USE OF THESES

This copy is supplied for purposes of private study and research only. Passages from the thesis may not be copied or closely paraphrased without the written consent of the author.
PROFESSIONALISM AND PROFESSIONAL ETHICS

by

BARRY R. MALEY

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Arts in The Australian National University

February, 1970
# CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>THE PROFESSIONS</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER I</td>
<td>Historical Development</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER II</td>
<td>ETHICS, PROFESSIONAL ETHICS AND PROFESSIONALISM</td>
<td>9</td>
</tr>
<tr>
<td>CHAPTER III</td>
<td>FACTORS DETERMINING THE EMERGENCE OF AN ETHICAL CODE</td>
<td>20</td>
</tr>
<tr>
<td>CHAPTER IV</td>
<td>THE ANALYSIS OF ETHICAL CODES</td>
<td>28</td>
</tr>
<tr>
<td>CHAPTER V</td>
<td>THE FORMULATION AND ENFORCEMENT OF ETHICAL CODES AND POLICIES - SOME AUSTRALIAN EXAMPLES</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Solicitors in New South Wales and the Role of the Law Society</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>The Law Society and Ethics</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Engineers and the Role of the Institution of Engineers, Australia</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Architectural Practice: Statutory Provision and the Role of the Royal Australian Institute of Architects</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Medical Practice and Statutory Authorities</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>The Australian Medical Association and Professional Ethics</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>The Implementation of Standards of Conduct</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>Chapter</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>VI</td>
<td>THE PROFESSIONS AND SOCIETY</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>&quot;Medical Ethics&quot;</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Professional Ethics and Social Control of the Professions</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Social Values and Professional Control - The Example of Law and Medicine</td>
<td>90</td>
</tr>
<tr>
<td>VII</td>
<td>PROFESSIONALISM AND COMMERCIALISM</td>
<td>95</td>
</tr>
<tr>
<td>VIII</td>
<td>PROFESSIONALISM AND COMPLEX ORGANIZATION</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>Professionals in a Bureaucratic Setting</td>
<td>121</td>
</tr>
<tr>
<td>IX</td>
<td>PROFESSIONAL ASSOCIATIONS</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>Professional Aims and Types of Association</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>Professional Associations and Professional Conduct</td>
<td>140</td>
</tr>
<tr>
<td>X</td>
<td>THE STATUS OF THE EMPLOYED PROFESSION</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Professional Employees and Professional Associations</td>
<td>156</td>
</tr>
<tr>
<td></td>
<td>CONCLUSION</td>
<td>161</td>
</tr>
<tr>
<td></td>
<td>BIBLIOGRAPHY</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>APPENDICES</td>
<td>Pocket inside cover</td>
</tr>
<tr>
<td>I</td>
<td>Copies of Codes of Ethics of -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(i) Australian Medical Association</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ii) Royal Australian Institute of Architects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(iii) Institution of Engineers, Australia</td>
<td></td>
</tr>
</tbody>
</table>
APPENDICES

APPENDIX II  
Copies of -
(i) "A.M.A. Gazette"
(ii) "Winthrop Impulse"
(iii) "A Doctors' Business Review"
(iv) "Riker Service"
TABLES

Table 1 | SUMMARY OF ETHICAL OBLIGATIONS CONTAINED IN CODES OR RULINGS OF (i) AUSTRALIAN MEDICAL ASSOCIATION (ii) ROYAL AUSTRALIAN INSTITUTE OF ARCHITECTS (iii) INSTITUTION OF ENGINEERS, AUSTRALIA (iv) LAW SOCIETY OF NEW SOUTH WALES

Table 2 | ELEMENTS OF PROFESSIONAL CODE (as shown in Table 1)

Table 3 | PERCENTAGE OF TOTAL SPACE IN ETHICAL CODE DEVOTED TO AREAS OF RESPONSIBILITY SHOWN

Table 4 | SHOWING CONTENT ANALYSIS OF FOUR ISSUES OF "A.M.A. GAZETTE"

Table 5 | SHOWING CONTENT ANALYSIS OF FOUR ISSUES OF "WINTHROP IMPULSE"
INTRODUCTION

Many factors, historical and otherwise, have shaped the professions as we know them to-day and the process is still dynamic and continuing. This essay is concerned in the main with analysing the nature and function of professional ethics and its relations with professionalism.

Professionalism is a distinctive way of preparing for and carrying out certain kinds of work, but such a simple description implies a host of complex social processes and relations between social groups which it is one of our tasks to explore. In particular, professionalism and professional ethics can be approached in two ways -

(i) through an analysis of the various forms of organization of professional work and the ethical observances and prescriptions associated therewith, and
(ii) by examining the interaction of the species of professional culture with other social movements and trends.

Because the professions (or at least those of them which are more or less firmly established and recognized as such) are strongly institutionalized and relatively
stable, the first approach is not particularly difficult, but it is nevertheless an essential preliminary to the second, for it would not be possible to understand the transactions a profession has with its environment without some appreciation of the continuing themes (the values and attitudes) which have been inculcated in the members of a profession and which constitute its "professionalism". Autonomy, expertise and responsibility, for example, are amongst the characteristics which have been held by various writers to exemplify professionalism, and if this is true then we can hardly understand the relations between a profession and other aspects of society until we have some insight into the significance of "autonomy", for example, for professionalism.

Conversely, we can assess the possible influence of other social processes on professionalism by analysing the way in which certain trends (for example, the growth of "bureaucratism") impinge upon what are presumed to be essential features of professionalism (such as "autonomy"). Similarly, if it is true that commercialism, as a general trend, is invading wider areas of social life it is important to know, in relation to the ethic of professionalism, whether the professions are being affected and if so in what ways.
When such questions are asked about the professions, the scope of professional ethics becomes wider than the sets of rules for professional conduct which have often been taken to constitute the subject. The rules, as Durkheim clearly saw, prove the existence of a complex moral order which underlies them and which must pre-date them. To study professional ethics is therefore to study not only formal and informal codes of conduct, but also the moral order (or ethic) which supports them.

The spirit of professionalism and the expertise which has always been associated with it are therefore profoundly social in the sense that the development of the former and the exercise of the latter require both long periods of socialization and training as well as induction into the corporate body of the profession and its traditions. In so far as this treatise may be said to be guided by an hypothesis, it is that any identifiable moral order must, to persist,

(a) maintain a certain solidarity among its members;
(b) control, preserve and promote the interest (in the case of the professions, a technical one) which is the basis of association;
(c) achieve forms of accommodation with the larger society and other social groups and movements.
What follows is therefore intended to show, in part, how professionalism and professional ethics are related to these themes.

It would clearly be impossible within the limitations of an essay such as this to deal with all of the major professions, so the profession of Medicine has been chosen as the paradigm, essentially because it possesses in high degree the features which the majority of writers have held to be characteristic of the professions, including a richly-articulated associational structure, detailed codes of conduct and complex relations with the larger society. Where, however, it has been deemed essential to introduce comparative material to justify generalizations, this material has been drawn from the professions of Law, Architecture and Engineering; and where more intensive comparisons have seemed useful (for example, in the discussion of social control of the professional "licence and mandate"), Law and Medicine have been contrasted.
CHAPTER I

THE PROFESSIONS

Historical Development

The professions, as a distinct form of the division of labour characterised by the application of specialized knowledge and skills to the affairs of mankind, had their beginnings as corporate vocations in Europe and England during the eleventh and twelfth centuries. At that time there was a growing trend to the formation of associations around crafts and specialized functions and by the sixteenth century there were professional associations for lawyers, doctors, teachers, merchants, shopkeepers and craftsmen of various types. Through systems of licensing and apprenticeship, these associations exercised considerable authority and control in the management of the vocations with which they were concerned and this tradition has remained largely intact up to the present time, importantly influencing the organization and control of professional practice today.

More or less concurrently, the universities arose during the twelfth century out of "gilds of learning" constituted by societies of teachers and students which, following the craft rule that one might not practise
without a licence, offered degrees which were, in effect, permits to carry on the craft or vocation of teaching.

Despite their secular beginnings, the universities soon came under ecclesiastical domination and it became customary for students to become "clerks". With the administration of the country largely in clerical hands, it was natural that administrative responsibility should increasingly fall to "graduates" of the universities. Since both education and administration were virtual monopolies of the Church, it is not surprising that those vocations which we now regard as professions - the law, medicine, the civil service, for example - developed within an ecclesiastical system which provided for the assumption of specialized (professional) functions by members of the Church; such that for "younger students the university was simply the door to the church; and the door to the church at that time meant the door to professional life".1

The later history of the professions, however, is a story of increasing detachment from the Church and growing association with the universities, which in turn were becoming more and more secular. The Law, for

---

example, had dissociated itself from the Church by the beginning of the fifteenth century, at which time the English Inns of Court were fully established and wholly secular. The Royal College of Physicians, on the other hand, maintained its links with holy orders for longer and it was not until the eighteenth century that medicine was established as a secular profession. But it is interesting to note that at this time the connection between the profession and the universities was a tenuous one and remained so until the middle of the nineteenth century, when the forward surge of biological science in association with the universities made it imperative that improved medical practice be based on sound biological training.

At the beginning of the eighteenth century there were the "three professions of divinity, law and physic". Two hundred years later the number of recognized and marginal professions had multiplied enormously as a result of the burgeoning of the scientific movement and the industrial revolution.

As Carr-Saunders and Wilson point out, there is an intimate connection between the growth and character of

1 Addison, quoted by the Oxford English Dictionary.
the professions and the history of the scientific movement, but the implications of science for practice, especially professional practice, worked themselves out slowly:

In 1543 Copernicus and Vesalius, one at the end and the other at the beginning of his career, each published a book now famous in the annals of science; on that account this year is sometimes taken as marking the opening of the scientific age. The spirit of free and original enquiry gained a firm hold in the seventeenth century and led to systematic research. Pure research was thereafter pursued for itself, though few workers were oblivious of the possibilities of its practical application. But for some 200 years the scientific movement made so few additions to the arts that it exerted little influence upon the existing professions and brought no new professions into being.¹

The flood-tide of the professions had to await the growth of large-scale industrial organization which followed the application of scientific discoveries and principles to the mechanical arts by civil engineers and others. With the growth of industry and the complex division of labour associated with it, there arose a need not only for concomitant specialities (such as chemistry and metallurgy) but also for "service" professions or semi-professions such as accounting, banking, an expert civil service, etc. At the same time the growth of scientific knowledge dramatically affected

¹ Ibid., p.296.
not only the practice of medicine, dentistry, and veterinary science, but also the character of the education and training appropriate to them. The twin processes of increasing professional specialization and university training as a professional pre-requisite were firmly established by the end of the nineteenth century and have continued ever since to mould the development of professional practice.

The Problem of Definition

In the considerable literature on the professions much attention has been given to the problem of definition.

Morris Cogan defines a profession as

...a vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning or science, and upon the abilities accompanying such understanding. This understanding and these abilities are applied to the vital practical affairs of man. The practices of the profession are modified by knowledge of a generalized nature and by the accumulated wisdom and experience of mankind, which serve to correct the errors of specialism. The profession, serving the vital needs of man, considers its first ethical imperative to be altruistic service to the client.¹

This definition is notable for introducing the notion of "altruistic service to the client" as a distinguishing feature of the professions and this is echoed by other writers who see the professional as one who, amongst other things, accepts a special responsibility for the client's welfare; if need be at the expense of his own. The extent to which ethical responsibility is demanded of a profession in the professional-client relationship will depend largely upon the "moral closeness" of the relationship and the extent to which the expert services of the professional are essential for the well-being or welfare of the client.

Some writers have considered the existence of a professional association an essential feature of a profession, but obviously any occupational group can form an association. The claim has then been made that it is not so much the mere existence of the association which is important but the nature of the values which the association fosters or supports - and in particular the requirement that the members should adhere to rules of conduct backed by sanctions, of which expulsion is the most serious. Lewis and Maude, for example, have argued strongly that professionalism must be attenuated where the professional is employed, that the code of
conduct forged in the relations between practitioners and clients is fundamental to professionalism, that "the basis of professional morality lies in the fiduciary capacity of the man practising his profession" and that "it would appear that a moral code is the basis of professionalism".¹ But this is not altogether satisfactory because it is open to any occupational association to lay down a moral code for its members and this will not automatically turn the occupation into a profession. As it is hoped to show, the emergence of a moral code depends on a number of factors embedded in the structure of professional practice, which vary from one profession to another, and it is also conditioned by the relations between the profession concerned and public and clients.

Logan Wilson, though concerned primarily with the academic profession, has suggested a number of defining criteria of a professional behaviour system which, he claims, apply also to the major professions:

1. Prolonged and specialized training based upon a systematized intellectual tradition that rarely can be acquired through mere apprenticeship.

¹ R. Lewis and A. Maude, Professional People, Phoenix House, London, 1952, p.64.
Jrous standards of licensure, fulfillment of which often confers upon the functionary a degree or title signifying specialized competence.

Application of techniques of such intricacy that competency tests cannot be deduced upon any simple continuum scale, nor can supervision be more than loosely applied.

4. Absence of precise contractual terms of work, which might otherwise imply a calculated limitation of output and an exploitative attitude toward productivity.

5. A limitation upon the self-interest of the practitioner, and a careful insulation of professional considerations from extraneous matters such as private opinions, economic interests, and class position.

6. Certain positive obligations to the professions and its clientele.¹

Though wider in scope and more precisely worded than Cogan's definition, exceptions and qualifications immediately spring to mind. The difficulties in defining professionalism arise largely from the fact that professional activity cannot be distinguished from other forms of social activity in terms of absolute differences but only in terms of relative variations in certain common features. Professionalism is a continuous scale and the position which any vocation occupies on the scale

will depend upon the particular values which may be ascribed to certain general properties which are held to be characteristic of the professions. There is a fair measure of agreement as to what these general properties are, but continuing disagreement as to their relative importance. But the latter issue need not detain us at this stage. The main characteristics about which there is considerable agreement seem to be (following Barber):¹

(i) a high level of generalized and systematic knowledge leading to a formal qualification;

(ii) work directed towards general community or cultural benefit rather than to individual self-interest;

(iii) large measure of autonomy correlated with recognition of responsibility towards clients or employers, and public;

(iv) self-consciousness and measure of corporate control of professional group through lengthy socialization processes and traditional codes of conduct;

(v) money and honours regarded as symbols of work achievement and thus as ends in themselves rather than as means to serve other self-interests.

Despite the frequency with which each of the above characteristics appears at one time or another in the

---

various discussions of the professions, there is a degree of arbitrariness not only in the selection of the list but also in the manner of describing each of the characteristics, as may be observed by comparing them with Logan Wilson's list given above.

However, a more pertinent comment would be that some further refinement is needed of the terms used. How are we to judge, for example, between work which is "directed towards general community or cultural benefit" and that which is not? Clearly, much non-professional work is necessary in order that cultural activities (however defined) and essential community services may be maintained, and it does not follow that such work is necessarily not self-interested. Engagement in cultural activities or community services can occur from

1 See, for example, Becker (1962); Bowen (1955); Carr-Saunders and Wilson (1933); Cogan (1955) (1953); Habenstein (1963); Hughes (1960); Lewis and Maude (1952); Marshall (1939); Millerson (1964); Montague (1963); Parsons (1954); Pike (1963); Reader (1966); Vollmer and Mills (1966); Wilson (1942).

2 The vagueness of the term "community services" is apparent; almost any work activity, any business or enterprise, can be construed as in some sense community service.
interested motives of various kinds. But it is nevertheless true that in analyses of the professions a recurring theme is the way in which professionalism is commonly associated with disinterestedness and dedication, with being caught up in the (professional) activity for its own sake, often to the neglect of egoistic considerations. Perhaps also, there may be some force in the contention that the professions are in a position to make an especially significant contribution to social life by the way in which their special knowledge and skills maintain or bring about states of affairs which are peculiarly supportive of, or central to, a host of other activities of a contingent or derivative kind. Health, for example, is the condition of much human activity, and hence of the special place of the doctor. Similarly, veterinary science, agricultural science and engineering science are of the utmost importance in maintaining the production of food and an advanced technology. And, of course, underlying these "applied" sciences are the pure sciences and the academic and teaching professions.

But this view entails a special difficulty with regard to the Law as a profession. Legal knowledge is not "generalized and systematic" in the sense that scientific knowledge is. It is
...concerned not with the prediction and explanation of events on the basis of natural laws, but rather with a body of social norms and with rules for their application. These norms and rules can be systematized for the convenience of teaching or for avoiding inconsistencies and contradictions. But the resulting body of knowledge remains a description of a single normative system, designed for aiding its application and preparing its further development.¹

This issue is taken up again later, but at this stage it could be said that Barber's criteria (i) and (ii) may be seen as linked, and the special knowledge which all agree to be essential to the professions to imply a peculiarly strategic role for the professions and a propensity for eliciting disinterestedness in performance.

So far as Barber's remaining criteria are concerned, they succinctly express the views of the majority of writers on the topic, and, subject to the refinements suggested in relation to (i) and (ii), and combined with them, form a scale or "ideal type" of professionalism which is approached to a greater or lesser extent by a variety of occupations. To E.C. Hughes' question "How professionalized in identifiable respects is a particular

occupation", which he argues is a more fruitful approach than to ask "What is a profession", Carr-Saunders and Wilson would reply that:

The ancient professions of law and medicine stand near the centre. The practitioners, by virtue of prolonged and specialized intellectual training, have acquired a technique which enables them to render a specialized service to the community. This service they perform for a fixed remuneration whether by way of fee or salary. They develop a sense of responsibility for the technique which they manifest in their concern for the competence and honour of the practitioners as a whole - a concern which is sometimes shared with the State. They build up associations, upon which they erect, with or without the cooperation of the State, machinery for imposing tests of competence and enforcing the observance of certain standards of conduct. Material considerations of income and status are not neglected, but the distinguishing and over-ruling characteristic is the possession of a technique. It is the existence of specialized intellectual techniques, acquired as the result of prolonged training, which gives rise to professionalism and accounts for its peculiar features.¹

Carr-Saunders and Wilson also emphasise the significance, in respect to the professional status of an occupation, of the employment of a technique requiring an attitude of responsibility:

The more its practice is likely to arouse a sense of responsibility, the closer will be the approach of the vocation to the centre, whatever the nature of the technique may otherwise be. Practice which involves direct and personal relation to clients evokes a special feeling of responsibility, and on that account nurses and midwives make an advance inwards. In general the salaried status implies that there is no such direct relationship, and on that account it has been doubted whether any but fee-takers can be professionals. But that is to exaggerate one element and not the most important element, in the complex characteristics which mark out a profession. Again, the sense of responsibility is called forth when the practice involves personal judgement, and the degree to which judgement is needed does not vary directly with the degree to which there is personal relation to clients.¹

The professions vary, therefore, in closeness of fit to the ideal type which has been sketched. Degree of responsibility is one dimension in which there is considerable variation; mode of remuneration is another. Payment by fee still predominates in law and medicine whereas the scientific, engineering and academic professions are almost entirely salaried; pharmacists and opticians depend on profit-making and no doubt largely for this reason² are commonly included in the

¹ Loc. cit.
² For other reasons, see Norman K. Denzin and Curtis J. Mettlin, "Incomplete Professionalization: The Case of Pharmacy", Social Forces, 46 (3), March 1968, pp. 375-381.
marginal or quasi-professions. As will be shown in more
detail, variations in degree and type of responsibility,
mode of remuneration, and other professional dimensions,
are of considerable significance in determining the
emergence, and form, of professional ethics.

Much more could be said about the vexed question of
defining a profession but it would not be essential to our
purpose, which has been to make four points:

(i) the professions have a history as corporate
bodies which stretches back to the Middle Ages;

(ii) the basis of professional association has been the
exercise of a special skill whose benefits are
sought by others;

(iii) the foundation and extension of the skills
peculiar to the professions have been powerfully
affected by the emergence of the scientific
movement and university training;

(iv) the training for, and exercise of, specialized
skills has important moral consequences for the
practitioner and for the relations between
practitioners and others.

Each of these conclusions bears upon what follows,
but it is the last which will be considered in more detail
in the next three chapters.
ETHICS, PROFESSIONAL ETHICS AND PROFESSIONALISM

Ethics, considered as the science of morals or as a system of moral principles, is concerned with the rules of conduct and the definition of right and wrong action. Professional ethics traditionally has been regarded as a sub-division of ethics-in-general which treats of the moral observances appropriate to the relations between professionals and others. It is important to remember, however, that professional ethics has always been seen as subordinate to, and consistent with, general ethics or the prevailing moral principles of society. Professional ethics is thus legitimated by its conformity with the broader principles of right conduct which apply to all of the moral relations between men.

This is not the place to consider the criticisms by moral philosophers\(^1\) of this traditional view of the subject matter of ethics nor shall special attention be paid to the fact that there is fierce disagreement in society about what the "principles of right conduct"

\[^1\] See, for example, the various articles on ethics in John Anderson, *Studies in Empirical Philosophy*, Angus and Robertson, Sydney, 1962.
ought to be. For our purposes it will be sufficient to assume that there is a dominant morality or a prevailing ethical consensus which lays down guidelines for behaviour; which requires, for example, honesty and fair-dealing between men in non-professional as well as professional situations.

Professional ethics is itself subdivisible into:

(i) professional ethics proper, or obligatory customs, explicitly or implicitly constituting a code backed by the corporate authority of the profession;

(ii) professional etiquette, or the manners which are generally observed by professional colleagues in their exchanges with each other (e.g. the conventions governing precedence, etc. in medical consultations);

(iii) ethical issues which are especially significant for particular professions; for example, the procuring of an abortion in medicine, the knowledge of a client's guilt in law, etc., where the professional is faced with a situation in which the faithful execution of his professional task, in one respect, appears to entail a failure in professional duty in another.
It is often difficult to establish, simply by reading what has been formalized and written down, what the essential "ethical rules" of a profession are and exactly what they are intended to achieve. Frequently the most important guiding principles are not written down at all, yet they are common knowledge within the profession. Even the highly formalized and detailed codes of the medical profession leave, as they must, a great deal unsaid which is of ethical relevance. Nevertheless, two essential characteristics are either explicit or implicit in any ethical code:

(i) a broad declaration of the aims of the profession;
(ii) detailed instructions or guidelines believed to be essential to the achievement of the professional aims.

Thus, it may be taken, for example, that the broad aims of the medical profession are to investigate and treat sickness and disease and to strive to restore or maintain the health of those seeking medical advice and treatment. The rules of the ethical code are supposed to subserve these aims. Consequently, the ethical rules are not obligatory in a general sense, as general ethical "principles" are, but in a conditional sense. That is
to say, before each prescriptive rule we are to "read in" the clause "in order to investigate and treat sickness and disease and...maintain the health of those seeking medical advice and treatment" do X, or do Y, or don't do Z. There need be no concretely ethical content in the rules themselves - their function is to help achieve the professional aims. In what sense, then, are such codes "ethical"? The position may be made clearer by supposing that there is a profession of businessman. Suppose also that businessmen are not entitled to carry on business until they have completed a recognized course of tertiary education, that the profession has laid down an ethical code and that the code follows the pattern suggested - namely a statement of aims ("to sell as many goods as possible") and various rules for the achievement of the professional aim. Suppose some rules were "sell at every opportunity and use any device of deceit or misrepresentation that may be useful in achieving the professional aim". If it is sufficient that an ethical code should comprise a statement of aims and rules of conduct believed to be necessary for the achievement of those aims, then this would be an ethical code. Of course we would want to deny this, but the grounds of our denial would be the conviction that
neither the aims of the profession nor the means of attaining them are ethically justifiable, or cannot be described as good; and that any conscientious member of the profession would be acting wrongly and doing evil if he accepted the aims and lived by the code. On the contrary, ethical behaviour (doing the right or good thing) would consist, in part at least, in not following the code.¹

It seems, then, that there is implicit in the conception of codes of professional ethics an assumption that the professional aims or activities are good or ethically justifiable,² and that the code of conduct which is enjoined finds its justification in being seen to be necessary for the achievement of the fully-fledged professional activity and the good ends which that entails.


² "The term (profession) in ordinary intercourse, however, implies more than an abstract classification of work; it also portrays a morally desirable kind of work. It becomes a term of invidious comparison and moral evaluation. In applying it to a particular occupation, people mean to say that the occupation is morally praiseworthy." (Joel B. Montague, Jr., "Pharmacy and the Concept of Professionalism", Journal of the American Pharmaceutical Association, Vol. NS8, No.5, May 1958, pp.228-230).
Consequently, it may be concluded, in respect to the relationship between general ethics and professional ethics, that the rules of conduct enjoined by professional ethics (which in detail may vary from profession to profession) are usually conditional statements whose ethical relevance consists in the support they offer, or presume to offer, to a professional activity which is widely accepted to be good or worthwhile in itself; that is, to be absolutely, and not conditionally, "justifiable" and to constitute, in short, a social "value".

There is another sense to ethics which should be mentioned - and this is derived from the word "ethos" - where it refers to a certain spirit or all-pervading attitude which informs a community or a system. The word "professionalism" is sometimes used in this way to mean a "professional ethos" or an "ethic of professionalism", where the intention is clearly not to denote a system of rules or customs, but to identify a characteristic "spirit" or organizing principle which is common to those who are intensely committed to a way of life and which focuses and lends coherence to their activities.
Professionalism, in this sense, carries with it the idea of an occupational ethos which is intrinsically absorbing and satisfying and which prepares people for, and draws from them, performance of consummate skill and dedication. The notion of a vocation or calling, over and above the mere earning of a livelihood, has long been associated with professionalism.

The pursuit of the professional end as an end in itself and not merely as a method of earning the daily bread, or, if you will, the jam and cream which professional success may bring, is to my mind at the very core of the idea of a profession. To pursue or to do the task for its own sake, to have it well and faithfully done, to be to no small degree a perfectionist, to engage to the full the talent, the skill and the knowledge in the daily task, usually in the service of some other human, seem to me the very heart of the concept of a profession.¹

T.H. Marshall expresses a similar viewpoint when he says:

The professional man is distinguished by the further fact that he does not give only his skill. He gives himself. His whole personality enters into his work... (and he) cannot labour in a detached, impersonal way, with his eye on the clock and his mind on his cheque. He, too, must give something that is deeply rooted in his nature, something

that cannot be commanded or coerced, or even bribed.¹

Past and current cynicism notwithstanding, the concept of a professional vocation is still a powerful one, and in so far as the leading members of any profession bear its stamp and still carry on its traditions, it, through them, continues to influence the profession as a whole. Indeed, it might be said that the character of a profession depends largely upon the extent to which professionalism in this sense is to be found within it and actively supported by the organized body of the profession.

CHAPTER III

FACTORS DETERMINING THE EMERGENCE OF AN ETHICAL CODE

The existence of a professional ethic, whether formal and explicit or informal and understood, presupposes the existence of a professional group of which it is the product. As Durkheim has put it:

A system of morals is always the affair of a group and can operate only if this group protects them by its authority. It is made up of rules which govern individuals, which compel them to act in such and such a way, and which impose limits to their inclinations and forbid them to go beyond.¹

The professional group has both external and internal relations and, as such, it interacts with the public, with governments, with educational institutions, with other professions, with communications media, and so on. Within the profession and its daily work there are relations between fellow members of the group and between professional and clients or patients.

These relational categories are common to all of the professions, although one or other of them may be more

important in some professions than in others. This is not to say, however, that there is a common basic ethic for all professions (except in the special sense discussed elsewhere in this essay) but simply that relationships of this type occur within all professions irrespective of the "moral" content of the various ethical rules.

Professional ethics, taken in the broadest sense to include not only statutory obligations and formal codes of conduct, but also the unwritten rules, the customary observances, the values and attitudes which characterise professional behaviour, are thus the visible evidence of the moral ordering of these forms of interaction, which may be grouped into intra-professional, inter-professional, professional-public and professional-client relationships.

Professional ethics can therefore be subjected to analysis which distinguishes those features of ethical codes which subserve these relationships by prescribing forms of behaviour appropriate to them. This task is undertaken below, but before going on to this, attention must be drawn to the profound implications, so far as the formal elements of the several professional ethics are concerned, of the wide variations in the nature and circumstances of professional practice, and in the functions performed by the different professions.
The circumstances under which he practises his profession have important consequences not only for the quality of the professional's own ethical behaviour but also for the effectiveness of his communication with, and participation in, the professional group and hence its ethical character. It matters, for example, whether the characteristic type of professional practice is carried on in an institutional or non-institutional setting. From the point of view of the solo practitioner, the isolated individual can communicate with his professional culture on questions of moral or ethical decision only by recourse to written material which takes the place of consultation with colleagues. On the other hand, where professional practice is typically institutional in form, not only is colleague consultation made easier but two other possibilities emerge - either the formal structure of the institution and its rules will reflect the prevailing professional ethic or it will overshadow and dominate it. In either case the conditions favouring the formulation of an ethical code in institutional settings will be weak while in the case of predominantly individual practice it will be strong. Whilst recognizing the intrusion into this complex of a further variable - namely, the deliberate use of a consciously formulated code by
an occupation aspiring to professional status in support of its claims - it nevertheless seems reasonable to conclude that the circumstances of professional practice may be viewed as a continuum, with the solo practitioner at one end, passing through partnerships and group practices to decentralised institutions (e.g. churches) and classical bureaucratic structures, at the other. The progression is accompanied by a diminishing need for a formal code - but not necessarily by any lessening of the reality and importance of the professional ethic itself, as shall be seen in the discussion of professionalism and bureaucracy in a later chapter.

Where the relationship between professional and client involves a high degree of trust on the part of the latter, due either to the vital nature of the client's affairs which are the subject of the professional performance, or to the impracticability of the client's having any worthwhile understanding of the professional art concerned, the moral ramifications of the professional-client relationship are greatly extended and the possibility of serious harm and deception greatly enlarged. To illustrate, we might contrast the doctor and the barrister, on one hand, and the accountant or artist on the other. With the former, the professional relationship
commonly involves matters of great moment for the client and they are dealt with through arts of which the client usually knows nothing. Since the profession must always strive to retain public confidence and since public interest in professional responsibility is more or less proportional to the seriousness of the consequences of poor practice, and its inability to understand the professional art, the affirmation of a formal ethical code serves powerfully to reassure the public (and the client) that the professional group is aware of its trust and responsibility and is prepared to exercise its moral authority over its members in the client's interests.

These two factors, then, the fiduciary nature of the professional-client relationship and the extent of the client's understanding of the professional art, help to determine the need for a formal code, and again we can conceive continua for each factor, ranging from the fiduciary to the non-fiduciary, on the one hand, and from complete incomprehension of the professional technique to complete or partial comprehension (e.g. social work), on the other.

---

1 An important qualification of this statement in relation to legal practice is discussed in a later chapter.
In addition to the nature and circumstances of practice and the client's comprehension of technique, a third major structural variable influencing the need for an ethical code is the form of the transactions between the professional and client and, in particular, whether their relations are direct and personal or indirect and impersonal and whether the professional is dealing with one or several clients at the same time. The doctor or solicitor usually has direct and personal relations with one patient or client at a time, whereas the writer's or engineer's or actor's relations with his clients are usually impersonal and indirect and, at least with writers and actors, with several "clients" simultaneously. The possibilities of abuse of a direct personal relationship with one client are greater than in an impersonal indirect relationship with several clients. Confidences are given to the practitioner and the practitioner's actions are not subjected to multiple scrutiny. The responsibility devolving upon the practitioner and the chances of "getting away with" poor performance are therefore greater and the need for an ethical code to regulate the situation is therefore more pressing.

The foregoing discussion has brought forward some of the more important structural features, kinds of
professional practice and their effects on the nature of the relationship between professional and client which either enhance or reduce the need for an ethical code to regulate these relationships. But the mere existence of a need for a code is not sufficient to determine its introduction (let alone its enforcement) and the factors having the greatest force for the articulation of a code must now be sought within the structure of the profession itself.

If it is true, as was suggested earlier, that a code owes its existence to a group of which it is the product, it would be reasonable to suppose that the likelihood of a code being formulated depends upon the solidarity and common purpose of the professional group. It follows, other things being equal, that occupational features which are common to all members of the profession, which mark them off sharply from cognate occupations, and which place them in a strong position vis-à-vis their clients, will be conducive to the emergence of an ethical code. The more "exclusive" the occupation and the more visible its exclusiveness, the greater the similarities of the daily occupational tasks of its members, and the more divided and numerous the consumers of its services, so
will the solidarity and strength of the profession be greater.¹

Perhaps the first and most important marks of this exclusiveness are education and training. Rigorous educational requirements and extended and difficult training separate a professional field from invasion and overlap by other occupations. If, moreover, there is only one way of entering an occupation, if a single, specific qualification is required for entry, and if the untrained and unqualified are rigidly excluded, then the chances of a code being introduced are stronger.

If there are important and fundamental similarities in the daily work of the members of a professional group then the occurrence of specialisms within the profession is not likely to be of crucial significance in vitiating solidarity born of common interests and common problems. This is clearly a question of degree. In medicine for example, where specialization is rampant, the sense of common identity is still strong and overriding despite the emergence of specialism and even

¹ Further support of this statement and additional criteria of professional solidarity are given in the chapter on Professional Associations.
of professional groups clustering about regional interests. In engineering, on the other hand, the specialties, and the differences in the daily work situation, are sufficiently radical for the practitioners in the different regions to perceive only a tenuous professional connection. This reduces (but of course does not eliminate) the chances of a code being adopted, and, if is is, it is more likely to be concerned mainly with the general responsibilities of the professional situation than with the minutiae of intra-professional obligations and etiquette.¹ Overall, then, a trend to specialization which begins to obliterate important occupational similarities is professionally divisive whereas if the type of work available for members of a given profession is fairly uniform, professional solidarity is more likely to remain strong.

The forms of employment which prevail within a profession and hence the nature of the contractual arrangements (the "market situation") between professional and clients or employers are determined largely by the

¹ That this is in fact the case, is apparent from a comparison of the ethical codes of the Institution of Engineers, Australia, and the Australian Medical Association, where the degree of specificity in the latter is incomparably greater.
number of employers. Where there are multiple employers and especially where there is a degree of competition between employers for the professional service, the professional identity is more easily preserved and the circumstances are more propitious for the establishment of a code. But where a single employer dominates the scene (e.g. teaching) professional prerogatives and identity tend to be lost in hierarchial and bureaucratic rules (which, as suggested above, may nevertheless concede certain professional prerogatives).

So far as the factors affecting the likelihood of introducing an ethical code are concerned, the extent to which a profession controls the behaviour of its members is of crucial importance. And effective control of behaviour is largely a question of organization. If a profession is so organized that it is in a position to impose sanctions for misconduct then it is likely to specify the circumstances under which the sanctions will apply, and these specifications are therefore more likely to appear in a formal code. If the profession is so organized that it controls the qualifications for entry to the profession then it has an important weapon for controlling conduct; the more so if expulsion from the professional organization automatically results in
cancellation of the qualification to practise. More commonly, however, the qualification to practise is governed by statute and de-registration is the prerogative of a Statutory Board. Nevertheless, professional members predominate on these boards and the professional organization thereby exercises an indirect authority in respect of breaches of "professional conduct". Expulsion from a professional body which does not entail loss of the qualification to practise may nevertheless be an important sanction if the structure of the profession is such that it results in the withdrawal of colleague-support and co-operation and if this support is important for the professional livelihood. Informal sanctions of this kind are significant in private medical practice, which depends to an important extent upon referrals, consultations and "good standing". But, even so, it must not be forgotten that this in turn depends upon the degree to which the profession is organized and the extent to which the members belong to and actively support the professional association. In the last resort then, enforcement of an ethical code, if one exists, depends either on the statutory registering body or on the organizational strength of a professional association which has the will, and the formal or informal sanctions, to enforce a code.
To sum up, it has been argued that the factors influencing the establishment of an ethical code can be divided into two groups. On the one hand there are those features pertaining to the nature and circumstances of professional practice, which determine the need for a code, and on the other hand there are those elements of the structure of the profession itself which set limits to the possibility of a code being successfully introduced. At the one extreme there is the solo practitioner involved in a direct, personal, fiduciary relationship with his client and practising a complex art which is quite beyond his client's comprehension. This is a situation pregnant with diverse and important moral implications for both practitioner and client and as such needs an ethical code to order it. Conversely, and at the other extreme, is the situation of the professional in a bureaucratically-organized institution using a widely-understood technique in simultaneous dealings with a number of clients. In this situation, it has been suggested, the need for a professional code (distinct from the rules of the institution) is not pressing.

Granted, however, a certain degree of need, the likelihood of a code being established will be mediated
by such elements of the professional structure as nature of training, the presence or absence of multiple qualifications, uniformity of work, number of employers or clients, strength of professional organization and presence or absence of a Statutory requirement to register prior to practice.
CHAPTER IV

THE ANALYSIS OF ETHICAL CODES

We are now in a position to take up the deferred task of analyzing professional codes in terms of intra-professional, professional-client and professional-public relationships, which, as was suggested earlier, constitute the three main relational categories of professional work. The professions to be examined will be Law (or rather, Solicitors), Medicine, Engineering and Architecture.¹

Other investigators have adopted different approaches to the analysis of codes. B.Y. Landis posited four classes:²

(i) A collection of specific rules.
(ii) A mixture of specific rules, plus general principles which set no standard.
(iii) Only general principles.

¹ For copies of the Codes of Ethics of the Australian Medical Association, the Institution of Engineers, Australia, and the Royal Australian Institute of Architects, see Appendix 1.
(iv) General principles constantly applied by the rulings of practice committees.

But this does not take us very far in revealing the direction of interest of the professional codes in question. The classification of the types of professional relations implied by the codes and the method and extent of their enforcement (or non-enforcement) seem, therefore, to be the approaches most likely to reveal some of the social processes at work.

Following Millerson, ethical codes may be analysed by abstracting from them certain fundamental conventions, rules, or required observances, and classifying them along two dimensions -

(i) the type of relationship involved, e.g. professional-public; professional-client; professional-professional;

(ii) the "moral" or "ethical" quality which is served by observance of the rule, e.g. "loyalty", "responsibility", "service", etc.

Applying this technique to the ethical codes of the Institution of Engineers, Australia, the Royal Australian

---

<table>
<thead>
<tr>
<th>Professional Relationship</th>
<th>Loyalty</th>
<th>Responsibility</th>
<th>Service</th>
<th>Independence</th>
<th>Remuneration</th>
<th>Advertising</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and Client</td>
<td>9. Must act impartially in administering contract (Arch., Eng.)</td>
<td>12. Must inform client of conflicts of interest (Arch., Eng.)</td>
<td>14. Must provide service of high standard (Arch.)</td>
<td>17. Must not place himself under obligation to those with whom client or employer has dealings (Eng.)</td>
<td>18. Must uphold scale of charges (Arch., Eng., Law)</td>
<td>21. Must not solicit professional isications in accordance with rules prescribed by professional association (Eng., Law)</td>
</tr>
<tr>
<td>Professional and Professional</td>
<td>11. Must act as faithful adviser to client (Eng., Med.)</td>
<td>13. Must constantly work to improve his skill (Med.)</td>
<td>15. Must work assiduously and conscientiously (Eng.)</td>
<td>19. Must not engage in another occupation which brings work or may compromise position (Law)</td>
<td>22. Must not solicit professional work from colleagues when necessary (Eng., Law, Med.)</td>
<td>23. Must report breaches of code by colleagues (Arch.)</td>
</tr>
<tr>
<td></td>
<td>23. Must compete fairly with colleagues (Arch.)</td>
<td>26. Must promote advancement of the professional subject (Arch.)</td>
<td>27. Must advance training of subordinates (Eng.)</td>
<td>31. Must not give or receive commission or discount (Eng., Law, Med.)</td>
<td>33. Must not engage in professional competitions in accordance with rules prescribed by professional association (Arch., Eng.)</td>
<td>35. Must not advertise except in accordance with rules of the profession (Arch., Eng., Law, Med.)</td>
</tr>
<tr>
<td></td>
<td>24. Must maintain good relations with colleagues and observe rules of professional courtesy and etiquette (Arch., Eng., Med.)</td>
<td>28. Must consult client's previous advisers, or only undertake work if previous advisor no longer engaged (Eng., Med.)</td>
<td>29. Must not call in question the integrity or ability of colleague unless in public interest (Eng., Med.)</td>
<td>32. Must not share client's fee with consultant colleagues (Med.)</td>
<td>34. Must not poach &quot;peach&quot; staff (Eng.)</td>
<td>36. Must not damage practice of colleague with whom formerly in professional relationship (Med.)</td>
</tr>
</tbody>
</table>
Institute of Architects, the Australian Medical Association, and, so far as it is possible to do so, to the regulations made under the Legal Practitioners Act and the Rulings of the Law Society, yields a classification of ethical statements in terms of the two dimensions mentioned, as shown in Table 1.

The extent of overlap between professions, and the divergences in terms of ethical orientation or preoccupation, is brought out in Table 2 which indicates whether a given element appears in one or several of the codes. Bearing in mind that the absence of a certain kind of statement does not necessarily mean that the profession concerned has no interest in the subject concerned (it is taken for granted, for example, that the members of the profession will give best service and behave with dignity, and that a formal statement to this effect is therefore unnecessary), it is nevertheless reasonable to assume that the presence of a certain kind of statement does indicate either, or both, a manifest or latent function. The elements which occur most frequently in the codes are, first of all, the proscription of advertising except in carefully defined ways, which appears in all four codes; injunctions to maintain the scale of professional charges; to eschew commissions and
| Profession & Professional Association | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 |
|--------------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|
| LAW (Law Society)                    | X |   |   | X |   |   | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| ENGINEERING (Institution of Engineers Australia) | X | X |   | X | X | X | X |   |   |   | X | X | X | X | X | X | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| ARCHITECTURE (Royal Australian Institute of Architects) | X | X |   | X | X | X | X |   |   |   | X | X | X | X | X | X | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| MEDICINE (Australian Medical Association) | X | X | X | X | X | X | X | X |   |   |   | X | X | X | X | X | X | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| FREQUENCY                            | 3 | 3 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 2 | 1 | 3 | 1 | 7 | 2 | 3 | 1 | 3 | 7 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 3 | 1 | 4 | 1 |
discounts; to accept remuneration only by fee or salary and to refrain from soliciting; and exhortations to serve the community and uphold the dignity and honour of the profession.

Although analysis along these lines gives a reasonable indication of the range of interests of the professional codes, and those which recur from one profession to another, it does not give any indication of the relative importance of some interests as against others within a profession. Clearly, there can be no infallible or wholly reliable measure of relative importance, but content analysis of the professional codes in terms of amount of space devoted to certain areas of responsibility does give some insight and yields a gross measure.

Thus, if the elements and dimensions dissected in Table 1 are re-combined and generalised in terms of areas of responsibility, they fall into five groups:

(i) General responsibility to serve clients and the community and to obey the conventional ethical principles of the society.

(ii) Specific responsibilities to client or society.

(iii) Responsibility for skilful practice of the
(iii) profession and the advancement of the professional art or science.

(iv) General responsibilities to professional colleagues or mode of professional practice.

(v) Specific responsibilities to professional colleagues or mode of practice or public behaviour in a professional respect.

The foregoing groups can be further classified into two broad categories, which may be called "extrinsic" and "intrinsic", the former including those responsibilities which are external to the professional group (the "profession" in its corporate sense), and the latter those which are internal to the profession and which serve to regulate group divisiveness and competition and to minimise sources of friction in intra-professional contacts.

If the content of the ethical codes of the Australian Medical Association, the Institution of Engineers Australia, and the Royal Australian Institute of Architects are then analysed quantitatively for the amount of space, in words,

1 In this instance the Federal Code is used.

2 Because of the absence of a consolidated, formal code for solicitors, no attempt has been made to include legal ethics in this analysis.
<table>
<thead>
<tr>
<th>Professional Body</th>
<th>(1)</th>
<th>(1i)</th>
<th>(1ii)</th>
<th>Sub-Total</th>
<th>(4)</th>
<th>(4i)</th>
<th>(4ii)</th>
<th>Sub-Total</th>
<th>Total</th>
<th>Length of Code (No. of words)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General responsibility to</td>
<td>Specific responsibilities</td>
<td>Responsibility for skillful</td>
<td></td>
<td>General responsibilities</td>
<td>Specific responsibilities</td>
<td>Professional practice or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>serve clients and community</td>
<td>for client or society</td>
<td>practice and advancement of</td>
<td></td>
<td>to professional colleagues</td>
<td>for professional practice or</td>
<td>mode of professional practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and to obey conventional</td>
<td></td>
<td>professional art or science</td>
<td></td>
<td>or mode of professional</td>
<td>or public behaviour in a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ethics of society</td>
<td></td>
<td></td>
<td></td>
<td>practice</td>
<td>professional respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Medical Association (Federal)</td>
<td>10.1</td>
<td>18.8</td>
<td>2.1</td>
<td>31.0</td>
<td>65.4</td>
<td>69.0</td>
<td>100.0</td>
<td></td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>Institution of Engineers, Australia</td>
<td>15.4</td>
<td>15.4</td>
<td>3.0</td>
<td>32.8</td>
<td>55.4</td>
<td>86.2</td>
<td>100.0</td>
<td></td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td>Royal Australian Institute of</td>
<td>25.0</td>
<td>16.7</td>
<td>2.8</td>
<td>44.5</td>
<td>50.0</td>
<td>55.5</td>
<td>100.0</td>
<td></td>
<td>500</td>
<td></td>
</tr>
</tbody>
</table>
devoted to each of these five areas of responsibility, the results are as shown in Table 3.

The table reveals two significant trends. First, the preponderance of "intrinsic" material over "extrinsic" in all cases and, second, the tendency for this preponderance to increase as the code itself becomes longer and more detailed.

By far the most attention is paid in all codes to category (v), which refers to detailed prescription of the professional's obligations to his colleagues, to matters of etiquette, and to carrying on his practice in ways which do not infringe colleague-prerogatives or give him a professional (especially economic) advantage.

In the face of this, some scepticism is justified in relation to Morris Cogan's dictum, quoted earlier, that one of the distinguishing marks of a profession is that it "considers its first ethical imperative to be altruistic service to the client". Rather would it appear that the vital function of the codes and the most cogent of their ethical imperatives concern the management of colleague-relationships and the maintenance of associational stability.

---

But to draw this conclusion is to place undue weight on the mere quantity of intrinsic material in the codes, and this may not necessarily reflect the relative extent or strength of motives oriented towards "altruistic service to the client". This issue may, however, be clarified by considering the zeal with which the professions enforce their codes. As Millerson argues:

Level of enforcement seems more important. At what point is the regulating authority prepared to act? It does not matter whether a code is implicit or explicit; an idealistic objective or a working reference; a positive statement allowing action or a negative statement limiting behaviour. The essential consideration remains the point and degree of enforcement. This is one of the questions taken up in the next chapter.

---

1 Loc. cit.
CHAPTER V

THE FORMULATION AND ENFORCEMENT OF ETHICAL CODES
AND POLICIES - SOME AUSTRALIAN EXAMPLES

Whether or not it is possible to make valid
judgements as to what is and what is not "ethical" conduct
raises questions of moral preference and moral philosophy
beyond the scope of this essay. The sociologist concerned
with professional ethics is limited, at least in the first
instance, to the description and classification of moral
attitudes and sentiments and moral statements (irrespective
of their logical status and consistency), as social facts.
The fact of moral consensus or dissensus may be studied
independently of the views of the participating parties.
So in studying professional ethics one is not necessarily
concerned with an evaluation or critique of moral
attitudes and the assumptions which underlie them. It is
sufficient for the sociologist's purpose to note the
directions of interest and, if possible, to bring out
formal and contextual similarities and contrasts which may
be connected with structural and functional features of
the professions in question.

If forced to give a moral characterization of the
prevailing professional ethical codes the simplest answer
would be to describe it as the Protestant Ethic coloured by the code of the English gentleman\(^1\) of a century or two ago. But even this "simple" description covers what is in fact a highly complex situation, as it is hoped to show. In all of the codes certain general ethical principles are taken as settled and the professional codes are then seen casuistically as special instances of their application.\(^2\)

The history of the established professions of Law, Medicine, Engineering and Architecture in Australia is continuous with their earlier history in England and, with the notable exception of nationalized medicine in Britain, their present modes of practice and organization are basically similar.

Ethical orientations, attitudes towards questions of professional conduct, and procedural mechanisms, therefore reflect their English origins.

---

\(^1\) The first professional organization of lawyers in England was the formation, in 1739, of the Society of Gentleman Practitioners in the Courts of Law and Equity. Consider also the phrase "Gentlemen by Act of Parliament" commonly used of solicitors, the authority for which is believed in some quarters to be derived from an Act of Henry V.

\(^2\) E.g., Paragraph 5.2 of the Code of Ethics of the Australian Medical Association: "These statements illustrate the practical application of ethical principles...."
Solicitors in New South Wales and the Role of the Law Society

The formal arrangements for dealing with questions of ethics and professional conduct for solicitors in N.S.W. involve, apart from the common law, both the Law Society of N.S.W. and The Legal Practitioners Act 1898-1967. The Society has not promulgated a formal code of ethics and (perhaps not surprisingly in view of the profession concerned) the considered views of the Society on ethical questions are to be found only in its "Rulings" which have not been officially consolidated or codified in any way.\footnote{1}

In 1843 the members of the legal profession in New South Wales decided to establish the N.S.W. Law Society

...to promote good feeling and fair and honourable practice amongst members of the profession so as best to preserve the interests and retain the confidence of the public in conjunction with their own just rights and privileges; to aid all such measures as shall best promote a cultivated understanding and propriety of conduct in articled clerks during the period of clerkship; to attend to all applications for admission, so as to guard the Court, the public, and themselves from persons disqualified by conduct or education from being admitted to the profession; and to offer to the proper authorities from time to

\footnote{1} A valuable compendium of rulings has been put together by R.J. Atkins, The New South Wales Solicitor's Manual, Law Society of N.S.W., 1967, pp.151-172.
time such efficient new Rules of Practice as may appear useful and necessary for the conduct and despatch of business, with due regard to the saving of expense to suitors. ¹

This is as concise a statement as may be found of the grounds of association and ethical objectives of professional associations in general and reflects the typical ethical attitudes of the professions of that time, following English precedents and traditions.

Under the Legal Practitioners Act, The Law Society is recognised as the administering authority in respect of certain functions in the government of the profession, subject to the overriding authority of the Court itself, since Section 79 states that "nothing in this Act contained shall prejudice, diminish, or affect the jurisdiction, powers and authorities which are exercisable by the Court over Solicitors."² Nevertheless the powers exercised by the Law Society, as a body representing solicitors, are considerable and include, inter alia, power -

(i) to issue and cancel Annual Practising Certificates;

(ii) to regulate and enforce professional standards of conduct in the practice of a solicitor's profession;

¹ Ibid., p.4.
² Ibid., p.6.
(iii) to provide the membership of a Statutory Committee to exercise disciplinary functions and to investigate and refer to such Committee matters for the exercise of its functions;

(iv) to protect the public against dereliction of duties by a solicitor and to move the Court for the appointment of a receiver of a solicitor's practice in certain circumstances.

In effect, therefore, Parliament has endowed the professional body with statutory authority to take the initiative in protecting standards of professional conduct and to deal with breaches. An important instrument of this machinery is the Solicitors' Statutory Committee (provided for under the Act) set up for the purpose of hearing charges (brought by the Law Society or Court) of professional misconduct on the part of solicitors. Although the Statutory Committee operates independently, in practice the Council of the Law Society suggests the names of suitable appointees to the appointing authority (the Chief Justice) and these have usually served on the Council. Any person may make a charge of professional misconduct in writing to the
Council of the Law Society which may then investigate it and either dispose of it itself or refer it to the Statutory Committee. A complainant may, however, insist on a formal charge being referred to the Statutory Committee. The committee has powers of expulsion and suspension and may fine up to $1000.

For guidance on professional conduct, the solicitor has no formal code to which he can turn but must find it, with the exception of a few matters covered in Regulations under the Legal Practitioners Act, in the precedents and customs of professional life or refer to the recorded rulings of specific determinations by the courts and the Law Society. Even then, of course, the rulings or judgements simply reflect, for the most part, the generalisations of a conventional view of morality and "professional responsibility".

A charge of misconduct as relating to a solicitor need not fall within any legal definition of wrong doing. It need not amount to any offence under the law. It is enough that it amounts to grave impropriety affecting his professional character and is indicative of a failure either to understand or to practise the precepts of honesty or fair dealing in relation to the Courts, his clients or the public. The particular transaction must be judged as a whole and the conclusion drawn whether it betokened unfitness to be held out by the Court as a member of a profession in whom confidence could be placed.\footnote{Dictum of Mr Justice Rich in Kennedy v. Incorporated Law Institute, quoted in Atkins, op. cit., p.48.}
So far as the professional conduct of solicitors in New South Wales is concerned, therefore, the guidelines are a species of common law within the common law and, except for the grossest derelictions, the Law Society is its day-to-day guardian.

**The Law Society and Ethics**

The Law Society of N.S.W. does not keep a statistical account of the number of ethical issues which are referred to it in the course of a year nor does it attempt any formal classification of types of issues. Many matters are disposed of with a telephone call to the Law Society but more serious complaints require that the complainant (if a member of the public) must make a statutory declaration which then forms the basis of an investigation by the officers and Council of the Society.

It is estimated that approximately 200 complaints are received from members of the public each year. There are some 3500 solicitors in practice in New South Wales (i.e. in a population of about 4.5 million). Complaints by one solicitor about the conduct of another are much less frequent.

The most common complaints levelled against solicitors (not necessarily in order of frequency) are:
misuse of Trust Funds;
(b) gross carelessness;
(c) being a party to the swearing of a false affidavit;
(d) persistent and unreasonable delay;
(e) failure to answer correspondence.

The Chief Executive Officer of the Law Society made the interesting observation that the majority of ethical complaints, and more serious charges, arise in relation to solicitors in solo practice, presumably because they are more economically vulnerable, more often overworked, and more frequently subjected to pressures through illness, than those in partnerships or large firms. A similar trend was evident in Carlin's investigation of New York lawyers.¹

Engineers and the Role of the Institution of Engineers, Australia

The Institution of Engineers, Australia, was established in 1919 and incorporated by Royal Charter in 1938. A formal Code of Ethics was first introduced in 1923 and remains substantially unchanged in the version most recently promulgated (June, 1966).

Revisions of the Code of Ethics and the interpretation and consideration of ethical issues are the responsibility, in the first instance, of the Ethics Committee of the Council of the Institution, but the Council is the supreme disciplinary authority.

Bye-law 96 of the Royal Charter and Bye-laws of the Institution provides that:

All members of the Institution shall observe and shall be bound by the Code of Ethics as approved by the Council from time to time and issued to the members. Any alleged breach of this Bye-law shall when brought under the notice of the Council be investigated and the Council may exercise the powers conferred on it by the Charter in respect of the temporary limitation of the privileges of membership or deal with the matter under Bye-law 55.

Bye-law 55 says, inter alia, that

The Council shall have power to expel or suspend any member or Affiliate who in the opinion of the Council has failed to observe a high and honourable standard of professional conduct or the requirements of Bye-law 96, or who is believed by the Council to be or have been guilty of any act or conduct which the Council may consider is or may be detrimental to the best interests of The Institution or its members.

As laid down in Bye-law 55, the only sanctions available to the Council in dealing with misconduct are expulsion or suspension, neither of which deprives an engineer of his right to continue in employment or practice. Whatever force the sanction has applies
primarily to the engineer in private practice (either solo or in partnership) but, because of the different structure of the profession, which depends a great deal less on referral and consultation, this does not penalise to the same extent that it does in medicine.

In the last 22 years the Council has expelled only three members, and in each case expulsion followed civil convictions for criminal offences. All three were employees.

Although the Institution, like the Law Society, does not keep statistical records of complaints, the Secretary of the Institution has indicated that "only two or three" are received each year. Apart from the occasional complaint about overcharging a client, the most common ethical complaint is an accusation of "advertising" levelled by one engineer against another.

Architectural Practice: Statutory Provisions and the Role of the Royal Australian Institute of Architects

No one may practise as an architect in Australia unless he has the registrable qualifications prescribed under State legislation, and this legislation usually describes in general terms the causes for which an architect may be de-registered. The Architects Act, 1921-1957, of New South Wales is typical. The
formalities of registration and the supervision of conduct are the responsibilities of the "Board of Architects of New South Wales", provided for under the Act and consisting of two members appointed by the Governor; two practising architects; the Dean of the Faculty of Architecture in the University of Sydney; the Professor of Architecture in the University of New South Wales; and the President and Senior Vice-President of the New South Wales Chapter of the Royal Australian Institute of Architects.

Section 17 (i) of the Act provides, inter alia, that an architect may be de-registered if -

(a) he is convicted of a felony or misdemeanour;
(b) he accepts a commission from a contractor or supplier to any building of which the architect is the designer or supervisor;
(c) he is guilty of "infamous conduct in a professional respect";
(d) he enters into collusion with a builder against the interests of a client.

The Act also provides penalties for breaches of various technical kinds, punishable by fines.

The Royal Australian Institute of Architects was incorporated in 1930 and has always had a formal code of
Ethics. Article 52 ("Professional Misconduct") of the Institute's Memorandum and Articles of Association provides that:

Any member conducting himself in a manner which in the opinion of the Council is derogatory to his professional character, or which is likely to bring the Institute into disrepute or to lessen the confidence of the public in the Institute or in the Profession, or is contrary to the standard of ethics and professional practice from time to time established by the Institute, or who shall engage in any occupation which in the opinion of the Council is inconsistent with the profession of an architect or who in the opinion of the Council shall be guilty of misconduct in a professional respect, shall be liable to reprimand, suspension, a fine not exceeding $200, or expulsion in manner hereinafter provided. Any member who may be convicted of any felony or misdemeanor or of any offence which if committed within the State in which he resides would be a felony or misdemeanor shall, ipso facto, cease to be a member of the Institute.

Article 53 then goes on to describe the procedure for investigating and dealing with charges lodged under Article 52.

The general specifications of Article 52 concerning conduct are articulated at more length by the Institute's recently revised "Code of Professional Conduct", but even so this Code is still couched in generalities (e.g. "to provide professional services of a high standard"; "to maintain a high standard of personal integrity", etc.)
This has apparently come about as the result of consideration and deliberate policy on the part of the Council of the Institute, since the Secretary of the Institute has indicated that the "old code was very restrictive and primitive".

The present code is relatively specific, however, in regard to two matters:

(a) advertising and publicity;
(b) supplanting, or attempting to supplant, a member.

"Advertising" by a member is, in fact, the most common subject of complaint by other members and about four or five cases annually are dealt with by the Institute either informally or by an official reprimand after enquiry. The second most common complaint concerns efforts by one architect to supplant another, but the total number of cases in any one year is "very small".¹

Occasional charges are levelled (very infrequently) of incompetence or negligence, or overcharging or fee-cutting.

Within the twelve months ended September 1969, no members were expelled for misconduct.

¹ Information supplied by the Secretary of the Royal Australian Institute of Architects.
Medical Practice and Statutory Authorities

In all Australian states the right to practise medicine is governed by State Acts and the position in New South Wales is similar to that in the other states. The New South Wales Medical Practitioners Act provides for the registration of those who satisfy the New South Wales Medical Board, a statutory body appointed under the Act, as to their medical training. The membership of the Board comprises nominees of the Minister for Health, the Australian Medical Association, the Senate of the University of Sydney, the Council of the University of New South Wales, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal Australian College of General Practitioners and the Under Secretary of the New South Wales Health Department. Medical members predominate.

Charges of infamous conduct from any source are referred to the Board of Health and, if the Board believes the circumstances warrant it, are passed on to the Disciplinary Tribunal constituted under the Medical Practitioners Act. The tribunal may de-register a practitioner convicted of a felony or misdemeanour or a practitioner who has been found guilty of infamous conduct (e.g. drunkenness, seducing a patient).
In 1968, the New South Wales Medical Board de-registered two practitioners by direction of the Disciplinary Tribunal, but the cause of action was not disclosed.\(^1\) The Disciplinary Tribunal also dealt with six other cases involving, variously, charges of having been convicted of criminal offences; of drug addiction; of writing false prescriptions; and of not supplying drugs to a person named in a prescription. Although the penalties, if any, are not revealed, it may be inferred that no more than two of the doctors were de-registered.

The Board expressed concern, in its most recent report,\(^2\) over the proliferation of private practices (usually group practices) styling themselves "medical clinics" and "medical centres" and deplored the possibility that this practice may give some "an unfair advantage" over their professional colleagues.

The Australian Medical Association and Professional Ethics

Article 13 (a) (b) of the Memorandum and Articles of Association of the New South Wales Branch of the Australian Medical Association provides, inter alia, that membership of the Association may be terminated

---

\(^1\) Report of the New South Wales Medical Board 1968, N.S.W. Government Printer.

\(^2\) Ibid.
...by expulsion (after the inquiry and in the manner prescribed by the next succeeding Article) on the ground that the conduct of the member is detrimental to the honour and/or interests of the medical profession or of the Association or is calculated to bring the profession or the Association into disrepute or contempt or on the ground that the Member has grossly contravened the customs of the medical profession....

By-law 34 of the By-laws of the New South Wales Branch lays down the elaborate procedure to be followed in determining "questions as to whether a medical practitioner, has been guilty of conduct detrimental..." etc., and makes provision for the establishment of an Ethics Committee which shall be especially responsible for attending to general ethical questions and for the investigation, if need be, of actual cases involving ethical questions.

The detailed written Code of Ethics of the Association is derived from the rulings of the General Medical Council of Great Britain on what constitutes "infamous conduct in a professional respect". The Code is therefore directly linked with the English tradition of medical ethics and is thus a codification of "professional common law" in medicine.

The bodies concerned with the formulation and enforcement of ethical policy are the Federal Council of the Australian Medical Association, and the State Branches.
The Federal Assembly of the A.M.A., which is a council of State Branches, is responsible for formulating the general ethical principles which are held to be binding on all doctors, whilst the State Branches may also promulgate more detailed material, on the understanding that it will be consistent with Federal principles. There is, however, no formal machinery for ensuring that this must always be so. Both the Federal body and the respective State Branches issue handbooks of ethics to members and there are large sections of the State handbooks which are identical with the Federal handbook.

The initiative for changes in the Federal Code may come either from the Federal body or from the State Branches, but they must be approved by the Federal Assembly.

It is the State Branches, rather than the Federal body, which deal with ethical transgressions which do not fall within the scope of the State Medical Practitioners Acts; that is to say, the less serious breaches or, as the lawyers style it, "unprofessional conduct" (as distinct from "professional misconduct").1 If more

---

1 The reader will see affinities between this distinction and the distinction made elsewhere between "professional ethics" and "professional etiquette").
serious charges are brought to their attention, the complainant would be advised to take action through the courts or to refer to the Department of Health or Medical Board, depending upon the appropriate procedure in the State concerned.

At State Branch level, formal notice is taken of a complaint by referring it to the Ethics Committee after the complainant and the defending doctor have been given the opportunity to describe, explain and defend their respective positions - usually by correspondence. The Ethics Committee then adjudicates and if it believes the charge has been substantiated, may recommend a reprimand, suspension, or expulsion.

The great majority of complaints come, as might be expected, from aggrieved patients or from other doctors. No reliable statistics are available on the number of complaints received annually by the New South Wales Branch of the A.M.A. from members of the public and from patients, but the Medical Secretary of the N.S.W. Branch says that they are "very few". Those that are received concern, almost exclusively, disputed accounts or rudeness by the attending doctor.

Statistics are not kept of complaints registered by doctors against one another. The Medical Secretary of
the New South Wales Branch of the A.M.A. estimated that the number of cases would not exceed six per annum. It appears, however, that the most common complaints are:

(a) encroachment and supplantation ("patient stealing");

(b) advertising or undue personal publicity by a doctor in private practice.

The Implementation of Standards of Conduct

In this review of the statutory and associational provisions for the control of professional conduct in four professions, authority is seen to be of two kinds:

(i) Statutes provide for the registration of qualified practitioners and a Board (or equivalent body) representative of professional interests is empowered to punish misconduct in accordance with power given under the Statute. Serious penalties, including prohibition of further practice, may be imposed upon a practitioner who misconducts himself (Medicine, Law, Architecture).

(ii) Registration is not required in order to practise the profession, but the profession is dominated by an association, membership
(ii) of which is necessary for certain types of appointment or promotion. Expulsion from the association may therefore cut off opportunities to fill certain appointments or to receive promotions, but it does not prevent continued practice (Engineering).

There is, of course, a third situation, not represented by the four professions discussed, where the profession is unregistered and not dominated by a particular association, so that practice is not dependent upon membership. This is especially the case with the scientific, academic and artistic professions; those professions in the main, which are either dominated by institutions or organizations and which do not deal directly with the health, liberty or property of citizens in relationships of special trust.

These three kinds of control cover the gamut of disciplinary effectiveness from power to end a professional career to power to inflict only a transitory inconvenience.

However, in terms of effectively controlling professional conduct, this power is futile in the absence of vigilant surveillance of behaviour and the will to punish transgressions of the law or the codes. Effective
surveillance involves not only the profession but also the provision of practicable procedures whereby clients or public may register protests and have them attended to.

One of the most striking features of the four professions discussed is the apparent lack of concern on the part of the appropriate professional associations with the surveillance of professional conduct and the enforcement of ethical codes. No records in the form of formal statistics or classifications of complaints or punitive actions taken are maintained and, from the slight information which is available, it would appear that professional misconduct is remarkably rare. There are, for example, over 14,000 doctors in Australia who belong to the Australian Medical Association.\(^1\) If it is conservatively assumed that 10,000 of them are in active, daily practice, and if it is further conservatively assumed that each of these doctors has an average of 150 patient-consultations per week\(^2\) for 48 weeks of the year, then there are something like 12 million patient-doctor

---

contacts between members of the A.M.A. and the public each year. Yet "very few" of these contacts are the subject of complaint, let alone formal investigation, by the A.M.A. A similar situation obtains within the other professions discussed.

On the whole, it would seem that the professional associations, by the evidence of their keen concern with breaches of the codes in respect of advertising and supplantation, are more interested in maintaining intra-professional solidarity than with policing professional-client relationships. When this is conjoined with the preponderance of "intrinsic" obligations in the formal codes, observed in the preceding chapter, it seems reasonable to conclude that professional stability and the preservation of associational bonds within the profession are amongst the most important functions of professional ethics. Nevertheless, this is not to say that high standards of fair dealing with clients and public do not prevail, nor that the claims of "service" are ignored by the professions discussed. There is no real evidence of this. The lack of machinery for effective surveillance of professional conduct might well indicate that no such machinery is needed, but in the absence of reliable knowledge about standards of conduct and service generally, this must remain an open question.
CHAPTER VI
THE PROFESSIONS AND SOCIETY

The role of professional ethics in ensuring conformity between professional practices and the ethical expectations of society, and in ordering the moral relations between the professions and the public, has already been referred to.

In this chapter attention will be paid, first of all, to the way in which the exercise of professional skills in certain contexts can throw into relief the ethical presuppositions which underlie the exercise of the professional "licence and mandate". Such situations arise with special sharpness and variety in medical practice, so illustrations will be drawn from that profession.

The second major theme of this chapter will be the way in which the development of professional ethics can be treated as a response to the social need to control the independent exercise of professional skills in the service of social values (e.g. health, justice, etc.)

"Medical Ethics"

Within the medical profession a distinction is sometimes made between "professional ethics" and "medical
ethics", the former term being used to refer to the principles and conventions which govern extra-professional and intra-professional relationships generally, while the latter has the more restricted sense of those medical procedures which are morally right or wrong in certain definable circumstances. Medical ethics, in this sense, is therefore a special area of professional ethics and the interest and keen discussion the subject often evokes in medical and lay circles is due to the fact that it raises questions of general ethical debate (e.g. the desirability of therapeutic abortion, heart transplants, the definition of death, etc.) which, in their practical carrying out, must necessarily involve medical procedures, and hence the application of professional skill and knowledge which, in the "ethical definition of the profession", can only be exercised in accordance with the requirements of an ethical consensus. By acting contrary to the prevailing consensus (e.g. in procuring unlawful abortions) the profession as a whole runs the risk of losing its "licence and mandate". Therefore, until public opinion changes (i.e. until a new consensus is established), the profession will invariably
discountenance, or, as in a recent example, force the resignation of, any of its members who exposes it to this risk - and this despite the fact that a substantial body of medical opinion, perhaps even a majority, may run counter to the popular consensus.

Although there is no reason to suppose that the doctor's ethical acumen is superior to anybody else's, he is nevertheless able to make an important contribution to debate on the ethical aspects of controversial medical procedures by his knowledge of factual data which is not available to the layman, and especially through his close involvement with the consequences of these procedures on patients, relatives, etc. It is therefore not surprising, but to be expected, that doctors will often play a vital role in leading public opinion in new directions on such matters. Conversely, by exposing and

---

1 The case of Dr Wainer, the Victorian member of the A.M.A., who publicly confessed in 1969 to procuring abortions in an attempt to publicize, and force public debate upon, the current legal position in Victoria in relation to abortion.

2 See, for example, the series of articles and editorials on the subject of abortion in the Medical Journal of Australia during 1968 and 1969:
   (a) M.J.A., 1969, 2: Supplement, page 32 (20 September),
   (b) Ibid., 1969, 1: Supplement, page 39 (27 September),
   (c) Ibid., 1968, 1: 273, 359 and 499 (17 February, 2 March and 23 March),
   (d) Ibid., 1969, 2: 833-834 (25 October).
criticising medical procedures (e.g. certain sorts of clinical trials, "human experimentation", etc.) which entail risks to life and health which cannot be justified in relation either to therapeutic advance or climate of general ethical opinion, the doctor can bring public opinion to bear on those colleagues he believes to be acting wrongly.¹ But, to repeat the point, this is only possible if he has correctly judged that he is on the side of the prevailing consensus. Nevertheless, this sort of situation does draw attention to a more general issue in professional ethics; the responsibility which is held to devolve upon the professional to abandon his colleagues or to publicly declare the facts when, through his specialized knowledge, he becomes aware of actions or procedures which would not be condoned by society if it knew and appreciated what was going on. It is this sort of argument which was raised at the Nuremberg trials against the Nazi doctors and which is still heard in relation to the devising and

¹ Heart transplants would be a case in point. However, this was an especially interesting example of the complex interaction of opposed medical opinion, and public opinion, combined with a number of other factors, in bringing about a rapid change in both medical and lay attitudes in a relatively short period.
manufacturing of weapons of chemical and bacteriological warfare.¹

And it is here that one sees the nexus between professional ethics and general ethics, and the source of the dilemma which gives force and moral passion to some of the central issues in medical ethics. For if the doctor conscientiously accepts the responsibility to expose malpractice or incompetent and unethical professional behaviour, that is, if he accepts an obligation to serve the wider social ethic, then he can do so only at the risk of undermining the professional solidarity which it is one of the functions of professional ethics to maintain.

Perhaps it is the fear of division arising out of such ethical issues which partly explains the "conservatism" of official medicine in relation to them. There seems to be little doubt that the Australian Medical Association, for example, shies away from the adoption of an official position on abortion for fear either of raising doubts in the public mind about the ethical "reliability" of the profession or of dividing

¹ See, for example, J.B. Macdonald, "Medical Ethics Today", The Lancet, 11 March 1969, pp.563-564.
the profession itself. As the editorial writer of the "Sydney Morning Herald" put it in referring to the forced resignation of a member of the Victorian Branch of the A.M.A. over the question of abortion law reform:

Dr Wainer's break with the Victorian Council of the Australian Medical Association has weakened the few remaining hopes that officially the profession might play a more adventurous role in the debate on abortion law reform. From the time he confessed to his first abortion last June the A.M.A. in both Victoria and New South Wales has appeared more embarrassed by Dr Wainer than the legislators he set out to challenge.¹

Further difficulties arise, of course, at times of rapid social change and constant challenges to accepted ethical "principles". If a casuistical approach is taken to professional ethics, then casuistry becomes much more difficult when established orthodoxies crumble and "decisions as to conduct can no longer be referred to a generally accepted set of principles but have to be taken afresh in each individual case by each individual practitioner".² One consequence is confusion and debate within the profession as to what "ought" to be done in...

² Sir Roger Ormrod, "Medical Ethics", British Medical Journal, 6 April 1968.
various therapeutic (and non-therapeutic, but medical) situations. Perhaps another way of putting this is simply to say that any doctor, depending on his own history and his involvement with other social movements and groups, will have established a personal equilibrium between the ethical demands of his profession and his "conscience". In short, the nexus referred to above, of general and professional ethics, occurs also within the individual; the doctor is both citizen and professional and as such is the field within which the sometimes competing, sometimes co-operating demands of society and profession struggle for motivational supremacy. No doubt it is something like this which the leader writer of the Medical Journal of Australia had in mind when he wrote, in relation to the abortion issue:

It would be impertinent for us to suggest what should be the individual attitudes of doctors as citizens. Nor indeed would we presume to question the individual doctor's right to follow the dictates of his own conscience and judgement within the limits of the law and the generally accepted mores of our own profession. ...it is not the prerogative of the medical profession as such to determine the moral standards of the community or to frame the laws governing those standards..., on the other hand, the community

---

1 Emphasis ours.
cannot fairly impose upon a doctor as a professional duty a course of action that is repugnant to his personal conscience or seriously at variance with his professional judgement - as the procurement of an abortion can be.¹

Indeed, there are references in this statement to all of the major constraints which enter into the determination of professional ethics: "conscience", which stands for ethics in general and the particular attitudes and adjustments which they have engendered in minds; "laws" or the external compromises which broadly reflect and maintain a formal ethical consensus; "the mores of the profession", which, subordinate to "conscience" and "law", are guidelines to the forms such subordination should take; and finally, "professional judgement" which through its special knowledge and skill establishes what is the case and what must, or can, be done to bring about a certain (medical) state of affairs whose desirability is independently established by "conscience", "law" and "the mores of the profession".

Examples could be multiplied of the puzzles and dilemmas which are quoted in discussions of medical

ethics. Some, such as heart transplants and the
definition of death, abortion, and euthanasia, have
already been mentioned; but there are many others - the
duty of the doctor whose patient insists on working in
a food shop while suffering from a communicable
infection; the bus driver who suffers from giddiness;
the patient with syphilis who continues to sleep with
his wife, and so on.\textsuperscript{1} But interesting though these
problems might be in themselves, they are not of special
theoretical importance for the purposes of this essay
and all that need be said is that they vividly
highlight what is of theoretical importance - the
intersection of distinct moralities and the way in which
one morality (in this case the medical profession as
such) attempts functional accommodation with the larger
society in the interests (a) of maintaining the
solidarity and integrity of the professional group, and
(b) of preserving the free play of "professional
judgement".

\textsuperscript{1} Examples from Ormrod, op. cit., (1968)
Professional Ethics and Social Control of the Professions

In discussing "medical ethics" as a special instance of a general problem in professional ethics, one aim has been to demonstrate how the legitimation of a professional activity depends upon its compatibility with what society defines as good or worthwhile. The existence of professional enclaves within society would not be possible if professional ethics were not presumed to be, and manifestly seem to be, consistent with the "rules of universal moral application".¹ It is obvious, of course, that difficulties must arise where there is widespread uncertainty about the value or worthwhileness of the professional activity itself or the ends to which professional skills are regularly applied. But this is a special problem which can only be dealt with in outline here in order to throw into relief the main issue - the structural relationships between professional ethics and the social need to supervise those who have a special responsibility in the promotion and preservation of certain values.

Professional ethics can be seen as a species of social control. Law and Medicine, for example, are concerned with central social values - health, justice, liberty of the subject, protection of property - and the social control of those who are the expert custodians of these values poses special problems. The doctor or lawyer serves these central values by bringing to bear specialized and systematic knowledge to solve practical problems inherent in them; but because the non-professional does not share this knowledge he is unable to judge the quality of the professional performance and hence to impose two of the commonest forms of social control - supervision within a hierarchical, formalized context (e.g. bureaucratic organization) or evaluation and selection by the consumer.

In these circumstances the need for social control can be met in two ways - by individual and collective self-control within the profession or by the development of a class of "guardians" who, though trained in the profession concerned, owe primary allegiance to formal organs of control, such as statutory boards and tribunals, government departments, management, etc. But these are imperfect instruments if it is intended that they should be wholly detached in carrying out the job of
professional control since, quite apart from technical difficulties, their professional personnel will inevitably have absorbed the prevailing values and attitudes of the profession in the processes of professional training and professional socialization. This, as has been indicated elsewhere, will be especially true of those professions (e.g. Medicine) for which there is only one form of training and licensure, one main professional association and a relatively homogeneous professional culture.

In short, the guardians will still be "members of the profession" and thus not wholly autonomous or detached instruments of the social interests who wish to employ them. Their willingness to act at all will in large measure depend upon the consonance they see between the objectives of social control of the professions, and professional norms and values.

If the need for social control of professionals in their role as custodians of central social values cannot be met by external supervision, it must be met, or at least appear to be met, by mechanisms of control within the professional community itself and within the individual profession.
The main sources of this control are the professional organizations and professional socialization processes.¹

Because it lacks the knowledge effectively to do so, and in exchange for earnests from the professions of good faith and fair-dealing consistent with the general ethical system, society foregoes a very large part of its supervisory role so far as the professions are concerned and this privileged position carries with it high status, prestige and incomes well above average for the professions. (It is in this context, incidentally, that the adoption of a formal ethical code by an occupation aspiring to professional status assumes considerable symbolic force.)

If, as has been argued, the codes formulated by the professional associations and the informal usages of the profession have amongst their functions the protection of the integrity of the professional community whilst simultaneously preserving ethical conformity with the larger society, how, in practice, is this achieved?

Attention has been drawn elsewhere in this essay to the universality, within the established professions of

---

¹ See, for example, J.S. Western and D.S. Anderson, "Education and Professional Socialization", The Australian and New Zealand Journal of Sociology, 4,2, October 1968, 91-105.
Law, Architecture, Medicine and Engineering, of the proscription of advertising. It is reasonable to enquire into the function served by this rule. The first thing that comes to mind is the way in which the absence of advertising distinguishes the professions from the business world. In the business world, advertising has the manifest purpose of bringing to attention, describing, and evaluating, goods and services on the basis (among others) of invidious comparisons with rival goods and services. It assumes that the consumer can judge the product, on the whole, in terms of rational criteria.\(^1\)

But it is inherent in the nature of professional services that the "consumer" (the patient, client or employer) is not a wholly reliable judge of professional performance because he lacks the necessary knowledge. Advertising of professional services would therefore take it for granted that consumer judgements, not professional assessments and criteria, should be the dominant influence on professional standards, and this would make it impossible to keep professional standards high since control would have passed from the hands of those with the knowledge to evaluate them.

\(^1\) Leaving aside special questions such as the use of "depth psychology" in advertising.
Advertising would also have a divisive effect within the professions since, under the stress of the competition which would inevitably accompany it professionals may be led to depart both from professional behavioural norms and ordinary standards of service. Conversely, a ban on advertising forces the profession to concern itself with the overall level of performance. It denies the individual the opportunity to excel publicly and reinforces the mechanisms which make the individual turn inwards to the professional community for recognition and identification, thus strengthening the forces of collective control.\(^1\)

The ban on advertising therefore serves to protect the professional group from competition and divisiveness, and by helping to ensure that professional standards are judged by those competent to judge them it justifies, in the eyes of society, the profession's licence to protect and serve the central social values which have been vouchsafed to its care.

Similar considerations underlie the professional prohibition of undue personal publicity, and analysis of this kind may be extended to the other code elements dissected in Table 1. Specifically, amongst the most

---

common injunctions of the professional codes there analysed, we may select at random:

<table>
<thead>
<tr>
<th>Code Element Number (from Table 1)</th>
<th>Injunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Must maintain, integrity honour, etc. of profession.</td>
</tr>
<tr>
<td>2</td>
<td>Must apply skills for benefit of community.</td>
</tr>
<tr>
<td>10</td>
<td>Must maintain secrecy.</td>
</tr>
<tr>
<td>18</td>
<td>Must uphold scale of charges.</td>
</tr>
</tbody>
</table>

Taken separately each of these elements clearly functions either to maintain professional solidarity or to reassure society of the profession's responsible intentions and its adherence to standards of technical competence in exchange for the special power which society gives it. As Goode puts it:

The advantages enjoyed by professionals thus rest on evaluations made by the larger society, for the professional community could not grant these advantages to itself. That is, they represent structured relations between the larger society and the professional community.  

---

The particular code elements identify special aspects of these basic moral relations, and it does not negate the analytic significance of this model if, in practice, individual delinquencies are not infrequent, if professional control is not as strong as it might be, or if there is a degree of deliberate lip-service, cynicism and evasion in the daily transactions of the professional world. Putting this another way, we might say that the model remains valid if it is conceivable that widespread, serious and persistent failure to observe the central code elements would seriously threaten the professional structure, the quality of its service and the prevailing modes of its accommodation with society.

This would certainly seem to be true in relation to advertising. It seems true, also, in relation to professional confidences and secrecy: "The client cannot expect to be properly advised unless he is prepared to disclose all the facts; but such disclosure will not be made unless it is understood to be confidential."¹ And it seems true again of those elements of the code which

regulate forms of remuneration and scales of charges, where their function is to make the quality of the professional advice and service as independent as possible of self-interested motives. By keeping the professional-client relationship on a strict fee-for-service or salary basis under circumstances where the financial components are known to, and agreed upon, by both parties, the dangers to the fiduciary and service relationship which might arise from fee-splitting, secret commissions and the like, are avoided or kept to a minimum.

Examples could be multiplied, but they would add little but detail to the central proposition which is that there is a chain of implication linking the special observances mentioned above with the fundamental condition that the granting of the professional licence by society and collective control of behaviour by the profession are structurally integrated.

**Social Values and Professional Control - The Example of Law and Medicine**

The application of specialized knowledge and technique in the service of a central social value is the basis both of a profession's claim to self-control and to social status and prestige. In this sense, strategic service to society (or, more precisely, to a widely-diffused
value) is necessary for unequivocal professional status and all that follows from it. No occupation, no matter how skilled, would be accorded professional status simply on that basis, or on the presumption that it existed to serve only the selfish interests of its members or the professional group itself. It is for these reasons that the claims of "business" to professional status have been rejected. The primary orientation of business is to make money for its stockholders without breaking the law. While it may serve extrinsic social values indirectly or incidentally through market processes its structure is designed to achieve the former, and not the latter. The legal system recognizes and reinforces the differing objectives of the professions and business by requiring of the one that its efforts be directed to serving the interests of client and public, and of the other, that it seek maximum profits (within legal limits) for the stockholder. As Barber says, professionalism "is possible for businessmen in only extremely small measure at the present time, not because of their mean-spiritedness but because of the structure of the social and cultural situation in which they have to act." ¹

However, even amongst the established professions there are differences between them in "ethical homogeneity" which are related to the degree of consensus within society about the definition of the values which professional work supports. If medicine and law are compared, there is remarkable uniformity in the definition of health and near-universal agreement about its importance in relation to other values, whereas the definition of justice is obscure and shifting, despite the wide agreement about its importance.

Since, in medicine, the nature of the ultimate social values to which it is oriented are relatively clear cut and the subject of considerable consensus, there is less scope for ambiguity and argument about the professional procedures which are appropriate to the attainment of an end which is relatively clearly defined. In law, on the other hand, because justice is so ill-defined and the degree of consensus as to its nature so much the less, there is more room for disagreement about the professional norms which should guide professional practice. The doctor's patient is interested in health, but the lawyer's client may be less interested in justice than in using procedural expertise for ends that may or may not be "justified". The lawyer is thus more likely to be subject
to pressure from his client to serve his ends in ways which are incompatible either with "justice" or procedural norms.

The definition of justice is thus to an important extent variable with the social interests which offer the definition. The law, as it stands at a given moment, is a mosaic of legislative compromises. There need be no necessary correlation between the state of the law and "justice". One has only to compare the laws of different nations to observe the contradictions between them and to infer that at least one set of laws must be unjust. Legal knowledge and its exercise in legal procedures may therefore be totally unrelated to the securing of justice, even though it may be necessary to the securing of a "successful outcome" for a particular client. The notion of "unjust law" is not an uncommon one, and the pejorative term "legalistic" is a recognition of the fact that legal expertise may be employed wholly for procedural purposes.

It may be said, then, that while society as a whole strongly values both "health" and "justice", there is a wider and clearer consensus about the former than the latter and also a more clear cut relevance of the specific competence of the doctor, based as it is on scientific knowledge which lends itself to objective validation, in
attaining health than that of the lawyer in achieving justice.

Because he operates in an area which is at the centre of social value-conflicts, the lawyer is exposed as the doctor is not to the consequences of dissensus about the necessary concomitance between professional expertise and the guardianship of values. One result is an ambiguous attitude towards lawyers as a group. As Reuschemeyer says: "The public image of the legal profession seems indeed to be characterized by suspicions and ambivalences".1

This is a subject which merits further enquiry in its own right, but our purpose here is to indicate that the relationships between the status of a profession, its specific competence, and the "rules of universal moral application" are in reality very complex and while one may expect an analytic model which presupposes "value consensus", important qualifications must be made in the face of the stubborn fact that dissensus may often be profound in certain areas of professional expertise.

CHAPTER VII

PROFESSIONALISM AND COMMERCIALISM

It is common in discussions of professionalism for the professions to be contrasted with "business" in terms of the "altruistic" motivation of the former and the "egoistic" motivation of the latter. Parsons, on the other hand, has taken the view\(^1\) that it is impossible to distinguish them on these grounds and draws attention instead to the fact that both are "rational", "functionally specific in their authority" and "universalistic in behaviour criteria" - characteristics they share with the total occupational structure of technologically advanced countries. The differences are rather in the "institutional patterns" of the professions and business, neither of which forbids the pursuit of self-interest but simply defines it differently. Both seek "recognition" in the successful attainment of institutionally-defined goals: "the difference lies in the different paths to the similar goals, which are in

\(^{1}\) Talcott Parsons, "The Professions and Social Structure", *Social Forces*, 17 (4), May 1939, 457-467.
turn determined by the differences in the respective occupational situations.\textsuperscript{1} Success and recognition in both business and the professions are thus equally self-interested, to that extent, but are gained by "different paths". However, Parsons points out:

There are two particularly important empirical qualifications to what has been said. In the first place certain things are important not only as symbols of recognition, but in other contexts as well. This is notably true of money. Money is significant for what it can buy, as well as in the role of a direct symbol of recognition. Hence, insofar as ways of earning money present themselves in the situation which are not strictly in the line of institutionally approved achievement, there may be strong pressure to resort to them so long as the risk of loss of occupational status is not too great.

Moreover, in real situations, "objective achievement which is institutionally valued, and acquisition of the various recognition symbols may not be well articulated" and "such lack of integration inevitably places great strains on the individual placed in such a situation".\textsuperscript{3} Parsons goes on to quote "commercialism" in medicine and

\textsuperscript{1} Ibid., p.464.
\textsuperscript{2} Ibid.
\textsuperscript{3} Ibid., p.465.
"dishonest" and "shady" practices in business as reactions to the strains caused by lack of integration between institutionally-defined ends and approved means. Nevertheless, he says, it is doubtful whether such practices result primarily from egoistic motivation; rather it would seem to be a case of breakdown in the "normal", integrated state of affairs where the "interests" in self-fulfilment and realization of goals are integrated and fused with "the normative patterns current in the society, inculcated by current attitudes of approval and disapproval and their various manifestations."¹ Where the close correspondence of objective achievement and the bases and symbols of recognition is disturbed, the individual is placed in a conflict situation to which commercialism and dishonesty may be reactions.

Granting the validity of Parson's argument against the "altruistic" motivation of the professions and the "egoistic" motivation of business, and granting also the general argument about the consequences of lack of consonance between institutional goals and approved means, we must ask how this lack of consonance can occur, for

¹ Ibid.
clearly this is a question of some importance for the sociology of professional ethics. Also, on what grounds does Parsons characterise "commercialism" as "behaviour deviant from the institutional pattern" of medicine? Presumably he would contend that commercialism is dysfunctional in that it introduces motives and modes of behaviour which, at some point, are incompatible with high standards of professional service to the client or patient, or which would threaten the basis of trust which is essential to the professional-client relationship.

A clue to one important source of means-end dissonance is given by Parsons in the reference, quoted above, to "ways of earning money...which are not strictly in the line of institutionally approved achievement". While we can be sure that Parsons is not referring here to dishonesty so far as professionals are concerned, he is not specific as to what other sorts of things might not be "strictly" approved. Nevertheless, it is apparent that he conceives money as playing a special role as a "symbol of recognition" which may substitute for "institutionally approved achievement" provided "the risk of loss of occupational status is not too great".

Parsons may therefore be paraphrased as arguing along the following lines:
(i) Lack of integration between institutionally approved ends (e.g. "objective achievement which is institutionally valued.") and the means for attaining them leads to conflict situations in individuals.

(ii) In such conflict situations attempts at resolution induce individuals to adopt alternative modes of behaviour which lead to widespread deviation from institutional patterns.

(iii) The most important of the "alternative modes" is the acquisition of "recognition symbols", of which money is the most significant.

If Parsons is correct, does this mean that we are entitled to infer lack of integration, as defined, in professions in which "commercialistic" or money-making preoccupations are in evidence? And, if so, in what does the lack of integration consist and what is its significance for professional ethics?

Parsons' reference to commercialism in medicine is echoed, more pungently, by C. Wright Mills, who also offers a short answer to the questions just posed. He has spoken of "the commercialization of the professions" and "the
professionalization of business"., and observes of American doctors that:

The profession as a whole is politically uninterested or ignorant; its members are easy victims and ready exponents of the U.S. businessman's psychology of individualism, in which liberty means no state interference except a rigid state licensing system. The professional ethics in which this interest group clothes its business drive is an obsolete mythology, but it has been of great use to those who would adapt themselves to predatory ways, attempting to close the ranks and to freeze the inequality of status among the population at large.2

On this view, too, there are no significant differences between the motives of the businessman and the motives of the doctor; the differences are "not between egotistic self-interest and altruism", but "in the way the professional and business groups are socially organized and controlled; and a difference in the rules that govern the internal and external relations of the members of each group".3 Professional ethics (i.e. rules against advertising, competition, selection of patients, etc.) is not, therefore, a support for altruism, but a

3 Ibid., p.138.
strategy for maintaining group solidarity in the ultimate service of the selfish interests of each member of the group, and this is made possible for doctors "because they are organized in a guild-like system so as best to promote long-run self-interest. It does not matter whether as individuals they are aware of this as a social fact or understand it only as an ethical matter". 1

These remarks are made, of course, in an American context, but it is pertinent to ask whether there is evidence of a growing commercialism in Australian Medical practice; not because the problem of commercialism is peculiar to Medicine but simply because the issues involved can be seen more clearly in a medical context. Although the economics of medical services are very much in the forefront of current public debate, with discussion centred around the level of doctors' fees and the level of Health Service benefits, little attention has been paid to the professional attitudes which may underlie this debate and which might help to throw some light on "commercialism" as a possible factor. In the absence of a wide-ranging survey it would seem, however, that objective data which might give a clue to these matters

1 Ibid.
are to be found in the profession's own publications and those aimed at the profession by others, notably the pharmaceutical industry. Even admitting a modicum of ideological and propagandist intent in the publications which the profession produces for consumption by its members, it nevertheless seems reasonable to assume that, by and large, they will reflect prevailing preoccupations, and that the relative amounts of space devoted to particular subjects will be a rough measure of the relative strength of certain motives and interests.

The most important of the regular publications of the Australian Medical Association are:

(i) "The Medical Journal of Australia" (weekly)
(ii) The "A.M.A. Gazette" (monthly)

The Medical Journal of Australia is the official journal of the Australian Medical Association and although its contents are predominantly original articles of a medical or scientific character, its scope is wide and a significant proportion of its space is devoted to matters relating to the medical profession as such and to "general" articles and shorter pieces, many of which would not be out of place in a journal or magazine aimed at the educated layman or other professions. Thus, while it is essentially an educational and scientific journal for the
practising doctor, it nevertheless performs other important functions, not least of which is to serve as a forum for current professional opinion on a wide variety of topics. Articles of a medico-political kind are not uncommon, especially at times when voluntary health insurance, or radical reorganization of health services, are being debated in parliament or publicly. By and large, however, the non-medical and non-scientific material is relatively "lofty" and serious in tone and characterised by objectivity and impersonality.

The "A.M.A. Gazette" first made its appearance in 1968 and is, by contrast, essentially a professional, tabloid-size newsletter and journal of news and comment on matters outside, or on the periphery of, strictly medical and scientific matters. It is "light" reading for doctors and is intended to cover the whole spectrum of professional interests which would be out of place in a serious, academic journal like the Medical Journal of Australia. As such, it gives a useful insight into many common preoccupations of the profession which are either neglected or given only muted recognition in the M.J.A. If one can assume that the contents of the Gazette and the relative amounts of space devoted to different sorts of material reflect more or less
accurately, current medical opinion and interests outside the strictly technical interest, then analysis of its contents should be a reliable guide to the trend of these interests and thus to some of the values of the profession. On this assumption, a content analysis was carried out of four randomly-chosen issues of the Gazette (Numbers 9, 10, 14, 17) published between December 1968 and September 1969. The material in the Gazette (excluding advertisements) was analysed in terms of five main categories, and a number of constituent sub-categories, as follows:

1. **Emoluments, Income and Economics of Medical Services**
   - (a) Fees
   - (b) Salaries
   - (c) National Health Insurance Scheme
   - (d) Pensioner Medical Service
   - (e) Finance and Investments
   - (f) Practice Management and business problems associated with private practice.

2. **Organization of Medical Practice and Health Services**
   - (a) Professional ethics and etiquette
   - (b) Politics (excluding 1(c) and 1(d))
   - (c) Status of the Profession
   - (d) Medico-legal matters
<table>
<thead>
<tr>
<th>Analytic Category</th>
<th>Issue No. 9 (Column Inches)</th>
<th>Issue No. 10 (Column Inches)</th>
<th>Issue No. 14 (Column Inches)</th>
<th>Issue No. 17 (Column Inches)</th>
<th>TOTAL SPACE (by categories)</th>
<th>% of TOTAL space</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 (Emoluments, Income and Economics of Medical Services)</td>
<td>104</td>
<td>347</td>
<td>132</td>
<td>143</td>
<td>726</td>
<td>38.4</td>
</tr>
<tr>
<td>Category 2 (Organization of Medical Practice and Health Services)</td>
<td>63</td>
<td>113</td>
<td>95</td>
<td>47</td>
<td>318</td>
<td>16.8</td>
</tr>
<tr>
<td>Category 3 (Health and Medical)</td>
<td>76</td>
<td>85</td>
<td>98</td>
<td>71</td>
<td>330</td>
<td>17.5</td>
</tr>
<tr>
<td>Category 4 (Cultural and Recreational)</td>
<td>124</td>
<td>41</td>
<td>94</td>
<td>15</td>
<td>274</td>
<td>14.4</td>
</tr>
<tr>
<td>Category 5 (General and Miscellaneous)</td>
<td>67</td>
<td>35</td>
<td>98</td>
<td>45</td>
<td>245</td>
<td>12.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>434</td>
<td>621</td>
<td>517</td>
<td>321</td>
<td>1893</td>
<td>100.0</td>
</tr>
</tbody>
</table>
(e) Hospitals
(f) Overseas developments.

3. **Health and Medical**

(a) Information on medical discoveries and developments, improvements in treatment, equipment, research, public health, medical education, general health news

(b) Pharmaceutical industry.

4. **Cultural and Recreational**

Books, travel, hobbies, motoring, sports, general cultural interests.

5. **General and Miscellaneous**

"Gossip", personalities, conferences, general news of professional interest or relevance.

The amount of material, in column inches, in each of the five main categories in each of the four issues of the "Gazette" analysed, is set out in Table 4. Some comment on the categories and the constituent sub-categories is required.

Category 1 is economic in bias. It includes all those items which bear upon the doctor's financial position and economic status, and the underlying principle of selection was to gather together all material which is essentially financial or economic in orientation even
though the ostensible subject matter is of mixed character—that is, including, for example, questions of organization as well as questions of method or level of payment. Within Category 1, most space was devoted to the National Health Insurance Scheme and to aspects of the payment of fees in relation to the scheme. Information and advice on finance and investments (similar in style to the financial columns of the daily press) figured largely in three out of the four issues analysed (No. 9, 37 column inches; No. 10, 30 column inches; No. 14, 13 column inches). Care has been exercised to distinguish possible areas of overlap between Categories 1 and 2 and to restrict Category 2 to purely organizational or status issues which deal with questions of principle or practice which do not necessarily have economic or financial implications—for example, the rapid growth of medical specialism and the declining status of the general practitioner (No. 9, p.3, 19 December 1968).

Category 3 is oriented to technical interests and general health news, including such items as the distribution of influenza vaccine, cannabis smoking, organ transplantation, etc.

Categories 4 and 5 are straightforward and self-explanatory.
It is worth noting, in passing, that in the issue of the "A.M.A. Gazette" for 3 July 1969, there is an inserted brochure advertising a weekend seminar on "Income Management for the Medical Practitioner" the aim of which is to develop "basic guidelines for income generation, protection and expansion". A similar seminar (organized by a different firm) is advertised in the 6 November 1969 issue of the "A.M.A. Gazette" with the title "Income Management for the Professional Man"; with the difference that this seminar was held on the liner "Gaileo", cruising between Melbourne and Sydney. The main subjects of this seminar were: (i) "Practice and Financial Management"; (ii) "Taxation and Estate Planning"; (iii) "Investment opportunities in Equities, Options, Real Estate and Primary Production". These brochures were not included in the content analysis.

One would expect the pharmaceutical industry, which depends so heavily upon the goodwill and support of doctors, to be a shrewd judge of the doctors' interests and, in public relations activities aimed at the medical profession, to serve these interests as often and as effectively as possible.

In addition to straight advertising matter which is mailed in huge quantities to the medical profession, many
of the drug companies produce newsletters which are distributed free of charge to all doctors. Typical of these publications are "Riker Service", which describes itself as "a monthly classified advertisement service for doctors"; "A Doctor's Business Review", a monthly "service newsletter to the Medical Profession" from Nicholas Pty Limited and "Winthrop Impulse", a fortnightly newsletter which is "published as a service to the Medical Profession of Australasia" by Winthrop Laboratories, a Division of Sterling Pharmaceuticals Pty Limited.

"Riker Service", as it states, is a newsletter which offers a free classified advertising service for doctors (see Appendix 2). Its contents include lists of partnerships and practices for sale or wanted; locum tenens and other positions available; cars, equipment, etc., for sale; accommodation wanted or for rent; group overseas flights; and so on. Its major function is to facilitate business and employment transactions between doctors in private practice.

"A Doctor's Business Review", as its name suggests, is almost entirely devoted to finance and investment and to the business problems of private medical practice. Some idea of its characteristic interests may be gleaned

---

1 For copies of the publications discussed see Appendix 2.
from the following complete list of articles from two sets of consecutive issues, published in 1969:

Vol. 7. No. 1, February 1969
(i) "Uranium - Next Boom Mineral?"
(ii) "Tax Gains Can Make Assurance Most Attractive Investment"
(iii) "The Birdsville...and Beyond!" (motoring article).

Vol. 7. No. 2, March 1969
(i) "How Solid Is Our Mining Boom? Does It Depend on Hot Money?"
(ii) "Motor Vehicle Tax Deductions Depend On Car's Professional Use"
(iii) "Researchers Find Wine Doubles Slimming Rate"
(iv) "Real Australian Mateship Survives on 'The Birdsville'".

Vol. 7. No. 7, August 1969
(i) "Recent Share Slump Had Overseas Origins: Australian Topline Stocks Are 'Sound'"
(ii) "Mineral Developments Create 4 New Ports, Modernise 51 Others"
(iii) "Anatomy of the Ad. Game" (article on advertising industry)
<table>
<thead>
<tr>
<th>Analytic Category</th>
<th>Issue No. 18 (Column Inches)</th>
<th>Issue No. 9 (Column Inches)</th>
<th>Issue No. 8 (Column Inches)</th>
<th>Issue No. 13 (Column Inches)</th>
<th>TOTAL SPACE (by categories)</th>
<th>% of TOTAL space</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong> (Emoluments, Income and Economics of Medical Services)</td>
<td>26</td>
<td>13</td>
<td>15</td>
<td>217</td>
<td>271</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Category 2</strong> (Organization of Medical Practice and Health Services)</td>
<td>32</td>
<td>-</td>
<td>26</td>
<td>-</td>
<td>58</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Category 3</strong> (Health and Medical)</td>
<td>99</td>
<td>116</td>
<td>136</td>
<td>21</td>
<td>372</td>
<td>33.6</td>
</tr>
<tr>
<td><strong>Category 4</strong> (Cultural and Recreational)</td>
<td>22</td>
<td>-</td>
<td>37</td>
<td>-</td>
<td>59</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Category 5</strong> (General and Miscellaneous)</td>
<td>55</td>
<td>160</td>
<td>66</td>
<td>65</td>
<td>346</td>
<td>31.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>234</td>
<td>289</td>
<td>280</td>
<td>303</td>
<td>1106</td>
<td>100.0</td>
</tr>
</tbody>
</table>
A detailed content analysis of the above issues is not necessary to show the overwhelmingly economic orientation of this particular publication, and, in particular, the attention which it pays to advice on the investment of surplus income for profit. Not less than two-thirds of the contents would fall within Category 1 of the categories used for the analysis of A.M.A. publications (Table 4).

The third of the pharmaceutical industry newsletters, "Winthrop Impulse", is more elaborate and broader in scope than the other two. In format and range of contents it is not unlike "The A.M.A. Gazette" (see Appendix 2). Table 5 summarizes a content analysis of four randomly-chosen issues for 1969, using the same analytic categories used for the content analysis of "The A.M.A. Gazette".

The contents of "Winthrop Impulse" reveal a heavier emphasis on Category 3 items - "Health and Medical" - compared to the "A.M.A. Gazette" (33.6% as against 17.5%); and a similar discrepancy in Category 5 - "General and Miscellaneous" - where the respective percentages are 31.3 as against 12.9. Category 2 - "Organization of Medical Practice and Health Services" - figures more prominently in the "A.M.A. Gazette" (16.8%) than in "Winthrop Impulse" (5.2%).
What is the overall picture conveyed by these four newsletters - one produced by the profession for its own members and the other three by drug companies whose principal motives, presumably, are to ingratiate themselves by providing "service" and "interest" publications which will be vehicles for their prestige and straight advertising matter? Does it provide any evidence in support of a supposed "commercialistic orientation" among Australian doctors?

The answer would seem to be a qualified affirmative.

The economic interest (Category 1 of the content analyses) plays a dominant role in the "A.M.A. Gazette", comprising 38.4% of total content - more than twice as much as any other category. In "Winthrop Impulse" it occupies third place with 24.5%, whilst "Riker Service", in a specialised way, is almost wholly economic in purpose. This is also true of "A Doctor's Business Review" which is unblushingly devoted to money-making and commercial advantage.

In sum, there can be no question of the important role of economic interest in determining the content of these four publications. But such an observation should

---

1 Advertising (other than classified advertising) has not been taken into account in the content analyses of these newsletters.
not be asked to bear too much weight. It would be necessary to know a great deal more about the extent of readership of these publications amongst doctors, and also of their relative position in the total "professional" reading of the doctor before confident conclusions could be drawn. It would be interesting, for example, to survey the readership of the newsletters discussed in relation to readership of medical and scientific journals like "The Medical Journal of Australia", "The Lancet", etc. Circulation is no sure guide to readership since the three drug company newsletters are sent to all doctors free of charge, while the "A.M.A. Gazette" and the "Medical Journal of Australia" are circulated automatically to all financial members of the A.M.A., that is, to the 85% of the doctor population of Australia which belongs to the A.M.A.\(^1\) Nevertheless, the apparent success and persistence of these publications\(^2\) suggest that their

1 Estimate by the A.M.A. See A.M.A. Gazette, no.19, 6 November 1969, p.1.

2 On the basis of the identifying volume numbers, "Winthrop Impulse" is now in its eighth year of publication and "A Doctor's Business Review" in its seventh. It is interesting to note the relatively recent appearance of these publications and to conjecture whether it is a response to a new climate of outlook and interests in the medical profession.
publishers believe they are gaining a reasonable degree of acceptance and readership and, if this is so, it seems fair to conclude that their contents, and the relative emphasis on certain interests, are a guide to attitudes of some importance in constituting the professional outlook and morality of the doctors. Because of the consistently high rating of material devoted to the profit-making investment of surplus income and to the commercial advantage of certain modes of professional organization and management, the business ethic must be allowed an important place in contemporary Australian medical practice.

What is the significance of this for professional ethics?

Elsewhere in this essay in discussing professional ethics as a species of social control, it is argued that such control is a functional response to the exploitative opportunities which fall to the professional by virtue of his specialised, problem-solving knowledge vis-à-vis his patients or clients and his "licence" to determine the conditions, including fees charged and extent of service given, under which he will work. In return for this freedom there is a presumption that the professional will not exploit and that the opportunities
for exploitation will be policed by the professional association. But, as Goode puts it:

This is not to say that professionals are nobler than lay citizens. Instead the professional community holds that exploitation would inevitably lower the prestige of the professional community and subject it to stricter lay controls. It is at least clear that if individual clients believed that their practitioners were seeking to exploit them, they would not trust them so far as they do.¹

Since trust is at the heart of the professional-client relationship, anything which erodes that trust, or which leads to the suspicion that the adequacy of the professional performance may be modified by extrinsic motives, affects not only that relationship and the privileged position of the professional, but also the whole quality of professional practice. If it is true, as the evidence suggests, that the extrinsic motives of money-making and the manipulation of modes of practice for the primary end of commercial advantage are claiming the increasing attention of doctors, the stage is set for an exploitative attitude towards patients which cannot but erode the basis of trust and prejudice the structural relations between society and profession which are founded

on the presumption that professional self-control, through professional ethics, is oriented not to the private advantage of the practitioner but to excellence of professional performance.

It is in this way, therefore, that an orientation to money-making and emphasis on the commercial aspects of professional practice can become dysfunctional within the "institutionally approved pattern" to which Parsons has referred. The failure in integration arises from the opportunities which money-making presents for alternative "symbols of recognition" outside the institutionally approved pattern of objective, technical achievement, and this, in turn, is made possible by forms of organization of medical practice which tend to subvert professional energies from strictly professional performance. The average doctor in private practice is, of necessity, as much small businessman as disinterested professional and the strains between these conflicting roles are exacerbated when the claims of business advantage and the opportunities for economic preferment tend to overshadow the professional commitment.

If, as seems to be the case, the publications analysed

---

represent a relatively new development, it is surely remarkable that their contents place the emphasis they do on what has been described as "commercialism". Though clearly far from conclusive, the facts support the suggestion that a growing commercialism in society as a whole is becoming deeply rooted in the medical profession and, given the validity of Parson's structural analysis, represents an important example of the way in which broad social trends may come to influence the "ethical integration" of a profession. That the pharmaceutical industry should be an important vehicle of this trend so far as Medicine is concerned is not so remarkable. The medical profession is unique to the extent that no other profession is so openly assailed by a rich and intensely competitive industry, the members of which depend so heavily upon the goodwill and favour of the individual professional practitioner.
CHAPTER VIII

PROFESSIONALISM AND COMPLEX ORGANIZATION

Amongst the important influences on the form and survival of professionalism and professional conduct generally are the forms of organization of professional work and the organization of colleague-relationships of various kinds and for various purposes through professional associations.

Professional work is characterised by three main structures -

(i) the private independent practitioner dealing with fee-paying clients or patients;

(ii) the professional partnership or group practice or the small-scale firm or clinic which is not large enough or sufficiently sub-divided by specialization to display bureaucratic features;

(iii) the large-scale organization in which professionals figure as salaried employees and which is bureaucratic in form.

In discussing earlier the factors determining the emergence of an ethical code, attention was focused on the influence of the circumstances under which a profession is practised, and it was contended that,
other things being equal, the need for a formal code in maintaining professional attitudes and standards will be relatively strong where professional practice is typically in the hands of individual practitioners involved in a direct, personal, fiduciary relationship with clients who have no comprehension of the professional art concerned, and relatively weak where professionals work in a bureaucratic setting, using a widely understood technique in simultaneous dealings with many clients.

Before dealing with the kinds of professional association our first focus of interest will be on the effect on professional attitudes and conduct of variations in the social organization of professional practice. Since this has been discussed already in the Chapter on "Factors Determining the Emergence of an Ethical Code", attention will be fixed primarily on the implications of bureaucratic organization for professionalism and professional conduct. The underlying hypothesis is the expectation that professional attitudes and conduct will be conditioned to some extent by the structural variations in work settings mentioned above and, on the other hand, that professional attitudes and professional skills, especially in so far as the latter are unsupervisable, may force modifications in the usual modes of operation of these structures—particularly in bureaucratic settings.
Professionals in a Bureaucratic Setting

In the extensive literature\(^1\) on the role of professionals in complex organizations and on the effect of such organizations on professional attitudes - for example, autonomy and commitment to "service" - it is frequently assumed that there is a radical incompatibility between bureaucratism and professionalism. This view begins with a conception of formal organizations on the classical Weberian model characterized by a hierarchical chain of command, specific duties associated with particular offices, with objectives, and the procedures for attaining them, determined at the top of the hierarchy and relayed down through the system by a descending chain of command. Such an organization, it is held, would be anathema to the characteristic professional attributes of autonomy, independent judgement and innovation.

Insofar as adherence to the ethical code of the profession is taken as a mark of professional status, it

is obvious that this has relevance primarily to private, independent practitioners, for only they have the freedom to deviate from professional norms without necessarily putting their livelihood at hazard. The salaried professional, on the other hand, "can hardly be guilty of unprofessional conduct without being merely incompetent". Nevertheless, it would be wrong to infer from this that professionalism occurs only in private practice, even while admitting that professional codes and standards of professional conduct developed historically from the relations between practitioners and clients.

If the specialised knowledge of the professional, his "specific competence", is taken as the point of departure, the problem faced by the complex organization in which professionals predominate is usually one of integrating several professional groupings in the achievement of the organization's goals. The strictly bureaucratic solution would be for a hierarchically organized management to issue decrees aimed at achieving the objectives. But there is considerable evidence that the typical bureaucratic model is the exception rather

---

than the rule in professional organizations and that the problem of integration is frequently met by a continuing political process. Universities, for example, have an elaborate political machinery for resolving competing and conflicting professional interests through a system of committees, faculties, boards and senates and forms of administration which tend to be weak and decentralised when compared with less professional, complex organizations. Similar tendencies, though not carried quite so far, are to be seen in a predominantly scientific organization such as the Commonwealth Scientific and Industrial Research Organization, or in large hospitals, especially teaching hospitals. The chief sign of this professional political process is the ubiquitous committee.

On the basis of their investigations of doctors, medical and other scientists, nurses, social workers, occupational therapists and clinical psychologists working in general hospitals, university hospitals, mental hospitals, and medical schools, Bucher and Stelling concluded that "approaches to formal organizations dominated by Weberian concepts of bureaucracy simply did

---

1 See, for example, Bucher and Stelling, op. cit., p.10.
not fit organizations dominated by professionals", 1 and that "the degree of professional control in a larger organization can be highly variable". 2

At the heart of the political process which characterises the interaction of professionals with a bureaucratic or quasi-bureaucratic organizational structure, is the strain between the traditional independent judgement and creativity of the professional and the organization's requirement of subordination and regulation in the interests of a specific goal or product. Bureaucratism seeks functional integration and the effective coordination of many activities and various skills, whilst professionalism seeks autonomy and the resources with which to pursue the professional activity, including professional creativity.

But if the organization needs the specific competence of the professional, and if that specific competence requires a certain independence to sustain it, there is an obvious dilemma for the organization which demands a thoroughgoing rationalization and control of activities in accordance with the ideal Weberian bureaucracy. Clearly, there must be a compromise.

1 Ibid., p.3.
Similarly, in a social structure increasingly characterized by the transformation of professional work from occupations carried on by independent professional individuals to activities carried out in large institutions and organizations, professionalism must turn to these organizations for resources and employment.

The political process referred to, in which the professional and bureaucratic "moralties" work out their accommodations and compromises, is evidence of a sort of symbiosis in which the "organization does not wholly absorb professionals, nor do professionals wholly absorb the organization". ¹

Another way of looking at this is to emphasise that the professional working in an organization has a dual commitment which mediates his professional performance. He participates both in the profession and in the organization, and the loyalty he brings to the latter is in an important degree qualified by his commitment to the former. Bureaucracies manned by professionals "are likely to be unable to fully control the criteria by which their professional personnel are to be recruited, since

professionals themselves will demand some voice in these matters; and they will have difficulty in controlling the efforts of professionals once recruited insofar as these members retain an identification with their profession and attempt to adhere to its norms and standards.\(^1\)

The conflicts which mark the progress of this political process have been the subject of a number of studies\(^2\) dealing primarily with professional resistance to bureaucratic regulations and standards and submission to bureaucratic supervision. The non-professional worker in a bureaucracy performs an assigned task which represents a fragmentary contribution to the complete organizational operation and in this situation he is unable to make any rational judgement about either the ends or means. He thus has no grounds upon which to raise an objection to the regulations governing his role in the overall operation. His performance can be judged only on the extent to which he obeys, or deviates from, the rules that regulate his work. The professional, on the other hand, is normally expected to perform tasks of considerable complexity and

\(^1\) Op. cit., p.266.

\(^2\) Cf. references quoted in loc. cit.
of some internal coherence and completeness, in relation to which professional judgement as to means and ends may be called into play. So long as the rules of the organization allow flexibility to the professional, conflict may be avoided. But if the rules operate to prevent or inhibit the exercise of professional judgement in a manner contrary to the ethics or norms of the professional group, then difficulties may arise, and in his opposition to the enforcement of bureaucratic rules the professional can appeal to "the standards of the profession" to legitimate his stand.

Similar problems may arise in relation to bureaucratic supervision. Professional authority is based on competence; bureaucratic authority on hierarchical position. In a professional situation, the claim to supervise derives from superior knowledge and the client or fellow-professional being supervised expects to receive advice, not orders. In a bureaucratic context, supervision, although superior competence may be involved, depends primarily upon the occupation of a place in the structure which carries with it the right to supervise. It is inherent in professional training and socialization that supervision of the fully-fledged professional is not only unnecessary but redundant, since the professional is
presumed to have mastered the skills necessary for complete performance and to be guided by internalized norms which guarantee conscientious execution. The supervision of the professional by a non-professional administrator who claims authority over him by virtue of bureaucratic position is therefore pregnant with possibilities of conflict, and there is a considerable body of evidence\(^1\) attesting the continuing friction which occurs when professional specialists are expected to accept the authority of administrators who claim the right, at least in some aspects of their work, to order and coordinate.

Other causes of conflict when professionals work in bureaucratic settings are the professional's tendency to reject, at least initially, the standards of the employing organization in favour of those inculcated during training and professional socialization; and allied to this, his tendency to give loyalty to the profession, to seek a reputation amongst his professional peers at large, rather than within the organization - in Gouldner's terminology, a "cosmopolitan" rather than a "local" orientation.

\(^{1}\) Ibid.
Space forbids a detailed examination of these aspects which would, in any case, become increasingly peripheral to the main point of this discussion which has been to indicate some of the areas of collision between a professional ethic which values autonomy and the free play of professional judgement, and a model of bureaucratic organization committed to regulation, supervision and coordination. As was hinted at at the beginning of this section, the interaction between professionalism and bureaucratism forces a number of compromises and adjustments in both. As Bucher and Stelling\(^1\) demonstrate, the transformation of bureaucratic dimensions in an organization dominated by professionals may be such as to make the model almost unrecognizable. Conversely, the survival of professional autonomy and independence may be very much in jeopardy in some bureaucratic settings where the professional ethos has been unable to withstand the overriding claims of regulation, uniformity and control. School-teaching is perhaps a notable example of the latter, and if one asks why these variations occur one is led back, on the one hand, to the "specific competence" of the professional, to the length of

\(^1\) Op. cit.
training, degree of specialized knowledge and technique required of him, and its importance in relation to the performance of certain tasks, and on the other, to the level of prestige\(^1\) of the profession concerned. The more vital the professional knowledge and technique are for the functioning of the organization and the greater the prestige of the profession, the more likely it will be to have an important say in determining the conditions under which it will work. School-teaching, it might be observed, has been notoriously subject to "dilution" schemes of recruitment in times of crisis, usually without public outcry or serious embarrassment to the employer, from which it could be inferred that the competence of the teacher lacks the specificity and centrality to the functioning of the organization of, say, the nuclear scientist in an atomic power plant or the hospital doctor. Even so, the recent history of school-teaching in Australia is largely the history of the struggle over "professional" claims advanced by

\(^{1}\) No doubt there is a connection between prestige and degree of specific competence but it is not a 1:1 relationship and more is involved; especially, it is suggested, the extent to which the profession is composed of individual practitioners remunerated by fee.
teachers' organizations against State departments of education and their bureaucratic control. Questions of "professional status", and hence of prestige, are also at stake, but the motivation in this respect is complex, and this is discussed separately in a later chapter.

To sum up, the structural problem presented by professionals in organizations of providing a degree of autonomy and achieving integration in order to reach organizational goals, may be solved either in the direction of lessening conflicts by providing more professional incentives and relaxing organizational controls, or by an assertion of the primacy of control and integration and a decision to "live with" a level of professional disaffection. The crucial factors in determining which direction will be taken are (1) the length and type of training of the professional concerned, (2) the nature of the organization or organizational unit and the centrality of the professional skill to its functioning, and (3) the "general" prestige of the profession.

From the point of view of the professional, the conflict with bureaucratic organization consists

---

primarily in resisting the alienation\(^1\) which occurs when his autonomy is diminished by the demands of coordination, control and integration. But this autonomy does not merely mean absence from constraint as an end in itself, but the freedom to find in the carrying out of the professional work the "high intrinsic satisfaction, positive involvement, and commitment to a reference group composed of other professionals"\(^2\) which are marks of the ethic of professionalism. The contribution which "professional reference groups", especially in the form of professional associations, make to the professional ethic is considered in the next section. This in turn will be followed by a discussion of the social status and prestige of the employed professional and the role of the professional association in raising his status and ordering his conduct.

---

2 Ibid., pp.758-759.
CHAPTER IX

PROFESSIONAL ASSOCIATIONS

The history of the professions is nearly synonymous with the growth of professional associations and these associations in the latter half of the eighteenth century and especially in the nineteenth century proved a most powerful means of professionalizing various occupations. By assuming, in particular, the right to confer a vocational qualification and especially by having this right formally recognized by statute, such associations wielded great social power. However, the main functions of the professional associations are to organise the profession, to focus a range of vocational interests and to use the group power of the organization to foster these interests. Amongst these interests may be the promotion of study and investigation in the professional field, maintenance of high standards of professional conduct, control of entry to the profession, protection of the profession, and public agitation to secure professional advantages or privileges of various kinds. These different functions are matched by distinctive
sorts of association. Millerson\(^1\) distinguishes four basic
types of professional organization:

(i) The Prestige Association of which the Royal
    Society is a leading example.

(ii) The Study Association, whose prime objective is to
    study and promote a particular subject. There
    are numerous examples, of which the Sociological
    Association of Australia and New Zealand is one.

(iii) The Qualifying Association, which sets out to
    examine and qualify individuals wishing to
    practise a particular profession. The
    Australian Society of Accountants is an example.

(iv) The Occupational Association, which organizes
    professionals without attempting to qualify
    them. The Australian Medical Association is
    an example of this sort of association.

Some associations, of course, are mixed types. The Royal
Australasian College of Physicians is an example of a
prestige and study association which also offers a valued
qualification. It is notable, however, that this
association has played a very minor role as an
occupational association. This role has been filled,

\(^{1}\) Geoffrey Millerson, The Qualifying Associations,
for physicians, by the Australian Medical Association.

It is the occupational association, and to a lesser extent the qualifying association, which brings professionals into closest contact, and sometimes conflict, with the larger society. It is the occupational association which most closely approximates a trade union, although there are important differences. The common features are the preoccupation with the protection or improvement of income and the extraction of benefits and privileges of various kinds. But the distinguishing features are numerous and important. The trade union's predominant concern is with wages and conditions of work; it enforces membership, it has only one grade of membership, it does not require any formal qualification of its members and it does not hesitate to direct its members and to resort to direct action if necessary. The professional occupational association, on the other hand, and especially when it is also a qualifying association, has a broader range of interests than the trade union. It may concern itself with both social and economic status, it may have various grades of membership, it may include both employers and employees, and it does not enforce membership (except
insofar as it may control the exclusive qualification for practising the profession. By and large, the professional organization eschews anything which smacks of direct action over, or even an overt interest in, remuneration and conditions for the professional.

To descend to the market place might disturb the delicately balanced superiority of his position. To quarrel over payment may destroy the ideal of public service. Bureaucratization and mass employment have removed many qualms; in medicine and teaching, "union" consciousness grows. Chemists, physicists and engineers, although subject to bureaucratization, have operated in a "sellers market" during recent years, which may help to account for their lack of interest in unionism. How far will professionals go before they adopt true trade union tactics? Strikes, working to rule, compulsory membership, demarcation disputes - all have been used, or threatened, but such action can harm the reputation of any professional group.1

But the situation is tending to change and with it, the conduct of the professional. The Engineers' Award, the controversy over medical fees (including the unprecedented public quizzes and debates on television and in the press on the subject) and, more recently still, teachers' strikes, are examples of a fairly rapid breakdown in the traditional reluctance to reveal, to bargain for, and to justify, the professional's pecuniary

1 Millerson, op. cit., pp.41-42.
interests. Nor can there be serious doubt that the naked revelation of this interest jeopardises public regard and threatens "the delicately balanced superiority" of the professional's position. As we have seen, the part played by bureaucratization is an important question, but the position is not nearly so clear-cut as Millerson might seem to imply, and the effects of bureaucratization on professional conduct and performance do not necessarily diminish professionalism as an ethos in all circumstances.

Although the activities of the occupational association, as a type of professional organization, establish a point of contact between a profession and the public or other social groups and organizations, this is not its sole function, and when the occupational association has a mixed character, when it examines qualifications for example, it may function also to maintain standards of professional practice and conduct. Amongst these may be provision of training courses, postgraduate education, organization or support of research, educational publications, formulation of codes of conduct and attempts to enforce them.

The extent to which the four basic types of association are to be found within a particular profession varies with the nature of the profession.
Professional Aims and Types of Association

Those professions, or marginal professions, most closely associated with trade and commerce, such as stockbroking, banking, accountancy and advertising rarely have prestige or study associations. On the other hand, the artistic professions - music, painting, literature, etc. - commonly have prestige associations but rarely occupational associations. Academics are heavily involved with study associations but only peripherally with occupational and qualifying associations and, to some extent, prestige associations. Medicine has each type of association.

What are the reasons for these variations? To begin with, it seems reasonable to assume that each of the types of association serves a certain sort of professional interest and experience, and the more various the range of possible experiences and problems of the profession the more likely it is to cover the gamut of associational types. Where, for example, the practitioners of the profession are commonly concerned with the development and refinement of the areas of knowledge and the intellectual disciplines underlying their profession, it is more likely that study associations will be formed. This is pre-eminently the case with academics and with medicine.
Where, however, the profession is mechanical or derivative, in the sense that its practitioners are not required to contribute to, or keep closely abreast of, a developing and systematic intellectual discipline, then the establishment of study associations is unlikely. This is so with the majority of the commercial professions.

Where the formal qualification for entry to a profession can be obtained in existing institutions (technical colleges, universities) there is little need for the formation of qualifying associations. In some cases, however, qualifying associations which were formed before public institutions offered the appropriate professional training, continue to examine and award qualifications which offer alternative modes of entry to the profession concerned. Some associations offer higher qualifications which, though not necessary for entry to the profession, are the *sine qua non* for advancement to higher professional levels and certain forms of practice. The examinations offered by the Royal Colleges of Physicians and Surgeons are examples of the latter.

The prestige association is a special case. By definition its claim to confer a special status on its members must be widely accepted. It is very difficult for any profession to establish, *ab initio*, a prestige
association which will win general acceptance; the process is normally a long one drawing upon ancient traditions. The most important conditions determining the successful establishment of a prestige association seem to be -

(a) that the association's objectives are directly related to the culture's central intellectual and artistic disciplines and traditions (e.g. the British Academy, the French Academy, the Royal Society, Australian Academy of Science, the Royal Academy);

(b) that it should serve (or appear to serve) disinterested motives and the furtherance of these intellectual and artistic disciplines.

The prestige they enjoy as associations is, therefore, dependent, among other things, upon the value the society places on the associations' objects. Their significance for professional conduct consists in their representing professional ideals of high achievement, dedication and disinterestedness which, when attained, bring rewards in the form of social distinction and prestige.

Professional Associations and Professional Conduct

The professional associations influence professional conduct inadvertently or implicitly by the
mere processes of membership and intercourse and deliberately or explicitly by the formulation (and occasionally the enforcement) of codes and rules to which the professional is expected to adhere. Despite the emphasis which has often been given to the latter in discussion of the determinants of professional conduct, there is much to suggest that the former is more important. And this, of course, would not be surprising if we see the formulation of an ethical code as a response to attitudes and forms of behaviour which are already firmly entrenched within the profession. Looking at it in another way, we may take the mere existence of the professional association and its persistence over a period as evidence of a "moral order", in Durkheim's sense, and thus inextricably involved in the moulding of professional conduct.

The elaborateness of a formalized code of ethics is therefore no sure guide to the influence which a given profession wields over the conduct of its members. A surer guide is the elaboration of the professional structure itself, as revealed in the strength and comprehensiveness of its associations. As Durkheim observes:

...the greater the strength of the group structure, the more numerous are the moral
rules appropriate to it and the greater the authority they have over their members....

and

...it can be said that professional ethics will be the more advanced in their operation, the greater the stability and the better the organization of the professional groups themselves.¹

We would thus expect to find, as a corollary of the foregoing, that a strong, well-organized and comprehensive professional associational structure would wield greatest authority over its members and tend to promote consistency and predictability of professional conduct. Whether or not this conduct will be "ethical", in the sense of conforming to community standards of right and wrong, is a separate question.

A first step in determining whether this relationship occurs in fact is to devise means of measuring and comparing professional associations in terms of their structural strength, organizational efficiency and comprehensiveness. Progress in this direction is reported by Akers and Quinney² in their study of the comparative


organizational structure of five health professions - chiropractic, dentistry, medicine, optometry and pharmacy.

They begin their analysis of the internal social organization of these by making a broad division on two dimensions: the resources at the disposal of the profession (more precisely, its leading professional association) and its structure or social organizational characteristics. The resources considered are size, wealth, and the knowledge and skill of its members, as measured by years of education.

The structure of the professions is analysed in terms of -

(a) orientational cohesion, or the degree to which the goals, values and policies of the professional association are shared by the members of the profession, and

(b) relational cohesion, or the degree of unity or conflict between professional sub-groups.

Indices of orientational cohesion include -

(i) membership homogeneity,
(ii) involvement and participation,
(iii) membership stability,
(iv) overlapping of organizational membership.
Indices of relational cohesion include -

(i) intra-professional conflict,
(ii) completeness,
(iii) communicative integration,
(iv) structural integration,
(v) duration and stability of the major association.

The professions concerned in the study were compared by ordinal rankings on the preceding indices. Data were obtained from journals, reports, transcripts of meetings, etc. and from a questionnaire submitted to and completed by the five major professional associations (American Chiropractic Association (A.C.A.); American Dental Association (A.D.A.); American Medical Association (A.M.A.); American Optometric Association (A.O.A.); and American Pharmaceutical Association (A.Ph.A.).

The data showed that, in terms of organizational resources, the A.M.A. is easily the largest and wealthiest and the most abundantly endowed with manpower resources. It is followed by the A.D.A.

On the indices of the structural variable "orientational cohesion", it was not possible to rank for membership homogeneity; the A.C.A. scored highest on involvement and participation, followed by the A.D.A. and the A.M.A.; the A.D.A. scored highest for membership
stability, followed by the A.M.A. "Overlapping of organizational membership" and "intra-professional conflict" were treated as a single variable and the A.M.A. and A.D.A. were assessed as scoring highest on this index. In this connection Akers and Quinney make the point that "there is no necessary relationship... between number of within-profession associations and degree of intra-professional conflict. There are, for instance, at least 86 medical and 49 dental speciality organisations".1

It is interesting to contrast the situation in medicine and dentistry with that in pharmacy, where an intra-professional conflict has developed over basic policy between the A.Ph.A. and the National Association of Retail Druggists. The latter represents the interest in "successful retailing while the A.Ph.A. is more concerned with professionalization, codes of ethics, proper handling of prescriptions and drugs, and relationships with client-customers and other professions".2

The conflict is thus essentially one between business and professional orientations, or, more generally,

2 Ibid., p.113.
between interested and disinterested motives. In terms of completeness, by which Akers and Quinney mean the extent to which the whole of the profession is included in one organization, both the A.D.A. and A.M.A. score highly, along with the A.O.A.

The A.M.A. scores highest on "communicative integration" which is measured by the degree of communication within the organization through journals, reports, meetings, etc.

Structural integration "refers to the extent to which all levels (national, state and local) are bound up into an integrated unit"¹ within the overriding framework of the major association. On this dimension the A.D.A. ranks highest and the A.M.A. follows.

The A.M.A. scores highest on "duration and stability of the major association", followed by the A.D.A. and the A.Ph.A. The authors conclude² that dentistry comes first on a summary ranking of unity and integration of the professions and displays: "Highest degree of membership completeness; high degree of organizational spread and geographic completeness. One overriding organization

---
¹ Ibid., p.117.
² Ibid., p.118.
with others allied with it. Minimum amount of intra-professional cleavage".¹ This may be contrasted with chiropractic's "low degree of membership completeness; no organizational spread and no geographic completeness of organizational units; polarized intra-professional cleavage and rivalry within the profession".²

Finally, in terms of the summary ranking on unity and integration of the major association, the A.D.A. and to a lesser extent the A.M.A., show high degrees of structural integration from national to local level and well-developed communication systems.

In describing this investigation at some length one purpose has been to bring out the consonance between the authors' rankings of familiar professions on certain dimensions and what is usually assumed by the layman to be true of those professions. The objective data support the commonly-held view that dentistry and medicine are strongly organized professions, and that the members of these professions are cohesive.

What, then, are the implications of these findings for a consideration of professional conduct?

¹ Loc. cit.
² Ibid.
It was hypothesized above that consistency and predictability of professional conduct would be functions of a "strong, well-organized and comprehensive associational structure". The first point to note about this formulation of the issue, considered in relation to Aker's and Quinney's data, is that "consistency" of conduct is, implicitly, one of the indices of structural integration and cohesion of the profession if we take "membership stability", "involvement and participation" and "absence of intra-professional cleavage" as to some extent co-extensive with consistent professional conduct. Another way of putting it, perhaps, is to question whether "consistency" or "predictability" are very useful descriptions of professional conduct. Given that a professional association defines compatible aims, given absence of "intra-professional conflict" and given membership stability and involvement, it would seem that consistent and predictable professional conduct must follow.

It appears, therefore, that to give real content to the notion of professional conduct it is necessary to go beyond these formal criteria and to consider modes of behaviour and moral norms, especially those which are institutionally articulated, and to take account of
professional aims and practices in order that both intra-
professional conflicts and professional disdemeanors can
be accommodated in general behavioural descriptions.

Nevertheless, the study empirically verifies the
Durkheimian association between the structural strength
of a profession and its moral authority over its members.
It reinforces, too, the significance of the preponderant
concern of the formal codes of ethics of the professions
with "intrinsic responsibilities" (see Table 3) whose
function it is to establish and maintain professional
solidarity.

So far as conflicts within the profession are
concerned, it might be expected that these would tend to
be most serious (and the moral authority of the
professional association to be therefore in jeopardy)
when there are two or more radically different forms of
practice common within the profession; when, for example,
the profession is more or less evenly divided between
those in private, independent practice and those in
employment. The way in which such a situation may affect
the moral and social functions of the professional
association is amongst the subjects discussed in the next
chapter.
CHAPTER X

THE STATUS OF THE EMPLOYED PROFESSIONAL

Having considered the general characteristics and varieties of professional associations, it is now possible to take up the theme of the status and prestige of the professional in a complex organization, which was held over from the discussion of professionalism in a bureaucratic setting. The issue here concerns the problem for the employed professional of achieving or maintaining status as a subordinate and of the support which the professional organization can give.

It is a problem which occurs especially in relation to the professional technologists - the scientists and engineers - whose contribution to the "professionalization" of increasing areas of work is already important and growing constantly. They represent, too, a large proportion of the professionals employed in complex organizations, particularly if hospitals and universities are excluded. Because they are by common consent less "professional" in the eyes of society than, say, doctors and lawyers, and almost exclusively employees rather than independent practitioners, the question of their
professionalism and the role of a professional ethic amongst them raises interesting questions about the connections between professionalism and class and status.

It has already been noted that only some professional associations are occupational associations, and those which are are not trade unions; popular sentiments to the contrary notwithstanding. Despite the common interest in economic advantage, a trade union is essentially a bargaining body and an organizational instrument in class confrontations, while professional associations are status bodies which bestow a qualification or seek to maintain or enhance prestige.

It is a commonplace of social comment to remark the reluctance of professional associations to engage in bargaining of any kind or to use anything resembling the methods (such as strikes) which are employed by trade unions. Teachers' strikes and appeals to industrial tribunals by professional engineers are recent exceptions, but by and large such behaviour has been held to be "unprofessional". For the old-established professions, such as medicine and law, which are still predominantly

---

1 For example, the common accusation that the Australian Medical Association is "just the doctors' trade union".
composed of independent practitioners, the question of using such methods simply does not arise because they are not in a subordinate position and the minority who are are protected, by this fact and its implications for the market, from the normal consequences of subordinate status; the conditions of their employment contain residual elements akin to the client-practitioner relationship.

Does it follow, therefore, that for those professions whose members are predominantly employees, and therefore in a subordinate status lacking any of the elements of a client-practitioner relationship, that their professional associations will increasingly take on the character of trade unions? There is some evidence that this may be so, but the seeming hesitancy and delay may be explained in part by some features of professionalism rather than any purely economic factors. Another way of putting the matter is to ask why, in spite of their expertise and economic importance, technologists have failed to gain anything like the power, prestige and influence of the older professions. If one thinks of social class as stratification in terms of power, particularly economic power, then technologists must be assigned to the middle ranges. But society is also stratified in terms of status, that is, in degree
of honour and prestige. In fact, of course, class and status are inextricably linked, but for the purposes of enquiry they can be formally distinguished.

Status which is based on the differential distribution of honour and prestige arises out of the pre-existing class situation. It derives from the attempt of those with power to legitimize their position. They claim that this power is a result of their possession of some criterion of superiority. Their ideology emphasizes the gradation of society into a hierarchy according to the possession of the honorific criteria, and with themselves at or near the apex.1

It may be said, then, that the ideologies associated with social stratification will be either of a class or status type, linked in a continuum, and acceptance of a status ideology would entail the view that honour and prestige are concentrated at the top of the hierarchy in the hands of those who, by virtue of their status, exercise legitimated power, whilst a class ideology would require that these claims be challenged and the exercise of power declared illegitimate. It may further be argued that whether one tends towards a status ideology or a class ideology will depend upon whether one exercises, or expects to exercise in the ordinary course of events, authority. This, in turn, will be largely a function of

degree of subordination and hence of one's employment situation. Those who share authority, or expect to share it, will favour a status ideology, but those whose subordination in the work situation emphasizes their alienation from authority will reject it.

The association of class conflict, trade unionism and rejection of status ideologies is plain enough. Similarly, it is not difficult to accept that a model of professionalism based on the independent, fee-supported private practitioner would include acceptance of status ideologies - particularly when one keeps in mind the origin of the established professions in occupations 'fit for gentlemen'. But the position is not nearly so straightforward when the professions concerned are composed largely of employees, and one would

---

1 Whilst recognizing, however, the survival of status ideologies (or, in Marxian terms, "false class consciousness") in certain "white collar" groups and "black-coated workers".

2 "These professions reached their full stature and others began to make their appearance at a period when the conception of the 'gentleman' was supreme, and from the 'gentlemen' with whom their members associated they derived other ideals which are no less a part of the professional code. This a 'gentleman' might be rich and might even seek riches. But certain roads to the acquisition of riches were closed to him; in particular he must not seek riches through the avenue of trade." (Carr-Saunders and Wilson, 1933, p.421.)
expect to find at least a mixture of class and status attitudes being expressed both informally and officially through their professional associations. One example would be the New South Wales Teachers' Federation, which regularly oscillates between "professional" and trade union postures, as circumstances change.

It is of course, difficult to say with certainty at which end of the status-class spectrum the prevailing attitudes of engineers and scientists would fall; there is just not sufficient information. Nevertheless, it may be assumed that a large proportion would occupy managerial positions, exercise considerable authority - or have the prospect of doing so - and be relatively well paid. Status attitudes might therefore be expected to predominate.

The consequences of this for the technologist are curious. As an employee-subordinate having special knowledge and skills and holding status attitudes, he is caught in a dilemma which can best be revealed by comparing and contrasting the roles of his professional associations with those of the independent practitioner. For this purpose, the Institution of Engineers, Australia, and the Australian Medical Association may be taken as examples.
Professional Employees and Professional Associations

The Institution of Engineers, Australia, is primarily an educational body. Although its functions are various, the overriding raison d'être is to promote technical study and to facilitate the dissemination of technical information amongst its members. Although it is far from unconcerned with the non-academic interests of its members, compared to the A.M.A. it is relatively less committed to professional "interests" in the narrow sense. One of the most important of its functions is to bestow a qualification (Membership or Fellowship). A professional qualification, particularly when it is not a pre-requisite for registration, is more than a mere badge of competence; it is also a symbol of status. It serves to mark off a section of an occupation as a distinct group in an occupational hierarchy, and by offering the qualification the professional association performs a status function. But at this point a significant difference between the Institution of Engineers and the Australian Medical Association emerges. The Institution makes no attempt to control the use of the professional qualification. A member of the Institute is free to use his qualification as he sees fit and, if he is not one of the small percentage in consultant practice, enters into an employment relationship which is entirely personal.
The A.M.A., on the other hand, while it does not offer a qualification, attempts to monopolise the use of medical qualifications, to serve the interests of its individual members and to claim rights as an interested party in employment contracts. Although it carries out an important educational function, this is overshadowed by its role of collectively furthering professional status and professional interests - pre-eminently, through the power it derives from the doctors' jealously guarded right to exact, and control, the level of fees. As agent and spokesman for the independent practitioner, the A.M.A. is the repository and vehicle of the status ideology which is so deeply rooted in his traditions and history.

The professional associations of the employed professional, such as the Institution of Engineers, are in different positions, which is the source of the dilemma referred to above. Despite their concern with

---

1 For example, by refusing space in its publications for advertisements of positions of whose emoluments and conditions it does not approve.
the status of their members,\textsuperscript{1} they are much less able
directly to further or support it because to do so would
entail bargaining and negotiation with the employers to
whom their members are subordinate and who pay their
incomes. And this would be an admission of a radical
conflict of interest, a confession of inequality of status
and hence distasteful to their status attitudes.

The upshot is that the professional associations of
the employee-professionals accomplish very little in the
way of protecting or promoting status. They temporize and
vacillate, and in a social climate which increasingly
equates status with high income and/or independence, the
structure of their professional work is such that they
can only press their claims by methods which are
inappropriate and alien both to status pretensions and to

\textsuperscript{1} "At the present time engineers in many lands are deeply
concerned over the problem of raising their professional
status. Recently there has been an increasing interest
in this question amongst members of The Institution of
Engineers, Australia. From published comments it would
appear that members hold widely differing views as to
what constitute the necessary pre-requisites of an
attained professional status; and in addition many
engineers seem unduly pessimistic in the view they take
of the whole question. That this should be so is
unfortunate, for if engineers themselves are not persuaded
of the feasibility of raising their status it is very
unlikely that the community will take the initiative and
force a new status upon the profession." (F.G. Sublet,
"The Institution and Engineering Education", Transactions
of the Institution of Engineers, Australia, vol.XVII,
p.123.)
the organizational structure of the association itself. Their effective defence of status is therefore confined largely to the provision of a professional qualification and to promoting technical study of professional subjects.

All of this is significant for the relationship between the professional association and the control of professional conduct. For technologists, and also, to a lesser extent, for architects, the claim of the professional association to a significant role in the ordering of professional conduct is a hollow one. The tepid concern of all the professional associations with control of conduct and exposure and punishment of misconduct, especially in client relationships, has already been noted. But this is especially true of the Institution of Engineers, Australia, and the Royal Australian Institute of Architects. The few cases which did arise were overwhelmingly concerned with advertising or undue publicity, which can only occur in relation to private practitioners. If those parts of their professional codes which are relevant only to private practitioners are taken away, all that is left are vague injunctions to service and honesty. This loss of specificity in relation to the professional employee
parallels a loss of relevance. An ethical code functions primarily to maintain the solidarity of a group of independent professionals and to serve their long-term interests, but the relationship between employer and professional employee requires no such code. Like any other employee, he will be dismissed if he does not do his job properly or if he is dishonest, and while "he may have much more loyalty to management,...this is an indication of his status ideology, not of his professionalism".¹

The extent, therefore, of the part played by the occupational association in controlling professional conduct will be conditioned by the employment situation of the members of the profession, and it may also be expected that, as the proportion of the employee-subordinates in a profession rises, the "trade union" character of the professional occupational association will become stronger, leading inevitably to conflicts within the association and the likelihood of breakaway associations being formed, provided there are sufficient independent practitioners to make new associations viable.

¹ Prandy, op. cit., p.178.
CONCLUSION

The ethical features of professionalism occur within three main contexts -

(i) in the professional activity itself; in the involvement and dedication which, given certain conditions, professional performance tends to draw from the practitioner;

(ii) in the moral order of the professional group; in the traditions, values, usages and norms which develop within the several professional cultures and which largely determine the professional role;

(iii) in the transactions between the professional cultures and other social forces and institutions.

Within these broad areas, and especially within the second and third, a number of structural variables operate differentially to influence the ethical character of the activities and relationships involved.

The man transformed by professional training and socialization, for example, frequently brings to his daily work attitudes, beliefs and commitments which deeply affect the nature of his relations with others and the quality and purpose of his own performance.
The sources of this transformation are to be found, in the main, within the professional culture, but the particular shape it will give is influenced by variables within the profession. In so far as codes of conduct, whether formal or informal, are significant, we have seen how their emergence may be affected by such things as the type and nature of professional practice, occupational diversity within a profession, the degree of occupational control exercised by a profession, the supply of professionals, degree of understanding of professional art by client, closeness of contact with client, and so on.

In analysing the codes themselves it soon becomes apparent that underlying the specific injunctions are two broad functions which may be designated "intrinsic" and "extrinsic". The intrinsic function is to maintain solidarity within the profession and to specify a system of intra-professional observances aimed at avoiding divisiveness and competition (except in strictly prescribed ways which ensure that professional pre-eminence is defined and legitimated by professional colleagues). The extrinsic functions provide an assurance and a reminder; they assure clients and the world at large that the profession is aware of
its responsibilities and that it recognizes an obligation to abide by general ethical principles in the performance of a role which is essentially unsupervisable; and they remind the members of the profession itself that its professional licence and mandate are conditional upon its ethical conformity.

Matching these two functions are two mechanisms for the enforcement of standards of professional conduct - the extra-professional, in the form of legal-social sanctions by statutes, boards of control, etc., and intra-professional sanctions of which expulsion is the most significant. In practice, however, the professions themselves evince only slight interest in the policing of professional conduct, and the areas of most frequent arousal are those which threaten stable intra-professional relationships and the economic interests of members. It is concluded, in view of the significant predominance of "intrinsic" material within the codes themselves, and the keener interest shown in ordering the relations between professional and professional rather than between professional and client, or others, that the overriding interest of the body of the profession is in maintaining its own identity and solidarity.
The professions exist within the social matrix and, as the professional individual is himself the performer of many roles, so is the profession itself penetrated by other social movements and forms of organization in ways which may significantly affect its ethical character. Two major social trends were chosen as examples of the way in which the professions may interact with these forces. Bureaucracy and commercialization have been held by others\(^1\) to be the outstanding contemporary influences on the professions, and in examining the consequences of both for professionalism a special focus of interest was the effect of these trends on some of the central ethical features of professionalism. Thus, in enquiring whether commercialism may be detected as a significant factor or attitude in current medical practice it was suggested that there was a fundamental incompatibility between an ethic of professionalism oriented primarily to quality of professional performance and the achievement of social status by institutionally approved means within this context, and the maximization of money-making in a

\(^{1}\) See for example, C. Wright Mills, *White Collar*, Oxford University Press, New York, 1951, pp.112-141, and especially p.113: "These two coexisting themes - of bureaucracy and commercialization - guide our understanding of the U.S. professional world to-day."
context of private enterprise practice which equates professional achievement and social status with economic success. Such trends, it was held, lead inevitably to the exploitation of clients or patients as "units of production" and hence, as Parsons observed, to ways of earning money "which are not strictly in the line of institutionally approved achievement".\(^1\) Indirect evidence of a growing commercialistic orientation in Australian medical practice was adduced from the trend of interests revealed in a number of publications directed to the professions. This material is broadly consistent with the findings of a number of American investigations.\(^2\)

Similarly, the discussion of professionalism and bureaucracy pivoted about the consequences of rational, bureaucratic organization for professional autonomy and the constellation of ethical factors derived from it. In the struggle between the opposed demands of organizational integration and professional independence an elaborate political process takes place which is now

\(^2\) See for example, Gross (1966); Rayack (1967); Badgley (1967); Tunley (1966)
a feature of many complex organizations employing professionals in large numbers. An important factor determining the direction of the outcome is the degree of specific competence of the profession concerned, and it may therefore be deduced that professional autonomy is a function of expertise, other things (such as supply of professionals, occupational prestige and solidarity, etc.) being equal.

This theme was resumed in the discussion of the status of the employed professional and of the differential significance of the professional association for professional employees and independent professional practitioners. It was argued that degree of professional subordination in the work situation is correlated with social status generally and that the extent to which the professional association can promote the (economic) status of the employed professional is in turn dependent upon the extent to which it is prepared to adopt trade-union tactics; but that to do so is to admit a radical divorcement of the professional from claims to status on other grounds. This, it is suggested, has important consequences for professional ethics in that it tends to channel professional energies into status struggles based on
economic considerations rather than on strictly professional criteria.

In its role as public representative of the profession and as the repository of the profession's moral authority over its members, the professional association, particularly the occupational association, is of considerable significance. But its significance varies with its strength, which in turn seems to be connected with the proportion of its membership which is composed of independent practitioners, and their numbers. This is not true to the same extent of the study and prestige associations, which nevertheless powerfully influence the commitment of members of the profession to ideals of high standards of professional performance.

Although the relations between the professions and society are many and complex, so far as their ethical features are concerned, most of them can be analysed in terms of the service which professional activities are deemed to render to various social values and the techniques developed for the social control of potentially dangerous professional expertise and independence. It was suggested that where there is wide consensus about the nature of a social value and
the means by which it may be preserved, and where, in addition, the appropriate professional art is scientifically based, the relations between profession and society, and the "ethical control" of the profession are much more straightforward than in a situation where the value in question is the subject of conflict and opposing interests, and where the professional art is not universal, objective and scientifically based. In these terms, medicine and law provide interesting contrasts and the way in which ethical give and take between profession and society may occur was illustrated by examples from medical ethics. Carlin's excellent study of the New York bar\(^1\) is a mine of information on the ethical strains which attend certain forms of organization of legal practice and particularly of the variation, and even contradiction, of ethical norms within the profession which follow upon the stratification of legal practice. It is from such material that a further development (beyond the scope of this paper) of ethical contrasts between professions could be made.

---

This treatise has concentrated, therefore, upon the moral dimensions of professionalism and has attempted to trace the underlying connections between the maintenance of professional cultures and certain ethical categories or prerequisites which seem to be essential for stability within the profession and for the orderly relations of the profession with its social environment.

In justification of this approach it may be said that although sociological interest in the socialization processes of the professions and in the professionalization of occupations has grown apace in recent years, the middle ground of analysis and classification of professional ethics in relation to professional solidarity and professional-societal relations has been largely untilled. Professional ethics is often regarded as an epiphenomenon of slight practical significance and not theoretically challenging. The subject is thus frequently seen as a mere description of what constitutes good manners in intra-professional relationships or as a smoke-screen of high moral purpose concealing money-grubbing and self-interest. In either case, so it is implied, nothing of great sociological moment is at stake. One purpose of this essay has been to show that it does raise issues which are important
to the whole theory of the professions and to the nature of the relationships which maintain occupational groups within society and which order their moral exchanges with it.
AKERS, Ronald L. & QUINNEY, Richard


ALLEN, V.L.


ANDERSON, D.S.

"Homo Medicus Embryonis", paper delivered to Conference on Learning and Teaching in the Pre-Clinical and Para-Clinical Department of Medicine, University of Melbourne, August, 1968.

ANDERSON, John


ANDERSON, N.


ANONYMOUS


AUSTRALIAN MEDICAL ASSOCIATION

BADGLEY, Robin F, & WOLFE, Samuel

BANKS, J.A.

BARWICK, SIR GARFIELD

BECKER, H.S.

BEN-DAVID, J.


CARR-SAUNDERS, A.M. & WILSON, P.A.
The Professions, Oxford, 1933.

CATES, JUDITH N.

CHILDs, M.W. & CATER, D.

CIBA FOUNDATION

CLEVELAND, H. & LASSWELL, H.D. (Eds.)
Ethics and Bigness: scientific, academic, religious, political and military, New York, Harper and Bros., 1962.

COGAN, M.L.


COHEN, E. & SCHWAB, J.J.

COLOMBOTOS, JOHN
COOK, F.J.  

COOKE, M.L.  

CRANBERG, L.  

DAEDALUS (Journal)  

DENZIN, N.K.  

DIBBLE, V.K.  

DRINKER, H.S.  
Legal Ethics, New York, 1953.

DURKHEIM, E.  


EDDY, W.H.C.  

EDEL, A.  

ENGEL, GLORIA V.  


<table>
<thead>
<tr>
<th>Author</th>
<th>Title/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Title</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>HEALY, S.</td>
<td>Medical Ethics, Loyola University Press, 1956.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>LANDIS, B.Y.</td>
<td>Professional Codes: A Sociological Analysis to Determine Applications to the Educational Profession</td>
</tr>
<tr>
<td>LEAKE, C.P.</td>
<td>Percival's Medical Ethics</td>
</tr>
<tr>
<td>MACDONALD, J.B.</td>
<td>&quot;Medical Ethics To-day&quot;</td>
</tr>
<tr>
<td>Author</td>
<td>Work</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
MONTAGNA, PAUL D. "Professionalization and Bureaucratization in Large Professional Organizations", American Journal of Sociology, 74(2), September, 1968.


NORTH, C.C. Social Differentiation, Chapel Hill, 1926.


<table>
<thead>
<tr>
<th>Author</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORMROD, SIR ROGER</td>
<td>&quot;Medical Ethics&quot;, <em>British Medical Journal</em>, 2, April 6, 1968, 7-10.</td>
</tr>
<tr>
<td>Author</td>
<td>Reference</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
SLOCUM, W.L.  


SMIGEL, E.O. et al.  


SMIGEL, E.O.  


SUBLET, F.G.A.  


SUPER, D.E.  


SUTTON, F.X. et al.  


TAEBUSCH, C.F.  


TAGIURI, RENATO  


TANNENBAUM, F.  

A Philosophy of Labour, New York, Knopf, 1951.


WEINBERG, MARTIN S.
&
HAAVIO-MANNILA, ELINA


WESTERN, J.S.
&
ANDERSON, D.S.


WESTERN, J.S.


WHYTE, W.F.


WILENSKY, H.L.


WILSON, L.

The Academic Man, Oxford University Press, 1942.

WINTER, G.


WISE, R.L.


WOLFF, KURT H.

THE INSTITUTION OF ENGINEERS, AUSTRALIA

CODE OF ETHICS

Approved by Council under Bye-law 96

June, 1966

SCIENCE HOUSE,
GLOUCESTER & ESSEX STREETS,
SYDNEY, N.S.W.
CODE OF ETHICS

PREAMBLE

The further development of civilisation, the conservation and application of natural resources, and the improvement of the standards of living of mankind depend largely upon the work of the Engineer. For that work to be fully effective, it is necessary not only that Engineers strive constantly to widen their knowledge and improve their skill, but also that the community avail itself of the assistance that Engineers can give and that it be able to place its trust unreservedly in the integrity and judgment of the Profession.

It therefore behooves all Engineers, and members of The Institution in particular, so to order their lives and work as to merit and gain this confidence.

To this end all members of The Institution are enjoined to conform with the letter and the spirit of the Code of Ethics set out hereunder and, in addition, to comport themselves at all times with such dignity and propriety as will earn for the Profession the respect of the community.

CODE

Duty to Community

1. An Engineer's responsibility to the community shall at all times come before his responsibility to the Profession, to sectional or private interests, or to other Engineers.

Matters of Fact

2. If called upon to give evidence or otherwise to speak on a matter of fact, he shall speak what he believes to be the truth, irrespective of its effect on his own interests, the interests of other Engineers, or other sectional interests.

Matters of Opinion

3. Unless he is convinced that his duty to the community compels him so to do, he shall not express opinions which reflect on the ability or integrity of another Engineer.

Intra-professional Courtesy

4. He shall neither maliciously nor carelessly do anything likely to injure, directly or indirectly, the reputation, prospects or business of another Engineer.

Unfair Advantage

5. He shall not use the advantages of a salaried position to compete unfairly with Engineers in private practice, nor use unfairly the advantages of private practice to the detriment of salaried engineers.
Diligence

5. In whatever capacity he is engaged, he shall assiduously apply his skill and knowledge in the interests of his employer or client.

Limitations

1. If he is confronted by a problem which calls for knowledge and experience which he does not possess, he shall not hesitate to inform his client or employer of the fact, and shall make an appropriate recommendation as to the desirability of obtaining further advice.

Training of Subordinates

1. When in a position of authority over other Engineers, he shall see every care to afford to those under his direction every reasonable opportunity to advance their knowledge and experience.

Credit to Subordinates

1. He shall ensure that proper credit is given to any subordinate who has contributed in any material way to work for which he is responsible.

Acceptance of Favours

1. He shall at all times avoid placing himself under any obligation to any person or firm in whose dealings with his employer or client he may be concerned. If such an obligation exists, he shall fully disclose the fact to his employer or client. He shall not accept any substantial gift or favour from such person or firm.

Financial Interests

1. If he has any substantial financial interest in any firm or company at tender or contract for the construction of, or the supply of, materials or equipment for any works for which he is in any degree responsible, or if he is entitled to any patent royalty or gratuity respect of any equipment or process likely to be used in connexion with such works, he shall fully disclose in writing the circumstances to his employer or client. He shall not report upon or make recommendations on any tender on a company or firm in which he has any substantial financial interest or on tenders which include such a tender.

Confidential Information

1. He shall not use for his personal gain or advantage, nor shall he disclose, any confidential information which he may acquire as a result of special opportunities arising out of work done for his client or employer.

Contract Preparation and Supervision

1. In the preparation of plans, specifications and contract documents, and on the supervision of construction work, he shall assiduously watch and conserve the interests of his client or employer. However, the interpretation of contract documents, he shall maintain an
attitude of scrupulous impartiality as between his client or employer, on the one hand, and the contractor on the other, and shall, as far as he can, ensure that each party to the contract shall discharge his respective duties and enjoy his respective rights as set down in the contract agreement.

Consulting Practice
14. He shall not describe himself, nor permit himself to be described, nor act as a Consulting Engineer unless he is a Corporate Member and occupies a position of professional independence and is prepared to design and supervise the construction of engineering work and/or to act as an unbiased and independent adviser on engineering matters, and unless he conducts his practice in strict compliance with the conditions approved by the Council of The Institution.

Business Interests
15. If he is a Director or employee of any Company that offers Consulting Engineering Services in a manner and/or on terms other than those approved by the Council of The Institution for a Consulting Engineer he shall not permit his name to be used in any advertisement of such services.

Soliciting Work
16. A Consulting Engineer shall not solicit professional work, either directly or indirectly, or by an agent, nor shall he reward any person who may introduce clients to him.

Advertisements
17. A Consulting Engineer may publish notices or professional cards, permit the display of his name on works under construction and on commemorative tablets and prepare brochures giving details of his practice provided that all published matter shall be in accordance with conditions approved by the Council of The Institution.

Replies to Advertisements
18. A Consulting Engineer may reply to advertisements or circular letters inviting applications for appointment provided that he does so in accordance with conditions approved by the Council of The Institution.

Continuance of Partnership
19. No member shall continue in partnership with, nor shall he act in association or conjunction with, any Engineer who has been removed from membership of The Institution because of unprofessional conduct.

Simmons Limited, Glebe, Sydney.
THE INSTITUTION OF ENGINEERS, AUSTRALIA

Conditions of Professional Practice for Consulting Engineers

Adopted by the Council of The Institution, 21st November, 1966

SCIENCE HOUSE,
GLOUCESTER & ESSEX STREETS,
SYDNEY, N.S.W.
1967
Conditions of Professional Practice for Consulting Engineers

Adopted by the Council of The Institution, 21st November, 1966

These are the Conditions referred to in Clauses 14, 15, 17 and 18 of the Code of Ethics.

1. Preamble.

Consulting Engineers are among the relatively small group of professional engineers who come into direct contact with the public as individuals and it is therefore particularly important that they conduct themselves in such a manner as will earn the respect of the community for the whole engineering profession.

Consulting Engineers are required to conform to the Code of Ethics of The Institution and to the following Conditions of Professional Practice.

2. The Public Interest.

A Consulting Engineer's responsibility to his client and to the profession in general shall have full regard to the public interest. It is improper for him to be or to remain associated with any project which he has reason to believe is promoted with dishonest motives.

3. Intra-Professional Relations.

A Consulting Engineer shall not agree to execute professional work at a lower scale of charges than the minimum approved from time to time by The Institution, or as otherwise specifically approved by the Council of The Institution. He shall not compete with another Consulting Engineer on the basis of fees.

A Consulting Engineer shall not:

(i) Attempt to supplant another Consulting Engineer.

(ii) Accept engagement from a client in replacement of another Consulting Engineer without first ascertaining that the other engineer's appointment has been properly terminated in writing.

(iii) Accept an engagement from a client to review the work of another Consulting Engineer except with the latter's full knowledge of the circumstances.

(iv) Accept an engagement from a client to extend the work of another Consulting Engineer whose appointment has not been properly terminated.

4. Remuneration and Relationship to Client.

A Consulting Engineer shall in all professional matters act as a faithful adviser to his client. In his administration of contract he shall maintain an attitude of scrupulous impartiality as between his client and the contractor. His charges to his client shall constitute his only remuneration in connection with the work.

A Consulting Engineer shall not accept any trade commission, discount, allowance or indirect profit in connection with any professional work.
A Consulting Engineer normally may issue certificates for payment but shall not make payments on his client's behalf unless specially requested to do so.

His relationship to his client shall be that of a professional adviser and not that of an employee.

5. Impartiality.

A Consulting Engineer shall take care to avoid any circumstances which might affect the impartiality of his judgment.

A Consulting Engineer shall fully disclose circumstances of any nature, financial or otherwise, which might appear likely to influence the impartiality of his advice or decisions.

6. Advertising.

A Consulting Engineer may not solicit professional work by advertisement or otherwise. It nevertheless shall not be deemed improper for him to:

(i) Forward notices by mail to persons, firms and organisations with whom he has a direct connection on the occasion of the establishment of a practice or of a branch office, or of a change in name, partnership, address or field of practice. Only one notice may be forwarded for each event and a copy shall be sent to the Secretary of The Institution and to the Secretaries of Divisions in all areas in which the firm practises. The content of such notices shall be confined to a statement of the name of the firm, the addresses of its offices, the names and qualifications of partners and of branch office managers and its fields of practice.

(ii) Insert notices or professional cards in technical journals. Such notices shall comply with all restrictions applying to notices forwarded by mail. The notice shall not be unduly prominent.

(iii) Prepare and use a brochure in accordance with Clauses 7 and 9 hereof.

(iv) Exhibit his name and/or that of his firm outside his office and on buildings and engineering works in course of construction, alteration or extension, when engineering services are provided by him. This shall be done in a dignified manner and in accordance with the policy determined by the Council of The Institution.

7. Offer of Services.

A Consulting Engineer shall not solicit professional work. When replying to an advertisement or circular letter inviting Consulting Engineers to apply for appointment his application shall be confined to:

(i) A statement of the academic and professional qualifications of himself and leading members of his staff.

(ii) A list of previous work carried out by him.

(iii) An indication of the amount of time that could be given to the work and the date on which it could be commenced and/or completed.

(iv) A statement of the basis upon which fees would be charged, such fees being in no case less than the minima approved by The Institution.

A brochure as defined in Clause 9, may be enclosed with the application.
8. Honorary Works.

While a Consulting Engineer is required to observe the minimum scale of fees in respect of work carried out by him, it is permissible for him to act in an honorary capacity for any charitable, religious, educational, or sporting body in which he is interested.


A Consulting Engineer may prepare a brochure giving details of his practice. Brochures must be dignified in form and factual in content which shall be limited to particulars of:

(i) Constitution of firm, including details of head and of branch offices. This may include numbers of employees.
(ii) Names, qualifications and photographs of partners, associates and senior engineers. Partners shall be identified as such.
(iii) Fields of engineering in which services are offered.
(iv) A list of works, giving a brief description of the size of the works and type and extent of service provided by the firm. Such description shall be so given that no inference can be drawn that the firm has provided services on the project that have been provided by others.
(v) Factual illustrations of works carried out to the design and/or under the administration of the firm. The limits of the firm's responsibility in each project illustrated should be clearly noted. A description of the project with an indication of size may be given.

One copy of the completed brochure and of every revision thereof shall be lodged with the Secretary of The Institution.

10. Engagement of Staff.

A Consulting Engineer when employing staff shall endeavour not to draw upon the staff of another Consulting Engineer. He, however, may engage an employee of another Consulting Engineer where the employee has initiated the change in employment or where the employee has replied to an advertisement by the Consulting Engineer seeking staff.

11. Professional Practice Outside Australia.

For the purpose of carrying out work in a country outside the Commonwealth of Australia or Territories under the control of the Commonwealth, a Consulting Engineer shall order his conduct and scale of fees according to the rules of the professional engineering association appropriate to that country and recognised accordingly by the Council of The Institution.

12. Competitions.

A Consulting Engineer shall not submit an entry in a competition conducted within the Commonwealth of Australia or Territories under the control of the Commonwealth and involving the submission of proposals and designs for engineering work unless such competition is conducted in accordance with the general conditions for competitions prescribed by The Institution.

Simmons Limited, Glebe, Sydney.
ROYAL AUSTRALIAN INSTITUTE OF ARCHITECTS

CODE OF PROFESSIONAL CONDUCT

1. Members of the Royal Australian Institute of Architects are governed by the Articles of Association, By-Laws and Codes of the Institute.

This code indicates the standard of conduct to which members of the Institute must adhere.

Any member whose conduct is contrary to this Code, or to those standards or rules established by the Council of the Institute from time to time, shall be liable to disciplinary action as provided in the Articles of Association.

Cases of unprofessional conduct not covered by specific provisions of this Code shall be dealt with by the Council, having regard to the particular circumstances of the case.

It is the duty of every member to report any apparent breach of this Code for investigation in accordance with the provisions of the Articles of Association.

2. RESPONSIBILITIES OF EVERY MEMBER

2.1 To the public

2.11 to ensure that his professional actions do not conflict with his general responsibility to contribute to the quality of the environment

2.12 to be of constructive service in civic affairs and to apply his skill to the creative, responsible and economic development of his community.

2.2 To clients and employers

2.21 to provide professional services of a high standard

Footnote:

1 Fourth Draft of Code currently under revision, at time of writing.
2. RESPONSIBILITIES OF EVERY MEMBER (continued)

2.2 To clients and employers

2.22 to inform his client or employer of the existence or likelihood of any conflict between his own interest and that of his client or employer

2.23 to act with fairness and impartiality when administering a building contract or when arbitrating in a dispute.

2.3 To the Institute and fellow members

2.31 to maintain a high standard of personal integrity

2.32 to promote the advancement of architecture

2.33 to conduct himself in a manner which is not derogatory to his professional character, nor likely to lessen the confidence of the public in the Institute or the profession nor bring them into disrepute

2.34 to compete fairly with other members

2.35 to observe and uphold the Institute's Conditions of Engagement and Scale of Charges

2.36 not to supplant or attempt to supplant another member

2.37 on being instructed to proceed with professional work to enquire whether another member was previously engaged in connection with the work and if advised in the affirmative to notify such member in writing

2.38 to comply with the Institute's rules and code for architectural competitions and not to compete in or act as assessor for an architectural competition unless it has been approved by the Institute.
3. **RULES REGARDING PUBLICITY**

3.1 A member shall not advertise his professional services nor shall he allow his name to be included in advertisements or to be used for publicity purposes subject to the following exceptions all of which are permissible in an unostentatious form:

3.11 advertisements including his name may be published in connection with the calling of tenders, staff requirements and similar matters.

3.12 a notice of change of address may be published on three occasions and correspondents may be informed once by post.

3.13 his name may show outside his office and on buildings under construction and completed for which he is the architect provided the lettering does not exceed three inches in height.

3.14 he may allow his name to be associated with illustrations and descriptions of his work in the press or other public media but he shall not give or accept any consideration for such appearances.
CODE OF ETHICS

1969

77-79 ARUNDEL STREET,
GLEBE, SYDNEY, 2037
N.S.W.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Code of Medical Ethics</td>
<td>7</td>
</tr>
<tr>
<td>2. Ethics and the Medical Profession</td>
<td>7</td>
</tr>
<tr>
<td>3. Declaration of Geneva</td>
<td>8</td>
</tr>
<tr>
<td>4. International Code of Medical Ethics</td>
<td>9</td>
</tr>
<tr>
<td>4.2 Duties of Doctors in General</td>
<td>9</td>
</tr>
<tr>
<td>4.3 Duties of Doctors to the Sick</td>
<td>9</td>
</tr>
<tr>
<td>4.4 Duties of Doctors to Each Other</td>
<td>10</td>
</tr>
<tr>
<td>5. The Australian Medical Association and Medical Ethics</td>
<td>10</td>
</tr>
<tr>
<td>6. The Doctor-Patient Relationship</td>
<td>10</td>
</tr>
<tr>
<td>6.2 Professional Confidence</td>
<td>11</td>
</tr>
<tr>
<td>6.3 Emergency Attention</td>
<td>12</td>
</tr>
<tr>
<td>7. Doctor and Practice</td>
<td>12</td>
</tr>
<tr>
<td>7.1 Locum Tenentes-Assistants</td>
<td>12</td>
</tr>
<tr>
<td>7.2 Notices</td>
<td>13</td>
</tr>
<tr>
<td>7.3 Premises</td>
<td>13</td>
</tr>
<tr>
<td>7.4 Telephone Directories</td>
<td>14</td>
</tr>
<tr>
<td>7.5 Group Practice -- Descriptive Titles</td>
<td>14</td>
</tr>
<tr>
<td>7.6 Lay Persons and Medical Companies</td>
<td>14</td>
</tr>
<tr>
<td>7.7 Medical Certification</td>
<td>14</td>
</tr>
<tr>
<td>7.8 Sterilization</td>
<td>15</td>
</tr>
<tr>
<td>7.9 Unethical Medical Appointments</td>
<td>16</td>
</tr>
<tr>
<td>8. The Doctor and his Colleagues</td>
<td>16</td>
</tr>
<tr>
<td>8.2 Examination in Consultation</td>
<td>16</td>
</tr>
<tr>
<td>8.3 Medical Inspectors</td>
<td>19</td>
</tr>
<tr>
<td>8.4 Workers' Compensation Insurance Practice</td>
<td>20</td>
</tr>
<tr>
<td>8.5 Industrial Medical Officers</td>
<td>21</td>
</tr>
<tr>
<td>8.6 Change of Medical Attendant: Supersession</td>
<td>21</td>
</tr>
<tr>
<td>9. Dichotomy</td>
<td>22</td>
</tr>
<tr>
<td>10. The Doctor and other Professions</td>
<td>22</td>
</tr>
<tr>
<td>10.1 Dentists</td>
<td>23</td>
</tr>
<tr>
<td>10.1.2 Dental Consultations</td>
<td>23</td>
</tr>
<tr>
<td>10.1.3 Dental Anesthetics</td>
<td>23</td>
</tr>
<tr>
<td>10.2 Urology</td>
<td>23</td>
</tr>
<tr>
<td>10.3 Chemists</td>
<td>24</td>
</tr>
<tr>
<td>11. The Doctor and Commercial Undertakings</td>
<td>24</td>
</tr>
<tr>
<td>11.2 Testimonials and Reports for Trade Purposes</td>
<td>25</td>
</tr>
<tr>
<td>11.2.1 Testimonials or Laudatory Certificates</td>
<td>26</td>
</tr>
<tr>
<td>11.2.2 Clinical Trials</td>
<td>25</td>
</tr>
<tr>
<td>12. The Doctor and the General Public</td>
<td>26</td>
</tr>
<tr>
<td>12.2 Press Interviews</td>
<td>27</td>
</tr>
<tr>
<td>12.3 Lectures to Lay Public</td>
<td>27</td>
</tr>
<tr>
<td>12.4 Photographs</td>
<td>28</td>
</tr>
<tr>
<td>12.5 Advertising in the Lay Press</td>
<td>28</td>
</tr>
<tr>
<td>12.6 Condonation of Publicity in the Press</td>
<td>28</td>
</tr>
<tr>
<td>12.7 Publicity in General</td>
<td>28</td>
</tr>
<tr>
<td>13. Conclusion</td>
<td>29</td>
</tr>
<tr>
<td><strong>APPENDIX</strong></td>
<td></td>
</tr>
<tr>
<td>14. State Medical Boards</td>
<td>30</td>
</tr>
<tr>
<td>15. Press Interviews</td>
<td>30</td>
</tr>
<tr>
<td>16. Declaration of Helsinki</td>
<td>31</td>
</tr>
</tbody>
</table>
PREFACE TO 1966 EDITION

More than 2,000 years ago, Hippocrates insisted that members of his profession should subscribe to an oath pledging them to observance of the highest standard of moral and ethical conduct. Hereby was laid the foundation on which the profession of medicine has built the traditions of service to humanity which we inherit today. We, in Australia, are mindful of the nobility of these traditions of dedicated service and as very junior members of world medicine enter upon this heritage with due humility. The medical profession in this country can, with justice, be proud of the manner in which the standards of medical ethics have been preserved in the Hippocratic tradition. One of the first actions of the newly formed Australian Medical Association was to resolve that, as a national association, it was desirable that a Code of Medical Ethics should be prepared which should be uniformly applicable throughout Australia. This task was placed in the capable hands of Dr. John Hunter, who for many years had been Secretary, both of the New South Wales Branch and of the Federal Council of the British Medical Association in Australia, and in addition had been lecturer in Medical Ethics in the Faculty of Medicine at Sydney University. With his unrivalled knowledge of his subject it was anticipated that the result would be a comprehensive and authoritative document and this anticipation was realized.

When presented to the Federal Assembly general approval and appreciation of the Code was expressed, but in view of the fact that some variations exist from State to State, it was decided that it should be circulated to the Branches for any comments or amendments considered necessary. It was obvious that some central body would need to undertake the task of revising the Code in the light of all the suggested amendments with a view to co-ordinating and adapting them to present the uniform Code applicable to a national association, which was the desired objective. The Queensland Branch of the A.M.A. offered to undertake this arduous task, and the unanimous approval and appreciation with which it was received and adopted by the Federal Assembly in May of 1964 is an indication of how well they succeeded. The Queensland Branch has on more than one occasion expressed its gratitude and appreciation of Dr. Hunter’s basic work, and while fully agreeing in regard to this, the Australian Medical Association also acknowledges with gratitude their appreciation and admiration of the very real service the Queensland Branch has given to the Association in the compilation of this Code of Ethics.
CODE OF ETHICS

1. Code of Medical Ethics.

1.1 "Inspire in me a love for my Art and for thy creatures. Let no thirst for profit or seeking for renown or admiration take away from my calling . . . . Keep within me strength of body and of soul, ever ready, with cheerfulness, to help and succour rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being.

1.2 If those should wish to improve and instruct me who are wiser than I, let my soul gladly follow their guidance; for vast is the scope of our Art.

1.3 In all things let me be content, in all but the great Science of my calling. Let the thought never arise that I have attained to enough knowledge, but vouchsafe to me over the strength, the leisure and the eagerness to add to what I know. For Art is great, and the mind of man ever growing."

(From the prayer of Maimonides—
Moses ben Maimon, A.D. 1135-1204.)

2. Ethics and the Medical Profession

2.1 The medical profession occupies a position of privilege in society because of the understanding that a doctor's calling is to serve humanity, and because members of the profession have built up a tradition of placing the needs of the patient before all else.

2.2 On admission to the brotherhood of medicine, every new member not only succeeds to the benefit of its special place in society, but also takes upon himself the duty of maintaining this high position. The justification for the freedom of medicine lies in the hands of those who practise it.

2.3 Some two thousand three hundred and fifty years ago Hippocrates demanded that every member of his profession should subscribe to his famous oath. The principles of this oath may be stated as follows:
(a) To live a pure and moral life and to pay due respect to his teachers, to share a knowledge of medicine with the rest of the profession and to have no secret remedies or processes.

(b) To do no man any harm by the misapplication or criminal application of a knowledge of medicine.

(c) To undertake only such things as are within the competence of the individual practitioner.

(d) To keep secret anything learned as the outcome of professional relationship with a patient which should not be divulged.

(e) To avoid abuse of the doctor-patient relationship.

2.4 Today these general rules still form the basis of a code or standard of professional behaviour which must be observed if the honour and dignity of the profession are to endure. To command the respect of his patients and of the public should be the aim of every doctor. The strict observance of basic ethical principles will enable the doctor to attain this end and to be worthy of the appraisement given of the doctor by Robert Louis Stevenson:

2.5 “He is the flower, such as it is of our civilization, and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race.

Generosity he has such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what is more important, herculean cheerfulness and courage.”

3. Declaration of Geneva

3.1 The modern version of the Hippocratic Oath is contained in the Declaration of Geneva adopted by the World Medical Association at its meeting in Geneva in 1948:

3.1.1 “At the time of being admitted as a member of the medical profession I solemnly pledge myself to consecrate my life to the service of humanity;

3.1.2 I will give to my teachers the respect and gratitude which is their due;

3.1.3 I will practise my profession with conscience and dignity;

3.1.4 The health of my patient will be my first consideration;

3.1.5 I will respect the secrets which are confided in me;

3.1.6 I will maintain by all the means in my power the honour and the noble traditions of the medical profession;
3.1.7 My colleagues will be my brothers;
3.1.8 I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
3.1.9 I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
3.1.10 I make these promises solemnly, freely and upon my honour.

4. International Code of Medical Ethics

4.1 The World Medical Association in 1949 prepared an International Code of Ethics for Observance by doctors in all countries.

4.2 Duties of Doctors in General.

4.2.1 A doctor must always maintain the highest standards of professional conduct towards both the individual and society.

4.2.2 A doctor must not allow himself to be influenced merely by motives of profit.

4.2.3 The following practices are deemed unethical:
(a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.
(b) Taking part in any plan of medical care in which the doctor does not have professional independence.
(c) To receive any money in connection with services rendered to a patient other than the acceptance of a proper professional fee, or to pay any money in the same circumstances without the knowledge of the patient.

4.2.4 Under no circumstances is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being, except from strictly therapeutic or prophylactic indications imposed in the interest of the patient.

4.2.5 A doctor is advised to use great caution in publishing discoveries. The same applies to methods of treatment whose value is not recognized by the profession.

4.2.6 When a doctor is called upon to give evidence or a certificate he should only state that which he can verify.

4.3 Duties of Doctors to the Sick

4.3.1 A doctor must always bear in mind the importance of preserving human life from the time of conception until death.
4.3.2 A doctor owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

4.3.3 A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

4.3.4 A doctor must give the necessary treatment in emergency, unless he is assured that it can and will be given by others.

4.4. **Duties of Doctors to Each Other**

4.4.1 A doctor ought to behave to his colleagues as he would have them behave to him.

4.4.2 A doctor must not entice patients from his colleagues.

4.4.3 A doctor must observe the principles of "The Declaration of Geneva" approved by the World Medical Association.

5. **The Australian Medical Association and Medical Ethics**

5.1 In the following pages are set out some statements of policy, definitions and rules developed over the years when the State Branches were attached to the parent body, the British Medical Association.

5.2 These statements illustrate the practical application of ethical principles, for while a formal code of ethics may provide the doctor with a standard, problems will always arise in the course of his professional work on which he needs specific guidance. They may occur, for example, in the setting up of practice, in his relationship with colleagues, in dealings with official bodies, in contact with the general public, and in numerous other ways.

5.3 One of the most important functions of the Australian Medical Association is to advise and assist members on ethical problems.

5.4 The Council of each State Branch appoints a Standing Committee which concerns itself expressly with problems of medical ethics, and has the necessary machinery for dealing with disputes between members of the profession. A medical practitioner who has an ethical problem not covered by any of these statements or who has doubt as to the line of conduct he should adopt in any professional difficulty is urged to seek advice from the State Branch of the Association.

6. **The Doctor-Patient Relationship**

6.1.1 The basis of the relationship between a doctor and his patient is that of absolute confidence and mutual respect. The patient
expects his doctor not only to exercise professional skill but also to observe secrecy with respect to the information he acquires as a result of his examination and treatment of the patient. On the doctor's side an awareness of the patient's trust should evoke a sense of personal responsibility which should ensure the observance of ethical standards in their relationships at all times and advice given or action taken should always be in the patient's best interests.

6.1.2 Every patient has a right to expect a complete and thorough examination into his condition and that accurate records will be kept.

6.1.3 A doctor should be ever striving in the interests of his patients to improve his knowledge and skill.

6.2. Professional Confidence

6.2.1 It is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.

6.2.2 The complications of modern life sometimes create difficulties for the doctor in the application of the principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be the adoption of a line of conduct that will benefit the patient or protect his interests.

6.2.3 The principle of professional secrecy still applies as between husband and wife but there are times when consent if not actually given by a spouse could be reasonably inferred. The decision whether to divulge the information to the other spouse, when consent has not been obtained, would be a matter for the discretion of the attending practitioner which he must exercise with the greatest care and for which he must accept full responsibility at all times. He must adopt a line of conduct that will benefit the patient and protect the patient's interest. Moreover, if he does anything which damages the patient's interest he renders himself liable to an action at law.

6.2.4 The doctor's usual course when asked in a court of law for medical information concerning a patient in the absence or refusal of that patient's consent is to demur on the ground of professional secrecy. The presiding judge, however, may overrule this contention and direct the medical witness to supply the required information. The doctor has no alternative but to obey unless he is willing to accept imprisonment for contempt of Court.

6.2.5 Generally speaking, the State has no right to demand information from a doctor about his patient save when some notification
is required by statute, as in the case of infectious disease. When in doubt concerning matters that have legal implications a doctor may also wish to consult the medical defence organization of which he is a member.

6.2.6 The greater concern of Government with the welfare of the community has brought doctors into close contact with government departments, hospital boards and many other bodies composed partly or wholly of non-medical persons, with the result that requests are made by medical or lay officials for clinical records or other information concerning patients.

6.2.7 Other parties who frequently seek information from a doctor are employers who request reports on the medical condition of absent or sick employees, insurance companies requiring particulars about the past history of proposers for life assurance or deceased policy holders and solicitors engaged in threatened or actual legal proceedings.

6.2.8 In all such cases where medical information is sought, the doctor should make it a rule to refuse to give any information in the absence of the consent of the patient or the nearest competent relative.

6.3. Emergency Attention

6.3.1 The duty of a medical practitioner to render care to a patient in need is paramount, and unless for some very good reason must transcend other considerations. In an emergency or in the absence of any other available practitioner refusal to attend would be hard to justify on ethical grounds. Once a practitioner has commenced to treat the patient, he must continue until he can do no more, or the patient requests him not to attend or he himself decides to refuse to attend further. If the practitioner decides to withdraw, his withdrawal should be carried out in such a manner as to prevent any ill consequence to the patient.

6.3.2 It has always been the custom of members of the medical profession to help one another to the utmost, to attend one another in illness without regard to fee or reward, and to do each other's work in emergencies and when incapacitated by illness. Called as a substitute in an emergency, the first duty of the doctor is to do what he can in the interests of the patient and then relinquish the care of the patient to the usual medical attendant.

7. Doctor and Practice

7.1. Locum Tenentes—Assistant

7.1.1 The legal agreement commonly entered into by a principal and his partner, assistant or locum tenens usually contains a restrictive covenant precluding practice for an agreed time in a defined area by the partner, assistant or locum tenens after the termination of the contract. Apart, however, from the legal aspect of the matter
there is an ethical obligation on a doctor not to damage the practice of a colleague with whom he has been engaged lately in professional association.

7.1.2 Unless the written consent of the principal or partner or partners is obtained, a doctor who has acted as an assistant to or locum tenens for that principal or as a member of a partnership should not set up in any form of private practice in opposition to his former principal or partner in the area of practice of that principal or partner, nor should any doctor act similarly towards another with whom he has unsuccessfully negotiated for a partnership or made enquiries thereon; to do so would be considered an unethical procedure. A period of time during which this restriction shall apply will be related to the period of time spent in practice with principal or partners and this may be considered when a reference is made. Even though the principal by a breach of faith may have caused bona fide negotiations to break down, the other doctor concerned should not start a competitive practice with him unless and until he satisfies himself, by a reference to his Branch Council, that the action he contemplates is free from ethical objection.

7.2 Notices

7.2 From time to time it may happen that a doctor, whether in general or consultant practice, wishes to make some formal announcement about his practice to his patients or his colleagues. A general practitioner, for example, may wish to notify his patients of a change of address or of surgery or consulting hours, or that he has taken in a partner. In any such case the notification should be sent as a circular letter, under cover, to the bona fide patients only of the practice, that is, to those who are on its books and are not known to have transferred themselves to another doctor. There is no objection to a suitable notice being placed in the waiting room. Provision may be made in the ethical rules of Branches for notices of commencement or resumption of practice, changes of address and similar matters to be published in the lay Press. Members must consult the office of the Branch concerned for advice concerning such notices.

7.3 Premises

7.3 In selecting premises for his surgery a doctor should preserve the dignity of his profession and bear in mind certain ethical considerations. It is undesirable to establish a surgery in a hotel or in the same premises as a chemist’s shop. There may occasionally be special circumstances in which a modification of this rule is justified, but in any such case the advice of the Branch Council should be sought.
7.4. Telephone Directories

The entry of a doctor's name in a telephone directory, whether ordinary or classified, should appear in small type only.

7.5. Group Practice—Descriptive Titles

There is no objection to members of a group practice using the term "clinic" in relation to the practice. A title describing the clinic should not be associated with the name of a suburb, town or district, and to do so would be regarded as unethical.

7.6. Lay Persons and Medical Companies

Lay persons may not be admitted as partners in a medical partnership, nor allowed to hold shares in a company formed for the practice of medicine.

7.7. Medical Certification

7.7.1 Under no circumstances should practitioners antedate or postdate certificates, reports and other documents of a like character signed by them in their professional capacity. The purposes for which these certificates and documents are required are many, but whatever the purpose, statutory or otherwise, they should not be issued without great care and a due sense of the responsibility for the statement of fact or opinion expressed therein.

7.7.2 It must be borne in mind that a medical certificate may be preferred as evidence in a court of law and for this, as well as for others reasons, it is highly important that any statement made in the certificate should be absolutely correct and should be a record of fact and not of inference, unless it be expressly set out that statements are expressions of opinion.

7.7.3 The issuing of a false or misleading certificate may lead to a charge of infamous conduct being laid against a practitioner. Accuracy in every detail is absolutely necessary in regard to certificates and reports. No certificate should be given unless there is objective evidence of the illness or injury. The facts set out in the certificate must be demonstrable and free from all traces of exaggeration.

7.7.4 No statement should be given in respect of any illness if the patient has not been under the practitioner's care for that illness.

7.7.5 Under no circumstances should a practitioner antedate or postdate a certificate. If he does the onus may be placed on him to show that the certificate was not wilfully misleading.

7.7.6 No certificate or report should be given by a practitioner regarding a patient under his care to a third party without the consent of the patient or the patient's representative. Failure to
comply with this rule may expose a practitioner to an action for damages in a court of law.

7.7.7 Even if it is a government department or a medical officer of such a department that is the third party, the certificate should be refused unless the patient’s consent has been obtained. There is, of course, no objection to the certificate being given to the patient for transmission to the department. If a department requests a certificate but the patient asks that the diagnosis be not shown, his wishes should be respected.

7.7.8 No practitioner may give a certificate or report to a person who is under the care of an unqualified practitioner which would have the effect of “covering” the unqualified practitioner.

7.7.9 The World Medical Association has laid down the following principles in regard to medical certification:

7.7.9a When providing a certificate a physician should always observe professional secrecy within the limitation of national laws.

7.7.9b The physician should be as accurate and objective as possible and prudent in filling out a certificate.

7.7.9c The purpose of a certificate not issued on a prescribed form should be clearly stated on the certificate by the physician.

7.7.9d The statements in the certificate should be sufficient to achieve its purpose.

7.7.9e The statements resulting from the physician’s examination and observation should be easily distinguished from statements based on information given by the person concerned or by others. In stating on a certificate the results of special investigations made in writing by another physician the certifying physician should specify the name and address of the former physician.

7.7.9f The physician should give sufficient information regarding the person whom the certificate concerns, such as name, sex, occupation, age, address. It should be stated whether or not the person concerned has been known previously to the physician.

7.7.9g The certificate should bear the date of the examination, the date of issue and the signature and address of the physician, all clearly legible.

7.7.9h Medical certificates should be restricted to matters which involve medical knowledge and judgement.

7.8. Sterilization

Except for therapeutic reasons no medical practitioner should perform an operation for sterilization on a male or female.
7.9. **Unethical Medical Appointments**

It is unethical for a member:

7.9.1 To accept or continue to hold an appointment which is deemed by the Australian Medical Association to be inimical to the interests of the profession.

7.9.2 To accept or hold appointment as medical officer to:

(a) Any medical aid, association, institution or hospital which touts or canvasses for patients.

(b) Any such association, institution or hospital carried on by laymen for their own profit.

(c) Any friendly society or friendly society institute or similar body that offers per capita payment or rates less than those set out in an agreement approved by the Branch Council.

(d) Any society, institution or hospital in a State, if such society, institution or hospital has been declared by the Branch of the Australian Medical Association in the State to be inimical to the interests of the profession.

7.9.3 To act as honorary medical officer to any racing, sporting or athletic club or any institution which is carried on for other than charitable purposes. This shall not apply to amateur sporting clubs, provided that the general rules regarding anonymity are preserved.

8. **The Doctor and His Colleagues**

8.1 Modern medicine cannot be practised by a doctor in isolation. He is in continual contact with his colleagues for many purposes. He may need to have a patient examined by a consultant; it may be necessary for a patient to be examined by a medical officer representing some third party; or if the patient is in industrial employment a medical officer at his place of work may have a continuing interest in his health. Whenever two doctors are simultaneously concerned with a patient each is under certain ethical obligations and is expected to observe certain ethical rules of conduct. The following code of recommendations has been prepared to guide the practitioner who may be called upon to examine another doctor's patient.

8.2. **Examination in Consultation**

8.2.1 In conformity with his own sense of responsibility, a medical practitioner should arrange consultation with a colleague whenever the patient or the patient's friends desire it, provided the best interests of the patient are so served. As it is always better to suggest a consultation than have one forced upon him, the practitioner would be well advised to propose a consultation in all doubtful, difficult or anxious cases. It should be remembered that a practitioner suffers no loss of dignity or prestige in meeting
a fellow practitioner in consultation, and, moreover, he then shares the responsibility of the case with the consultant. It is well that a practitioner should be well acquainted with the rules which should guide him in the case of a consultation, viz.:

8.2.1a In these rules a practitioner consulted is a practitioner who, with the acquiescence of the practitioner already in attendance, examines a patient under this practitioner's care and, either at a meeting of the two practitioners or by correspondence, co-operates in the formulation of a diagnosis, prognosis, and treatment of the case. The term "consultation" means such a co-operation between practitioners.

8.2.1b It is the duty of an attending practitioner to request a consultation in obscure and difficult cases, or to acquiesce in any reasonable request for a consultation expressed by the patient or his representative.

8.2.1c The attending practitioner may nominate the practitioner to be consulted, and should advise accordingly, but he should not refuse to meet a registered medical practitioner selected by the patient or by the patient's representative.

8.2.1d The arrangements for consultation should be made or initiated by the attending practitioner. The attending practitioner should where possible acquaint his patient of the approximate expenses which may be involved in specialist consultations and examinations.

8.2.1e In cases where the consultant and the attending practitioner meet and personally examine the patient together, the following procedure should be observed, unless in any particular instance there is substantial reason for departing from it:

(a) All parties meeting in consultation should be punctual, and if the attending practitioner fails to keep the appointment the practitioner consulted, after a reasonable time, may examine the patient, and should communicate his conclusions to the attending practitioner in writing and in a sealed envelope.

(b) If the consultation takes place at the patient's residence, the attending practitioner should, on entering the room of the patient, precede the practitioner consulted, and after the examination the attending practitioner should be the last to leave the room.

(c) The diagnosis, prognosis, and treatment should be discussed by the practitioner consulted and the attending practitioner in private.

(d) The opinion on the case and the treatment as agreed should be communicated to the patient or the patient's repre-
sentatives where practicable by the practitioner consulted in the presence of the attending practitioner.

(e) It is the duty of the attending practitioner loyally to carry out the measures agreed upon at, or subsequent to, the consultation. He should refrain from making any radical alteration in those measures except upon urgent grounds or after adequate trial.

8.2.1f If for any reason the practitioner consulted and the attending practitioner cannot examine the patient together, the attending practitioner should send to the practitioner consulted a brief history of the case. After examining the patient, the practitioner consulted shall forward his opinion, together with any advice as to treatment he may advise, in a sealed envelope addressed to the attending practitioner; and he may give to the patient or to the patient's representatives such information as he judges appropriate to the position.

In cases where the attending practitioner accepts the opinion and advice of the practitioner consulted he should carry out the measures recommended as in the event of agreement (Rule 8.2.1e (e)); where, however, the attending practitioner finds he is in disagreement with the opinion and advice of the practitioner consulted he should by suitable means communicate his disagreement to the practitioner consulted.

8.2.1g Unless in emergency, the arrangements for any future or other consultation or additional investigation shall be left to the initiative of the attending practitioner.

8.2.1h The practitioner consulted shall not attempt to secure for himself the care of the patient seen in consultation. It is his duty to avoid any word or action which might disturb the confidence of the patient in the attending practitioner. The practitioner consulted should not communicate with the patient or the patient's representatives subsequent to the consultation except through the attending practitioner.

8.2.1i The attending practitioner should carefully avoid any remark or suggestion which would seem to disparage the skill or judgement of the practitioner consulted.

8.2.1j Except by mutual consent the practitioner consulted shall neither supersede the attending practitioner during the illness with which the consultation was concerned, nor shall he act as attending practitioner to the patient in any subsequent illness. (In view of the fact that it not infrequently happens that consultations are held with and assistance given by general practitioners, e.g. in country and suburban practice, the principle set out in Rule 8.2.1j cannot be followed absolutely in such type of practice. Having regard to the rights of the patient, it would be unreason-
able to debar the consultant from attending the patient in any subsequent illness.)

8.2.1k Should the practitioner consulted and the attending practitioner hold divergent views, either on the diagnosis or on the treatment of the case, and should the attending practitioner be unwilling to pursue the course of action advised by the practitioner consulted, this difference of opinion should be communicated to the patient or his representatives by the practitioner consulted and the attending practitioner jointly, and the patient or his representatives shall then be advised either to choose one or the other of the suggested alternatives or to obtain further professional advice.

8.2.1i Note: In the following circumstances it is especially desirable that the attending practitioner should endeavour to secure consultation with a colleague:

(a) When the propriety has to be considered of performing an operation or of adopting some course of treatment which may involve considerable risk to the life of the patient or may permanently prejudice his activities or capacities and particularly when the condition which it is sought to relieve by this treatment is not itself dangerous to life;

(b) When any procedure likely to result in death of a foetus or of an unborn child is contemplated, especially if labour has not commenced;

(c) When continued administration of any drug of addiction is deemed desirable in the case of a person who does not need it otherwise than for the relief of symptoms of addiction;

(d) When there is reason to suspect that the patient:

i. has been subjected to an illegal operation, or

ii. is the victim of suspected criminal poisoning.

(The general principle involved in the rules in regard to consultants is that the consultant, whether he be specialist or general practitioner, must not take an unfair advantage of the practitioner calling him in consultation. It follows then, for a reasonable period at least, he should refrain from giving medical attendance to any of the near relatives of the patient.)

8.3. Medical Inspectors

8.3.1 It frequently happens that a medical practitioner is asked to examine on behalf of an interested person, e.g. insurance company, a patient who is under the care of another practitioner. Subject to any statutory requirements, the practitioner acting on behalf of the interested person, and who is frequently known as a medical
inspector or medical examiner, should be governed by the following rules of conduct:

8.3.1a Except where circumstances justify a surprise visit or when circumstances necessitate a visit within a period which does not afford time for notification, or when after due inquiry no information is available as to whether the patient is under medical care, the medical examiner should give the patient's medical attendant such notice of the date, time, and purpose of his visit as will afford reasonable opportunity for the medical attendant to be present, should he so desire; should the medical attendant fail to appear at the time fixed, the medical examiner may proceed with the examination, subject of course to the patient consenting. Should he avail himself of the exceptions referred to before, the medical examiner should as soon as possible notify the medical attendant of his visit, and the reason therefor.

8.3.1b The medical examiner must not, without the consent of the medical attendant, do anything in the course of his examination which involves active interference with the case.

8.3.1c The medical examiner must not make any comments to the patient which are of the nature of criticism of or reflection upon the treatment, nor must he express, without the concurrence of the medical attendant, any opinion to the patient, as to the etiology, diagnosis or prognosis of the case. His duty is strictly confined to examining in such matters as are necessary for the purpose of his report and reporting to his employer, and to his employer only, his conclusions from such examination.

Provided, however, that the medical examiner may with the consent of his employer and of the patient furnish to the medical attendant a copy of his report or disclose to the medical attendant the contents of the same.

8.3.1d If the medical examiner finds it necessary to recommend any modification in the treatment which is being carried out he should so inform the medical attendant.

8.3.1e The medical examiner should not except with the express consent of the medical attendant, previously obtained, prescribe for or otherwise advise or treat the patient.

8.3.2 The medical attendant should not put any unnecessary difficulties in the way of fixing a time convenient to both practitioners. In fact, it is desirable in the interests of the patient that the medical attendant should give the medical examiner the benefit of his knowledge of the patient.

8.4. Workers' Compensation Insurance Practice

8.4.1 Members of the profession are reminded that the rule regarding professional confidence applies equally well to an injured worker as to any other patient, and no certificate or report should be
given to an employer or insurer without the express sanction of the worker.

8.4.2 A specialist called into consultation by another practitioner has the same obligation as his colleague in regard to the confidences of the latter's patient, and he should not furnish information to an employer or insurer without receiving the patient's consent through the medical attendant.

8.4.3 A practitioner who is requested to examine on behalf of an employer or insurer an injured worker under the care of another practitioner must observe the ethical rule in this regard. He must not make any comments to the patient which are of the nature of criticism of or reflection upon the treatment, nor must he express, without the concurrence of the medical attendant, any opinion as to etiology, diagnosis or prognosis of the case. His report on the patient should be furnished to his employer, usually the insurer, and his employer only, but he may with the consent of his employer and of the patient furnish to the medical attendant a copy of his report or disclose the contents of the same.

8.5. Industrial Medical Officers

8.5 Many industrial undertakings employ medical officers to supervise the health and welfare of the employees and the environmental conditions of their work. The position of the industrial medical officer is such that without constant care a conflict of loyalties is liable to arise, for, while he holds his appointment from the management, the object of his duties is the welfare of the workers, individually and collectively, and in the course of his duties he will come into contact with the family doctors of individual workers. As a doctor his paramount concern must be for the patient, and his behaviour should be guided by the customary ethical rules of his profession.

8.6. Change of Medical Attendant: Supersession

8.6.1 If a patient desires to change his medical adviser he has a perfect right to do so, no matter how long continued their relations may have been. In effect, a patient has a perfect right not only to choose his medical attendant, but also to change his medical attendant. This change, however, should be brought about in a seemly fashion, and in regard thereto there are certain intraprofessional obligations. The general principle is that no medical man, whatever his type of practice may be, should do anything to try to detach a patient from his usual medical attendant. Providing, however, that he has not seen the patient in consultation with the usual medical attendant, or when acting as locum tenens, assistant, or substitute, and providing that patient is not under treatment, then a medical practitioner is free to attend the patient.
It is a general principle that, if a patient is under the care of a medical practitioner for an illness of any kind, he should not be seen during that illness by any other medical man except in consultation. A medical practitioner should not supersede another medical practitioner in the care of a patient without satisfying himself that the latter has been duly informed by the patient, or those responsible for him, that his services are no longer desired.

8.6.2 It is customary in Australia for some specialists to see at their consulting rooms patients who desire to see them and such a practice has come to be accepted, even though such action is not in accord with the principle just stated. However, there is no doubt the closer this principle is followed the better; and patients known to be under the care of another practitioner should be seen by specialists only with the practitioner, or when referred by letter, or with his knowledge and sanction. When this is not practicable, the specialist should communicate, preferably by letter, with the medical attendant.

8.6.3 If a practitioner, whether specialist or general practitioner, is requested to visit a patient for the purpose of giving advice or treatment and has reason to believe that another practitioner is in attendance, it is his duty to inform the patient or his representative that he cannot attend without the presence or consent of the practitioner in attendance. If the attending practitioner, after being informed, declines to meet the practitioner called in, and the patient or his representative persist in the request in full knowledge of this fact, or if he retires, then the other practitioner is free to provide the medical care required.

9. Dichotomy

9.1 Dichotomy or the practice whereby a practitioner recommending a patient to a consultant shares the fee or fees with the latter or where the consultant pays the practitioner a percentage of the fees received by him cannot be too strongly condemned. If circumstances compel a practitioner to delegate the post-operative treatment of a patient to another medical practitioner other than a locum tenens, assistant or partner, the practitioner to whom the treatment is delegated should collect the fee direct from the patient, or from the person legally responsible for him.

9.2 Fee sharing where two or more practitioners are in partnership or where one practitioner is assistant to or acting for the other, is permissible.

10. The Doctor and Other Professions

The doctor is frequently in contact with members of other professions, e.g. dentists, pharmacists, and the clergy. Those relationships may give rise to ethical problems. It is therefore desirable
that a medical practitioner should have some knowledge of his position in regard to them.

10.1. DENTISTS
10.1.1 Doctors in their professional relationship with dentists should observe the following rules:

10.1.2. Consultations
10.1.2a Where a patient, in the opinion of his medical attendant, needs dental treatment, the patient should be referred in all but exceptional circumstances to his own dentist. In the event of the patient having no regular dentist, there is no objection to a doctor recommending a dentist or, preferably, more than one.
10.1.2b When on behalf of one of his patients a doctor wishes to consult a dentist, the doctor should communicate in the first instance with the patient's own dentist. In the event of the patient having no regular dentist there is no objection to the doctor consulting the dentist of his own choice.
10.1.2c Where there is a conflict of opinion between a doctor and a dentist concerning the diagnosis and/or treatment of the condition of a patient, they should consult with each other to reach an agreement which is satisfactory to both. Where the conflict of opinion remains unresolved, the patient should be so informed and invited to choose one of the alternatives or assisted to obtain other professional advice.

10.1.3. Anaesthetics
10.1.3a Where an anaesthetic is advised by the dentist, it is competent for him to select the anaesthetist, but, if such anaesthetist is not the patient's doctor, no objection should be taken to the patient inviting his doctor to be present. Where the patient is under dental care and the doctor advises operative or other major treatment arising from the patient's dental condition the dentist should be consulted.
10.1.3b On completion of any dental operation and especially if there is any reason to think that post-operative complications may ensue, the patient should be advised to consult the dentist immediately if such complications arise.

10.2. CLERGY
10.2 Co-operation with the clergy is especially desirable when the doctor believes that religious ministration may be conducive to his patient's health and peace of mind, or may assist recovery.
10.3. CHEMISTS

10.3.1 Collusion between doctors and chemists for financial gain is reprehensible. It is unethical for a doctor to receive from a pharmaceutical chemist any commission on business transacted or to hold a financial interest in a chemist’s shop in the area of his practice. Professional cards should not be handed to chemists for further distribution. It is undesirable for messages for a doctor to be received and left at a chemist’s shop.

10.3.2 The following ethical principles should be observed closely:

10.3.2a A doctor and a pharmacist should not practise from the same premises unless the means of access to the two practices are completely separated.

10.3.2b A doctor should not have a financial interest in directing his patients to a particular chemist.

10.3.2c In order to preserve the principle of free choice and to avoid abuse, it is undesirable that a doctor should recommend a particular chemist, or sanction the recommendation of himself by a chemist.

11. THE DOCTOR AND COMMERCIAL UNDERTAKINGS

11.1 A general ethical principle is that a doctor should not associate himself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients.

11.2 It is unethical for a member to hold for personal advantage patents for any surgical appliance or medicine.

11.3 A doctor should not have a financial interest in the sale of any pharmaceutical preparation he may have to recommend to a patient. If such be unavoidable for any good and sufficient reason, he should disclose his interest when ordering that preparation or article.

11.4 This is not held to apply to the acquisition of shares in a public company marketing pharmaceutical products, subject to the proviso that the acquisition of shares is not conditional on ordering products of the company. In this regard the attention of members is directed to the following resolution adopted by the Federal Council of the British Medical Association in Australia, and the principle of which still applies:

11.5 “That the Federal Council is of the opinion that it is unethical for a member of the British Medical Association, directly or indirectly, to apply for or to be interested or concerned in the application for or to acquire or retain whether in his own name or in that of his nominee any stock shares or other interest in any company engaged in the sale of drugs medicine or medical
or surgical appliances (hereinafter referred to as 'the Vending Company') or in any other company which to the knowledge of such member holds shares in the Vending Company where it is directly or indirectly a term condition agreement or understanding attaching to the acquisition or ownership of such stock shares or other interest that the member will prescribe products of the Vending Company or otherwise promote the sale of such products."

11.2. Testimonials and Reports for Trade Purposes

11.2.1. Testimonials or Laudatory Certificates

11.2.1a Testimonials or laudatory certificates, whether for publication or not, of any medical or surgical appliance or apparatus or dressing or any drug or medicinal preparation or any cosmetic should not be given by medical practitioners. Nor should they give any report for publication of any drug or medicinal preparation or any substance capable of being advertised as possessing therapeutic properties to any proprietor or distributor or vendor thereof.

11.2.1b Further they should not sanction the quotation of any extract from any publication by them dealing with any medical or surgical subject for the purpose of trade advertisement, except in accordance with the rules approved by the Australian Medical Association relating to the supply of reprints of published articles.

11.2.2. Clinical Trials

11.2.2a The participation of members in clinical trials of new pharmaceutical agents is, however, a different matter and approval is given to scientifically conducted clinical trials of new pharmaceutical agents (subject to the ethical recommendations of the World Medical Association). Members should be encouraged to accept responsibility for performing clinical trials by modern scientific methods, e.g. double blind trials, double blind with cross over, statistical analysis of results, etc.

11.2.2b It is recognized that

(a) doctors conducting such clinical trials must communicate with the pharmaceutical supplier. Such communications are entirely ethical.

(b) Doctors conducting such clinical trials must forward provisional or progress reports to the pharmaceutical supplier. Such reports are entirely ethical.

11.2.2c The reports mentioned under (a) and (b) must be used only for policy decisions by the pharmaceutical supplier or for internal circulation within the pharmaceutical company or for information of the other research workers engaged in testing new pharma-
11.2.2d These clinical reports, however, including unexpected toxicity observations, may be made available to assist any medical advisory committee to the Federal Government acting in accordance with any National Health Service legislation.

11.2.2e It should be obligatory for a medical practitioner approached by a drug company to conduct a clinical trial to obtain in advance the written consent of the drug company for him to publish the results of the trial even though this may not show the product in a favourable light.

11.2.2f There should be no objection to a clinician being re-imbursed for any expenses or costs incurred by him in the conduct of a clinical trial.

11.2.2g No individual doctor or medical association should conduct a clinical trial for financial gain.

12. THE DOCTOR AND THE GENERAL PUBLIC

12.1.1 One of the strictest rules of Medical Ethics has to do with the restrictions which are placed on medical practitioners in regard to the methods of attracting patients. In general it may be said that no medical practitioner should attempt in any way to advertise himself except by the legitimate means of proficiency in his work and by skill and success in the practice of his profession. The word “advertise” is used in its broadest sense and includes all methods by which a practitioner may be made known to the public, either directly or indirectly, with the object of obtaining and promoting his professional advantage.

12.1.2 Modern life brings the doctor into contact with the general public in numerous ways both directly and indirectly, and raises for him problems of conduct unknown to his predecessors. The general public interest in medical knowledge, the dissemination of medical information through radio and television, and the Press interview, all demand the exercise of the utmost caution by the doctor, whose professional standards condemn self advertisement and publicity. However, it is realized that the public has a legitimate interest in the advances made in the science and art of medicine, and it is of advantage that medical information, discreetly presented, should reach the public through the medium of broadcasting, including television, the Press and other means.

12.1.3 Whatever the means, anonymity should be observed by members of the profession as a general principle. Departure from the principle is permissible only when the objective of publicity is apparent, paramount and justifiable, viz:

(a) in the interests of the general public; or
(b) in the interests of the medical profession; or
(c) as an essential part of providing authoritative information when necessary for the general public.

12.1.4 All members who are asked to make broadcasting and/or television appearances should first seek the approval of the Association in writing before agreeing to do so unless they have been authorised to make such appearances by an organisation approved by the Association (Appendix 15). No correspondence should be entered into by a doctor with the lay public on clinical matters arising out of a broadcast by him. Great caution is necessary in public discussions on theories and treatment of disease owing to the misleading interpretation that may be put upon these by an uninformed public.

12.2. Press Interviews

12.2 No interview with a newspaper reporter on subjects relating to diseases and their treatment should be given by any member of the profession engaged in active medical or surgical practice except with the following express stipulations:

(a) That the name of the medical practitioner interviewed should not be published, nor his identity revealed in any report published of the interview except with the approval of the Association or of an authorised organisation. (Appendix 13.)

(b) That, if possible, a copy of the report proposed to be published be submitted for approval to the practitioner interviewed.

(c) That the person interviewed should not imply that he has superior ability in the diagnosis or treatment of disease.

12.3. Lectures to Lay Public

12.3.1 Members of the profession engaged in private practice should not give lectures to lay audiences on professional subjects except on occasions organized by the profession, or under the auspices of the Australian Medical Association or a University or Public Health Department, or scientific societies recognized as such by the Association, or unless sanction for the delivery of the same has been given by a Council of a Branch. This restriction does not apply to the regular courses of instruction given by officially recognized bodies such as the St. John Ambulance Association.

12.3.2 Special care is needed in the presentation of material when it is known in advance that a representative of the Press is to be present. If the lecturer knows that a Press representative is to be present he should intimate that he does not desire any report of his lecture to be published.
(c) as an essential part of providing authoritative information when necessary for the general public.

12.1.4 All members who are asked to make broadcasting and/or television appearances should first seek the approval of the Association in writing before agreeing to do so unless they have been authorised to make such appearances by an organisation approved by the Association (Appendix 15). No correspondence should be entered into by a doctor with the lay public on clinical matters arising out of a broadcast by him. Great caution is necessary in public discussions on theories and treatment of disease owing to the misleading interpretation that may be put upon these by an uninformed public.

12.2. Press Interviews

12.2 No interview with a newspaper reporter on subjects relating to diseases and their treatment should be given by any member of the profession engaged in active medical or surgical practice except with the following express stipulations:

(a) That the name of the medical practitioner interviewed should not be published, nor his identity revealed in any report published of the interview except with the approval of the Association or of an authorised organisation (Appendix 15.)

(b) That, if possible, a copy of the report proposed to be published be submitted for approval to the practitioner interviewed.

(c) That the person interviewed should not imply that he has superior ability in the diagnosis or treatment of disease.

12.3. Lectures to Lay Public

12.3.1 Members of the profession engaged in private practice should not give lectures to lay audiences on professional subjects except on occasions organized by the profession, or under the auspices of the Australian Medical Association or a University or Public Health Department, or scientific societies recognized as such by the Association, or unless sanction for the delivery of the same has been given by a Council of a Branch. This restriction does not apply to the regular courses of instruction given by officially recognized bodies such as the St. John Ambulance Association.

12.3.2 Special care is needed in the presentation of material when it is known in advance that a representative of the Press is to be present. If the lecturer knows that a Press representative is to be present he should intimate that he does not desire any report of his lecture to be published.
12.4. Photographs

12.4 A practitioner's photograph appearing in connection with an interview or an article published in the lay Press on professional subjects is a most undesirable form of publicity, and every reasonable precaution should be taken to ensure that such photographs are not published.

12.5. Advertisements in the Lay Press

12.5 Except where permitted for specified purposes by the By-laws of the Association or Branch, the use of the advertising columns of the lay Press to publicize the professional activities of an individual medical practitioner, even in the absence of a name, is unethical. A particularly reprehensible form of advertising of this type is the submission to the Press directly or through an agent of information concerning the personal movements, vacation, or new appointments of a medical practitioner, for publication in social columns.

12.6. Condonation of Publicity in the Press

12.6 Exception cannot reasonably be taken to publication in the lay Press of a doctor's name in connection with a factual report of events of public concern. On occasion, however, in Press reports, articles or social columns, statements are made without previous consent, commenting favourably on the professional activities or success of medical practitioners. These statements cannot fail to place the named practitioner in a critical and embarrassing situation, and should not be allowed to pass unchallenged. In every case of this type the medical practitioner involved should send a letter of protest to the editor marked "Not for publication", demanding that statements concerning his professional activities be not published in future without previous personal consent. Statements disclaiming responsibility for offending publicity should not be offered to the lay Press for publication.

12.7. Publicity in General

12.7 After making all allowances for all those modes of publicity for which there may be some justification, there remain many instances which can be regarded as contravening the spirit of the rule regarding advertising. The Association is convinced that in taking up the attitude of determined opposition to undesirable methods of publicity it is acting in the best interests of the public as well as of the medical profession. Advertising by the profession in general would certainly destroy these traditions of dignity and self-respect which have helped to give the medical profession its high status. The Australian Medical Association therefore draws
the attention of the profession to the danger of these objectionable methods, and stresses the need for every member of the profession to offer a firm resistance to them.

13. CONCLUSION

13.1 It is impossible to draw up a minute code of medical ethics that will deal satisfactorily with every conceivable circumstance of medical practice in Australia. The foregoing principles and rules are intended to serve as a guide to members of the profession in maintaining a high standard of ethical conduct, and as a basis for answering many of the problems which confront them in their relationship with one another, with their patients, and with the community as a whole.

13.2 Furthermore it is unethical for a member to meet professionally, in consultation, as assistant, or in any other way, any practitioner who is known to have violated any of the above principles. If a medical practitioner is in any doubt as to the interpretation of these principles and rules he should seek the advice of the Council of the Branch of the Association in whose area he resides.

13.3 In his professional life it means much to a doctor to know that he enjoys the goodwill and regard of his colleagues. And the only way he will gain that goodwill and regard is by personally observing the high principles which he has inherited from his predecessors as far back as Hippocrates.

APPENDIX

14. STATE MEDICAL BOARDS

14.1 The State Medical Boards constituted under the Medical Practitioners Act in the various States control the medical profession in the public interest. A medical practitioner who has been convicted of a felony or misdemeanour or who is proved to have been guilty of conduct which is regarded by a Medical Board as "infamous" may have his name removed from the medical register. What may be considered as "infamous conduct" is a matter which is determined by a Medical Board on consideration of the circumstances of each particular case.

14.2 In the British Commonwealth the General Medical Council of Great Britain which controls the profession in that country has, by its rulings on what constitutes "infamous conduct in a professional respect", given to the medical profession guidance in regard to the matters at issue. A summary of the resolutions and decisions of the Council upon the forms of unprofessional conduct which have been brought before them and which render a medical practitioner liable to have his name removed from the medical
the attention of the profession to the danger of these objectionable methods, and stresses the need for every member of the profession to offer a firm resistance to them.

13. Conclusion

13.1 It is impossible to draw up a minute code of medical ethics that will deal satisfactorily with every conceivable circumstance of medical practice in Australia. The foregoing principles and rules are intended to serve as a guide to members of the profession in maintaining a high standard of ethical conduct, and as a basis for answering many of the problems which confront them in their relationship with one another, with their patients, and with the community as a whole.

13.2 Furthermore it is unethical for a member to meet professionally, in consultation, as assistant, or in any other way, any practitioner who is known to have violated any of the above principles. If a medical practitioner is in any doubt as to the interpretation of these principles and rules he should seek the advice of the Council of the Branch of the Association in whose area he resides.

13.3 In his professional life it means much to a doctor to know that he enjoys the goodwill and regard of his colleagues. And the only way he will gain that goodwill and regard is by personally observing the high principles which he has inherited from his predecessors as far back as Hippocrates.

Appendix

14. State Medical Boards

14.1 The State Medical Boards constituted under the Medical Practitioners Act in the various States control the medical profession in the public interest. A medical practitioner who has been convicted of a felony or misdemeanour or who is proved to have been guilty of conduct which is regarded by a Medical Board as "infamous" may have his name removed from the medical register. What may be considered as "infamous conduct" is a matter which is determined by a Medical Board on consideration of the circumstances of each particular case.

14.2 In the British Commonwealth the General Medical Council of Great Britain which controls the profession in that country has, by its rulings on what constitutes "infamous conduct in a professional respect", given to the medical profession guidance in regard to the matters at issue. A summary of the resolutions and decisions of the Council upon the forms of unprofessional conduct which have been brought before them and which render a medical practitioner liable to have his name removed from the medical
register is set out in a Warning Notice issued for the guidance of members of the profession and which covers the following main points:

14.2.1 Untrue, misleading or improper certification.
14.2.2 Covering or association with an unqualified or unregistered person and thereby knowingly enabling such a person to act as if he were duly qualified or registered.
14.2.3 Contravention of the Dangerous Drugs Act.
14.2.4 Advertising, whether directly or indirectly, for the purpose of promoting professional advantage.
14.2.5 Canvassing directly or indirectly for patients.
14.2.6 Dichotomy or fee splitting.
14.2.7 Adultery or improper conduct or association with a patient.
14.2.8 Treating or attending patients while under the influence of drink.
14.2.9 Abuse of dangerous drugs.
14.2.10 Commercialization of a secret remedy.
14.2.11 Gross and/or prolonged neglect of duties and disregard of personal responsibilities to patients.
14.2.12 Improperly obtaining or attempting to obtain payments from the National Health Service or otherwise to which they are not entitled.

14.3 The General Medical Council has, of course, no disciplinary control over medical practitioners in Australia, but its decisions as to the nature of the acts which will be regarded as infamous are generally accepted.

15. Press Interviews

15.1 Any College, Society or Medical Organization can apply to the Association through the Ethics Committee to be designated an "Authorized Organization" within the meaning of the regulations.

15.2 This Authorized Organization then assumes full responsibility for any individual acting under its auspices. Principles, guidelines and regulations can be laid down by the Association in conjunction with the Conjoint Conference governing these organizations who will agree to abide by them. In this way the Association retains ultimate policy control by its power to grant or withdraw authorization.
Declaration of Helsinki

RECOMMENDATIONS GUIDING DOCTORS IN CLINICAL RESEARCH

ADOPTED BY THE 18TH WORLD MEDICAL ASSEMBLY, HELSINKI, FINLAND, 1964

Introduction

It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfillment of this mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words: “The health of my patient will be my first consideration” and the International Code of Medical Ethics which declares that: “Any act, or advice which could weaken physical or mental resistance of a human being may be used only in his interest.”

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, The World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and the clinical research, the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

1. Basic Principles

1. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.
5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. Clinical Research Combined with Professional Care

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgement it offers hope of saving life, reestablishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. Non-Therapeutic Clinical Research

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgement it may, if continued, be harmful to the individual.

New Dialysis And Transplant Unit in Brisbane
First Free Organ Transplant Service In Australia

Australia's first free organ transplant service will commence operations at the Princess Alexandra Hospital, Brisbane, by the middle of this year. Construction work on the new facilities has already started.

Initially, the new section, the first of its kind in Queensland, will be established for the purpose of providing renal and renal transplantation. These operations will be part of Queensland's normal free hospital service.

In Queensland the estimated death roll from correctable kidney failure is about 75 per cent, which makes the need for the proposed renal unit apparent.

So far, Queensland patients suffering from end-stage chronic renal failure have been treated in other Australian States. Already in existence at the Hospital is a renal unit which is responsible for general care of patients and for acute dialysis for acute renal failure.

The new Brisbane Dialysis and Transplant Unit will be operated at an annual running cost of approximately $100,000, which will include all services from surgical to medical and nursing care.

It will be headed by Dr. J. A. Clark, formerly of Edinburgh University where he worked with one of the world's pioneers in organ transplant surgery—Australian-born Professor M. F. A. Woodroffe. Professor Clark is also Reader in Surgery at the University of Queensland.

Internally, the Unit will be staffed by four or more surgical staff, including one or more surgical specialists as well as appropriate nursing and administrative staff. These will be able to treat up to 12 patients at one time.

As the Unit will eventually be operating a seven-day-week routine service at all levels, it will follow the staffing recommendations for a full Dialysis and Renal Unit.

It will allow for time and opportunity for research activities and training programmes.

At that stage the Unit's centre will be the theoretical needs for renal transplantation and dialysis.
**DISASTER MAYOR**

A distressed female journalist began her emotionally-charged account recently on a chilly day with a tale of personal triumph, a taped recording of a brave and determined woman struggling against the odds to save her family from a fiery inferno. The woman, who had been trapped inside her house, finally managed to break through the flames and escape to safety. She recounted her harrowing experience with tears in her eyes, describing the intense heat, the smoke, and the fear that gripped her as she fought for her life.

Dr. Dallas became Mayor of Greymouth, New Zealand, one of the commercial centres of the West Coast of the South Island, on October 5th, 1965, and has continued to serve in this capacity ever since.

The city of Greymouth, located on the West Coast of the South Island of New Zealand, has faced its share of challenges, including a major earthquake in 1968 and a significant mining accident in 1990. Dr. Dallas has been a consistent and influential figure in the city's recovery efforts, working tirelessly to ensure the safety and well-being of its residents.

Dr. Dallas has been a vocal advocate for disaster preparedness and response, emphasizing the importance of community resilience and the need for effective planning and strategic decision-making in the face of adversity. His leadership has been characterized by a deep commitment to public service and a unwavering dedication to the welfare of the people of Greymouth.

**Four Australian General Practitioners' Convention - Scientific Programme**

**Monday, 5th May, 10 a.m.**

**Introduction and Welcome**
Chairman: Dr. W. J. McLean
Organiser: Dr. W. J. McLean

**10.30 a.m.**

**The Revolution in Medical Education**
Chairman: Dr. W. J. McLean
Panelists: Dr. W. J. McLean, Dr. P. H. F. Pethick

**2.30 p.m.**

**The General Practitioner and the Patient**
Chairman: Dr. R. T. Smith
Panelists: Dr. R. T. Smith, Dr. J. F. Brown

**5.30 p.m.**

**The Medical Practice of the Future**
Chairman: Dr. R. T. Smith
Panelists: Dr. R. T. Smith, Dr. J. F. Brown

**Wednesday, 7th May, 10 a.m.**

**Joint Disability**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

**10.30 a.m.**

**Some G.P. Problems and Complications**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

**11.30 a.m.**

**Hazards of Pregnancy**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

**12.00 p.m.**

**The Problems of Maternal Morbidity**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

**2.30 p.m.**

**The General Practitioner as an Obstetrician**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

**5.00 p.m.**

**An Introduction to General Obstetric Care**
Chairman: Dr. D. T. Robertson
Panelists: Dr. D. T. Robertson, Dr. H. C. Corrigan

During his three-year stewardship as Mayor of Greymouth, Dr. B. M. Dallas has been a steadfast advocate for public health and safety, particularly in the wake of the city's recent earthquake. His leadership has been characterized by a commitment to the well-being of Greymouth's residents and a strong belief in the power of community collaboration and resilience in the face of adversity.
Q: What is Fortral?
A: Among more than 1,400 patients, nausea was the most frequent adverse effect, and occurred with approximately 5.0 per cent. The drug should be administered, however, with caution, since extensive liver disease appears to predispose to greater side effects than the usual clinical dose. (This may be the result of decreased metabolism of pentazocine by the liver.)

Q: How is Fortral administered?
A: The intramuscular route is usually preferred but Fortral may be administered subcutaneously or intravenously, too.

Q: How quickly does Fortral relieve pain?
A: Significant analgesia usually occurs within 15 to 20 minutes after intramuscular or subcutaneous injection, or within 2 to 3 minutes after intravenous administration.

Q: How long does analgesia last?
A: Analgesia usually lasts 3 hours or longer with a single intramuscular injection.

Q: Is the relief of pain obtained with Fortral influenced by the patient's age?
A: No, Fortral is as effective in patients over 65 years as it is in young adults. It is well tolerated as an analgesic even by the aged, the debilitated, and the very ill. (Until recently, sufficient experience is gained, Fortral is not recommended for children under 12 years of age.)

Q: Does Fortral have a sedative action?
A: Fortral provides some degree of sedation in about one-third of patients.

Q: How does Fortral affect respiration?
A: Fortral has not caused, or increased, hepatic congestion. In addition, means of maintaining proper oxygenation should be available. The usual narcotic-antagonists, such as nalorphine (Nalline—Meck Sharp & Dohme), are ineffective respiratory stimulants for depression due to Fortral.

Q: What is the treatment of Fortral overdose?
A: In case of unintentional overdose or of severe respiratory depression due to Fortral, methylenedinitrile (Ritalin—Ciba) should be administered parenterally. In addition, means of maintaining proper oxygenation should be available. The usual narcotic-antagonists, such as nalorphine (Nalline—Meck Sharp & Dohme), are ineffective respiratory stimulants for depression due to Fortral.

Q: For what is Fortral used?
A: Fortral is used for relief of pain due to trauma, orthopedic conditions, and dental procedures.

Q: What are the surgical uses of Fortral?
A: Fortral is indicated for relief of pain following major or minor surgery; for preoperative narcotic administration; as a supplement to surgical anesthetics; and for relief of pain due to trauma, orthopedic conditions, and dental procedures.

Q: Are there contraindications to the use of Fortral?
A: Yes. As with morphine, respiratory depression, increased intracranial pressure, head injury, or pathological brain conditions in which clouding of sensorium is undesirable, generally preclude its use. Because of the possibility of provoking withdrawal symptoms, Fortral should not be given narcotic addicts.

Fortral should be given with caution to patients with the following disorders: Cachexia, severe renal or hepatic diseases, hypothyroidism, and arteriosclerosis. It should be avoided in children under 12 and pregnant women in the first trimester (although no teratogenicity has been demonstrated).

Q: Can Fortral be administered concurrently with other drugs?
A: Yes. To date there have been no reports of clinical incompatibility between Fortral and other medications administered concomitantly.

Q: Can Fortral be administered for prolonged periods of time?
A: Yes. Fortral has been given to patients with chronic pain (caused by such conditions as malignancy, arthritis, and cardiovascular diseases) for prolonged periods—in some cases for more than 360 days—with no morphine-like withdrawal symptoms, even when the drug was abruptly discontinued. Furthermore, since no tolerance to analgesic effect occurs, the dosage need not be increased to control the same degree of pain.

Q: Does Fortral have any special advantage over morphine or pethidine as a postoperative analgesic?
A: Yes. Fortral lacks the dependence potential of morphine and pethidine and is relatively free from the undesirable reactions associated with morphine, such as severe respiratory depression, constipation and urinary retention. Furthermore, Fortral produces less nausea, vomiting and swelling than pethidine.

Q: What is the usual Fortral dose for an adult?
A: The average recommended single dose for an adult is 30 mg administered intramuscularly, it may also be given subcutaneously or intravenously.
VITAMIN B-6: Essential Food Additive?

Pregnancy Toxaemia, Mental Retardation and Bladder Cancer

Convulsions, mental retardation, anaemia, bladder cancer and toxoaemia of pregnancy have recently all been linked to deficiency of vitamin B-6. This little-studied member of the vitamin B family is not among those added to our vitamin-fortified foods.

Until about 10 years ago, B-6 (pyridoxine) was all but unknown. Now researchers realise that, though it is needed in tiny amounts (as few as 2 milligrams a day), it is as essential to health as its cousin—niacin, and thiamine—which are added to foods such as bread and cereals.

There pyridoxine is naturally present in vegetables and meat, some investigators believe that a high percentage of persons do not get enough B-6 in their diets—particularly those who consume large quantities of protein-rich foods.

The vitamin plays a key role in the body's metabolism of amino acids. In the absence of B-6 the body cannot properly use proteins or fats; it cannot manufacture red blood cells; and the nervous system cannot function normally.

Studies of both animals and children show that B-6 deficiency during the first weeks of life affects normal brain development, with symptoms including hyperactivity, deranged behaviour and convulsive seizures. EEG shows abnormal, and biochemical tests reveal changes such as the creation of amino-acid products.

But the case is extreme. In many cases, a dose of 100 mg of pyridoxine B-6 corrects the biochemical, electrophysiological and clinical signs within 24 hours.

Some studies relate vitamin B-6 deficiency to pregnancy. Toxaemia of pregnancy is possibly associated with either vitamin B-6 deficiency or failure to metabolise it normally.

Measured levels of B-6 in the placenta show that those of toxaeamic women are markedly deficient, compared with healthy women. Pyridoxine plays an important role in the biochemical reactions of proteins held to be vital to the growth of the placenta and the foetus.

Camels Aid Blood Studies, Perth—Australian researchers are planning to analyse the milk of camels for folic acid content in an attempt to understand why nomads who drink the milk are apparently free of anaemia, while their children are not.

Vitamin B-6 promotes the formation of blood cells in certain parts of the body, and is believed to be lacking in goat's milk and camel's milk, both of which are consumed by the nomads who keep goats.

State workers, who are dressing wild camels in North Western Australia, because their numbers are excessive, are being asked to milk the animals, put the milk in a vessel containing preservatives and send it to the Royal Perth Hospital.

Antepartum—regular washing or showering with phosphates during the last trimester of pregnancy helps to deliver the patient with a clear skin and allows the patient to keep the skin clean and thus to avoid pressure sores. Regular washing and scrubbing allows the patient to maintain a high level of cleanliness and thus to avoid skin infections.

Postpartum—regular washing with phosphates helps to protect nursing mothers against staphylococcal and steller infections. A mild detergent is used to avoid skin irritation and to avoid the use of harsh chemicals.

Approved Hospital Benefit in Australia

RESEARCH COMPUTER FOR AUSTRALIA

Britain's Medical News reports that Australia will sell the world's fourth nation to join a growing international computer system for the storage of data on medical research.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which will be the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

CAMELS AND BLOOD STUDIES, PERTH:—Australian researchers are planning to analyse the milk of camels for folic acid content in an attempt to understand why nomads who drink the milk are apparently free of anaemia, while their children are not.

This is a problem that has been solved in Australia by the introduction of a central computer bank of data in Canada.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.

The move is expected to streamline advanced research in Australia by eliminating duplication in studies and by saving time by having access to a central computer bank of data in Canada.

It will unlock to Australian medical statistics references to findings published in biomedical journals around the world in different languages since 1964.

The service will be provided free to medical sources as a national contribution to health. The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which is the chief agency for the scheme.

They were given access to the American computer tapes and rewrote the coding so that Australian medical workers can locate the references they need through a major Australian computer.
Scientists have in the past paid little attention to the workaday clothing of men and women but this state of affairs is beginning to change. Some of the oddities in the wardrobe of today’s workaday man may disappear.

Man’s clothing troubles began when he first decided he must have a second skin to protect the one already provided by nature. It would have been logical to construct this second skin to fit it with the requirements and functions of the natural skin. Unfortunately, development did not go that way and so today’s clothing has little bearing on the function of the skin and sometimes ignores the body’s mechanical scope and limitations. Fashion and convention take precedence over common sense.

The scientific approach to clothing, which has emerged seriously only in the last decade or so, has until quite recently been confined to the needs of the military, of space research and expeditions. Those asking no part in these areas have put up with clothing far removed from considerations of comfort.

Men tend to overdress the upper part of the body and neglect the legs. Men will tolerate wet trouser legs while wrapping their torso lovingly in warm and waterproof materials. Recent work has shown that wet clothing, particularly wrapped around such large surfaces as the legs, may accelerate heat loss from the body but no practical conclusions have been drawn from this. Many Natural artists, measuring a client for tightening clothes, realize that they are upsetting the body’s microclimate and deforming two millimetre envelope of warm air which surrounds the body like a protective sheath. Disfiguring this layer of tights-fitting clothing does not produce any immediate and disastrous effect, but it is well known that it will affect health in the long run.

That ergonomic abomination—the waist—would probably never have been invented had common sense been applied to the aperture left for the neck. Its size is normally a matter of fashion or convention with complete disregard for the heat losses involved. We now know that there are certain lines along which the body does not stretch or extend and that there are the ideal places for the location of seams. Yet, how frequently is this ignored? Ever the most elementary anatomical principles are often neglected with, for instance, bad carrying pockets not being placed near the body’s centre of gravity, where they should be, but forwards and sideways. Materials for a specific purpose are selected correctly only to have their function impaired by some ill-chosen lining. All these things, and more, are drawbacks in clothing from a scientific point of view.

However, the clothing trade may change its approach to men’s clothing. Some months ago the International Wool Secretariat in London came out with new design for workaday clothes which incorporated at least some of the lessons that had already been produced by research in this field. Project Adam it was called and it was not an easy proposition.

As a first step a preliminary study was commissioned and a team which included a medical physiologist, a constraint psychologist and a clothing technician started work on the project. They first had to collect data from laboratories dispersed all over the world, from occupational research programmes, from military records and space research. Then what was relevant to the exercise in hand had to be selected. Next, a British designer, who had already made an earlier study of clothes for motorists, was asked to write a specification that could be easily interpreted by clothing technicians. Finally, a number of well-known international menswear stylists from France, Germany and Britain were invited to produce prototypes. These were then given to wearers trials and duly modified where required.

The collection was finally completed in 1956 and was not only as revolutionary as one would have perhaps expected but, it was deliberate. A collection flying in the face of convention, looking too radically different, would have been a one-day sensation but not much more. There is little point in designing clothes that are unacceptable to the average wearer and the clothes that eventually emerged, while original in their approach and far more in harmony with scientific principles than anything in the shops today, were not violently different that they would put off the consumer.

Some, like the Holster coat, at long last took account of the fact that men like to stuff things into their pockets. This coat takes the place of the normal waistcoat and is so designed that anything from keys to paperbacks can be stowed into them without making the wearer look like a Christmas tree. A new-design sheepskin coat was scientifically ventilated so that it cannot turn into a sweatbox as it gets a little warmer. The “Sundowner” is a dinner suit that unashamedly allows for the fact that some of us do expand after a good meal.

Probably some of these excellent clothes will never be made. Others will be taken on by manufacturers and produced in a modified way. To expect anything else would be to underestimate the strength of convention. Nevertheless, this pilot project has been well worthwhile. It has enabled the clothing industry, on an international scale, to become familiar with ergonomic design. It has proved to them that fashion and ergonomics are not mutually exclusive.
If you have under five hours sleep a night for two nights running it is likely to have a bad effect on how well you do your job.

And less than two hours' sleep in a single night is liable to impair your performance the next morning. These are two tentative conclusions which have emerged from work being carried out at the Applied Psychology Research Unit at Cambridge (U.K.) by Dr. Robert Wilkinson. He emphasizes, however, that the results of his experiments cannot be directly applied to ordinary working conditions, because they were carried out in the laboratory. None the less, the results are striking enough to provide a strong argument for more research on the effects of lack of sleep under ordinary working conditions.

Dr. Wilkinson carried out his experiments on 19 young volunteers from the armed forces for a period lasting six weeks. Two different tasks were set. In one the volunteers listened to short musical notes, played to them against background noises, and they were asked to pick out the notes which were deliberately made longer than the others, while in the second task the men had to add up columns of figures. Though the second task represented any routine mental activity, the first one was more in common with inspection work in industry where people are engaged in looking out for the occasional small and unexpected fault. It is also similar to driving a car along a good road, where it is essential to be alert for the emergency caused by something unexpected happening. Although the men rose at the same time every morning, during the experiment, to start their tasks, they were made to go to bed at different times each night: before, at one; at 1.30 in the morning, giving 5 hours sleep, one at 3.30—3 hours sleep—one at 4.30 who got 2 hours sleep, one at 5.30—one hour's sleep—one at 6 who got no sleep at all. Having carried out their day of tests the men followed exactly the same procedure the next night, so that for the second working day each man had had two nights running on his particular sleep ration. In each of the six weeks the program was the same, except that the sleep rations were changed round, so that each man had experienced each ration of sleep by the end of the experiment.

Results showed the performance was significantly worse after one night's deprivation by a matter of several per cent.

As you go to sleep earlier, you can fall to sleep in 2 hours or less in a single bath and this applies to both tasks. But, more important, in terms of normal life, efficiency was also lowered in both tasks after two successive nights of only 3 to 5 hours sleep. Physiologists do not yet know how much sleep we need, or how it varies between individuals, but nearly all of us, if not all, evidently need at least 5 hours and 7 seems a more sensible figure. The first 2 hours or so of our night's sleep are much more important than the rest. We sleep most deeply and are least likely to dream during those first 2 hours. Dr. Wilkinson found that people who got 5, 3 or even 2 hours sleep only were able to perform their tasks just as well as they could with a full 7 hours. They were just losing more and more of their drive to work efficiently. This drive could be restored by offering quite small rewards and incentives for better work. But when the amount of sleep was reduced to less than 3 hours, to one hour, or to no sleep at all, then the ability to perform tasks itself became less.

Apart from the obvious implication for pilots, policemen, doctors, nurses and other vital members of the community who frequently miss their sleep, there is an evident moral here. If you must miss your sleep try not to go on two nights running, and always get at least 2 hours' sleep in any one night.

Mr. John Meredith, medical technologist with Biological Laboratories Ltd., of Auckland, New Zealand, prepares a batch of ALG similar to the anti-rejection serum administered to Australia's first heart transplant patient, Mr. Richard Pye, last year.

**New Zealand ALG Project Helped First Australian Heart Transplant**

Early production in New Zealand of the immuno suppressant Anti-lymphocyte Globulin (which was administered to Sydney heart transplant patient, Mr. Richard Pye) resulted from a co-operative effort involving the Auckland Blood Transfusion Service, the medical unit of the Auckland Hospital and Biological Laboratories Ltd., a New Zealand company.

Dr. N. T. Dalton, physician to the Auckland Blood Transfusion Service, told "Tamahou" that acquisition of the necessary typing sera was such a problem. Usually an exchange blood transfusion could be arranged with New Zealand any time but in this case the Auckland Blood Transfusion Service, gladly co-operated with the Auckland Blood Transfusion Service, of Auckland Blood Transfusion Service, Ltd., of Auckland, New Zealand, prepares a batch of ALG from horse serum.

Early research was similar to that carried out in America by Stuzir and involved subcutaneous injection of horses with antigens from human spleens.

Methods of producing ALG differed from Stuzir's in one respect. Instead of using fresh spleens the organ were deeply frozen, enabling injections to be given to horses at regular and convenient times. The injection of the spleen suspension produced antibody titres comparable to those obtained in America. This SOS capsule could help to save a life. It can be fastened to a watch strap or bracelet, and consists of an emergency identification, which is about 9 inches long, giving the particulars of the person involved in an accident. The capsule is water-proof.

**Blue Light Halts Neonatal Jaundice**

A new technique for treating newborn babies with jaundice by the use of a blue light, beamed from fluorescent bulbs installed over the cradle, was described recently to the Canadian Society for Clinical Investigation.

This is reported in Britain's Medical News.

Dr. Reel Schmid, Professor of Medicine at the University of California, Berkeley, said that the blue light changed the xanthomous pigment by process of photodestruction and stopped it reaching the brain where it could lead to darkness, cerebral palsy or mental retardation.

The transient neonatal jaundice caused by the lack of the liver to calcium xanthinul decision of Jaenmelz for three or four days after birth might do damage, he said.

Usually an exchange blood transfusion is used in about one per cent of cases, but Professor Schmid pointed out that the blue light technique was "an important advance" because it could be used by small hospitals not able to handle the complicated procedures of exchange blood transfusion.

Dec 6

*These are only emergency IDs.*

Mr. Richard Pye, last year.

**New Zealand ALG Project Helped First Australian Heart Transplant**

Early production in New Zealand of the immuno suppressant Anti-lymphocyte Globulin (which was administered to Sydney heart transplant patient, Mr. Richard Pye) resulted from a co-operative effort involving the Auckland Blood Transfusion Service, the medical unit of the Auckland Hospital and Biological Laboratories Ltd., a New Zealand company.

Dr. N. T. Dalton, physician to the Auckland Blood Transfusion Service, told "Tamahou" that acquisition of the necessary typing sera was such a problem. Usually an exchange blood transfusion could be arranged with New Zealand any time but in this case the Auckland Blood Transfusion Service, gladly co-operated with the Auckland Blood Transfusion Service, of Auckland Blood Transfusion Service, Ltd., of Auckland, New Zealand, prepares a batch of ALG from horse serum.

Early research was similar to that carried out in America by Stuzir and involved subcutaneous injection of horses with antigens from human spleens.

Methods of producing ALG differed from Stuzir's in one respect. Instead of using fresh spleens the organ were deeply frozen, enabling injections to be given to horses at regular and convenient times. The injection of the spleen suspension produced antibody titres comparable to those obtained in America. This SOS capsule could help to save a life. It can be fastened to a watch strap or bracelet, and consists of an emergency identification, which is about 9 inches long, giving the particulars of the person involved in an accident. The capsule is water-proof.

**Blue Light Halts Neonatal Jaundice**

A new technique for treating newborn babies with jaundice by the use of a blue light, beamed from fluorescent bulbs installed over the cradle, was described recently to the Canadian Society for Clinical Investigation.

This is reported in Britain's Medical News.

Dr. Reel Schmid, Professor of Medicine at the University of California, Berkeley, said that the blue light changed the xanthomous pigment by process of photodestruction and stopped it reaching the brain where it could lead to darkness, cerebral palsy or mental retardation.

The transient neonatal jaundice caused by the lack of the liver to calcium xanthinul decision of Jaenmelz for three or four days after birth might do damage, he said.

Usually an exchange blood transfusion is used in about one per cent of cases, but Professor Schmid pointed out that the blue light technique was "an important advance" because it could be used by small hospitals not able to handle the complicated procedures of exchange blood transfusion.
"The link between urinary tract infection and severe renal disease is becoming more widely recognised. So there is good reason for aiming at early detection and eradication of urinary infection before the kidney is damaged."

Leading article, Lancet 1:732, 1968

**in cystitis**

**negra**

right from the start

**PHARMACEUTICAL BENEFITS [S.P.]**

effective against more Gram-negative urinary pathogens than any other agent in common use.

Tablet: each tablet contains 350 mg nalidixic acid. Adult dosage: 2 tablets q.i.d. for at least 7 days. Suspension: 250 mg/5 ml in bottle of 90 ml. Available in bottles of 250 ml. Powder/Resuspension: Use with caution in patients with liver disease.
**Classifieds Advertisement**

**Address please replies to advertisements with a box number as follows:**
*Impulse* No... P.O. Box 12, Ermington, N.S.W. 2155.

Terms.

Central Australia no practice for sale, man to run. One owner, good practice, wide variety of work, No. B127.

For Sale: 26. $60 pneu Base for 2-way radio. Excellent condition. Selling only because of compulsory wave length change. Address: Ermington Bank, 87-99, Box 12, N.S.W. 2155.

Wanted to Lease: Practice in Sydney area by experienced GP. Address: Box 262, Sydney, N.S.W.

Terms.

Wanted: To rent or buy: Large house suitable for surgery in medical practice in inner suburbs, north or west of Melbourne. No. B5.254.


Highly recommended receptionist seeks evening work North Shore (From 7pm5 daily except Thur. Tuesday. B350.305)

**Wanted:**

Recently married couple, looking to set up practice. Willing to pay honest price, but needs finance for building. Phone 425471 (Sydney).

Terms.

**Term: $22,500.**

Experienced semi-retired practitioner with own car and bag open for short engagements in Victoria or Tasmania. Phone Frankston, Victoria 3564. (Melb. 7250)

Telephone answering machine, any "Impulse" interested please phone 4601011 (Glen Waverley) 9am-10am. No. B390.277


Experienced semi-retired practitioner with own car and bag open for short engagements in Victoria or Tasmania. Phone Frankston, Victoria 3564. (Melb. 7250)

**Terms:**

Vaccination city's GP requires retired partner, seeks assistant with view toward filling the space of his growing family. Facilities both modern (two general and two consulting rooms) and traditional (kitchen and rear area). No. B409.404.


**Terms:**

**Recorder for Sale:** Brand new, owned Akai XV, $100. Phone 311917 (Sydney), or write to Box No. B13.

Long-term termine required West Suburbs Sydney (ref 8) at 28-8921 (message). No. B5.985.

Terms.

Experienced doctor prepared to accompany patient to U.K. or U.S. or other country. Excellent remuneration plus medical expenses. No. B389.527.

**Terms:**

Microphone for use in general practice. Phone 687249 (Brisbane). No. B45.309.


Terms.

**For Sale:**

Phone Repair for Sale: Brand new, owned Akai XV, $100. Phone 311917 (Sydney), or write to Box No. B13.

Phone Repair for Sale: Brand new, owned Akai XV, $100. Phone 311917 (Sydney), or write to Box No. B13.


**Terms:**

**For Sale:**

**WANTED: Microphone for use in general practice. Phone 687249 (Brisbane). No. B45.309.

**Classifieds Advertisement**

**Your Advertising Form**

<table>
<thead>
<tr>
<th>Block Capitalised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Box number required: Yes/No</td>
</tr>
</tbody>
</table>

---

The views expressed by contributors to "Impulse" are not necessarily those of Winthrop Laboratories.
Fees will not be "fixed"

STATEMENT BY PRESIDENT

In setting up working parties to discover the most common fees charged for operations and procedures in each State, the Australian Medical Association is not seeking "such fees", as some newspaper headlines may have suggested.

In fact, one important object of the exercise is to prevent a fixed schedule of fees being imposed on the profession from outside, Dr. C. O. F. Rieger, President of the Association, stated.

Dr. Rieger, in an interview with the A.M.A. Gazette: "The A.M.A. has always been aware that a fee for service is a personal matter, between the doctor and his patient."

"We've had for many years Branches of the A.M.A. and local hospital committees recommended levels of fees, and these have been accepted generally as a reasonable basis for general practitioners. Some of these recommended fees have been validated from time to time in accordance with economic conditions and have been accepted by the vast majority of practitioners on a purely voluntary basis."

"It is now proposed that all practitioners charge on a purely voluntary basis—should not appear to be a state matter in regard to fees for operations and procedures."

"The need for this guidance has arisen, not because of the wide variations in fees because of the wide variations which have not been demonstrated by studies which have been made to the A.M.A."

"One of the main effects of these wide variations is it is difficult to determine the true cost of giving a reasonable return to society. It is difficult to persuade the Government to increase Commonwealth benefits."

"It is constantly being suggested that the A.M.A. or the Branches of the A.M.A. are making a profit. In my own experience, fees have been more uniform, benefit schedules will be greatly improved, and the voluntary health insurance schemes, which the A.M.A. believes to be in the best interest of the whole community, will be strengthened."

"Another alternative, which is being actively canvassed in some quarters, is a fixed schedule of fees, in which the A.M.A. is strongly opposed."

"It must be stressed that the A.M.A. is not opposed to the principle of a fixed fee, but merely to offer greater uniformity in fees that decisions on fees be made in an informed and thought-out manner. If the doctor wishes to charge significantly above the average, he will be expected to discuss the matter first with his patient."

A cheap is charter flight to Britain for doctors which did not quite come to pass because of a successful sequel, Dr. J. D. Stark, a former registrar at the Mater Hospital, Brisbane, believes.

Last-minute withdrawals forced cancellation of Dr. Stark's plan to get Australian doctors to Britain for post-graduate studies more economically than by normal air fares.

But although the Quintas one-way charter, planned for January 4, 1968, had to be cancelled, Dr. Stark believes that a similar scheme could be arranged for next year's flow of doctors to the northern hemisphere.

Dr. Stark told the story of the scheme in Auckland, New Zealand, of his way to that country by air with his wife and four children.

Looking for an economica fare for his family so that he could make the most of the pre-graduate studies in ophthalmology, he put the idea to his wife who suggested that a group of doctors might charter an aircraft for the purpose.

"It was impossible at that time because they required a two-way charter," said Dr. Stark. "But when regulations allowing a one-way charter were passed, Quintas got in touch with me about June."

With a little assistance, a medical student at the University of Queensland, Mr. Bob Anderson, Dr. Stark drew the lengthy and involved task of locating enough doctors to take up the equivalent of 140 adult fares, perhaps 140 children, when wives and children were taken into account.

"Graciously the numbers built up. With fares at 100 cheaper than the normal fare, the offer was worthwhile."

"But then we had the withdrawal of 14 paid places in the last few weeks. This took the numbers back to the minimum level we had to make things work. We decided we were forced to cancel it early in November."

"It would have been the first one-way charter flight. We have just passed the new regulations and it would have been the first flight by doctors for this purpose," said Dr. Stark.

Dr. Stark felt that if the next charter was to be in 1969, tickets for the average doctor should be available in December. He also said that the A.M.A. should be given medical support for organizing the charter.

In the meantime, Dr. Stark gave the Group of doctors and his family and settled down to a shipboard holiday from the stress and worry of the last few months.

The report of the N.H. and M.R.C. Committee on organ transplants, the main points of which were widely published in the media, included a strong plea for an active programme of prevention to reduce the number of expensive kidney transplant operations required.

The report stated: "The treatment of end-stage renal failure by dialysis and transplantation is very costly, whereas the application of relatively minor funds, for example, to the detection and treatment of renal infection can significantly reduce the numbers of "candidate" patients.

The report quoted a statement of the U.S. Department of Health and Welfare which said:

"It is evident from the foregoing documents that concentration in future programmes on the treatment of end-stage kidney disease is not likely if the problem of annual deaths due to transverse renal infection is not overcome. The funds to be spent are considerable, available for an indefinite series of such programmes. Thus steps must be taken in some way to reduce the incidence of irreversible fatal stage by early detection and treatment of the primary kidney disease in such a way as to reduce its progressive downhill course."
It is right, and may on occasion be a duty, for university people to form and express strong views on political issues. But it is equally a duty for them to protect their university from the effects of their own individual actions lest it be harmed by them.

Dr. J. A. L. Matheson, Vice-Chancellor of Monash University, made this statement to 200 Sir Richard Powell Orators at the Royal Children’s Hospital, Melbourne. He said that, as Australians, we are solidarity-minded, and the idea of higher education is that it would lead us to see that the world is our university, with a million people, instead of one million students within its walls.

There are a number of students who have been involved in political activities, and the question arises whether their activities have affected the university. Dr. Matheson said that the university is a community, and that the community action in the face of floods, storms, or disaster has been active in organising successful "Meals on Wheels" projects, which have been successful in meeting the needs of the elderly and the disabled.

The auxiliary of the National Safety Council of Australia has been providing a "Meals on Wheels" service for over 20 years. The service has been successful in providing a nutritious meal to the elderly and the disabled, and the Auxiliary has been active in promoting health education through educational films and special enlisting for voluntary work.

The Auxiliary also provides educational and health education through its educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enlisting for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.

The Auxiliary has also been active in promoting health education through educational films and special enrolments for voluntary work. It has been active in promoting health education through educational films and special enrolments for voluntary work.
Quokka’s muscles give research lead

A type of wallaby called a quokka, which lives only on Rottnest Island near Perth, is playing a key role in a promising programme of research to find a cure for muscular dystrophy. The programme has already gained international recognition.

At the University of Western Australia’s Western Australian Medical Research Foundation, researchers have been able to support the research in the Department of Pathology of the University’s School of Pathology. This led to the establishment of a hypothyroid dysphasia, a technique which is proving to be of value in the study of muscular dystrophy.

The research is being led by Dr M. V. Clarke, a senior pathology technician at the University, and Dr E. C. B. Clarke, a research fellow at the University.

The team has been working on the discovery of muscular dystrophy, and has made significant progress in the field of enquiry and on which the new research is based.

The research is being reported in the A.M.A. and the Australian Rotary Clubs, and is supported by Western Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.

The research is being supported by the Australian Rotary Clubs, and is designed to provide essential equipment which the team has been able to acquire.
The frying pan or the fire

If you disapprove of "nationalisation", then you also disapprove of the "universal" health insurance scheme which is currently under discussion through the desultory trills by Mr. Whitlam, Leader of the Opposition.

The purpose of such schemes are clear, but the end result would be the same — dissatisfied doctors, dissatisfied patients, and patients receiving second best.

Mr. Whitlam proposes that existing voluntary insurance programs be replaced by a Government controlled National Health Insurance Scheme. This Commission would be financed by a 1 per cent levy on taxable income, plus a matching Treasury grant.

Free practitioners would continue to be paid for each visit, irrespective of the diagnosis, but doctors, with similar qualifications, would be required to join this Commission or forfeit their practice.

Doctors who choose to join the scheme would be paid to the same as on a taxable income, plus a matching Treasury grant.

Bills would be submitted to the government which, after appeal to the Patients' Authority, would be paid to the doctor. Doctors, however, would be between the frying pan and the fire.

Doctors who chose to join the scheme would be paid to the same as on a taxable income, plus a matching Treasury grant.

What Mr. Whitlam is suggesting is that doctors would have to accept a fixed schedule of fees for every service, and any fees paid above this schedule will be penalised by the government.

Mr. Whitlam has stated that doctors would be paid on the basis of equal importance to the patient, and that doctors would be paid on a fixed schedule of fees. This means that doctors would have to accept a fixed schedule of fees for every service.

Mr. Whitlam has also stated that doctors would have to accept a fixed schedule of fees for every service, and that doctors would be paid on a fixed schedule of fees.
Mobile heart unit: Australia's first

A unique mobile intensive care unit being built for Perth hospitals is expected to save at least $50,000 a year.

The unit is equipped to deal with sudden cardiac arrest, including the transport of such cases to a hospital of its kind in Australia, and one of the first in the world.

Total cost of the ambulance, its equipment, and facilities at the Perth hospitals is $15,000. A second ambulance is expected to be in operation within a year.

Dr. Polit suggests the mobile unit is a striking example of how new ideas can help the community and the medical profession at-large. He says the Perth V.H.O. and other metro hospitals and their support for the unit are a great help to other hospitals.

The hospital said: "When they first discussed it..."

Dublin HQ

Office has been established for the Australian Secretary-General of the International Federation of Voluntary Health Insurance, Dr. Philip O'Connell, who arrived in Sydney recently from London.

The office has been established to assist in the development of the federation and to provide a center for the exchange of information and ideas.

The federation, which includes over 100 organizations, was founded in 1920

Bethlehem bound

By Hypobrysis

Jerusalem has been hot and dusty, fascinating in its antiquity and in the way the ages had passed the Holy City. It is a land of the old and the new.

The road from Bethlehem to Jerusalem is a picturesque one. The walled city is a scene of ancient splendor.

The city is built on a hilltop. At its summit is the Dome of the Rock, a mosque.

The city is surrounded by a series of walls, each of which is a symbol of the past.

Are you interested in providing for a comfortable retirement?

It's surprisingly easy through City Mutual. TAX FREE PERSONAL SUPERANNUATION PLAN FOR THE SELF-EMPLOYED.

The plan offers a range of benefits, including a tax-free retirement income.

Are you interested in providing for a comfortable retirement?

Business proprietors, farmers, graziers, professional people and independent tradesmen.

Are you interested in providing for a comfortable retirement?

Business proprietors, farmers, graziers, professional people and independent tradesmen.

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?

Are you interested in providing for a comfortable retirement?
Unit trusts spread investment risks

By a financial correspondent

Today there are about 150,000 Australians who are investors in unit trusts. At the end of the last financial year the total value of these trusts was nearly $270 million.

Although this is still only a drop in the bucket of total national savings, with the size of investment in shares traded on the stock exchange, the unit trust figure has grown from nothing 20 years ago. Most of this growth has occurred in the last 5 years.

Investors in trusts come from all walks of life and from all age groups. But, what is a unit trust?

Simply, it is a method of investment whereby comparatively small sums of money can be aggregated over a number of shares in various companies.

For instance, an individual who wants to buy shares may not have the capital to buy a significant amount of shares in a company, but a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.

But will unit trusts suit everyone? They will suit anyone who wants to buy shares but does not have the necessary capital to buy a significant amount of shares in a company, or a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.

But will unit trusts suit everyone? They will suit anyone who wants to buy shares but does not have the necessary capital to buy a significant amount of shares in a company, or a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.

But will unit trusts suit everyone? They will suit anyone who wants to buy shares but does not have the necessary capital to buy a significant amount of shares in a company, or a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.

But will unit trusts suit everyone? They will suit anyone who wants to buy shares but does not have the necessary capital to buy a significant amount of shares in a company, or a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.

But will unit trusts suit everyone? They will suit anyone who wants to buy shares but does not have the necessary capital to buy a significant amount of shares in a company, or a collection of such individuals, by pooling their resources (and hence buying into a unit trust) can do so and enjoy all the benefits of investment of far larger sums.
Occupational health goes "national"

An organisation which has been mooted for 15 years has reached a reality with the formation of the Australian Society of Occupational Medicine at a recent meeting in Canberra.

Dr. Gordon C. Smith, head of the Public Health Section in the School of Medicine, Sydney University, has been in charge of the organisation.

The Australian Medical Association has been considering the possibility of forming a society for occupational health for several years, but until recently the committee had been unable to raise funds for a secretariat.

Dr. Smith said: "We are now in a position to make public health a part of the curriculum at the university and to provide courses in occupational health for medical students."

Dr. Smith said the society would be able to hire a full-time secretary and to provide courses in occupational health for medical students.

The society will also be able to conduct research in occupational health and to provide a forum for the discussion of issues related to occupational health.

The society will also be able to provide a forum for the discussion of issues related to occupational health.
PARTNERSHIPS & PRACTICES

WESTERN AUSTRALIA

PERTH. Female grad., 10 yrs. exp., seeks position 1969. Reply: Box FNX, Rikerservice.

SOUTH AUSTRALIA

CITY AREA. 5th yr. woman grad., with 2 yrs. psychiatric exp. would like a 2-day p.w. position, not night or weekend work. Reply: Box FW, Rikerservice, or phone 5168115 (Adel).

VICTORIA

SOUTHERN SUBURBS (Melb.). Woman practitioner, with anaesth. exp. requires assistance in g.p. Reply: Box FZX, Rikerservice.

QUEENSLAND

NEW SOUTH WALES


NEW SOUTH WALES

INNER CITY. Doctor exp. g.p. is looking for an assistantship with a view to a g.p. position in the city area of Sydney, which deals mainly with city workers and dwellers. Reply: Box FZW, Rikerservice.

NORTH SIDE (Syd.). Pref. coastal area. Exp. country g.p. required to assist in busy surgery, with surgical ability, seeks opportunity to practice and to purchase solo practice. Reply: Box GSF, Rikerservice.

NORTH SHORE OR MANLY-WARRINGAH AREA (Syd.). Pref. grad. in 2 yrs. hosp. and 2 yrs. exp. seeks assistantship to assist in general practice and to purchase solo practice. Reply: Box FW, Rikerservice.

NORTH SHORE (Syd.). Pref. British grad. M.B., Ch.B., D.A., partly committed to teaching, potential to full-time work, g.p. or anaesth. during school hours. Own car and bag. Reply: Dr. Jennifer Green, 2 Allisoon Ave., Lane Cove, N.S.W. 2066, or phone 62 0666 (Syd.).

NORTH SHORE OR EASTERN SUBURBS (Syd.). Pref., but essential, woman grad., g.p. exp. prefers assistantship or permanent sessional work, for 12 months from June, 1969. Reply: Box FW, Rikerservice.

WESTERN SUBURBS (Syd.). Required g.p. available. Reply: Phone 32 9880 (Syd.).

NEwCASTLE AREA (Pret.). Grad. in 1958, grade with wide general exp. Requires assistantship, or practice. Reply: Dr. E. Donogh, c/o 82 Platt Street, Wartall, N.S.W., 2250, or phone 68 1815.

NORTHERN SUBURBS OR BEACHES (Syd.). Assistantship in home practice or part-time practice. Reply: Box 9662, Rikerservice.

NORTHERN SUBURBS OR BEACHES (Syd.). Assistantship in home practice or part-time practice. Reply: Box 9662, Rikerservice.

S.E. ASIA


ANY STATE


HUSBAND-WIFE PARTNERSHIP. Seek position in country anywhere in Australia, preferably within or near capital city. Assistantship or partnership in established practice with keen colleagues and good facilities, available from Dec. 1969. Reply: Box FTP, Rikerservice.

ENGLISH DOCTOR recently arrived in Australia aged 42 yrs., married, 2 children, seeks opening in g.p. town or country anywhere in Australia. Reply: Box GBD, Rikerservice.

AMERICAN INTERNIST — Cardiologist desires long-term association (group, individual, or hosp.). Reply: Box GBB, Rikerservice.


HUSBAND-WIFE PARTNERSHIP. Seek position in country anywhere in Australia, preferably within or near capital city. Assistantship or partnership in established practice with keen colleagues and good facilities, available from Dec. 1969. Reply: Box FTP, Rikerservice.

WEST COAST. Practice available, no goodwill, stock at valuation. Very quiet, suit elderly, or non-robust, working mother, or those who believe that life is more than a 24 hr. drudgery. Dispensing practice, quite lucrative, capable of expansion. Magnificent coastline, isolated and well out of the rat-race. For details reply Dr. R. West, Box 9, P.O., Elstern, S.A., 5670.

COUNTRY. Assistant with view to partnership or opposite country practice. Reply: Dr. W. I. Bres, All facilities available in city. G.C.T. exceed $50,000. Salary $3000 p.w. Equal shares of partnership. Reply: Box FTE, Rikerservice.

The Australian College of General Practitioners

"ETHICAL PROBLEMS"

N.S.W. FACULTY

Commencing: 9.15 a.m.

The Seminar deals with topics such as GOING INTO PRACTICE, PATIENT REFERRAL AND THE TERMINATION OF PREGNANCY.

COLLEGE HEADQUARTERS
49 LOWER JUPT STREET, SYDNEY

Registration and Lunch — $4.00

To Dr. M. V. AARONS
58 PITT STREET, MORTDALE 2223
DISIPAL...  

DISIPAL is an anti-Parkinsoin drug that also has a mild psychotrophic effect—mood elevation. With this double action, the various phenomena of Parkinson's disease can, in most cases, be successfully controlled.

**COMPOSITION:**
Each DISIPAL tablet contains 50 mg. orphenadrine hydrochloride.

**DOSEAGE:**
PARKINSONISM—requires individual adjustment according to the progression of the disease. The optimum dose is usually 200-250 mg. daily (in three divided doses). Full data available on request from Riker Laboratories.

AN N.H.S. BENEFIT
LOCUMS

TASMANIA

2nd YR. GRAD. avail. for 2 weeks at $380 p.w. Own car. Reply: Box FWB, Rikerservice.

TASMANIA OR VICTORIA

SEMI-RETIRED EXP. DR. with own car and bag avail. for engagements weekly or sessional in Vic. or Tas. Reply: Phone 783 8628 (Frankston).

VICTORIA

NORTH - EASTERN SUBURBS (Melb.) Exp. locum with own car and bag avail. for full time or sessional work after 2 Feb. 1969. Reply: Box FTJ, Rikerservice or phone 439 7364 (Melb.).

EASTERN AND SOUTHERN SUBURBS (Melb.). Post grad. student with considerable g.p. exp., avail. for weekend locums. Own car. Reply: Dr. G. A. Nathan, phone 31 4554 (Melb.) after 6.00 p.m.

VICTORIA OR NEW SOUTH WALES

EXP. G.P. avail. for locums - long or short term. Own car and bag. Reply: Box FTV, Rikerservice.

NEW SOUTH WALES

FEMALE G.P. 23 yrs. exp. reports long locum. Working hours 8.30 a.m. to 6.00 p.m. No weekends. $380 p.w. Reply: Phone The Entrance 72.

GROUP FLIGHTS

SAN FRANCISCO—May, 1969

To attend Annual Meeting of The Aerospace Medical Association.

Departing Sydney or Brisbane, 2nd May, for 3 weeks. 20% reduction for group of 15.

For details reply Box FCB, Rikerservice.

UNITED KINGDOM—Oct.-Nov., 1969

Intended stay 6 weeks—medical or otherwise. Those interested in charter flight please contact Gynaecologist at Whylla Hospital, South Australia, or 'phone Whylla 57 240.

UNITED KINGDOM—for Christmas—13th Dec., 1969

For 4 or 5 weeks—return group flight. Fare 30% to 40% reduction depending on numbers—children ½—infants free.

Reply to Box FRD, Rikerservice.


To attend Combined Meeting of AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS AND ROYAL COLLEGE OF GENERAL PRACTITIONERS, Aberdeen, April 11, 1970.

Reply to Dr. A. Brown or Dr. M. V. Amsom, Australian General Practitioners, 45 Lower Fort Street, Sydney, N.S.W. 2000.
LOCUMS

POSITIONS WANTED
TASMANIA
2nd YR. GRAD. avail. for 2 weeks—Own car. Reply: Box FWB, Rikerservice.

Semia-Retired Exp. Dr. with own car and bag avail. for engagements weekly or sessional in Vic, or Tas. Reply: Phone 733 8628 (Frankston).

VICTORIA
NORTH-EASTERN SUBURBS (Melb). Exp. locum with own car and bag avail. for full time or sessional work. After Feb., 1969. Reply: Box FTF, Rikerservice or phone 439 7364 (Melb.).

EASTERN AND SOUTHERN SUBURBS (Melb). Post. grad. student with considerable g.p. exp. avail. for weekend locums. Own car. Reply: Dr. G. A. Nathan, 'Pine Hill', phone 51 6540 (Melb.) after 6.00 p.m.

VICTORIA or NEW SOUTH WALES
Exp. G.P., avail. for locums—long or short term. Own car and bag. Reply: Box FTV, Rikerservice.

NEW SOUTH WALES
FEMALE G.P., 23 yrs. exp. reports long locum. Working hours 8.30 a.m. to 6.00 p.m. No weekends. $580 p.w. Reply: Phone The Entrance 72.

GROUP FLIGHTS
SAN FRANCISCO—May, 1969
To attend Annual Meeting of The Aerospace Medical Association.
Departing Sydney or Brisbane, 2nd May, for 3 weeks.
30% reduction for group of 15.
For details reply Box FCB, Rikerservice.

UNITED KINGDOM—Oct.-Nov., 1969
Intended stay 6 weeks—medical or otherwise. Those interested in charter flight please contact Gynaecologist at Whylla Hospital, South Australia, or 'phone Whylla 57 240.

UNITED KINGDOM—for Christmas—13th Dec, 1969
For 4 or 6 weeks—return group flight. Fare 30% to 40% reduction depending on numbers—children 1/2—infants free.
Reply to Box FRD, Rikerservice.

(Approx.)
To attend Combined Meeting of AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS AND ROYAL COLLEGE OF GENERAL PRACTITIONERS, Aberdeen, April 11, 1970.
Reply to Dr. D. A. Brown or Dr. M. V. Amons, Australian Medical Council, Own Practitioner, 45 Lower Fort Street, Sydney, N.S.W. 2000.

PEN FRIENDS

GIRLS
(916)—Katrina Duthie, Dundarg Deveron Road, Yurrrh, Aberdeenshire, England.
(10)—Hope Flavin, 457 Pepper Ridge Road, Stamford, Connecticut 6900, U.S.A.
(11)—Lise Morin, 628 Glover Road, Lake Charles, La. 70601, U.S.A.
(12)—Patrice Morin, 625 Glover Road, Lake Charles, La. 70601, U.S.A.
(13)—Jana Wehling, 2940 Forest Lane, Marced, Calif. 93545, U.S.A.
(14)—Laura Herrin, 50 Pine Street, Garden City, N.Y. 11530, U.S.A.
(15)—Isolde Julian, Tansvenver 49, Oslo 5, Norway.
(16)—Annie Challoner, The Bay Hotel, Tynegv, Merthyr, South Wales, U.K.
(17)—Tone Lydal, Tingstowen 16, Bestum, Oslo 2, Norway.

BOYS
(9)—Reindra Midha, Gorwydd Lodge, Gowerton, Swansea, Glam., Wales, U.K.
(10)—Michael P. Horan, 83 Windsor Avenue, Lurgan, Co. Armagh, N. Ireland.
(11)—Liz Houghton, Cecil Lodge, Spa Road, Wells, Radcliffe, Wales, U.K.

GIRLS
(13)—Bamblo Amsden, 9700 Lasalka, Pinnean, North Carolina.
(14)—Liz Houghton, Cecil Lodge, Spa Road, Wells, Radcliffe, Wales, U.K.
(15)—Michael P. Horan, 83 Windsor Avenue, Lurgan, Co. Armagh, N. Ireland.
(16)—Liz Houghton, Cecil Lodge, Spa Road, Wells, Radcliffe, Wales, U.K.

BRUDDO (Syd.). Locum wanted for 2—3 days. May 12. $175 p.w. No nights if not living in area. Reply Dr. B. Hoolahan, 'phone 747 4285 (Syd.).

WESTERN SUBURBS (Syd.). Locum required for sole G.P. from Monday 12th May to midday Sat. 17th May. No obsts. or surgery. $150. Reply stating exp. and qual. References essential, to Box FXB, Rikerservice.

FAIRFIELD DIST. (Syd.). Regular weekend locum required to cover every third weekend for sole found in district. Start Sat. 11.00 a.m., and next day, Sun., from 9.30 a.m. to 11.00 p.m. Quick weekends. Ideal for studying, relaxing. Salary $134 plus meals provided. Reply: 'Phone 72 2170 (Syd.).

BYDE AREA (Syd.). Part time locum required. Replies to: Dr. J. Sandiford, 'phone 345 6789, Sydney. Good facilities and conditions. Reply: Box FJJ, Rikerservice or 'phone 523 6577 (Syd.).


WESERN SUBURB (Syd.). Locum or assistant wanted for 4-5 months, starting from May, June or July. $200 p.w. including car and living allowance. Cheap accommodation available. 3 weeks' notice required. Reply to Box FTP, Rikerservice.

QUEENSLAND

VICTORIA
WEEKEND LOCUM WANTED every 2nd or 3rd weekend, 6.00 p.m. Friday, or 9.30 a.m. Sat. to 10.00 p.m. Sunday. Live in essential. Full post. grad. student. No mids or surgeries unless desired. Salary by arrangement. Minimum term 6 months. Reply: Box FTA, Rikerservice.

POSIIONS AVAILABLE
NEW SOUTH WALES
WOMAN GRAD. (1960) exp. in part time or sessional work and emergency day work. Own car and bag. Reply Phone 89 0746 (Syd.).

ST. GEORGE AREA (Syd.). Fifth yr. teaching hosp. resident studying for M.R.C.O.G. Exp. locum seeks to change his locum work to area closer to home. Prefer group or solo practice. 1 weekend in 4, 1 night p.w. Long term arrangement. Reply: Box FPM, Rikerservice.

EXP. G.P. seeks locum position for 2 weeks any time between March 15th and end of June, excepting May 5th to 17th. Reply: Box FGP, Rikerservice.

CITY AND EASTERN SUBURBS (Syd.). 4yr. grad. avail. for night and weekend locums. Considerable locum exp. Own car and bag. Reply: Box FPT, Rikerservice.

NORTH SHORE OR MANLY-WARRINGAH AREA (Syd.). Exp. gp. own car and bag, avail. weekends and evenings, locums of time considered. Full time or sessional. Marriage, 2 yrs. teaching hosp. grad. Living locally. Reply: 2/52 Cook Road, Centennial Park, N.S.W. 2021.

NORTH SHORE OR MANLY-WARRINGAH AREA (Syd). Exp. g.p. own car and bag, avail. weekends and evenings, locums. Regular basis, alternatively, would consider part time assist. Reply: Box FHT, Rikerservice.

LIKE AN AFTERNOON OFF?! Exp. locum 3rd yr. grad., avail. to do afternoon surgery and calls 1 afternoon p.w. Prefer St. George area, but other area would do. Reply: Box FXK, Rikerservice, or 'phone 57 7964 (Syd.).


LOWER NORTH SHORE (Syd.). pref. Hosp. registrar with post. degree, available for evening surgeries and weekend calls. Reply: Box GDB, Rikerservice.
VICTORIA

COT. fly wire (meat-safe) with inner spring mattress. As new. Call: Reply. Phone: 42 4044 (Melb.).

INSTRUMENTS. Extensive range of general and physiological surgical instruments, in excellent condition at reasonable prices. Reply: Phone: 63 1766 (Melb.). Visit shop at 41 Collins St., Melbourne, Vic.

1965 VE VALIANT SAFARI. V8 motor, automatic transmission, 4,000 miles, $3,000. Call: Reply. 170 Lonsdale St., North Melbourne, Vic.

ELIZA MICROSCOPE, with light. Perfect condition. Eyepieces x 5 x 10 x 15, objectives x 4 x 10 x 100 (oil immersion). Price $25. Reply: Phone 942 3880 (Melb.).

MICROSCOPE, Carl Zeiss. Mosaic bright field and dark field. Reply: 61 Wilmot St., Northcote, Vic. 3070, or phone 85 1437 (Melb.).

3 EXAMINATION COUCHES, E.G.O., 1947. Reply: Phone 27 9944 (Melb.).

RAY-LAMP (table-model), includes 3 office desks, and a varied selection of medical and surgical instruments for g.p.s. Reply: Phone 94 2828 (Melb.).

LANCIA AURELIA V6 Gran Turismo 2600 coupe, fully serviced, $1,200. Reply: Phone 89 2009 (Melb.).

ANY STATE

2-WAY RADIO, base and one mobile, in excellent working order, suitable country area. 60 kcs. $130. Call: Reply. Phone 66 1633 (Melb.).

The intention of the Conference is to draw together medical and other personnel working in the tuberculosis field and to permit the interchange of views rather than to depend on didactic papers from outside authorities. All medical practitioners will be welcome to attend.

For further details reply to:

Dr. Ellis A. Macpherson, M.D., M.R.C.P.
Department of Tuberculosis
Booth’s Building
Brisbane 2300

NEW SOUTH WALES

ANAESTHETIC MACHINE. Portable anesthetic. First box of high quality anesthetic vaporizer complete. Carrying case. 2 man portability. Owner has given up specialty. Reply: Dr. B. S. Gracius, North Sydney Psychiatric Centre, North Ryde, N.S.W. 2113, or phone 98 6291 (Syd.).

OPERATING MICROSCOPE. Bausch and Lomb binocular microscope, complete with various offers. Reply: Occupier, 38, Oloa, Ave., Vaucluse, N.S.W. 2036, or phone 37 1179 or 28 6840 (Syd.).

SUTURE COUCH, etc., Reply: Phone 90 2609 after 5:00 p.m., and you can be assured 43,972, after 5:00 p.m. (Syd.).

1 KROMAYER LAMP $100. 1 galvanic unit $75. 2 infra-red lamps $15 each. 2 ultra violet therapy lamps $60. 1 full length mirror $20. Can be sold for a fraction of the original cost. Reply: Box FWA, Riker Service, or phone 27 6839 (Syd.).

MARK 7 BIRD SPECTRAL, excellent condition, $300. Arranged for delivery. Reply: Box PTN, Riker Service.

CABIN TRUNKS—3 metal fitted with lock and keys. Sydney. Reply: Box FWA, Riker Service, or phone 27 6839 (Syd.).

CARDIOGRAPH inc mark E.G.O. unit in good condition. Reply: Dr. P. N. H. N.S.W. 2113, or phone 98 6291 (Syd.).

BRAND NEW EXAMINATION COUCH with matching stool—sliding cupboards underneath drawer, leak tight $72. Reply: Phone 72 6200 (Syd.).

MICROSCOPE, monocular (Carson-Ayer) with 8 x 10 x 15, objectives and eyepieces. Magnification $50. Reply: Phone 36 5933 (Syd.).

PAKO RAPID DRYER suitable for rapid drying of large sections. This unit is in perfect order and is only offered because it has been replaced by automatic processor. Reply: Phone 41 2173 (Syd.).

MICROSCOPE, Olympus, monocular, 4 objectives, oil immersion, mechanical stage, $95. Reply: Phone 29 1897 (Syd.).

THIRD AUSTRALIAN CLINICAL TUBERCULOSIS CONFERENCE

The Third Australian Clinical Tuberculosis Conference will be held in the week beginning 28th April, 1965, in the Hotel Vaucluse, George Street, Brisbane. The previous two conferences held in Sydney and Melbourne have been extremely successful. The intention of the Conference is to draw together medical and other personnel working in the tuberculosis field and to permit the interchange of views rather than to depend on didactic papers from outside authorities. All medical practitioners will be welcome to attend.

For further details reply to:

Dr. Ellis A. Macpherson, M.D., M.R.C.P.
Department of Tuberculosis
Booth’s Building
Brisbane 2300

NEW SOUTH WALES

ANAESTHETIC MACHINE. Portable anesthetic. First box of high quality anesthetic vaporizer complete. Carrying case. 2 man portability. Owner has given up specialty. Reply: Dr. B. S. Gracius, North Sydney Psychiatric Centre, North Ryde, N.S.W. 2113, or phone 98 6291 (Syd.).

OPERATING MICROSCOPE. Bausch and Lomb binocular microscope, complete with various offers. Reply: Occupier, 38, Oloa, Ave., Vaucluse, N.S.W. 2036, or phone 37 1179 or 28 6840 (Syd.).

SUTURE COUCH, etc., Reply: Phone 90 2609 after 5:00 p.m., and you can be assured 43,972, after 5:00 p.m. (Syd.).

1 KROMAYER LAMP $100. 1 galvanic unit $75. 2 infra-red lamps $15 each. 2 ultra violet therapy lamps $60. 1 full length mirror $20. Can be sold for a fraction of the original cost. Reply: Box FWA, Riker Service, or phone 27 6839 (Syd.).

MARK 7 BIRD SPECTRAL, excellent condition, $300. Arranged for delivery. Reply: Box PTN, Riker Service.

CABIN TRUNKS—3 metal fitted with lock and keys. Sydney. Reply: Box FWA, Riker Service, or phone 27 6839 (Syd.).

CARDIOGRAPH inc mark E.G.O. unit in good condition. Reply: Dr. P. N. H. N.S.W. 2113, or phone 98 6291 (Syd.).

BRAND NEW EXAMINATION COUCH with matching stool—sliding cupboards underneath drawer, leak tight $72. Reply: Phone 72 6200 (Syd.).

MICROSCOPE, monocular (Carson-Ayer) with 8 x 10 x 15, objectives and eyepieces. Magnification $50. Reply: Phone 36 5933 (Syd.).

PAKO RAPID DRYER suitable for rapid drying of large sections. This unit is in perfect order and is only offered because it has been replaced by automatic processor. Reply: Phone 41 2173 (Syd.).

MICROSCOPE, Olympus, monocular, 4 objectives, oil immersion, mechanical stage, $95. Reply: Phone 29 1897 (Syd.).
ACCOMMODATION

NEW SOUTH WALES

WooD (Syd.). Locum wanting 2 weeks from May 12. p.m. No nights if not living within 3 miles. Reply: Dr. B. Hoolahan, 1747 4285 (Syd.).

TERN SUBURBS (Syd.). Required for solo g.p. Monday 12th May to mid. Sat. 17th May. No obelix, injury. $150. Reply: stating and qual. References es-

ACCOMMODATION TO LET

SOUTH AUSTRALIA

ADELAIDE SUBURB. Large well-

turnished house to let; 4-12

months. Lessee can have prac-

tice. Fee. Semi-retired. Reply: Box FXK, Riker-service, or phone 6s 6510.

Queensland

BROADBEACH. A bedroom

cum house over looking water.

fully furnished mailli cane furnish-

ting, television, washing machine, etc. Delight-

fully comfortable $35 weekly. Reply: Box FXX, Riker-service, or phone 6s 6514

or 67 3706 (Brns.).

VICTORIA

MELBOURNE AREA. Furnished

house, 3 bedroom, television, washing machine, 2

bathrooms. Avenel, June- Oct. 6. Reply: Box GBK,

Riker-service, or phone 50 2542.

NEW SOUTH WALES

MANLY. Opposite ocean beach,

mod. upstairs, furn. flat, 1 bed-

room, large lounge, w.w. car-

petals, tiled showor, mod. kit-

chen, laundry. D.J.F.R., h.w.s. lease 1 year, $22. Reply: Box FSX, Riker-service.

EASTERN SUBURBS. Furnished

house for 6 months from May

1969 FZA, 6 bedrooms, separate lounge/dining/sunrooms. Nice garden with panoraminc ocean views. Reply: Box GBK, Riker-

service.

BELLEVUE HILL (Syd.). Doctor's

residence, fully furnished, har-

bour view. Large sitting room, 2

bedrooms, study, dining room, etc. Move date April 29. Reply: Box FXE, Riker-

service.

HOLIDAY ACCOMMODATION FOR SALE

NEW SOUTH WALES

NEWPORT (Syd.). Holiday resort 4 bedroom house home for sale $19,500. On transport. Handy to schools, beach and Hotel. Reply: Box GBA, Riker-service, or phone 5s 1881.

HOLIDAY HOME, ULLADULLA. 
2 storey 12 square modern alu-

minum frame. New home with

30 ml. ocean view. 79 Bonython Ave, Ulladulla. Reply: Dr. K. M. Doust, 55 Sutherland St, Ulladulla, N.S.W., 2535.

Nuclear Medicine Seminar

Tuesday, 20th May to Thursday, 22nd May, 1969.

THE ROYAL ADELAIDE HOSPITAL

ADELAIDE

arranged by

the South Australian State Committee of the

College of Pathologists of Australia

Tuesday

20.00 Registration and

late arrivals

6.00 Lecture: The application of nuclear medicine

Wednesday

21.00 Lecture: The production and use of radio nuclides

22.00 Combined meeting of Nuclear Medicine, 

EM 5 60 SEMINARS

radio nuclides and Hematology.

The proposed fee for the seminar will be about $20.00.

For further information, a detailed program, and application form, please contact

Dr. J. A. Kirkland

Director of Nuclear Medicine

Healesville Hospital

WODDIE, S.A. 3011
POSITIONS WANTED

SOUTH AUSTRALIA


QUEENSLAND

GOLD COAST AREA. Exp. doctor's receptionist seeks position. References if required. Reply: Box FTV, Rikerservice or phone 5 1107 (Gold Coast).

VICTORIA

DOCTOR'S WIFE, S.C. nurse, desires part time position in Hawthorn-Werribee area. Reply: Mrs. W. Colebatch, 3/12 Epsom Rd, Kew, Vic. 3101, or phone 81 3382 (Melb.).

SENIOR RECEPTIONIST, wide exp. typing ability. Fluent German and Italian. Part time. Reply: Box FIV, Rikerservice.

NEW SOUTH WALES

T COASTAL VIEW IN AUS.

LIA. High over Kilcare, 30 mins from Manly. Great opportunity for the Right Person. Reply: Box FWA, Rikerservice. (Syd.)

AUSTRIAN COLLEGE OF ENERAL PRACTITIONERS

Western Australia Faculty

continuing Advanced_raining Courses, remantle Hospital, Wednesdays, 8 a.m. to 12 noon Margaret Hospital, Thursdays, 8 a.m. to 12 noon Erin Besse, 382 Princess Margaret Hospital, Wednesdays, 3 p.m. to 6 p.m. Swan District Hospital, Thursdays, 3 p.m. to 6 p.m.

The content of the course will include all aspects of gastroenterological disease and is aimed primarily at general practitioners and interested physicians. Full details of the course and further enquiries to:

Dr. A. Kerr Grant
Director, Gastroenterology Unit
Queen Elizabeth Hospital
Woodville, South Australia 5011

NOW LISTED AS Nhs ITEMS

ISO, ISO FORTE

and EPI

300-DOSE 15 ml. REFILLS

for rapid relief of bronchospasm

A CHOICE OF 3 MEDIHALER PRODUCTS LISTED AS Nhs PHARMACEUTICAL BENEFITS

MEDIHALER-ISO

isopropropyl 1-iso-terpineol aerosol suspension 15 mg/ml (15 mL. 300 doses)

(0.03 mg per inhalation)

MEDIHALER-Iso FORTE

isoprocodeine 1-iso-terpineol aerosol suspension 15 mg/ml (15 mL. 300 doses)

(0.04 mg per inhalation)

MEDIHALER-EPI

Adhesive and tampons salbutamol suspension 7 mg/ml (15 mL. 200 doses)

(0.22 mg per inhalation)
WANTED

MICROSCOPE. Low and high power app. for micro-urines. Reply: A. L. Morris, 46 Princes Highway, Moruya, Victoria 3214, or 'phone 71723.

NEW SOUTH WALES

MOBILE LIGHT-WEIGHT CASUALTY TABLE. Required functions should include ability to til and to break for lithotomy position. Small theatre light required also. Reply: Dr. Chaffey and Partners, 286 Princes Highway, Dapto, N.S.W. 2530, or 'phone 612 099 (Well).

LARYNGOSCOPE. Secondhand for O.P. Emergency bag use. Reply: Box FZP, Rikerservice.

SURG. EQUIPMENT. Setting up any equipment usable in country general practice. Reply: Box FZJ, Rikerservice, or 'phone 655 7271 (Syd.).

METAL FILING CABINET. With three or four large drawers. Syd. area. Reply: Box FWL, Rikerservice.

SECOND HAND OPERATING TABLE. In good condition. Also Centrifuge to 5000 revs. and associated. Reply: Box FWH, Rikerservice.

DOCTOR'S BAG. Also auriscope, ophthalmoscope, intramammary examiner. Reply: Box FTR, Rikerservice, or 'phone 96 1152 (Syd.).

EL-SE. Or similar telephone answering machine. Reply: Box Syd. 70 3002 after 6 p.m. weekdays.

NEW SOUTH WALES

EQUIPMENT. For histopathological, microtome, tissue culture bath, wax incubator-technician processor etc., also air conditioning. Reply: Dr. H. H. Howarth, 12 Turner Street, Griffith, N.S.W. 2600, or 'phone 62 3885 (Griffith).

"APPROACH TO CHEMISTRY" published by University of New South Wales, will quite possibly need more than one copy. Reply: Dr. D. H. E. Parr, 23 Greenbank Street, Hurstville, N.S.W. 2220, or 'phone 97 5229 (Syd.).

STERILIZER in good condition approx. 15 x 8 x 10 ins. Also microscope for micro-urines only. Please 'phone Dr. Poole 41 7175 (Artarmon, Syd.).


ANY STATE

ELSE Automatic telephone answering device (second hand). Reply: Dr. J. D. McKeen, P.O. Box 256, Bega, N.S.W. 2550, or 'phone Bega 291.


U.F.O. REPORTS for survey. Include all relevant details. Reply: Dr. P. W. Zuck, 254 St. Georges Terrace, Perth, Western Australia 6000, or 'phone 21 5413 (Perth).
“Never has so much been wagered by so many on so much,” might be a useful precis of the recent behaviour of Australian stock exchanges as the minerals boom hits yet another of its peaks. It inspired many writers to speak yet again of “all-time” highs, a claim to prescience that is usually rapidly proven wrong.

How Solid Is Our Mining Boom? Does It Depend On Hot Money?

Star performers in the rise this time were the uranium stocks, which were discussed in these columns only recently. Then would have been a good time to buy in. The uranium miners have been nominated by the newspaper pundits—and some brokers—as the glamour stocks of 1969 and, if Federal Government statements are a good guide, this could prove true. But it is worth remembering that for the investor, as distinct from the speculator, these are a medium-term purchase.

Apart from uranium, the record mining turnovers were reached also through quite hectic activity in oil stocks. When the Sydney index hit a (then) peak of 632 in February by far the bulk of trading was in mining. Nickel, copper and manganese miners, the last section including a newcomer, Southlands, added a strong boost.

With the oils, it was noticeable that all the interest was in those companies engaged in offshore drilling. Woodside and Mid-Eastern starred because of oil shows in their areas off West Australia. Genoa Oil, which is fathering a new company to share its W.A. offshore areas, was solidly supported.

This floating off of new companies to share the assets of an existing one has become a regular pattern in the Australian oil exploring business. It would hardly succeed at any other time but in mid-boom. There are casualties from the practice still lying around.

Considering this feverish activity in Australia what is the ground for supposing it will continue? How solidly is the boom based?

It is a known fact that much of the money now going into Australian mining stocks is coming from Britain and, to a lesser extent, from the U.S. and the Continent. On the face of it, this is wise investment on the part of the owners because there can be little doubt that our long-awaited shift from riding on the sheep’s back is about to take place—provided there is no major calamity to world trading.

In that regard it is significant that much of the money now flowing into this continent-size quarry, on whose edge we Australians live, is “hot” money. The alarms and excursions about sterling, the French franc and the U.S. dollar have been muted but not eliminated, for the good reason that the underlying causes of uncertainty still remain.

In Britain, Mr. Wilson seems to be on the verge of a retreat from the welfare state. He has been driven to it by the patent fact that it is not viable in a competitive world.

In France, de Gaulle recently came to grief—and devaluation—when student revolts and union unrest forced him to grant big pay rises when high costs were already threatening inflation.

The hard business line expected from the new Nixon administration in the U.S. will probably help the dollar, but at the expense of someone else.

Germany, which has refused to revalue because it claims that France should devalue, is facing a real threat of inflation.

All this brouhaha about the major trading currencies is contributing to the Australian mining boom, quite apart from the real value of investment here. It creates the “hot” money which is continually circulating, its owners hoping that they can keep ahead of a devaluation in one currency or profit by a revaluation in another. At the height of the French crisis the currency traders were rapidly turning their francs into gold and buying Deutschmarks for safety.

Some part of this “money on the run” is currently resting in Australian shares, pushing up prices but making no promises that it will stay here to support them. It’s rather like a migrant with an assisted passage (the exchange rate) who has no intention of staying beyond the necessary term.

Exactly what margin this kind of money is adding to Australian prices—chiefly mining—is difficult to gauge. Some kind of pointer is the low point to which a stock falls when news as far as we can tell—the “hot” money operators have pulled out. But since these gentlemen don’t advertise their intentions in the newspapers, one can’t be sure.

(Continued P.6)
Motor Vehicle Tax Deductions

The background against which a deduction for more vehicle expenses may be
claimed by a taxpayer (as distinct from concessional deductions already dealt with in
previous articles) rests for the most part upon Sections 48 to 51 inclusive of the Income
Tax and Social Services Contribution Assessment Act.

Section 48 is expressed in the following words:—

48. "In calculating the taxable income of a taxpayer, the total assessable income derived
by him during the year of income shall be taken as a basis and from it there shall be
deducted all allowable deductions."

Sections 49 and 50 deal with successive deductions from composite incomes and in effect set out the
order in which the deductions shall fall against the different classes of income such as personal exertion,
property other than dividends and income from dividends.

Section 50 in particular states in effect that where a deduction or part of a
deduction relates directly to a class of income that deduction shall be made
first against that class of income, and if the deduction is not fully absorbed
against that class, it shall be made successively against the other classes.

For example, take the case of dividends. A deduction related to this class of income would be interest
on money borrowed to purchase the investments. This deduction would be
applied first against the income from dividends, then against income from property and finally (if not already absorbed)
against income from personal exertion.

Section 51 (1) is expressed as follows:—

"All losses and outgoings to the extent to which they are incurred in gaining or producing
the assessable income, or are necessarily incurred in carrying on a

business for the purpose of gaining or producing such income shall be
allowable deductions except to the extent that they are losses or out-
goings of capital, or are incurred in relation to the gaining or production
development or exempt income."

From this it is clear that for a deduction to be

allowable the loss or outgoing must be incurred in

earning or producing assessable income, or necess-ary incurred in carrying
on a business for the purpose of gaining or producing
such income. Section 54 on depreciation is also
important because depreciation is one of the ex-

penses to be taken into account in assessing motor

End patient dislike of oral Group B therapy

WITH 'ALTORVITE'

SPECIALY COATED HIGH POTENCY B GROUP TABLETS PLUS ASCORBIC ACID

- Disintegration is complete
- Improved retention of potency
- No extra cost to consumer
- Formulated for conditions requiring high potency B Group vitamins and ascorbic acid.

RECOMMENDED DOSE:
Adults: 1 to 4 tablets daily.
Children: 1 to 2 tablets daily
PACKAGING: in bottles of 100.
FORMULA: Each tablet contains
Thiamine — Vitamin B₁ 5.0 mg
Riboflavin — Vitamin B₂ 2.5 mg
Pyridoxine — Vitamin B₆ 0.5 mg
Niacinamide 25.0 mg
Ascorbic acid 37.5 mg
Calc. Pantothenate 1.0 mg

Nicholas
a wholly Australian owned Company

PD/1983
Wine for Health

Part

By Harry Cox, author of "The Wines of Australia"

RESEARCHERS FIND WINE DOUBLES SLIMMING RATE

Ever since the primitive but perceptive days of Hippocrates in 400 B.C., many medical men have been aware of the soothing and healing properties of wine. In a general way, they have known, these faithful observers, that wine is good for you. Always in moderation, of course. But what they haven't known is exactly why.

Why does wine seem to be more medicinal than any other kind of alcoholic beverage? What is there in wine that makes it different, in its affable sojourn in the human body, from, say, whisky, gin, beer?

OVER THE CENTURIES

For many centuries doctors have been noting the influence of wine on the human system, without ever getting down to a scientific analysis.

More than a hundred years ago a German specialist, Professor von Liebig, was writing:

"Wine is a restorative. As a means of refreshment where the powers of life are exhausted — of giving animation and energy in man's days of trial and sorrow — as a means of correction and compensation where disproportion occurs in nutrition, and as a protection against organic disturbance, wine is surpassed by no product of nature or art." 

Strong, hearty, comforting words for all wine lovers. But, of course, purely empirical. Most doctors a hundred years or so ago were aware that wine, generally, seemed to be a good, and in moderation, harmless restorative in convalescence, and a safe stimulant and reviver for the sick.

One impassioned doctor wrote:

"In many affections of the body wine is of more service than anything physicians can point to in their pharmacopoeias. It enables the system to resist the exhausting attacks of intermittent and malignant fever."

Other doctors followed this by prescribing wine as a treatment for specific diseases and illnesses. French doctors often prescribed it as a cure for wounds, ulcers and other external eruptions. Port wine was given to patients with relaxed or low inflammatory states of the bowels (To this day the common bar-room cur dare for diarrhoea is port wine and brandy).

POWERFUL PREVENTIVE

"Sound port wine," wrote one doctor, "is a powerful preventive of bowel irritation. It promotes the tone, strength and vigor of the system, so enabling it to overcome the predisposing causes of debility."

"In some cases the severest spasms arising from incontinence or precursory attacks of cholera, a draught (two or three glasses) of good port, put in a tumbler and drunk off cold and at once, have carried the spasms off like a miracle, and have often been succeeded by a calm sleep."

Wine was also sometimes prescribed for fevers like typhoid, for weakness or debility, or for almost any ordinary deficiency of vital energies. Said one doctor:

"There is nothing equal to the restorative powers of a sound, pure wine. It fortifies the system against the insidious attacks of intermittent and malignant fever, allays nervous excitability and alleviates the infirmities of old age."

SHERRY FOR NERVES

Still another doctor recommended sherry as a tonic and champagne as a cure for hypochondria and nervous complaints. Anybody who has followed Andre Simon's benign advice and taken champagne last thing at night and then first thing in the morning will probably testify that, so stimulated, so elevated, it is rather difficult to be gloomy or worried about anything.

Until recently all these cures and treatments were little more than a genial blend of observation, prejudice and blind confidence. They certainly weren't scientifically established.

But today researchers, particularly in the United States, are sedulously gathering up the facts into a solid body of medical exactitude.

The wine growers of California are financing a programme of medical research into all aspects of the influence of wine on the human being. Over fifty separate medical research units are delving into, not merely the health giving aspects of wine, but into its sometimes strange power over specific diseases and ailments.

WINE INDUCES WEIGHT LOSS

One of the researchers, Dr. Georgio Lollis, of New York, has specialised in a study of thirty-five obesity patients, all on a reducing diet. He has found that most of them, taking wine regularly with or after dinner lowered their intake of calories and induced a gradual but consistent loss of body weight.

The most emphatic reductions were among twenty-seven patients taking wine with dinner, but not afterwards — an average loss of .53 per cent of body weight in a week. This compared with .26 on a reducing diet alone, without wine. The patients who took wine after dinner or at bed-time registered only a moderate reduction in weight. It was the wine with dinner that did the work. Exactly how and why Dr. Georgio Lollis has still to discover.

(Continued May issue)