to compare this thinking with the official government monograph on public health promotion published in 1980 and introduced as follows:

At the forefront of the current health care debate is the general recognition that many of to-day's health care problems are related to personal behaviour and are largely preventable by action at the individual level... Prevention in this context is seen not so much as a new approach but as a traditional approach re-explored.20

Man seems doomed eternally to re-invent the wheel!

Before leaving the general area of research discussion and without in any way detracting from the work of Derrick in the founding of the Queensland Institute of Medical Research, it should be said again that Cilento had been among the earliest and most ardent proponents of an institute for continuing research in Queensland. In connection with this concept he had written to the Minister early in 1940 and in November 1942. In September 1944 he again wrote advocating that, as the Sir William McGregor School of Physiology was about to be transferred to the St Lucia University campus, the large building could be used for the purposes of a medico-legal institute, research laboratories, bacteriological laboratories and a public

19. The Argus (Melbourne), 11 August 1939, Frederick Stewart Cutting Book, C.P.S. I4 B109541 (AA)

20. Trevor Wood in 'Forever Amber', Inaugural Sir Raphael Cilento Oration, ibid, p. 14
pathology section. He saw a first class research establishment as an essential adjunct of any worthwhile department of public health. His letter concluded with this plea for government recognition of the true worth and potential of the gifted researcher:

Sir Howard Florey, the co-discoverer of penicillin, and a fellow student of mine at the University of Adelaide... very truly points out that if gifted medical men (and I am thinking particularly of Dr Derrick and some other members of this department) are tied merely to a routine programme, their efforts are not only wasted but they are likely to be attracted to other places which offer greater opportunities.

Shortly after that letter was written, and in response also to an urgent plea by Derrick, Hanlon authorised the Medical Research Advisory Committee chaired by Derrick to plan an Institute of Medical Research. (Cilento at that time was fully occupied in Canberra). The resultant Queensland Institute of Medical Research has flowered into an instrumentality where research is anything but ad hoc. It is a force linking the Commonwealth government, through the NH&MRC with the University of Queensland and the state health department. Its founding is also a measure of Hanlon’s greatness, since by nature and by nurture, he was instinctively pragmatic. Cilento’s influence in creating an awareness of the importance of medical research as an economic, social and scientific component in individual and community health can be traced back to his first meeting with Forgan Smith in 1922 on the subject of Weil’s disease.

As with nutrition and national fitness, the theme of research was continually emphasised in his writing, public addresses and professional reports. He took full

20. Cilento to Undersecretary, Department of Health and Home Affairs, 20 September 1944, Fryer coll. 44/ unreal.


22. Derrick in ‘The Birth of the Queensland Institute of Medical Research’ (Med. J. Aust 2 (1972) pp. 552-59), pays tribute to Cilento whom he describes as a revitalising influence. Professor B Mayes to Cilento, 29 May 1944, Fryer coll. 44/, (your influence at NH&MRC can be of considerable help in matters affecting commonwealth .... and teaching of students).
advantage of his position with both levels of government both independently and interactively to win official support for activities which embodied these basic functions so commonly accepted to-day as to be axiomatic.
CHAPTER ELEVEN

Cilento and the Aborigines

Who casts the first stone?

Cilento's life long interest in Aboriginal health and his early concepts of social medicine were born in him as a senior medical student in 1917 when, because it was war-time, such students were permitted to 'do' locums. One visit to an aboriginal woman lying sick in filth and squalor was sufficient to show him in a flash of insight that the health and social conditions of detribalised aborigines was a single and indivisible problem. Army service in New Guinea in the following year gave further opportunities for empirical observation of another ethnic group affected by its contact with Europeans. In the Federated Malay States in 1921 Cilento fell into step on the outer marches of the colonial era in medicine when European powers saw their responsibilities towards native people as part of the White Man's burden: a duty of care.

In 1922, as Director of the Australian Institute of Tropical Medicine in Townsville, he was expressly instructed to promote the White Australia Policy, which happened to accord with his convictions. Therefore his stated belief in the supremacy of the white races was both timely and seemly.

Conversely, and by 1925 simultaneously, he was charged with putting above all else, the health of native people; a condition of Australia's mandate in New Guinea. Yet he had no difficulty in reconciling his duty and his value system. As he saw it, the white man had special advantages that entailed special responsibilities to the less fortunate.

Throughout his long public life he remained a white supremacist. As public attitudes changed this was to bring him under attack from some quarters for being totalitarian by conviction and racist in attitude. Labels can be both mischievous and
misleading. Rarely, in cases such as this, do they reflect considered opinion. Cilento laboured consistently to improve the health and living conditions of native peoples, because of his attitudes, not in spite of them. This contribution was so impressive as to attract a knighthood in recognition of his work among the coloured peoples of Australia's dependencies.

The groundswell of world opinion that discrimination on the grounds of skin colour can no longer be condoned is one factor that has made Australians much more aware of their Aboriginal people; it has also encouraged debate on such issues as their place in society and their rights to tribal lands. Inseparable from the question as a whole is the Aborigines' right to their health.

As a Mandatory, Australia recognised this responsibility in New Guinea almost sixty years ago. The following extract from a Melbourne paper, published anonymously, is almost wholly based on the text of Cilento's reports; it has a contemporary ring and would be highly topical in Australia to-day:

Our motto should be the preservation and development of the native races and the securing to them of their lands and rights for their future use and well being...

The examination of native life and conditions as viewed by the medical authorities in the Territory throws a great deal of light on the complex tasks which face us in the carrying out of the above ideal, and particularly reveal the primary importance of the native mind and will in the solution of these questions...

The medical authorities have learned the vital and foundation truth that the uplift of the native must come through the native, and an ever-increasing staff of medical tultuls (orderlies) is being trained and sent forth to minister in an elementary way to their health...  

Cilento's belief was that the good of mankind is best served by improved administration and the use of present resources; his guiding principle as an

1. The Age (Melbourne), Australia's Mandate, The Administration of Health, (by our special correspondent). No. 11, 31 October 1925, Cilento cutting book, Fryer coll. 44/
administrator. This meant identifying first causes and organising workable remedies. One such causal connection, that between poor nutrition and the disease beri-beri then seriously depleting the health of plantation labourers, was seen by him as warranting a legally enforceable remedy to compel reluctant planters to improve the quality of their workers' diets. In bringing pressures from Canberra to force an equally reluctant Administrator to supervene in the interests of the natives, he put his career in jeopardy. Although the immediate solution was a compromise, Cilento's principle of the relationship between nutrition and health was accepted by the League of Nations and marked him as a world leader in this area of enlightenment.  

In New Guinea with minimal resources and little experience he established the system of native medical care officially described at Geneva as the best feature of the Australian trusteeship; he also set up the Territory's first lazaret at Analua with the enormous number of 400 patients. This initiative, like his work on native diets, has relevance to his later involvement with aboriginal health in Australia.

Cilento's lofty assumption that government should always treat public health obligations as paramount more than once worked to his personal disadvantage, yet he never sacrificed his principles to expediency.

On his return to Australia in 1929, fresh from his Pacific Islands health survey with Hermant on behalf of the League of Nations, Cilento was anxious to look at the Australian Aborigines: he wished to ensure that the nation was doing as much for her own indigenous people as for those of her neighbours. He approached Cumpston for permission to make a survey of tropical health conditions which would take him as far north as the Torres Strait Islands. Wary of further involvement in Queensland,


3. Cilento, 'Review of the position of Tropical Health in Australia', F H C Report 1931, App.II became a major guideline document. One result with many ramifications was that leprosy was placed on the agenda of successive Council meetings for more than a decade. Cilento ceaselessly hammered home the importance of this (numerically insignificant) disease; his key to Aboriginal health and to medical research in Queensland. It was one of the subjects on which Australia had agreed to provide epidemiological information to the International Hygiene Commission as a member nation.
Cumpston allowed him to undertake the journey as a personal initiative.

During the next five years Cilento undertook several arduous journeys to rugged Cape York and in 1933, went to the Northern Territory where he was joined by the Chief Medical Officer and authority on Aboriginal health, Dr C Cook.

Cilento's field studies were thorough. Pocket diaries extant record vital statistics of semi-tribalised and institutionalised groups in sufficient detail to provide a record of many facets of their culture. Diacritical marks are carefully placed to indicate pronunciation of names and places; a lilliputian English-Aboriginal dictionary he carried as an aid to communication was found among his papers. Work in such depth required close personal contact and observation. His reports were submitted to both levels of government and reveal both empathy for Aborigines and a determination to help them. He noted that native diets were always deficient in protein, for as the land had been cleared for settlement, birds, lizards and other animals lost their shelter and Aborigines became pensioners on the bounty of the settlers who had dispossessed them. Plant foods similarly became inaccessible leaving them ultimately to a diet of white flour, sugar and tea so completely lacking in essentials that the perfect dentition of the Aborigines that had earlier prompted every important museum to acquire Aboriginal skulls... had been ruined. He criticised the use of chlorodyne-based medication on settlements; it induced drug dependency. These were just some of the aspects of white man's effect on the aboriginal condition which Cilento spelled out in his reports to both levels of government and in his unofficial speeches and writing. Although they were intended as a guide to future policy, not all his reports were heeded.

Regular landfalls of narcotics were being made up and down the coast, usually by Japanese lugger crews poaching in Reef waters. There was clear evidence too, that these crews were prostituting native women. At Bloomfield River Cilento watched a slant-eyed native boy signalling boats in through a break in the Reef. Packages were dropped some distance from shore and later floated to the surface marked by coloured flags. Cilento found that they had been weighted with salt which dissolved slowly enough to allow the smugglers to escape. As he suspected, they

contained narcotics. To his dismay his reports on this practice were ignored by the Queensland government (probably because they had no means of policing it).

Hanlon of Queensland was one man who came to take Aboriginal problems seriously.

Speaking of his reasons for coming to Queensland, Cilento wrote that there was more hope - more scope? - in the state where ninety five per cent of tropical residents lived and practically all the natives under actual control.6

In a statement to the Federal Health Council, Hanlon asserted that Cilento had been appointed for many reasons not the least of which was to advise on the medical aid available to Aborigines in Queensland.7 At the same time compulsory health checks for Aborigines became law and special provision for their health was made in that year's budget.8 Hanlon told the parliament that Cilento had given very fine assistance to the 'Aboriginals Department'... and would be a tower of strength to the government (on these matters).9

The weight of Cilento's accumulated evidence may have influenced the government to rescue many of them from starvation. As he stated officially:

During the current year, stringency occasioned by the Depression has drawn a large proportion of Aborigines into reserves and mission stations and provided the opportunity to examine what may be called 'Australia's floating debt' in respect of endemic and tropical diseases....

No one who demonstrated insights such as those so early could fairly be called an unfeeling racist.

5. Cilento, 'A Patrol of Cape York Peninsula', Cilento diary, 4 November 1933, Fryer mss 44/23 FHC Report, 1933
8. Hanlon, QPD 1934: (V) CLXVI, p. 1584
10. Cilento, 'Review of the position ...', ibid, p. 33
Hanlon, an urban man whose experience of the Aboriginal condition was relatively slight, was fair-minded and humane. In all sincerity he explained:

> It is our paternal duty to care for our Aborigines:
> 3,400 are still nomads including those in Mission stations; 2,524 are in government settlements; 3,350 live in Torres Straits and are practically self-supporting; 2,869 engage in paid employment under government supervision which includes control of their earnings and business transactions.\(^{11}\)

Hanlon's words, 'paternal duty' express the difference in attitude between people genuinely concerned with alleviating the distress of Aborigines in his day and those supporting their bid for recognition as a people in their own right today. The late 1960s saw these changes coming in full flood; by then, indigenous people had acquired self identity. Pride of race, stemming from the national standing of the Aboriginal artist, poet, politician, state governor, renowned singer, and the shy young tennis champion who won the hearts of millions throughout the world, gave them a new self-image. Political awareness, stimulated by the rise of black power movements overseas, stiffened their resolve to achieve rights to their land; pride in their ancient culture, re-awakened by the interest of the white anthropologist, became a powerful focus for these claims. Europeans were by now sufficiently enlightened to acknowledge these things and many joined them in their struggles. Until then, those concerned with the welfare of aborigines believed that their duty lay in caring for them as for children, supplying them with meagre resources because they would never be able to contribute to the Australian economy or manage their own affairs. They needed compassion, protection, and kindness. This was paternalism, used in its most pejorative sense.

In the past two decades the medical outlook on Aboriginal health has matured. It is realised that they suffer more than average ill-health and that this is chronic; they have a high infant mortality rate, recurring gastro-enteritis in the young, are prone to eye and ear infections, and readily become diabetic. Alcohol is a scourge among them and brings with it a high accident rate, pneumonia, shortened life expectancy, and psychic disability. Their high mortality and morbidity rates shame thinking people. As an ethnic group in the detribalised state, they tend to be poorly

\(^{11}\) Hanlon, 'The Work of the Home Department', Daily Standard (Brisbane), 1935 repr. Oxley Library, (Brisbane)
housed and lack the facilities that make for easy cleanliness; they are inadequately educated and therefore condemned to menial jobs or none at all. Socially they are excluded from the more admirable advantages of Australian life.

As a medical administrator in Queensland Cilento was a prisoner of his times. Aborigines and their reserves were controlled by the Protector of Aborigines and intrusion into their health affairs by an outside officer was seen as professional trespass. He was caught between a depression and a war; in the impoverished thirties, lack of money restricted progress in material provisions on their reserves. Queensland voters, especially the powerful rural moiety, were less than enthusiastic about spending money on Aborigines. Their reserves, even including the Fantome Island Lock Hospital, were expected to be more or less self sufficient. One of Cilento's early initiatives as Director General was an attempt to remedy this situation by replacing the lay superintendents with medically-trained supervisors. He was advised by H D Dignan, who had been seconded from the office of the Public Service Commissioner to guide him on procedural matters, to defer this move. Until it could be included in the full organisation of Aboriginal settlements as part of the general reform programme, industrial trouble could arise due to the exclusion of settlement officers from the Public Service Act. These were all reasons why only limited improvement in provisions for Aboriginal health care were made under Cilento.

He first appears in the definitive record of medical literature on the health of Australian Aborigines in 1924, which is very early. In all this bibliography lists some sixteen papers by Cilento, six of which appear in his annual reports as Director General between 1934-45. They are fairly bland in tone, as befits such documents; it would be surprising if the fire of commitment inflamed the sentences by which

12. H D Dignan, Memorandum to the Director General, HHA/11 (QSA) undated.
13. Under Health Act 1937 (S.15), Cilento gained authority to 'enquire into all matters affecting the medical welfare of aboriginals': a significant advance.
governments of all parties announce year by year the progress that has been made. Nevertheless, there is a continuing, judicious emphasis on the problem of native nutrition; a graphic account of the spread of leprosy, supported by maps, graphs, and hard data appears in the 1938 report. It says much for Hanlon, given the community's attitude to the Aborigines, that he took official note of these things.

Cilento demonstrated his perception of the socio-cultural factor in human pathology in another sphere of interest. His reference to Queensland's unique opportunity for Aboriginal health studies within the new medical school reminds the reader of his early interest in physical anthropology at the Adelaide medical school, an academy long noted for its experience in this subject.\(^{15}\) Almost as soon as he took over in Queensland, he wrote to Professor A P Elkin:

> I am trying to get work on Aboriginal stations on a better footing so that a big source of anthropological material might not be wasted.\(^{16}\)

The famous anthropologist jumped at this hint of co-operation and suggested that there was scope for a government anthropologist in the Gulf area formerly studied by Sharp, McConnell, and Thompson on a Rockefeller grant.\(^ {17}\) This was too much for Hanlon; he exploded at the suggestion that money be wasted on their 'fairy stories' maintaining that the government's job was to feed them.\(^ {18}\)

This is a further illustration of the different levels on which Hanlon and Cilento thought. Hanlon had a fund of commonsense and political acumen that led him straight to the practicalities of a problem. Cilento was a long-range, lateral thinker who looked at the parameters and synthesized his solutions to take account of these in the long term.

The doctor maintained his contacts with Elkin and leading overseas anthropologists. One is again reminded of Virchow, that great medical scientist

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15. Cilento, Report to the Advisory Committee on the Foundation of a Faculty of Medicine within the University of Queensland, ibid, Fryer coll.
16. Cilento to A P Elkin, 28 August 1935, Fryer coll. 44/11
17. Elkin to Cilento, 18 September 1935, Fryer coll. 44/11
18. Hanlon, Telegraph (Brisbane), 31 July 1937
whose nineteenth century dicta provided the scientific basis for medicine down to World War II, a pioneer in social medicine and an anthropologist. It would seem that anthropology is a discipline that stimulates interest in the cultural causes of disease.

In his plea for the inclusion of the subject of nutrition in the state’s health legislation, Cilento drew Hanlon’s attention to his major reports on the health of Aborigines (1932 and 33) and to considerable references in his report to the League of Nations printed in 1929. There is testimony in the writings of missionaries that he demonstrated in action the value he placed on Aboriginal life. The question of nutrition he saw as one of the most important aspects of medical work which would become increasingly so as world opinion follows science.

All this evidence, peripheral and central, suggests that Cilento’s precocious understanding of the social components of ill-health took full and continuing account of the Aboriginal condition. Yet, Aboriginal health improved but little in his time because, as he wrote, their living conditions were sordid to the point of misery, and he could do little to ameliorate those.

To rise above the local inertia, Cilento pursued the matter at the national level, as has been stated. He was, of course, particularly effective in persuading the federal government, through the national council, to spend money on the investigation of leprosy. In this way he gained access to Aborigines across and within state boundaries. Before picking up the story, it is advisable to look more closely at the background of the federal body’s involvement with the epidemiology of the disease.

19. R H Wilson to Cilento, 14 January 1936, Mornington Island Mission Station HHA/6 (QSA). G Rose, The Heart of a Man, A Biography of Missionary G H Schwarz, Ch 5, p. 4, Fryer coll. 44/- As recently as January 1984, Fred Deeral, an elderly Aboriginal at Hopevale Lutheran Mission recalled that Cilento had ordered dugong oil for the treatment of tuberculosis, then causing concern at the station. H D Marsh, research fellow, James Cook University of North Queensland, personal communication.

20. Director General to Minister, memorandum, 14 January 1935, HHA/1 (QSA)

21. Leprosy investigation by Graham Croll under NH&MRC grant, 1939/40 HHA/6 (d) (QSA). Federal Health Council and National Health and Medical Research Council Reports 1931-44.
In relative terms, leprosy is usually a disease of low incidence but because, since biblical times, it has been a theme of horror, it has always stimulated less than rational response. In 1927 Dr Cecil Cook produced a definitive study on leprosy in Australia.\(^{22}\) He claimed, on sound evidence, that it had increased and become endemic among Aboriginal people. Consequently there were foci of infection which would increase the spread of the disease. Coming from the pen of Cook, who was admired and respected as a reliable witness given to under-statement, this report commanded reluctant attention; the more so since it followed immediately upon Australia's commitment to the intelligence service of the International Health Committee of the League of Nations. Leprosy was high on the list of those diseases required to be studied and reported upon by member nations.

Cumpston had few resources and apparently decided that these ought to be spent in the south east corner of Australia where diseases such as tuberculosis were all too obviously sinister and numerically significant and where leprosy was virtually unknown. On the other hand, in an historical survey published in 1931, he supported the view expressed in 1894 by Ashburton Thompson and Bancroft, who had been Queensland's earliest leprologist and who had recognised it in that state in 1868,\(^{23}\) that leprosy was an introduced disease and acknowledged thereby a moral responsibility to the Aborigines upon whom it had been implanted.\(^{24}\) He ordered that chaulmoogra trees, source of the loathly oil which was then the only known medication for leprosy sufferers be planted in Cairns, Townsville and Rockhampton, an act which indicates official concern about the endemicity of the disease in the Australian wet tropics at that time.\(^{25}\) It is interesting too, to read that Dr Edgar North of the Commonwealth Serum Laboratory in Rockhampton carried out research into the possible relationship between human and rat leprosy (1927-30). This project

\(^{22}\) C E Cook, The Epidemiology of Leprosy in Australia, CDH Service Pamphlet, No. 38, Canberra: Government Printer, 1928


\(^{24}\) J H Cumpston, Public Health in Australia: the first Forty Years, Med. J. Aust, 1: 491, 1931

\(^{25}\) The Telegraph (Brisbane), 25 March 1931
was funded jointly by the State and Commonwealth governments. 26

Cilento had the strongest possible grounds for supporting Cook. His later surveys showed that there was a distinct possibility that the incidence of leprosy was increasing alike among white and Aboriginal peoples. 27 He complained in the Federal Health Council of years of official lip service and little effective action. 28

Under pressure, Cumpston agreed to place leprosy research on the agenda for the next meeting and Cilento was authorised to present a case for a national programme of control. Meanwhile, it was resolved that leprosy among Aboriginals would be a matter for local Aboriginal welfare authorities (which seems unbelievable coming from public health men) and that European and Asiatic lepers should be under state government control. Racial distinction could not have been more explicit or discriminatory.

Cilento's case succeeded. The first resolution of the NH&MRC at its second meeting was that the federal government be asked to fund its research as a matter of policy and the second was that, in view of the prevalence of leprosy and its spread to white people, an immediate investigation at suitable foci in Queensland be made and a survey carried out in Western Australia to detect and treat sufferers. The Council further recommended that 500 pounds be made available immediately to Queensland for the purpose of leprosy investigation. So the first research project under the auspices of the NH&MRC was, due to Cilento's persistence, directly and exclusively concerned with Aboriginal health. And that is a significant fact. 29

26. Human and Rat Leprosy File, Fryer coll. 44/8
27. Cilento, Interim Report on Aborigines, Surveys 1 and 2, Sydney School of Public Health and Tropical Medicine, 1932, based on Cilento's medical surveys on behalf of the Chief Protector of Aboriginals, 1931, 1932. Fryer coll. 44/8
NH&MRC Report, Inaugural session, February 1937. Resolution No. 3, p. 9
Hanlon offered free use of the Palm Island native settlement for this study, but Cilento persuaded Cumpston that a closed group should be the subject. It was the Kuranda Tribe, which he had been looking at since he first discovered an active case of leprosy among them on his 1929 patrol of Cape York.\(^{30}\) As several members of the tribe had since been traced to the Peel Island leprosarium, he was interested in the possibility of inherited susceptibility as well as in the means of contagion. In 1938 he produced a report on the history and progress of the Kuranda study and outlined a programme for a further three years. This he personally supervised until war claimed his principal research officer, Graham Croll. With his usual economy of means, Cilento conducted a general health and dental check of the Aborigines at the same time, realising that it would yield useful information at minimal cost, in fact the only way it could feasibly be done.

In the same year he updated Cook's 1927 survey. This report was the more disturbing in that it showed that the incidence of leprosy was increasing among Europeans especially in the south east corner of Queensland.\(^{31}\) The 1939 NH&MRC report featured eight resolutions on the health of Aborigines beginning with:

\[(a)\] Complete investigation of the health of Aborigines and associated environmental circumstances throughout areas recognised as the Aboriginal districts of Australia should be definite objective of the Council

and resolving in conclusion:

\[(g)\] The final objective should be the health and welfare of the Aborigines and the most satisfactory system of administration to ensure uniformity throughout Australia.\(^{32}\)

In short, Cilento's long battle had been won inasmuch as it was now officially recognised that Australia had an obligation to care for Aborigines' health and that this could not be separated from their living conditions, as he had always maintained.


\(^{32}\) NH&MRC Report, 1939, Minutes
In 1940 the Lock Hospital at Fantome Island was converted into a lazaret for coloured people. Patients came under the care of a resident medical officer at times, but more frequently were supervised by regular professional visitors. Regretfully, it must be said that conditions at Peel Island were not much improved in Cilento's time, although his agitation bore fruit by mid-August 1946 when Dr E Reye served almost continuously as resident medical officer either there or at Fantome Island.

Whatever Cilento's political orientation, and in spite of the now unacceptably racist, though never disparaging, language in which he expressed himself, he displayed consistent care and concern for the health of native peoples throughout his career. More than most intelligent people of his era, he saw that the massive ill-health of Australia's Aborigines had roots in their disastrous social and economic circumstances. Failure to improve these conditions as he would have wished was in large measure a function of the prevailing attitudes of the society, the total inability of the Aborigines to see any relevance of its mores to their social structure and the sheer lack of constitutional means to bring Aboriginal Health as an entity under the purview of federal or state health departments. Cilento's work and influence both with Hanlon and the national councils contributed significantly to such helpfulness and understanding as had been achieved.

Cilento's belief in the superiority of the white races, expressed in active responsibility for the care of those whom they had dispossessed, was the colonial expression of the 'white man's burden'. One can but speculate as to why it was that he was unable to modify this stance in the sixties when he was still actively concerned with racial considerations. The answer may lie in the attitudes and values he had internalised in his formative years. He had always been elitist; mindful of an aristocratic family tradition of 'noblesse oblige', reinforced by the ideals of his own ancient profession of healing. It is worth while to reflect that until very recently, people who showed compassion and concern for their less fortunate fellows were expected to be both paternalistic and elitist.\(^{33}\)

\(^{33}\) Yarwood and Knowling, Race Relations in Australia, ibid, puts the development of a broader based tolerance towards Aboriginal people in clear historical perspective, demonstrating that to-day's position, while far from ideal, is a very recent and historically accelerated level of achievement.
CHAPTER TWELVE

'The State, the Public and the Medical Profession'

The title of this chapter, borrowed from Cilento's paper of the same name published in August 1937, indicates its main thrust, discussion with Commonwealth governments of the early blueprints for national health insurance in which Cilento was heavily involved. The time span is roughly from 1939-45. Brief mention will also be made of certain of Cilento's other responsibilities arising directly or indirectly from the war situation which greatly increased his workload.

First, in May 1940, on the recommendation of the relevant parliamentary standing committee, the Minister for Defence Co-ordination (R G Menzies) approved the formation of a Medical Services Advisory Committee. The limited purpose of this body was to furnish advice on technical matters referred to it by the medical directors of the fighting forces and later to liaise with the American Forces. Lt. Colonel Sir Raphael Cilento and Sir Stanton Hicks of Adelaide were the only two of the fourteen members who did not come from Melbourne or Sydney. Members of the committee tended to be scientists or senior administrators in the field of medical science and proved to be useful to doctors in the armed services. For example, the committee sent out technical bulletins on topics such as the latest treatment for malaria, the management of air-crews under stress, the use of the then new penicillin, and the like. In certain cases it arranged for research to be done in areas where existing knowledge was sparse. This applied in particular when the armed services moved into the southwest Pacific region; Cilento's metier.

The second matter dealt with the military and civil conscription of members during World War II. Compulsory allocation of doctors, not only to the armed forces

1. Medical Services Advisory Committee Cp.77, Bundle 3, A/A, 20 May 1940
2. Cilento wrote special lectures for post-graduate students entitled: 'Epidemiological and Tropical Aspects of Military Medicine, 1940', Fryer coll. 44/
The problem of dust in coal miners as distinct from dust in hard rock miners became particularly sensitive in both the United Kingdom and Australia, mainly because at that time the need for coal during the war years became particularly urgent.
but also to the civilian population, had become necessary. The number of practitioners available to civilians was greatly reduced because the armed forces required one doctor for every 250 people in their ranks. This produced a thin spread of doctors for civilians, one doctor for every 2000 people. The corresponding figure in 1982 is approximately one doctor for 500-600 people. This became a highly contentious matter and will be considered more fully below.

The third activity in the federal sphere to which Cilento was seconded in 1944 was the chairmanship of the national survey into the health of coal miners; this involved him (and his team) in the physical inspection of the nation's coal mines. Following the discovery of a substantial dust problem affecting the lungs of coal miners in the United Kingdom concern for the health of this industrial group was very pressing at that time; completion of the report on this survey was Cilento's last official act as an Australian government servant.

Blueprints for the Re-Organisation of Health and Medical Services in Australia now become the central concern of this study. It was Cilento's destiny to conceptualise, and formulate, the first detailed master plan on which might be based constructive yet practical policies to safeguard the health of the people; an obvious responsibility of government brought sharply into focus by wartime conditions and one which inevitably placed medicine in the centre of the political arena. He therefore assumed the role of polemicist in the heated debates which followed.

Following World War I governments in the United Kingdom became increasingly vocal about social security, a concern stimulated by the human sufferings inflicted by the great financial depression of the thirties. This movement generated inquiry about the use of public funds to establish and maintain preventive and curative medical services. In the intensity of argument which government intrusion into health has provoked ever since, it is often forgotten that this was only one segment of an extensive social movement towards the welfare state.

3. Cilento, Transcript of (in camera) evidence before the Joint Parliamentary Committee on Social Security, 15 December 1942. Fryer coll. 44/108, hereinafter Transcript EE or EEE...), EEE 36
4. Cilento, 'The World ...,' (Ch 16) pp. 40-41, Fryer coll. 44/2
As discussion, debate, and confrontation have crystallised about this subject during the last half-century, the following topics have emerged as those principally germane to government interest in health care delivery:

1) administrative structures
2) economic considerations
3) the physical plant required for hospitals of all kinds, health centres, laboratories and diagnostic centres
4) personnel to man the health services
5) the need for and nature of formal preventive services.

In the beginning all these considerations had to be drawn together in a reasoned statement as a basis for policy decisions and enabling legislation. As chairman of the NH&MRC which had been asked by the federal government to advise on the whole question of national health insurance, Cumpston asked Cilento to prepare the initial submissions. This was an obvious choice. Officially, through the exchange of information at federal council meetings, and no doubt through his personal observations, Cumpston was aware that Cilento's working model in Queensland addressed the preliminary problems facing Canberra. As Australia's top medical administrator, Cumpston had always used Cilento to the full whenever circumstances called for his special knowledge or skills; they shared the great social purpose of laying the foundations of a reliable national health system in Australia. Both men knew that this could not be achieved without the understanding and support of qualified medical men. In Canberra Cilento could speak to this body with greater freedom than had been possible in Queensland. He accepted with great enthusiasm the challenge which he regarded as one of the most important of his career. Cumpston knew his man; decades later Gordon wrote:

Sir Raphael had an inherent genius for quickly discerning what was wrong in any area of public administration and in devising the appropriate legislation to meet the situation. His far-sighted health legislation in Queensland has stood the test of time. He functioned just as efficiently as an administrator in New Guinea, the southwest Pacific, as a member of the National Health and Medical Research Council, in war-ravaged Germany and with the United Nations. He had a rare capacity to look at the world around him, both as a lawyer and as a medical graduate.9

5. D Gordon 'A rare man', The Australian, Letters to the Editor, 15 September 1983
Cumpston also knew his doctors and the code of convention that governed their discussion and negotiation. Even in situations where he was 'first among equals' he knew that due deference was pre-requisite to their trust and co-operation. Cilento's forthright, serious and somewhat didactic approach, by contrast, certainly weakened his influence with both the BMA and rank and file practitioners, as will be shown.

In any case, the majority of practising doctors would have found many of the considerations listed above irrelevant and boring. The first of these, Administrative structures, the relationship between medical services and government, they saw as a matter for public health practitioners - a race apart.

Economics, the second, interested them mainly in two aspects; professional freedom and the right to practise when and where they chose; the right to determine the number of hours worked, the drugs prescribed, and the scale of fees charged should be theirs irrespective of whether the patients or governments paid such fees. Perceived challenge to any of these choices evoked the hell-fire and brimstone aura of nationalisation.

On the other hand, most members of the medical profession would seem to have realised that some organisation of their profession was necessary. The most important deficiency apparent to it was the increasing inability of Australian people to pay for medical care; a higher proportion of the population was using public hospitals and general practitioners carried the burden of giving free service outside public hospitals to the impoverished. The population could be divided into two main groups which had different needs:

a) The pensioners, unemployed, and chronically ill, who could pay little or nothing. At first it was not recognised, as it is now, that the composition of this moiety is influenced by national economic factors as well as by individual circumstances. The near-poor have defied categorisation throughout recorded history.

b) The so-called middle income group who worried about paying for major surgery and its accompanying hospital costs much more than about visits to the doctor and buying pharmaceuticals.\(^7\)

Defects due to geographical factors characterised the provision of medical care in the 'outback' where there were numerous one doctor towns. Many such places provided neither an adequate living nor sufficient professional stimulation to attract and keep competent doctors. In the metropolitan cities, where a high proportion of the population lives, distance imposed another kind of defect, the need to attend outpatients departments at centrally situated city hospitals. In what Cilento has movingly described as 'chasms of wasted time' gatherings of the sick and wretched waited miserably for treatment; a living demonstration of the word 'patient'. Moreover, poor suburbs had fewer doctors than were needed.\(^8\)

**Inadequacies in physical plant**, the third consideration, concerned all doctors since these existed in greater or lesser degree in hospitals and nursing homes of all kinds providing in-patient care, as well as in health centres, laboratories and diagnostic centres. In this category consideration had to be given to need, planning, siting, control, methods of financing and the places such facilities occupy in any administrative structure. Drawing on his experience, thought, and the data collected in 1943 as a member of the Medical and Hospitals Services Sub-Committee (of the Social Services Planning Committee), Cilento devised solutions to problems in this category which will be referred to in the following chapter.

**Personnel to man the health services**, the fourth category, included matters such as professional qualifications, staffing levels, and remuneration for those who chose a salaried medical career. Medical and nursing education was deficient in many respects; medical graduates had little or no exposure to social and preventive medicine and no experience of general practice. As well, there was no official definition of what constituted specialist education (except after 1939 when this was laid down in Cilento's *Medical Act* in Queensland). In the case of nursing, the

7. Transcript ..., EEE 33
8. Transcript..., EEE 3
traditional image of the lady with the lamp made up for obvious shortcomings in nursing education and remuneration.

There were many essentials lacking in Public Health, the fifth and last area of consideration listed above. Generally speaking, however, neither the profession nor the public clamoured for remedies in this large area of public usefulness. Governments and the BMA were lavish in their lip service to prevention and research. Unfortunately the money available for public health as a proportion of the total health budget including allocations for prevention and research was always trivial. An example was the failure to implement the recommendation of the 1926 Royal Commission on Health that a medical demographer be seconded to what is now the Australian Bureau of Statistics, a defect which has still not been remedied. As a result there was little factual knowledge about health and health problems in Australia apart from, perhaps, mortality.

Before introducing a discussion on Cilento's proposals to remedy some of these defects, it would be useful to describe the political context.

9. K Jones, 'Development and Allocation of Health Resources in Australia' Med J. Aust, 1 (11-12) 1982, sets out various pronouncements made by BMA 1941 and 1943. In a very high-sounding statement by the Federal Council (BMA) (Med J. Aust 11, 373, 1943) the profession agreed to the proposition that reform in terms almost identical with the deficiencies set out above were needed. Whether or not individual members were prepared to change their methods of practice cannot be said. With the coming to power of the Labor Party in 1941 there is evidence that a number of doctors considered change inevitable. (See letter Dr A Fryberg to Cilento written from the Middle East, 16 November 1941, Fryer coll. 44/11 and also evidence given by Sir Trent de Crespiquy to the Federal Council of the BMA in Med J. Aust, ibid p. 376). Nevertheless it is doubtful if members of the Council at that meeting were seriously arguing for evolutionary change in their methods of practice. Dr A Lee, of Brisbane, was particularly forceful in this regard. Stress was placed on the profession's right to control its own affairs and discipline its peers regardless of the fact that medical boards were made up of doctors, a large proportion of whom were BMA nominees.

Cilento accepted that it was natural that medical practitioners would be particularly interested in the effect on income of any proposed change. He was also convinced that the salaried service would be so attractive with its superannuation benefits, career opportunities, and regular hours of work that doctors would be attracted to it for economic reasons. Hayden was to make the same mistake years later.

10. Powell, Medical Research and Public Policy, ibid, p. 101. Blueprint..., EE 21
The genesis of a national health service as a matter for government consideration in Australia was the Royal Commission of 1926 set up by the federal government to study, inter alia, the question of national health insurance. There was a precedent in Britain where, since 1912, a national insurance scheme had been operative under which a panel system of medical care had existed. As the Australian enquiry did not refer to medical care for participants in any form of national insurance, the medical profession was not alarmed by its findings. Yet, by this time, the principle had been clearly stated and accepted that 'the care of health within the community is a social duty and no longer entirely an individual responsibility. Governments have a duty to legislate to protect the less fortunate members of society.'

In 1937 a noted British authority, Sir Walter Kinnear, was invited to advise the Australian government on all aspects of national health insurance. In the same year Prime Minister Lyons promised major extensions to the social services of the nation which, however, due to a political debacle of major proportions, were never implemented. Leadership struggles within the governing United Australia Party and its ally the Country Party between 1939 and 1941 virtually destroyed electoral confidence in the government. The man at the centre of the storm was R G Menzies and the issue, over which he resigned from the Lyons Cabinet in 1939, was the failure of the government to implement its election promise of a national insurance scheme.

The National Health and Pensions Act 1938, introduced not by the Health Minister but by the Treasurer, passed both Houses and caught the BMA completely by surprise. It sought to establish a general practitioner service for all employed or self-employed persons earning, in today's language, $730 per annum or less on the basis of a capitation fee of fifty five cents per annum. This benefit ceased at the

12. Ibid
door of the hospital and did not cover dependants or the sick aged. The profession saw the Act as reminiscent of the old Lodge System, with all its inequities, and refused to work under its provisions. All state branches of the BMA mobilised resources to fight the legislation: that particular affray came to an abrupt end when the principal legal advisers and accountants amassing evidence of the Association to lay before yet another Royal Commission were all killed in an air disaster. Yet, it was by now clear to government and profession alike that a government health service was inevitable and necessary and planning for its creation continued throughout the war years. (The term 'national health' has been used until recently; this activity is really concerned with medical insurance).

National Insurance was the noose with which the Liberal led government finally hanged itself. Earle Page had made a bitter and base attack on Menzies for his promotion of the principle, despite which his party voted with the government to keep it in power. Labor was in a cleft stick; had its amendments to repeal the Act been carried, the legal status of approved health societies would have been immediately demolished. Many, such as lodges, had roots in the Trades Hall.

By August, Frederick Stewart, then Minister for Health, had gained ministerial support for the introduction of an amended scheme of national insurance to cover small farmers, employers and the like. Page, who was undoubtedly conducting a personal vendetta against Menzies, campaigned against this move saying that the money should be spent on defence. Lyons, under Country Party pressure, had been tempted to repeal the 1938 Act but public reaction was too strong; he substituted amendment for repeal. By now the Act was a complete bungle. Page had the political effrontery to state that the Country Party believed in national insurance, but that the select committee of enquiry suggested by Menzies made the government look ridiculous. It must be seen to make up its own mind.

15. Cutting Book Sir Frederick Stewart, AA CP.77, The Argus (Melbourne), 14 June 1939. In his opening address at the NH&MRC Conference in Brisbane 1938, Hanlon applauded the BMA wholeheartedly for opposing this legislation which did nothing for the needy and failed to grasp the nettle of hospital care provisions.

16. The Sun (Melbourne), 14 June 1939

17. The Sydney Morning Herald, 22 August 1939
Meanwhile the political gyrations of the governing parties were bewildering. Upon the death of Lyons in 1939, Menzies narrowly defeated Hughes for leadership of the United Australia Party. He was anathema to Page and Fadden. In the next two years four different combinations of the coalition parties emerged; two headed by Page and Fadden, two by Menzies. The electorate showed its disapproval in the general elections of 1940; Labor made significant gains and the balance of power was held for the Liberal government by two independent members. In the 1941 Budget debate these two voted against the government and overthrew it.

This ushered in eight years of Labor rule, first under Curtin and then under Ben Chifley. Wartime defence powers, the adoption of uniform taxation laws, and control of the war economy enabled Labor to tighten economic strategies and strengthen the Commonwealth's weak constitutional position vis-à-vis the formerly independently financed states, by grasping the power of the nation's purse. This in turn allowed the government to move towards the provision of Commonwealth social services, paramount among which was health.

How was it to be paid for?

The 1938 National Insurance Act still remained on the statute book; a Damoclean sword over the head of the government until some satisfactory alternative was devised. Before looking in detail at subsequent developments with which Cilento was involved, an outline of the major events in medical politics should be sketched.

In the first period from 1937 until somewhere in 1942 the NH&MRC was commissioned to advise the government, somewhat covertly at first. As its role became overt the BMA strongly deprecated turning the Council into a political body. Clearly, with its roughly equal membership of government and BMA representatives, it was destined to become a house divided against itself. And so it proved. Next the Joint Parliamentary Committee on Social Security set up in July

19. T Kewley, 'Social Services ...', ibid, p. 342
1941 by the Menzies Government embraced the field of health services and health insurance and reported to the government. Cilento served on two sub-committees of this body. Finally in June 1944 J M Fraser, then Minister for Health, without the Parliamentary Committee's knowledge and to its deep chagrin, commenced to negotiate directly with the BMA and was advised by a section of the Treasury.

It soon became clear that, despite high sounding sentiments about its commitments to the health of the community, to positive health, and research, the main discussions (and confrontations) would be about who controlled any organised service and about how doctors would be treated and paid. The medical profession piously affirmed that unless they controlled all matters dealing with health, politicians would inflict upon the population a system of medical care both soulless and mediocre. On the other hand, as has already been demonstrated in Queensland, governments considered that if public money was used to pay for curative services, they had a duty to exercise some control. After 1945, both sides were locked in violent struggle for mastery of the situation.

Kewley summed up the major philosophical differences between the Commonwealth government and the BMA:

The attitude of the Commonwealth Labor Government was conditioned by the belief that it had the ultimate authority to determine policies and medical services after seeking the advice of the medical profession. The medical profession, on the other hand, believed that the profession itself should be the arbiter in such policies and that it could not wisely be subordinated to non-medical or lay control.

Pensabene looked on the battle which has continued between Commonwealth governments and the BMA/AMA for over forty years now as an argument as to whether the providers, the doctors, or the consumers, those who pay for the service, should control it.

20. Ibid, pp. 344, 345
It must be said, as well, that the more pragmatic considerations motivated the doctors. The BMA was determined that unless circumstances were unusual no free service should be set up in competition with private practitioners without a means test. There was also the inescapable implication that if the public purse was to be used to help people pay for medical care, then wherever possible, such services should be provided by private practitioners.\textsuperscript{23}

Cilento had the strongest views possible about the principles involved in using public funds to help provide medical services. In his evidence given in camera before the Joint Parliamentary Committee on Social Security he asked:

\begin{quote}
Why should the people who are paid for this service dictate its terms? Surely the person who pays the piper should to some extent call the tune?\textsuperscript{24}
\end{quote}

In Blueprint for the Health of a Nation he was even more explicit.

\begin{quote}
The underlying issue is not the right of a private professional organisation to set out exclusive requirements in respect of the economic security of its own members or to attempt to tie all medical practitioners to a particular form of economic discipline; it is ... whether a private medical organisation may determine how public money for a public service shall be expended, or how public functions must be exercised.\textsuperscript{25}
\end{quote}

It is logical now to discuss the proposals which Cilento put forward to remedy existing defects in Health and medical services in Australia. They will be considered in detail because his responsibility in devising the structure of medical services (mainly curative) for the whole nation was the great challenge and inspiration of his professional life. He failed at the time because his detractors had the power to forestall many of his innovations. In the 1960's and 1970's many of these proposals were re-discovered and introduced but never attributed to their originator. Fortunately Cilento has provided the historian with substantial documentation setting out his ideas, ideals, beliefs and recommendations: evidence which vindicates his reputation but cannot now redress the appalling consequences to the man and his

\textsuperscript{23} Jones, 'Development and Allocation...' ibid, Med J. Aust, pp. 11-12

\textsuperscript{24} Transcript..., EEE 27

\textsuperscript{25} Blueprint, ibid, p. 153
career which followed his attempts to move ahead of society in his time into the untried area where no man is ever understood. Even with hindsight, the detail of his proposals will be the clearer if his first two major schemes are first outlined.

1. Overall administrative structure.26

a) A Central Co-Ordinating Health Corporation was to be a federal body to co-ordinate policy, set standards, and determine grants-in-aid to the states. Power was to be exercised through monetary control. This Corporation would be advised by a constituted NH&MRC.27 The head of the Corporation would be the Commonwealth Director General of Health and the body would be responsible to the Commonwealth Minister of Health. The theory was that such a corporation would have greater flexibility than a public service department.28

b) State Health Councils, headed by the chief health officer in each state and reporting to the Health Minister, would determine policy and direct its implementation.

c) Health Regions, each with its health service committee, would be constituted to control both preventive and curative services at regional level. They would be supervised and directed by the State Health Council.29 Such regional bodies would take over the management of all

26. The most important of these documents to this topic are:
(1) Transcript of Cilento's in camera evidence before Parliamentary Joint Committee on Social Security (Transcript... EEE), Fryer coll. 44/108
(2) Commonwealth Parliamentary Committee on Social Security Int. Reports, Fryer coll. 44/108
(3) R W Cilento, Blueprint for the Health of a Nation, Cilento coll. Fryer Lib.
(4) Correspondence held in Fryer Library
(5) Papers prepared by Cilento either as an individual or a committee member and published in the NH&MRC reports of the period and/or Med.J.Aust
(6) Rejoinders by BMA spokesman in both these sources.

27. Transcript...' ibid, EE 18 et seq, EEE 40

28. This recalls Cilento's notion of a Ministerial Executive at state level.

29. Cilento, Blueprint, ibid, pp. 129, 131
public hospitals, health institutions and centres, as part of their general function. Cilento paid lip service to the value of citizen-involvement in government at local authority level but then enunciated the commonsense view that local authorities in Australia had not the resources, permanent officers of calibre, or members of sufficient knowledge and experience to maintain complex modern health services. Regions were therefore envisaged as quite sizable administrative units. Each would ideally have at least one large hospital. The base hospital system in Queensland was such a scheme in embryo although, as the reader will recall, Hanlon's government would not entertain the idea of separate regional health administrative units.

The above scheme encouraged private practice of all kinds providing a parallel service in competition with free state health care provision. Cilento believed that the alternative service scheme was feasible since Australians who could afford private health care seemed to prefer it. The implementation of such a system required the referral of the requisite powers to the Commonwealth Government by referendum. Cilento predicted that this would happen and it duly did.

It is of interest to note that Cilento, allegedly inflexibly centralist, favoured delegation of appropriate powers to regions as commonsense dictated. State governments in Australia even to-day are less than keen about regionalisation. One must admit however, that the average practising doctor would not have been worried by such a development; it would have appeared irrelevant to his personal concern. But the same cannot be said about the second of Cilento's two major proposals which dealt with matters all too close to every medical heart.

30. Cilento, Blueprint, ibid, pp. 129 et seq. The drawing up of the above structure produced ambivalent attitudes in its architect. His administrative sense told him that the Commonwealth government would have to manage any national health scheme and yet he was head of the medical services of a state. He knew as well that Canberra's centralist fantasies of dealing directly with local authorities would not work in Australia. They were, in fact, later abandoned in England and Wales as far as curative services were concerned.
2. Contributions to the cost of curative services by the government.

Here Cilento is talking about the way public monies were to be spent to meet the costs of medical care: namely doctors' fees, hospital costs, and drug charges. Cilento's scheme was clear and simple. Out of public money, state and federal governments would pay the costs associated with the building and maintaining of public hospitals and their out-patients. In metropolitan and larger regional towns health centres would be built to provide mainly general practice care near to where people lived. Public beds, out-patient care, consultations at health centres, and drugs provided would be free on such sites without a means test. Doctors working in public hospitals or health centres would be salaried either on a full-time or part-time basis. It was expected that a substantial number of private practitioners would work on a sessional basis in health centres or in public hospitals. In defence of the avoidance of a means test, Cilento, elitist though he probably was, made a statement which forever after should be seen as testimony to his humane and compassionate understanding of the pride and sensitivity of the less fortunate patients in our midst.

It is hardly necessary to add that the "means test" - the most humiliating and degrading feature of social commercialism would be in full operation in any competitive system of practice, doubtless doing its best to warm and enrich the patient/practitioner relationship! The rank flavour of deliberate charity is repugnant to its recipients and damaging to its dispensers. The "means test" makes the medical provision in that sense a State dole and penalises thrifty, or sensitive people who have fallen on hard times. It might be more necessary perhaps to institute a "needs test" to permit supplementary or extraordinary assistance in special circumstances where people are diffident about seeking it themselves.

Regrettfully many practising doctors lacked this perception and concern. One of their rallying cries regarding what became known as the NHS in Australia was: 'Help to those who help themselves'.

31. Cilento, Blueprint, ibid, p. 169: Cilento quoted Lord Forster here: 'In helping only those who can help themselves and who can persuade others to help them, we have left unhelped those who most need help', ibid, p. 150
Now the profession saw two red lights. Firstly, practising doctors were not going to receive one penny of the public money to be 'lavished' on paying the costs of health care unless they worked for a part-time sessional salary. Second, state governments were going to set up free medical services in competition with them. In desiring to provide any service which private practice could supply, even though the government was paying for it, the profession was following standard practice in a free enterprise society; where it differed was in its determination to control the conditions of service and even the way in which governments collected money to pay for such services.

Cilento scrupulously defended the right of the patient to choose between government and private medical services.32 His personal belief was that with the passing of time a process of attrition would erode away a proportion of the population which would go to private doctors.33 Obviously the BMA feared that he might be right, although the NH&MRC was later to express reservations about Cilento's view on this point. This will be discussed later.

A cardinal point in curative medical care under Cilento's scheme was to be the restoration of the general practitioner to his rightful place in the scheme of things. Every person must have a family doctor, he said, who would be in charge of his health. Some twenty years later, the general practitioners and the Queensland medical faculty began to say the same thing. For Cilento, whether the practitioner was in private practice or at a health centre was irrelevant; the importance was the status of the general practitioner and his essential place in society.

Alas, Cilento's staunch support for the general practitioner, the family doctor, did nothing to assuage the wrath of the medical profession. Unquestionably, the rank and file, alarmed by the emphasis placed by its spokesmen on his advocacy of nationalisation, itself a loaded word, simply did not listen to what he was saying. Forever after he might speak with the tongues of angels and the logic of a latter-day Aristotle, but the doctors would not heed him. They visited upon him their own sins, portraying him as the apostate who had destroyed their power in the Brisbane

32. Ibid, p. 139
33. Ibid, p.141
General Hospital and who was now threatening their freedom and power in general practice.

What did occur was sad and deplorable. The many admirable changes Cilento had advocated outside the sphere of paying for medical care, often highly innovative and manifestly helpful to the practitioner, were completely ignored and lost in the orchestrated fury and inuendo directed at him by his own profession.

To sum up: Cilento's proposals for the use of public money to pay for medical care were simple. These contributions were to be spent first of all on "free public hospitals"; that is, public hospital beds were to be available, without means tests, for those who desired to use them when hospitalisation was necessary. In metropolitan and larger provincial cities there would be free public health centres, consultation centres, or group practices - call them what you will. These health facilities would be regionalised. Doctors employed in public hospitals or health centres would be salaried, either on a full-time basis or sessional basis. At all levels of practice attempts would be made to co-ordinate and combine both curative and preventive medicine.

Cilento was flexible about the way in which governments would raise the monies to finance the above contributions to medical care. In the main he favoured graduated general taxation. The NH&MRC took the view that the salaried system should be financed by direct taxation.

In 1943 the Chairman stated that:

The National Health and Medical Research Council recommends as the ultimate objective the control or transfer to the Commonwealth of all aspects of preventive and curative medicine, including hospitals. This scheme is to be financed by direct taxation spread over the whole of the community.

34. Cilento, Blueprint... ibid, p. 159

35. Agenda Joint Party Committee on Social Security, 1943: Resolution 4 NH&MRC, Medical Planning Committee, Minutes 1944, Cp. 71/12 Bundle 09539 (AA)
This was Cumpston's dream, presaged in various statements by him.\textsuperscript{36}

Cilento was opposed to these sweeping changes in control and to direct taxation: opposed to them in principle, as he was to the compulsory salaried medical service later proposed by the Victorian State Council of the BMA.

He stressed that private practice should continue to exist and that there would be no attempt to coerce either patients or doctors into the salaried service. The major strength of the Cilento scheme was the administrative simplicity in a service which potentially covered everyone.

It will now be clear to the reader that Cilento was, potentially at least, on a collision course with both the government (whose stalking horse he undoubtedly was) and the organised profession. To complete the picture of his relationships with the latter after 1940, the development of the plan for war time conscription of doctors will now be reverted to.

The first Resolution of the 9th Session of the NH&MRC (November 1940) was as follows:

This Council recommends to the government through the Minister that the central committee for the Co-ordination of Medical Services take immediately such steps as are necessary to provide for a progressive supply of medical men for civil needs in association with and complementary to military needs.\textsuperscript{37}

It is noteworthy that the NH&MRC here took the initiative, virtually instructing government to manpower the medical profession. Under National Security legislation a central medical co-ordination committee, with sub-committees in each state, was set up. The chairman of the Queensland committee was Sir Raphael Cilento but its executive officer was the late Dr John Wagner, President of the Queensland Branch of the BMA. This reflected the fact that the BMA, speaking for Australian medical practitioners, volunteered to be conscripted, if that is not a

\textsuperscript{36} Director General - Memorandum for Minister, 30 March 1936, Fryer coll. 44/11
\textsuperscript{37} NH&MRC Report. Resolution I, 9th Session, November 1940
contradiction in terms, provided that its representatives had executive control of the scheme.

Cilento had spent years in devising plans for the more efficient distribution of medical manpower in Queensland, plans going right back to the Inland and Island scheme of 1923. If Australia had an expert on the subject of medical manpower it was he; but here he had to give way to amateurs in his own state and adhere to policy determined by majority opinion on his committee. As far as other states were concerned, this type of administrative structure did not arouse him, but he was incensed by its being applied to Queensland. While expressly stating that Dr Wagner was doing a capable job, he claimed that his Minister (a euphemism in this case) resented being by-passed when he had all the machinery to handle the situation.38 In evidence before the Social Services Advisory Committee Cilento entered the lists piously warning against the dangers of centralised bureaucracy and using the "medical manpower operations" to give point to this thrust.39 With returning men in mind, he cited his own postwar experience as a young doctor to demonstrate that unplanned, uncontrolled release of hundreds of medical men onto a scene manned by a skeleton of independent practitioners was "the very genesis of chaos". By extrapolation, only by the planned co-ordination of essential services by government machinery, already operating in Queensland, could this be avoided.

Against this background Cilento's proposals and his endeavours in Canberra may be discussed in greater detail.

38. Transcript...", EEE 18 et seq
39. Ibid
CHAPTER THIRTEEN

'Blueprint for the health of a Nation'

Medicine is an instrument of social policy but mere juggling of facts will not provide a solution. What we do not have is a coherent theory of the relationship between the multitude of facts and the achievement of health, which is the object of the service.¹

Cilento's experience in the field and at the drawing board of medical planning in New Guinea and in Queensland, together with extensive study of developments in America and the United Kingdom, had crystallised into a set of concepts and ideas about government, professional, community and individual responsibility in health matters. It was his task in Canberra to place these ideas at the disposal of the government through the NH&MRC, the aegis of the Medical Planning Committee of the Parliamentary Joint Committee on Social Security and through his Blueprint for the Health of a Nation. In his evidence given in camera before the Parliamentary Joint Committee on Social Security which runs to some thirty thousands words he had the freedom to express views which, he stressed, were personal. The transcript of this evidence and his Blueprint, which was in the main a brief for a salaried medical service, are used in this chapter as the principal bases for discussion of Cilento's proposals in outline.²

2. R W Cilento, Transcript of evidence before the Parliamentary Joint Committee on Social Security, ibid, (hereinafter, 'Transcript ...' EE or EEB), Fryer coll. 44. R W Cilento, Blueprint for the Health of a Nation, ibid (hereinafter Blueprint). A fuller discussion of these sources is given in Appendix 1 of this study.
Cilento was not antagonistic to his profession. He was a traditionalist, an intensely committed upholder of its ideals and ethical values.\(^3\) He was adamant that doctors only should make the decisions about patient management, whether they were private or salaried practitioners. He stressed that, within the ambit of the law, they were to be allowed complete professional freedom.\(^4\)

He stressed with emphasis that no doctor or nurse should be coerced into joining any kind of public service.\(^5\)

In contradistinction, on the question of administering services paid for by the public purse, he had this to say:

For administrative purposes medical men would be entirely subordinate to administrative officers. At one time, I myself had the feeling that the medical profession should conduct its own administration and not be subject to a lay body, but a long experience of administrative life has made me feel that this is not equitable... the body providing the service, 'doctors' is being paid for it, but the public is the purchaser and should very definitely control the situation. Another consideration is where anything is paid for from the public purse, it should be under supervision and this would be paid for from the public purse... My feeling is that medical men can control everything that deals with active care of the patient and that they should do so.\(^6\)

Elsewhere, however, Cilento castigated doctors for their lack of interest in the holistic implications of their high calling:

Medical men are to blame for having pushed public health into a position of contempt and so have made it the province of clerks - a province to which

\(^3\) Cilento, Blueprint, p. 183. A section of his Medical Act 1939 had been designed to reinforce these values. While Cilento was Director General of Health in Queensland, efforts to detect and prosecute illegal abortionists and offenders against other medical laws were so sustained as to be remarkable by Australian standards.

\(^4\) Cilento, Blueprint, p. 162

\(^5\) Transcript ...', EEE 38

\(^6\) Ibid, EEE 31
naturally enough clerical officers bring - like cuckoos - their own eggs for hatching. Medical men are to blame if the cuckoos' offspring growing lustily in the medical nest, shoulders out to splash to the ground, the legitimate offerings of science.  

Cilento was speaking here not only of the faith in the efficacy of the hospital bed held by the electorate and manifested by Hanlon and Chuter, but in hospital management by laymen unenlightened by scientific and medical knowledge and concerned primarily with finding money to pay for the beds provided. He was challenging doctors to take a legitimate and responsible interest in preventive medicine.

This was a cry from the heart. Cilento was by title Director of Medical as well as of Health Services in Queensland, yet he had no say whatever about what went on in the state's public hospital system, other than the power to veto the appointment and dismissal of medical officers. He had every reason to resent this situation. Chuter, having got rid of both medical advisory committees and doctors on hospital boards, had attained his aim of lay control of the public hospital system.  

What Cilento sought as a medical administrator was a balance between lay and medical control: 'Render unto Caesar' was his policy. One point on which he and Chuter did agree was that doctors working in government medical services should be salaried. Chuter wished to restrict this to full-time service only, while Cilento preferred to encourage input from part-time medical officers as well. He expressed the goal of consensus and administrative equilibrium unequivocally:

We want to see not only that the medical men get a fair go, but also that the public gets a fair go... We believe that medical men should have a very definite voice in all medical matters but we regard a plea for medical control in all medical matters as such, as an indication of administrative inexperience. There are a large number of things that cannot possibly be controlled medically. In my opinion there is no

7. Cilento, The State, the Public and the Medical Profession, presented to NH&MRC, 2 February 1937, Fryer coll 44/, p. 19
8. Cilento to Dr H Power, Palmwoods, 24 April 1939, Fryer coll. 44/11
9. Cilento to Dr T Price, 8 December 1937, Fryer coll. 44/11
activity in which those who provide the service are given full control whilst those who pay for it are excluded... There are two things which are essential before you arrive at any comprehensive health scheme for Australia. The first is discussion with the medical organisations, which they were promised, and which I consider absolutely essential and the second is to collect facts. 10

'Promised', in the above quote, refers to the NH&MRC report on the subject of a national health service made at the end of 1941. That body accepted Cilento's plan for an optional salaried service but declared that this decision must remain tentative until such time as the medical profession had been fully consulted. (The whole problem was to be taken out of the hands of the NH&MRC before any real consultation had taken place).

As had been demonstrated, Cilento felt strongly about the medical and social shortcomings of out-patient departments conducted by public hospitals. He believed that they constituted a threat to his firmly held principle that every person should have a family doctor. In addition they caused discomfort and expense to patients who had to travel long distances to reach them and wasted a colossal amount of community time and resources. 11

He viewed the increasing tendency for doctors to specialise with some misgiving. He feared that patients' ills would be fragmented into bodily parts with no family doctor left to treat him as a whole person functioning in his own environment. This outlook is reflected in his drafting of requirements for the registration of specialists under the Medical Act in Queensland; if we were to have a surfeit of specialists, at least they would be well trained. Supporting the concept of Group Practice, a concept then new and unacceptable to the profession as a whole, he observed:

'... there is an increasing tendency for the specialist to divorce himself from medicine. That is one of the great perils we are trying to meet - a stage at which medicine has become unco-ordinated from specialisation, we shall reintegrate it so that not

10. 'Transcript...', EEE 21
11. Ibid, EEE 23. Blueprint..., p. 68, 69
only will a patient not need to go to twenty specialists, but when he goes for attention from one doctor, group practice will provide him with the whole of these necessities. In other words, medicine will be reintegrated by group practice. 12

How prophetic! After World War II the tide of specialisation became a flood. As Cilento predicted, private enterprise medicine altered to the winds of change; group practice has become the norm while specialists, recognising a public desire for convenience, are taking 'sessions' at the numerous clinics that dot the suburbs.

Enlarging on the question of the distribution of hospitals and medical personnel which is central to Cilento's scheme, we see that he visualised base or teaching hospitals devoted almost entirely to severe illness or major surgery. These were to be staffed by specialists only, although the family doctor would be encouraged to visit his patients therein. Surrounding these hospitals would be smaller hospitals where patients would be treated mainly by general practitioners, with visiting specialists as needed. 13 In the 'outback', medical superintendents of hospitals would be salaried, either full or part-time. In many instances a part-time superintendent might be treating both public and intermediate patients in 'his hospital'. Where necessary, the system would be supplemented by flying doctors, aerial ambulances, and flying specialists.

Public funds would be used to adjust the deficiencies of the maldistribution of doctors in large cities with fully supported health centres free to the public.

For doctors working in the salaried service, Cilento offered the following advantages; practical training under supervision, secure salary, study leave, and a clearly defined ladder of promotion. There was also freedom for the doctor's wife, eternally tied to the telephone in the days when few doctors had paid receptionists. It looked a most attractive package and increasingly since World War II doctors have gone into salaried service in hospitals, government departments, private commercial institutions and universities. However, at that time, to doctors trained in the one-

12. 'Transcript ....' EEE 40
13. Ibid, EEE 37
to-one operation of a cottage industry and encouraged to see the larger issues through the eyes of the organised profession, it had all the hall-marks of socialism. Cilento was offering the apple in the Garden of Eden.

The question which the BMA was asking doctors to consider was that, if the welfare state was about to provide money for medical care, how could the private practitioner be assured of his share? This was a direct stimulation of the hip pocket nerve which produced a highly emotional response. There were three possible ways.

The first of these was payment of an annual sum for each patient or family treated. Before World War II this was referred to as 'insurance' following Lloyd George's panel system of contributory insurance instituted in Britain in 1912. We are a highly derivative society and this was never more truly said than of the BMA in the days when it still made obeisance to the parent body in England. Therefore it is necessary to distinguish carefully between the British panel system, which became notorious for what it did not provide, and our own NHS or Medibank Insurance. In Australia its colonial counterpart was the Lodge System, which went further in that it covered not only the worker, but his family (although not for specialists consultations, surgery, or hospitalisation). This was the system which Cilento referred to as 'insurance'.

The second way was fee-for-service, whereby the doctor was paid a specified fee for each service rendered to a patient. Sometimes, by agreement, the fee was concessional; that meant that the doctor received less than the scale fee for a particular service rendered.

The third option was the salaried service. Here, the only means by which the doctor could be paid from the public purse was by working for a salary, either full or part-time.

Cilento disliked 'insurance' (per capita payment) because of its deficiencies and often sub-standard quality of service and also for its history of divisiveness in Australia. Fee-for-service he deprecated because of in-built administrative inefficiency, and inconvenience to patients. He predicted that the endless recording and book-keeping for every contract between doctor and patient would not only be
costly in itself but open to grave abuse. Cilento clearly understood human nature!  

Inevitably, as Trevor Wood recognised some forty years later, he saw the salaried service 'as the best fit'. It was administratively simple and therefore economical, could be introduced gradually, compelled neither doctor nor patient to use it, yet was freely available to all who wished to do so. No financial records of patients' visits to doctors were necessary and there was no means test required. He was totally conscientious in leaving open the option to use either private practice or salaried service. It seemed clear to him that the salaried service had so many advantages that the majority of patients and doctors would sooner or later come to use it. This, as will be demonstrated later, was one of Cilento's great miscalculations. The obvious charge that it was offensive to Australian egalitarianism could not be sustained if it became popular alike with the middle class and the poor. Cilento became bewitched by the creature of his own administrative brilliance. Overlooking, in his legalistic way, the vagaries of human nature, he made the classic Marxian error of failing to foresee the effects of postwar prosperity in raising the levels and expectations of an upwardly mobile middle-class in Australia, who would perceive in 'private health care', as in 'private schools', a social advantage they could not afford to ignore.

The BMA was adamant that all patients should have free choice of doctor. This obviously conflicted with the practicalities of a salaried service in health centres and public hospitals. Cilento defended his scheme by attacking the validity of the opposing proposition which, he said, was largely illusory outside the city centres where so many Australians lived. He remarked that pressure for free choice came rather from doctors than from patients. That was probably true. The BMA played into his hands by supporting the proposal that the approach of patient to specialist should be controlled by the family doctor. That advocacy had a long gestation period, coming to light again in the 'differential benefit' under the so-called NHS.

14. Ibid, EEE 22, 37
16. Transcript .', EEE 21, 25
17. Ibid, EEE 22, 24
18. Blueprint..., p. 80
At this stage, consideration may be given to the methods by which Cilento and his supporters, advising the government, endeavoured to put into practice what had hitherto been a theoretical concept in Cilento's fertile brain.

Judging by his utterances, Raphael Cilento did not materially alter his views about the way public monies should be used to pay for health care delivery between the mid-thirties and his departure from the Australian scene in May 1945. As opportunity could be created, he used all his persuasive skills to convince Queensland doctors of the merits of his salaried scheme which, after all, had its roots in attempts by him and Elkington to provide medical protection for the isolated people of the outback. There are several recorded instances of his having addressed groups of doctors; in a letter to Roy Rowe, secretary of the Joint Parliamentary Committee on Social Security, he described one such meeting with the Queensland Branch of the BMA as a contrived confrontation, a conspiracy characterised by much head-counting and conniving. His reception was hostile but he faced the challenge and, formally at least, won from the meeting a duly minuted acknowledgement that his scheme did not involve the destruction of private practice. His paper given on that occasion was published in the Medical Journal of Australia.

Active support came from his close friend Dr L Winterbotham. As president of the Queensland Branch of the BMA he attempted to set up in Brisbane's southern suburbs health centres of the type advocated by Cilento. While expressing pleasure at this initiative, Cilento noted that without pivotal co-ordination through the health department, such centres were unlikely to be effective.

In general however, his apostolate in Queensland, though unremitting, was less than successful because his seed fell on stony ground.

19. Transcript . . . ' EEE 35

20. Cilento to R Rowe, undated, circa early March 1944, Fryer coll. 44/11. (Description of Cilento's use of wit and will to defeat BMA 'diehards'). Cilento to Rowe, 15 March 1944, Fryer coll. 44/11. Cilento, 'A Salaried State Medical Service', Brisbane, 6 February 1942, Med J. Aust, 1942: 1

21. L P Winterbotham to Cilento, Fryer coll. 44/11
In the federal sphere his activities to this end can be categorised into three major involvements:

1. A paper entitled 'The State, the Public and the Medical Profession' which he read at the inaugural meeting of the MH&MRC in 1937.

2. His activities with and on behalf of the NH&MRC in 1941. These were part of the Council’s deliberations at its 10th, 11th and 12th Sessions.

3. His work on behalf of the Parliamentary Joint Committee on Social Security. It is difficult to be precise about a time-span for this but it probably involved him between 1942-1945. This was very onerous.

Certain things must be interspersed into this time-scale to give a bare-bones historical context. In 1938 the National Health and Pensions Act had caught the BMA napping. In Queensland at the beginning of 1939, as has been noted, the 'honorary system' was abolished in the state’s public hospitals. This reduced the part-time staff (former honoraries) to virtual impotence in policy and administrative decisions at the Brisbane General Hospital. History has recorded that Cilento had nothing whatever to do with this: it was a resolution of the opposing forces of the BMA and the government. Undoubtedly he was blamed for it. As Dr Fryberg told the writer, he was blamed for everything after he became Director General. It would be surprising if doctors in Queensland did not judge the salaried scheme by the results of that happening, although the manner in which the "General" subsequently worked was not as Cilento had visualised. He expected doctors and lay administrators to work in combination and consensus where public money was being spent. The third occurrence was unusual. On his return from the inaugural session of the NH&MRC in 1937, where he was harassed and harried, he took two full pages in the Brisbane Telegraph to make an appeal to all doctors in Queensland to join together to institute and promote a more efficient and compassionate national
medical service.\textsuperscript{22}

These results confirmed in him the conviction that the BMA did not represent the profession, whereas his own altruistic vision did so.

Certain changes in Cilento's own attitudes should be fitted into this time span. While his ideas about the salaried service scheme were scarcely modified at all, his own career ambitions began to take a new line. He had come to Queensland in good faith to become head of what was to be a department devoted to health and medical services. For reasons already given, he achieved neither the headship nor the department as such. Nevertheless he accomplished his central task, and many that were peripheral to it, in a most efficient and far-sighted way. As early as 1938 he was putting out feelers for a new job.\textsuperscript{23} By October 1942 he was becoming impatient with the limitations of Brisbane. He wrote to Roy Rowe:

\begin{quote}
In fact during this year I felt rather marooned and at a dead end here in Brisbane... and our duties reduced in the department to matters of mere routine which anyone could handle.\textsuperscript{24}
\end{quote}

By 1943 he was admitting confidentially that he had become engrossed in matters outside Queensland and that this was somewhat unfair to his Minister, Hanlon. He wrote to Barnard (Chairman of the Joint Parliamentary Committee on Social Security) at this time seeking his help in obtaining a position either in the Commonwealth Department of Health again or administering some aspect of the salaried medical service which he had reason to believe the Labor government would introduce. Job security, Cumpston's approaching retirement, and above all his realisation that effectiveness, power, and excitement in any publicly-supported

\textsuperscript{22} Cilento, 'An Open Letter to Medical Men', Telegraph (Brisbane) March 1937, Fryer coll. 44/132. Cilento followed this up by sending a confidential questionnaire to every practitioner in the state; he claimed that almost all replied and a huge majority said they would be agreeable to work within a salaried service. This survey was unofficial, and like the 'Open Letter', had nothing to do with Cilento's Minister or his department as he was careful to point out. Med J. Aust, 1942, 1:364

\textsuperscript{23} Cilento to W M Hughes, 19 January 1938, Fryer coll. 44/11

\textsuperscript{24} Cilento to Roy Rowe, 20 October 1942, Fryer coll. 44/11
health scheme were going to be found in Canberra, probably motivated him.\textsuperscript{25} Also, while all this was going on, he was straining at the leash to enlist in the Australian Armed Services. He was suspected by some of having unacceptable sympathies towards Italy and this cast an aura of doubt over his loyalty that may have kept him out of the fighting services. This will be referred to again later.

It is now appropriate to clothe with some flesh the skeleton of events just drawn.

The Inaugural Meeting of the National Health and Medical Research Council

From 1937 onwards the national government began to take account of the possibility of the outbreak of World War II and to consider essential services in that light. High on the list of these considerations was the provision of medical services for the community. Such forward planning was 'top secret'. Cumpston, as Chairman of the NH&MRC, was asked to provide a plan for what amounted to the manpowering of the medical profession in the event of war. In strictest confidence he asked Cilento to prepare a plan which would cover the situation without disclosing its underlying purpose.\textsuperscript{26} Ostensibly it was to be a discussion paper looking at the defects in medical service distribution with which this chapter began and suggesting workable remedies for these. Cilento's interest in and formidable knowledge of detail on this subject was well-known and it was therefore to be expected that he would be asked to formulate the plan for discussion. The BMA, however, unaware of its true purpose, suspected the thin edge of the wedge of 'nationalisation' and used its

\textsuperscript{25} Cilento to H C Barnard, 24 September 1943. On 11 March 1943 the Executive Council granted the request of the Commonwealth that Cilento be lent to that government from 15 March for three months. Director General to Deputy Director General, 13 March 1943 HHA/1 (QSA)

\textsuperscript{26} Cumpston, wary of committing himself publicly on contentious issues, frequently made bullets for Cilento to fire. Exercising his right to preview the text of Cilento's Presidential Address to the Medical Science section of the ANZAAS Conference (1932) he told him to "say nothing on the contentious side, but to stress that this (the tropical area of Australia and her possessions) was of great importance and one of the great major health problems in Australia". The significance of this gratuitous advice was that it was being given by the same authority who was simultaneously affirming in his house journal Health that the "tropical health" problem was virtually solved. J H L Cumpston to R W Cilento, 18 July 1932, ANZAAS File, Fryer coll. 44/
first appearance on the NH&MRC to abort any discussion of Cilento's paper, 'The State, the Public and the Medical Profession'.

Cilento felt bitterly about this. In his evidence to the Joint Parliamentary Committee on Social Welfare he related:

I began this activity in 1937. In that year I gave an address at the first meeting of the NH&MRC... advocating a scheme such as this. It had the distinction of being the only paper asked for that has not been printed as an appendix. It was extremely badly received.27

Thirty seven years later an eminent medical administrator, Dr Trevor Wood, also deplored this outcome:

It is a pity that the Paper was allowed to lie in a drawer as several, now evident, axioms were propounded. These include the comment that health is the absolute right of individuals; that the sickness rate varies in inverse ratio with the ability to pay; that the poor must receive medical care of a high standard; that the co-ordination of all services was imperative; that technology in medicine increased the costs and involved a third party - the government; that to ensure the quality of service and the integrity of the physician, coupled with professional freedom seemed to suggest to Cilento that a salaried system was the best fit. His final premise was that the primary purpose of medicine is to protect the community and that it was the responsibility of the medical profession to ensure that the community was protected in both public and private sectors which meant regulation and government intervention.28

The ancient motto of the Cilento family is 'Tace, Vigila' (Be Watchful, be Silent!): Cilento was ever watchful and could be silent but never when he thought he ought to speak. After his rebuff in Hobart, he courageously published his views in his 'Open Letter to Medical Men' in March 1937.

27. Transcript ...', EEE 27

28. T Wood, Forever Amber, ibid, p. 16
In 1941 he was to be given another chance to state a case for a salaried medical service. Opening the Tenth Session of the NH&MRC in May of that year, Commonwealth Health Minister, Sir Frederick Stewart, stated that he hoped to revive the national insurance scheme which had been held in suspension since 1938; he invited the Council to submit recommendations on this or an alternate plan for providing for the health of the people. The Session responded by appointing a committee to work on this and report back.29

Cilento was clearly the active member of this group. Its report was vintage Cilento, very similar in outline to the rejected plan of 1937. He had stimulated discussion on the topic at the 1941 meeting with a paper entitled 'The Future of Medical Care' and followed with 'A Comprehensive Health Service' which bore the imprimatur of the Medical Services Sub-Committee.

After due consideration at the Eleventh Session (July 1941) and at the Twelfth Session (November 1941) it became known as the 'Outline' (an abbreviation of its full title - 'An Outline of a Possible Scheme for a salaried medical service', while the BMA's riposte became known as 'The Plan'.30

There was one important proviso stipulated by the Council. The 'Outline' was tentative, to be finalised only after satisfactory consultation with the medical profession. (Cumpston was too sensible and too subtle to propose anything which would throw his medical colleagues into a blind frenzy of resistance. It was to be the role of Sir Earle Page to use his powers of seduction upon the profession). For a variety of reasons this consultation between the NH&MRC and the BMA never took place in any meaningful way.

The 'Outline' was not simply a re-hash of Cilento's earlier considerations. Details published at the time reveal an up to date and thorough report. The

29. Medical Planning Committee, Medical Services Sub-Committee: Members were: Dr J H L Cumpston (Chairman), Professor Dew (Universities having medical schools), Dr Newman Morris (BMA), Sir Raphael Cilento (in his own right)

regionalisation of every district in Australia is set out, as are all financial details down to the last penny. Even the salaries and conditions of service of various grades of medical officer are numerically described. It must have been a formidable task, yet it was accomplished very quickly. The NH&MRC, while not unreservedly committing itself to this detail, nevertheless adopted in principle Cilento's concept of a salaried service as a basis of its recommendations to government.

Meanwhile the Victorian Branch of the BMA produced its own plan. The main difference between this and Cilento's is almost unbelievable in that the priestly caste here advocated a salaried service on a compulsory basis. Although it was published with Cilento's 'Outline', it was crushed to death under the weight of national professional opinion.

The BMA's reaction to both these reports and to the one which its national Federal Council itself had commissioned and which became known as the Bell-Simmons Report will now be studied. Here the path becomes tortuous indeed because it is difficult to discern what the BMA really wanted.

In the beginning Cilento had every reason for optimism. The first nine months of 1942 brought a feeling of accomplishment to Cilento: there seemed to be only a few items of contention between the Council's 'Outline' and the BMA's 'Plan'. There was a confident ring in Cilento's letter to Fryberg, who with his colleagues on active service in the Middle East, were following events anxiously:

... We were on the last lap of the nationalisation of medical services scheme and managed to get it through the Council in detailed form. The Commonwealth Minister for Health and Social Services (E J Holloway) will now run it round to the various State Ministers of Health and also discuss it with the practising medical profession. We have gone to great pains to put every legitimate thing recommended by the BMA in it, and to justify everything that we exclude or limit...

One point that has cut a lot of ice has been my representation regarding the increasing proportion of young medical men who have left for the front immediately after graduation... everyone with whom I have spoken has been impressed with the necessity
to protect these fellows when they return and to see that they can step into something safe and secure.\textsuperscript{31}

The BMA's 'Plan' was called 'A General Medical Service in Australia'; it had been commissioned by the Federal Council and drawn up by Drs Bell and Simmons, the New South Wales delegates to the NH&MRC, and published in the Medical Journal of Australia.\textsuperscript{32}

The BMA, long conditioned by the Lodge scheme in Australia, thought in terms of capitation insurance. They proposed that everyone earning less than 416 per year (roughly \$750 in to-day's language) be compelled to contribute to a National Insurance scheme. Doctors would treat these for a capitation fee. All things considered this scheme seemed less than fair to doctors and certainly failed to provide satisfactory coverage for the patients.\textsuperscript{33}

At two subsequent Federal Council meetings the deficiencies of the 'Plan' struck home. These meetings were held on 25 September 1942 and March 1943.\textsuperscript{34} It became obvious that the BMA did not wish to support any major changes in practice and was determined to do nothing until after the war. It rejected salaried service as a form of payment and determined to accept only 'fee for service' as a method of remuneration. From the March meeting in 1943, the 'Plan' had undergone a metamorphosis and was now promulgated as 'Principles which govern a general medical service for Australia'. The Victorian scheme of salaried service had become irrelevant and, after circulation to the various branches of the BMA in each state, was buried in an unmarked grave.

\begin{itemize}
\item \textsuperscript{31} Cilento to Capt. A Fryberg, 1 December 1941, Fryer coll. 44/11
\item \textsuperscript{32} 'A General Medical Service in Australia', Med.J.Aust, 22 September 1941
\item \textsuperscript{33} Cilento, Blueprint, p. 154, noted that people with a taxable income of more than 400 amounted to 583,874. The average salary of a bank officer belonging to the Bankers' Health Society was claimed to be about 400. (Med.J.Aust, 1 January 1943). This gives pause for consideration of the validity of the information supplied to Bell and Simmons in 1941. They were, in fact, proposing to treat about 9/10ths of the taxpayers for a concessional fee. Cilento's comment was that doctors would have been ensured payment for treating the large group who could not pay for full medical care, but for those above 416 per annum 'the poor wretches who pay everything now, the BMA recommends no alleviation'. Cilento to Fryberg, ibid.
\item \textsuperscript{34} Med.J.Aust, 1942 11:443, Med J. Aust, 1943 1:371
\end{itemize}
Holloway, the Labor Minister for Health, was alleged to have assured the BMA that no scheme would be introduced until after the war; while contrary to this the NH&MRC was still officially considering the 'Outline'. A complex series of events followed, all marked by varying degrees of professional umbrage, and at one stage the BMA representative would not attend the NH&MRC meeting.

In March 1943 the BMA Federal Council again modified its stance with a plan promulgated as the 'Principles'. On paper this looked fine. Closer analysis revealed that most of the improvements advocated were in the field of what is satirically known as 'motherhood reform'; better nutrition, housing, flying doctor services, extended preventive services especially for Tuberculosis and Venereal Disease; improved ambulance services; better medical services to the middle income group (sic), and provision of domiciliary treatment for the indigent; hostels for waiting mothers; extension of invalid pensions and extension and unification of hospital contribution schemes. None of this involved much activity on the part of private practitioners.

About the only concessions made to Cilento's carefully devised and ardently pleaded salaried service were the following:

1. Establishment throughout the Commonwealth of decentralised diagnostic laboratory centres. These were supplied and maintained by the federal government and were a great help to private practitioners.

2. Acceptance of Group Practice initiated by members of the profession; this was private practice.

3. Increased subsidised practitioner services for the outback centres (that is, where private practice was not viable). Otherwise it was said that the optimum efficiency of medical services to the people of Australia would be provided by the existing consultant, general practitioners, and hospitals services.

Cilento and his profession were poles apart after all.
Ciletto's evidence before The Parliamentary Joint Committee on Social Security on 15 December 1942 has already been heavily drawn upon. His purpose was to elucidate the views of the NH&MRC on its 'Outline'. This was a brilliant piece of ex-parte pleading, revealing both the medical expert thoroughly conversant with his subject and its historical and global context and the clarity and subtlety of the legal mind of the barrister.35

One tangible and immediate result issued from this evidence. He had drawn attention to the lack of reliable data about the number and distribution of medical facilities such as hospitals and chronic disease institutions and about the distribution of medical manpower. He emphasised this in a letter to Chairman Barnard in which he supplied what limited data there was on the subject of hospitals in Australia. In a very warm response, Barnard agreed that a full survey should be undertaken as soon as possible and that the services of a medical man and 'some officer who is qualified to obtain statistical data' should be obtained.36

Accordingly, in March 1943, the Medical and Hospitals Survey Sub-Committee was set up by the Joint Committee: Ciletto was again a serving member. Looking at the composition of this body one would conclude that its Chairman, Dr A B Lilley, would have been well equipped to assess critically the functioning of the hospitals and that Ciletto would have provided the technique for data collection, recording and collation.37 Between March and June inclusively, the members visited all states and collected a mass of information that had hitherto been lacking; a strenuous undertaking in war time. As a result of this survey Ciletto was able to provide the Joint Committee with an authoritative statement on medical faculties in Australian hospitals and suggest how these might be maximised.38

35. According to Dr Geoffrey Hayes the popular view in Brisbane in the time when Sir Raphael flourished in the Industrial Court, barristers did not appear anxious to submit him to much cross examination. He had too many claws (Oral history source)

36. H C Barnard to Ciletto, 30 January 1943, Fryer coll. 44/11

37. Blueprint, ibid, p. 21, 34

38. Ibid, p. 13
The Queensland Director General was still on the Medical Planning Committee of the Joint Committee which meant that he carried an extremely heavy burden of meetings, report preparation and travel at this time, virtually taking him from one end of the continent to the other. Without reading widely outside the scope of this study of Cilento's activities in Queensland, it is hard to assess what influence, if any, the Joint Committee had on the development of government support for the cost of curative services. Social security, the overall concern of the Joint Committee and other parameters such as the need for obtaining the views of medical officers serving in the Defence Forces and factors arising from the divergent views of the medical profession, tended to dissipate the focus on a comprehensive health service.  

Cilento mentioned that the Joint Committee in its Sixth Interim Report (hastily presented in July 1943 before the dissolution of Parliament), had recommended:

that group practice clinics in various forms should be the basis of practice in all areas other than remote areas.  

The Seventh Interim Report of the Parliamentary Joint Committee (1944) is the last statement of its Medical Planning Committee available to this study. To-day it would seem slightly platitudinous. Most of its recommendations have been implemented; a few have not. The front-ranking BMA authorities appear to have steamrolled Cilento. There is hardly a line in the report that does anything to diminish the power of the BMA vis-a-vis the State. Most noticeably, the question of payment is always left open and the salaried service is no longer considered an option.

No doubt, when Chifley's government won the 1946 referendum giving it full powers over health as a national service, it believed the battle was won. But can legislation counter the political clout of the sovereign state? Consider Premier Bjelke Peterson and Aboriginal Land rights - or the Barrier Reef issue!

39. Barnard to Cumpston, 12 November 1943, Fryer coll. 44/11

40. Blueprint, ibid, p. 65

41. Seventh Interim Report of the Medical Planning Committee, 1 March 1944, Fryer coll 44/108
Cilento had not been playing politics. He earnestly tried to make everyone see that there were areas in health care delivery which private practice could handle and increasingly, due to advances in science and technology, those which it could not. Salaried doctors to-day are found in universities, laboratories, public and private instrumentalities of all kinds, the public service, the armed services, leading research teams in specialised areas, and manning hospitals devoted to chronic morbidity. Many of these activities attract the best medical brains available with appropriate professional status and financial reward. Cilento saw, as Whitlam was to discover thirty years later, that the nub of the issue was not private versus public medical careers; as the battle over Medibank showed, the main issue was whether or not the profession could, or should, lay down the terms by which the population and the government collected money to pay doctors. On this he had made his position consistently clear.42

In June 1944 the Minister for Health, Senator J M Fraser, began independent negotiations with the BMA. Thus, the two lines of influence open to Cilento, went dead. The NH&MRC and the Parliamentary Joint Committee became almost irrelevant to the question of how public money was to be spent to help meet the costs of medical care.43 There was little left for Cilento to do but write Blueprint. Here again he was badly let down by the government that commissioned it:

There was a sardonically amusing twist to the fate of Blueprint. At the moment of its appearance, the Government, putting out a toe to test the cold stream of apathy or the hot stream of disapproval withdrew, and left me to pay for the whole edition.44

From that time onwards relationships between the federal government and the BMA went from bad to worse. Chifley determined to give the people 'free' pharmaceuticals. Under the *Pharmaceutical Benefits Act 1944* the patient's doctor had to restrict drugs prescribed to a formulary drawn up by the government and to

42. Kewley, 'Social Services...’ ibid, p. 178, note 17: Cilento, Blueprint ...., p. 153. Cilento obviously saw this point very early. It was at the heart of the dispute between the Whitlam government and the AMA forty years later.

43. Ibid, p. 342

44. Cilento to Mel Pratt, Oral History transcript, ibid.
use 'forms' drawn up by the Commonwealth Department of Health. (If these conditions were not met the patients had to meet the cost of their drugs). 45

There was a referendum, two appeals against the official ruling before the High Court, both of which were won by the profession, and years of incredible bitterness. At one stage the profession responded to official instructions by sending the government forms back. Out of about 6,500 practitioners some 3,200 did so. Only two percent of doctors used the forms for prescribing. 46 Clearly this was not an argument about doctors' monetary rewards but about power and control.

Chifley got nowhere with the profession. Labor lost the election late in 1949. Nevertheless, according to his biographer Crisp:

He made it politically inevitable that his successor must put some sort of health and medical benefits programme forward and that the BMA would have to acquiesce in it. 47

The issues surrounding doctor government relationships certainly received the attention of the incoming Menzies government whose ideological base, shared by the BMA, provided common ground for mutual co-operation. Health Minister Earle Page, himself a senior physician and wealthy grazier, mediated between government and the profession with diplomacy and understanding, gradually coaxing both sides towards reconciliation and a new beginning. Nevertheless, it was not until 1953 that the Earle Page Voluntary Health Insurance Scheme came into operation. 48 The Menzies government, by its more flexible approach, succeeded in implementing the substance of the Chifley Labor Government policies on health that had been so consistently rejected by the BMA. 49 Cilento had a great deal to do with the creation of those policies in the early, planning stages and, ironically, a great deal to do with the intransigence of the doctors.

45. Kewley, ibid, p. 343
47. Ibid
48. Wood, Forever Amber, ibid, p. 20
49. Kewley, quoting Sawyer, 'Social Security ...', p. 345
In New Guinea, in Queensland and in Canberra Cilento had been called upon to provide urgently, solutions arising from situations that had brought about a state of crisis in health affairs: solutions to meet present needs and the conditions of the foreseeable future. This was his role and his forte. There can be no doubt of his conspicuous ability as a planner with a talent for policy. He could work speedily and provide original concepts that met the needs of the society at a practical level and involved the people in an organic way, as with his ideas on social medicine and all that flowed from them. He knew that by removing bottle necks in administration resources could be made to go further but only if government had some control of the way money was to be spent. He did not ever say how doctors in private practice should be paid and constantly stressed that both salaried and private practice were necessary to run a national health service.

In stating his views on what he believed to be professionally correct he was a very courageous person; the fact that his honest views (expressed in the manner of a man who had little doubt as to their infallibility) brought him professional disfavour, did not deter him from stating what he believed to be best for society. He did not try to persuade the doctors; he told them. Socialist reformers do much the same thing.

He took full responsibility for Blueprint, an extensive medical plan for the future of which the salaried service was only one aspect. He stressed that it was offered as a basis for discussion, although naturally he hoped it would be adopted.50

Apart from advocating graduated general taxation in preference to insurance (which to him smacked of the inequities of the Lodge system), and denouncing the principle of means testing, Cilento did not have much to say about government financing of the scheme.51 He was more concerned with how resources could be used to best effect than how they should be raised in the first place. It would, of course, require government action to direct their use. To fail to recognise the importance of social and political planning to this end was, to Cilento, an

50. Blueprint, introduction: Cilento also made it plain to the Planning Committee in his in camera evidence and in open session that, in putting forward his ideas, he did not in any way speak for his minister but as a private individual.

51. Blueprint, p. 159
irresponsible act of great folly.

There was obviously truth in his remark that:

Every one of the advances secured has been initiated and assisted by the best brains of the medical profession... but there has always been a proportion of medical men who see nothing in any new assumption of responsibility by the state but an attack upon those privileges which they have come to regard as rights. 92

Apart from a short and depressing period in Adelaide, Cilento had never functioned as a private practitioner in the centres of medical power in Australia: Melbourne, Sydney and Adelaide. Nor, having missed the experience of internship by joining the Army immediately he graduated, had he served his noviciate in the great public hospitals where the leaders of the profession and the doctors of the future got to know and understand each other and the inflexible code of professional manners that governed their interpersonal and public relationships. It was difficult for Cilento to communicate with these doctors in terms they understood or to influence their august professional leaders because he never really learned his professional prayers. As a public health man, he spoke in a strange language, of matters largely irrelevant to their concerns. Worse, blinded by his own successes in the field of preventive medicine and medical planning, he did not understand the doctors' point of view or realise that he was not making sense to them. He seemed not to realise the folly of 'telling' senior medical men as he 'told' politicians. During the period under review, these influential leaders presented a united front in their dealings with government advisers and used their power implacably and skillfully to thwart the perceived challenge to their authority. In doing this, many believed that they were fighting to protect the people of Australia from cheap, mediocre medical service.

Cilento stuck doggedly to his opinion that the BMA was an ageing oligarchy that did not truly represent the profession. 53 This gave him the courage to fight on persistently through the war years. He believed, on sound evidence, that he had the support of the younger doctors in the fighting services, who would eagerly embrace

52. Cilento, 'The Future of Medical Care', Brisbane, May 1941, p. 4
53. Transcript..., EEE 27, 35
the opportunities offered in the salaried service on their return. He was probably influenced in this also by his own remembered experiences after demobilisation which had been depressing and humiliating.

The medical profession's united stand against Chifley over the issue of pharmaceutical forms in the late forties proved that Cilento was wrong in his belief that members of the BMA did not speak with one voice when it wished to be heard.

Lack of contact with the practising doctors made it difficult for him to appreciate the deep seated fears that beset them. This, in turn, blinded him to the limits of feasibility in medico-legal politics. In this most conservative of all callings, change can come only gradually. The salaried service could not have been imposed upon the doctors as a fait accompli: it needed to be implemented persistently and persuasively over time. This has happened.

The manner in which he put forward this proposal terrified the doctors into believing he was bent on nationalising the profession, whereas, in fact, he was not advocating anything more revolutionary than the system that has been operating in Queensland since 1946 and for which he had laid the foundations a decade earlier. What strange compulsion made him proclaim from the housetops that his salaried service would in no time attract most of the population? It was probably his very real, but tactless, integrity.

In Queensland his Health Act 1937 and Medical Act 1939 have stood the test of time and given many leads to the medical and government policy makers in the rest of Australia. More than most individual reformers he can be seen to have upheld and promoted the highest ideals of the profession to the benefit of its members and of the society at large.

He was a precursor and, like most visionaries, was rejected by his own kind because they could not understand what he was really saying. The non recognition of his Blueprint was not a measure of its worth: the Curtin government's decision to defer the implementation of national health insurance until after the war, at the
behest of the doctors, aborted all the various plans that had been put forward in the great debate which still flourishes with all the acrimony, fury and confusion of Cilento's time. To the contemporary reader, the accounts of the times have a distressingly familiar ring.

In addressing the profession he constantly expressed the view that eventually government must control medical care:

... there is no longer any question as to whether there will be state control of medical care, it is only a question of what form it will take...\(^55\)

... the promotion of health and the prevention of disease and the provision of medical care in all its aspects must inevitably become, at an early date, a function of government, preferably upon a basis arrived at by agreement with the medical profession and endorsed by the public.\(^56\)

Taking these words in their full context one can see that Cilento was not wishing his professional colleagues to be overcome by bureaucracy. He was warning them that unless they came to accept the facts of the situation they would get an undesirable, inadequate type of service planned by bureaucrats. He was challenging them to take a realistic look at the situation and help to plan a national health care service worthy of the profession and the people. To the BMA this was intolerable lese majesty and they branded him the arch priest of socialism. Cilento! Sadly, the many admirable features and innovations of medical care that he was advocating were lost in the fury of innuendo directed at him. It was twenty to thirty years before they were to be rediscovered; the wheel re-invented, the originator forgotten.

In January 1946 all public hospitals in Australia became free without a means test.\(^57\) One plan at least of Cilento's cultivating would have fallen into his lap, but by then he was overseas fighting his biggest public health battle yet against the

\(^55\) Med.J.Aust, 1942, 1:364

\(^56\) Blueprint, ibid, p. 114

\(^57\) Under the Commonwealth Hospitals Benefit Act, 1945, Hanlon negotiated the bed-day subsidy that brought to reality his dream of free public hospitals in Queensland which no subsequent state government has ever dared to dismantle.
threat of epidemic among refugees somewhere in Europe. The momentum of this
dissertation has impelled the writer to follow him there to draw final conclusions
about the man in a more objective situation.

Time has vindicated most of Cilento's opinions if not the manner in which he
expressed them. Even his most hostile opponents might well accord Cilento latent
respect after reading these conclusions written recently by a former federal
president of the BMA, another medical knight, Sir Keith Jones:

> It does not appear that any of the legislative changes of the past ten years have made any
alteration to the delivery of the traditional diagnostic and curative services apart from
increased costs.

Cilento would be more gratified by the exquisite and no doubt unconscious tribute
from his corporate medical foe in the rest of the statement which read:

> However, a wide range of community services have become available free of charge to the consumer.
Aboriginal health services have been expanded and lifestyle education programmes have been
introduced.  

Nor would the unconscious irony of the apologia have been lost upon him.

58. K Jones, Med.J.Aust,
EPILOGUE

By taking a degree of liberty with the poet's meaning, his words may be construed to fit men of Cilento's calibre: men of vision who expatiate freely over the human condition and long to change things for the better. Cilento had undoubtedly done this but never as fully, never as quickly as he would have wished. Frustration always walked with him, restraining and diminishing his achievements. Until he met Montgomery of Alamein. Montgomery liked Cilento's plan for a mighty maze and gave him the freedom he needed to execute it brilliantly and expeditiously. This is the high note on which this dissertation ends, leaving the reader to ask, with the writer: Who was this man, Cilento?

He was looking for new fields to conquer, even as he renegotiated his contract with the Queensland Government in October 1939. By its terms he could not resign without Cabinet consent; war had just broken out and this was a manpower requirement. It was a frustrating situation, for he longed to serve in a more exciting arena. With only the provisions of free hospital care outstanding, Cilento's reorganisational work had been completed with the passing of the Medical Act 1939. Nothing further could be done to consummate Hanlon's ambition until the distribution of taxation powers between the states and commonwealth had been decided. The prospect of spending the next seven years consolidating by routine management a system whose interest for him had lain in its creation was unattractive to Cilento, who thrived on challenge and change.
Considerations of financial security had been uppermost in his mind when he signed on for a second term as Director General of Health and Medical Services in Queensland. He was in his 47th year and had six children to educate, at some length and expense he would have hoped and expected. Yet he was well aware that he was still dependent upon a limited, unpensionable contract of employment. Therefore he had both professional and financial reasons for wanting to advance his career in a new direction.

There were two possibilities: the Commonwealth public service, or a military post. In 1938 he made tentative moves in both directions. He appraised W M Hughes of his willingness to rejoin the federal service, should a suitable position arise, and he transferred from the Reserve of Officers (AIF) to the active list and was gazetted Lieutenant Colonel.

In January 1940 he wrote to his old friend John Elkington that he was "doing his damnedest" to get to Malaya. The urgency of those words reflects the patriotic fervour then activating most men to do what was necessary to get on with the war. It was natural that he would want to serve where he had most competence, in the field of tropical medicine, combating or preventing sickness under wartime conditions. In 1940 he volunteered for overseas service but was requested to remain on home service which involved him in high level military liaison. No one entrusted with such responsibilities could have been seen officially as a security risk, but the fact that the Army did not see fit to send him to New Guinea as a malarialogist later in the war was used by those who sought to discredit him as evidence to the contrary.

Soon after war began he was dismayed to learn that because of his Italian name and his presidency at that time of the Dante Alighieri Society in Brisbane, his frequent (official) visits to north Queensland where most of Queensland's Italians lived, had brought him under official surveillance. Wartime xenophobia foments vicious rumours that by their very nature are unanswerable by their victims, who must suffer this cowardly form of character assassination with as much dignity as they can muster. Cifento, a patriot of the old-fashioned kind who expressed pride in his country almost to the point of jingoism, both at home and abroad, was bitterly humiliated. He was, of course, a second generation Australian whose pride in his name, moreover, had been from his youth, the energizing current of his ambition, expressed in an ideal of service to his country whether at peace or at war. In his
memories, he refers to the smear tactics used against him, but, like Breinl before him, did not allow their damaging consequences to vitiate his personal war effort. This, even by his standard of achievement, was prodigious.

From the beginning of his career with the Commonwealth Department of Health in 1922, Cilento had often been called upon to do two jobs for one salary and had gladly done so. Sometimes it had been three simultaneous tasks, as in 1926 when he had been commissioned to look at the causes of depopulation in the western islands of the Pacific while directing both the AITM in north Queensland and the health department of the Territory of New Guinea. He relished any opportunity to travel. His exceptional physical stamina and his interest in observing ethnic groups in relation to their environments, fitted him well for these assignments; his capacity for drawing his observations together in a report upon which government could base policy statements and plans was a resource exploited alike by Cilento and officialdom. His first report on New Guinea, and its successor dealing with the survey of health conditions in Melanesia generally, made with Dr Hermant of France in 1928, had brought both him and his country to the favourable attention of the League of Nations. From then on, federal governments of whatever complexion called upon him to conduct ad hoc surveys and enquiries into a wide variety of matters upon which they needed informed opinion. Besides the rugged treks to Cape York looking at Aboriginal health between 1929 and 1933, he was also commissioned in the latter year to carry out the entomological survey of Australia's first overseas air-route. Later that year, while still a member of the Commonwealth service, he was seconded to Queensland to look at the Sister Kenny dilemma and his appointment to Queensland twelve months later was advanced in order that he be available to settle the Weill's disease strike on the canefields. In 1937 Canberra requested that he go to Rabeaul to study and report on the medical sequelae of the Vulcan Island volcanic eruption and his last official task in Australia was to conduct a national enquiry into the health of coal miners in 1945.

Reflection on the fact that these highly responsible and demanding tasks were carried out concurrently with his normal duties reveals a great deal about Cilento's capacity and enthusiasm for work and also about the way in which governments took this for granted. Although Canberra made such overtaxing demands on his planning expertise from 1941 onwards, it was not considered necessary to find him a permanent post in the Commonwealth arena to secure his services and relieve him of
his responsibilities in Queensland. Consequently, the willing horse galloped ceaselessly between Brisbane, Canberra, and the Atherton tablelands pulling in each case a different cart, heavily laden with its own distinctive problems.

He probably would have taken this mammoth workload in his stride had not the politically sensitive nature of the health care discussions let him be seen in some quarters as a hydra-headed socialist monster, who sought to enslave the medical profession; some vocal detractors, for political reasons, continued to brand him a fascist or even a communist. Clearly he could not have been all three at once but, in the irrational climate of the times, that was overlooked. Like all prophets he was either genuinely misunderstood or deliberately misinterpreted. Ceaselessly he pondered the implications of this for his future. Would his contract be renewed? If so, could he continue to serve a society that had trampled his name in the dust? Hanlon remained staunchly loyal but he was no longer his Minister and Cilento scarcely knew his successor, Foley. Forgan Smith had retired from politics and become Chairman of the Sugar Board. He longed to get right away, to re-think his position from a distance.

He was therefore delighted to receive and accept an invitation from the United Nations Relief and Rehabilitation Administration to become, under its aegis, malarialogist in chief to the Balkans. The request for his services had come from the United States government to the Commonwealth authorities and they in turn had asked the Queensland government to allow Cilento twelve months' leave of absence for the task.

To Cilento, the three months still to complete the mines survey and write his report must have seemed like three years. No one seemed to want him in Australia but he knew that with war in Europe about to end there was urgent work to be done in the war zones if postwar epidemics were not to take an even greater toll of life than hostilities had done.

With a light heart and eager anticipation Cilento flew to Cairo, Middle East headquarters of UNRRA (as the organisation is commonly known). Flying via India, he arrived on 9 May 1945, five days after leaving Australia. There was no one to meet him and seemingly no one in Cairo who had even heard of UNRRA. This was
not a promising start. After fifteen confusing days waiting for his call-over letter, he eventually found it himself, in the pigeon hole office that passed for UNRRA headquarters, and took the next plane to Athens. There the situation was even more confused. In a very short time he came to the conclusion that his talents, medical and organisational, were wasting while he remained in Greece. Apart from that, he had intuitive thoughts as to where he really would be needed in the coming months; it was not in the Balkans!

Life-long involvement with bureaucracies had taught him that if he wanted to alter a situation urgently it was futile to go through the proper channels. Cilento decided to go to London and talk to the 'top brass' of the UNRRA Regional Office in that city.

Pausing no longer than was necessary to tell the UNRRA Mission Chief in Greece of his intentions, he slipped quietly aboard an allied plane at the war-damaged Eleusis airfield and, flying via Naples and Paris, arrived next day at Bovingdon in Wiltshire.

So clandestine were his travel arrangements that he was by no means certain that he would be allowed off the small military airfield. Lacking proper authority to be there he would, if challenged, find it hard to explain his presence.

Fortune favours the brave. No one checked him. Unhindered and unchallenged Lieut-Colonel Sir Raphael Cilento, wearing the khaki battle dress and red shoulder flashes that distinguished the UNRRA uniform, walked to the local railway station and took the next train to London.

Destiny walked with him the following day also when, still bluffing his way through Whitehall's tight security system, he succeeded in reaching UNRRA's inner sanctum. Here he was greeted with open arms.

It was now the first day of June, a little more than three weeks since the victorious Allies had demanded Germany's unconditional surrender. Many units, however, continued to resist mainly because those who should have ordered them to cease fire had suicided or escaped from the country. This meant that anyone going
on land to Allied Headquarters in north west Germany was likely to have to go through German lines. Nevertheless, medical teams were most urgently needed.

At Belsen concentration camp early in April, without food, water, or medical services, of the 40,000 prisoners abandoned by the fleeing Germans 10,000 died of typhus within three weeks and were left unburied. Before this horrifying situation could be arrested by the incoming British, another 11,600 were to die. The control of this epidemic by Dr Glyn Hughes and his staff, augmented by 100 volunteers, all brand new graduates of English medical schools, is described by Cilento as one of the major medical miracles of the war.

Now with countless hordes of refugees and displaced persons, lice-ridden and debilitated, fleeing westwards from the advancing Russians or in the opposite direction trying to get back to Poland, Cilento was under no illusions as to the chilling gravity of the situation.

UNRRA teams, ‘flying squads’ so called, were already attempting the gargantuan task of mass disinfecting of refugees by intercepting them on the roads and ‘puffing’ their clothes inside and out with DDT. These squads were composed of civilians working as attached personnel to various military units, under orders from the unit medical officer in each case. Their own UNRRA Chief Liaison Officer stationed at British Army Headquarters, Bad Oyenhausen, had almost no further contact with the teams once they had been allocated; there was no co-ordinated approach to the mounting problem of potential epidemic. Time was running out if a major catastrophe were to be prevented.

This was the apt moment at which Cilento appeared in the office of Commander Jackson, the young Australian officer in charge of UNRRA’s European operations. He acted swiftly, offering Cilento the post of Chief Medical Officer of the as yet undefined British Occupation Zone. Cilento accepted and while awaiting orders to leave for Germany drew up a plan of organisation and scrounged all the staff and vehicles he could, in total two of each! The staff had instructions to have the vehicles thoroughly overhauled, collect essential spare parts, and never let them out of sight. Despite the appointment he had been given, his embarkation for the Continent was almost stopped on Tilbury docks by the officious intervention of a civil servant who insisted that Cilento had not got the right papers. As usual he had
Following his dash to Bad Oyenhausen, Cilento made a swift reconnaissance and then organised his 'flying squads' along military lines. There was no epidemic.

Next he organised the vast Glyn Hughes Hospital taken over by UNRRA from the Army. Here he played the healer's role as well. Although he had so much to do, he made a point of visiting patients separately and giving them encouragement. Dr Fischova-Gachova, UNRRA's principal welfare officer at Belsen, could not find words to praise the work he did; she described him as an inspiration to staff and patients who regarded him as an almost supernatural being.

Meanwhile hostilities gradually ceased. About 12 June the British Zone of Occupation was officially defined and attention focussed on the health requirements for refugees and displaced persons in the 103 camps within it.

A few weeks later the administrative officer in charge of the Zone collapsed under the strain and Cilento was asked to take his place temporarily. This was a swift and significant promotion; his responsibilities now included all aspects of the refugee problem, from immunising the young, to reuniting families, clothing, feeding, and relocating some half million displaced persons, all in war-shattered conditions affecting housing, sanitation, communication, food supplies, and adding considerably to the difficulties of travel.

Cilento made a comprehensive plan and reported to Chief of Staff, Major General Sir Gerald Templer. Templer took him to see Field Marshall Montgomery.

Bernard Law Montgomery and Raphael West Cilento, two vastly different men, shared certain fundamental character traits. Both were totally dedicated to their respective professions; both were born to be decision-makers and, in the context of war and its aftermath, were required to exercise that responsibility in circumstances that could mean life or death to millions of people. To that end each relied upon skilfull organisation and tight control of staff. In order to have the free hand he needed now, Cilento wanted total authority in his sphere. Throughout his career, with one brief exception, he had always been the man at the top. He had no intention now, in war-ravaged Germany, of being anything less.
Montgomery, whilst proclaiming his sceptical view of UNRRA, a cynical mistrust of doctors, and an antipathy towards the Americans who largely funded and therefore largely directed UNRRA, nevertheless recognised in Cilento qualities indispensable to the task in hand. These he attributed to Cilento's legal training; this, the latter privately remarked, showed how little "Monty" knew about lawyers. It was in any case remarkable that a man whose military experience had been limited to junior rank in the AAMC in the closing stages of World War I and who had never had the benefit of any staff training in the logistics of a modern army, could so impress Montgomery with his plan for full scale demilitarisation and relocation of all the displaced persons in the British Zone: the successful implementation of which was of such professional importance to Montgomery, that he decided to back his new medico-legal administrator by giving him the rank to match those responsibilities. Cilento entered Montgomery's office a Lieut.-Colonel and emerged, slightly dazed, with the (assimilated) rank of Major General.

'I realised', he said afterwards, 'that this was a moment of destiny'. And so it proved to be.

Just three months after he had slipped quietly out of Greece, Major General Cilento received the following signal from Commander Jackson:

EN CLAIR ORIGINATOR R.G.A.J. JACKSON
FROM UNRRA (LONDON) TO 21 ARMY GROUP EXPOR FOR C.A. UNRRA
12.30 pm 21.8.1945

Important

Please pass the following to CILENTO, UNRRA from JACKSON

Begins: PERSONAL

1. The Director General has requested me to ask you whether you would be willing to assume the appointment of Chief of UNRRA Operations in the British Zone of Occupation. We both feel confident that you will carry out this appointment with success and distinction and it is hoped that you will agree to assume this appointment.

2. Mr Bruce, High Commissioner for Australia, has also indicated that the assumption of this appointment would be a matter of satisfaction to the Commonwealth Governments.
3. We are confident that steady progress is being made in improving UNRRA's work with displaced personnel and over the next few weeks it is the intention of the European Regional Office (which has been considerably strengthened recently) to devote primary considerations to strengthening in every way dealing with displaced persons operations.

4. If you agree to assume this appointment I should be grateful if you would inform me at an early date. A formal announcement will then be made in about ten days' time. I hope you will let us know forthwith any specific assistance you require from us.

Message ends.

One can well imagine what were Cilento's innermost thoughts and feelings as he read, and re-read, those heartening words of vindication and challenge, and savoured alone the bitter-sweet taste of condign justice. Australia's endorsement of his appointment would have raised his proud spirits even though recognition of his distinguished service came in respect of work in far-off Germany.

A prophet is not without honour, save in his own country and in his own house

St Matthew Xiii, 57

FINIS
APPENDIX

The Precursor

How innovative was Cilento as a thinker and planner in the health field? The two documents examined in the preceding text answer that question in much greater detail than the scope of the discussion has hitherto allowed.

The first of these, his evidence before the Parliamentary Joint Committee on Social Security (taken in March 1944), has a broad social application. Cilento here construes the findings of the Medical Planning Committee of the above body and speaks in camera; as always in such circumstances, he expressly accepts responsibility for ideas that are his own. Indeed his stamp is on the statement. When taken in conjunction with his writings and utterances over the years, there is much that is familiar and predictable. Drawing on his own experiences, his wide reading, observation of world wide trends and contemporary discussion and debate, Cilento gives a set of opinions that reveal his apperception of the relationships between medicine and society and offer some solutions to its problems. Taken seriatim from the transcript (Fryer coll. 44/108), some of his more perceptive conclusions are listed hereunder in abbreviated form.

Cilento noted,

1. the need to establish the facts about health risks in middle age
2. the inevitability of an ageing population; measures would be required to ensure that it need not be old in spirit
3. the need to record still birth
4. the need for national morbidity surveys and scepticism about the benefit of regular medical examination of adults
5. that a medical statistician should be seconded to the Australian Bureau of Statistics
11. that the foundations of physical fitness are laid in childhood; teachers should be trained in physical education
12. that schools should have programmes of health education (including sexuality)
13. that there should be an awareness of the requirements of nutrition; (a national survey between 1936-1938 had shown that a 6 per cent minority could not obtain adequate food)
14. that all schools should have trained nurses or social workers empowered to visit the homes of children whenever it seemed likely that they were suffering as a result of an unsatisfactory environment; there was a need for a home help service to manage households in case of sickness
that there should be uniform drug regulations throughout Australia

the need for improved industrial hygiene services

there should be adequate control of venereal disease and tuberculosis; for the latter, surveys using the new micro-radiotherapy were required

that mental deficiency should be thoroughly investigated; there was need for both research and preventive measures

that adequate health and medical facilities should be maintained in the Australian tropics

there should be a hospitals' advisory committee at Commonwealth level to help the states plan hospitals. (This was done in the Whitlam era but has since been dropped)

hospitals should be regionalised

that the shortage of beds in hospitals especially for sub-acute and chronic disease patients should be made good

that there should be a college of nursing education to raise nursing standards

that there should be a course of training for hospital administrators

that any public health service should include comprehensive, co-ordinated and planned public health and preventive services to achieve positive health; this should be part of a national policy

that Outpatients' Departments should be reduced in size

that the medical needs of the community should be the responsibility of medical men

that in each region there should be a salaried district health officer to promote and maintain preventive services; a trained officer of a State Health Department

that there was a need for Chairs of Social Medicine in all medical schools (accepted in the 1970s)

that medical students should serve part of their medical training in group practices outside the hospitals; facilities should be provided for improved postgraduate study in the health field.

Most of these suggestions were new in 1944 although they are now widely accepted and in most cases a matter of common practice. Interactively they reinforce modern socio-medical services in the community.
In Blueprint for the Health of a Nation, in the main a brief for a salaried medical service, Cilento builds his case on what might be called medical precedent. He quotes many authorities to support his views on the future structure of medical services. He also makes some observations about matters unconnected with the salaried service concept. These are:

(i) that doctors are reluctant to admit to full recognition and partnership other than legally qualified medical practitioners, social workers for example (p.109)

(ii) that government departments are unsuitable to supervise day to day doctor/patient relationships (p.132, 133). Government departments are required to make policy and to control the wider aspects of a health organisation

(iii) that there should be fertility clinics (p.31)

(iv) that education and research are the two great essentials for positive health (p.100)

(v) that there is an obvious connection between economics, lifestyle and health. There are diseases of deficiency and diseases due to excesses (p.102)

(vi) that rehabilitation after illness or trauma should be regarded as essential (p.103)

(vii) that doctors, ignoring world trends, were refusing to join in co-ordinated or co-operative forms of practice (p.107)

(viii) that competition in medical practice has fostered jealousy and aggression (p.147)

(ix) better community provisions could reduce hospital admissions

(x) that medical students should have benefit of training outside hospitals (p.86) and that geriatrics and gerontology will become increasingly important areas of study and practice (p.97)

In his closing remarks Cilento emphasises that no system will work unless medical men are satisfied with their terms and conditions and pays tribute to their knowledge and community standing.

It is not claimed by or for Cilento that all the foregoing ideas were his; he acknowledged many sources. Cilento's unique contribution was to correlate, synthesize and demonstrate desirable goals as attainable through education, research and administrative structures.
BROAD OUTLINE OF A CONVENTIONALISED HEALTH SCHEME FOR AUSTRALIA.
BIBLIOGRAPHY

Introduction

Much of the research in this thesis is based on papers in the Sir Raphael Cilento collection which is deposited in the Manuscript Section of the Fryer Memorial Library. As has been told, this collection was established from papers rescued from Sir Raphael's home after the Brisbane flood of 1974. During the subsequent three years the Fryer Library repaired the damaged documents and catalogued it as its Collection 44. Since that time a significant body of additional material has come to light and the library now plans to recatalogue.

It is likely that a new numbering system for items will have to be devised for the Collection. In this thesis items have been identified by their present number and indications given where an item is part of uncatalogued additions.

Many of the references to contemporary newspapers have been taken from Cilento cutting books. Some have been photocopied from the originals which are now in an advanced stage of deterioration and cannot be used. The photocopies are part of the uncatalogued additions to Collection 44.

In some categories, most notably professional correspondence and unpublished reports, the collection is sparse. Where possible deficiencies have been made good by items photocopied from official archives.

PRIMARY SOURCES

ARCHIVAL INSTITUTIONS.

Australian Archives, Canberra, ACT.
Parliamentary Joint Committee on Social Security, Reports No 6 and 7. The titles and dates of these reports are:
Sixth: A Comprehensive Health Service, 1 July 1943
Sub-Committees: Medical Planning, interim reports Medical Services Advisory Committee (Hospitals)
Professional Correspondence C/P 71/2
Stewart, Sir Frederick. Cutting Book C/P 77
Commonwealth Archives of Australia, Brisbane
Tropical Hygiene Division (CDH) C/P 46 Departmental circular, 1928.
Cumpston-Cilento correspondence.

Commonwealth Department of Health Library, Canberra, Archival Collection
Federal Health Council Reports: Canberra
* 5th Session March 1931
* 6th Session February 1933
* 7th Session March 1934
8th Session March 1935
9th Session April 1936
10th Session September 1936

National Health and Medical Research Council Reports: Sessions 1 to 18:
* + 1 February 1937, Hobart
* 2 June 1937, Canberra
* 3 November 1937, Sydney
** 4 May 1938, Brisbane
** 5 November 1938, Canberra
*** 6 May 1939, Adelaide
  7 November 1939, Canberra
** 8 May 1940, Canberra
* 9 November 1940, Canberra
* 10 May 1941, Canberra
11 July 1941, Canberra
* 12 November 1941, Canberra
13 May 1942, Canberra
14 November 1942, Canberra
15 May 1943, Canberra
* 16 November 1943, Canberra
* 17 May 1944, Canberra
18 November 1944, Canberra

* Indicates paper asked for and not printed as an appendix: published elsewhere under the title: 'The State, the Public and the Medical Profession'.

* Indicates major papers printed as appendices written by Cilento and/or his special committee or policy involvement.

Queensland State Archives
Collection HHA/1 – HHA/11: Reports and memoranda concerning the reorganisation of the Home Department, 1934 onwards. Includes draft plan of reorganisation, ministerial correspondence, draft bills and recommendations by Director General.

HHA/12 Correspondence and statement by Sir Raphael Cilento to Joint Parliamentary Committee (NSW) regarding hospitals, honoraries, graduands and patients, Nov. Dec. 1939

Home Secretary's Office: Kenny Clinics
Correspondence 1934 (A/31750)
1938-1946 (A/31752)

Royal Commission on the Investigation of Paralysis: Queensland 1936 (A/31754)
LIBRARIES

Australian National Library
Papers of J H L Cumpston: R W Cilento: Sir Walter Crocker (all restricted)

Commonwealth School of Health, Sydney
Aboriginal Health and Leprosy Surveys: AITM Reports: John Fielding's Journal

University of Queensland Libraries:
(a) Main Library
Annual Reports of the Director General of Health and Medical Services
Queensland Parliamentary Papers, 1934-1946
Queensland Parliamentary Debates, 1922-1946

(b) Fryer Library
Sir Raphael Cilento Special Collection 44/1-157

Principal categories used:

1. Biography (including unfinished autobiography R W Cilento), transcripts, oral interviews, voice tapes: individual item 'My work as Director General ...' dictated 6 October 1971

2. Correspondence: official 1927-1971: personal and professional 1932-1972

3. Diaries and letter-books of R W Cilento, 1914-1971 (includes letter-diaries to his wife as bases for official reports)

4. Manuscripts: holograph and typewritten drafts of reports, memoranda, etc.

5. Public lectures: Presidential Addresses: Orations etc., correspondence and published references

6. Broadcast materials: radio scripts, debates

7. Reports: routine, special investigations, evidence to parliamentary committees (transcripts), including Parliamentary Joint Committee on Social Security, December 1942: 'An open letter to medical men': Royal Commission (broadcasting, V.D. paralysis etc.), ministerial

8. Reprints: Articles by R W Cilento in professional journals and academic publications in Australia and elsewhere

9. Reports and cutting books relating to UNRRA and UNO
Additional related sources:

P D (Lady) Cilento Collection (acquired 1982)
F G Fisher collection: correspondence, oral history

Official reports uncatalogued
- Report on the Administration of the Territory of New Guinea, 1 July 1921 - 30 June 1922
  An abbreviated copy of this report is available in QPP 1930: 645-707

Queensland Institute of Medical Research
Anton Breinl Papers (AITM)

University of Queensland Museum of Anthropology
(Cilento Collection)

University of Adelaide Medical School Library (Archives)
Cilento records

South Australian Museum
Cilento material

NEWSPAPERS

* Advertiser (Adelaide)
* Age (Melbourne)
* Argus (Melbourne)
* Australian 1964-
* Brisbane Courier (Brisbane)
* Courier Mail (Brisbane)
* Canberra Times (Canberra)
* Daily Mail (Brisbane)
* Daily Telegraph (Brisbane)
* New York Times (New York, USA)
* North Queensland Register
* Rabaul Times (Rabaul)
* Review (Jamestown, S. Aust.)
* Smith's Weekly (Sydney)
* Sun (Melbourne)
* Sydney Morning Herald (Sydney)
  Townsville Daily Bulletin (Townsville)

* Indicates that references used are collated in various cutting books in Fryer Collection 44.

Official Publications

Acts of Parliament and Government Regulations
Queensland:
  1923-1932 Hospitals Act
  1925 Medical Act (Geo.V. No. 1)
  1934 Health Act (Amendment) Act: (25 Geo.V. No. 29) (Cilento's appointment)
  1934 'Rat Prevention and Destruction Regulations, (Weil's Disease Regulations)
    Govt. Gazette 15 November
  1936 Hospitals Act (1 Geo.V. No. 4)
  1936 Health Act Amendment Act (1 Geo. VI. No. 5)
  1937 Health Acts, 1937-1941 being 1 Geo. VI No. 31: as amended by 3 Geo. VI No. 34 (Dec. 1939) and by 5 Geo. VI No. 8 (Nov. 1941)
  1938 Backward Persons Act (2 Geo. VI, No. 30)
  1938 Mental Hygiene Act (2 Geo. VI, No. 10)
  1939 Medical Services and Pharmacy Act (3 Geo. VI, No. 10)
  1944 Health Act (Amendment) Act
  1945 Queensland Institute of Medical Research Act (9 Geo. VI, No. 21)

Commonwealth of Australia
  1945 Commonwealth Hospital Benefit Act

Queensland Government Publications
  Queensland Government Gazette 1923-1946
  Queensland Industrial Gazette 1934-1938
  Queensland Law Reports April 1937 (Cardillo case)
  Queensland Year Book, 1932-1934

Commonwealth Parliamentary Papers
  Australasian Medical Congress Report 1920, No. 103 - F5473
  Commonwealth of Australia
Journals: Special Reports and Papers

Health: Official Journal of the Commonwealth Department of Health: Sept. 1933

Medical Journal of Australia:
- Federal Council Meeting, Feb/Mar 1940 reported 23 Mar 1940
- Federal Council Meeting, Mar 1941 reported 12 Apr 1941
- Federal Council Meeting, Aug 1941 reported 1 Nov 1941
- BMA Queensland Branch, reported 28 Mar 1942
- R W Cilento: A Salaried State Medical Service'
- Federal Council Meeting, 25 Sept 1942 reported 14 Nov 1942
- Federal Council Meeting Mar 1943 reported 24 Apr 1943
- Federal Council Meeting Mar 1943 reported 22 May 1943
- Federal Council Meeting Sept 1943 reported 6 Nov 1943
- M Scott-Young: The Nationalisation of Medicine
  Supplement, Sydney, 18 Aug 1982

MANUSCRIPTS, MONOGRAPHS AND SERVICE PAPERS

(1) R W Cilento: As this study is primarily concerned with Sir Raphael Cilento, the following bibliography includes a separate list of his relevant writings, published and unpublished, some of which have not been cited in the text. However, some items cited have not been listed as they are of relatively minor significance.

Cilento, R.W. The World, my Oyster, an autobiography, 1972 unfinished. (Fryer ms. includes holograph notes)

Cilento, R.W. The Australian Institute of Tropical Medicine Health, 1928: 16


Cilento, R.W. 'Blueprint for the Health of a Nation', Sydney: 1944

Cilento, R.W. The Conquest of Climate' (Anne Mackenzie Oration, Canberra: 1932), Med.J.Aust. 8 Apr 1933

Cilento, R.W. 'Dental research survey of north Queensland Aborigines', NH&MRC Report, Brisbane: May 1938


Cilento, R.W. Epidemiological and Tropical Aspects of Military Medicine, Fryer Coll. 44

Cilento, R.W. 'Health, Food and Fitness', Dept. Health and Home Affairs, Queensland 1937: CDH, 1940

Cilento, R.W. 'Health and Medical Services for the Southwest Pacific', repr. from Report 4th International Congress on Tropica Medicine, Washington, USA: 1948
Cilento, R.W. 'Hookworm Diseases and Hookworm Control', CDH, 1940
Cilento, R.W. 'Leprosy in Australia, as a problem of Preventive Medicine'. NH&MRC Report, Canberra: June 1937, App. 1
Cilento, R.W. 'Leprosy in Queensland', Int. Jnl. of Leprosy, 1939
Cilento, R.W. Malaria and Filaria Survey, CDH, N.E. Div. file 516/6, 1923 (with special references to Australia and its dependencies)
Cilento, R.W. 'Nutrition and Numbers', Livingstone Lectures, 1936: Camden College, Sydney: 1936
Cilento, R.W. 'Observations on the white, working population of tropical Queensland', Health, Jan and Mar 1926
Cilento, R.W. 'The problem of the pre-school child', NH&MRC Report, Canberra: Nov 1938
Cilento, R.W. 'Progress on Leprosy in Queensland'. NH&MRC Report, Brisbane: May 1938, App 11
Cilento, R.W. 'Protection of the workers in sugar cane areas', Queensland Department of Health, Brisbane: 1934
Cilento, R.W. 'A salaried State Medical Service', Med. J. Aust. 28 Mar 1942
Cilento, R.W. 'The State, the Public and the Medical Profession', Inaugural NH&MRC meeting: Provisional Agenda, Hobart 1937 (discussed, no resolution)
Cilento, R.W. 'A visit to Peel Island Leprosarium, Aug. 1931, Fryer mss. 44/

Cilento, R.W. 'Weil’s disease and Rat Control’, Queensland Department of Health, 1934

(2) Other authors this category:


Cilento, P.D. 'Square Meals for the Family’, Social Services Publication: Brisbane, Queensland Govt. Printer, 1933

Cook, C.E. 'The Epidemiology of leprosy in Australia’, CDH. No. 38, Canberra: 1928


Cumpston, J.H. 'A History of intestinal infections and typhus fever in Australia', CDH, No. 1788, 1927


Derrick, E.H. 'The Challenge of north Queensland fevers', Australasian Annals of Medicine, 8:3: 1957

Derrick, E.H. and others: 'Epidemiological observations on Leptospirosis in north Queensland', Australasian Annals of Medicine, 8:2: 1954


Elkington, J.S. 'Tropical Australia: Is it suitable for a working, white race?’ COA: F11958, 1905


Meyers, E.S. 'A Queensland Medical School and some matters of interest to the medical profession’. Med. J. Aust, 1: 9: May 1932


<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Institution/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bryant, H.</td>
<td>The University of Queensland, 1910-1960, Fryer Mss.</td>
<td></td>
</tr>
<tr>
<td>Cilento, R.W.</td>
<td>The Versatility of the medical pioneer'. Inaugural Elkington Oration, Brisbane: 1959, Fryer coll. 44</td>
<td></td>
</tr>
<tr>
<td>Doherty, R.L.</td>
<td>Funding, structures and academic function: Crises in Australian medical education'. Cilento Oration, Brisbane: 1982, Fryer mss</td>
<td></td>
</tr>
</tbody>
</table>
BOOKS

Barrett, J. 'The health problems in the Mandated Territories' in *The Mandate and the Australian People*, Melbourne 1928

Bolton, G. *A Thousand Miles Away: a history of north Queensland to 1920*. Brisbane 1963


Carroll, B. 'Forgan Smith' in *Queensland Political Portraits*. (ed.) D.J. Murphy, R.B. Joyce, St Lucia 1979

Chuter, C. *Local Government, Law and Finance*. Brisbane 1921


Cilento, R.W. *Tropical Diseases in Australasia 1940* (second edition) Brisbane 1944


Courtenay, P.P. *Australia - A Geography*. (ed.) Jeans, D.N. Sydney 1977

Crisp, L.P. *Ben Chifley*. Sydney 1977

Cumming, A.J. *Our First Half-Century*. Brisbane 1909

Dark, E.P. *Medicine and the Social Order*. Sydney 1942

Gordon, D. *Health, Sickness and Society*. St. Lucia 1976


Hale, H.M. (ed.) *The First Hundred Years of the South Australian Museum*. Adelaide 1956

Heiser, V.G. *An American Doctor's Odyssey*. New York 1936

Jordan, K. *Labor in Power* (ed.) Murphy, D.J., Joyce, R.B. and Hughes, C.A. St. Lucia 1980

Jupp, J. *Australian Party Politics*. Melbourne 1964

Lack, C. *Queensland Political History*. Brisbane 1962

Lambert, S.M. *A Doctor in Paradise*. Sydney 1946


Marr, D. *Barwick*. Australia: Allen and Unwin 1980


Murphy, D.J.  T.J. Ryan. St. Lucia 1975
Nohl, J.  The Black Death. London 1926
Pearn, J. and Carrigan, C. (ed.) Quest for Colonial Health. Royal Children's Hospital Brisbane 1983
Page, Sir Earle C.  Truant Surgeon. Sydney 1963
Price, A. Grenfell.  The Western Invasion of the Pacific and its Continents. London 1963
Robinson, R.H.  For My Country. Brisbane 1957
Robinson, Nancy  Change on Change. Adelaide 1971
Rose, G.  The Heart of a Man: A biography of Missionary Schwarz. no publication details. (Fryer Library mss)
West, F.  Hubert Murray. Melbourne 1962