

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

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

## Chief Medical Officer to the Government\*

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

## John Ashburton Thompson

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

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

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

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

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

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

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

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

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

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

## The administration of the Chief Medical Officer

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

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

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

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

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

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

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

## The Director-General of Public Health

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

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

## Robert Thompson Paton

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

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

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

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### William George Armstrong

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

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

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

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

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

### Robert Dick

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

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

### Emanuel Sydney Morris

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

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

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

heard.

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

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

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

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

"Yes, Brothers, another pious resolution!"

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

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

### Hugh Gilmour Wallace

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

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

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

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

### Cyril Joseph Cummins

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

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

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

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

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

connotations nor any relationship to the historic title.

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

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

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

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

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

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

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

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

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

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

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



**Word Health Organisation Seminar**  
(L to R) Lordship Bishop Freeman  
Dr C. Cummins, Dr A.G. McManus

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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