Dr Cecil Cook's Contributions to Public Health in Western Australia 1924 - 1974

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A Vision for Australia's health: Dr Cecil Cook at work

by Barry Leithhead (Scholarly 2019)

and the ***Cook Corpus***, over 100 of Dr Cook papers,

http://cecilcook.com

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INTRODUCTION

The biography of Dr Cecil Cook, *A Vision for Australia's Health: Dr Cecil Cook at work* has three formats – 1) the printed book, 2) the Cook Corpus (http://cecil.cook.com) of over 100 of Dr Cook's papers that informed the book and 3) the digitized booklets that each develop a theme in the book by drawing on the Corpus. This booklet, *Dr Cecil Cook's contributions to public health in Western Australia, 1924 – 1974*, is the first in this series.

To introduce this booklet, two papers delivered at its belated launch in Perth W.A. in October 2023 explain different aspects of Dr Cook and his work. The first, by Nicholas Hasluck AM, KC, a well-known writer and a former judge of the Supreme Court of Western Australia, provides a brief overview of Dr Cook's involvement in Aboriginal affairs.

The second, by Associate Professor Dr Paul Genoni interprets Dr Cook's role and work with reference to Western Australia's history and development. Paul also assesses the author's contribution to revealing this history.

The rest of the introduction, by Barry Leithhead, the biographer, outlines this booklet's special theme: *Dr Cecil Cook's contributions to public health in Western Australia, 1924 – 1974*.

DR COOK'S INVOLVEMENT IN ABORIGINAL AFFAIRS

AN OVERVIEW BY NICHOLAS HASLUCK, AM, KC

We are here to celebrate the launch of a recently published biography: *A Vision for Australia's Health: Dr Cecil Cook at Work* by Barry Leithhead. His book covers not only public health issues in Australia from the 1920s through to the post-war era and beyond but also the administration of Aboriginal affairs.

In a moment, in my role as MC, I will invite Associate Professor Paul Genoni from Curtin University to say more about the nature of Dr Cook's achievements and to launch the book. But first, let me set the scene by welcoming the author and his wife Robin to Perth from their home in Sydney. It is a special time for both of them. Robin is the daughter of Dr Cook and earlier today, as the custodian of his papers, she finalised arrangements with the State Library to donate certain of her father's papers to the library bearing upon his work in Western Australia. She deserves our thanks for doing so.

Dr Cook's first involvement with this state, as a specialist in tropical medicine, was to prepare a report on leprosy in the Kimberley in the 1920s. This led to his appointment as Chief Medical Officer and Protector of Aborigines for the Northern Territory. These events are of particular interest to me because at that time, in the pre-war era, my father, Paul Hasluck, was interested in Aboriginal affairs. As a journalist for *The West Australian* newspaper, covering the work of a Royal Commission, he wrote many articles about Aboriginal conditions in the Kimberley. Some years later, in the early 1950s, as Minister for Territories in the Menzies government, he convened a conference in Canberra attended by state ministers and influential advisers with a background in Aboriginal affairs, including Dr Cook. Their aim was to clarify the policy generally observed by governments and agencies throughout Australia known as 'assimilation'; that is, a recognition or acceptance that Aboriginals and part-Aboriginals should have and enjoy the same rights and privileges as other Australians and live, if they choose to do so, as members of a single Australian community.

Not surprisingly, as we shared these links between Dr Cook and Paul Hasluck, Barry and I got to know each other while he was working on his book. I am therefore immensely pleased to be playing a part in the launching of his book.

You will learn that the matters I have just described in a summary form are only one facet of Dr Cook's wide-ranging career, which obliges me to add this. As it happens, Dr Cook's involvement in Aborig-

inal affairs bears upon a matter of current concern which serves to underline the importance of this book. We are on the eve of a referendum as to whether an advisory Voice to the federal government proposed by Aboriginal leaders in the Uluru statement should be enshrined in the Australian Constitution.

Wide-ranging debate about this issue has, unfortunately, included denigration of the assimilation era in certain quarters. Wrongdoing has been attributed to various well-intentioned people in that era, from administrators to missionaries, patrol officers, and even teachers and nurses, people who not only sought to improve the prospects of Aboriginal people in the modern world but strove for a full recognition of their entitlements, as citizens and fellow Australians.

Criticisms of what happened in the past, when times and conditions were different, should be viewed with care. The fact is that the wave of support for equality by assimilation reached its peak in the celebrated referendum of 1967. An astonishing 9 out of 10 Australians voted for a constitutional change that put the Aboriginal race on the same footing as everyone else. But now, there are different interpretations as to what happened in the past and as to what that decision meant: was it a new vision, a first step on the way to an uncertain place envisaged by the Uluru statement, or simply a revision or adjustment to certain democratic values reflected in the existing constitutional structure – another step in an ongoing process of securing equality and inclusion?

On a pleasant occasion such as this, I have no wish to re-open debate about such matters. I have reduced a host of complex issues to a single question simply to illustrate the relevance to contemporary issues of the book before us, for most readers of goodwill seek to understand the past and strive to see the picture as a whole.

This brings me to Paul Genoni who will launch the book. He is an Associate Professor from the Curtin School of Media, Creative Arts and Social Inquiry. He has a deeply-rooted background in Australian social, literary and political history. In 2019 a book he co-authored with Professor Tanya Dalziell won the Prime Minister's Literary Award in the non-fiction category; with *Half the Perfect World: Writers, Dreamers and Drifters in Hydra 1955-1964,* a book about the Australian literary community on the Greek island of Hydra established by the well-known writers Charmian Clift and George Johnston.

DR COOK'S ROLE IN THE DEVELOPMENT OF WESTERN AUSTRALIA

AN INTERPRETATION BY ASSOCIATE PROFESSOR DR PAUL GENONI

It is somewhat unusual to be launching this book *A Vision for Australia's Health: Dr Cecil Cook at Work*, which was effectively published some four years ago. The obvious reason for this delay was of course the onset of the COVID pandemic very soon after the book's 2019 publication. If there is a beneficiary of this delay, then it is undoubtedly me. Had the book been launched here in Perth in 2019, it would have been someone else charged with the honour that is now mine. In 2019 I knew nothing of either the book's subject, Cecil Cook, or its author, Barry Leithhead. Happily, these 'gaps' have been corrected, and I am now privileged to be a part of this occasion, which celebrates both men.

That COVID should have been a reason for delay might now be seen as relevant. If there was ever a man who would have grasped the opportunity to manage a pandemic and the intricate web of policy responses required across our federation with its complex amalgam of governments and health bureaucracies, then it was Dr Cecil Cook.

But although it may have been delayed, it is absolutely important that this book does receive, in Western Australia, the public acknowledgement that a launch provides. By the time you have finished reading Barry's book, you will be as convinced as I am, of Cook's significance as a public servant and a health administrator. He deserves to be highly regarded by far more than just public health insiders, and his work in Western Australia should be recognised as a crucial phase in a career of national and international importance.

Indeed, WA was twice to be Cook's workplace, and on both occasions he left a significant impression on the State's health care and management. The first of these two periods, in 1924, was at the start of a three-year survey that produced a groundbreaking and influential report on the incidence, impact and possible treatment and prevention of leprosy. It was important work in itself, but it was also important to Cook in that it established his reputation and shaped his career options.

Cook's initial medical training, followed by brief experience in general and hospital-based practice in Queensland, confirmed that he was not destined be a physician. Rather he chose to dedicate his working life to the planning and management of health services. In his book Barry makes the point that "Cook became a public servant to combine the two specialties that appealed to him—public health and tropical hygiene." By the end of his first stint in WA, he was set on turning his public service career into a means to benefit the health of a nation. In other words, he saw it as his destiny to have influence and to be a man who made a difference—not by providing health care to specific individuals, but rather by shaping the health and well-being of populations.

Where this ambition took him next was arguably the most fascinating part of his career, when in late 1926 he accepted the joint roles of Chief Medical Officer, Chief Health Officer and Chief Inspector of Aborigines in the Northern Territory. This blending of responsibilities precisely suited Cook's ambitions—as Barry explains, the hallmark of his approach to health care and public policy relating to health, was that he saw good health as being the foundation stone of a sound community. In the NT at the time he was confronted by huge challenges: firstly, of a small non Indigenous population adjusting to the unique health problems associated with living in the tropics; and secondly, a much larger Indigenous population confronted by the many health and social issues resulting from the sudden advent of colonial settlement.

I found Cook's experience of over twelve years working in the Territory to be one of the most compelling periods of his life, and in turn Barry's book. The work he was asked to do in the NT between the wars, when medical services in Darwin let alone elsewhere in the Territory were all but non-existent, and when a strategic approach to the development of the Indigenous community was a foreign concept, took him to the pointiest end of the challenges facing the Commonwealth public service. The word 'pioneer' barely does justice, to either the life that Cook led, or the work that he did.

Being so far from Canberra and the sorts of scrutiny that would occur elsewhere would prove to be both a blessing and a curse. Cook was undoubtedly confident in his own intelligence, education, experience and judgement, and as a result was a passionate advocate of his own opinions and his preferred approach to the challenges he faced. No doubt he developed a reputation for being strident, even pugilistic. But he needed to be, as he frequently found himself standing astride the fault-line of local and national politics at a time when the two were often poles apart. But in order to realise his own vision, he also understood the importance of developing the political instincts that were necessary to being heard and respected in Sydney, Melbourne and Canberra.

On the contentious matter of Indigenous welfare and 'Aboriginal protection' as it was then known, Cook appears to have done as well as possible. Certainly, he dodged nothing –be it Indigenous health, housing, criminal justice, inter-racial marriage and miscegenation, child removal, reserve lands, the role of missions, employment, wages —he tackled them all. Not only because it was within his remit to do so, but because he also saw these matters as being inextricably linked to health outcomes. In this way Cook became a practitioner and advocate of 'population health' long before the concept had been articulated or achieved academic credibility. His belief in a wholistic approach to community health was the foundational worldview that he took into his administration of both health and Indigenous affairs in the NT, and it would stay with him for the rest of his career.

For Western Australians readers of this book, Cook's exercise of his powers in the Northern Territory will bring to mind the work of our own Chief Protector of Aborigines of the same period, Auber Octavious Neville. The high regard in which Neville was held at the time, as compared with the scorn andeven vitriol which his name now attracts, are a harsh reminder of how history has distanced itself from the then prevailing values and widely accepted policy responses. While Cook hasn't escaped similar criticism, what

should be said about him is that he remained true to his ideals and to his principled belief that the long-term health benefit of the entire population was of paramount importance. During this period he fought both battles and wars over health and Indigenous issues, within the Territory and with the Commonwealth. Along the way he had wins and losses, but he achieved widespread respect from his peers. His work, and the lessons of his experience during this period, will reward scrutiny as Australia continues to grapple with its intractable crisis of Indigenous health.

This section of the book is also enhanced—as it is elsewhere—by the appearance of some interesting familiar names. These include ethnologists and anthropologists Baldwin Spencer, A. P. Elkin and Ted Strehlow, the erratic Xavier Herbert, and the guillotining Federal Minster John 'Black Jack' McEwen, who finally brought Cook's role in the Territory to an end in 1939. And also a special word for another great Northern Territory character in the effortlessly romantic figure of the pioneering medical aviator Dr Clyde Fenton—a man who was as much daredevil as doctor, and who proved to be Cook's enduring friend.

Having been dispatched from a role he loved in Darwin, the War probably came at the right time for Cook. He enlisted early and found himself for a short while posted to Ceylon (SL), but as the focus turned to the Pacific and the defence of Australia he found his specialty in tropical hygiene and medicine was in great demand. He also found he had a new population to protect, this time the men and women of the 2nd AIF. Malaria and typhus were Cook's enemies as much as the Japanese, and by war's end, Lieut-Colonel Cook was the Army's senior ranking field medical officer. There is little doubt that in circumstances early in the war where malaria could kill and debilitate at a greater rate than enemy action, Cook's expertise was an important contribution to Australia's later success in New Guinea and the wider Pacific.

Shortly after being demobilized, Cook found himself in the role for which he is specifically remembered in WA, when he took the position of Commissioner of Public Health, the State's senior public health officer. The book establishes that Cook inherited this crucial arm of State government policy and practice at a time when it was unfit for purpose. Already inadequate at the outbreak of the War it had since been further diminished, and Cook single-mindedly set out with the goal of creating for WA the nation's best public health system. And although his time in Perth was bedeviled with bureaucratic entanglements, his legacy on WA health was profoundly beneficial and continues to this day.

I should also note the personal cost to Cook of accepting this position in the west, while his wife Jessie and three children remained, for practical reasons, in Sydney. It meant that from the time of taking up war service until the cessation of his appointment in WA in 1949 Cook sacrificed his family life for nearly a decade. By returning to Canberra for the final phase of his career he was at last able to reunite with Jessie and their now grown children on weekends.

Moving to Canberra led to what was the most influential stage of Cook's career. Suffice it to say Cook continued to seek out and engage with the great passions of his life: tropical health, tropical disease, Indigenous health, and disease prevention, while embracing a whole new raft of health challenges, and restructuring the Canberra health bureaucracy. All the while he retained his characteristic verve, passion and energy, up until his retirement in 1962. By that time he had been a health administrator for four decades, most of it in senior roles where he never baulked from accepting a challenge or wielding his influence. It isn't too farfetched to say that by the time his active participation in health management ceased there were few Australians who hadn't been directly touched by his work.

About the book itself, and its author: firstly, it is clear that Barry Leithhead is a born researcher. It is rare to find someone who, in what might politely be described as their 'advanced years', undertakes the research and writing of their first book with anywhere near this degree of discernment and success. The result fully displays Barry's meticulous approach to the task of data collection, assimilation and interpretation. The range of sources he has drawn upon—both primary and secondary—is impressive; his ability to marshal evidence is impressive; his capacity to extract key information; to sustain and expand thematic connections; and to subtly foreground the links between the public and private life of his subject, are all impressive.

You will have gathered that Cook was a man who approached his work with ambition, energy and a clear understanding of what he wanted to achieve and the process that would get him there. Barry writes of Cook's demeanor "as a determined man. When he decided on an objective and a course of action to achieve it, he never relented". (316)

I suspect that in these attributes Cook has found his match in his biographer.

Fortunately, Barry's skills as a writer are equal to those as a researcher. I refer here to his capacities in both compiling a text and structuring a narrative that conveys information with precision and purpose, and at a tempo that readers will find engaging. It is no easy task to meaningfully condense a life of eight decades into a manuscript of 90,000 words—certainly not one as rich and active as Cecil Cook's. Barry's success in this regard has produced a small jewel of the biographer's art—a book that is not only a necessary record of an important life, but also one that is intrinsically interesting, and a pleasure to read. *A Vision for Australia's Health: Dr Cecil Cook at Work* deserves to be widely read, and it is sure to be widely admired.

DR COOK'S CONTRIBUTIONS TO PUBLIC HEALTH IN WESTERN AUSTRALIA 1924 - 1974

OUTLINED BY DR COOK'S BIOGRAPHER, BARRY LEITHHEAD

The biography *A Vision for Australia's Health, Dr Cecil Cook at work* explains Cook's objectives, principles and actions in the context of his time. Such an approach allows the reader to learn and understand what Dr Cook wrote and did.

Reflecting on the book's completed story, other stories emerge, to develop:

- Public health into population health from social influences, particularly for Indigenous people;
- Whole-of-life health literacy and personal responsibility for one's health;
- Public policy in purpose, style and content;
- *Public and population health in Western Australia and the nation*, which is the focus of this booklet.

Cook's intellectual and career profile, in brief:

- High achievements at secondary school in ancient and modern history and languages as part of being Dux in his final year; his rational research, writing and debate and challenging successfully HG Wells' 1914 contention that World War I was 'the war to end all wars';
- His constant reading, extensive knowledge, total recall and prolific writing developed his professional life;
- His qualifications in Medicine and Surgery, Tropical Diseases, Public Health, Anthropology and Malaria;
- Awarded Commander of the British Empire in 1936, aged 39;
- His early understanding of the social and other determinants of life health, population health and health literacy, well before international standards were established;
- His application of health and medical approaches in his role as Chief Protector of Aborigines, while others in similar roles (e.g. A. O. Neville) favoured administrative solutions;
- In W.A. in 1946, Dr Cook aimed for the best public health standards in Australia.

Cook's activities and references related to Western Australia:

- 1924 meeting Commissioner Dr Everitt Atkinson and Under Secretary F, J, Huelin; researching Leprosy and Venereal disease in the North-West; advising the State Government;
- 1946-1949 Commissioner of Public Health and Principal Medical Officer.
- 1946-1949 W.A.'s representative on the National Health and Medical Research Council and NHMRC's Tropical Physiology and Hygiene committee (1947-69);
- 1950-1962: Liaison with the W.A. Commissioner of Public Health via the NHMRC's committees for Tropical Physiology and Hygiene, Public Health (of all Chief Health Officers), Epidemiology and Poliomyelitis.
- 1950-1974: Informal, advisory liaison with W.A. health officers Dr Dudley Snow and Dr W. S. ('Bill') Davidson, who he recruited in 1948. Davidson gained direct responsibility to the Minister, as Cook had long advocated
- 1974: RETROSPECT; at Davidson's retirement, of his 1924 journey and more,

In Western Australia, Cook developed seven areas of public health practice of which he migrated to six other states through his roles on NHMRC Committees. Dr Cook's papers on these topics make up the contents of this booklet:

1. Revitalized Local Health Area services through the education of Health Inspectors;
2. Revised public health department functions; formed a State Health Council to advise the Minister; used medical services to inspire public health;
3. Researched stillbirths, introduced postmortems to advise practitioners;
4. Claimed medical positions and services from Native Affairs;
5. Surveyed health services and Indigenous health in the North-West in 1948;
6. Managed the 1948 polio epidemic;
7. Initiated Home nursing service for all mothers in the West Australian N-W, appointing Sister Lucy Garlick to that developmental role (1949-51)

Cook moved to Canberra in 1950, as Advisor to the Director General of Health and NHMRC liaison officer. Most of the innovations he developed in Western Australia he migrated to the other States as better practice standard, through NHMRC Public Health and Tropical Physiology & Hygiene Committees, in a general, chronological sequence:

1. Contributed to establishing the NHMRC Public Health Committee, comprised of all States' Chief Health Officers;
2. In 1950 surveyed Aboriginal health in 55 locations across Northern Australia and wrote detailed reports of conditions and needed actions;
3. Applied his mantra that 'Protection is a province of Health' to coordinate policy and practices between Health and Native Affairs in liaison with Minister Paul Hasluck;
4. Advised the Director General that 'the NHMRC had lost contact with its source of inspiration (medical practice)' and communicated this need over 4 years with the RACGP, created the NHMRC Preventive Medicine committee;
5. As a member of the NHMRC Epidemiology Committee from 1950, created and chaired the Polio committee from 1952, with oversight of the national immunisation campaign in 1956;
6. Insisted that all States establish State Health Councils;
7. In all states surveyed stillbirth definitions, incidence, causation and preventive practices, creating a national standard
8. Organised and conducted training for 12 young Aboriginal men in Darwin as Mission Health Inspectors;

CONCLUSION:

Cook first engaged with public health in Western Australia in 1924, which he celebrated 50 years later at Bill Davidson's retirement celebration in 1974;

Davidson achieved the Commissioner's direct responsibility to the Minister for Health that Cook could not – the cause of his resignation in 1949.

Cook achieved his purpose - *to bring the public health services in W.A. to a standard higher than exists elsewhere in the Commonwealth'*.

Cook's history of public and population health in Western Australia is important for the State and the nation.

As the summary above indicates, and the following booklet substantiates, Cook's work had an influence over the development of public health in Western Australia during most of his more than four decades as a health administrator. He possessed a rare combination of clinical, research, administrative and personal skills that would have been influential in any generation, and he was ahead of his time with regard to his advocacy of what is now referred to as "population health".

A portrait of Dr Cook by Elizabeth Durack for the 1948 Archibald Exhibition

Retrospect – reflecting on his career; with a tribute to Bill Davidson[1]

First let me thank you for affording me the opportunity to join you this evening in your farewell to Bill Davidson with whom it has been my privilege and pleasure to work first in the Department here and later on the National Health and Medical Research Council. It happens that 1974 is the fiftieth anniversary of my first association with the West Australian Department of Public Health and perhaps in paying my own tribute to a valued colleague and esteemed friend, it would not be out of place to mention some of the major changes that have marked its progress in that time.

In 1923 having taken the Diploma in Tropical Medicine and Hygiene at the London School, I was awarded a Research Fellowship in Tropical Medicine and I cabled Dr. Cumpston, Commonwealth Director-General of Health, in Melbourne asking how I could use this in Australia. He replied that the West Australian Government was seeking a medical survey of the Aboriginal population of the North-West and Kimberleys with particular attention to leprosy and it was arranged that I should undertake this.

I heard no more of the matter until in March of the following year, when being in Sydney with a newly acquired bride on our honeymoon, I was intercepted late one afternoon by a Custom Officer at the Neutral Bay Ferry turnstile at Circular Quay. He informed me I was expected to leave by train that night for Perth as all arrangements for the survey had been completed and the West Australian Department was impatiently awaiting my arrival.

As best I could, I arranged for the financial security of my wife and left that night for Melbourne with a little silver. In Melbourne I saw Cumpston who outlined for me the purpose of, and arrangements for the survey, explaining that the West Australian Government would be responsible for my actual expenses but would pay me no salary. I was to catch the mail train to Adelaide that night and join the Transcontinental train at Port Augusta changing to the Perth Mail at Kalgoorlie later. He explained that the Transcontinental railway track was not fully ballasted and the whole journey would take some five days to complete.

For my part I explained that I had no money and had expected to receive an advance in Melbourne. This not being officially practicable from the Commonwealth, he offered personally to lend me what I would need until I reached Perth. Feeling under an obligation to ask for as little as possible, I accepted one pound and arrived eventually in Perth with three pence.

In Perth I called on the Commissioner, Dr. Atkinson, who after a friendly chat, told me he had a golfing appointment and handed me over to the Under Secretary, Mr. Huelin. Mr. Huelin was surprised to see me and expressed at length, and with some vehemence, his annoyance that I had arrived so soon. Arrangements for my transport through the North had not been completed and a start would not be possible for another three or four weeks. He was obviously dismayed at the prospect of maintaining me in idleness in Perth in the meantime. With alacrity I offered to return immediately to Sydney at the Department's expense of course, but after a hurried calculation he decided to lodge me in the King Edward Hostel, a Temperance Hotel nearby, which he recommended as being convenient to the Department but with which I was not impressed. In passing perhaps, I might mention that in my first experience of a Perth Hotel, I was surprised by the dearth of local products on the table. Even the butter and the jam were of interstate origin, as was the dried milk powder which substituted for fresh milk. I gained the impression that for the West Australian of that day, farm production was of little moment, wealth was better sought on the gold fields of Kalgoorlie or the pearl beds of Broome.

After a few days I was dispatched to Moore River settlement to examine the aboriginal population there. This task took only a couple of days and I returned to Perth eager for more work. My return shocked the Under Secretary - apparently he had been congratulating himself on having transferred the obligation for my maintenance to the Native Affairs Department.

I suspect that about this time he began to regret the proximity of the King Edward Hostel to his office. This convenience originally commended as a merit, permitted, even encouraged, frequent visits from me seeking not only opportunities for employment but financial accommodation to supplement my

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1. A talk to the Association of State Medical Officers, July 8, 1974

resources which were still limited to the three pence with which I had arrived in Perth. The Under Secretary held the view that my financial situation was a Commonwealth responsibility and steadfastly refused to admit any obligation in this matter.

On one of these visits, I was told that the visiting Medical Officer at the Old Men's home would like me to see there, an inmate whom he suspected was suffering from leprosy. I readily agreed and asked for a cab - to be told I could use public transport. Thereupon I asked for the fare, once more re-opening discussion of my finances. The fare was not forthcoming and the visit was never made. Whether the old man was or was not suffering from leprosy, I do not know, but the incident convinced me that in the view of the lay administration of the Department of Public Health, the conservation of petty cash was more important than the condition of the patient.

You may feel I have unduly laboured these trivialities and perhaps I should assure you that I do not relate them as derogatory to the Under Secretary. I fully appreciate that he was resolutely refusing to abandon a principle made important to him in his training - the responsibility for the careful husbanding of public money. For this, as the lay financial controller of the Department, his steadfast resolution under what must have been extreme provocation, can be admired. For me, however, the subordination of the minutiae of Health Administration to monetary consideration was a dismaying indictment of lay control in a professional Department and the experience has influenced my attitude to my lay colleagues throughout my working life.

Eventually, arrangements for the survey were completed and we sailed on the "SS Minderoo" for Derby. We were a party of four with an ornate, deluxe T-Model Ford tourer with a fold back cloth hood and brightly polished brass accessories. Besides a driver-mechanic, my companions were the Member for the Electorate of Roebourne, who represented the Department of Native Affairs and a Senior Officer of Police who was taking the opportunity afforded by my survey to conduct an enquiry into the death of an Aboriginal sought on a charge of murder.

Our Kimberley itinerary was planned to permit the medical inspection of natives on every station, settlement or camp accessible by car, on horseback or by boat between Derby and Wyndham and of course, involved leaving the main stock route to journey by side tracks and detours to visit those lying to either side. In fact, we managed this reasonably well, although we failed to reach a couple of centres in the Mount House area.

There were no roads as we use the term today. Vehicles drawn by bullocks, donkeys or horses required a route giving reasonable access to water and feed for the night camp and tended to follow the major rivers. This necessitated the crossing of innumerable tributaries - large and small. The wagons followed the tracks left by earlier transport of similar type through the lightly timbered country, to cross creeks and rivers at points where the banks permitted safe descent and ascent by the floundering wheels and the stream bed was sufficiently level, clear and stable to allow passage. Riders with packhorses, travellers in drays and buggies, drovers' teams and travelling stock, followed roughly the same route, breaking up the surface where it was sand, cutting the black soil and clay pans into pock marked morasses in the wet and in the dry abrading the punctate surface once more into a trafficable surface.

Road making and road repair were effected by simple expedients. When a section of the track became difficult or impassable, a detour would be cut around it through the timber by felling trees "stump high" - low enough to clear the axles of wagon or buggy but high enough to permit easy avoidance by team and wheel. The damaged section would be closed by felling a tree or dropping a log across the track at each end of it. These improvisations handy enough for the teamster and rider, were a serious hazard for the early motorist. During the wet season traffic ceased for weeks at a time and grass and shrubs grew quickly, not only obliterating the new detour but concealing the obstacles blocking the old track.

Stumps grew foliage and simulated little bushes, necessitating constant vigilance in order to avoid collisions disrupting the chassis frame, breaking the axles, cracking the oil sump or differential housing. The sandy beds of creek and river crossings were badly broken by the hooves of teams and the wagon wheels cut tracks which a motor vehicle could not span. Models in those days often relied - as did our Ford- upon gravity feed to the carburettor from a fuel tank under the driver's seat and it was a familiar experience

having struggled laboriously across a sandy stream bed, to commence the ascent of the nether bank and there stall with no fuel feed for the motor. The alternative of crossing in reverse had its own hazard - the driver being unable to see where he was going - as the driving wheels threw up clouds of sand and dust.

At stations, the crossings could be effected with the assistance of horses or teams of laughing lubras, but for the most part the passengers had to do the pushing.

In limited areas of the North West, where the T-Model Ford had recently come into use as a Station Vehicle, we met a new inconvenience. There being no well-defined road, it was natural to assume that where car tracks deviated from the track to one or other side, there was an obstacle to be avoided or a better surface to drive on. Too often, however, these were digressions by the Station truck to a distant yard or well to inspect a watering place or simply an aimless excursion in search of stock. On the sandy plain behind the 80 mile beach on the road from Broome to Wollai Downs where we expected a run of unprecedented speed and comfort, we spent many hours lost in this way.

Apart from damage by obstructions there were mechanical hazards in plenty. Burned out transmission bands - the T-Model Ford had no gear box - broken crown or pinion wheels, broken springs and axles all had to be repaired by the roadside or in the sand, whilst the load of necessary tools and spare parts added to the weight of the passengers, their swags and stores made a burden beyond the capacity of the springs of the vehicle to carry on an ungraded road.

I shall not dwell upon the experiences and vicissitudes of our journey from Derby to Moola Bulla, at that time a Native Affairs Department Cattle Station and Reserve, beyond mentioning that in that comparatively short and easy section of our proposed itinerary, it became abundantly clear that our vehicle was quite unsuitable for the terrain to be traversed and prospects for an uneventful or even reasonably safe journey became, each day, more dismal.

The police officer, a veteran bush traveller, seems to have realised this early in our trip. At Moola Bulla there were some hundreds of aborigines and I took some days to work through them.

Affecting to be irked by the delay, he one day asked me how long I was likely to be, and when I suggested a couple more days, he elected to move on to Halls Creek where he could transact some police business whilst awaiting us. He left in a buckboard and it was arranged that he would re-join the car at Halls Creek when we eventually got there. When we did arrive at Halls Creek - at that time on the original gold fields site, since abandoned - we were told he had left in his buckboard the day before and we were to pick him up at the Black Elvira or earlier if we overtook him. Arrived at the Black Elvira, we found he had already gone, nor did we ever overtake him. Indeed, in his buggy he covered the 600 odd miles to Wyndham by the Ord River Road three weeks ahead of us and had sailed for Perth long before we reached the port.

From Wyndham we returned to Halls Creek via Turkey Creek and travelled down to Broome and finally Port Hedland and Roebourne where the car, now virtually a total wreck, was abandoned.

My guide and I continued the trip to Onslow in a hired Buick, which in its turn was wrecked on a stump some miles from Onslow. The survey in the Ashburton area was completed with Dr. Stenning of Onslow driving us in his private car.

Throughout the North, as distinct from the North-West, one could not but be impressed by the striking difference in the living standard of the people - with the single exception of wealthy Broome - compared to that of their compatriots nearer Perth.

There was of course, no radio communication short or long wave nor apart from the land line connecting Wyndham with Perth via Turkey Creek, Halls Creek, Fitzroy Crossing and Derby was there any means of telegraphic or telephonic communication. Mails were carried by pack horse or buggy at monthly, 6 weekly or longer intervals.

Housing was inadequate and often disintegrating without prospect of repair, water supplies were unreliable and hazardous, diet seasonally deficient, and hygiene poor. The people, in addition to the common maladies and indispositions afflicting humanity, were unusually exposed to accident and to endemic disease without benefit of advice or warning nor access to medical care or ambulance transport. There were small hospitals at each of the little ports and these were served by a general practitioner in private practice who received from the Government a subsidy by way of salary for undertaking the duties of Government

Medical Officer, Local Magistrate, Protector of Aborigines, Quarantine Officer and sometimes Treasury Pay Master. At Fitzroy Crossing and Halls Creek the Australian Inland Mission had established hostels each staffed by two trained nurses, interested as much in providing for the social and religious welfare of the bush worker as in rendering medical first aid.

There was no laboratory service, large areas exposed to the endemicity and epidemicity of communicable bacterial protozoal and helminthic disease, lacked any diagnostic aid to assist in the prompt identification of pathogens, the early detection of hazard, or the recognition of unusual prevalence demanding remedial action.

There were no x-ray facilities even of the primitive type useful in detecting fractures of the long bones of the limbs - even electric power was available only in special situations, for instance at the meat works at Wyndham during the killing season. The only special piece of equipment I recall was a decompressor at Broome for the treatment of "the bends" in pearl divers. This I learnt was never used, as the crews "staged" their patients at sea instead of subjecting them untreated to the long journey from the pearling beds to the port. Beyond the little ports and settlements, there was a notable absence of white women - a refining influence without which the white male was permitted by his "absentee" employer to adapt to his environment - tending of necessity to live at a level determined by his aboriginal companions. In the more settled areas, except in Broome, the primitive accommodation discouraged all but a few loyal wives of mature age. Young men, usually soldier settlers, attempting to pioneer new pastoral properties in virgin land, in their isolation faced other hazards than those of poor communication and inaccessibility of medical aid. Three of those I visited in the course of my journey were fated to be murdered by natives within a year or two of our meeting.

Cook starts his 1924 Leprosy survey in Western Australia

The survey I found had originated from persistent allegations that there was a high incidence of leprosy and/or syphilis in the aboriginal population, more particularly in the Kimberleys. Most of these reports had been based upon the observation of the acute and chronic disfigurements of yaws which was widely prevalent among aborigines at that time. Leprosy was in fact strictly limited, cases were few and as yet there were no endemic areas. Prospects for easy control seemed promising, but without effective measures, wide dissemination in both races threatened. Venereal disease occurred sporadically, gonorrhoea in foci near the coast or along the stock route. Syphilis I did not see. Granuloma venereum was quite common in the aboriginal population and I saw it twice in white males in the East Kimberleys. At Wyndham I met a Medical Officer who held rigid views upon the incidence and management of venereal disease in white and native. He had let it be known that amputation of the external genitalia was the only treatment for granuloma venereum, a published opinion which spared him the necessity of attending or notifying any great number of cases in either race. I later discussed this embarrassment with Dr. Atkinson who agreed with me that its implications were serious, but doubted whether much could be done about it as he was a private practitioner "and a good magistrate". He did in fact continue in Wyndham until he was relieved some four years later by a young Melbourne graduate who had recently attempted, unsuccessfully, to cross the continent in record time from East to West, by car.

This young man, no doubt deeply impressed by his recent experience of the hazards of outback road transport was struck by the possibility of the Wyndham marshes as air fields. He decided to teach himself to fly - after all, he argued, the pioneers of flight had had no flying instructors but had had to learn in aircraft which initially, had never been proved capable of flight. He at least had the advantage of access to aircraft

of proved performance and the marshes offered him ample room to practise his take offs and landings. So in due course there arrived in Wyndham a shipment of aeroplane parts which he carefully and eagerly assembled in accordance with the instructions provided. Unfortunately, in his impatience to begin, instead of waiting until his aircraft could be towed or carried to the extensive marshes south of the port, he decided to attempt to fly it there, taking off from a small clay pan near the town. Once airborne, probably in an adverse wind current, he lost control and crashed, in rough ground, wrecking the machine beyond hope of local repair but himself unharmed. In the depth of despondency he decided to leave Wyndham telegraphing a months' notice to the Commissioner in Perth and left for Darwin on the state ship "Koolinda" on which his successor arrived.

At that time I was in Darwin as Chief Medical Officer, Chief Protector of Aborigines and Quarantine Officer. The local general practitioner had left some months before, and I found it impossible to cope with the obligations of general and hospital practice as well as with my official duties. The arrival in Darwin of an unattached doctor presented opportunity for relief that could not be ignored. The pleas and blandishments however, of my friends and myself seemed to leave him unmoved, but under the influence of our hospitality, he lost track of time and I had his effects brought ashore from the ship which sailed without him. Clyde Fenton ultimately realised his ambition to fly and in doing so became in the strict sense, Australia's first Flying Doctor, pioneering at no little expense and risk to himself, an Aerial Medical Service for outback Australia, which made him a legend in his own life time.

Mulla Bulla men, who were examined for Leprosy

The purpose of this perhaps dreary recital of apparently irrelevant personal experiences in country with which you are familiar in very different guise has been to give you the background for attitudes adopted and decisions taken long ago, which perhaps in some small measure, have influenced your personal and official lives today. We learned, as Medical Administrators in those days, that there was a dire need to provide in the remote areas of Northern Australia, a medical service staffed with competent men with means of communication and transport permitting access to them at costs within the capacity of the poorest to pay; to provide a medical and health service for the Aboriginal population, tribal and detribalised to regulate the employment of aborigines and limit their exposure to industrial hazards; to control the conditions of their association with immigrant races so that the dissemination of communicable disease from one race to the other might be minimised; to develop a social environment encouraging white women to enter and remain in the area, with a sense of security and happy to make their homes and rear their families there - indeed to initiate and perform the function which you and your colleagues undertake as a routine today. But behind it all was the conviction that the ideational centre, the inspiration and the direction of this service must be free of restraint artificially imposed by Public Service conventions designed for metropolitan conditions and applied by lay administrators from a remote administrative centre. It must be flexible enough to meet suddenly emerging problems in an unstable area, the individual officer at the focal point being free to act on his own responsibility with resource and enterprise in strict compliance with the principles of an over-riding medical and native policy. It must be capable of maintaining an alert vigilant and informed supervision to detect epidemiological, social and ecological changes in the environment and in the behaviour or incidence of disease. To these objectives, I subsequently devoted my years in the Northern Territory in building up the N.T. Medical Service and its aerial activities, hoping it would serve as a model for comparable areas in adjacent Queensland and Western Australia.

Years later while serving with the Australian Army in the Netherlands East Indies as they were then known, my attention was drawn to a notice circulating amongst officers inviting applications for the position of Commissioner of Public Health, Western Australia. I submitted an application and was eventually informed that I had been appointed. About the same time I received from Dr. Kingsbury an assurance that neither Dr. Henzell, Director of Tuberculosis nor himself, who were together discharging the duties of Commissioner had applied for, nor wanted the appointment so that I need have no qualms in accepting or misgivings of acquiring a pair of disgruntled or superseded colleagues. Whilst these expressions of loyalty were gratifying, the news that the office of Commissioner held no attraction for either of the two logical successors to it was rather disconcerting.

The Army resisted all requests for my release until after the Japanese Armistice and in the meantime a luminary from Army headquarters visiting the area in which I was then serving confided in me what I had previously not known that my immediate predecessor had resigned because he could not brook interference by the Under Secretary in his administration. Recalling my own experience of this Under Secretary I promptly wrote personally to the Minister for Health in Perth assuring him of my eagerness to accept the challenges and opportunities of the Commissioner's Office but stating emphatically that I would not consider appointment unless I had his personal assurance that I should be indisputably permanent head of the Department with direct access to him.

In his reply Mr. Panton told me he was no longer Minister for Health but he had discussed my letter with his successor and was able to give me the unqualified assurance I sought. This letter I still have - it closed the first of a serious of disputes about the status of Commissioner vis-a-vis the Under Secretary, the last of which led to my resigning and returning reluctantly to the Commonwealth.

On assuming office there appeared to me to be a number of activities and responsibilities of the Department which were completely neglected and with the exception of the Tuberculosis division admirably directed by Linley Henzell practically no activity which was not run down to basement level in spite of talent and diligence, in subordinate staff. Rightly or wrongly I attributed this inactivity to the dead hand of the type of lay administration I had observed in the Department twenty odd years before. Amongst capable and conscientious officers there appeared to be a moody acceptance of inescapable stagnation and frustration attributed to a variety of factors peculiar to Western Australia as a "mendicant" state within the Commonwealth. I found my staff loyal, capable and as we proceeded, zealous and enterprising and I cherish the notion that I may have made some contribution to stimulating an enthusiasm formerly lacking in their work.

We gave early attention to the North and North West which during the war had relied heavily upon the Armed Services for medical and health requirements but which after evacuation of troops seemed unable to attract or hold Medical or Nursing staff of a satisfactory quality. The terms of appointment clearly needed change.

Salaries superficially attractive enough were so highly taxed as to be rendered repellent and any attempt to raise them was itself defeated by the increased tax scale. Special new terms of appointment were devised to permit relatively long periods of study leave on full pay to be earned by a completed term of service. This device in effect raised the salary substantially without incurring extra tax. The expectation was that these tenures would prove attractive to younger graduates of merit and ambition anxious for opportunities for post-graduate study which they could not themselves afford and for which taxation would not permit them saving. Five well qualified young men were recruited in the United Kingdom and their quality may be judged by the fact that they included Eric Saint who later became Dean of your faculty of Medicine and Dudley Snow, your former Deputy Commissioner.

I found that members of Road Boards probably influenced by the title, found it hard to believe that as the Local Authority they had a responsibility for the administration of the Health Act. Several rejected this role completely insisting that they had insufficient funds to discharge their "proper" function - provision and maintenance of roads - without incurring any other obligation. A great deal of time and travel was devoted to correcting this misapprehension and to assuring the appointment of properly trained inspectorial staff to individual Road Boards or convenient groups of them.

We set up a special school for the training of Nurses for Country Hospitals. This promised well and permitted rapid improvement in Country Hospital staffing.

Improved staffing facilities for infant and child health were planned and attempts begun to assure adequate preventive and therapeutic medicine for Aborigines. As a first step for this proposal the office of Medical Inspector was taken over from the Department of Native Affairs.

There were difficulties - a housing shortage and a rapidly increasing population led to improvisations which threatened the creation of slum conditions. These we had to combat at the political rather than the administrative level. To crown all we were confronted by an epidemic of poliomyelitis for which we had no reserve of trained physiotherapists: this led to provision of a special hospital for which staff had to be recruited in the Eastern States.

As part of the general plan to improve preventive medicine at Community level the Minister agreed to set up a State Health Council upon which representatives of Specialist and General Medical Practice would sit with the Commissioner to exchange epidemiological and social information to discuss public health and medical service problems and debate projects for their resolution. This body was intended to secure a measure of professional co-operation affording the Department greater opportunity for effective action at the community level.

I had high hopes for the State Health Council but I suspect the medical profession of Western Australia has not taken full advantage of the opportunities for collaboration if offered. Some years ago, a Member of the Western Australia Faculty of the Royal Australian College of General Practitioners who was very active in attempts to improve liaison and co-operation between the College and the Department told me he had never heard of its existence and assured me it no longer functioned.

At intervals there were incidents of friction between lay and Medical staff in the Department. The Under Secretary never accepted the Minister's assurances to me that the Commissioner was permanent head even though the Public Health Act left no doubt of this. Supported by the Public Service Commissioner it seems he was able to persuade successive Ministers - or so he claimed - that the undertaking given me by Mr. Panton was beyond the power of a Minister to give and was of no effect. No Minister ever confronted me with this disavowal of the earlier assurance. So from time to time incidents occurred trivial enough perhaps in themselves which led to acrimonious confrontation terminating in uneasy compromise. Ministers continued to assure me privately that there had been no qualification of my status and according to the Under Secretary to confirm him in his view that he was the permanent Head of the Department. To assist you to understand why I attach such importance to this matter of status you should recall that in my own experience I had seen or thought I had seen lay domination of the Department in earlier years bring it to a deplorable level of inefficiency and inaction as an instrument of Health administration, an agency without initiative and without prospect of change. With this background an excerpt from my representation to the Minister:

> I am not prepared as one charged with certain responsibilities by an Act of Parliament to risk decisions being made without my knowledge by a subordinate officer to whom I have not expressly given authority.

In the midst of these uncertainties there was introduced into my office one day a naval type with a marked Scots accent who I was told intended to commence practice in Dalwallinu. He was of pre-possessing personality and in addition to his medical qualifications held a D.P.H. (Aberdeen). It was perhaps natural that I should make a mental note that Dr. W.S. Davidson might prove a valuable acquisition to the Department. Later when I saw that my retirement was inevitable and recalled that Linley Henzell had expressed reluctance to accept appointment as Commissioner I made the trip to Dalwallinu to suggest to Bill that he join me in the Department as my Deputy with a view to succeeding me as Commissioner in the not very distant future. In due course he joined me and I was grateful to find he shared my interest in the health and welfare of the North and North West. Incidentally in one of his earlier reports he gave a description of social conditions and attitudes in the North at that time which is a masterpiece and which I trust has been preserved in the Archives of the State; I commend it particularly to those of you who work in that area now.

When I finally prepared to leave and to return as I say, reluctantly to the Commonwealth, assuming without, I must confess reasonable ground and without confirming the assumption, that Linley Henzell still would not want the office, I recommended Bill Davidson as my successor. In the event, Linley was appointed and served with distinction. I have always since felt guilty of a gross breach of faith to both of these two men although I have never had from either of them any suggestion of reproach on the subject.

After my departure I watched with eager interest the work, first of Linley and his team and later of yours, Bill. As I look back at the Department of Public Health in Western Australia, as I have known it over the years and compare it with what you present to me today I am filled with admiration for what you have achieved from such an unpromising beginning. I do not presume to congratulate you Bill, on this outstanding performance but am impelled to express my admiration for it. I believe in Western Australia you have presided over a golden age in Public Health administration and attained here a standard of achievement unrivalled in Australia since Burnett Ham, Ashburton Thompson and Elkington lifted the eastern states from barbaric negligence to the civilised standards of their day. Not only have you achieved this in the conventional fields of health administration enshrined in the Health Act, but in the wider arena of modern endeavour in special measures for Child Health, in environmental control and in community health.

On this occasion marking your retirement may I express the hope that your years of rest will be as happy and enjoyable as your working years have been laborious and fruitful and the expectation that your career will serve as an inspiration and a challenge for your successors.

Transition from War to Peace. Lt Colonel Cook addressed Commonwealth Occupation troops at Morotai, in late November 1945, on his environmental health survey of Japan. Soon after, he rejoined his family in Sydney, where he is seen with his daughter Robin. He took up new public health appointments in Western Australia in early March, 1946

First two mages courtesy Australian War Memorial, image references 121046, 121048

Dr Cook writing on Public Health in Western Australia

A Warm Welcome

Dr Fleming, the Chief Medical Officer at Perth Hospital in early March 1946 wrote to welcome Dr Cook and offer him support. Cook replied:

> I feel that the volume of work required in modernizing the State Health and Medical Services is so great that the task can only be approached with prior assurance of such eager co-operation as you have so readily proffered. As is it my purpose to endeavor to bring the services to a standard higher than exists elsewhere in the Commonwealth, your assurance of welcome and co-operation is all the more gratifying.

The initial W.A. Health Inspectors' conference - 1946

(DRAFT)
The Town Clerk (Location) 20th June 1946

Dear Sir,
On Saturday morning 6th July 1946 in the Nurse's Lecture Hall at the Perth Hospital a meeting of all full-time health inspectors to local authorities will be held.

The purpose of the meeting is to enable inspectors to meet the Commissioner of Public Health Dr C. E. Cook who wishes to address them and he will be supported by other speakers. The cooperation of your Council is sought so that your Health Inspector may be present.

Will you please advise early if your Health Inspector will be attending so that the necessary rail voucher may be forwarded to him.

W. P. Sutton
Chief Clerk (Health)

The Commissioner of Public Health 4th July 1946

Dear Dr Cook
I am very disappointed that I cannot attend to open your health conference on Saturday next Sometime ago I promised to go to Manjimup to open a new Infant Health Centre and it is because of this prior engagement that I cannot be present,

I am glad that you have seen fit so early in your tenure of office to pull together the Health Inspectors of the Local Authorities in our State in order that matters relative to our Health laws can be discussed to the fullest advantage,

That in itself is a step in the right direction and I have no doubt that the deliberations of the conference will lead to a greater understanding and appreciation of the problems associated with Public Health administration in this State.

I hope that such Conferences will become annual events

Will you please convey my apologies for non-attendance and I wish the Conference every success

Yours faithfully
Emil Nulson
MINISTER OF PUBLIC HEALTH

Mr. H.J. Stitfold, the Under Secretary of Health was also unable to attend because of his providing support for the Minister on that day

Agenda for the Health Inspectors' Conference

Saturday, July 6th 1946

Conference to be opened at 10 a.m.

Before Conference officially opened letters of apology were read from the Minister of Public Health (Hon. E. Nulson, M.L.A); and Mr. H.T. Stitfold, Under Secretary; and apologies for Inspector Smith (Claremont), Inspector Berry (Fremantle) and Inspector Carlson (Northam)

Dr. C.E. Cook, Commissioner of Public Health;
"Duties of Local Inspector and General Inspection Work"

Dr. L. Henzell, Director, Tuberculosis Branch;
"Some phases of the T.B. question"

Mr. W.P. Sutton, Clerk in Charge, Health;
"Relationship of the Public Health Department to the Local Authorities"

Lunch

Conference resumes at 2 p.m.

Mr. A.G. McKenna, Senior Dental Officer of Schools;
"Teeth of School Children"

Mr. W. Dow, Chief Inspector, Public Health Department;
"Health Inspection"

Mr. D.L. Davidson, Town Planning Commissioner;
"Town Development and its relation to Hygiene"

General Notes of the Health Inspectors' 1946 Conference

The conference of Health Inspectors which was called by the Commissioner of Public Health on Saturday 6th July was the first to be held since 1912. It was attended by 68 inspectors out of the 71 invitations issued.

Dr Cook spoke at length on 'Duties of the Local Inspector and General Inspection Work'. The position of the Local Inspector in his own particular area was as an officer who virtually represented the Commissioner. He called for the implementation of the Health Act By-Laws and Food and Drug Regulations and assured those assembled that if objections were raised to their actions by the Local Authority because of the fact that they were doing their job, they could be assured that they would have all his support, should such be necessary. He hoped that as time went by, he would see them all in their own districts, but the present conference was called so that he could at least talk to them generally on their work.

He realised that possibly they were dealing with bodies of men who formed Local Authorities who had no knowledge of the Act generally, and what could and should be done under the Act. He realised that an Inspector at times came up against some very personal problems. He hoped that they would create in their own particular areas a feeling of trust and become educators of the public in Health matters. It was also hoped that from time to time, circulars would be issued to Local Inspectors dealing with matters which affected health generally. For instance, some information should be supplied with regard to D.D.T. etc. Health generally was virtually controlled by three authorities, the Commonwealth, State and the Local Authority and the most important of these three he considered was the Local Authority as the implementation of any matter sent out by the Commonwealth through the State Department or from the State Government itself had to be put into effect by the Local Authority and if neglect ensued here, then a definite breakdown occurred.

Inspector Salter of the Perth City Council commended Dr Cook on the action he was prepared to take and thought a much-needed amendment to the Health Act was that working Inspectors should be clothed with authority to take action under the Act instead of having to wait, as in his own case, a period of three weeks before the Health Committee met to endorse the necessary action, and in most country areas the Local Inspector had to wait four weeks. The waiting period was too long and some discretionary powers should be given to Inspectors under the Act

Mr. Grey, of Head Office Staff made two points:

1. The Public Press should be taken advantage of by Local Inspectors for the purpose of Health education
2. That a Health Week be inaugurated by the Inspector of the Local Authority and the program be arranged so that a different item took place every day. He said that when he was a Local Authority Inspector such a week had to be run in the district concerned by a Committee of citizens and apart from being educative in Health matters generally, had raised much money in hospitals, etc.

General discussion, much of which centred around the question of the supply of milk and instances cited of the obstruction that Inspectors found in dealing with government property resulted in the first motion of government property resulted in the first motion of the conference, which was:

Proposed by Inspector F Senior, (Bunbury) and seconded by Inspector, A Neale (Collie) "In the opinion of this conference, the Health Act can never properly function nor protect the community until its provisions bind the Crown". The motion was carried.

Presentation highlights:

Dr. L. Henzell, Director, Tuberculosis Branch; "Some phases of the T.B. question"
Dr Henzell said that 1 in 300 of the State's population were active T.B. cases. T.B. does not show itself immediately and it was likely that 1,900 people in the State needed treatment but Wooroloo and other institutions had only 300 beds. He strongly recommended that every person in the population should be tested should be X-rayed but the time, money, buildings and personnel were difficult to provide. He advocated mobile X-Ray units so people in the country could be tested on the spot. T.B. could be totally abolished in 20 years if X-Ray and treatment could be carried out amongst the whole population.

Dr Davidson moved the following Motion:

> That in the opinion of this Conference it is in the financial interest of the State and every individual in it to be X-Rayed periodically to prevent the spread of the preventable scourge – Tuberculosis. The conference urges adequate Hospitals – for treatment of the cases discovered – be provided to this end.

The Motion was carried

Mr. W.P. Sutton, Clerk in Charge, Health;
Mr. Sutton suggested that the excellent attendance besides being stimulating was a happy augury for the tenure of the office of the new Commissioner of Public Health. Questions were asked with regard to the protection of Inspectors when their Local Authority had seen fit to dismiss them, and instances were quoted of how the Commissioner, by powers vest in him by the Health Act, has sometimes overruled the decision of the Local Authority when investigation had been made into their charges and such charges were found not to be correct.

Mr. A.G. McKenna, Senior Dental Officer of Schools;
Mr. McKenna said that the aim of the School Dental Service should be to ensure that as many children as possible should leave school without the loss of any permanent teeth. The scheme should begin as regards each child with its entrance into school life and should provide for an annual re-examination of each child up to the end of school life with the opportunity for treatment, if necessary after each inspection. In the country, regions should be established, the centre of each being one of the larger towns. Mr. McKenna also referred to the need to recruit dentists to provide these services and provide accommodation for dentists visiting country areas.

Mr. W. Dow, Chief Inspector, Public Health Department;
Mr. Dow said that Health Services should not be controlled absolutely by the State, [implying that control needs to be shared with Local Authorities]. He suggested that in the metropolitan area the local Boards of Health could be abolished, replaced by a Metropolitan Board of Health, leading to appointment of a Medical Officer of Health, highly qualified Senior Inspectors. Health Nurses could deal with the swabbing of throats of school children.

Dealing particularly with country sanitation, he said that it was worse than 20 years ago, when supervision was on a much higher plane than it was today. Blame lies with the Public Health Department in their policy of economy. He specifically cited sanitation of country hotels. What could be done to raisethe standard of Health Sanitation? He stressed the fact that education of the public would be very helpful.

Mr. D.L. Davidson, Town Planning Commissioner
In relating Town Planning and Hygiene, Mr. Dow criticized the current garbage tips, which should be replaced by incinerators. He said that the first programme in town planning was drainage and how lucky Perth was to have the Swan River but how easy it would for this beautiful river to become polluted. He thanked

the many Health Inspectors who had assisted his Department with house to house surveys, recorded on a card system for all blocks and houses.

General discussion ensued which at times became heated. The Vice President of the Health Inspectors' Association thanked Dr Cook for having seen fit to call such a conference which had been instructive and enjoyed by all. Dr Cook responded, apologizing that time had been pressing and he hoped that the next conference would cover two or three days and included some visits to places where food was manufactured, etc. The Conference closed at 5.20 pm.

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Health Inspectors' Association of Australia (W.A. Branch)

Dr C.E. Cook 10th July 1946
Commissioner of Public Health
57 Murray Street
PERTH

Dear Sir,
On behalf of the members of this branch of the above Association may I express our deep gratitude and appreciation of your foresight and efforts in bringing about the recent successful conference of Health Inspectors in this State.

I can assure you that this initial move on your part was very much welcomed and appreciated by our members. The lectures given were of a highly interesting and instructive nature and our members will benefit much thereby.

The opportunity which was given for instructive and advisory talks by yourself, Mr. Dow and Mr. Sutton will be of mutual advantage, I am sure to all, and which has been eagerly awaited by the members will be inspiring and helpful, helping to make the function a success, and in this connection we would like to pay a tribute and to express our thanks to the Chief Clerk Mr. W P Sutton for his efficiency and courtesy in the many efforts he displayed in this direction. Thanking you again

Yours faithfully
S Law
Branch Secretary

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The Secretary
Health Inspectors' Association of Australia (W.A. Branch)
c/- Health Department
City Council, Perth

Dear Sir,
I thank you for your letter to me of the 10th July in which you express your deep gratitude and appreciation with regard to the recent Conference of Health Inspectors in this State. As I said at the Conference, time was pressing during the whole of the proceedings and I hoped that at our next conference it will be possible to have two or three days in session, to have many outside speakers and to arrange some visits to places where food is manufactured.

C. E. Cook
Commissioner of Public Health

Cook addresses a meeting of Bunbury ratepayers - 5th November 1946

About the State and Local Government public health roles and relationships

May I at the outset, express my gratitude for the opportunity you have afforded me of addressing you upon the role of the Local Authority in the administration of the Health Act.

As you know I am but a newcomer to Western Australia. Nevertheless, I am charged with the duty of administering a comprehensive Health Act over a very extensive area of small, widely scattered and deprived settlements, each with a host of local civic ailments, incapable of remedy by any State-wide panacea. Each of these multifarious problems requires close study of local conditions and the development of an individual treatment, adapting the scientific fundamentals of disease control to the particular environmental peculiarities – social, economic, meteorological and geological – prevailing in the locality. Only thus can one hoped to plan the course of action which will at once provide effectual remedy and avert the risk of new, unexpected and possibly graver consequential embarrassments developing in other fields of local administration. This being so, I believe it to be humanly impossible for a Central Health Authority to achieve, by its own effort, maximum efficiency and local health administration.

I believe that ideal health administration can only be expected when, subject to guidance by the Central Authority, the initiative and executive powers in any area lie in the hands of an energetic and conscientious Local Authority elected upon a democratic franchise by an enlightened people.

Personally, I feel that if I am to perform the duties of my office with that measure of success which the government is entitled to expect, and which my personal inclinations demand, it will only be through the agency of local authorities of such a calibre. For this reason, I welcome an occasion such as this, affording me as it does, an opportunity to discuss with the people in whose service I administer the Act, the obstacles with which they themselves unwittingly obstruct the execution of their expressed wishes, and to enlighten them up on the part they themselves must play in safeguarding their own security.

There is a fundamental conflict of interest between the Central and Local Authorities as to the division of administrative functions between them. There has been a tendency for the Central Authority to assume more and more of the powers and responsibilities formally vested in the Local Government. This transfer has proceeded further in Australia than in Britain where the sovereignty of the Local Authority has been more jealously guarded.

Owing to the imperfection of human nature, there is much to be said for and much against either system. For the Central bureaucratic system, it may be said:

a) It enables the Central Government to impose its will for the national welfare upon the local community, thereby achieving uniformity without dependence upon the whim of the Local Authority.

b) It theoretically, at least, permits the use of national funds to develop in the national interest the impecunious and backward areas which, without such aid, must continue static or retrogress, to the National loss;

c) It permits the use of the few highly trained specialists in nation-wide administration, whereas their service with the local authority would exclude large sections of the population from the benefit of their labours;

d) It develops a corps of trained administrators, research workers and planners devoted to nation-wide social and economic advancement with knowledge gained in many fields for the benefit of the whole nation.

e) It establishes the administrative corps on a basis of responsibility only to the Central Authority unaffected by the influence of pressure groups and local vested interests.

As against these advantages, the bureaucratic system has been proved to have the following serious defects:

a) Its freedom from local responsibility is only an advantage when the individual community is not more progressive than the Central Authority. By curbing local endeavour and frustrating local enterprise, the Bureaucratic system may become a worse encumbrance than the inefficient local authority by

virtue of the very fact that national strength will defeat local efforts to achieve freedom

b) The national budget, which is the aggregate of local budgets, is so depleted by national expenditure of administrative or diversionary character that the sum available for local areas is usually far less than required. For an adequate dividend of the limited funds, local communities must compete for the favours of Bureaucrats, who have no local knowledge or interest, whose training is to suspect the bona fides of the petitioners, and his guiding principle is to reduce expenditure to a minimum.

c) The safeguarding of permanency and promotion by seniority operates towards a natural selection of the mediocre. Promotion by seniority is based on broad experience rather than upon specialised attainment and specialisation. The permanent bureaucratic tends to develop an attitude in which he is unresponsive to any influence, except Departmental expediency or political direction.

In this State, at the, the responsibility of implementing disease prevention measures rests with the Local Authority under certain powers of direction by the Commissioner of Public Health, acting for the State Government. It must unfortunately be frankly admitted that Local Authorities have failed properly to discharge their functions in this respect. Paradoxically, the functions most effectively discharged are those which directly affect the liberty of the subject whilst those more uniformly neglected are those which concern his pocket.

Sufferers from and carriers of infectious diseases are subjected to vigorous control in some conditions, to the extent of prolonged incarceration and yet conditions such as defective latrines, accumulations of filth, negligence in the handling of food for sale and so on, equally effective as agencies in the transmission of disease, are left uncorrected.

It must, the think, be conceded that the explanation of this anomaly lies in the fact that the control of infectious disease is largely effected by the Central Authority through medical practitioners and hospitals who are not directly responsible to the Local Authority so that one is forced to the conclusion that the measure of success achieved by local administration is directly proportional to the activity of the Central Authority in interfering with the Local Authority. If this be accepted, it is an admission that control by a Central Administration is more efficient than it preferable to controlled by a Local Authority.

In recognition of this, there has arisen a demand that all these functions should be the subject of direct administration by the Central Authority. Three components may be seen in force, which operate to frustrate local administration in Western Australia today:-

a) Parsimony [Thrift]: Local Authorities are reluctant to collect and spend the necessary funds;

b) Fear of offending vested interests or susceptibility to pressure groups within the Community

c) Apathy: A tendency to hope that the Central Authority will eventually assume the duty and take the necessary action.

It may be profitable to reflect upon their possible origins.

Certain powers vested in Local Authority in Britain – Education, Hospital Administration, Schools Medical Services, care of the Aged – have, for a variety of good reasons, already been undertaken by the State in this country.

This loss of power impairs the status of the Local Authority. The community tends to lose interest in local affairs and look more and more to the superior authority for direction and action. This attitude is reflected in apathy towards local civic administration and a deterioration of the type of candidate for Local Authority elections. Any further depletion of function must be expected to aggravate this social malady: local administration must inevitably enter a vicious cycle with deeper apathy, less and less competent local boards and still further depletion of function until the final extinction of the local authority and complete surrender to the Bureaucratic system become a necessity. Conditions in the Local Authority area would be bad enough if local administration were completely surrendered to the State, but certain of the functions of the State as they bear upon the local heritage have recently been transferred by Referendum to the Commonwealth, the central administration of which is which is more remote still.

The remedy, I think, lies not in further depletion of Local Authority power and functions, but in revitalising local community interest in and educating the public to appreciate the value and importance of retaining civic administration in local hands. That done, it may be possible to restore some of the lost functions to the Local Authority, with a consequent improvement in the status and calibre of candidates so that local affairs may enter the reverse cycle of greater power, improved administration and finer quality of administrator.

I urge you as one among you with the status and potentialities of a bureaucrat, to eschew [i.e. avoid] bureaucracy and so order your civic life that you retain and expand the powers of Local Government thereby developing for yourselves a healthy and prosperous community, with high social and cultural status without impediment imposed upon you by the apathy of your neighbours or their competition with you for a share of the national funds. If you fail in this, compulsive action may be taken by the State to correct your negligence, or you may be left to deteriorate at the whim of a bureaucracy whilst a neighbour, no more enterprising and no more deserving, enjoys development partially at your expense.

Use your powers of Local Government to the limit, thereby establishing a claim to have them expanded. Rely upon your Central Authority, not as an alternative Executive to which you may publicly ascribe responsibility for the result of your own negligence, but as an expert guide and adviser can also furnish you with financial assistance.

Population Trends in Relation to Health Administration

Cook considered infant death was a great waste of human life and when statistics indicated still-births were out of control, he developed a course of actions to reduce the rate of still-births. With the Minister's approval, he selected medical specialists for a new State Health Council Infant Mortality committee which examined autopsy reports of all still-births.

TO: THE HON. MINISTER FOR HEALTH:

Attached is an important report and recommendation by the Commissioner of Public Health, which is recommended for your favourable consideration.

A laboratory such as that suggested seems to be an essential part of an important hospital, and the conclusions which might be reached following the research indicated, might prove to be a very great value indeed.

In the event of your approval to the recommendation it will be necessary for me to approach the Treasury for the finance necessary.

H.T. Stitfold

UNDER SECRETARY
16.4.47

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TO: UNDER SECRETARY FOR HEALTH:

I am in entire agreement with the report of the Commissioner and shall be glad if you will place his matter before the Under Treasurer with a view to the necessary finance being made available.

Emil Nulsen
MINISTER FOR HEALTH.
18.4.47

THE HON. MINISTER OF PUBLIC HEALTH:

Population Trends in Relation to Health Administration

The material increase in the expectation of life resulting from improved living conditions, health administration and medical practice, coupled with the serious fall in the birth-rate of recent years, has resulted in an alteration in the structure of the population.

In 1911 the age distribution of population was roughly as follows:

Age range - years	
0 -19 years	39.19%
20 - 44	44.62%
45 - 64	13.83%
65 and over	2.36%

In 1946 it was:

0 - 19 years	34.00%
20 - 44	38.70%
45 - 64	19.55%
65 and over	7.75%

In 1966 it is estimated to be:

0 - 19 years	31.65%
20 - 44	34.66%
45 - 64	23.58%
65 and over	10.11%

It will be seen that-

(a) By 1966 34% of the population will be aged 45 and over compared to 16% in 1911. Unless the birth-rate materially improves or the death rate rises the progressive ageing of the existing population will still further load the senior age groups.

(b) Broadly speaking, the productive and reproductive age group, 20 to 44, will in 1966 constitute but one third of the population compared with one half in 1911. During the subsequent 20 years it will be less than one third and its future will be determined by the birth-rate in the decades prior to 1966.

(c) Meantime the proportion in the aged and infirm age group, 65 and over will be more than 10%, a proportion four times greater than it was in 1911. At a time when there is agitation to raise the school leaving age and to lower the retiring age, to increase the amount of and entitlement to old age pensions, it is disquieting to note that the ratio of potential pensioners to the reproductive group has moved from 1 – 20 in 1911 to 1 – 5 in 1946, and is estimated to be 1 – 3 and still rising in 1966.

Social trends of this nature are beyond control or influence of the Department of Public Health. The Department can, however, and must, call attention to the need to provide for the care and comfort of the aged who have ceased to earn, and attempt to prevent the infant wastage associated with abortion, still-births, infant mortality and chronic invalidity following birth injury.

1. Aged and Infirm: The proportion of aged to the working group which must in years to come provide for them, is steadily increasing, and it may well be, if the birth rate does not improve, that at some not distant date the care of the aged and infirm will become such a responsibility and financial incubus upon the earning individual that he will violently reject it. It seems desirable, therefore, that provision for the aged and infirm should be made by the ageing themselves in anticipation of their ultimately requiring it, in other words, the cost of the ultimate provision for him should be levied-during his productive period upon the future beneficiary.

These persons are not usually in good health, and even if normally in good health they fre-

quently require institutional care. At present they constitute an acute embarrassment in hospitals where they occupy beds for long periods with imminent risk of being discharged prematurely to make room for the acutely ill. It is necessary to consider the adequacy or otherwise of provision outside hospital for these aged people at a time when housing shortage and the increased tendency to live in flats and tenements has made it difficult for the younger generation to care for its aged.

It is estimated that in 1966 there will be 57,000 persons aged 65 and over, compared to 6,656 in 1911. In 1911 the State provided accommodation for 450 aged and infirm at its facility, "Sunset", a ratio of 1 – 15 (450/6,656). In 1921, when the population in this age group was 10,834, State provision remained the same. In 1946, there were 38,358 over the age of 65 in Western Australia. State provision [of housing] for them totalled 630, a ratio of 1 – 61.

Clearly, attention must be given to the formulation of a policy in respect to the aged. Such a policy must embrace a wide field including such diverse components as age of retirement from earning, entitlement to pension and provision of accommodation.

2. Sterility: Childless married couples are unable with facility to ascertain whether some remediable cause is preventing conception. Few specialists competent to examine and advise them are available in Perth, their identity is known to but a few and their fees place them beyond the reach of many. Such couples, therefore, waste valuable time and sometimes considerable sums of money in seeking advice from medical practitioners neither competent nor equipped to conduct an exhaustive examination, or charlatans wholly unqualified to examine or advise.

A properly staffed and adequately equipped Sterility Clinic is a pressing need in the Metropolitan area, and if the principle is approved, a detailed plan will be submitted for consideration.

3. Abortion: There is quite considerable wastage by abortion. In the five months ending 19th March, 1947, the Royal Perth Hospital alone notified 159 cases of abortion, approximately one thirtieth of the State's births during the same period.

In the six months ending December, 1946, various Midwives have reported 42 cases. The aggregate figure must be regarded as but a small fraction of the State total.

Of the 159 cases reported by the Royal Perth Hospital only four were described as Therapeutic. Seven others were described as induced, presumably illegally, and the remaining 148 as apparently spontaneous, because insufficient information as to interference could be obtained by the Medical Attendant. When the Commissioner of Police was asked to investigate cases of abortion with a view to determining criminal interference, he intimated that his Department was only concerned where there was danger of death.

It is improbable that such a large number of abortions, in whom a proportion are healthy unmarried girls, should be spontaneous. If, however, they are, enquiries should be directed to the factors occasioning this spontaneity.

Attention should be given to:

(a) Research into the causes of abortion.

(b) Identification and eradication of social influences leading to and affording opportunity for criminal induction.

(c) Identification and correction of causes leading to spontaneous abortion.

4. Still-births: Still-births during 1946 totalled 293, an estimated rate of 24.3 per thousand confinements. Regional analysis of this still-birth rate is not yet possible but in the first six months of the year the Metropolitan rate was 30.78 and the rural rate 17.52.

During 1945 the Metropolitan still-birth rate was 22.07 per thousand confinements, so that for the first six months of 1946 the rate in the city increased roughly 40 per cent.

Actual births during 1945 were 10,672 and during 1946 12,105. It will be seen, therefore that a substantial increase in the birth rate has accompanied the increase in the still-birth rate. Whether these observations are in any way related as cause and effect it is not possible at the moment to say, but the figures do suggest that the increase in the birth rate may have been directly associated with increased risk to the foetus in one or more of the following ways or in other ways.

(a) By the extension of births into a group of mothers at risk.
(b) By imposing upon busy practitioners and on over-worked nurses of under-staffed Hospitals a stress which prevented them affording all mothers pre-natal observation and care, adequate to permit their forecasting and avoiding obstetric risks to the foetus.
(c) By inducing overworked obstetric attendants to afford rushed and unsatisfactory attention at the time of delivery.

Maintenance of the present birth rate, even of a higher birth rate is a matter of first importance to the State and to Australia. It is the only effective demographic factor which can correct population trends at present threatening to convert the population into one predominantly senescent.

At present it is not possible to collect the full information regarding still-births necessary to elucidate their fundamental causes. Some information, however, is available from the records of King Edward Memorial hospital, where the still-birth rate for 1946 was 30.8 per thousand confinements. It should be born in mind in considering these figures that the experience of King Edward Memorial Hospital does not necessarily reflect the obstetric experience of the Metropolitan Area at large for the following reasons:

(a) Cases suffering from toxaemia and requiring special attention, are commonly sent to King Edward Memorial hospital by private practitioners and private hospitals before delivery.
(b) Cases of difficult labour are commonly sent to King Edward Memorial Hospital beforehand or during labour when they are found too difficult for the average practitioner.

At King Edward Memorial Hospital still-births during 1946 totalled 73, and were ascribed to, by percentage:

Cause	**No.**	**%**
Toxaemia	12	16.4
Maceratin of Foetus	21	28.8
Difficult Labour	15	20.6
Premature Labour	5	6.8
Maternal Haemorrhage	5	6.8
Cord Accidents	4	5.5
Monsters	3	4.1
Placenta-praevia	1	1.4
Rh. Factor	1	1.4
Unstated or Uncertain	6	8.2
	73	100

Viewed broadly the figures indicate that the high quality of specialised obstetric attention to patients at King Edward Memorial Hospital reduces foetal mortality from causes other than toxaemia and pre-natal foetal death to a relatively low figure. The death rate from difficult labour at King Edward Memorial Hospital is inflated by the number of cases arriving late in labour from outside sources.

Efficient pre-natal observation and care may be expected materially to reduce the foetal death rate from difficult labour, but research is required into the two fruitful causes of mortality which may indeed be one, toxaemia and pre-natal foetal death.

5. Neo-natal deaths: The magnitude of the loss of infant life through pre-natal and natal causes is not fully represented in the still-birth figure. A number of infants recorded as live births have been so influenced by the same pre-natal conditions as cause still-birth that they die shortly after birth or survive crippled, or presenting some less gross abnormality unfitting them for full and normal ultimate citizenship.

Analysis of Infant Mortality Statistics reveals that some 55% of all infant deaths during the first year of life occur during the first week after birth. The causes of these deaths are primarily thosewhich play such a significant part in the still-birth rate, namely prematurity birth injury and inherent defect following abnormal conditions in utero.

Research into causes and prevention of prematurity, the avoidance of birth injury and the influence of maternal toxaemia is necessary to reduce not only the still-birth rate, but also the number of neo-natal deaths and the birth of crippled children.

Recommendation: It is recommended that approval be given to the appointment of a Special Committee to be known as the Advisory Committee on Infant Mortality, which shall sit with the Commissioner of Public Health for the purposes of:-

(a) Investigating the causes of sterility, abortion, still-birth and neo natal trauma.
(b) Preparing an ordered plan for Medical and Pathological research into the problems arising from its studies, and for the collection of such information as it desires for its purposes.
(c) Recommending to the Commissioner of Public Health measures to be taken by statute and otherwise for the purpose of assisting its researches and implementing prophylactic measures.

The Committee should consist of:

(a) A specialist obstetrician.
(b) A specialist Physician
(c) A Paediatrician
(d) A Pathologist
(e) A Serologist
(f) A Midwife.

The Committee should meet with the Commissioner of Public Health as Chairman and Convenor, not less frequently than once a month and should have power to co-opt for special purposes decided by itself. In discussion with members of the medical profession, including possible appointees, I believe that members would be glad to serve on such a Committee in an honorary capacity.

The purposes of the Committee will require Serological, Bio-Chemical, Microscopical and Pathological investigations at King Edward Memorial Hospital which can only be performed in a laboratory by competent technicians. Such facilities do not exist at King Edward Memorial Hospital.

Every woman attending the Ante-natal clinic at King Edward Memorial Hospital should at least be submitted to Serological tests for the identification of syphilis and to Blood grouping to determine whether there is any incompatibility in paternal and maternal blood.

Attempts to have the first of these services rendered in the laboratory of the Department of Public Health have proved unsuccessful, particularly on account of the distance separating the two Institutions. Blood grouping has hitherto been undertaken by the Red Cross Blood Transfusion Service which has now

intimated to the Commissioner of Public Health that it can no longer undertake this work owing to the strain imposed upon its resources by the increasing demands made upon it.

Serological and Bio-chemical investigation of the mothers is a measure of first importance in any plan attempting the reduction of still-births, particularly of those recorded as Toxaemia, Maceration or Premature. Reasonable prospect of success can only attend investigations undertaken as an ordered routine made in the Hospital itself.

Sufficient space to permit the establishment of a small laboratory is actually at the moment available at King Edward Memorial Hospital in the old building formerly used as an Infant Health Training School. Subject to installation of certain fittings making available water, waste connections, gas, steam and electricity where necessary, cost of furnishing and equipment is estimated at £1,000.

Staff is recommended to consist of an Honorary Pathologist, assisted by a technician and junior assistant. It is estimated that the annual salaries involved will be approximately £700 per annum.

The annual maintenance, provision of glass ware, chemicals etc. is estimated at approximately £175.

Approval, therefore, is sought for –

(a) The preparation of an estimate by the Principal Architect for the installation of the necessary fittings to permit certain rooms at King Edward Memorial Hospital being used as a laboratory.
(b) Equipping of a laboratory at King Edward Memorial Hospital at an estimated cost of £1,000.
(c) The appointment of a technician at an annual salary of £450 to £486.
(d) The appointment of a junior assistant at an annual salary of £156.
(e) For maintenance expenses at the rate of £175 per annum.

Autopsy upon still-births in the Metropolitan Area should be made obligatory by law and should be performed in the laboratory at King Edward Memorial Hospital by the Honorary Pathologist who should report to the Committee through the Commissioner of Public Health. Autopsies on still births in the Metropolitan Area may be expected to total approximately 150 annually.

Dr. A.T. Pearson, Demonstrator in Anatomy at the University of Western Australia has intimated that he is willing to undertake the autopsies involved without fee, provided he is afforded adequate facilities at King Edward Memorial Hospital, that the cadavers are brought there for examination and that he is reimbursed travelling expenses estimated at approximately £50 per annum. For this purpose he could be appointed to the Infant Mortality Committee.

The legal enforcement of autopsy upon still-births and neo-natal deaths may be effected by order of the Coroner or by amendments to the Health Act. Subject to your approval, and pending appropriate amendment of the Health Act, a memorandum for despatch to the Coroner through appropriate channels indicating the desirability of these post-mortem examinations can be prepared for you.

CE Cook
COMMISSIONER OF PUBLIC HEALTH
14th April, 1947
CEC/PW

Nursing Shortage in Western Australia - 1947

The following is an attempt to analyse the factors concerned in the current shortage of nurses, a study of which will, it is hoped, indicate the measures necessary to solve the hospital staffing problem.

1. TRAINED NURSES

Hospitals other than Private Hospitals in Western Australia are 217 trained nurses short of the number necessary to maintain adequate staffing on the basis of a 44-hour working week.

Factors operating to produce this deficiency include:-

(a) Increased demand by the public for admission to hospital:

- In 1911 public hospitals in Western Australia provided accommodation for only 31 per thousand of the population compared to 108 per thousand in 1946.
- In 1911 the ratio of nurses to patients in Public Hospitals was 1 to 24 compared to a ratio of 1 to 48 in 1946.
- It is apparent that the demand for hospital beds has far out-stripped the provision of trained-staff for hospitals.

Factors contributing to this increased demand include:-

(i) Elimination of Home Nursing.

The Nurses' Registration Act, 1921, and the Midwives Registration provisions of the Health Act 1911, have tended to eliminate the untrained woman who was formerly available to nurse patients in their own homes whilst the urge for employment outside the home has removed therefrom the bulk of those members of the family who formerly would have been available to care for its sick.

(ii) Elimination of the Private Nurse.

In the earlier years after the Registration Acts a considerable number of registered nurses engaged in private practice nursing cases at home. Several factors have since operated to eliminate this class of nurse:-

– Depletion of domestic assistance in the home which has induced nurses to avoid a type of practice which inevitably involved performance of menial household tasks.

Increasingly exacting demands for proficiency made by medical practitioners. Under the influence of advances in medical practice, medical practitioners found it preferable to admit cases to private hospitals.

– Realisation by the private nurse that hospital practice offered better conditions and remuneration. The increased demand by hospitals for staff consequent upon the increasing demand for hospital accommodation has gradually diverted the private nurse from home to hospital practice.

– Greater facility of nursing the same or a greater number of patients in hospital as compared to nursing them in their several homes or flats.

(iii) Increased use of Tenements and Flats as Dwellings.

In 1911 the ration of the population occupying flats and tenements to those occupying private homes was 1 to 20. At 1933 census this ration had become 1 to 12. The discomfort and disabilities of nursing under flat and tenement conditions has driven increasing numbers of sick into hospital.

(b) Reduction of Working Hours.
In 1911 working hours were considerably longer than they are today, most nurses working without question 54 to 60 hours a week. The statutory nursing week in 1947 is 44 hours.

(c) The low output of graduates from Western Australian training schools in 1943, when there was a reduction of 36% on the figure for the previous year.
Factors associated with the outbreak of war in 1939 doubtless contributed to this fall.
Factors contributing to the diversion of Trained Nurses from hospital practice after graduation include:-

(a) Incompatibility of Temperament.
Nursing as an avocation is not one carrying an enduring appeal to most women. A successful nurse today must attain a high proficiency in an extremely technical training annually becoming more specialised and intricate with the advance of medicine and surgery and with the delegation to the nurse of many procedures formerly regarded as exclusively the proper field of the medical practitioner. In addition to being trained to allay suffering she must possess a personality which will enable her to dispel fear and anxiety and inspire confidence in the patient.

The exacting nature of nursing practice nowadays with its demand for relentless elimination of waste time and for high pressure attention to more specialised duties in the absence of even untrained assistance tends to eliminate that contact with the patient that psychologically is of such value both to the nurse and to the patient. Furthermore nursing under these conditions frays the nerves of the nurse and in many induces an irritation and exasperation which destroy that spirit of idealism which characterised the nurse in the early years of the profession's development.

In such situations minor disabilities of accommodation, lack of amenities and social intercourse in leisure hours to which the individual might have been tolerant or adaptable at other times are magnified into major disabilities and the nurse speculates enviously upon the advantages enjoyed by her sisters in less exacting occupations with equivalent salary and a more regular roster or limited hours.

By providing the nurse with a choice of domicile in the metropolitan area where she can choose her own accommodation and provide her own amenities they compare favourably to hospital service particularly where the daily routine is beset by minor irritations increasing each day in number and in important as the nurse broods upon them.Exacting Standards.

(b) The rising standard of technical proficiency required by medical practitioners of nurses tends further to eliminate some who formerly would have passed muster as trained nurses of average quality.

(c) Migration.
There is no opportunity for training in Infant Health in Western Australia. Nurses who wish to take the third certificate must leave the State for the purpose.
Opportunities for training in midwifery are limited in Western Australia. There is only one training school for midwives (King Edward Memorial Hospital, Subiaco) and its training capacity is limited by the restricted number of public beds. Pressure by private practitioners unable to obtain accommodation for their patients in private hospitals is constantly being directed towards further reduction of the public bed allocation. King Edward Memorial Hospital cannot provide instruction for all the general nurses graduating from the general training schools of Western Australia in any one year and nurses who are not prepared to wait until called up proceed to the Eastern States for training.

The opportunities offered ex-service nurses to undertake refresher and post-graduate courses without expense to themselves, have been frequently used as a means of travel to the Eastern States where influences towards diversion from nursing operate even more strongly than they do in Western Australia.

RECOMMENDATIONS:

Little indication for practicable immediate action emerges from study of the forces causing the current shortage of trained nurses. For the future guidance of policy, however, it may be concluded that:

(a) Reversion to home nursing should be facilitated and encouraged. This may be attempted by the training of girls in elementary nursing before they leave school. The curriculum should include Anatomy, Physiology, Hygiene, Asepsis, elementary surgical and medical training and the general care of the bed ridden. Girls as part of their training should serve some weeks in the district hospital and on passing an examination should be issued with a Certificate of Competency in home nursing by the Nurses' Registration Board. The service of these girls in country hospitals will in some measure relieve staff shortage and might be remunerated at Nursing Assistant rates. Many who otherwise would not have considered nursing as a career might under the influence of this training be attracted to the profession.

(b) The appointment of trained nurses, particularly of double and triple certificated nurses to Departmental administrative duties is unsound policy.

(i) It diverts trained nurses from hospital practice.]
(ii) It virtually involves waste of a vacancy in a training school during the currency of their training.

When nurses are selected for these appointments they should be drawn from the ranks of those who for any reason are unsuitable for hospital practice. For the rest consideration might well be given to providing a special training for these appointments. Further reference will be made to this suggestion at a later stage.

2. TRAINEES

The known deficiency of trained nurses in public hospitals in Western Australia is 217, and the estimated deficiency in private hospitals 83 – a total of 300.

Public hospitals require a trained staff of 540 and licensed private hospitals 250. It is estimated that not less than 10% of trained nurses are lost to hospital nursing each year by death, marriage, retirement, migration, and diversion to extra hospital practice – a total annual wastage of approximately 80 for Western Australia, when hospitals are fully staffed. Before the deficiency of 300 can commence to be overtaken the training schools of Western Australia must produce sufficient nurses annually to make good this 10% wastage.

Training schools in Western Australia can, as at present constituted, produce 180 trained nurses per year. It is estimated that within twelve months of graduation 20% of these will be lost to hospital nursing by marriage, migration, or diversion to commercial practice. Their nett annual yield therefore approximates 144. After providing for the normal average wastage an annual yield of 144 will not reduce the existing deficit of 300 under four years.

The output of existing training schools is not likely to be materially supplemented by immigration from the Eastern States or from elsewhere in the world. Of nurses registered in Western Australia only 10% were not trained in this State, and this number will be little more than offset by migration from Western Australia. It has become, therefore, an inescapable necessity to increase the output from training schools by augmenting the numbers passing through existing schools, by extending training to other hospitals, or by both of these methods.

Meantime major country hospitals formerly partially staffed by trainees who served a portion of their training at Wooroloo, are short-staffed to the extent of 191 untrained nurses. This deficiency must be made good either by expanding training or by substituting nursing assistants.

(a) Increase in output from existing training schools.
The present effective capacity of West Australian hospitals is 144 trained nurses per annum. This may be doubled with occupation of the new Perth Royal Hospital, but cannot be materially increased for at least three years. Actually owing to poor recruiting of recent years it may not be approached in 1947.

Trainees entering during the current year at Perth Royal Hospital are expected to total 144, but earlier classes show that this is the impassable maximum for the existing building.

The effect of increased training in Perth Royal Hospital will not be felt for another three years. Meanwhile country hospitals remain unstaffed unless some other source of nursing supply is tapped.

(b) Part-time training in Country Hospitals:
Persons in opposition to full-time training in country hospitals have suggested that girls in training at metropolitan training schools should serve portion of their time, say, three months, in country hospitals. It is submitted by the protagonists of this plan that such a period would not materially interfere with their training in a major hospital and at the same time staff would be provided for the country hospitals.

This suggestion does not survive critical examination. Omitting Kalgoorlie hospital, the qualifications for which as a full-time training school are beyond dispute, 120 nurses are required for country hospitals. If these girls are drawn from metropolitan hospitals to serve one-twelfth of their training time in the country it follows that 1440 will be required to supply the demands of a 3 months term. Similarly a six months term will need 720 and a twelve months term of 360.

The total personnel of the metropolitan training schools to-day is 450. If 120 girls for country hospitals be added a maximum of 570 is required. Unless the accommodation and nursing material in the metropolitan hospitals is to be subjected to excessive demand these girls would require to serve nine months each in the country.

Whilst this may be found practicable it is apparent that the suggestion for a three months' training period in country hospitals is not.

It must further be considered that this rotation assumes that country hospitals will be staffed by girls drawn from all years in the metropolitan training schools. As far as the latter are concerned this would facilitate necessary movement of personnel but inevitably for the first three years of the operation of the scheme country hospitals would be principally staffed by girls in their first year and would not be fully staffed until the third year.

It may be possible later to evolve a system whereby trainees at country hospitals obtain one year's experience at Kalgoorlie or at a Metropolitan Hospital, but the reverse – movement of metropolitan trainees to country hospitals is not practicable.

(c) Full-time training in Country Hospitals:
It is estimated that the 10 major country hospitals – Kalgoorlie, Northam, Bunbury, Geraldton, Collie, Narrogin, Albany, Merredin, Katanning and Busselton could provide for the training of 200 nurses provided suitable residential accommodation is available.

Provision of training facilities in country hospitals may be expected to increase the number of applicants for training.

Many parents will refuse their consent to a daughter leaving home before 21 years of age. Under necessity of choosing an occupation such a girl will be restricted to those opportunities offering in her home town. Half the available labour pool is resident outside the Metropolitan Area and

the loss of recruits incurred in this way must be considerable.

Kalgoorlie, Northam, and Geraldton with a three year course should complete the training of approximately 40 nurses per year, and the remainder, with a four year course, 20 per year – an annual output of 60.

Objection to the use of these hospitals as training schools may be taken in certain quarters on the following grounds:-

(i) Some of the hospitals provide such inferior accommodation for staff that nurses will become discontented and terminate their training before graduation.

(ii) Country hospitals are usually so badly designed and constructed that they do not facilitate efficient nursing. This will impair the quality of training and contribute towards discontent precipitating termination of service.

(iii) Equipment in these hospitals is out-moded, defective, or deficient. Nurses cannot, therefore, be adequately trained in modern practice, will learn bad habits, and cannot be expected to achieve a standard of practical proficiency acceptable to the Registration Board.

(iv) The supervising and tutorial staffs of Government hospitals are more or less permanent Officers of the Public Service who over a period of years have served in small rural hospitals where the standard of practice is low. Many were trained in a period since which there have been considerable advances in nursing practice with which their country service has not made them familiar, and they have remained in the public service under influences operating towards the natural selection of the least efficient. Many may not be competent to serve as instructors for trainees aspiring registration.

(v) The low bed average in the smaller hospitals reduces the amount of nursing material available to trainees thereby depriving them of experience to be gained in larger hospitals and impairing the quality of their training.

The first four of these objections must be met by appointing competent persons to ascertain how true these charges are and to make recommendations, which should thereafter be promptly implemented to correct any defects to which attention is called.

The fifth is based upon the fallacious assumption that the hospital of 300 beds offers a girl 10 times the material that is offered by a hospital of 30 beds. In point of fact a girl nursing in a hospital of 300 beds will serve, throughout her training, in wards of 40 beds or less and will share the patients in that ward with three or more other trainees. The patient material available to her, therefore, day by day, is in fact not greater than is available to her in the smaller hospital. It is true that in the larger hospital a trainee during any given period, nursing as she will be in a ward exclusively devoted to a certain type of case, may during that period receive more intensive training in that particular field, but on transfer to another ward accommodating a different category of patients she will cease to be concerned with the first category.

In a small hospital, on the other hand, she will be likely to nurse a wider variety day by day and in the aggregate over the longer period of training will gain as much experience in the basic fundamentals of nursing as she would in the larger hospital.

The advantage usually claimed for the larger hospitals is the wider experience gained in the special and more infrequent types of cases – more particularly surgical. This advantage, though real for the medical student, is illusory for the nurse.

The fundamentals of nursing training are the same in each category of nursing activity, and although the girl in the small hospital may not see the rarer cases seen by the girl in the larger metropolitan hospital, she will in the aggregate nurse as many cases of that general category. In any event, the vast majority of trained nurses will ultimately not be employed in the Metropolitan hospitals and their competence for nursing elsewhere can only reasonably be measured by the demands made upon them in their field of service.

Too much emphasis it is felt can be placed upon the value of the training of a nurse in metropolitan hospitals. Fifty per cent of the cases nursed in Western Australia are nursed in country hospitals and comparatively few of the nurses trained in any year will ultimately serve in the major hospitals of the metropolitan area. It cannot be disputed that country hospitals can efficiently train nurses to the standard necessary for their efficient service in the country.

There is an increasing tendency to delegate to nurses in the greater hospitals more and more work of a highly technical and specialised character which was formerly regarded as the exclusive prerogative of the medical practitioner. Whilst theoretically the standard of nursing is raised by the assumption that the trained nurse must be competent to undertake these functions, the fact remains that a great majority of nurses registered by the Nurses' Registration Board in earlier years could not pretend to possess this competence, and the vast majority of nurses in nursing practice will, and can never exercise it.

Meantime the mass of the sick public in country hospitals must be nursed by women who have and can hope to secure no training whatever. It is fallacy to argue, as many do, that the training of nurses in smaller hospitals will involve the lowering of the standard of nursing. In point of fact the standard of nursing is determined by the competency of nursing practice throughout the State and in other States.

In other States of the Commonwealth with which this State has reciprocity nurses may be trained in hospitals with a daily average of ten beds. These women may apply for and receive registration in Western Australia as trained nurses and thereafter be appointed to positions as sisters or matrons of country or even of metropolitan hospitals. It is ridiculous under these circumstances to suggest that girls should be refused the opportunity to train in 20 and 40 bed hospitals in their own State in order that the standard of nursing may not be lowered.

A serious obstacle confronts country hospitals at present in an effort to maintain a bed average qualifying for approval as training schools. In a hospital with a normal daily average of 25 beds, for example, the shortage of trained nurses may have reduced the trained staff to 50% of requirements. In order to relieve the strain upon the staff it is necessary to limit admissions so that the daily average is maintained in the vicinity of 15 to 18.

Because the hospital is not, and with that daily average cannot be a training school it is not possible to recruit or retain for the assistance of the trained staff girls of a type qualified to train as nurses. The hospital therefore must have recourse to staffing by nursing assistants. These are untrained and under present conditions untrainable, so that the more highly specialised duties of nursing and the responsibilities still remain with the trained staff. Hours worked by the latter cannot be shortened and their work in the wards is not materially reduced, except at the expense of the patients' welfare. It is still therefore not possible to raise the daily average to a level permitting approval as a training school.

There is yet another serious difficulty here involved. Where the staff of a hospital is less than 80% normal strength its members are paid a Disabilities Allowance. Sisters in a hospital such as that under discussion, therefore, will receive additional emoluments as long as the shortage of staff continues. If, however, it is possible to appoint a number of nursing assistants sufficient to raise the total staff to over 80% of normal irrespective of the proportions of trained and untrained individuals, the Disabilities Allowance will cease. Trained nurses working in a hospital staffed by 20% of the normal trained staff but with sufficient untrained assistants to make the numerical strength of the whole staff, over 80% of normal, are not entitled to the Disabilities Allowance. Nevertheless by virtue of their being trained they must still perform most of the nursing and remain on duty as supervisors for tours of duty no less than if there were no untrained assistance. The tendency therefore is for the trained staff to discourage the appointment of nursing assistants, who do not relieve them materially in the wards either of nursing duty or responsibility and to limit hospital admissions retaining the Disabilities Allowance as some recompense for overwork.

Consideration should be given therefore to re-drafting the conditions of the Disabilities Al-

lowance so that it refers to the proportion of trained staff and untrained staff severally, rather than the total staff indiscriminately.

SUMMARY:

(a) It is necessary to increase the number of trainees by at least 200.

(b) This cannot immediately be implemented by existing training schools but could be effected by commencing training in major country hospitals.

(c) Such an extension may be expected to attract girls who at present for any reason will not leave country towns to train in Metropolitan Training Schools.

(d) Unless major country hospitals are constituted training schools, they must remain unstaffed, or unsatisfactorily staffed for at least three years.

(e) There is no reason why major country hospitals should not be training schools provided the standard of nursing practice, equipment, instruction and accommodation is assured beforehand.

(f) In order to facilitate rehabilitation of hospitals fallen below critical bed average the Disabilities Allowance should be revised to relate to the proportion of trained to untrained staff severally and not collectively.

3. NURSING ASSISTANTS

In all hospitals which are not training schools it is necessary to supplement the trained staff by women who undertake minor nursing duties and duties of a semi-domestic character to relieve the trained staff for more special and technical procedures. These women are especially employed by private hospitals and by country hospitals which are not training schools. Originally little more than Ward Domestics they have of necessity, during the period of nursing shortage, more and more invaded the field of the trained nurse and of the senior trainee.

Several Government hospitals which were formerly part-time training schools and which now have no trainees have been partially staffed with nursing assistants. A few country hospitals retain only their Nursing Assistant staff. If these girls can comply with the age and educational requirements of the Nurses' Registration Board they may ultimately transfer to training schools and become qualified nurses. For the most part, however, they lack the educational standard upon which the Nurses' Registration Board insists.

Latterly the demand for trainees by training schools having been roughly commensurate with the number of girls offering, most of the eligible nursing assistants have transferred to training schools. Nursing Assistants, therefore, usually comprise girls who have not yet attained the age of 18 years entitling them to train, or who do not possess the educational qualifications required by the Board. Application is not infrequently made to the Board for the recognition of part of the service of these girls towards their training for registration. The difficulties confronting the Board in considering these applications are principally:-

(a) The educational standard of the applicant:

It is felt that nursing in its higher branches has become such a technical occupation that the educational standard cannot be safely lowered without admitting girls who will be unable successfully to complete the more specialised training in their later years and comprehend the more intricate details of nursing practice in relation to modern medicine. On the contrary it is felt that the educational standard might well be raised.

This difficulty does not appear to be insuperable. If the Nurses' Registration Board will accept attainment of the educational standard at a date before final examination, or at least defer the test until two years after commencement of training instead of insisting upon its application before commencement of training is approved, it might be possible in many cases by arrangement with the Education Department to have the educational standard of the girls substantially raised during the period of their training.

Alternatively, where a girl commences nursing in a country hospital at the age of 15 or 17 she might devote that time to bringing her educational standard up to the level of that required by the Board.

(b) The age of the applicant:

Quite frequently nursing assistants commence service in hospitals at the age of 16. Ordinarily it is not possible for a girl to obtain the approval of the Board to train until she has attained the age of 18 years. It is, however, discretionary for the Board to lower the age of entry within narrow limits. Since a girl cannot be registered as a nurse until she is 21 no great hardship is involved in her being refused to the right to train until she is 18, provided she can subsequently enter a three years' training school. If, however, she is unfortunate enough to be posted to a four year's training school she will be anxious that part of her time in a small country hospital should count as training time for purposes of the Board. The Board's objection to crediting a girl with time served as a Nursing Assistant is based on:

(i) Country hospitals are usually so ill-equipped that the girl in her formative years learns bad nursing practice which her subsequent training may not eliminate.
(ii) They may be staffed by senior nurses who through defects in their own training, apathy, or lack of interest, are not competent to train girls as nurses, so that the value of the time served is largely lost.
(iii) The bed average of the hospital may be so low that the nursing material available to the trainee is inadequate.
(iv) The medical practitioner may be incompetent or unwilling to undertake his share of the girl's training.

It is felt that none of these difficulties are insuperable provided they are energetically attacked with the will to overcome them.

A number of girls must be lost to nursing owing to the interval between leaving school and attaining 18 years of age. The age limit for entry to a training school may well be lowered to 17. Particularly is this so in the case of a girl who has already served some months in the wards of a hospital.

Whilst it may be true that poor equipment in one institution will impair the training of a nurse it may reasonably be advanced that in a small hospital where this objection is not sustained a nurse should not be penalised by application of the generalisation. Similar comment may be made concerning objections in respect of nursing staff and medical practitioners.

The Board might well, in the interests of extension of training, not only ascertain how far these objections actually exist in an individual country hospital, but make representations to the proper authority to have them remedied. Once remedied to the satisfaction of the Board a girl might reasonably be credited with a portion of her time of service.

This may indeed be advanced as a responsibility of the Nurses' Registration Board, for the girls are in fact nursing for remuneration and it is, or should be, of vital concern to the Board to see that wherever employed, they are properly trained.

The standard of nursing may be regarded as bad in direct proportion to the nursing assistant – trained nurse ratio. Nursing Assistants must be trained whether for registration or not.

SUMMARY:

a) Nursing Assistants should be encouraged to train. This will require in certain cases:
   i. Assistance to attain the educational standard.
   ii. Modification of a minimum age limit for entry.

b) Consideration should be given to inspection and training supervision in hospitals employing Nursing Assistants so that the Board may satisfy itself they are receiving a proper grounding whether or not they intend to train for registration.

4. MIDWIVES

Legislation to provide for the training and registration of midwives was introduced under the Health Act in 1911. Previously it had been permissible for any woman to assist at childbirth and it was usual for even the smallest township to have a number of women who for reward attended mothers during labour and the puerperium with or without the advice of a medical practitioner.

Some of these women under the tuition of medical practitioners with whom they worked attained a certain degree of efficiency as midwives, even judged by modern standards; others learned little or declined to be taught refusing to admit that they were not fully competent.

Some merit, in many of these midwives, attached to their confidence in leaving the progress of their cases to nature. "First do no harm" – may not have been their acknowledged slogan, but it was commonly in fact their guiding principle.

It was believed that most of these women were a fruitful source of obstetric calamity and puerperal infection and in order to raise the standard of obstetric nursing "The Protection of Life" sections of the Health Act provided for the registration of practising midwives, the prohibition of practice by unregistered midwives, and the approved training of all women thence forward aspiring to become midwives.

A feature of obstetric nursing practice in those days which was possibly not important at the time but which has become of first importance since, was the function of midwives in rendering domestic and housekeeping service to the patient's family during the lying-in period. With the reduction in the number of midwives as a result of the training requirements and insistence upon an educational standard, it was impossible for registered midwives to spare the time for this service even if they were prepared to suffer what they came to regard as the indignity of performing it. When there was ample domestic assistance for the family in the home or nearby this may have been a small consequency, but more recently the extreme difficulty in obtaining domestic help has made confinement in the home a matter of acute embarrassment.

There has, therefore, been an inevitable trend towards maternity hospitalisation, a trend which has been sedulously fostered and financially assisted by successive Governments until today it is the rule rather than the exception and there are few who do not use the maternity allowances for the purpose of ensuring confinement in hospital, private or public.

In common with the public hospitals in Western Australia private hospitals have been seriously embarrassed by the shortage of trained nurses. A total of 256 private maternity beds, sufficient to accommodate 7000 mothers per year are licenced in W.A. Returns show that these beds during the past year together with a number of unlicensed beds introduced to meet the unprecedented demand for admission, have been consistently fully occupied.

Births in 1946 exceeded 12,000 of which 3,500 took place in major public hospitals.

There is only one training school for midwives in Western Australia – King Edward Maternity Hospital, which is capable of completing the training of some 60 midwives each year. It is probably impossible for this number to be exceeded even if the number of trainees is increased, because the Nurses' Registration Board requires that each trainee shall deliver not less than 20 cases personally.

The inability of medical practitioners to obtain nurses to attend mothers in their own homes, the progressive reduction in the number of maternity beds consequent upon the closing of maternity homes and private hospitals unable to secure staff, and the persistence of mothers in demanding admission to private beds in King Edward Maternity Hospital so that they may retain the services of a medical practitioner whom the Commonwealth maternity benefit enables them to pay, all operate towards a reduction in public beds in the State's only training school.

The contentious question arises whether the average medical practitioner, particularly when busy and in a hurry, is a preferable accoucheur to a properly trained midwife. If he is not, the enlightened course would appear to be to eliminate the medical practitioner from obstetric practice in the training school, except to the extent necessary for the training of midwives, the training of medical practitioners, and the retention of a specialist staff for abnormal cases.

If on the other hand it is premised that the medical practitioner is the best accoucheur or is the accoucheur of preference, it would seem unnecessary to demand that standard of manipulative dexterity in

the midwife which present practice implies to be necessary. Midwives could then be trained in the actual nursing of obstetric cases more expeditiously than is possible now.

An even more acute embarrassment will attend the development of a Medical School in Perth, when the limited number of public beds available will require to be shared between obstetric nurse trainees and medical students.

The availability of midwives is reduced by the appointment of women holding double certificates to hospitals and other appointments where they will not practise midwifery.

There offers no opportunity of expanding the current system of training for midwives in this State. The only public hospital with a bed average of obstetric cases adequate to meet the requirements of the Nurses' Registration Board is Kalgoorlie. Here practically all patients are under contract agreements with local medical practitioners who expect, and who are expected to attend the mother at the time of delivery. Admissions to the maternity ward at Kalgoorlie Hospital, therefore, are not available for the training of nurses.

The present tendency is for General Nurses to proceed to the "double certificate" by undertaking nine months training after obtaining the general certificate. Previously untrained girls served 18 months in their obstetric training. The number of General Trained girls available during the next two years will be unusually small. If the number of midwives is to be increased it will be necessary to admit for training to King Edward Hospital a larger number of untrained women.

Meantime sheer necessity will, in country areas, increase the number of wholly untrained women attending maternity cases and inexorable forces are compelling reversion to the pre-1911 Sarah Gamp type of midwife.

As the annual member of births has risen beyond the normal obstetric provision, so the still birth rate has increased disturbingly. It is significant that this increase in the still birth rate is a feature of urban practice rather than of rural.

In the first six months of 1946 the still birth rate for the Metropolitan Area reached 30.78 per thousand confinements compare to 17.52 in country districts.

The respective rates for 1942 were 21.35 and 19.81. During the same period the State maternal mortality fell from 2.76 to 1.83 per thousand births. Once cannot but be forced to the conclusion that the overloading of reduced hospital accommodation, to which there is no alternative, the strain upon depleted nursing staffs and the haste and pre-occupation of busy city medical practitioners, has led to a serious deterioration in obstetric practice resulting in a deplorable wastage of infant life.

SUMMARY:

The Health Authority and the Nurses' Registration Board must consider whether:

(a) The imposition of restrictive standards upon private buildings whilst reducing maternal mortality has imposed upon the licensed a burden of overwork which they cannot safely perform.

(b) Raising of the standard required of midwives, by preventing the normal case obtaining reasonable safe partially trained attention, has restricted obstetric practice to a few midwives who cannot safely cope with the volume of work now thrust upon them so that medical practitioners are driven to expedients which have raised the still birth rate by 50%.

(c) The training of medical practitioners who propose to practise obstetrics should not be made to conform to a higher standard and whether the competence to practise obstetrics should not cease to be implicit in the right to general practice carried by Medical Board registration.

(d) The standards required in the training of midwives should be lowered to permit the more rapid training of women competent to assist the medical practitioner at delivery, or whether it should be raised so that midwife may be available to displace the less competent general practitioner.

CONCLUSION:

All expectations of the probable success of measures designed to facilitate the training of nurses must be tempered by appreciation of the available labour pool.

It would be an advantage therefore, briefly to study the salient factors affecting the labour pool of females (aged 15-19) at different periods. Expressed as a percentage of general population this group has shown persistent decline in the last two decades.

In 1911 the birth rate in Western Australia was 28.2 per thousand of population. By 1931 it had dropped to 19.8 so that there must be proportionately much fewer girls of 16 years of age in 1947 than there were in 1927. Subsequently to 1931 the birth rate continued to fall until 1935 when it was 18.23. It varied-between 18.84 to 19.87 until 1941 when it rose to 21.35.

The trend in the female age group 15 to 19 years between 1936 and 1950 as calculated from birth rates in relevant years is graphically shown on the attached chart (*not attached*). This reveals that during 1946 the number of females aged 15 to 19 was slightly greater than the mean between 1939 and 1944 and appreciably greater than in earlier years.

Subsequently to 1946, however, the graph falls steeply until in 1949 and 1950 the figure is well below any in the previous decade. This suggests that the pool from which female labour may be drawn in the next few years is rapidly shrinking and calculations regarding the availability of girls to undertake nursing must be modified accordingly.

The high birth rate of recent years must be expected to swell the school age groups after 1950, and the available labour pool for trainee nurses will be increasingly taxed by extra demands for teachers. Certain it is that expansion of training has better prospects in 1947 than in any later year before 1951 and that each successive year will provide less and less raw material. Nevertheless at 30th November, 1946, 285 vacancies were offering for female juniors in all branches of industry in Western Australia. For these vacancies there were only 49 applicants, a number which would have been inadequate even to supply the requirements of hospitals.

Again the influence of the marriage rate of miners in reducing the number of girls likely to be immediately available to commence training is of interest. In 1938 the marriages of 775 females under the age of 21 were registered. In 1944 this number had increased to 1,327. The estimated number for 1946 is 1,332.

Recent figures for the employment of females it has not been possible to obtain, but the percentage of females employed in gainful occupations rose from 18% in 1911 to 24% in 1933. 1933 was a post-depression year and the proportion of females since entering industry is probably even greater so that the field of choice available to girls has extended even while the number of girls available to supply the labour demands has been limited by a falling birth rate and by the increased juvenile marriage rate of the last few years. Maintenance of the current juvenile marriage rate in synchronization with the falling population in the age group 15 to 19 will materially reduce the potential nursing labour pool during the next few years.

It will be necessary, therefore, to attack this problem in several ways:

a) The number of training schools must be increased immediately.

b) Encouragement must be given to nursing assistants to train as nurses. Consideration should be given to their being credited with the service period in approved minor country hospitals. Suitable supervising and assistance should be given them to attain the educational standard desired by the Board.

c) It is worth of notice that the girl who undertakes work as a Nursing Assistant under the present trying and frustrating circumstance may in fact be the most desirable type to train as a nurse and every opportunity, therefore, subject conservation of the nursing standard should be given her to train.

Hospital administrations must be reconciled to an enduring nursing shortage and steps must be taken to modernize equipment and modify nursing practise for the purpose of conserving effort and reducing

the waste of labour to a minimum. Influences attracting girls away from nursing should be, as far as possible, eliminated by improving accommodation, amenities, working and domestic conditions.

It will be impossible under the influence of persisting nursing and labour shortage and a competitive call of less arduous avocations to eliminate all these factors which destroy the will to nurse in a girl who is not a nurse at heart, but the less impatient at least may be retained.

d) Increased use of Male nurses. Male nurses may train under the same conditions as female nurses. The employment of Male nurses though more costly has the advantage that marriage does not, with them, as it does with girls, involve retirement from nursing. Consideration may well be given to meeting the impending emergency by assisting return to home nursing so that the strain on hospitals may be eased. This might be achieved in a variety of ways:

i. Girls before leaving public schools should be trained in the elements of general nursing, aseptic routine, the administration of drugs and application of dressing. This may inspire in a proportion, who otherwise would give the matter no thought, a call to adopt nursing as a profession.
ii. The licensing of sick attendants by the Nurses' Registration Board. This licence should permit the holder to nurse for reward ailments not requiring the more highly specialised procedures of modern medicine and surgery. Further reference will be made to this suggestion later.

It would be well, therefore, if the Nurses Registration Board of Western Australia, in association with analogous boards in other States, gave close consideration to the following:-

a) Legislation designed to improve nursing service for the public has produced a situation where it prevents 50% of the sick obtaining even moderately competent nursing attention. Some method of relating the supply of non-specialised nurses to the demands of the community must be solved. The present problem is not less serious than that which this legislation was intended to correct and the time has obviously arrived when the legislation itself must be reviewed and where necessary recast. Reform is inevitable and it will be better if it be unhurried.
b) The assistant nurse, originally a ward domestic has become, untrained, the mainstay of rural nursing staffs. These women nurse for gain and it is impossible for Nurses' Registration Boards longer to exclude them from the ambit of registration legislation.
c) The labour pool from which trainee nurses can be drawn is rapidly shrinking owing to social trends beyond control. If the deficiency of trained nurses is to be made good the numbers in training must be immediately increased and measures to this end could not safely be deferred another year.
d) The high standard of training demanded for nurses under the influence of advancing surgical practice in the great public hospitals, reduce the yield of trained nurses from training schools.
i. By excluding many incapable of attaining it.
ii. By restricting the number of training schools to the few hospitals capable of providing it, thereby reducing the annual yield below the minimum required.
(e) At the same time many registered nurses, trained in earlier years, cannot claim the proficiency of modern practice developed since their training days and now demanded of trainees. Nevertheless registration is afforded them without question.
(f) Many nursing assistants at present unqualified for training are in fact suitable for training and should be trained.

To meet this situation Boards should consider the following suggestions:

(a) All hospitals complying with present requirements of bed average should be constituted as training schools. All deficiencies of structure, equipment and professional staffing calculated to impair training should be rectified immediately so that recruiting may comment at once.

(b) Hospitals employing nursing assistants and of a bed average insufficient for the present requirements of the Board should be subject to inspection by the Board so that defects may be eliminated. After the elimination of defects the Board should prescribe a course of training for the nursing assistants there employed.

(c) Consideration may well be given to re-constituting the nursing profession and its training. It is suggested, for example, that there may be established are two grades of nurse:

i. A licensed sick attendant or junior nurse who may train to a special curriculum determined by the Board in an approved Hospital however small, and who may be licensed to practise for reward privately or in hospitals. Such a nurse would fill the role originally intended for practising nurses by the Act, and it is suggested that the training period should be three years in a hospital up to 40 beds and two years in a hospital of 40 beds and over.

ii. The Nursing Sister who may be a nurse trained for three years in an approved major public hospital or one who after completion of the training for a licenced nurse has undergone a further two years' training approved by the Board in a major public hospital. During at least one year of this training, opportunities should be given for specialisation.

(d) In association with Medical Boards, Nurses' Registration Boards should consider the relative role and status of medical practitioners and obstetric nurses deciding whether priority in training and function is to be given to the one or to the other and how adequate training material for both is to be secured under a National Health Scheme entitling all mothers to delivery by a medical practitioner.

(e) Consideration might also be given to the establishment of two grades of obstetric nurse:

i. A licensed nurse qualified to attend maternity cases in charge of a medical practitioner. In large training schools associated with public hospitals the training period for such a nurse might be somewhat shortened.

ii. The Obstetric Sister – one who has completed an advanced training qualifying her to attend Obstetric cases independently or with an obstetric consultant.

C.E. Cook.

COMMISSIONER OF PUBLIC HEALTH

Administrative Inadequacy – functions of a modern Public Health Department

To the Hon. the Minister for Health:

ADMINISTRATION: Administrative Inadequacy

One cannot escape the conclusion that effective health administration is seriously impeded and the extension of activity into new fields largely frustrated by the out-moded and irrationally devised establishment of the Department.

In the past the apotheosis of the lay administrative officer and the traditional reliance upon him to determine the scope and design of the Department, have developed a structure which, though doubtless in harmony with Treasury and Public Service pre-conceptions, is ill-adopted for its avowed purpose and alien to technical requirements.

The functions of a Department of Public Health should be-

(a) To study the incidence of disease and the causes of morbidity and mortality in the community.

(b) To identify factors which are preventable and to devote itself to removing them.

(c) To conduct research into improved diagnosis and methods of treatment in order to shorten the period of illness, avert a fatal outcome or mitigate the effects of innumerable lesion, and actively to engage in extending the knowledge of and facilities for the universal application of these.

Health Departments as at present constituted are largely the unplanned growth of bodies originally formed to control morbidity and mortality during the last century when the herding of population in cities following the industrial revolution led to the recognition that filth and squalor were important agents in the transmission of disease and when the epidemiology of infectious disease was but imperfectly understood.

These bodies since their original establishment have contributed materially to the control of morbidity and mortality from the filth and infectious diseases, but owing to their origin and to their traditions, the training of the staff and legislation under which they operate, tend to emphasise the importance of waste disposal, drainage, ventilation, quarantine and disinfection. Their procedures are largely outmoded and even archaic when studied in the light of modern advances in our knowledge of immunity, epidemiology and therapeutics,

It is true that from time to time the influence of other factors, industrial hazards for example, in contributing to morbidity and mortality, has become so obvious in modern civilisation that attention has sporadically been given to extending the scope of public health departments into the newer fields.

Speaking generally, however, the long pre-occupation of health departments and their staffs with the narrower field of sanitation and infectious disease control has contributed to these new functions being vested rather in specialists evolved independently in the occupations and industries affected.

In Western Australia this trend has been even more marked than elsewhere, even such conventional public health activities as sewage disposal, the control of water supplies, the marketing of milk, bread manufacture and industrial hygiene having been vested in other departments of Government unprovided with trained medical staff.

Over a long period the inadequate professional staff of the Health Department has been pre-occupied with traditional sanitary routine and its predominantly lay organisation has received or responded to no inspiration from contact with medical practice and advances in medical knowledge.

Meantime the medical practitioner actually in contact with disease has become accustomed to leave prevention to the organisation provided for that purpose and has devoted all his attention to curative medicine and to encompassing the many rapid advances made in this field in recent years.

The local health authorities upon whom lies the responsibility of administering the Health Act in local areas are in consequence deprived of advice or inspiration from medical practitioners with a high sense of public health responsibility or adequate knowledge of modern methods of control. Under the general influence of a static central authority and lacking trained admonition, they have gradually fallen into a

retrograde and outmoded routine hardly to be differentiated from negligence.

The subjoined graph [on diseases by mortality rate] will at a glance reveal the progress of the major killing diseases since control by a department of public health has been undertaken. They show that those diseases which are largely associated with filth, contaminated food and polluted water have been substantially reduced until from being important agents of morbidity and mortality they are now comparatively unimportant.

A new field for an efficient and re-organised Health Department is disclosed. The graphs show that there are a number of causes of death apart from those directly associated with the ageing of the population, to which a re-organised health Department might profitably devote attention. For this purpose, however, it would be essential to establish the Department on a basis where there was the closest liaison between the administration and the practising medical profession. This is a field of activity not generally or effectively hitherto undertaken by a health department, but is a logical function already cited in (c) above.

Effectively to embrace this wider field, the Central Health Authority will require the close co-operation of every medical practitioner throughout the State, more particularly for the purpose of:-

(a) Assuring a high standard of ante-natal care and midwifery practice,

(b) Maintaining adequate medical supervision of the pre-school and school child.

(c) Assuring a progressively higher standard of medical practice, the collection of such statistical and clinical information as may be required for purposes of research and organizing the early and universal application of improved methods of diagnosis and treatment.

(d) Ensuring the discharge of public health obligations in association with this medical practice at consistently high level of efficiency and uniformity.

It will also require constant access to specialist advice in all branches of medicine, but particularly in paediatrics, obstetrics, medicine and surgery. The State can ill afford to appoint such advisers on a salaried basis to its Health Department staff, but they are accessible in the community itself, and are doubtless willing to serve the State whenever required. It remains but to provide the organisation through which this advice may be obtained.

The Health Department must obtrude prominently into the field now administered by the Medical Department, a lay administration nominally advised by a Principal Medical Officer who has no prescribed function and no defined authority.

It is recommended, therefore:-

(a) That the Department of Public Health and the Medical Department be united as a Department of Health. The Department of Local Government, the Department of Native Affairs, the Child Welfare Department and the Shops and Factories Department, have many points of close contact with health administration and require specialist advice and guidance. Unless this is to be provided for them independently it would be well to integrate these Departments closely, preferably under one Minister.

(b) That the Local Health Authority – whether Municipality or Road District – in its own area or in co-operation with adjacent areas, undertake health and hospital administration under the supervision and direction of the Department of Health.

(c) That there be established a Health Council of which the functions should include:-

i. Discussing of and recommendations regarding factors of morbidity and mortality.

ii. The organisation of medical practice both in its preventive and therapeutic phases.

iii. The initiation of such public health and hospital legislation as may be necessary from time to time to establish the health and medical organisation on a secure basis.

iv. To serve as a liaison body between the Government and the medical profession.

v. To give the medical profession an effectual voice in health and medical organisation.

vi. To serve as a co-ordinating body organising the medical profession in public health and medical practice within the State.

(d) This Council which should have power to co-opt for special purposes should include four specialists, namely a physician, a surgeon, an obstetrician, a paediatrician elected by their specialist groups, two general practitioners elected by the British Medical Association; a layman representing hospital administrators; and a layman representing the Department of Local Government. The Council should be chaired by the Commissioner of Public Health and its Secretary should be a public servant in the Department of Public Health.

It is important that the professional persons appointed to the Council shall be-

i. Spokesmen of their professional categories.
ii. Themselves specialists of the highest qualification

To achieve the first purpose it is desirable that they shall not be selected by the Minister, but shall be the elected representative of their groups.

(e) As opportunity offers local authority areas individually or in regions might as appears necessary be provided with subsidiary committees similarly constituted.

These local committees of professional and executive members would be responsible for implementing in their areas the policy of the Council.

Routine administration throughout the State should continue to be conducted by the Department of Health under the professional guidance of the Council, and in local authority areas by municipal councils and roads boards under direction of the Department.

Enlightened health control in our time has become a function of the practising medical profession in all its branches. The system here outlined is calculated to mobilise the forces in contact with disease, to study and control it so that this function shall not continue to be vested in a detached administrative body largely guided by outmoded tradition and an atavistic outlook.

Dr Cook with his senior officers, 1949

Native Administration and Public Health

BACKGROUND

Cook assessed Aboriginal health in North West of Western Australia in 1948. Cook was concerned that the Native Affairs branch was responsible for Aboriginal health in W.A. not the Commissioner of Public Health, a condition which Cook sought to redress. He also saw that to redress deficiencies in remote areas needed Commonwealth funding, hence his reporting his survey to the Tropical Hygiene Committee of the National Health and Medical Research Council (NHMRC) as well as to his Minister in Western Australia. In 1950 in Canberra, Cook built on this report for discussion with Health and Native Welfare officers from all States, leading to his extensive survey across Northern Australia in June-July 1950 and further developments with the Commonwealth Minister for Territories in 1951-2.

To the NHMRC Committee on Tropical Physiology and Hygiene

Health control in the North and North-west of Australia is beset with special difficulties and necessities which are not met to the same extent elsewhere.

(a) The major portion of the area is tropical in climate and as such is suitable for the endemicity and epidemicity of tropical diseases, notably malaria, leprosy, hookworm, dengue, Amoebiasis and the dysenteries.

(b) The white population is sparse and lives under primitive conditions, at widely scattered points difficult of access for purposes of prompt diagnosis or early application of measures of control.

(c) There is a comparatively large coloured population predominantly aboriginal, living under conditions of squalor and insanitation eminently suitable for dissemination of communicable disease. These people lack any knowledge of the fundamental principles of hygiene and have not even an elementary appreciation of human epidemiology. They are largely uncontrolled migratory, and for the most part beyond civic discipline.

(d) The quarantinable diseases smallpox, typhus, cholera, plague and yellow fever, may, owing to disruption of health services in adjacent countries of Asia, and to the increased rapidity of modern air transport, be introduced to this region by aircraft at any time, and it may be stated as a truism that the Commonwealth Quarantine Service can no longer hope with confidence to avert this contingency.

(e) Conditions obtaining in the area are such as to favour the uncontrollable dissemination of quarantinable diseases should they be introduced and their ultimate conveyance per medium of the local population to centres of white settlement elsewhere in Australia.

i. Universal vaccination, the only effective prophylactic against smallpox, has never been attempted in Western Australia and has been neglected in the Northern Territory for several years. Owing to the dispersal and migratory habit of the uncontrolled native population, it cannot be effectively undertaken during the course of an epidemic.

ii. Amongst natives indiscriminate soil pollution and exposure of faeces to flies is the rule rather than the exception, even in areas of closer settlement. Water supplies are drawn principally from shallow wells and from surface water, most of which are continuously or periodically exposed to faecal pollution by natives. Water in a great part of the area is distributed and stored by primitive methods involving considerable risk of pollution, particular by natives. The control of cholera under these circumstances would appear impossible.

iii. The distribution of the insect vector of plague is unknown, but the almost universal neglect of any effectual waste removal service, the utter disregard of natives for the careful disposal of organic wastes and the littering of the vicinity of camps and settlements with discarded rubbish provide ample food supply and harbourage for rodents.

iv. The insect vector of yellow fever breeds freely in the rainwater storage containers in the vicinity of dwellings and in the considerable and scattered areas of cans and broken bottles which litter the vicinity of settlements. Migratory natives are apt to transport such litter to new localities over a wide area, and would no doubt in epidemic times disseminate the virus during the incubation period to all parts of the region.

(f) Conditions in respect of endemic diseases are equally bad.

i. Leprosy imported into the coloured population has spread extensively amongst natives, until in the Kimberly region it has attained an incidence comparable to that in the areas of highest endemicity in the world. The migratory habit of the population has disseminated infection throughout the Kimberly division where incidence was negligible 20 years ago. Leprosy is now being communicated through families and the uncontrolled employment of lepers and potential lepers in European households constitutes a grave menace to the security of the white population of the area.

ii. Malaria – The insect vector of malaria in this region has not certainly been identified, but anophelines suspected of being efficient carriers are numerous in the major River basins during the autumn months. At times following the introduction of infection by new migration virulent epidemics of high fatality have occurred, infection being rapidly disseminated from one point to another by natives. The reintroduction of the malaria parasite must be regarded as an ever present and imminent probability.

iii. Hookworm – The unhygienic practice of promiscuous defaecation characteristic of the native fosters the free dissemination and intensive incidence of hookworm in suitable environments. Sporadic efforts at control have proved abortive hitherto, owing to their being conventionally designed and inadequate to meet the epidemiological situation created by native social practice. This disease has become, and will continue to be, a menace to the fitness of the white population.

iv. Amoebiasis and other bowel infections are impossible to control in face of the pollution of water supplies, and exposure of infective material to flies and the unclean handling of food, which are inescapable epidemiological features of the situation created by the native population in its present condition.

(g) The accepted instruments of Health Administration in Western Australia – Local Health Authorities – are quite unable, owing to lack of staff, insufficient funds, and inadequate knowledge, effectively to control endemic or epidemic diseases within their areas. In the Northern Territory, no local health authorities exist; their function being undertaken by Medical Officers of the Northern Territory Medical Service. This Service, originally designed and created to meet the peculiar sanitary problems of the region has become more and more preoccupied with therapeutic medicine and has largely lost its original character.

(h) Tuberculosis, introduced by European and Asiatic immigration has now involved the native population. The extent of this involvement has not been ascertained but it must be expected that tuberculosis will spread rapidly and extensively amongst natives who will in turn serve as a reservoir for its later dissemination to the population of the future.

Health control in the North, therefore, largely resolves itself into control of the native population, an objective the pursuit of which demands that the health authority shall be invested with all those powers over the group and over the individual which the law invests in the local and central health authorities in respect of the white population. These powers which include:-

(a) control of the disposal of human wastes;
(b) scavenging and cleansing;
(b) ordering the standard of dwellings;
(c) effecting the abatement of nuisances;
(d) safeguarding the quality of food;
(e) protecting water supplies;
(f) submitting persons to medical examination, immunisation, detention, and treatment;
(g) controlling migration;
(h) effecting the destruction of property presumed to be infective;

… can only be secured in respect of the native by vesting in the health authority the powers possessed by the Native Affairs Department. Health control in the North, therefore, can only effectively be undertaken either by a medical service charged with the responsibility and powers of native protection or by the Native Affairs Department itself.

The latter alternative will require the establishment in the Native Affairs Department of a highly organised medical and health service which, unless it is to be charged with the additional duty of undertaking the care of the white population, must be supplemented by a similar organisation to operate in areas of white settlement. Duplication in such a sparsely populated and economically poor area is not to be recommended, and whereas it is doubtful whether a medical service vested in the Native Affairs Department could satisfactorily serve the best interest of the white population, a medical service set up primarily for the care of the white can quite efficiently embrace the care of the coloured.

It is evident that the health authority will be powerless effectually to function in the North until it has the undisputed right to initiate, execute, and/or veto native administration policy, even in its routine minutiae.

In the interest of the National health and in the interests of the native, it is imperative that the authority controlling Native Affairs be integrated into the Health Authority. It may be advanced in contention against this statement that a Department of Native Affairs is concerned with controlling employment, safeguarding wages, regulating housing, managing institutions and supervising religious missions, activities which appear to be exclusively phases of native administration and wholly beyond the ambit of the health authority.

It must, therefore, be emphasized that it is of the utmost importance that the Health Authority possess free rein in the exercise of these very functions.

(a) Employment:

One of the great dangers to the maintenance of a satisfactory standard of health in the North, stems from the employment of natives by Europeans. Persons carrying certain infections should not be licensed to employ natives. Native suffering from, or likely to develop certain diseases, should not be employed by the white population or permitted access to white settlement. Conditions under which natives are employed should be such as to protect each race from infection by the other and should not predispose a native to impairment of health.

These precautions can only confidently be attempted by one Department, or by very close integration of two Departments, since it is not always possible for the Health Department to impart to the Native Affairs Department that necessary information or consciousness which are a necessary prerequisite to sustained and enlightened prophylaxis. It is, for example, impossible to notify the Native Affairs Department of clinical conditions from which prospective white employers of native labour may be suffering.

(b) Wages

In many areas money wages are largely nominal, and to the extent that they involve cash or book payments must be handled by an Accounts Branch in either Department. Wages in these areas, however, also include food, clothing, accommodation, medical care, etc., for the employee and for his dependants, and the adequacy or otherwise of such wages requires specialist knowledge available in a Department of Public Health but not necessarily so in a Department of Native Affairs.

(c) Housing:

The conditions under which natives are housed in or out of employment, in institutions or elsewhere, are primarily and almost wholly the concern of the health authority just as is the housing of the white population. From control of native housing, however, the health authority is at present excluded, notwithstanding that the deplorable conditions or squalor in which natives live constitute an ever present menace to their health and to the security of the white population.

(d) Native Institutions:

The greater part of a Department's responsibility in administering a native institution will be that involved in safeguarding the health of a number of persons of nomadic habit lacking in hygienic conscience, who are concentrated in a settlement and detained there. Management of the institution demands in the administering Department a basic knowledge of hygiene and medicine which must cover all administrative decisions, planning and development.

(e) Religious Missions

Possibly nowhere in native administration is it more necessary that the Health Authority should have effective control than it is in respect of religious missions. Here are concentrated large numbers of nomadic natives who are held in a restricted area, housed under abnormal conditions, fed unfamiliar food, taught new wants, and deprived in time of their social organisation. The site where the mission is established, its sanitation, the quality of the water consumed, the standard of housing provided, the quantity and character of the food available, the conditions under which the diseased are permitted contact with their fellow, the promptitude with which infectious disease may be recognised, the handling and treatment of infected persons, the care of the newborn in the strange environment, the education of the nomad in communal life particularly as it affects hygiene and morality, the exclusion of tuberculosis and other disease from the mission, staff, and a host of other phases of mission activity, are of vital importance to the health authority.

These are not fantasies or abstractions, they are hard, cold facts clearly discerned by those experienced in health administration in this region and readily ascertainable by the study of the problem at first hand.

Incorrect feeding has in the past caused outbreaks of Scurvy and Beriberi with an appreciable loss of life, considerable suffering and no little expense. Neglect of hygiene and elementary measures of disease control at times when these could, with little expense or effort, have easily eliminated the potential danger, have left us a legacy of epidemic Malaria and endemic leprosy, hookworm and bowel disease which will cost the white race millions of pounds and both races years of debility, suffering and mortality before the damage can be repaired. Unless this sorry story is to become an interminable serial; unless new and even more tragic chapters are to be added to narrate the progress of smallpox, cholera and yellow fever through this unhappy region and from it to the more civilised community beyond, a hygienic conscience must be developed in native administration. This for a time at least can most effectually and expeditiously be achieved by integrating the protective function into the health authority.

In his natural state the Australian native was free from those endemic infections which constitute such a problem in the community life of other races. This circumstance together with his habit of migrating in tiny groups, his abstention from organised village life and the impermanence of his camping sites eliminated from his domestic economy those problems of sanitation which beset the more stable communities of

the white race. The inevitable result is that he is completely unadapted psychologically for rapid integration into community life. This incompatibility, though accorded its full nuisance value has never been squarely confronted by native administrations as demanding correction. Possibly retreat from this problem has be inevitable under the existing form of administration.

Lay executive officers though familiar with the objective manifestation of elementary sanitary routine in an organised community, have no deep appreciation of their significance and the importance and no knowledge of the basic principle underlying them. Without a hygienic conscience to guide every decision, and without the knowledge or ability to impart the necessary training to the mixed community during a period of transition, it is only to be expected that they would in despair accept the situation as it develops spontaneously.

Whatever the reason lay native administration has proved itself quite incapable of effecting the orderly integration of the migrant native into community life and it seems there can be no confident attempt to achieve this objective until native policy is subject to guidance by the health authority.

A somewhat similar situation confronted the Australian army during the recent war. For years a handful of men, experienced in tropical hygiene and holding subordinate rank, advised, argued and pleaded with the Defence Department in vain to establish an efficient hygiene organisation in its services.

Not until the medical disasters of Milne Bay, the Kokoda Trail and the Buna-Gona campaign jolted the Army out of it complacency, was an adequate opportunity given hygienists to conserve unit strength in the field from tropical infections. For the subsequent 2½ years the path of the Hygiene Officer was easier and unremitting efforts towards the necessary training of troops in camp and in the field enabled them to see the 9th Division successfully conduct a campaign in Borneo under the worse possible epidemiological conditions, yet with a standard of health conservation in troops unprecedented in history and unequalled by any other force similarly committed elsewhere in the world during the War.

Lessons so dearly learned in War should not be forgotten in peace. Whilst there is in the Commonwealth Department of Health no medical organisation to provide a hygienic conscience for native affairs administration, and whilst State and Territory Medical Services have no effective voice in the native policy, the National Health and Medical Research Council must remain the only body which can direct the Commonwealth Government's attention to the dangers confronting tropical white settlement and the only authority which can advise the Federal Minister for Health of remedial measures considered necessary to be taken. The most apparent and urgent of these at the moment is the close integration of the Department of Native Affairs into the respective Health Authorities administering North of the continent.

In a paper Dr Cook delivered at the Australasian Medical Congress (British Medical Association) Sixth Session, Perth, August 1948, he spoke on 'The Native in relation to Public Health'. While each of the measures is important, special attention is drawn to sub-paragraph (ii):

> The Problem
>
> Clearly the adaptation of the native to community life and his successful integration into the white social structure are public health problems of the first importance. Indeed, no department of government administration is more vitally affected than that of public health by the nation's failure successfully to orientate the native component into its general population. Nor is any more suitably equipped for attempting the solution of the problems arising from this failure.
>
> Measures necessary for meeting the problem include the following:
>
> i. Education of the native in citizenship, with particular emphasis upon the eradication of his background of hygienic irresponsibility and substitution of a consciousness of community obligation.
> ii. Education of the white community in its responsibility and obligations to the native and in the necessity for his social integration.
> iii. Provision for the hygienic housing of natives in local authority areas. Suitably designed and sited dwellings, provided with adequate and safe water supply, sanitation and where available electric light and power, should be provided in country towns for the accommodation of native families at present living on the fringes of townships under substandard conditions.

The national Poliomyelitis epidemic of 1948 confronted Health Departments that did not understand the cause, transmission or cure of this disease. The public was terrified and Cook used the public media almost daily to advise the simple measures to prevent new infections, primarily quarantine and avoiding crowds. He kept the schools open, noting that infection rates increased in school holidays and reduced in school terms. The Epidemiologist in Cook's staff, Dr Dudley Snow, compiled an extensive report of the disease.

Mrs Cardell-Oliver, Minister for Health, farewells Dr Cook with a gift, November 1949

The Garlick, Cook and Henzell letters 1950-51

This sequence of letters relates to the development of 'Home Nursing' in the Kimberley region, pioneered by Sister Lucy Garlick, whom Dr Cook engaged for this purpose.

The first letter is a personal message from Mary (later Dame Mary) Miller (nee Durack), a friend of Dr Cook possibly from his 1924 leprosy survey to the Kimberley region. 'Mick' was Cook's nickname, used by his colleagues, friends and family. The letter explains Mary's meeting Lucy in Broome in June 1950 and encouraging her to complete the report of her work in the Kimberley and send it to Dr Cook.

In May 1951, Lucy wrote to Dr Cook, enclosing and explaining her 5-page report. Disappointed by limited local support, Lucy sought Cook's intervention, despite his now being in Canberra. Cook's sympathetic response in early June was to encourage Lucy to continue in the role as best she could.

Lucy's response to Dr Cook in October included a copy of Dr Henzell's brief note about the relief arrangements during Lucy's absence on leave. That is, with no comment about support for, or continuation of, her Home Care nursing project.

Cook then wrote a strong letter to Henzell starting with Lucy's intention to 'transfer to the Native Affairs Department, or resign or some such'. After explaining the purpose and benefits of the Home Care Nursing role, Cook implored Henzell to be 'sure that the work continues as a precedent for securing similar appointments elsewhere in the Commonwealth'.

Broome
15/6/50

Dear Mick,

I was interested in arriving in Broome a week ago to meet Sister Lucy Garlick here and to hear from her of her activities over these seven months. Everyone I have met in the town speaks enthusiastically about her work and I think she has made great strides despite many setbacks.

When I arrived she was feeling pretty despondent I think, hearing rumours that the job was being officially represented as hardly worth the time of a Nurse of her qualifications. The seven months had been just long enough to convince her and a good few others just how important the position is and how much it could mean to the country if sufficient scope were given to carry it out fully.

I persuaded her to finish the report she was engaged on and to send it to you. Perhaps you will be able to give a few words of advice, or put in a word in the right quarters as to the importance of the work.

The clinic at the other end of town here has had a rather surprising effect to date. The coloured section have grasped onto the idea as <u>something</u> from which to get other activities going. They have started cleaning up rubbish, housing etc. and making a proper playground for the kids and have approached me to help them form a Committee which I will be pleased to do but definitely feel that this Clinic is the pivot of any activities they plan to start and if it were taken away they would be again disheartened. They have the usual grouch – "the police stop everything we ever try to do – perhaps if you could help". I do try very hard <u>not</u> to be a <u>Friend</u> of the <u>Original Australians</u> but the danger keeps cropping up. There seems to be the beginning of a healthy desire to do something for themselves here and at least should be given a chance.

Have left Bet in charge of the house at Nedlands while her own struggles are through Govt. Housing – I have Andrew and baby with me and it is lovely to be here in the sun again.

With every good wish and hoping to see you somewhere this year –

Always sincerely –

Mary Miller

Dr. Cook
Commonwealth Medical Service
CANBERRA F.C.T

Derby, W.A.
30th April, 1951

Dear Dr. Cook

It is now eighteen months since I commenced Infant Welfare in the Kimberleys and ten months since I met you in Derby. Once again the time has come to report to you on my activities, impressions and difficulties, which report I enclose herewith.

I am still keen to continue with this work but am afraid I will never make satisfactory progress until I can arrive at a better arrangement than that which at present exists. Is there any possibility of my working for the Commonwealth under your supervision and endeavouring to embrace the welfare of all women and children in the area, including living conditions, diet and general progress of children, ante-natal care, and any situation that might arise regarding the health of the community?

On two occasions, Mr. Middleton has suggested I might care to transfer to the Native Affairs Department, to take over the appointment of the Women's Welfare Officer here. I am rather vague at present as to where this officer is to operate, whether Broome of the whole area. I do know, however, that is would mean the welfare of only natives and half castes within the Act.

If I could combine this Native Affairs job with the welfare of all women and children in the area, instead of only people within the Act, it might prove to be a solution to the problem of visiting the Stations, bit I am told this can not be done as it would mean working for two separate Departments.

I, myself, feel that Native Affairs offers too narrow a field, for, as we know, there is an urgent necessity for some authority to care for the general health of the half castes not covered by the Act.

My comments regarding Beagle Bay and Lombardina Missions are included in this letter as it is, perhaps, as well they should not appear in the report.

As you will see in my report, I visited Beagle Bay and Lombardina in July last year. Travelling as I did with the police, my work there was limited, since I was unable to see any meals served at either mission. From the Father in charge at Lombardina I was given to understand that the Bishop had strong views of his own concerning the diet of natives, that at Beagle Bay the food was fair, but at Lombardina a state of 'iron rations' existed, the Bishop frequently forgetting to send supplies. At Beagle Bay the Bishop himself intimated that the diet of the natives is as it has always been and is "goot enuf", that the people working and living there were doing so "for the 'luf' of God". His attitude could be interpreted as a rule for living as laid down by the Bishop. One wonders if he has not, perhaps, invested himself with divine rights!

Knowing that you must have many problems of your own, I have hesitated to write to you. However, I should be most grateful if you could spare the time to give me your suggestions and advice concerning the above matters and the appended report.

Yours sincerely
Lucy Garlick

REVIEW OF HEALTH ACTIVITIES IN THE KIMBERLEYS FROM JUNE 1950 TO APRIL 1951, AND THE ATTEMPT TO CARRY OUT WELFARE WORK OF WOMEN AND CHILDREN IN THE AREA

Reported by Lucy Garlick

During these 10 months I have been directly responsible to three different medical officers in Derby, each one interpreting my duties according to his own ideas. This is not always a satisfactory arrangement.

The work here is still in a somewhat frustrating state for no sooner is one hospital fully staffed than another is depleted and my time is generally always occupied relieving staff shortage in either Broome or Derby district hospitals. This has been so from July 1950 until the present time. For one month during September and October. I relieved at the Derby Native hospital and from December 11 until the beginning of April this year was detained at the Broome District Hospital. On three occasions only during this time was I able to visit Derby to hold the clinics; an escort trip to Perth was also undertaken and a Flying Doctor trip instead of one of the above Clinics.

Under these conditions no definite planning for the other health work is possible, as this is apparently always regarded as being of secondary importance. Whilst not objecting to relieving in hospitals in an emergency, I resent having to remain there indefinitely when there is so much to be done for the health of the community elsewhere.

WYNDHAM: - Owing to relieving staff shortage in other hospitals, Wyndham has not been visited since June last year and no clinics have been held there since that time. Actually, the question arose with Dr Henzel as to whether he Wyndham was worth visiting owing to:

1. High cost of fares from Derby to Wyndham;
2. Seasonal population;
3. Very few babies;
4. Near impossibility of either mothers or myself obtaining transport, thus making either clinic or home visits, as the case may be, most difficult

BROOME: - Except for the month I relieved at the Derby Native Hospital the clinics have been held at regular fortnightly intervals. The numbers of babies and children attending the clinic for 1950 are as follows

Individual babies under 12 months	63
Individual children between one and two years	33
Total attendees of children under two years	486

If at any time, I am unable to hold the clinics there myself, a present matron, although not a triple constant certificated nurse, will weigh the babies at regular intervals if she is not too busy. This, unfortunately, has not been done during the month I was at Derby Native Hospital and therefore unable to visit Broome. However, I was pleased that instead of the usual apathy found in these towns, the Broome people banded together to write to both the Department and the Minister for Health, demanding a regular Infant Welfare Service.

At Broome District Hospital two college girls have joined the nursing staff and are showing ability. Their educational standard is poor, but I have arranged for them a Correspondence Course with the Education Department. It is unfortunate for these girls that their success will depend so largely upon the current matron and nursing staff; too often one finds the Broome colour prejudice sabotaging the attitude of the trained nursing staff. Housing, sanitation and hygiene of the natives and halfcastes in Broome is still appalling.

DERBY: The townsfolk are displaying more interest here towards Infant Health and clinics are now held at weekly intervals. The numbers of babies and children attending the centre of the 1950s are as follows.

Individual babies under 12 months	39
Individual children between one and two years	26
Total attendances of children under two years,	367

There has been a marked rise in attendances this year.

When I myself was unable to be present, Matron Howell carried on the clinics. She has assured me she will continue to do so during my absences from Derby. There now is an excellent co-operation between us. We feel that given a fair chance, there is much we can accomplish.

Following Dr O'Reilly's instructions Matron Howell and I have been visiting the homes of the half caste population situated on the fringe of the day Derby marsh. The majority of these people do not come within the Native Affairs Act. I am enclosing a copy of portion of the letter sent to Dr Henzel in January, also a copy of the resultant type of work we are doing concerning the housing conditions of these people.

The now completed staff of Derby District Hospital is supplemented by two coloured girls who, in addition to working with the trained staff are given nursing lectures by Matron Howell, and supplementary education by the schoolmaster. One such girl, Sylvia Ah Chee, who was similarly employed last year, is commenced nursing training at Royal Perth Hospital

DERBY AS A CENTRE:-

1. Training of coloured girls: Matron Howell and myself wonder if it could be made possible for the Derby District Hospital to become the initial training centre of the Kimberley's for coloured girls wishing later to become assistant, Mothercraft or Trained nurses. We realise, of course, it would be possible to train only three or four girls at one time. Matron Howell is well fitted for this task and is extremely interested in the possibilities of such a venture provided she could still retain her trained staff. At present there is no proper accommodation for the girls to live in the hospital. Consideration of the childhood, and present living conditions of the girls, makes it clear that they would be greatly benefited if they could, while doing elementary training, live in quarters with the other nursing staff. If such a scheme could be instituted, not only would it help to solve the shortage of nurses in this area and some of the health problems but would give the girls wishing to undertake this work a greater sense of security and some assurance of a job in the future. This security does not always present exist as, for example, in Broome.

2. Antenatal care of women living on stations: - Some pregnant women contact Matron Howell by letter, others do not. Sometimes Matron knows nothing of these women until they appear in hospital. As they have not received any antenatal care, this is most unsatisfactory for all concerned. Should I be able to visit stations, I would be in a position to make personal contact with the women and co-operate with Matron on their progress

3. Pedal Radio:- Whether from apathy, ignorance, or shyness, - perhaps a little of each – very few people make use of the pedal radio for Infant Health. No suitable service can be rendered unless personal contact can be made with the people living in outlying areas. The more dealings we have with these people the more we realise how far we at present fail to supply an adequate service. Only a few weeks ago, a sixteen month's old child from Gibb River died as a result of vitamin D deficiency. I had not, myself, visited Gibb River airstrip since last June, at which time the child had just begun artificial feeding. The mother was advised and asked to keep in frequent contact with Matron Howell in Derby concerning the progress of the child. She was also given a bottle of Pentavite, instructed in its use, and requested to notify Matron when a fresh stock was required; this the mother failed to do.

Except in cases of extreme emergency, I would like to be released from all hospital duties and responsibilities, in order to be free to carry out the other work so badly needed in this area. Working in close cooperation with Doctor and Matron in Derby, by use of pedal radio and with efficient transport, far-reaching improvements in the health of this isolated community could be effected

MEANS OF TRANSPORT TO STATIONS AND MISSIONS:- My only means of transport at present is plane, which of course limits one's visits to places possessing air strips and necessitates a stay of two weeks at some stations and even one month at missions. Much valuable time is thus wasted waiting for planes calling on fortnightly and monthly scheduled flights. While preferring to be independent, with proper organisation I should be able to visit stations and missions in planes charted by the Department for the survey party sent out from time to time.

It is extremely difficult, and indeed almost impossible, to carry out this work without a vehicle at my disposal. I am selling my own utility as it is too old to withstand the battering of these roads. Actually I have not used it for some time for my work as I receive no mileage expenses and was therefore unable to cope with running costs.

STATIONS AND MISSIONS. FLYING DOCTOR SERVICE

1. STATIONS:- Even now, with so much as yet undone, people from various stations have assured me of their co-operation should I be able to visit them.

2. MISSIONS:-
   a) Forrest River Mission: This mission now has a tripled certificated nurse stationed there, but would still appreciate a visiting nurse calling occasionally.
   b) Kunmunya Mission is in the process of being transferred to a spot on the mainland opposite Cockatoo Island. It is constantly reiterated that guests are not wanted until there is someplace for them to stay as this is their third move in a few years. One wonders how long it will be before they are prepared to receive guests!
   c) Beagle Bay and Lombardina Missions and Cape Levique: In July last year I was able to see the women and children at these centres. I travelled with police who were investigating two deaths from poisoning at Lombardina Mission. This, of course, meant that the time spent on my work was necessarily limited to the police schedule. We used my utility for transport, the police and myself sharing the cost of the petrol. The appalling state of the alleged road was directly responsible for several breakdowns which necessitated costly repairs after our return to Broome. This made me realise why the police were so anxious to use my vehicle instead of their own (to the sorrow of my pocket). In my limited time I was unable to make a thorough investigation of conditions at the two missions, but as we stayed overnight at Lombardina I was able to glean the following information:
   The mission is poor, relying on personal subscriptions from Melbourne. Money is also obtained from Native Affairs and Child Endowment

Population:-	Natives	100
	Indigents	2
	Children	12

Clothing of indigents is inadequate. A recent issue was:

Women	- 1 pair of bloomers but no dresses
Men	- 1 flannel shirt
	- 1 pair of pants
	- 1 pair long flannel underpants

Also included in this issue were 8 pairs of second-hand sheets but no clothing for children!
The blanket issue per year is half the double blanket per person
Food supplies from Beagle Bay rather sketchy and inconsistent.
Meat – 1 beast every two weeks, kangaroo, but main diet fish
White bread issued when baked several times weekly
Dripping is bought in Broome as mission beasts are in poor condition.
Kangaroo dripping is also used.
Eggs issued to mothers when possible.
Goats' milk is supplied and an effort was being made to build up the goat herds.
Fresh fruit and vegetables – information vague;
Bush berries and fruit eaten by natives but the quantity and properties are unknown

A very earnest attempt was being made by the Father in charge at that time to improve matters and to encourage natives to a useful way of living.

I was given to understand that natives in the Beagle Bay – Cape Levique area ate large quantities of the berry of a native shrub, commonly known as "Red berry". I forwarded specimens of this to the Government Botanist who was interested to receive further supplies for analysis. To date my efforts to procure these for Mr. Gardner are unsuccessful.

At Lombardina I had reason to suspect several children to be suffering from hookworm induced anaemia. This was reported to Dr Milne in Broome.

d) Palatine and Drysdale Missions: A visit to these missions would normally mean a stay of one month, so I have barely touched upon the possibility of visiting them. However, on May 14th Miss Harding of the Nutritional Survey is visiting Drysdale Mission for some days and has a special plane is being provided for the return trip. I hope to be able to accompany her.

3. FLYING DOCTOR SERVICE:-

As I am only permitted to travel on this plane when no doctor is aboard, Matron Howell is unable to give adequate notice to the Wyndham pedal base to notify women who would be interested in meeting me at the various airstrips; as usual this was found to be the case when making my two recent trips in March and April

The fortnightly Flying Doctor plane appears to be essentially a freight and passenger service run to strict schedule, and visiting mainly the same Stations each trip.

The time spent at the airstrips, whilst helping towards a friendly relationship with the station people, is not as useful as a visit to the home would be, and is of very little interest or service from a medical or maternal and infant welfare viewpoint.

MATERNAL AND INFANT HEALTH PROBLEMS PECULIAR TO KIMBERLEYS:-

1. In the Kimberleys, particularly in Broome and Derby, we find it a constant battle to teach coloured women even elementary mother craft details. It is difficult, also, to persuade mothers of the necessity of better feeding of babies and young children. Too often, one finds very young children receiving the usual diet of meat, bread and tea. Constant supervision is required, which however is not always possible as hospital staffing at present comes first.
2. DIET IN GENERAL: From November to April people are able to obtain fresh fruit and vegetables by the Government Subsidy scheme. At other times the usual freight rates are charged, thus greatly increasing the cost of living. A small amount of fruit and vegetables is brought to the towns by the State Shipping Service. Insufficient fruits and vegetables are eaten, demanded and supplied owing to the high cost of living, ignorance and apathy of the majority of the population.

   During the summer months when the 'Koolinda' is off the run, there is a shortage of various foods in the three towns. Shortage of dried milk, however, occurs throughout the year.

   Much difficulty is experienced by pregnant women and mothers of young children in obtaining

suitable foods. Knowing this, one feels that advice concerning diet is farcical.

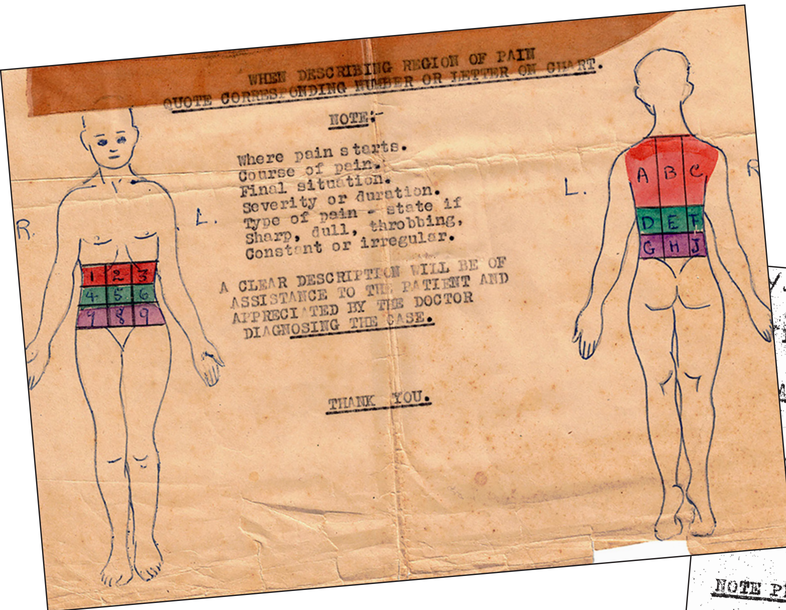
3. Among babies and children at certain seasons, discharging eyes, infected scabies and other skin diseases, acute tonsillitis and diarrhoea are rife, these are no doubt due to the unhygienic living conditions of the people, particularly the half caste population.

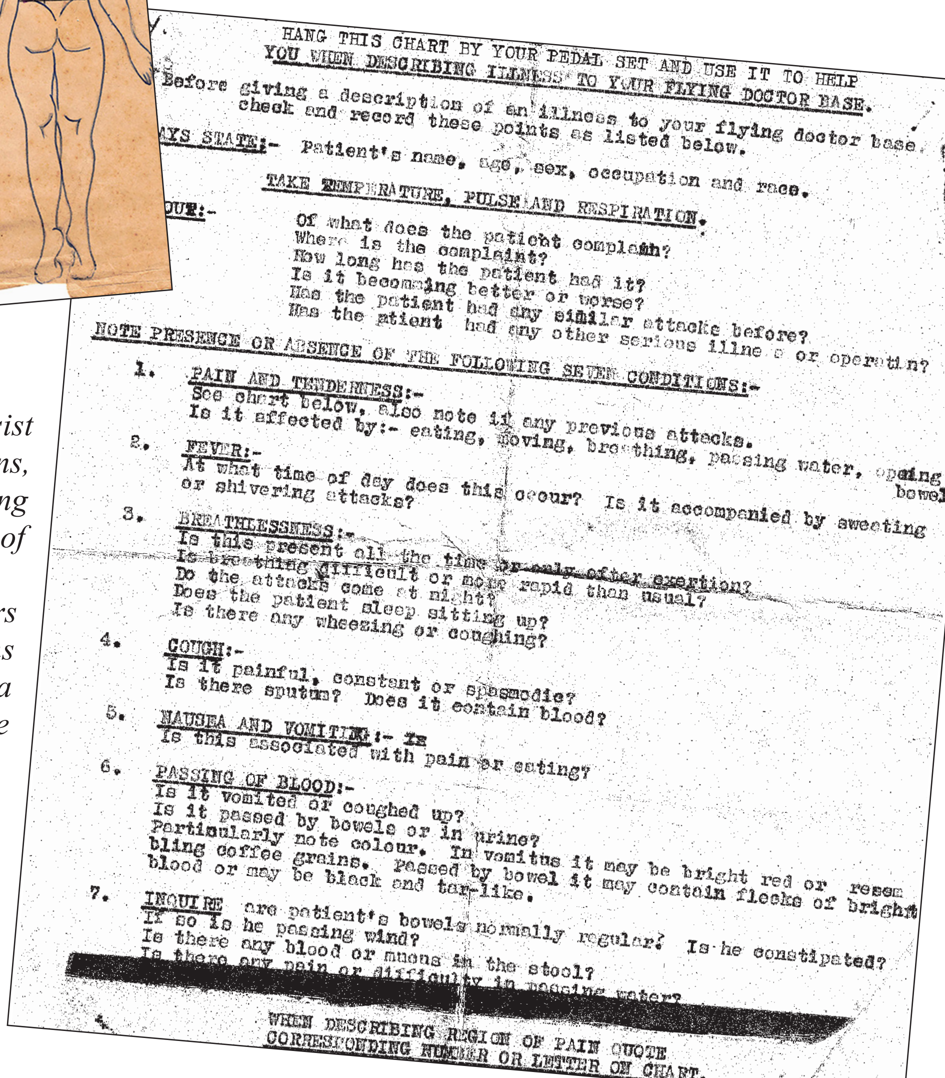
4. DENTAL CARE: The population as a whole, urgently requires dental care. No dentist has visited the area since June 1949. There is reason to suppose that propaganda is required to impress upon mothers the necessity of sensible care of the teeth.

5. HOOKWORM: Prevalence of hookworm in the Kimberleys has, I believe, not as yet been fully investigated but, quoting Dr O'Reilly, the medical officer now stationed in Derby, "Would it not be possible to procure suppliers of chenopodium sufficient to mass treat everybody at Forrest Mission every three months, pending the erection of proper sanitary facilities and a time interval necessary for the site to become non-infective, which, I believe, is seven years. I understand there has been only one child born there in the past two years and that one premature".

I am convinced there is a tremendous and most necessary field of work to cover in dealing with the problems concerning the general health of the Kimberley community. These will never be solved until long range planning, organization, inadequate staffing is introduced.

Derby 1/5/51




HANG THIS CHART BY YOUR PEDAL SET AND USE IT TO HELP
YOU WHEN DESCRIBING ILLNESS TO YOUR FLYING DOCTOR BASE.

Before giving a description of an illness to your flying doctor base, check and record these points as listed below.

AYS STATE:- Patient's name, age, sex, occupation and race.

TAKE TEMPERATURE, PULSE AND RESPIRATION.

OUR:-
Of what does the patient complain?
Where is the complaint?
How long has the patient had it?
Is it becoming better or worse?
Has the patient had any similar attacks before?
Has the patient had any other serious illness or operation?

NOTE PRESENCE OR ABSENCE OF THE FOLLOWING SEVEN CONDITIONS:-

1. PAIN AND TENDERNESS:-
See chart below, also note if any previous attacks.
Is it affected by:- eating, moving, breathing, passing water, opening bowel

2. FEVER:-
At what time of day does this occur? Is it accompanied by sweating or shivering attacks?

3. BREATHLESSNESS:-
Is this present all the time or only after exertion?
Is breathing difficult or more rapid than usual?
Do the attacks come at night?
Does the patient sleep sitting up?
Is there any wheezing or coughing?

4. COUGH:-
Is it painful, constant or spasmodic?
Is there sputum? Does it contain blood?

5. NAUSEA AND VOMITING:- Is
Is this associated with pain or eating?

6. PASSING OF BLOOD:-
Is it vomited or coughed up?
Is it passed by bowels or in urine?
Particularly note colour. In vomitus it may be bright red or resembling coffee grains. Passed by bowel it may contain flecks of bright blood or may be black and tar-like.

7. INQUIRE are patient's bowels normally regular? Is he constipated?
If so is he passing wind?
Is there any blood or mucus in the stool?
Is there any pain or difficulty in passing water?

WHEN DESCRIBING REGION OF PAIN QUOTE
CORRESPONDING NUMBER OR LETTER ON CHART.

Lucy Garlick's innovative charts to assist self-diagnosis by people in remote locations, in radio-telegraph messages to the Flying Doctor Service, by type of illness and area of pain.

The diagram was displayed for some years on an Australian bank note. These items were made available to and retained by a Nursing Exhibition conducted by Melbourne University.

Ms L. Garlick, Derby, W.A. 7th June, 1951

Dear Miss Garlick

Thank you for your letter of 30th April and the report enclosed with it.

I can well understand your sense of frustration in the persistence of readily removable obstacles to your progress. As you are of course well aware, the whole purpose of your appointment was to provide in the North, a trained officer concerned with the many and varied aspects of welfare for all women and children. There does not seem to me to be incongruity here. After all, the woman of Perth is afflicted at government expense with a multitude of busybodies purporting to be concerned with her welfare.

The costly paraphernalia of water and sewage boards, factory inspection, milk boards, pure food inspection, sanitary inspection and the like are intended to ensure that all the basic essentials of community life shall be so ordered that she can live and rear a family in the assurance of safety whilst this organisation protects her from her own and other people's follies. Baby health centres are available to advise her on the care of the child and the nurse visits the mother regularly.

Social workers, almoners, child welfare nurses and inspectors, immunisation clinics, child psychologists, kindergarten teachers, mothercraft nurses, orthoptists, speech therapists, dieticians and a host of other technical and pseudo-technical advisors are available to her or intrude upon her to assist her to live safely and rear a family successfully in a city where every precaution known to the Health Department has already been taken to make community life safe.

In the North, where practically all basic precautions have been neglected by government, it might be assumed that the need for personal advice in sanitation and the handling and preparation of food is really much greater than it is in the city and that if the costly works necessary to make the community safe are neglected on the ground of economy, at least the trivial expense involved in teaching the people how to look after themselves might not be begrudged.

At the moment, there can be no opportunity of your working for the Commonwealth. Indeed, I doubt whether under existing conditions there would be any future in such an arrangement. Appointment to the Native Affairs Department would solve one of your problems, but not the other. On the other hand, I feel that your place is with the Health Department which should be as vitally concerned for the welfare of the native woman, as is the Native Affairs Department itself. I can only conclude that your difficulty arises from apathy in the Health Department itself or in the medical officers of the area.

If you can hang on a little longer, I hope prospective developments may present a possible solution to your problem. In the meantime, I suggest you do what you can with the limited opportunities available to you to look after both sections of the population.

Thanks for your report on Beagle Bay and Lombardina and also for the note on housing at Derby. They will be very helpful.

I hope you found your trip around the Northern missions both enjoyable and profitable and I am glad that the opportunity of making it occurred.

I do not know when I will be up your way again. But I trust that I shall have an opportunity of discussing this work again with you soon and that on that occasion, I may be of greater assistance than I can be now.

Yours sincerely
CEA Cook

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Dear Dr Cook,

I am enclosing a copy of a letter from the Department which I received after having written to ask for my leave. After reading [it] I think your conclusion will be the same as mine that it is useless to hope for a satisfactory continuation of this position.

In view of this I am taking the liberty of writing to you to ask if you know anything further relating to your confidential letter of August 24th 1951. [not on file]

I would be grateful if you would answer this letter as soon as possible as if nothing is to eventuate I have no other choice but to apply to Native Affairs for a position in the Kimberleys before it is too late.

Yours sincerely
Lucy Garlick

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The letter from the Department: [hand written copy]

With reference to your letter of 24th September and previous correspondence, it is intended that the Correspondence Nurse takes over the Welfare work when you proceed on leave.

Instructions to this effect will be sent to you in a few days when Dr Stang returns from the Eastern States.

(signed) Linley Henzell

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Miss Lucy Garlick 18th October, 1951
DERBY W. A.

Dear Miss Garlick

Your letter of 11th October was awaiting me on my return from Melbourne on Tuesday, the 16th.

I have postponed replying in the hope of having an opportunity of discussing the matter with the Secretary, Department of Territories. I am leaving to see him now and will write you later when I hope to have some more information for you. In the meantime, I have written personally to Dr Henzell.

Yours sincerely,
CEA Cook

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From Cook to Henzell 19th October 1951

Dear Linley

I trust you will understand and tolerate my apparent intervention in a matter which is, viewed officially, is none of my concern. I refer to a letter just received from Miss Garlick at Derby from which I gather that she proposes to transfer to the Native affairs Department, or resign or some such.

My defence for writing to you in the matter is that this appointment was made for a specific purpose which I shall later discuss in some detail. I personally undertook to Miss Garlick at the time of her accepting appointment, that she would have a certain scope and certain duties, and devote herself to the development of a special service along the lines I discussed with her. She was, moreover to be directly responsible to me as Commissioner of Public Health. The fact that I left shortly afterward and that my undertakings seemed to be unacceptable to the Administration, prompted her to write to me on the matter and ask my advice.

I must therefore crave your indulgence to treat this purely as a communication between myself and you and to concede that she has not committed an official breach of procedure but has merely raised the matter personally with one who is mainly responsible for her present predicament.

If you feel you are unable to discuss the matter with except on an official basis, I suggest that you destroy this letter at this point without reading further.

As you know, I have always been committed to a policy of raising first the mixed blood and later

the native full blood to white status, and my purpose in appointing Miss Garlick was that she should, by personal approach and direct contact with mixed blood mothers in the home and elsewhere, enlighten them in the niceties and refinements of domestic life and hygiene, infant care and nutrition, so that at least those disabilities under which they labour, and which could in some measure be remedied by their own activity, might in time be eliminated.

To secure her appointment, it was hopeless to ask the Government of the day for approval of the expense involved in the constitution and conduct of such an office. I therefore approached it from the viewpoint of her also serving as an Infant Health Sister, relieving Sister, general medico and social contact with the white women in the back country.

Such an approach which secured approval had the disadvantage that in her capacity of Infant Health Sister she was liable to direction by Dr. Stang with whom she was not en rapport and who had little, if any, interest in the special task to which I indicated she should devote a great deal of her time.

It seems that after my departure she was handed over to Dr. Stang's direction and being largely rendered immobile for lack of transport, she feels that the work that was the particular purpose of her appointment has been neglected, even deliberately relegated to a very subordinate position amongst her duties.

She feels that there is, in the Health Department today, no sympathy for or interest in the objectives for which I had the appointment created, and which to her are the only reasons for her continuing in the district.

I understand that she could transfer to the Native Affairs Department tomorrow and realise her aspirations in full, but as one completely disillusioned of the advantages of her transfer, I am dubious of this, although I will not dispute she may be better situated with Middleton [Head of Native Affairs] than with the Health Department.

My point in writing to you is that if I am to advise her at all, having regard to my moral obligation to her, I should advise her to transfer to the Native Affairs Department, for in that administration she will be fully occupied and presumably financially supported in carrying on the work we set out to do.

I am implacably opposed in principle to a Health Department surrendering to any other a function which is properly its own. I cannot believe that any Health Department can with propriety and justice claim that the matter of living hygiene and diet standards in the native population is a function of any other Department than itself, and I have always been of the opinion that you agreed with me on this.

I am inclined to the view that you may have left the general supervision of the North to Davidson, and that the developments in relation to Garlick's office may have resulted from this circumstance.

Frankly, I do not know how to answer her letter, although she has asked me to do so by return mail. She has taken her cue for the present excess of dissatisfaction from a letter dated 1st October, 1951 from the Department, in which she is informed that during her absence on leave she will be relieved by a correspondence nurse.

This is a matter on which I would not venture to comment, but it has obviously been interpreted by her as an indication that the Department is completely indifferent to the special aspects of her duties and I would not venture to form an opinion on information available whether she is correct or not.

I wonder whether you might give some thought to the broader aspect of developing the Native Health visit facet of her office, interview her on her arrival in Perth and view sympathetically my plea that the duties involved in the field are of the first importance requiring to be energetically prosecuted and extended, not by the Native Affairs Department, but by the Department of Health.

If you are not convinced of this, you might discuss with Middleton, his taking her over, but I personally would be very grateful to you if whatever action is taken you are sure that the work continues with expanding scope and increasing energy, for I am endeavouring to use the West Australian precedent as a means of securing similar appointments elsewhere in the Commonwealth.

With kind regards,

Yours sincerely

CEA Cook

SUMMARY:

From June 1950, through the NHMRC Committees, Cook developed the subjects he dealt with in Western Australia into national projects and standards.

- Cook's 1948 reports on North West W.A. gained the Prime Minister's attention, prompting an extensive, evidenced-based survey of Indigenous health in over 50 settlements across Northern Australia. A national conference of senior health and welfare officers considered the results and decided on appropriate actions;
- Coordinating Indigenous health policy and practices between Health and Welfare departments and by the States and Commonwealth, from which the relevant Minister, Paul Hasluck, created the National Welfare Council of State and Commonwealth Health and Welfare Ministers, as well as a comparable Chief Officers' Council;
- Forming Health Councils in all States to adopt Cook's description of a modern public health service;
- Adapting an existing national research project on infant mortality to examine the different practices by the States to describe, identify, record and address infant mortality, especially still-births and to adopt a national, best-practice model;
- Responding to the renewed Poliomyelitis epidemic in early 1952, the NHMRC formed the Poliomyelitis Committee, with Cook as its chair, to develop a national campaign. The Committee met in Perth in 1954. The national immunisation campaign of which Cook had oversight commenced in mid-in 1956.

After Cook's resignation in 1949, the Minister appointed Dr Linley Henzell, the medical superintendent of the Wallaroo TB Clinic as Commissioner of Public Health. Henzell wrote of Dr Cook in the 1949 annual report:

> One must express appreciation for the work done by him in the three and a half years during which he served this State, Over (my) eight years' service in the Department, one has had the opportunity to observe at close quarters the vitalising effect on the Department's activities produce by his incisive intellect. The whole outlook on public health and preventive medicine in the State has been changed. One must therefore congratulate the Commonwealth Health Department on its new recruitment.

Dr William Davidson, Cook's preference for the Commissioner's role waited patiently for 13 years until he was appointed. It was Davidson who convinced the Minister that the Commissioner of Public Health should be the permanent head of the Department.

In the decades since 1949, there is ample evidence that Public Health in Western Australia has been a dedicated, developing and effective service to the State. Dr Dudley Snow's book, *The Progress of Public Health in Western Australia* covers the period to 1977. Davidson's book on Leprosy *Havens of Refuge* in the State is a useful supplement. Dr Cook recruited both these men, from the U.K, into the department of Public Health. At the local government level, the State's Health Inspectors number their annual Conference from 1946, their first, organised by Dr Cook. How much progress in the State was influenced by the legacy of Cook's post-war vision and determination is for others e.g. Richard Lugg, to consider.

A *Vision for Australia's Health: Dr Cecil Cook at Work* – reviewed by Ian Ring

If only we had more modern-day health administrators of the calibre of Dr Cecil Cook! Cook's many contributions to the health and health services of the Northern Territory, Western Australia and the Commonwealth, are little known and less recognised. And this void Barry Leithhead's carefully researched and very readable book, "A Vision for Australia's Health", now fills.

Significant achievements don't come easily, and Cook has many to which he could point. In the 1920s he undertook extensive journeys across the top end of WA, NT and Qld conducting leprosy surveys as the Wandsworth scholar for the London School of Tropical Medicine, where he studied for his DTM&H. These surveys led to a landmark report on the Epidemiology of Leprosy in Australia, for which he was later awarded an MD. In World War II he rose to become the most senior ranked field medical officer in the Australian Army. At a time when, in some theatres, there were more casualties from illness than from the battlefield, Cook introduced much needed reforms for the control of malaria, scrub typhus and hygiene.

After the war as Commissioner of Public Health in WA, he transformed that department from an outdated model, to one which based its services on studying disease incidence and the causes of morbidity and mortality, identifying and addressing preventable factors and conducting research into improved diagnosis and treatment – using and applying that knowledge to improve services. In 1950, he moved to Canberra as Senior Medical Officer in the Commonwealth Department of Health. He focussed particularly on health in tropical Australia and the health of Aboriginal people in the Northern Territory. For that goal, he conducted extensive health surveys of northern Australia in 1950 and was heavily engaged in improving health and welfare policies for Aboriginal people. He also played an important role in leading the NHMRC to a more productive role, applying the standards he developed in WA, for health departments on the national stage. It was fortunate for Australia that someone of Cook's calibre was in a key position at the time the Salk vaccine became available. Crucially, he preferred to overcome objections rather than accept them.

Throughout his career, Cook was vigorous in his pursuit of what he saw as the right course of action. Some in authority sometimes deemed his use of language "intemperate" and his style did not always advance his career prospects. He did not shrink from confrontation between health agencies and Aboriginal welfare departments, with the missions over policies and sub-standard services, or with civil authorities over run-down facilities. Yet in many, if not most of these battles, history will judge Cook kindly. In that different era, Cook lived by and for his values, and values change with time. Cook's views were shaped by his time and background, significantly ahead of his contemporaries, medical, bureaucratic and political.

What lifted Cook above others was a combination of intelligence, persistence in the face of opposition, training (in medicine, public health and tropical medicine, and anthropology) and the incorporation of a scientific approach into health and medical administration. He was a visionary who "saw problems on a national scale" and in the context both of past history and of the future horizon. He was a giant of public health in Australia and Barry Leithhead's account of his life does him justice.

Ian Ring AO

Dr Ring was head of the School of Public Health and Tropical Medicine at JCU, Foundation Director of the Australian Primary Health Care Research Institute at ANU and Principal Medical Epidemiologist, Qld Health. He has contributed a lifetime of work on public health aspects of cardiovascular disease, cancer epidemiology and Australian Aboriginal and Torres Strait Islander health, which has greatly contributed to knowledge as well as informing policy for both government and non-governmental organisations at national and international levels. He has done this work through James Cook and other Universities, state and federal governments, and through various professional organisations for more than 40 years.