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PROFESSIONALISM AND PROFESSIONAL ETHICS

by

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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

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1 Carr-Saunders, A.M. and Wilson, P.A., The Professions, Oxford, 1933, p.290.

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".[1] 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,[2] there is an intimate connection between the growth and character of

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[1] Addison, quoted by the Oxford English Dictionary.

[2] Op. cit., p.296 et seq.

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

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[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]

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1 M.L. Cogan, "The Problem of Defining a Profession", Annals of the American Academy of Political and Social Science, Vol. 297, 1955, p.107.

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.

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1 R. Lewis and A. Maude, Professional People, Phoenix House, London, 1952, p.64.

> ...rous standards of licensure, ...fulfilment of which often confers upon ...he 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

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[1] Logan Wilson, The Academic Man, Oxford University Press, New York, 1948, p.114.

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

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1 Bernard Barber, "Is American Business Becoming Professionalized?" in E.A. Tiryakian (Ed.) Sociological Theory, Values and Sociocultural Change, Free Press, London, 1963, p.12.

various discussions of the professions,[1] 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[2] can occur from

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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

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[1] D. Rueschemeyer, "Doctors and Lawyers: Comment on the Theory of the Professions", Canadian Review of Anthropology and Sociology, 1 (1), February 1964, p.21.

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:

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1 A.M. Carr-Saunders and P.A. Wilson, The Professions, Oxford, 1933, pp.284-285.

> 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 reason[2] are commonly included in the

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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.

CHAPTER II

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"

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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 <u>conditional</u> 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.

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1 For a detailed exposition of the basic argument summarized here, see R.S. Walters, "Professional Ethics", Proceedings of the Seventh National Conference of the Australian Association of Social Workers, Sydney, August 1961.

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 1968, 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

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1 Sir Garfield Barwick, "Some Legal Aspects of Professional Ethics", Journal of the Institution of Engineers, Australia, July-August 1960, N.54.

> 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.

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1 T.H. Marshall, "The Recent History of Professionalism in Relation to Social Structure and Social Policy", The Canadian Journal of Economics and Political Science, 5(3), August 1939, pp.328-329.

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

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1 Durkheim, E., Professional Ethics and Civic Morals, translated by Cornelia Brookfield, Routledge and Kegan Paul, London, 1957, p.7.

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.[1] 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.

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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

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[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

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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.

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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.

2 B.Y.Landis, Professional Codes: A Sociological Analysis to Determine Applications to the Educational Profession, New York, 1927, pp.IX, 87-88.

(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,[1] 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

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1 G. Millerson, The Qualifying Associations, London, 1964, Routledge and Kegan Paul, pp.164-165.

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

PROFESSIONAL RELATIONSHIP	LOYALTY	RESPONSIBILITY	SERVICE	INDEPENDENCE	REMUNERATION	ADVERTISING
Professional and Public	1. Must maintain integrity, dignity, truthfulness and honour of profession (Arch., Eng., Med.)	2. Must apply skills for benefit of community (Arch., Eng., Med.) 3. Must live pure and moral lives (Med.)	4. Must render service in emergency or special need (Med.)	5. Must maintain professional independence and impartiality (Eng., Med.)	6. Must not act in honorary capacity except for non-profit organizations (Eng., Law) 7. Must avoid commercial entanglements which might compromise service or objectivity (Med.)	8. Must not permit undue personal publicity (Arch., Law , Med.)
Professional and Client	9. Must act impartially in administering contract (Arch., Eng.) 10. Must maintain secrecy (Eng., Med., Law) 11. Must act as faithful adviser to client (Eng., Med.)	12. Must inform client of conflicts of interest (Arch., Eng.) 13. Must constantly work to improve his skill (Med.)	14. Must provide service of high standard (Arch.) 15. Must work assiduously and conscientiously (Eng.) 16. Must seek help from colleagues when necessary (Eng., Med.)	17. Must not place himself under obligation to those with whom client or employer has dealings (Eng.)	18. Must uphold scale of charges (Arch., Eng., Law) 19. Must not use advantages of salaried appointment or private practice to detriment of colleagues (Eng.) 20. Must only receive professional salary or fee (Eng., Med.)	21. Must not supplant or attempt to supplant a colleague (Arch., Med.) 22. Must not solicit professional work (Eng., Law, Med.)
Professional and Professional	23. Must compete fairly with colleagues (Arch.) 24. Must maintain good relations with colleagues and observe rules of professional courtesy and etiquette (Arch., Eng., Med.) 25. Must not call in question the integrity or ability of colleague unless in public interest (Eng., Med.)	26. Must report breaches of code by colleagues (Arch.) 27. Must promote advancement of the professional subject (Arch.) 28. Must advance training of subordinates (Eng.) 29. Must consult client's previous advisers, or only undertake work if previous adviser no longer engaged (Eng., Med.) 30. Must not "poach" staff (Eng.)		31. Must only engage in professional competitions in accordance with rules prescribed by professional association (Arch., Eng.) 32. Must not engage in another occupation which brings work or may compromise position (Law)	33. Must not give or receive commission or discount (Eng., Law, Med.) 34. Must not share client's fee with consultant colleagues (Med.)	35. Must not advertise except in accordance with rules of the profession (Arch., Eng., Law, Med.) 36. Must not damage practice of colleague with whom formerly in professional relationship (Med.)

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

TABLE 2

ELEMENTS OF PROFESSIONAL CODE (As shown in Table 1)

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								X				X										X	X		X	
ENGINEERING (Institution of Engineers Australia)	X	X			X	X			X	X	X	X			X	X	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		X	X	X	
MEDICINE (Australian Medical Association)	X	X	X	X	X		X	X		X	X		X			X				X	X	X		X	X				X							X
FREQUENCY	3	3	1	1	2	2	1	3	2	3	2	2	1	1	1	2	1	3	1	2	2	3	1	3	2	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,[1] the Institution of Engineers Australia, and the Royal Australian Institute of Architects are then analysed[2] quantitatively for the amount of space, in words,

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[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 3

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

	EXTRINSIC				INTRINSIC				
Professional Body	(i) General responsibility to serve clients and community and to obey conventional ethics of society %	(ii) Specific responsibilities to client or society %	(iii) Responsibility for skilful practice and advancement of professional art or science %	Sub-total %	(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 %	Sub-Total %	Total %	Length of Code (No. of words)
Australian Medical Association (Federal	10.1	18.8	2.1	31.0	3.6	65.4	69.0	100.0	10.000
Institution of Engineers, Australia	15.4	15.4	3.0	33.8	10.8	55.4	66.2	100.0	2,000
Royal Australian Institute of Architects	25.0	16.7	2.8	44.5	5.5	50.0	55.5	100.0	500

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".[1] 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.

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[1] M.L. Cogan, "The Problem of Defining a Profession", The Annals of the American Academy of Political and Social Science, CCXCVII, 1955, p.107.

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.[1]

This is one of the questions taken up in the next chapter.

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1 Loc. cit.

CHAPTER V

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

Whether or not is it 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.

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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.[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

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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;

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[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.[1]

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[1] 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:

(a) 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).

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[1] Jerome E. Carlin, Lawyers' Ethics: A Survey of the New York City Bar, Russell Sage Foundation, New York, 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 misdemeanour or of any offence which if committed within the State in which he resides would be a felony or misdeameanour 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.

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[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. drunkeness, 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

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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

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[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

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1 A.M.A. Gazette, no.19, 6 November 1969, p.1.

2 In their survey of general medical practice in Victoria, Scotton and Grounds found that responding doctors had an average of 186 general practitioner attendances during the week. (R.B. Scotton and A.D. Grounds, "Survey of General Practice in Victoria", Medical Journal of Australia, Supplement, vol. 1, no. 1, 18 January 1969).

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,[1] 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.[2]

Although there is no reason to suppose that the doctor's ethical acumen it 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

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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 Nuremburg trials against the Nazi doctors and which is still heard in relation to the devising and

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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

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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

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1 "Doctors and Abortion", The Sydney Morning Herald, 29 September 1969, p.2.

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.[1] ...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

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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

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1 "The Abortion Debate", Medical Journal of Australia, 2, 25 October 1969, p.833.

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.[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 <u>is</u> 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".

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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.

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1 E. Durkheim, Professional Ethics and Civic Morals, Routledge and Kegan Paul, London, 1957, p.3.

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

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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.

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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

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1 See Dietrich Rueschemeyer, "Doctors and Lawyers: A Comment on the Theory of the Professions", Canadian Review of Anthropology and Sociology, vol. 1, no. 1, February 1964, pp.17-30.

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

Code Element Number (from Table 1)	Injunction
1	Must maintain, integrity honour, etc. of profession.
2	Must apply skills for benefit of community.
10	Must maintain secrecy.
18	Must uphold scale of charges.

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.[1]

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[1] W.J. Goode, "Community Within a Community: The Professions", American Sociological Review, 22 (2) April 1957, p.196.

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

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1 A.M. Carr-Saunders and P.A. Wilson, The Professions, Oxford, 1933, p.423. See the extended discussion of the functional significance of professional ideals, pp.418-446.

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]

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[1] Bernard Barber, "Is American Business Becoming Professionalized?" in E.A. Tiryakian (Ed.), Sociological Theory, Values, and Sociocultural Change, Free Press of Glencoe, London, 1969, p.142.

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, depsite 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.

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1 Op. cit., p.22.

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

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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".[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.[2]

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".[3] Parsons goes on to quote "commercialism" in medicine and

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1 Ibid., p.464.

2 Ibid.

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

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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 widescale 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",[1] 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

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1 C. Wright Mills, White Collar: The American Middle Classes, O.U.P., New York, 1951, p.137.

2 Op. cit., pp.119-120.

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

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

Analytic Category	Issue No. 9 (Column Inches)	Issue No. 10 (Column Inches)	Issue No. 14 (Column Inches)	Issue No. 17 (Column Inches)	TOTAL SPACE (by categories)	% of TOTAL space
Category 1 (Emoluments, Income and Economics of Medical Services)	104	347	132	143	726	38.4
Category 2 (Organization of Medical Practice and Health Services)	63	113	95	47	318	16.8
Category 3 (Health and Medical)	76	85	98	71	330	17.5
Category 4 (Cultural and Recreational)	124	41	94	15	274	14.4
Category 5 (General and Miscellaneous)	67	35	98	45	245	12.9
TOTAL	434	621	517	321	1893	100.0

(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[1] 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 31 Others"

(iii) "Anatomy of the Ad. Game" (article on advertising industry)

TABLE 5 SHOWING CONTENT ANALYSIS OF FOUR ISSUES OF "WINTHROP IMPULSE"

Analytic Category	Issue No. 18 (Column Inches)	Issue No. 9 (Column Inches)	Issue No. 8 (Column Inches)	Issue No. 13 (Column Inches)	TOTAL SPACE (by categories)	% of TOTAL space
Category 1 (Emoluments, Income and Economics of Medical Services)	26	13	15	217	271	24.5
Category 2 (Organization of Medical Practice and Health Services)	32	-	26	-	58	5.2
Category 3 (Health and Medical)	99	116	136	21	372	33.6
Category 4 (Cultural and Recreational)	22	-	37	-	59	5.4
Category 5 (General and Miscellaneous)	55	160	66	65	346	31.3
TOTAL	234	289	280	303	1106	100.0

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 "Withrop 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?[1] 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

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[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

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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

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1 W.J. Goode, "Community Within a Community: The Professions", American Sociological Review, vol. 22, no. 1, February 1957, p.196.

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.[1] 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

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1 Op. cit.

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 -

(1) 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

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1 See, for example, the references cited in (i) Richard H. Hall, "Professionalization and Bureaucratization", American Sociological Review, 33 (1) February, 1968, pp.92-104; (ii) Rue Bucher and Joan Stelling, "Characteristics of Professional Organizations", Journal of Health and Social Behaviour, 10 (1) March, 1969, pp. 3-15.

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".[1] 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

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1 Roy Lewis and Angus Maude, Professional People, Phoenix House, London, 1952, p.62.

than the rule in professional organizations and that the problem of integration is frequently met by a continuing political process.[1] 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

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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.

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1 Ibid., p.3.

2 Ibid., p.14.

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 "moralities" 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

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1 William Kornhauser in Vollmer, H.M. and Mills, D.L., Professionalization, Prentice Hall, New Jersey, 1966, p.293.

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

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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.

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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

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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

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[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.[1] 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

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[1] See R.M. Pike, The Cinderella Profession, Ph.D. thesis, Australian National University, 1963.

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.

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1 See George A. Miller, "Professionals in Bureaucracy: Alienation Among Industrial Scientists and Engineers" American Sociological Review, 32 (5), October, 1967, pp.755-768.

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,

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1 Geoffrey Millerson, The Qualifying Associations, Routledge and Kegan Paul, London, 1964, p.33.

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

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[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 stock-broking, 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 those 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 implicity 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 Quinney[2] in their study of the comparative

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1 E. Durkheim, Professional Ethics and Civic Morals, translated by Cornelia Brookfield, Routledge and Kegan Paul, London, 1957, p.4.

2 Ronald L. Akers and Richard Quinney, "Differential Organisation of Health Professions : A Comparative Analysis", American Sociological Review, vol.33, no.1, February, 1968, pp.104-121.

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,

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1 Op. cit., p.112.

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.MA. 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 conclude[2] 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

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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?

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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.[1] 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

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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

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1 Kenneth Prandy, Professional Employees, Faber and Faber, London, 1965, p.174.

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.[1] 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'.[2] But the position is not nearly so straightforward when the professions concerned are composed largely of employees, and one would

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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.[1] 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

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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,[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

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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.

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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

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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

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1 Op. cit., p.464.

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.

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1 Jerome E. Carlin, Lawyers' Ethics: A Survey of the New York City Bar, Russell Sage Foundation, New York, 1966.

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.

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Appendix I

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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 behoves 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

7. 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

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

Credit to Subordinates

9. 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

10. 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

11. If he has any substantial financial interest in any firm or company that may tender or contract for the construction of, or the supply of, any 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 in 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 from a company or firm in which he has any substantial financial interest or on tenders which include such a tender.

Confidential Information

12. 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

13. 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, in 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.

9. Brochures.

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.

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Appendix I

ROYAL AUSTRALIAN INSTITUTE OF ARCHITECTS

CODE OF PROFESSIONAL CONDUCT [1]

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

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[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.

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Appendix I

AUSTRALIAN MEDICAL ASSOCIATION

CODE OF ETHICS



AUSTRALIAN MEDICAL ASSOCIATION

CODE OF ETHICS

1969

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

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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 magnanimous 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.



President
Australian Medical Association

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.)

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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 trace; 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 observation 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—Assistants*

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 an 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

7.4 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

7.5 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

7.6 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.:

8.2.1*a* 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.

8.2.1*b* 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.

8.2.1*c* 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.

8.2.1*d* 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.

8.2.1*e* 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.

8.2.1*f* 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 8.2.1*e* (*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.

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

8.2.1*h* 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.

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

8.2.1*j* 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 8.2.1*j* 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.)

8.2.1*k* 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.

8.2.1*l* 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 fœtus 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:

8.3.1*a* 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.

8.3.1*b* 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.

8.3.1*c* 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 ætiology, 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.

8.3.1*d* 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.

8.3.1*e* 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 ætiology, 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 intra-professional 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

0.1.1 Doctors in their professional relationship with dentists should observe the following rules:

10.1.2. *Consultations*

0.1.2*a* 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.

0.1.2*b* 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.

0.1.2*c* 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. *Anæsthetics*

0.1.3*a* Where an anæsthetic is advised by the dentist, it is competent for him to select the anæsthetist, but, if such anæsthetist 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.

0.1.3*b* 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:

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

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

10.3.2*c* 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

11.1.1 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.

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

11.1.3 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.

11.1.4 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:

11.1.5 "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*

11.2.1*a* 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.

11.2.1*b* 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*

11.2.2*a* 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.

11.2.2*b* 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.

11.2.2*c* 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-

ceutical agents, and such reports must not be used in any way for advertising or promotional literature.

11.2.2*d* 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.

11.2.2*e* 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.

11.2.2*f* 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.

11.2.2*g* 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 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.

(*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.

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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

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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.

I. 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.

3*a*. 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.

3*b*. 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.

3*c*. 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.

4*a*. 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.

4*b*. 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.

—Reprint, *World Medical Journal*, September, 1964.

AUSTRALASIAN MEDICAL PUBLISHING CO. LTD.
71-79 ARUNDEL ST., GLEBE, SYDNEY, N.S.W., 2037

Appendix II

C
CTICE
tion

profession
s Division
Ermington,

, 1969

Winthrop impulse

And Transplant Unit in Brisbane

ee Organ Transplant Service In Australia

t service will commence Hospital, Brisbane, by the on the correct facilities

that stage the Unit's ity will be in line with heoretical needs for renal lantation and dialysis.

Australia at present, and e reasonable future, the er of patients presenting ialysis or transplantation requiring such treatment be assessed at 30 per n of population per n.

hen in full operation the will be able to treat 15 nts at one time by dialysis, 20 to 30 patients a year ansplantation.

eady there are six patients ng for treatment at the Brisbane Unit.

e planning for the treat- of end-stage renal failure e new Unit by the tech- s of dialysis and trans- ation will include an active amme aimed at renal e prevention which may antially reduce the incid- of end-stage renal disease.

re at the Dialysis and plant Unit, as well as in Hospital's existing renal increased use will be of preventive, diagnostic therapeutic techniques in disease and research. of particular importance le urinary tract infection analgesic nephropathy.

nsplantation research it- will fall into three main —basic immunological re- ; transplant immuno- l research; and research, clinical and basic, which d feed back from all e transplantation pro- mes. In addition, un- d fields will be open for research.

e Unit's dialysis and organ lantation activities will with recurrent dialysis and lantation in conjunction the work at the existing which will be responsible cute end failure cases.

e ultimate aims and ons of the Dialysis and plant Unit and the renal unit will therefore be: The prevention, diagnosis and treatment of diseases of the renal tract; the training of specialists in the medical aspects of disease of the renal tract and the surgery of transplantations; research into all aspects of nephrology and in transplantation and related immunology; the proper provision of facilities for recurrent dialysis and transplantation; and the training of paramedical personnel in the methods and techniques required in these specialised fields.

The latter will include the establishment of a team with experience in grafts and transplants.

Once completed, the Brisbane Unit—the last one of the Australian capital cities to begin renal transplantations—is expected to incorporate the most advanced techniques in the control of body rejection processes.

Its physical facilities and equipment will ultimately include beds for investigation and treatment, a dialysis area for eight to ten patients, laboratory space, teaching and training area, offices, a sterile area for post-operation periods, and an out-patient area.

Patients admitted to the new Unit will be selected on medical grounds by the medical team of the Unit. So far, in Australia and overseas, renal transplantations have been carried out on kidney sufferers ranging from 3 to 74 years of age.

The selection of suitable donors is subject to all necessary legal requirements. Consideration and selection of potential donors will be undertaken on the referral by and with the approval of the patient's attending doctor, the final responsibility being with the medical members of the Unit.

The improving results achieved with cadaver organs will justify the predominant use of cadaver donors. At the Brisbane Unit most donors will therefore be accident victims.

Only in exceptional circumstances, the use of related living donors may be considered.

When the Brisbane Unit commences operations with an initial estimate of about twenty transplants a year, the total annual Australian renal transplantation figure would come close to one hundred and fifty. •

Floogle



Counterpane

INVESTOR

A Share In The Mineral Boom

Investors looking for a less speculative piece of the action in the Australian minerals boom could well study Mining Traders Ltd.

The company is an oil and mining investor, sponsored by one of Sydney's leading brokers—Patrick & Co. The attraction in this is that Mining Traders must be in the box seat to pick up some of the plums from the current Patrick mining floats including the juicy Carr-Boyd Minerals, Quest Mining & Exploration and Flinders Oil NL. Getting in on the ground floor should give the company a chance of showing substantial capital appreciation on these investments.

But Mining Traders has already built up an asset backing of 72 cents on its 20 cent shares up to June 30 last in just over one year's operations. It recently wiped out the remaining 30 cents liability on the original issued 50 cents shares paid to 20 cents. This was because directors felt that funds were now adequate to take advantage of any special situation that might arise.

Mining Traders floated, in fact, on a *"special situation"* parcel of Western Titanium shares bought at well under the market price. However, since then the company has successfully operated under booming market conditions.

It has also assisted in exploration and developing companies in the raising of funds. Directors expect that this activity will become an increasing part of Mining Traders' business in future years.

Chairman Mr. J. S. Millner pointed out at the last annual meeting that being a small board in close contact *"we are able to make quick decisions."* And this agility in today's mercurial mining market is a big thing.

What also must be a tremendous help is that one of the directors, Mr. R. L. Dowling, is also a senior partner of Patrick & Co. which assists the company in its investments. Other directors are Messrs. D. M. Carment and J. E. Roberts.

One diversified interest of Mining Traders which must contribute to its stability is its 50 per cent ownership of Construction Finance. This initially cost Mining Traders 200,000 of its shares following its acquisition of a major interest formerly held by CAGA. The other half of Construction Finance is owned by Mr. P. Miskin, the company's chairman and managing director.

Construction Finance was one of the companies which joined in the sponsoring of Australia's first commercial bill company, Bill Acceptance Corporation. It is one of five partners now holding a 20 per cent interest in Bill Acceptance.

Not all Mining Traders plans have succeeded. Last year the company tried to take over Lithgow Valley Colliery Ltd., but was beaten out of the race by Slater Walker.

But, while Mining Traders continues to get substantial parcels of shares in new minerals floats, investors should not go wrong. Through its investment in one new float alone the company could well see a market value of half its present capital. At around $1.75 Mining Traders don't look cheap but the shares backing and background should spell further capital appreciation and issue benefits in the future. •

STER
YOR

meteoric local authority career three-year career which has flood, an appalling earthquake ng.

same as those in the handling of the human body. *"The step between them is a short one."*

A problem arising has to be first accurately diagnosed and assessed. Then the best remedy must be determined—in the case of administration from a set of by-laws. The third factor is applying the right remedy.

But Dr. Dallas could hardly have guessed at the problems that were to face him. Not long after his election, an arsonist set fire to his surgery which was completely destroyed —along with the town's mayoral chain.

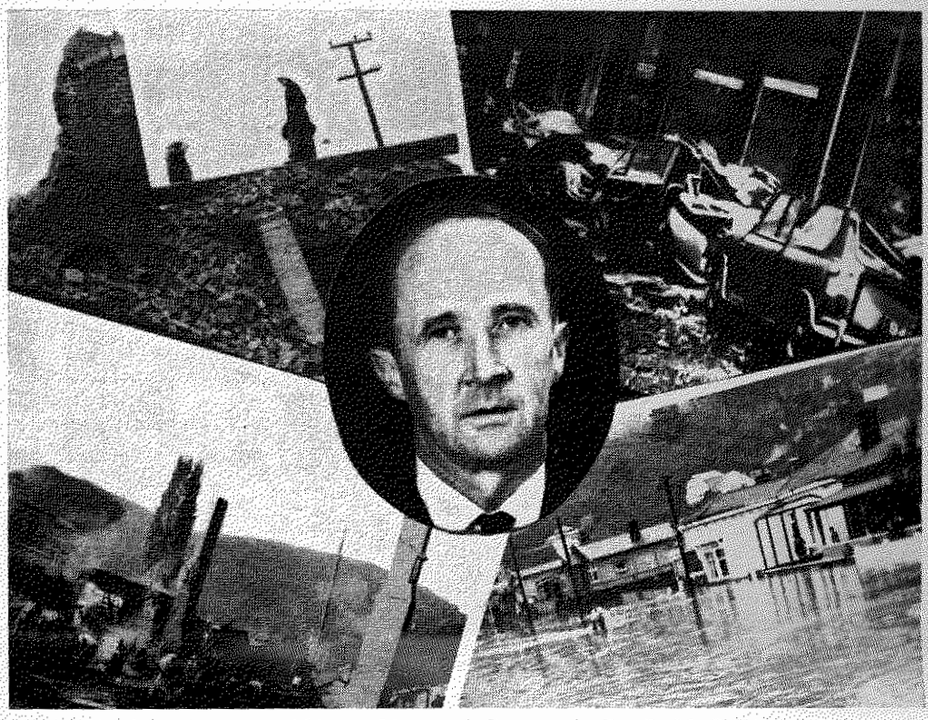
But then a most demanding situation arose.

On January 19th, 1967, an explosion of coal dust and gas killed 19 miners in the huge Strongman State colliery—a mine as big as Greymouth itself, the town in which most of those killed lived.

In the 72 hours following the explosion Dr. Dallas was required to visit all the next-of-kin and deal with the complicated mass funeral for 15 of the victims.

His general practice experience of breaking bad news and consoling bereaved relatives was never of more value. The Minister of Mines, Mr. T. P. Shand, who was faced with a similar task, described it as the hardest thing he had ever had to do.

It was made considerably easier for him he said, by having followed Dr. Dallas who was able to combine his civic and humanitarian duty with practical medical help for those worst affected.



During his three-year stewardship as Mayor of Greymouth, Dr. B. M. Dallas has seen almost every kind of disaster. Besides a mine tragedy, his town has been struck by a major earthquake, which is depicted in the upper two segments of the photo, a fire which gutted his surgery (lower left) and disastrous floods which inundated the town (right).

With the Mayor of an adjoining borough, Dr. Dallas set up a disaster fund which was *"an almost embarrassing success,"* providing handsome sums for the widows and assuring the future of the fatherless children.

On April 9th, 1968, a three-foot wall of water was pouring along the road fronting the doctor's surgery—a flood which inundated parts of the town, brought down many "slides" and caused thousands of dollars worth of damage.

Greymouth was still licking its wounds from this disaster six weeks later when a Magnitude 7.5 earthquake struck the town. The resulting damage cost millions of dollars.

"My responsibility in these disasters was to decide whether an official disaster situation had arisen," said Dr. Dallas. *"Fortunately there was no major casualty list and no real interruption to essential services, therefore I decided there was no reason to complicate normal recovery work, which was going smoothly, with compulsory emergency measures."*

Immediate re-development planning was begun for the whole of down-town Greymouth, the worst-affected part of the borough, and the oldest. Chimney repairs from the May quake were still going on when the biggest single threat ever to the economic life of Greymouth was posed with the announcement of the closing of the nearby Dobson State coal mine.

Its miners provided a major slice of Greymouth's business income. Since then, Dr. Dallas has been at the forefront of the drive to establish alternative industry and expand existing projects to compensate. Already he has had considerable success—particularly in negotiation at Government level. Once again he thanks his medical training. *"I am quite certain that because you are a medical practitioner one gets a much better hearing in the capital than would be normally accorded."*

To all medical practitioners, Dr. Dallas recommends local authority work at any level as a hobby.

"The position does not have to be as demanding as that of Mayor: but medical men should accept the challenge and offer themselves to the community—even a few hours a month brings a certain satisfaction."•

AN GENERAL PRACTITIONERS' CONVENTION — SCIENTIFIC PROGRAMME

The College at Work"
Practice Management"
hairman & Organiser: Dr. J. Trotter
anel: Dr. Wesley E. Fabb
"General Philosophy of Practice Management"
r. Richard Banks Geeves, E.D.
"The Purpose and Practice of Record Keeping
r. Neil E. Carson
"The Medical Practice of the Future"
1.00 a.m.-12.30 p.m.
Research in General Practice"
Organiser: Dr. G. B. Roberts
Chairman: Dr. John Radford
Panel: Dr. Ian L. Rowe
"Why Research in General Practice?"
Dr. Roy Freshwater
"Resuscitation in Cases of Sudden Death"
Dr. Jeannette Linn
"Total Patient Care"
Afternoon
Free

Wednesday, 21st May, 1969
Morning
.15 a.m.-10.30 a.m.

"Hazards of Pregnancy"
"Maternal Morbidity"
Chairman & Organiser: Dr. J. H. Buckley
Panel: Dr. E. J. Esler
Dr. H. P. Palethorpe

11.00 a.m.-12.30 p.m.
"Obstetric Emergency"
Organiser: Dr. Brian Elliott
Chairman: Dr. Neville Wilmer
Panel: Dr. Brian Elliott
"Some G.P. Obstetrical Problems"
Dr. Brian Hill
"Management of Unusual Obstetric Complications"
Dr. David Fraser
"Neo-Natal Aspects of Obstetric Emergency"

Afternoon

2.00 p.m.-3.30 p.m.
"Progress in Paediatrics"
Organiser: Dr. Harold Forbes, E.D.
Chairman: Dr. John Muller
Panel: Dr. Peter Grant, E.D.
Professor T. J. Rendle-Short

3.45 p.m.-5.00 p.m.
"Own Home or Nursing Home—Advances in Domiciliary Geriatric Care"
Chairman & Organiser: Dr. J. G. P. Ryan.
Panel: Professor F. A. Whitlock
Dr. P. G. Livingstone
Miss E. P. Dobbyn
Sister P. M. Farrell

Thursday, 22nd May, 1969
9.15 a.m.-10.30 a.m.
"The General Practitioner in Industry"
Chairman & Organiser: Dr. Robert Scott
Panel: Dr. E. M. Rathur
"Proles, Practitioners and Public Servants"
Dr. D. T. Robertson
"Is the Dermatitis Occupational?"
Professor Douglas Gordon
"Human Beings at Work"
11.00 a.m.-12.30 p.m.
"Ability with Disability"
Organiser: Dr. B. N. Adsett
Chairman: Dr. Rex Walpole
Panel: Dr. S. A. Mellick
"Vascular Lesions"
Dr. Paul Hopkins
"Prostheses and Their Scope"
Dr. A. B. Corrigan
"Joint Disability"
2.00 p.m.-3.30 p.m.
"Youth is Revolting"
Chairman & Organiser: Dr. Wm. Orford
Panel: Dr. R. C. Heddle
Dr. Murray Williams
Dr. W. Theile
3.45 p.m.-5.00 p.m.
"Risks of Modern Recreation"
Chairman & Organiser: Dr. Ross McGregor
Panel: Dr. A. B. Corrigan
"Over-Use Syndrome"
Dr. Andrew Fraser
Dr. Jean Hutchings
"Injuries in the Snow"
Dr. G. R. Anderson
"Water Skiing Injuries"

Friday, 23rd May, 1969
9.15 a.m.-10.30 a.m.
"The Increasing Importance of Virology"
Chairman & Organiser: Dr. R. S. J. Simpson
Panel: Dr. Beverley Allen
"The Virology Laboratory and the General Practitioner"

continued on back page.

—A

FORTRAL* (per

Q: What is Fortra

A: Fortral is a ne without the d cotics. It may and other narc systemically a very ill patien for prolonged

Q: To what class

A: Fortral, a pote member of the pounds, also series.

Q: Is Fortral a dr

A: No. Fortral, un other narcotics Addiction (S8), tion only (S4).

Q: How does the compare with

A: Fortral 30 mg i gesic as morp 100 mg. The d sometimes be

Q: In how many studied?

A: Fortral has be patients by m

Q: What percenta patients obtain average dose

A: At a dose level medical and su to excellent reli

Q: How is Fortral

A: The intramuscu but Fortral may ously or intrave

Q: How quickly d

A: Significant ana 15 to 20 minute cutaneous injec after intravenou

Q: How long does

A: Analgesia usu with a single i

Q: Is the relief o influenced by

A: No. Fortral is a years as it is tolerated as a the debilitated cient experien recommended of age.)

Q: Does Fortral h

A: Fortral provide about one-thir

—ANSWERING YOUR QUESTIONS—

AL* (pentazocine)

is Fortral?

l is a new, potent, injectable analgesic ut the dependence potential of nar-. It may be used in place of morphine ther narcotics. It is well tolerated both mically and locally, even by elderly or ill patients, and can be administered olonged periods.

hat class of drugs does Fortral belong?

l, a potent synthetic analgesic, is a ber of the benzazocine series of com-ds, also known as the benzomorphan s.

rtral a drug of addiction?

ortral, unlike morphine, pethidine and narcotics, is not a scheduled Drug of tion (S8), but is available on prescrip-nly (S4).

does the analgesic potency of Fortral are with morphine and pethidine?

l 30 mg is usually as effective an anal-as morphine 10 mg or pethidine 75 to g. The duration of action of Fortral may times be less than that of morphine.

ow many patients has Fortral been ed?

l has been administered to over 18,000 nts by more than 150 investigators.

percentage of medical and surgical nts obtain effective analgesia with an ge dose of Fortral?

lose level of 30 mg, 86 per cent of 1,846 cal and surgical patients obtained good cellent relief of pain.

is Fortral administered?

ntramuscular route is usually preferred ortral may be administered subcutane-or intravenously, too.

quickly does Fortral relieve pain?

icant analgesia usually occurs within 20 minutes after intramuscular or sub-eous injection, or within 2 to 3 minutes intravenous administration.

Q: How does Fortral affect respiration? Circulation?

A: Like all potent analgesics, Fortral may produce respiratory depression; however, severe respiratory embarrassment or apnoea has not occurred in any of the adult patients as a result of receiving the drug even though the doses employed were relatively high. Respiratory depression was reported as an adverse effect in 1.0 per cent of over 12,000 patients. Circulatory depression was well below 1.0 per cent.

Q: What have been the most frequent adverse effects of Fortral?

A: Among more than 12,000 patients, nausea was the most frequent adverse effect, and occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting and euphoria.

Q: How often has constipation or urinary retention occurred with Fortral?

A: Among more than 12,000 patients, the incidence of each of these adverse effects was well below 1.0 per cent.

Q: Have hallucinations and alterations in mood occurred?

A: Less than 0.1 per cent of over 12,000 patients had hallucinations; alteration of mood (nervousness, apprehension, depression, or floating feeling) was observed in well below 1.0 per cent of patients.

Q: How does Fortral affect hepatic function? Renal function?

A: Fortral has not caused, or increased, hepatic or renal impairment, as indicated by laboratory studies. 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: What is the treatment of Fortral overdosage?

A: In case of unintentional overdosage or of severe respiratory depression due to Fortral, methylphenidate (Ritalin—Ciba) should be

Q: What are the surgical uses of Fortral?

A: Fortral is indicated for relief of pain following major or minor surgery; for preoperative or preanaesthetic medication; as a supplement to surgical anaesthesia; and for relief of pain due to trauma, orthopaedic 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. Ideally 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.

However, Fortral should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

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 300 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

): *Essential Food Additive?*

ental Retardation and Bladder Cancer

nia, bladder cancer and been linked to deficiency ember of the vitamin B r vitamin-fortified foods.

rogen is another factor cing B-6 metabolism in nt women. When a is pregnant, or when kes hormone-rich birth- pills, the amount of gen in her body rises. of women in both ies have shown them to ficient in vitamin B-6. excreted unusually high of amino-acid products, 3-6 doses restored meta- to normal.

vould thus probably be e for pregnant women to -6, even though medical is not in a position to at a deficiency is a real

Perhaps the real value of current experiments lies in the proved relationship between B-6 and the hormones. We can use this as a tool for studying hormones to see how they create metabolic changes in the body.

The relationship between B-6 deficiency and bladder cancer is clearer. In the absence of B-6, increased levels of products of the amino-acid trypotophan are constantly passing through the bladder. These products, or metabolites, structurally resemble chemicals known to induce cancer. If an infection, or an irritant such as bladder stones, is present, the cells of the bladder wall are particularly susceptible to these metabolites, which may then cause cancer. ●

RESEARCH COMPUTER FOR AUSTRALIA

Britain's Medical News reports that Australia will be 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 Canberra.

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

The service will be provided free to medical sources as a national contribution to health.

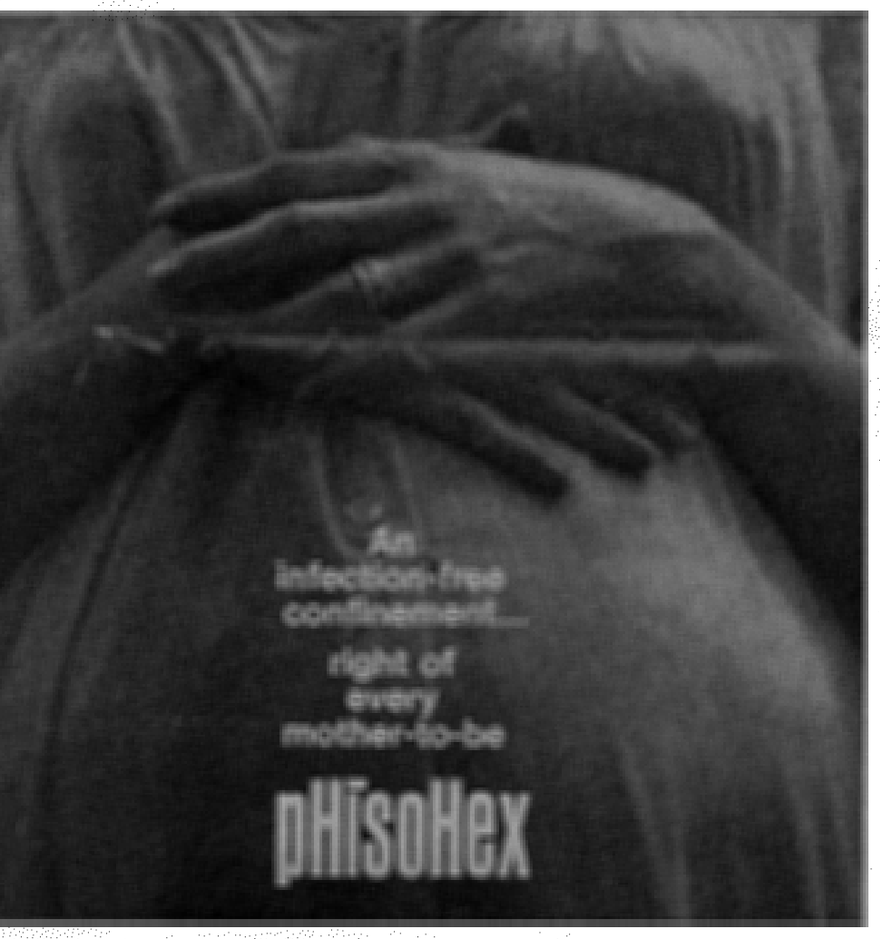
The agreement is being made between the U.S. National Library of Medicine and the Australian National Library, which will be the chief agency for the scheme. The Commonwealth Department of Health is sponsoring it through the National Health and Medical Research Council.

The computer system of rapid access to references over wide fields of medical science is known as *"Medlars"*—Medical Literature Analysis and Retrieval System. It has recently been installed in Britain and Sweden, and is being studied by other countries, including Japan.

As well as joining the system and providing its own computer resources, Australia will also contribute new material to the world computer index on the results of original work in Australia.

The study for the introduction of the system in Australia was made by Professor J. M. Bennett and Mr. R. B. Donnell, of the Basser Computing Department at the University of Sydney.

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 the Sydney University computer. ●



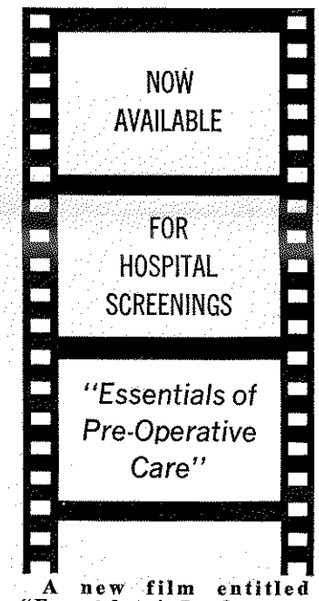
rtum—regular washing wering with pHisoHex the last trimester of ncy brings the patient very with her skin ally clean, better able to staphylococci and other gens. Daily exclusive pHisoHex builds up a ous, powerfully iostatic film of lorophene on the . . . Consistent use of lorophene has a ver effect . . ."[1]

Intrapartum—the use of pHisoHex by the obstetrician as a surgical hand scrub helps to protect the parturient by its unique ability to inhibit regrowth of micro-organisms beneath surgeons' gloves. It produces a ". . . real diminution of the numbers of bacteria on the fingers."[2]

Approved Hospital Benefit in Australia

Postpartum—regular pHisoHex baths for mothers and infants help to protect nursing mothers against staphylococcal breast abscesses and furunculosis due to contact with secretions from the infants' nasopharynx.[3] pHisoHex is non-alkaline, hypo-allergenic, "kind" to the skin. pHisoHex is available in *unbreakable* squeeze bottles, 6 oz and 16 oz, and in plastic jerricans of 1 gallon.

tes, A. C.: *J. Indiana M. A.* 53:445, March, 1960. 2. Beilby, J. O. W., and Thompson, R. E. M.: *Brit. J.* 48:598, May-June, 1961. 3. Carrington, Elsie R., and Sivak, Alice M.: *Am. J. Nursing* 58.1683, Dec., 1958.



A new film entitled *"Essentials of Pre-Operative Care"* is now available from Winthrop Laboratories for hospital screening. The film, which is in colour, was produced in a major American Hospital.

It illustrates the techniques involved in correct pre-operative care and deals with three medical procedures—catheterization of the urinary bladder; performing venepuncture and venous cut-down; and the passing of a nasogastric tube.

Also featured are the points to be covered in the final check of the patient by the resident prior to surgery and the routine for surgical preparation.

This film is an addition to the already extensive Winthrop Film Library. All Winthrop films are available, on request, to any hospital wishing to screen them.

Simply ask the Winthrop representative or write to Winthrop Sales Manager, P.O. Box 3, Ermington, N.S.W. 2115.●

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Mostly, we tend to the upper part of the neglect the legs. Men ate wet trouser le wrapping their torsos l wind and waterproof Recent work has sh wet clothing, par around such large surf as the legs, may heat loss from the bo practical conclusions l drawn from this. H sartorial artists, mea client for tight-fitti realise that they are the body's micro-clim delicate two millimetre of warm air which the body like a sheath? Distorting this tight-fitting clothing not produce any imme dramatic effect, but known that it will aff in the long run.

That ergonomic ab —the scarf—would



OMNISUIT. *Lack of tion at the waist and in seated position. H waist zip allows two suit to be separated fo and undressing. Zip is c by decorative belt.*

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NOW AILABLE

FOR OSPITAL REENINGS

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Science in Clothing

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 well-dressed man may disappear.

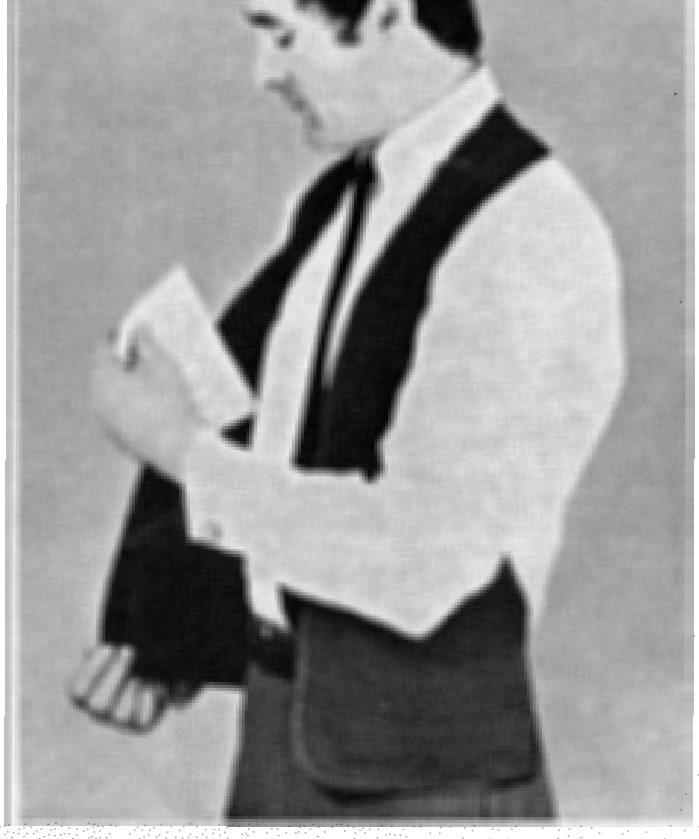
Man's clothing troubles began when he first decided he must have a second skin to protect the one already provided by nature. It would have been logical to construct this second skin to fit in with the requirements, and functions of the natural skin. Unfortunately, development did not go that way and 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 taking no part in these areas have to put up with clothing far removed from scientific considerations.

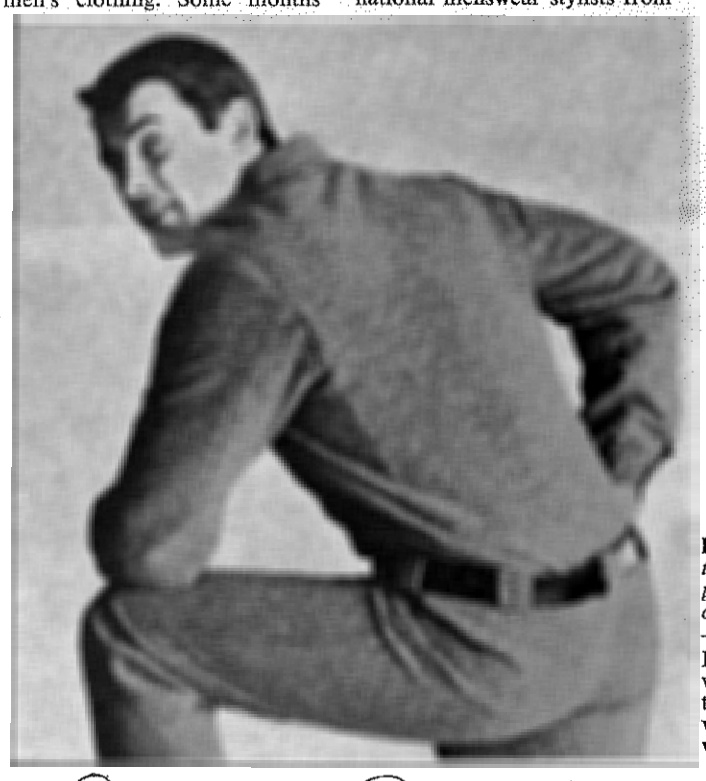
Mostly, we tend to overdress the upper part of the body and neglect the legs. Men will tolerate wet trouser legs while wrapping their torsos lovingly in wind and waterproof materials. Recent work has shown that wet clothing, particularly around such large surface areas as the legs, may accelerate heat loss from the body but no practical conclusions have been drawn from this. How many sartorial artists, measuring a client for tight-fitting suits, realise that they are upsetting the body's micro-climate—that delicate two millimetre envelope of warm air which surrounds the body like a protective sheath? Distorting this layer, as tight-fitting clothing does, will not produce any immediate and dramatic effect, but it is well known that it will affect health in the long run.

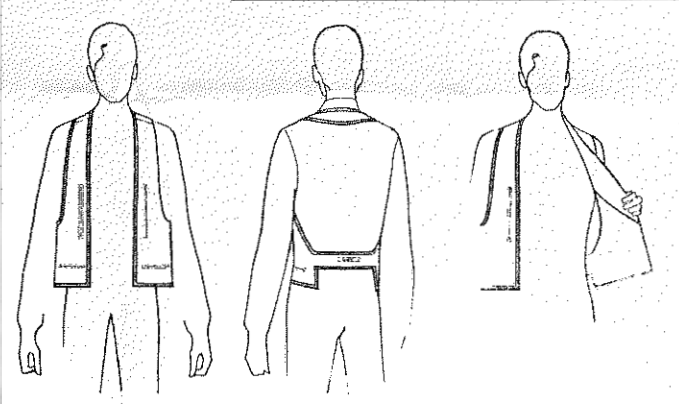
That ergonomic abomination —the scarf—would probably never have been invented, had common sense been applied to the aperture left for the neck. Its size is usually a matter of fashion or convention with complete disregard for the heat losses involved. We now know that there are certain lines along which the body does not stretch or extend and that these are the ideal places for the location of seams. Yet, how frequently is this ignored? Even the most elementary mechanical principles are often neglected with, for instance, load carrying pockets not being placed near the body's centre of gravity, where they should be, but outwards 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 Menswear Office (Menswear headquarters of the International Wool Secretariat) in London came out with new clothing designs 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.

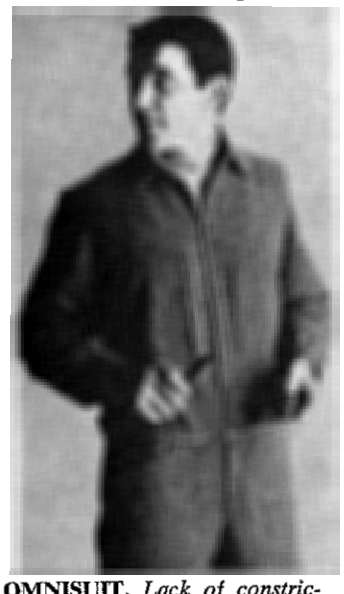
As a first step a preliminary study was commissioned and a team which included a medical physiologist, a consultant psychologist and a clothing technician started work on the project. They first had to collect data from laboratories dispersed all over the world, from occupational research programmes, 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 wearer trials and duly modified where required.



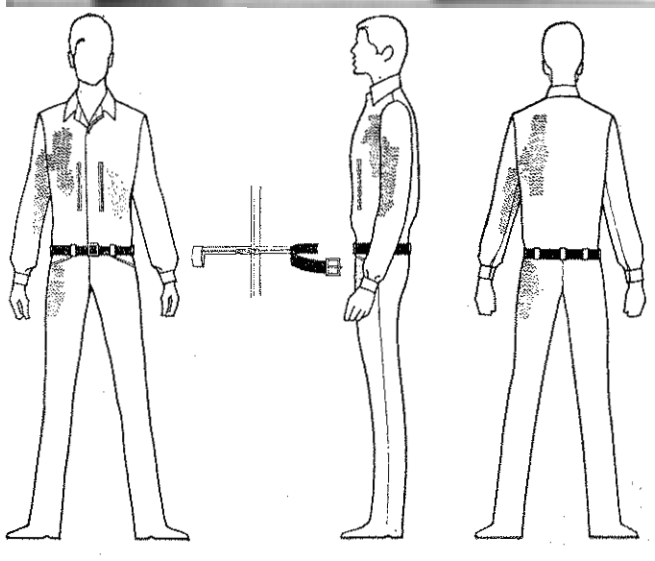




HOLSTERCOAT. *Weight of pocket contents should be carried by the spine rather than the shoulder extremities; contents should be placed to fit into the body cavities and the angle of entry should coincide with arc of hand movement.*



OMNISUIT. *Lack of constriction at the waist and comfort in seated position. Horizontal waist zip allows two halves of suit to be separated for dressing and undressing. Zip is concealed by decorative belt.*



When the collection was finally completed it was not as revolutionary as one would have perhaps expected but, this 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 so violently different that they would put off the conservative male.

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 stuffed 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. And 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 version. 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.●

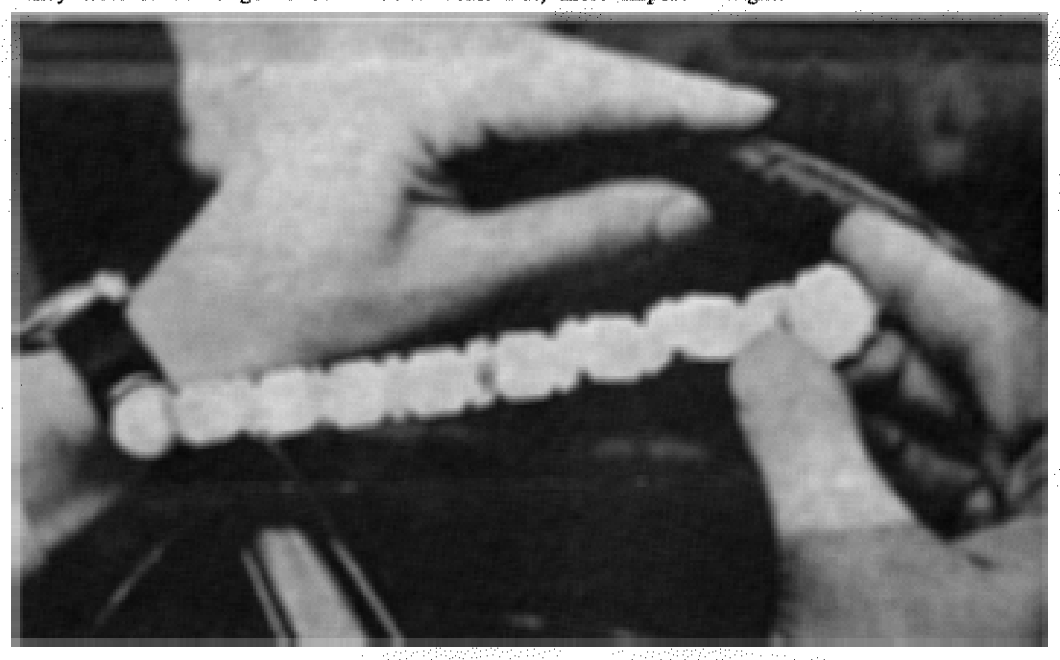
THE DANGERS OF LACK OF SLEEP

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 emphasises, 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 got up at the same time every morning, during the experiment, to start their tasks, they were made to go to bed at different times the night before, one at 11 in the evening, providing 7½ hours sleep, 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 —while one 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 programme 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 that performance was significantly worse after one night's deprivation by a matter of several per cent, as soon as the sleep rations fell to 2 hours or less in a single night and this applied to both tasks. But, more important in terms of normal life, efficiency was also lowered in both tasks after two successive nights of only 5 hours sleep. Psychologists 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 2 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 never to do it two nights running, and always get at least 2 hours' sleep in any one night.●



This SOS capsule could help to save a life. It can be fastened to a watch strap or bracelet, and contains an emergency identification, which is about 9 inches long, giving the particulars of the person's blood group, and further medical information that a doctor would want to know about a 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 crib, was described recently to the Canadian Society for Clinical Investigation.

This is reported in Britain's Medical News.

Dr. Rudi Schmid, Professor of Medicine at the University of California, Berkeley, said that the blue light changed the xanthomatous pigment by process of photoxidation and stopped it reaching the brain where it could lead to deafness, cerebral palsy or mental retardation.

The transient neonatal jaundice caused by the inability of the liver to oxidise the breakdown products of haemolysis 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 procedure of exchange blood transfusions.●



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 *"Impulse"* that acquisition of the necessary typing sera was such a long-term prospect that in May of 1967 it was decided to pursue research aimed at producing in New Zealand ALG fractionated from horse serum.

Early research was similar to that carried out in America by Starzl and involved subcutaneous injection of horses with antigens from human spleens.

Methods of producing ALG differed from Starzl's in one respect. Instead of using fresh spleens the organs were deep 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 the U.S.A.

Subcutaneous injections were given at monthly intervals until antibody concentration reached a satisfactory level when horses were bled of 7½ litres. This process was continued while the titres remained high after which the horses were retired.

Biological Laboratories gladly co-operated with the Blood Transfusion Service in collecting and processing the anti-lymphocyte serum and bore the expenses of their involvement in the project.

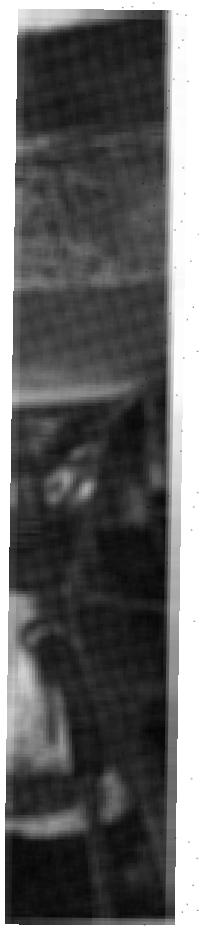
Dr. Dalton said that many more clinical trials would have to be conducted with ALG before its effectiveness as an immuno suppressant agent could be evaluated.

However, some time before ALG was administered to Australia's Mr. Pye a preparation of ALG was flown from Lyon (France) and administered to South African heart transplant survivor, Dr. Blaiberg, during what was considered to be a serious rejection crisis. The resultant improvement in Dr. Blaiberg's condition suggested that ALG had a value as an immuno suppressant.

The Auckland ALG costs about $6.00 per day to treat the average organ graft patient.

However, it is not possible to produce a standard preparation which immunologists can be certain will succeed because of the many variables involved in production techniques.●

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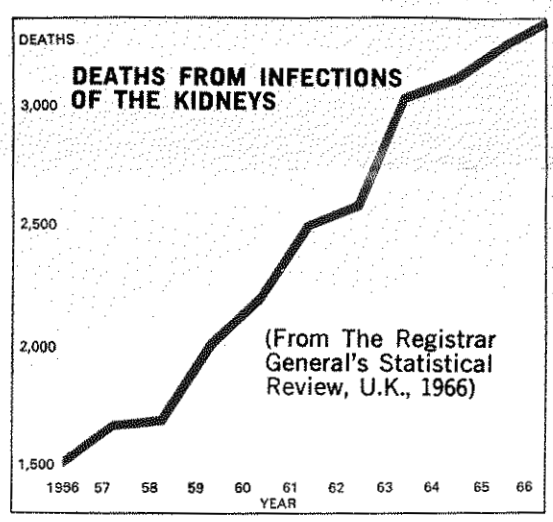
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today's cystitis patient-

tomorrow's statistic?



"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

negram

Trade Mark — Brand of Nalidixic Acid

right from the start

PHARMACEUTICAL BENEFITS [S.P.]

effective against more Gram-negative urinary pathogens than any other agent in common use.

Tablets: Each tablet contains 500 mg nalidixic acid. Adult dosage: 2 tablets q.i.d. for at least 7 days. Availability: 7 foil strips of 8 tablets, cartons of 56 tablets.
Suspension: Each 5 ml contains 250 mg nalidixic acid. Availability: Bottle of 200 ml. **Precaution:** Use with caution in patients with liver disease.

Classified Advertisements

Please address replies to advertisements with a box number as follows:
"Impulse" No....., P.O. Box 12, Ermington, N.S.W. 2115.

Would you like to live and work in a leading Victorian tourist resort? Ideally suited husband, wife medical team. No incoming. Modern, fully equipped, 19-bed hospital, adjacent medical suite. House available. Last year's practice grossed well in excess of $25,000. Eildon offers modern homes and shopping centre, sewerage, sporting and schooling facilities (kindergarten to matriculation level). Write to Mr. T. C. Marr, Hon. Sec., Eildon and Dist. Community Hosp. (Vic.) 3713, or phone Eildon 39.

Wanted to rent or buy: Large house suitable for setting up in medical practice in an outer suburb, north or west of Melbourne. No. B254.

Country practice 200 miles from Melbourne. No ingoing. Ten bed hospital. Three bedroom house and surgery suite $10 p.w. Consultants within easy reach. Reply Dr. J. Sammut, Church Street, Minyip, Vic. 3392.

Part time assistant, outer Western Suburbs (Sydney) required for six mornings weekly, Monday to Saturday inclusive, for surgery and associated calls. Permanent or long-term and stable arrangement required. No. B272.

Highly recommended receptionist seeks evening work North Shore (Sydney) three days weekly excluding Tuesday. No. B330.

Experienced, semi-retired practitioner with own car and bag open for short engagements in Victoria or Tasmania. Phone Frankston, Victoria, 783 8626.

Telephone-answering machine, any reputable make, send details of make and price to Dr. Smith, 165 Elphin Road, Launceston, Tas. 7250.

For Sale: Newcastle inner suburbs —third share of long-established standing general practice, gross takings in excess of $25,000 p.a. Retiring partner taking up other appointment. No. B331.

Progressive practice for sale, Newcastle. No. B332.

Car For Sale: VW 1961, $350.00 or O.N.O. Phone 661 0111 (Sydney).

For Sale: Ultra-modern 4-b. house in A-Class hills district Sydney. Solo practice takes $2,000 per month. No. B333.

Wanted: Regular weekend locum for four-man group, Sydney E. Subs., noon Saturday to Monday a.m. for office and visiting service. Bachelor quarters available and meals. $70 (incl. car) for well-experienced and well-trained G.P. No. B305.

For Sale: Examination couch, X-Ray viewing box. Both good. Phone 792 1986 (Melbourne).

Toyota Corona '65: Doctor's second car, cared for, radio. Tyres, duco, reg., o.k. Owner needs finance for building. Phone 42 4471 (Sydney).

Locum Orthopaedic Surgeon Wanted: 3 to 4 months, July-October, 1969. Far north Queensland. Further details enquire No. B306.

Furnished accommodation required by hospital registrar, wife, one child, Maroubra, Coogee, Randwick areas approx. one year. No. B307.

Locum Wanted For Fiji: 2½ to 3 months in August to October. Working holiday in practice south coast Viti Levu, Fiji. Woman doctor preferred or young married male doctor recently graduated without family. Salary by arrangement. Reply to Dr. C. E. Hands, Box 45, Sigatoka, Fiji.

Part-time Assistant Wanted: Busy general practice, inner Western Suburbs, Sydney, suit woman with initiative to build up personal following. Permanency offered, general practice and anaesthetic experience necessary. Knowledge of Greek or Italian helpful. Phone (Sydney) 56 6688 or 747 2194 or write to Box No. B336.

Victorian provincial city G.P. recently left partnerless, seeks assistant with view while there is still time to watch his young family grow up. Ample facilities, both medical (two general and obstetric hospitals, full ancillary services) and recreational. No. B299.

Gippsland group requires fifth partner. Modern premises and hospital. Long service leave. Opportunity any special interest. No. B304.

Tape Recorder For Sale: Brand new, unused Akai X-V, $300. Phone 31 2917 (Sydney), or write No. B300.

Long-term locum required Western Suburbs (Sydney) end of August, 1969, to Feb., 1970, large group practice. Attractive salary and working conditions. Dr. M. R. Clayton, 19 Chertsey Street, Merrylands, N.S.W. 2160.

Experienced doctor prepared to accompany patient to U.K. or Europe in return for single air fare. No. B301.

Wanted: Microscope for use in general practice. Phone 68 2740 (Melbourne).

Experienced G.P. living in Sydney East. Suburbs would like to do part-time work also some weekend calls close to home. No. B302.

Central Auckland solo practice for sale. No night or weekend work. Good income, wide variety of work. No. B303.

For Sale: 25 w, 60 kcs Pye Base Unit for 2-way radio. Excellent condition. Selling only because of compulsory wave length change. Suitable country area. $200. No. B329.

Wanted to Lease: Practice in Sydney area by experienced G.P. No. B327.

Locum Available: June-August, Sydney or coastal area. Six months' postgraduate obstetrics, G.P. experience. Group practice or partnership preferred. No. B326.

For Sale: Tonsil and D. & C. instruments, Sigmoidoscope, doctor's bag, pulse monitor, etc., all new, half price. Ring Matron, 36 6819 Melbourne.

To Let: Vacant for May holidays, beach house at Dromana, Victoria. Accommodates five. $35 per week. No. B325.

For Sale: Block of land, Bellevue Hill, wonderful views. Phone 37 5050 Sydney.

Receptionist Wanted: Four evening sessions weekly, 4 p.m.-7 p.m. Bankstown area (Sydney). Phone Sydney 759 9881.

Holidays: Gippsland Lakes. Mod., well-furnished house, takes 8, large lounge and sheltered sundeck have extensive lake views, near hotel, stores and public jetty. Good yachting and fishing. $55 per week. Dr. R. A. Cameron, Metung, Vic. 3904 or phone Metung 333.

To Let: Holiday cottage, Bilgola Plateau (Newport, N.S.W.), until end Nov., '69. Moderate rental. Please phone 71 5867 (Sydney) after 8 p.m.

Wanted to Buy: A solo practice in Sydney metropolitan area. No. B324.

Locum wanted part-time July, 1969, for one month. No night or weekend work. Contact Dr. Cook 57 7286 (Adelaide).

Locum Position Wanted Sydney: Locum position required by experienced male, 1956 Sydney University graduate. No. B323.

To Let: Long or short term, surfside cottage, sleeps six. Mona Vale, N.S.W. No. B322.

Third year grad. with exp. in obst. anaesth. and G.P. requires locum in Brisbane area, comm. approx. 15th Sept., '69, for 4-6 weeks. Married and with own car. No. B321.

For Sale: Solo practice in new rapid-growth area Eastern Subs., Sydney. Long lease available for rooms, also emergency service. No. B320.

Wanted Locum: For eight weeks December-January, centre Melb. Quiet practice. No. B319.

Shop in quiet residential area. Originally built for doctor in Balwyn, Melbourne. Suitable for any type of doctor wanting to start practice or establish branch. Residence behind shop is let at present on weekly basis. No. B318.

For Immediate Sale: Melbourne seaside suburb, small, established practice, capable of extension and modern style brick residence, containing 3 b.r.s. and surgery section of 3 rooms. Total $22,500. Terms negotiable. No. B317.

For Sale: An extensive selection of general, gynaecological and E.N.T. surgical instruments in excellent condition and at reasonable prices. Phone 63 1766 Melb. Inspect at 61 Collins Street, Melb.

Wanted to buy traction apparatus and traction couch. Phone Melb. 52 2151.

Experienced locum available Melbourne suburb or country for one week from 9th May. No. B316.

Practice For Sale: In pleasant, near-country area (N.S.W.). Excellent opportunity for G.P. with surgical interests. Five-doctor town. No. B312.

Holiday House: Pittwater, 4-bedroom, 2-bathroom, swimming pool, boat slips, mooring. Available July 21 to Nov. 14 while owner away. Ideal for family holiday. No. B315.

Short-term locum available, 2-4 month periods. Woman graduate 30 years, experience general practice, obstetrics and anaesthetics. Requires married accommodation. No. B314.

Private coin collector wishes to buy Irish "Money of Necessity." Send details, condition and price. No. B313.

Surgeon, F.R.C.S. Lond. and Edin. requires position as surgeon in group practice, Victoria suburbs or provincial city. Returning to Australia, Aug., '69. No. B311.

Woman doctor experienced in general practice desires day sessions, preferably mornings, in E. Suburbs, Melbourne. No. B310.

Experienced doctor (specialist) willing to accompany patient to England, Christmas, '69, in return air fare. No. B309.

North-west Victorian practice available situated 180 miles from Melbourne in prosperous wheat-growing area. No ingoing. G.T. $20,000. Modern house available at $10 per week rental. Reply Dr. R. Shiell, 96 Cromie Street, Rupanyup, Vic. 3388.

Consulting rooms available on sessional basis for use by specialist only. Phone Dr. Carter 43 1161 (Sydney).

Position Wanted (Perth, W.A.): Long-term locum positions for metrop. or country areas. Available Feb.-Dec., 1970. No. B308.

For Free: Front gate red light on pole (10 feet). Phone 86 7726 (Melb.).

HR white Holden, red seats, v. good, one owner, 20,000 miles, many extras, heater, etc. Going overseas. $1,385 or offer. Finance available. Phone 30 1516 (Melb.).

For Sale: Tropical fish tank, heater, filter. Phone 792 1986 (Melb.) or write No. B334.

To Let: Modern, fully furnished doctor's seaside residence. Alexandra Headland, Qld. Adults, June-October. $45 weekly. No. B335.

Wanted: Anaesthetic machine in good working order. Phone Melb. 842 3660.

Land For Sale: Wentworth Falls, N.S.W., panoramic views, fenced, V.G. $500, best offer. Phone 48 3144 (Sydney).

For Sale: Convalescent Hospital, 40 beds, land for extension to 80 beds, beautiful water views, approximately 4 miles from G.P.O., Sydney, well-established, showing excellent return, with high occupancy rate. Good fees, price $127,000. Principals only. Reply to Box No. B232.

N.Z. graduate with 4 years' G.P. experience and diploma in obstetrics seeks opening in Australia (city preferred). Available from August, 1969. No. B328.

To Let from May 12 until end July, 1969, suite of rooms in Macquarie Street, Sydney. Secretarial service optional. Write G.P.O. Box 875, Sydney 2001.

Cabin trunks or trunks. Must be in good condition. Melbourne area. State size and price. Tel. 49-6671 (Melb.) or write No. B341.

Perth: Locum available for weekends. No. B337.

Qld. country solo unopposed practice (150 miles—Brisbane) excellent hospital facilities, house and fully equipped surgery attached for sale or lease, reasonable practice could lend itself to partnership or husband-wife team. No. B338.

English graduate with F.R.C.S., F.R.A.C.S., D.R.C.O.G. and medically qualified wife wishes to form partnership or join small group in coastal town in S.E. Queensland or N.S.W. just south of the border. Dr. B. S. Mather, 8 Larbert Ave., Wahroonga, N.S.W. 2076.

For Sale: Solo unopposed practice. Prosperous district 160 miles from Perth. G.C.T. $20,000. Four-bedroom house for sale. Surgery premises for rental. Well-equipped 20-bed hospital. No. B339.

Violin, old instrument, reputedly by Josephus Antonius Laske. Fine tone. $200.00. Phone Sydney 28 9320 or (evenings) 918 2277.

Car on Lease—Hillman Hunter (2,000 miles) 18 months to go. Will throw in six months reg. and insurance to anyone taking over lease. Phone Sydney 451-1344.

Wanted to Buy: Bullworker. Phone Sydney 28-8921 (message).

To Let: Lock-up rooms in main street of Bexley (Sydney). Good position in densely populated area. Very suitable for General Practitioner. Rent-free terms for initial period to assist establishment of tenant. To arrange inspection write to Box No. B340.

Indian Graduate (1965) aged 28 years and married, available as locum in N.S.W. or Victoria from first week of November, 1969, for 8 to 10 weeks. Held hospital appointments in N.Z. and Aust. for 2½ years. Experienced in obstetrics, anaesth. and surgery. Own car. Dr. Prasad Shetty, Mersey Gen. Hospital, Latrobe, Tasmania 7307.

Locum Wanted for 7-man group practice with consulting surgeon, between July 12th and October 19th, 1969, to replace G.P. on holiday in U.K. Pleasant country area between Adelaide and Melbourne. Excellent working conditions in modern clinic and hospital. Apply to Terrace Clinic, Box 597, Naracoorte, S.A. 5271.

For Sale: National RQ158.S portable tape recorder. Automatic reverse. As new. $100. No. B342.

Woman Practitioner available for part-time or sessional work in Eastern or S.E. suburbs Melbourne. Phone 92 7408 Melb.

Wanted to Buy: Aneroid Sphygmomanometer, Ophthalmoscope, Auriscope (Sydney). No. B343.

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FOURTH AUSTRALIAN G.P. CONVENTION

continued from page 2.

Dr. Ralph Doherty
"Virus Disease and Virus Research in Queensland"

11.00 a.m.-12.30 p.m.

"The Recognition and Management of Mental Handicaps in Children"

Organiser & Panel Member: Dr. C. M. Donoghue

Chairman: Dr. Harvard N. Merrington

Panel: Dr. Patricia R. Davey
"Communication Defects"
Dr. Bertram J. Phillips
"Mental Handicaps"

2.00 p.m.-4.45 p.m.

"Psychiatry and the General Practitioner"

Chairman & Organiser: Dr. Walter Peretz

Panel: Dr. John Ellard
Dr. William Hamilton
Dr. Charles Elliott

4.45 p.m.

Convention Closing and Farewell
Dr. H. Stuart Patterson

The views expressed by contributors to "Impulse" are not necessarily those of Winthrop Laboratories.

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Appendix 2

Appendix II
18 DEC 1968

AMA GAZETTE

The newspaper of the Australian Medical Association

No. 9 December 19, 1968 Registered at the G.P.O. Sydney for transmission by post as a periodical Price: Ten Cents

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 to "fix 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 said in an interview with the *AMA Gazette*:

"It has always been accepted that a fee for service is a private matter between the doctor and his patient.

"However, for many years Branches of the A.M.A. and local Associations have recommended levels of fees which are regarded as reasonable for general practitioner consultations and visits. These recommended fees have been up-dated from time-to-time in accordance with economic changes, and have been accepted by the vast majority of practitioners on a purely voluntary basis.

"It is now proposed that similar guidance—again on a purely voluntary basis—should *be given to the whole profession* in regard to fees for operations and procedures.

"The need for this guidance has become apparent to us because of the wide variation in fees for most items listed in the schedule of benefits. This has been demonstrated by studies which have been made available to the A.M.A.

"Because of these wide variations it is difficult to devise a schedule of benefits giving a reasonable return to all contributors, and it is difficult to persuade the Government to increase Commonwealth benefits.

"It is confidently expected that if the recommendations made as a result of the action now being taken are accepted, fees will become more uniform, benefit schedules will be greatly improved, and the voluntary health insurance scheme, which the A.M.A. believes to be in the best interests of the community, will be strengthened.

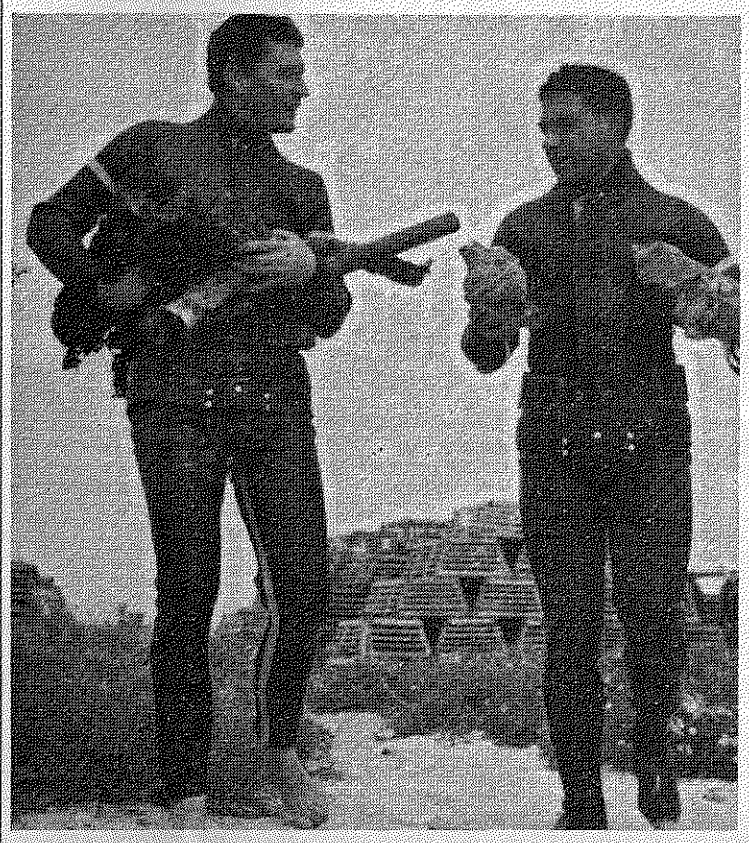
"An alternative, which is now being actively canvassed in some quarters, is a fixed schedule of fees, to which the A.M.A. is strongly opposed.

"It must be stressed that the A.M.A. has no wish to 'fix fees', but merely to offer guidance to the profession so that decisions on fees to be charged in individual cases can be made in an informed and responsible manner. If a doctor wishes to charge significantly more or less than the most common fee he will still be free to do so, but it is expected he will discuss the matter first with his patient."

The decision to request Branches to set up joint working parties of the A.M.A. and the benefit funds in each State to determine a most common fee for the maximum number of services possible, was made last month at a meeting of the Federal Executive Committee of the A.M.A. and the Special Federal Committee Representing Benefit Fund Organisations.

The State working parties have been provided with statistical guide-lines and have been asked to work on records provided by the major funds of fees charged for the months of September and October.

The most common fee arrived at on the basis of statistical significance will be subjected to "a test of reasonability" by the medical members of the working parties.



Dr. Naoom Haimson, of Perth (right), emerges with fellow Scuba diver Hugh Edwards carrying treasure from the "Batavia", which was lost in 1629 on Morning Reef on the northern Abrolhos group of islands. Dr. Haimson, Honorary Medical Officer of the Underwater Explorers' Club of Western Australia, writes about the exploration of this and three other wrecks on page 8.

Charter flight cancelled

A cheap jet charter flight to Britain for doctors which did not quite come off may yet have a successful sequel, Dr. D. J. Stark, a former registrar at the Mater Hospital, Brisbane, believes.

Last-minute withdrawals forced abandonment of Dr. Stark's plan to get Australian doctors to Britain for post-graduate studies more economically than by normal air or ship services.

But although the Qantas one-way charter, planned for January 4, 1969, had to be cancelled, Dr. Stark believes that a similar scheme could be successful in tapping next year's flow of doctors to the northern hemisphere.

Dr. Stark told the story of the scheme in Auckland, New Zealand, while on his way to Britain by ship with his wife and four young children.

Looking for an economical fare for his family so that he could take up post-graduate studies in ophthalmology, he put to Qantas the idea that a group of doctors might charter an aircraft early in 1968.

"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, Quantas got in touch with me again about June."

With a fifth-year medical student at the University of Queensland, Mr. Bob Anderson, Dr. Stark then began the lengthy and involved task of locating enough doctors to take up the equivalent of 100 adult fares—perhaps 140 individuals when wives and children were taken into account.

Gradually the numbers built up. With fares at $100 cheaper than the normal fare, the economy was worthwhile.

"But then we had the withdrawal of 25 adult passengers in the last few weeks. This took the numbers to four below the minimum we needed to make the trip economical and we were forced to cancel it early in November.

"It would have been the first one-way charter under the new regulations and it would have been the first joint flight by doctors for this purpose," said Dr. Stark.

Dr. Stark felt that if the next charter was timed to take advantage of the later ending of the hospital years in Melbourne and Sydney—about two weeks later than in Brisbane—many more interested doctors could take part.

In the meantime, Dr. Stark gave up completely the idea of flying, bought tickets on the Castel Felice for himself and his family and settled down to a shipboard holiday from the stress and worry of the last few months.

Labelling

The N.H. & M.R.C. has urged the early implementation of legislation to ensure that all medicines when received by the patient, are labelled to indicate clearly the active ingredients in the product, unless the prescribing doctor desires otherwise. Meanwhile, the Council recommends that doctors mark all prescriptions "N.P." (for *nomen proprium*) wherever there is no

Keeping down kidney costs

The report of the N.H. and M.R.C. Committee on organ transplants, the main points of which were widely published in the daily Press, 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 "end-stage" patients.

The report quoted a statement of the U.S. Department of Health Education and Welfare which said:

"It is evident from the foregoing models that concentration in future programmes merely on the treatment of end-stage kidney disease is not likely to solve the problem of annual deaths due to irreversible uræmia unless unlimited funds are available for an indefinite continuation of such a programme. Thus steps must be taken to decrease the number of people who enter the irreversible fatal stage each year by a systematic prevention or treatment of the primary kidney diseases which initiate their progressive downhill course."

Simple screening methods to detect asymptomatic urinary tract infections and public education about the hazards of analgesic abuse were particularly mentioned in the N.H. & M.R.C. report, which will be published in full in *The Medical Journal of Australia*.

The big reappraisal

The "A M A Gazette" continues on page four the series of articles discussing the future of Australia's National Health Service, which is now being re-examined by three official committees. In this issue some of the disadvantages of Mr. Whitlam's proposed compulsory health insurance scheme are outlined.

The next issue of the "Gazette" will be published in February. Meanwhile, we wish readers a Merry Christmas and a Happy New Year.

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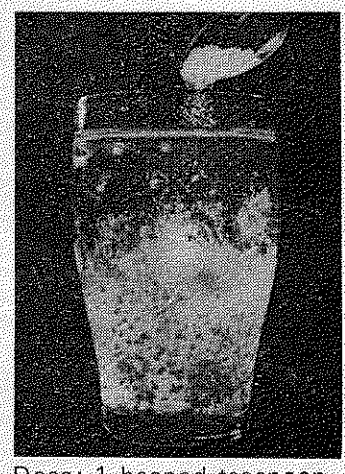
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Centres of liberty to be cherished

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 point in the 35th Sir Richard Stawell Oration at the Royal Australian College of Surgeons, Melbourne.

He said: "In our authoritarian anti-intellectual world, universities are precious centres of liberty which we should do well to cherish and should certainly not expose to risk.

"For these reasons I find myself at odds with those members of our society who carelessly involve the university in their own political affairs and I despise those who try to use the university for their own political purposes.

"There are a good many students, especially of the social sciences, who find the world which they are growing into quite repugnant. Who can blame them? The bomb; the wars and threats of war; the social injustices; the racial intolerance; the bland indifference of much of our affluent Society are quite enough to explain the hostility of many sensitive young people to the adult world.

"But how to make a change? The democratic processes of our parliamentary system, the niceties of international conferences, the procedures of the United Nations all seem equally ineffective—perhaps violence and the threat of violence would work better? And so the concept of student power, mimicking black power, takes shape and thrives in our tolerant environment."

The techniques were worked out long ago, Dr. Matheson said, and were quite simple and well-known. They required a small *number of dedicated determined* people; some vigorous carefully



Dr. J. A. L. Matheson

slanted journalism, enlivened here and there by a bit of sex or scandal or both; and an audience which could be relied upon to respond to suggestion of injustice.

Sooner or later an issue would be found to which authority reacted in such a way that the cry of injustice went up and was heard. Before long the original issue was forgotten or became irrelevant as reaction provoked counter-reaction in an increasingly excited atmosphere.

The time had long gone past when students could be treated as merely passive recipients of whatever was handed out to them, Dr. Matheson said.

"It is now well-recognised that their education will be very deficient unless they are brought more and more into the councils of the university to participate in the criticism of what exists and the planning of what should replace it, subject only to the obvious consideration that they are transitory members of the team who do not have to live with their mistakes.

"In order to further this line of thinking I have established a joint commission of students and staff to study how the University works; not what the statutes and regulations prescribe but what actually happens and what the members of the University, young and old, actually experience in their daily lives.

"From this examination, in which students are invited to participate fully, will come changes in the system which may well mean more student participation."

He added:

"I welcome this and will assist it unreservedly; if this were what is meant by student activism I should rejoice. Unfortunately it is not; student activism, alas, seems everywhere to rely upon dishonest and tendentious propaganda; to use destructive and sometimes violent tactics; to seek to reduce the university to anarchy rather than to protect it; and to use the university as an instrument in its fight against other, less vulnerable, institutions of society.

"'Here then is the dilemma: universities being by nature and definition hospitable to the free interchange of all ideas are particularly defenceless against any group that decides to exploit that hospitality for its own ends.

"If the university were to seek to protect itself against this exploitation by limiting the free interchange of ideas it would deny its very nature and cease to be a university. How then can it survive? This is the problem which all universities now face, in Australia as elsewhere."

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Doctors' wives take the lead

By Helen Marwick

WASHINGTON.—In America, whatever community problems the local doctor cannot cope with are liable to be handled by his wife. "Doctors' wives are one of the few groups that can enlighten the public to the true medical and health situation in our country today", says Mrs. C. C. Long, President of the Woman's Auxiliary to the American Medical Asociation, a group to which almost half the wives of medical men in that organisation belong.

The Woman's Auxiliary began in America's thinly populated West, at the turn of this century, and grew out of the loneliness and need of intelligent women to share in worthwhile activities that might lighten their husband's burdens, like health education and preventive medicine.

Today the Auxiliary, in a country of some 200 million people with more than 210,000 doctors, has over 90,500 members with fingers in every pie. Health education, vaccination and innoculation, road and water safety programmes, air pollution investigation, mental health, disaster preparedness, care of the elderly and the disabled, health legislation and the recruitment of more medical personnel are all the concern of Auxiliary members.

During 1968 they raised $389,924 for the AMA's Education and Research Foundation. Since 1951, they have donated more than $2 million to this fund, which, besides being used for research, gives loans to students and medical technicians and to medical schools.

Nurse recruitment is a perennial Auxiliary project as are all forms of health careers.

In one city, a couple of years ago, the doctors' wives, in cooperation with the principal hospitals (who agreed to standardise their on and off duty schedules), set up a child-minding service for women in medical fields who wanted to go back to work. In addition to nearly 60 nurses, they dredged up several doctors and psychiatrists and a number of therapists.

"Homemakers" in America mean women, usually middle aged, who, after a short "refresher" course in domestic science, can move into any kind of household and take over its management, either full or part-time. This is an activity very much encouraged by the A.M.A. Auxiliary. The Homemakers clean, shop, feed the children and take them to school, care for bedridden and elderly individuals, sometimes give overwhelmed or ignorant housewives some basic training in nutrition and simple cookery, and cope with any domestic problem short of nursing.

THEY are usually referred by doctors or some professional agency, and the recipients pay what they can afford. In New Jersey, the Homemaker Service is much utilised by a group of psychiatrists who find the womens' shrewd, knowledgable observation of a troubled household can often uncover unsuspected problems and sometimes allow women patients to remain in their home environment during therapy, without the need to go to hospital.

The Auxiliary has produced two practical, down-to-earth brochures on how to set up, finance and run Homemaker Services, and over 35,000 copies have been distributed by Government and voluntary agencies. A number of Auxiliary members, including a past President, Mrs. Asher Yaguda, serve on the National Council of Homemaker Services.

This year, at the A.M.A.'s annual meeting in San Francisco, the highlight of the Auxiliary's own 45th Convention was a big white bus labelled "Homemaking Unlimited" which was on show and demonstrated kitchens suitable for handicapped housewives—kitchens with shallow sinks and room for a wheelchair, oven doors that lifted up rather than dropped down, "reachers" to take cans and boxes from high shelves, and many gadgets such as graters held firm with suction that could be operated with one hand.

There are ten million disabled women in America and, as the Auxiliary's outgoing President, Mrs. Karl Ritter, pointed out, they can't avoid housekeeping—they just have to do it differently.

Another well established Auxiliary project has been the development of a training programme for baby sitters called GEMS (Good Emergency Mother Substitutes.)

KEEPING the public aware of health problems and what to do about them has always been a favourite Auxiliary work, through booths at country fairs, the distribution of literature, and such things as Healthmobiles—one of which, some years ago, visited over 40 community shopping centers in a year, showed historic exhibits and scientific ones (the favourite was a "Naked Lady" whose innards could be lit up to show her nervous system, blood circulation, etc.), and handed out innumerable pamphlets on how to seek help for cancer, diabetes, heart disease and arthritis —and the need for prompt diagnosis.

Safe driving courses for teenagers, seminars on road safety with representatives of the police, the medical profession and the public, the supervision of swimming pools and programmes to train the young in water safety bring almost annual awards to Auxiliaries from the National Safety Council.

MD's Wife, a glossy readable 30-page magazine, goes to members six times a year. As well as features, it gives news of successful Auxiliary projects. Here are a few typical ones:—

- Sex education: Many Auxiliaries are promoting educational films and special counselling facilities for young people who don't know as much as they should. Social disease prevention comes under this heading, too, and much constructive information is disguised by health and charm courses for teenagers.
- Audio and visual testing for communities, both to determine the amount of hearing and sight loss and realistic rehabilitation programmes. In one state, (Utah), an Auxiliary recruited enough trained volunteers to screen over 2,000 Indian school children who were not, until then getting attention from any other source.
- Friendly Visitors, recruited and trained by the Auxiliary, visit housebound and elderly people. Hospital volunteers are also organised. Many Auxiliaries have built up successful "Meals on Wheels" programmes.
- Auxiliaries have also been active in organising disaster training exercises, and working up blueprints for community action in the face of floods, storms, or war.

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 method of reversing the effects of muscular dystrophy. The programme has already gained international recognition.

A Muscular Dystrophy Research Association, actively supported by Western Australian Rotary Clubs, has been formed to raise $225,000 to support the research in the Department of Pathology of the University of Western Australia and the neuropathology laboratory of Royal Perth Hospital. A third of the money needed has already been raised.

It was found that nutritional myopathy in the quokka can be reversed by the administration of Vitamin E and that complete regeneration of muscle fibres occurs. This led to the establishment of a hypothesis which narrows down the field of enquiry and on which the new research is based.

The research is being led by Dr. B. A. Kakulas, Reader in Pathology at the University. The team so far includes a biochemist, a clinical research worker, an electron microscopist, a pathology technician and a computer specialist.

The team supplied the following notes on their research into the disease, of which there are probably 2,000 new cases in Australia every year:

"Although the underlying biochemical cause of muscular dystrophy is unknown, recent developments make possible formulation of a probable pathogenesis.

"In common with other inherited diseases in man it is likely that the genetic defect in muscular dystrophy is manifest as an enzyme deficiency.

"From the studies in the quokka it is known that cyclical degeneration-regeneration will lead to muscle changes similar to those found in human muscular dystrophy. In the human disease, muscle fibre necrosis is also likely to be primary, and other alterations, e.g. variation in muscle fibre diameter, central placement of nuclei, are secondary and non-specific. Fat and fibrous tissue simply replace lost muscle fibres when regeneration is essentially exhausted.

"From this it follows that if the cause of muscle necrosis in the human progressive muscular dystrophy was discovered, then full regeneration and recovery of muscle structure is at least a theoretical possibility.

"Regenerative changes in muscle are present in the early stages of the disease, and a precedent for regeneration does exist in human polymyositis. In this disorder muscle fibre necrosis is probably the result of a disordered immune function, and complete regeneration occurs when treatment with steroid hormones is provided.

"In the laboratory the main animal models for our research are the dystrophic house mouse and the quokka with nutritional myopathy.

"Skeletal muscle removed primarily for diagnostic purposes from the patient is also the subject of intensive study.

"In tissue culture, the morphology of growth and differentiation of normal and dystrophic muscle is studied by time-lapse cinemicrophotography, and electron microscopy and biochemistry are applied. Differences between normal and dystrophic muscle are documented."

Less private practice for physicians

There is a real contraction in the volume of private practice performed by general physicians in Victoria, Dr. Maurice V. Clarke said in his retiring Presidential address to the Victorian Branch of the A.M.A. "The trend will inevitably continue, perhaps at an increasing tempo", he add ed.

The proportion of consultant physicians in private practice in the State had dropped from one for every 27,000 people in 1947, to one for every 33,000 people in 1967.

Dr. Clarke said: "I do not believe that the lack of payment for honorary service is the prime reason. It is the changing structure of medicine that is the more fundamental consideration, especially in the two fields of general practice and hospital medicine.

"General practice is becoming increasingly a group or team endeavour. These teams are in a better position to handle the problems confronting the doctor of first contact than was the case a few years ago, and there is less need or desire to rely on the knowledge and judgement of the 'second opinion' of a physician.

"On the other side of the picture, hospital medicine is becoming more sophisticated and complicated and provides many necessary advances in investigation and management which can only be the province of the full-time staff because of its inbuilt requirements.

"Again there is the excitement of new techniques and expensive equipment which the consultant physician is not in a position to acquire or use within the present framework of private practice.

"Either of these vocations, the group practice or the salaried appointment, offers far more attraction and security to the young graduate than the prospect of the isolation of a physician in his rooms, dependent on the good-will of other colleagues, with no rights to superannuation or other 'fringe benefits', even if the reward for his endeavours is adequate, financially and intellectually."



Dr. M. V. Clarke

Dr. Clarke said that adequate recompense for patient care and teaching now done on an honorary basis was long overdue, a matter of natural justice, and necessary for the maintenance of acceptable standards of treatment and teaching while the present staffing situation obtained in public hospitals. But it would not reverse the trend.

Dr. Clarke said that because of the changes taking place, the training of future physicians would need close consideration, and it was logical to expect the R.A.C.P. would be the body responsible for such an investigation.

"I can visualise that eventually there will be training and certification, probably by some form of examination, for the physician who will work with the groups or teams outside the hospital complex, and a different type of training and examination (or qualifying procedure) for those physicians who will make full-time hospital practice, research and teaching their ultimate vocation", he said.

What of the consultant physician of today? Dr. Clarke said:

"He will continue his professional career along present lines, in dwindling numbers, providing as it were a bridging service for the community while general practice and the hospital develop in their different directions.

"He will ultimately fade from the scene—gracefully, I presume, for physicians are gracious people—as his successors deviate towards the teams or the hospitals.

"He will be retained for the foreseeable future as a teacher, because the whole system of medical education would collapse if his services were withdrawn. There are still insufficient numbers of full-time staff in the universities or hospitals to replace him.

"But this ratio will be reversed eventually with the rapid growth of new highly specialised departments and their staffs."

Big demand for AMA Road Safety Policy

Demand for copies of the A.M.A.s Policy on Road Safety have been so great that it will probably be necessary to produce a reprint.

The report received wide praise when it was published last month. At least four metropolitan daily newspapers carried editorials commending the report.

The report urged each doctor to take a lead in his community by personally adopting the following measures.

- By driving courteously and safely at all times himself, even when on urgent calls.
- By insisting on the maximum number of proven safety features when purchasing new vehicles.
- By installing and using seat belts for himself and at least his front seat passengers.
- By seeing that his own teenage children are taught correct driving procedures, and by direct enquiry into the driving experience and safety attitudes of those who escort their children to parties or on country trips.
- By counselling patients in similar safety practices.
- By active support of local organisations designed to sponsor Road Safety practices.
- By investigating and reporting on local accident problems and danger spots.
- By personally supporting and recommending to others insurance companies which introduce remission of premiums for safer types of cars, and drivers with good safety records.
- By publicly supporting the measures recomended in the A.M.A. Road Safety Policy, and particularly those in which the doctor can be regarded as having expert knowledge (such as compulsory blood alcohol tests).
- By being well versed himself, in emergency care of road accident victims, and casualty ward care.

Preventing heart disability

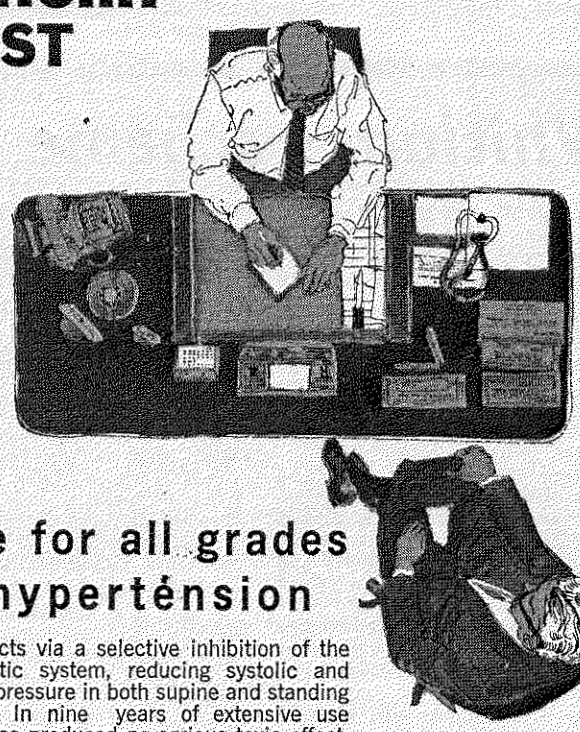
Community acceptance of the need for rehabilitation increased with each successful placement, and a climate of opinion had steadily built up which accepted that disability from heart disease could be prevented, Dr. C. C. Jungfer told the annual meeting of the South Australian Division of the National Heart Foundation.

One hundred and sixty new patients were referred to the centre in the 12 months to June 30—a 34 per cent increase over the previous year. An additional 83 patients attended the centre, making an overall total of 243.

Further progress in the standard of service would come in two ways:

- Still earlier attention to rehabilitation.
- A rehabilitation assessment for all children with potential or actual heart disability as soon as diagnosis was made.

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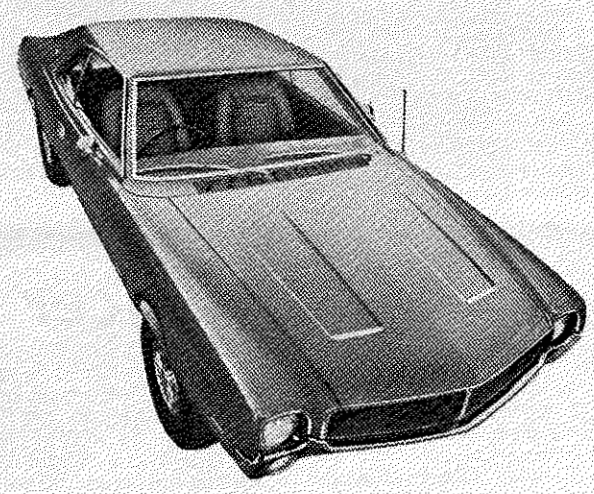
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AMR3096

The frying pan or the fire

If you disapprove of "nationalised medicine", then you must also disapprove of the "universal" health insurance scheme which is currently being advocated for Australia by Mr. Whitlam, Leader of the Opposition.

The patterns of such schemes are different, but the end result would be the same — dissatisfied doctors, unhappy taxpayers, and patients receiving second best.

This article, the second in a series discussing the current reappraisal of health services, is not an official statement of A.M.A. policy. Though the author uses A.M.A. policy as his framework, the arguments used and the inferences drawn are his own. Correspondence from members of the profession will be welcomed.

Mr. Whitlam proposes that existing voluntary health insurance funds should be replaced by a Government controlled National Health Insurance Commission. This Commission would be financed by a 1¼ per cent levy on taxable income, plus a matching Treasury grant.

Private practitioners would continue to be paid for each item of service and, since doctors cannot be "conscripted" under our Constitution, Mr. Whitlam would offer them a choice; they could, up to a point, opt out. The choice, however, would be between the frying pan and the fire.

Doctors who chose to join the scheme would be asked to bill the National Health Insurance Commission direct for 85 per cent of a fixed schedule of fees and accept this amount as payment in full. They would thus find themselves in a similar position to the British G.P., who is paid direct by Government.

Doctors who objected to becoming Government servants and chose to opt out would carry on as before. They would send out accounts in the normal way, and the patients would take the accounts to the National Health Insurance Commission to claim refunds.

However, if the majority of doctors chose the second course, Mr. Whitlam's scheme would lose most of its point. Therefore, strong pressures have been built into the scheme to ensure that doctors to do not opt out.

FOR details of these pressures it is necessary to turn to the statements of Mr. R. B. Scotton and Mr. J. S. Deeble, of the Institute of Applied Economic Research, Melbourne, who, though they have no connection with Mr. Whitlam, are the real authors of this scheme.

The first sanction is that patients who went to a co-operating doctor would receive no bill, whereas those who went to a doctor who had opted out would not only receive an account, but would have to pay at least 15 per cent of it out of their own pocket.

Secondly, they would have to pay a "service charge" of $2 to the National Health Insurance Commission for putting the Commission to the trouble of handling the account and paying a rebate.

Thus a patient who received a $10 bill from a doctor who had opted out, would receive a rebate from the Insurance Commission of not more than $8.50 (85 per cent), less a $2 service charge. This would return him $6.50, leaving him $3.50 to find out of his own pocket. The patient who went to a co-operating doctor, on the other hand, would bear none of these charges.

The choice from the point of view of the patient's pocket would be obvious — especially since he would already be paying for the scheme whether he liked it or not through the 1¼ per cent levy on his taxable income (no opting out is proposed for the public).

Should Mr. Whitlam's scheme be introduced despite the opposition of the medical profession, one can imagine a situation in which the A.M.A. would urge its members to opt out en masse, because of certain principles which will be mentioned later. This would make the profession highly unpopular, and strong political pressures would be applied. Under this pressure some doctors might give in and join the scheme, thus gaining new patients.

This would create bitterness, and before long the profession would be split. Eventually, one might fear, the A.M.A. would be forced to capitulate, leaving, perhaps, a few diehards fighting a rearguard action with threats of strike action.

Everyone would hope that such a train of events would not occur. However, the fact has to be faced that similar events have happened in other countries. Much better, surely, to try and ensure that the scheme is never introduced.

WHY should the A.M.A. be committed to a system of voluntary health insurance which, by implication, means opposition to Mr. Whitlam's scheme? Basically, it is because doctors would be forced to co-operate with the compulsory scheme in the end, and once they did they would become quite as much "nationalised" as doctors are in Britain.

They would be paid direct by a Government organisation and in this sense would become as much public servants as the girl behind the Post Office counter or the man you ring up at the Water Board. The patient would no longer have any direct responsibility for paying for his medical care, or even know how much it cost. The confidential relationship of doctor and patient would be diminished, and some measure of respect and trust would inevitably be lost.

Arguments about damaging doctor-patient relationships, though deeply and sincerely expressed by many practitioners, perhaps do not carry weight with everyone. However, there are many other very practical arguments against "nationalisation" of medicine.

One of its greatest drawbacks is that it leads to over utilisation; at least it has done in Britain, and also in the United States under Medicare. If something is "free" people will inevitably make use of it to a greater extent than if it has to be paid for. This applies not only to patient initiated services, but also to those ordered by the doctor.

It is true that Scotton and Deeble propose deterrent charges for patient-initiated services (minimums of 50 cents for a G.P. surgery consultation, $1 for a home visit, and $2 for an unreferred specialist consultation). However, there is little evidence that the deterrent charge of 50 cents for prescriptions under the Pharmaceutical Benefit Scheme has had any appreciable effect on the total bill, which has increased year by year.

Thus the cost of the compulsory health insurance scheme can be expected to rise, leading inevitably to financial embarrassment for the Government. For electoral reasons the Government will not dare to take away the "free" service, so the economies in expenditure which the Treasury will demand will have to be made in other directions — such as hospital building or doctors' remuneration. Under these circumstances the service will run down, and in the end the patient will suffer.

There is a further danger when money to pay for health comes solely from Government sources — or even from a so called "independent" National Health Insurance Commission. This danger is that Governments face financial crises from time to time, or alternatively, decide to purchase urgently needed equipment. One way of finding money for such expenditure is to cut down on other spending, such as housing, education or health.

Health care is an important item, and the private citizen would do well to keep the ordering of it in his own hands if he possibly can.

ANOTHER serious drawback to nationalisation of equal importance to the patient and the doctor, is that it forces the doctor to become a policeman, with another set of policemen watching him.

The reason for this is that no Treasury (or National Health Insurance Commission acting as the Treasury's agent), can hand out money without some kind of audit and check on how it is being spent. It would not be fair to the taxpayer.

The problems which these checking up processes create have already been experienced by the profession in regard to the "free" Pensioner Medical Service.

By training, tradition and ethical standards, it is demanded of the doctor that he put the patient first. A secondary role as Treasury policeman is incompatible with this primary concern and must lead to deterioration of the doctor-patient relationship in the end, to the detriment of the service and of patient care.

Perhaps the strongest argument of all against Mr. Whitlam's compulsory scheme is that there is really no need for it.

There may be a case for nationalised medicine in under-developed countries desperately trying to raise living standards and share out inadequate resources.

But it is an out-dated, old-fashioned concept for Australia. Here, health resources are among the best in the world and the great majority of Australians are sufficiently well-off to be able to decide for themselves how they will spend their money. They do not need a Big Brother to decide what is best for them, nor to dole out the nation's wealth in pre-measured packages of welfare services.

Health care is indeed one of life's necessities, and everyone is entitled to receive it. Food is also essential, yet no one suggests we should all queue up at a Government shop for free bread. Instead we try to see that nobody is so needy that he cannot buy his own.

This, in basic terms, is the solution proposed by the A.M.A. to the problems of Australia's present national health service. For those who because of circumstances are unable adequately to insure, the present scheme is not perfect, but this aspect is quite capable of correction by subsidising those who cannot afford to insure against illness in the ordinary way.

Subsidising those who genuinely cannot afford to pay is surely much cheaper than providing a "free" service for everyone, whether they need it or not.

MR. WHITLAM does not deny that the 1¼ per cent levy on taxable income required to pay for this scheme is equal to an 8 per cent increase in general taxation rates. He claims instead that payment according to taxable income is fairer than a flat rate contribution to a voluntary health insurance fund, which is the same for all income groups.

Whether you accept this claim depends on your definition of "fair". Some would feel that Mr. Whitlam's scheme amounts to a policy of "slugging the rich", as the following table indicating the order of costs under the scheme for different income groups suggests.

Taxable Income	*1¼% Levy*	*5% of Personal Tax**	*Total Health Bill*
$	$	$	$
2,000	25	10	35
4,000	50	37½	87½
10,000	125	170	295

** Assuming 5% of taxation revenue is spent on health services.*

In addition, under Mr. Whitlam's scheme, tax deductions for medical expenses would be lost.

The principle that taxes should be graded according to income has long been accepted, and is not disputed here. The principle already applies to that large portion of health expenditure paid for directly out of taxation revenue. The point made is that there is no need to extend the principle to all expenditure on health, and that in the long run it would be wasteful and harmful to do so.

Why replace a scheme that is basically sound and can be made to operate efficiently for the benefit of all, with an untried scheme, based on purely theoretical grounds, and which even in theory, exhibits so many fundamental errors?

* * *

The next article in this series will answer some of the unfair criticisms which have been made of the present voluntary health insurance scheme, and will discuss the A.M.A.'s solutions to some of the shortcomings of the present scheme which undoubtedly exist.

Salaried officer questions Mr. Whitlam's scheme

Letters to the Editor

Sir,

Mr. E. G. Whitlam's address, "The Alternative National Health Programme" at the Royal Prince Alfred Hospital Postgraduate Seminar on the 6th July, 1968 (reported in the **Medical Journal of Australia** of August 10), has been widely publicised. It is a most exhaustive and eloquent exposition on a matter of the greatest importance to the community and to our profession.

Whatever our politics, we can but appreciate and applaud his statement that the provision of effective health services should not impose a special burden upon the medical profession. And yet his address has provoked deep concern among many of our members and particularly among the full-time salaried staff, to whom it might have been expected to have the greatest appeal.

The full-time salaried medical officers constitute a large and important section of the profession, and their numbers are increasing—certain it is that if a national health programme, as outlined, is ever introduced in Australia, the increase will be dramatic.

Accordingly, their terms and matter for critical consideration, yet Mr. Whitlam manages to condense this aspect into one sentence of 12 words: "Salaries and conditions should be comparable with those of academics in universities".

"Comparable" can mean many things to many people and the varied salaries and conditions of academics in Australian universities make the position even more uncertain. Mr. Whitlam has made a detailed investigation of the costs of the proposed service, and it must be presumed that the cost of staff salaries has been included.

Mr. Whitlam mentions "proper superannuation arrangements"—also study leave and refresher courses — but these only in very general terms.

The medical profession has before it a warning of lessons learned elsewhere in the world, when agreements with governments were in general terms and not spelled out in detail. We in Australia must know that what is offered is realistic, not just "comparable".

What do the offers of study leave, sabattical leave, refresher courses and superannuation really mean and will the scale of staffing of hospitals practical proposition, not just a promise? Our members in the salaried service know of these problems and expect to see them solved before seriously considering this as a possible new scheme.

Mr. Whitlam rightly indicates his first objective is an adequate service for the patient, but the success of the scheme depends on the medical profession—"The provision of health services should not impose a special burden on the medical profession".

Mr. Whitlam should give the profession more details of salaries and conditions, even at this early stage.

"A Salaried Medical Officer".

Exchange sought

Sir,

My family and I are very

exchange for six months or less, with an Australian general practitioner and his family. I have a moderate sized Health Service practice plus a small private practice and the latter includes the care of a public school. My surgery is situated in my large house in the City of York and is completely separate from that of my two partners.

I am 30 years of age and have been in general practice for over three years. My family consists of my wife aged 28 years, two daughters aged 8 and 5 years, and one son aged 18 months. Our reasons for this exchange are a desire to broaden our outlook and experience plus a longing to see Australia.

I would like to contact a likely practitioner with whom I can exchange details and references.

A. K. Scott, M.B., Ch.B.,
140 Clifton, York, England.

Fire ban

Sir,

Your headline— *AMA Gazette* November 21—"No Point Yet in Clothing Fire Ban"—leaves me

risk of this dreadful and avoidable accident amongst young children gives this ban point at all times.

For the Standards Association of Australia to say that they need three or four years to look into the matter, and that research development could take considerably longer may be true. However, it is already only too clear that cotton fabrics, particularly those of the commonly used flannelette type, are extremely dangerous, and that the nightdress of a little girl makes her three times as likely to die as her small brother.

There is surely already a clear duty, as well as a moral obligation, for government agencies and the A.M.A. to educate the community in the risks of cotton fabrics, and of the advantages of pyjamas over a nightdress. The quickest and surest way of accomplishing this would be the compulsory printing of the relevant facts on the manufacturers' wrapping of the garment in which it is offered for sale.

One might ask in how many government institutions are flannelette nightdresses standard winter wear for small girls?

David L. Dey,
Royal Alexandra Hospital for Children, Camperdown.

Mobile heart unit Australia's first

A unique mobile intensive care unit being built for Perth hospitals is expected to save at least 50 lives a year.

The unit — an ambulance fully equipped to deal with sudden cardiac failure — will be the first of its kind in Australia, and one of the first in the world.

Total cost of the ambulance, its equipment, and facilities at three Perth hospitals, is about $25,000. A second ambulance is expected to be in operation within about a year.

The introduction of the mobile heart unit is a striking example of co-operation between the community and the medical profession. The idea came from the Perth Junior Chamber of Commerce, which approached doctors and hospitals for their support and raised the money with the help of other bodies.

A Perth heart specialist said: "When they first discussed it with me, I was sceptical of the idea, but I offered to seek further information for them — and the whole plan is working splendidly."

The further information came from Dr. James F. Pantridge, cardiologist at Belfast's Royal Victoria Hospital, which introduced the world's first mobile intensive care unit last year.

Dr. Pantridge described the unit's operation and provided statistics of the high mortality soon after cardiac arrest that prompted its establishment.

The Belfast research showed that 60 per cent of heart-attack deaths occurred within the first hour, and many victims reached hospital intensive care units too late.

In 78 per cent of calls made by the Belfast unit, patients were receiving treatment within 15 minutes, and in the first 15 months of operation not one of the 312 heart patients taken to the Royal Victoria Hospital died before they arrived. The prompt treatment also helped many in their subsequent recovery.

It is estimated that the Perth unit will save at least 50 lives a year because of the effective and prompt treatment that will reach patients, in some cases only minutes after an emergency call has been made.

Perth doctors will be circularised to advise them of the new service. They will be able to call the ambulance to a patient they are already treating, or send it if there is any delay in getting to a patient. The ambulance will in some cases attend if called by a member of the public.

The ambulance will be staffed by a doctor, two nurses and a medical student. All its equipment can be readily moved into a home or office so that a patient does not have to be moved until it is considered advisable. The equipment can be worked from batteries.

Dublin HQ

Offices have been established for the world secretariat of the International Federation of Voluntary Health Service Funds.

The Federation was formed in Sydney early this year at the Second International Conference on Voluntary Health Insurance.

Its offices have been set up in V.H.I. House, Dublin, headquarters of the Voluntary Health Insurance Board of Ireland. The General Manager of the Board, Mr. John F. O'Mahoney, is Secretary-General of the International Federation.

The immediate past chairman of the Voluntary Health Insurance Council of Australia, Sir Ronald Grieve, is first President of the Federation and Chairman of the Board of Management.

There will be three categories of membership. The Federation will be open to voluntary health funds, to other organisations — including governments — interested in voluntary health insurance, and to individuals with an interest in the subject.

Bethlehem bound

By Hypophysis

Jerusalem had been hot and dusty, fascinating in its antiquity and in the way the ages had passed it by. Donkeys clattered over the cobbles; at the roadside long-gowned, bearded men drank tiny cups of black coffee, smoked their water pipes, and spat.

I climbed the stepped street leading to the Damascus Gate. Outside the city wall lay my hotel, and inside the hotel lay an endless vista of bottles of Danish beer, with gold foil round the necks, and an icy mist on the glass. Flagging steps quickened.

"You come to Bethlehem?"

"No thanks".

"You no Americans?"

"No".

"You come to Bethlehem with me?"

"No, I'm only here for the day; no more time".

"Not take too long; home before dark; in my uncle's car".

I looked at the sun. It was already low, the brassy glitter had left the sky. This persistent fellow must be mad.

"You come with me?"

"Look, how far is it anyway?"

"Only seven miles,—not twenty minutes. You come?"

For all I knew, it might have been seven hundred miles.

We went through the gate in the city wall together. Uncle sat in a large aging Oldsmobile, head turbanned. The pilgrimage commenced. My guide was an Arab, earning his University fees during the Vacation. He didn't love Jews. The road wound left and right, up and down. Black skinned children laughed at us, their lop eared sheep and goats looked on. A man trudged along the dusty road, head bowed, stick bending under his weight, leading his donkey. His wife's head was shrouded, her figure was full.

Surprisingly, Bethlehem lay on a hilltop. At its summit stood the Church of the Nativity—like a citadel,—blank stone walls topped by the familiar bells,—their peal known wherever in the world a transistor is played on December 25. Across the square,—a mosque.

Inside the church, a series of chapels like communicating museums, with candles, altars, icons, tinsel and baubles, each patrolled by grim acolytes, bearded or tonsured, heavily draped, uncleanly, stale with incense.

Down winding, stony stairways—until an arch seemed to usher the very Underworld. Then bending into a tiny cave like space,—stones worn by Ages, in simplicity its furnishings contemporary,—just a Manger.

Walking the first few hundred yards back to Jerusaleum I looked down the steep incline on the right—saw a sign "The Shepherd's Fields"; sheep still there. Over my shoulder, the westering sun ignited the golden Cross crowning the serried erection over the stable. The car door slammed. The road from Bethlehem had but one ending; Jerusalem, outside the city wall.

Membership appeal by Kidney Foundation

Though the largest portion of its funds will be spent on research, the newly formed Australian Kidney Foundation plans to mail authoritative monthly bulletins on renal problems to family doctors throughout Australia. It will also liaise with Government authorities to improve diagnostic services and institute preventive measures.

The Foundation is about to launch an appeal for 10,000 members who, it is hoped will contribute more than $1,000,000 annually. In addition, a general appeal for a further $5,000,000 may be launched in 1970.

After investing a portion of the money received, there should be $400,000 to spend each year in the early stages.

The Medical Secretary of the Foundation is Dr. H. H. I. Pearson, a past President of the Urological Society of Australasia, who has already set up the Foundation's office at 175 Alinga Street, Canberra City.

The Foundation was formed following discussions between the Australasian Society of Nephrology, the Urological Society of Australasia, the Institute of Urology and interested scientists, clinicians and business men.

The Institute of Urology, a N.S.W. organisation, which appealed for $200,000 last year, of which $104,000 has already been allocated is merging with the new Foundation, bringing its remaining funds with it.

The Board of Directors will consist of eight members elected at the annual meeting (not more than two from each State), the presidents of the urological and nephrology societies, a representative of the N.H. & M.R.C. and one representative from each of the State Committees.

Priorities for spending the money raised will be recommended by a Medical and Scientific Advisory Committee of which Professor R. D. Wright, Professor of Physiology at the University of Melbourne, is Chairman, and Professor R. M. Mitchell, Professor of Surgery at the University of Tasmania, is Vice Chairman.



Dr. Pearson

Grants for research will be made at national level, but part of the funds will be channelled back to State Committees for spending locally on education, rehabilitation and, where necessary, on equipment for diagnosis and treatment.

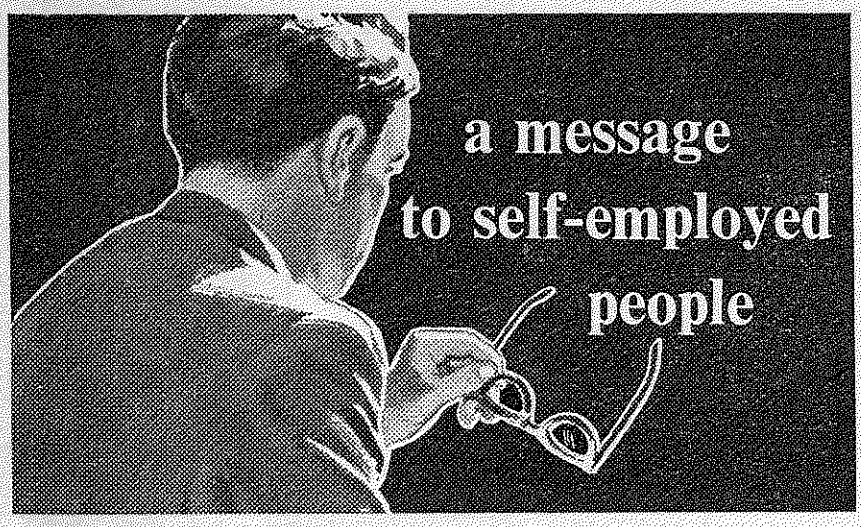
A pilot survey of the incidence of renal disease in Tamworth, N.S.W., will begin shortly to discover some of the priorities which should be applied in tackling the wide range of problems which come within the Foundation's orbit.

Areas of preventive medicine in which the Foundation will be interested include the screening of schoolchildren for proteinuria to discover the incidence of glomerulonephritis and more extensive screening of hypertensives for renal causes.

Other measures which may prevent the need for kidney transplants will also be encouraged, and national registers are planned of kidney transplants and cancers of the urinary tract. Better and faster diagnostic facilities for diagnosis of renal disease in country areas will be promoted.

The appeal to the public will be made partly on the basis that:

- One in five admissions to hospital is for genito-urinary tract disease or renal complications of other diseases.
- Mortality from disease of the urinary tract in Australia in 1963 was greater than mortality from road accidents and lung cancer combined.
- There is a very high rate of urinary tract infections among females, both children and adults, and there are parts of Australia where renal calculi are more common than in other areas, both requiring investigation, as to cause and prevention.
- It is estimated that between 500 and 600 Australians could benefit from kidney transplants or long term dialysis each year.
- Cancer of the bladder is increasing at the same rate as cancer of the lung.



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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.

FINANCE

Although this is still only a drop in the ocean compared with the size of investment in shares traded on Stock Exchanges, Government bonds and company debentures, the figure has grown from nothing 30 years ago. Most of this growth has occurred in the last 15 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 spread over a number of shares in various companies.

For instance, an individual who wants to buy shares may not have the capacity to buy a significant amount of shares in a company, but a collection of such individuals, by pooling their resources (i.e., into a unit trust) can do so and enjoy all the benefits that such investments may bring.

Each of the unit holders in the trust would then have a proportionate interest in all the shares the trust holds — and these could cover hundreds of companies.

The bigger the spread of investment the less risk involved for the unit holders. Even if one or two companies fare badly, or fail, the performances of the others, as a general rule, will cushion the impact of the loss

A unit trust is not a company as such, but an association or "club" of investors—a highly-developed form of co-operative investment.

To invest in a trust a person buys "units". Each unit is a share of all the investment a trust holds. When a new trust is formed units are available to the public in much the same way as company shares are offered. The opening price depends on the structure of the trust, but units in most are offered at 50 cents or $1 each.

After a trust is launched the value of the units fluctuates in line with the stock market. Units are readily negotiable with the trust managers, who will buy back units from investors who want to sell. But, the price paid may be higher or lower than the original outlay, depending on the overall value of shares held by the trust.

Despite the current record level invested in unit trusts and mutual funds (which have much the same aims as trusts), managers have failed to stem the flow of redemptions which is still outpacing subscriptions to new trusts and funds.

Commonwealth Statistician figures show that $30·9 million was paid into trusts in 1967-68 against $35·1 million paid out. In the previous year the figures were $20·2 million and $21.1 million respectively.

Latest figures indicate an increased activity because of the boom, but accentuate the trend to a net outflow of funds in this sector of the investment world.

Major reasons are probably the winding up of a number of major unit trusts operated by Australian Fixed Trusts (easily Australia's biggest with 97,000 investors and $125 million investments), without replacement, and a desire by investors to take a profit on substantial gains recorded by all unit trusts, etc., during the past year.

However, the situation has not always been as happy as this. In the early 1960's the trusts made a lot of bad friends when redemption prices were consistently lower than subscription prices.

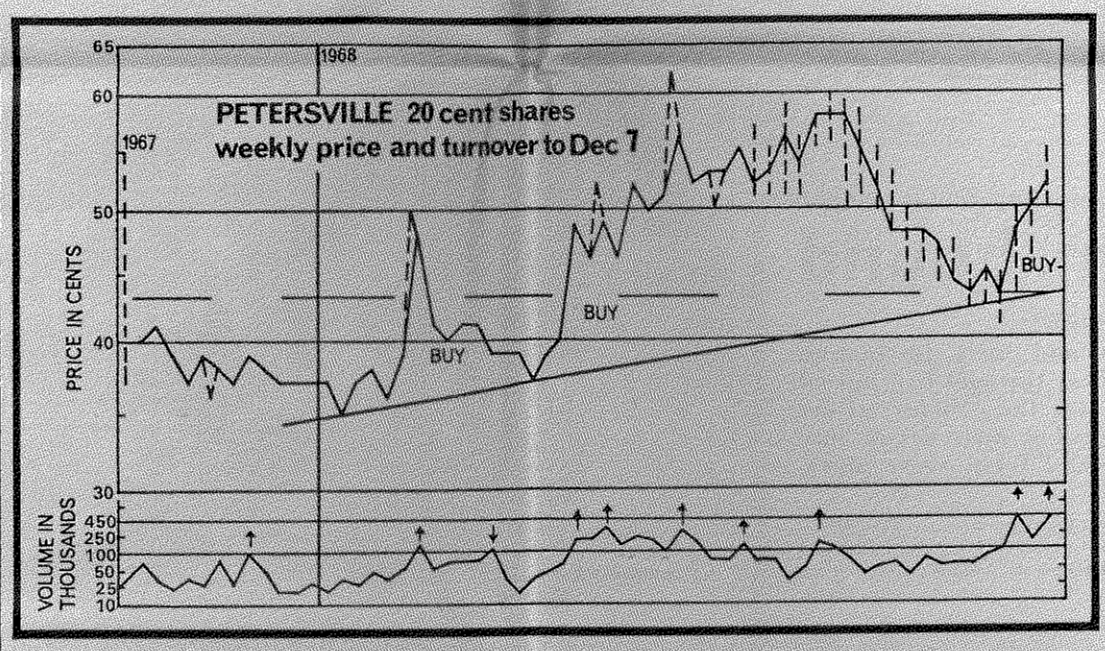
Complaints over high management charges (averaging around 8 per cent) did not help their image. But the charges compare favourably with those overseas where this type of investment eclipses all others.

The trusts have also been criticised for unimaginative investing and not taking full advantage of the mining boom. But the managers argue that they have not been able to do so because some miners do not pay dividends and therefore provide no income for the trust.

The unspectacular performance by the share trusts may be one of the reasons for the current demand for trusts investing in property and mortgages. These have been increasing in importance.

In 1963-64 trust investment purchases totalled $35·2 million. Of this, $25 million went into shares, $6·8 million into fixed interest (debentures, etc.), and the rest into property and mortgage. In 1967-68, of a total $33 million, $13·2 million went into shares, $7·3 million into fixed interest and $12·5 million into property.

Rising taste for ice cream



By our Chartist

During the whole of 1966 and 1967 Petersville shares were in a falling trend, falling from about 68 to 36 cents. Since the beginning of 1968 there has been a recovery pattern with several large unexplained rises on high volume of trading.

During most of 1967 the shares failed to rise above 43 cents; this resistance level is shown on the chart and it is of interest that the recent fall in price stopped at about that level. Three periods are marked as a good time to buy. An upward trend line can now be drawn, which is unlikely to be penetrated in the immediate future.

It should be noted that on almost all occasions on which turnover increased markedly there was a rise in price. This is a sign of buying power, probably from persons who have some sort of inside information, either of improved company profits or of takeover feelers. Many of Australia's established food and drink companies have been partly or wholly taken over by overseas companies in the past few years.

A trader who bought Petersville earlier this year would probably have taken his profits when the shares began to fall below say 55 cents, but the long-term investor should not have been unduly worried by the recent fall to 41-43 cents, because this fall was not associated with high turnover of shares.

He may have worried about the fall, but the last few weeks should have revived his spirits and even encouraged him to buy more shares. No prediction is made as to how high the price may go in the next few months. All that is offered is the opinion that prospects for a substantial rise are good, and the dividend yield is still reasonable.

The 'squatter' and the swinging patient

By Dr. G. A. Rickarby

In general, people who swing readily from one doctor to another tend to cause trouble. The following examples of the way in which the problem presents itself, and my solutions, may prove helpful.

Practice Management

This series of articles is published in co-operation with the Practice Management Committee of the Australian College of General Practitioners.

* * *

A. "Oh I go to Dr. Doe; but the football trainer brought me here."
My answer: Ring Dr Doe . . "I've got Joe Blow here. What would you like done . . . ."

B. "I usually go to Dr. Doe, but I'd like to see what you think about my . . . ."
My answer: "Have you asked Dr. Doe for another opinion? This is the right thing for you to do. I'm sure he won't mind." Exit.

C. "So that's what you think. I went to Dr. Doe last week and he said . . . ."
My answer: "I think you should have told me that before. I'm writing to Dr. Doe with my opinion. He should have the letter in tomorrow afternoon's post."

D. "I don't want to go back to Dr. Doe. I'd prefer to come to you."
My answer (if Dr. Doe has been currently attending the patient for an illness): "The correct thing to do is for you to inform Dr. Doe."

E. "I think Dr. Doe is a horrible man. He should be struck off the medical register."
My answer: I think, 'Here but for the grace of God . . . .' But I ring Dr. Doe: "Look John, there's a Mrs. K'Foops here from Smith Street. What's the strength . . . ."

F. "I have had medical attention before. Where? Well I would rather not say . . . ."
My answer: Many may disagree, but I let it go, and don't press the issue. The previous medical attention may have been received from a cniropractor. Whatever the problem, it usually leads to a break down of your own relationship with the patient.

G. "I won't get in touch with Dr. Doe and I don't want you to either."
These cases need deciding very much on their merits. In complicated cases, or where psychiatric disturbance is apparent, it may become urgent to get in touch with Dr. Doe.

H. There are patients who do not give a glimmer that they were seen two hours ago by Dr. Doe who diagnosed appendicitis. I'm sure there are always many more of these than we suspect. Perhaps they've run into one of the answers above on a previous occasion, and they find this way the least trouble. If the above answers produce this result, are they right?

The problem of the foot-loose patient can be particularly worrying for the doctor who has just set up a new practice. But despite the fact that all practices start by "squatting", a good choice of site and area, followed by ethical behaviour on behalf of 'the squatter' should lead to good professional relationships.

It is essential in choosing an area in which to practise to look for both economic and population growth. In choosing professional neighbours the best signs to look for are busy doctors with a good reputation.

A practice will soon grow in an area where you hear—"Dr. Doe is marvellous, but the poor man is working himself into the ground. I couldn't get an appointment to see him until next Tuesday".

When you squat, it is inadvisable to squat within a few yards of Dr. Doe's practice. There is nearly always a population nucleus that is a reasonable distance away from his surgery. A sure way of making your professional relationships difficult from the start is to squat next door to a doctor who is having troubles with his own practice.

Call on professional neighbours *before* you open your door to the public. In my experience very few doctors do the correct thing and call on their future colleagues early; many don't call at all. This is aggravating to the established practices, but is much more damaging to the 'squatter'.

In the round of calls which I made before starting in practice, not only did I make firm friends, but received invaluable unsolicited advice. At the end I had received two offers of partnership, one invitation to dinner, engaged the services of an anæsthetist and arranged an off duty cover with another solo practice.

I also gained an insight into the economics of practice within the area and the pitfalls, which do vary from area to area. In those first months I did short locums in three of those practices. And I didn't lose a thing by the calling.

The pill at Camelot

Thus to Merlin, reportyng,
The wily Vivien said,
"This news I have of Guenivere,
Fayre Queen to Arthur wed.

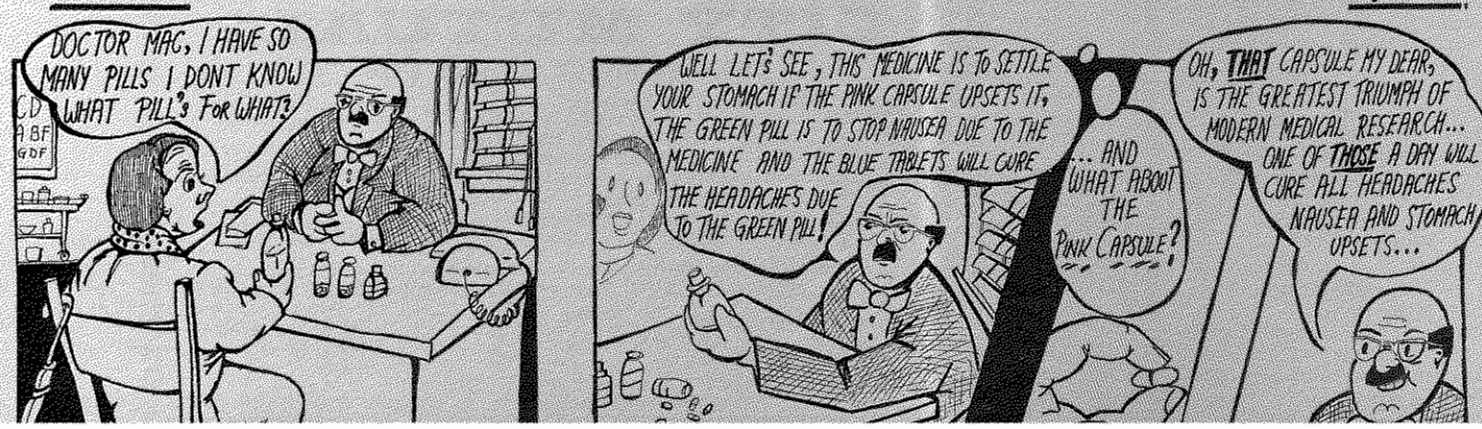
"Although he rides a-hawking
About the wooded heights
Upon his hunting holidays
With divers of his knights,

"The Queen, in idle dallyance,
Dysports at rout and ball
And acteth mighty naughtily
With scant restraint at all."

At this Merlin was not
surprysed
For well he knew the Queen
devised
Her royal spouse should not
dyscover

Her traffic with another lover.
He therefore in her reach did
place
Some pills to save her from
dysgrace;
He was aware there is no doubt
That lusty Lancelot was about.

Dr. Mac **By Sek**



Occupational health goes "national"

An organisation which has been mooted for 15 years became 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 Occupational Health Section in the School of Public Health and Tropical Medicine, Sydney, in moving that an Australian body should be formed, recalled that when he entered the field in 1940 he envisaged that 25 years hence the discipline would have become a true specialty recognised by the profession and others.

He expected that an education programme, a Chair and adequate postgraduate courses would have been established, and an Australian body formed. But none of these had yet been achieved.

Despite the recommendation of the 1959 International Labour Convention, which laid down the scope of a proper occupational health service for all classes of work, and which Australia, was pledged to implement, the great majority of workers received no such service.

With the formation of the new body a national voice had been created, with the object of advancing the knowledge, practice and standing of the specialty. The Society would assume leadership in the field, and constitute the authority which would deal with governments, the profession, tertiary institutions and industry on matters relating to education, research and occupational health practice.

A start had already been made with the support of the A.M.A., in pressing for the establishment of a course leading to a Diploma in Occupational Health at the School of Public Health and Tropical Medicine.

A steering committee was appointed to draft a constitution for the new Society comprised of Dr. Bill Nelson, consultant occupational physician (Chairman), Dr. David Ferguson, School of Public Health and Tropical Medicine (Hon. Secretary), Dr. Peter Bradley, Chief Medical Officer, Unilever Australia (Hon. Treasurer), and Dr. Harry MacCulloch, Senior Medical Officer, N.S.W. Department of Railways.

Minister outlines plans for elderly

Commonwealth and State Government officials are jointly exploring ways of strengthening services for the elderly. The Commonwealth Minister for Health, Dr. A. J. Forbes, recently sketched out a picture of how he saw the different elements of a comprehensive and co-ordinated programme of care coming together.

He said: "The team of people I see as involved in such an overall plan starts at the municipal level and includes general medical practitioners, social workers, public health and district nurses, meals on wheels volunteers and emergency housekeepers.

"There would be a recording and information service where the elderly, the infirm and the mentally and physically handicapped could be registered.

"There would be a close liaison and interplay with authorities in charge of special housing units, aged persons homes, nursing homes and, of course, with the public hospitals.

"It would be at this point that the enormous voluntary potential of the community would be marshalled.

"The regional public hospital could be a core for the whole web of services. People would be directed to it for specialised care and assessment. At the hospital you would have specialists—including I hope specialists in geriatrics—to treat and assess patients and to take a very active part in planning, in counselling and in advising the local general practitioners and all of the people involved in the ancillary services.

"From an assessment centre at the hospital, patients could be sent, according to their condition, back to their homes under the care plan, to rehabilitation units, to nursing homes or to terminal wards.

"Such a pattern of services, I hope, would mean an end forever to a situation where, even despite the goodwill of the community and the intent of the health and welfare services already in existence, it is possible for infirm and elderly people to have to spend the last years of their lives either sitting huddled in an institutional bed gazing glumly at the walls, because there is no occupational or social planning and leadership, or perhaps living equally lonely and sometimes fearful lives in their own homes because, with no appropriate level of help or assurance of assistance when needed, each meal time becomes a worry, each journey up or down stairs on stiff old limbs becomes an ordeal and recurrent minor illnesses become an overbearing element in their lives."

At another point in his address — at the Church of England Retirement Village Castle Hill, Sydney—Dr. Forbes said that in matching resources to needs, a system of priorities had to be accepted. "In the context of our federal system of government, these priorities must usually be worked out between the Commonwealth and State Governments."

Tasmania acts on home care

Tasmania's plan to keep sick and old people out of hospital has taken another step forward with a three-week course for instructors who will teach the public how to care for the sick, aged and injured in the home.

The course was organised by the Red Cross. Although doctors in Tasmania have not been officially advised, a medical spokesman said "It sounds a good thing".

A Red Cross spokesman said: "We are moving more and more into the geriatric field. It is part of our policy to assist the State Health Department to keep people out of homes and hospitals as much as possible".

Opening the "Health in the Home" course, the Minister for Health, Mr. M. G. Everett, said the objects were to:

- Foster self help for the sick, injured and aged,
- Develop a community sense of responsibility in this regard, and
- Teach people in the home to be as independent as possible in family care.

Mr. Everett said unless a national lead was given, the "true health of the community" would not be able to match the progress of medical science. "This health in the home programme must check the mounting physical, economical and financial burden on hospitals", he said.

Search for sunken treasure

By Dr. Naoom Haimson

Until the end of the fifteenth century, ships of the Dutch East India Company engaging in trade with the country we now call Indonesia, sailed from Holland to Cape Town, then followed the coast of Africa and India.

After the year 1600, the captains of these ships were ordered to sail from Cape Town to 40 degrees South latitude and use the prevailing westerly winds to take them approximately 3,000 miles across the Indian Ocean. Then to avoid the treacherous reefs, whose existence was well known to Dutch navigators, the captains were ordered to turn and sail N.E. long before they sighted the Great South Land.

For the next 200 years most captains obeyed these orders. However, in the years between 1629 and 1727, four vessels were wrecked on the West Australian coast, or nearby Abrolhos Islands. Interest in these wrecks has existed for a long time and the position of one, the Zuytdorp has been known since the 1920's.

It was the advent of Scuba diving which gave impetus to further searching, partly for adventure, partly to extend our knowledge of a largely neglected segment of Australian history, and lastly because we knew that on three of these vessels a larger or smaller amount of treasure existed.

Early in 1963, under the leadership of Hugh Edwards, an expedition of skin divers was organised to explore the wreck of the Zeewyck. This vessel was wrecked on the southern group of Abrolhos Islands in 1727. The approximate site of the wreck was well known.

After the wreck, a large number of survivors lived for nine months on the nearby coral island, (named Gun Island by Lt. Pascoe of H.M.S. Beagle in 1840, now the site of exploratory oil wells).

During their nine months on Gun Island, the survivors salvaged all the treasure of the Zeewyick. Using timbers from the wreck they built a small sloop, and after an incredible journey returned to Batavia with their log book. It was by using de Heer's translation of this log that we found and identified the wreck site.

In June of the same year, a similar expedition, with the assistance of the Navy and the Army Water Transport Section, explored the wreck of the "Batavia". This vessel was lost in 1629 on Morning Reef on the northern Abrolhos group of islands. Few works of fiction can compare with this saga for content of mutiny, shipwreck, murder, villany and high courage.

Dr. Haimson, Honorary Medical Officer of the Underwater Explorers' Club of Western Australia for the last five years, is fascinated by the world under the sea, and has become a proficient diver and underwater movie photographer. He has been particularly interested in the medical problems of very deep dives to 200 ft., and has studied the behaviour of fellow divers at that depth.

It is interesting to note that the first medical practitioner to come to these shores was Jerome Cornelius, apothecary, who was the leader and most evil of all the mutineers. Those who wish to know more of this fascinating tale are referred to Henrietta Drake-Brockman's book "Voyage to Disaster".

The Gilt Dragon was wrecked in 1656. For many years, pieces of eight and various artefacts had been discovered 60 miles North of Perth. Early in June 1963, a fifteen-year-old schoolboy, noticed an Elephant tusk sticking out of a reef when spear fishing. His father, Jim Henderson, and Alan Robinson, soon determined that this was an old Dutch wreck, probably the "Gilt Dragon".

Little is known of this vessel except that survivors did reach shore. Whether they died of thirst and hunger or were assimilated by local aborigines can always raise an argument.

However, that she carried a large treasure we do know. Somewhere between 6,000 and 10,000 silver pieces of eight have already been recovered. The Museums Act of W.A. vests ownership of all the Dutch wrecks in the W.A. Museum. However, considerable pirating still occurs, because it is not possible to police the areas in which the wrecks lie.

Before the Act was passed many items of historical value, cannon, pottery, and ancient mortar, candle stick and navigation instruments among others, were raised and given or loaned to the Museum.

In 1929 Tom Pepper found an ancient carved wooden figure in a crack in a cliff about 80 miles North of Geraldton. Subsequent searching also produced silver coins, breech blocks from cannon, bottles, buttons and various other early Dutch relics indicating that a fairly large party had lived on the cliff tops for a period of time.

Philip Playford, in a paper "The Wreck of the Zuytdorp on the West Australian Coast in 1712", established that at the foot of the 200 ft. high cliffs, probably lay the remains of the Dutch galleon Zuytdorp.

The area is probably one of the most inaccessible in Australia. It is 40 miles by very rough track from the nearest habitation. An eight-hour journey by four wheel drive vehicle leads on to the top of huge cliffs. At the base is a narrow rock ledge often covered by 10 to 20 foot high breakers.

A few yards from the edge in three to four fathoms of water lie the remains of one of the richest treasure ships ever to leave Holland. At Christmas 1964, Max Cramer, and Tom Brady of Geraldton swam over this wreck, recovered some small cannons and nearly lost their lives. Since then two or three further dives have yielded a small number of silver coins.

In May this year an expedition was formed under the leadership of Alan Robinson to try and further survey the wreck. Despite adverse weather and a couple of near fatalities the wreck was partly charted, position of cannon and anchors noted and the presence of some large areas of silver coinage confirmed. It is now up to the Museum of W.A. to add to our knowledge and obtain relics of this wreck.

From medicine to maths

A South Australian surgeon has resigned as Reader in Surgery at the University of Adelaide to become a student of mathematics. He is Dr. L. J. Opit, aged 43, a graduate of the University.

He left Adelaide on study leave last year to complete a third year of study in mathematics at Warwick University in the United Kingdom, and this year hopes to graduate there with the degree of Bachelor of Science with honours in mathematics.

Dr. Opit completed his first and second years study in mathematics as an external student in Adelaide. A keen musician and writer, he first became interested in mathematics while doing research in molecular biology at the Queen Elizabeth Hospital.

* * *

The foundation stone of the new building of the Victorian Branch of the A.M.A., at 293 Royal Parade, Parkville, was laid by the President, Dr. Maurice Clarke, on Sunday, November 30. The building is expected to be completed at the end of March, after which the official opening ceremony will take place.

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Appendix II

RIKERSERVICE

a monthly classified advertisement service for doctors

3rd March, 1969

PARTNERSHIPS & PRACTICES

POSITIONS WANTED

WESTERN AUSTRALIA

PERTH. Female grad., 10 yrs. standing, 8 yrs. g.p. exp., seeks position 1969. Reply: Box FHX, Rikerservice.

SOUTH AUSTRALIA

CITY AREA. 5th yr. woman grad. with 2 yrs. psychiatric exp. would like a 3 day p.w. position, pref. not night or weekend work. Reply: Box FWM, Rikerservice, or 'phone 65 8615 (Adel.).

VICTORIA

SOUTHERN SUBURBS (Melb.). Woman practitioner, with anaes. exp. requires assistantship in g.p. Reply: Box FZZ, Rikerservice.

QUEENSLAND OR NEW SOUTH WALES

COUNTRY. Christian g.p. living in remote area looking for opening in country town near large centre or outer suburbs of capital. Good schools essential. Aged 40, married. Very wide exp., small capital, much post. grad. work in obstets. and gynae (D.R.C.O.G.), capable doing intermediate surgery. Group sympathetic to evangelical outlook, or solo with rostered opposition. Has own E.C.G. Reply: Box FXW, Rikerservice.

NEW SOUTH WALES

INNER CITY. Doctor exp. g.p., is looking for an assistantship with a view in a g.p. Pref. in city area of Syd. which deals mainly with city workers and dwellers. Reply: Box FZN, Rikerservice.

POSITIONS WANTED

NORTH SIDE (Syd.) pref. coastal strip. Exp. country g.p. with surgical ability seeks opening in partnership or group practice. Reply: Box GBJ, Rikerservice.

NORTH SHORE OR MANLY-WARRINGAH AREA (Syd.), 1965 grad. with 2 yrs. hosp. and 2 yrs. g.p. exp., seeks assistantship view partnership in good group practice, with adequate income and free time. Chief interests paed. and anaes. Avail. now. Reply: Box FPW, Rikerservice.

NORTH SHORE (Syd.) pref. British grad. M.B. Ch.B., D.A., partly committed to domesticity, would love part time work, g.p. or anaes. during school hours. Own car and bag. Reply: Dr. Jennifer Green, 2 Allison Ave., Lane Cove, N.S.W. 2066, or 'phone 42 1066 (Syd.).

NORTH SHORE OR EASTERN SUBURBS (Syd.) pref., but not essential. Woman grad. with g.p. exp. requires assistantship or permanent sessional work, for 12 months from June, 1969. Reply: Box FWF, Rikerservice.

WESTERN SUBURBS (Syd.). Reliable young g.p. avail. for morning surgeries (any number). Reply: 'Phone 631 8890 (Syd.).

NEWCASTLE AREA (Pref.). 1958 grad. with wide general exp., requires assistantship with or without view or long term locum. Catholic, married, 3 children. Reply: Dr. E. Doenau, c/o 82 Platt Street, Waratah, N.S.W., 2298, or 'phone 68 1812.

POSITIONS WANTED

NORTHERN SUBURBS OR BEACHES (Syd.). Assistantship view partnership, or want to purchase solo practice. Syd. grad. with 5 yrs. post. grad. exp. Aged 34 yrs., anaes. and obstet. interests. Reply: Box GBM, Rikerservice.

ANY STATE

BRITISH TRAINED DOCTOR, aged 48, married, 1 child, seeks opening in private g.p. anywhere in Australia. Country town pref. Further details from: Dr. K. R. McLachlan, 241 Castlereagh St., Sydney, N.S.W. 2000.

HUSBAND-WIFE PARTNERSHIP Seek position in country anywhere in Australia, pref. within reach coast. Assistantship or partnership in established practice with keen colleagues and good hosp. facilities, avail. from Dec. 1969. Reply: Box FTK, 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 GBR, Rikerservice.

AMERICAN INTERNIST — Cardiologist desires long term association (group, individual, or hosp.). Reply: Box GBZ, Rikerservice.

BRITISH GRAD., 29, exp. in g.p. and anaes. to be released from R.A.F. in July, seeks assistantship with view in Australia. Reply: J. W. Searson, 14 St. Andrews Way, Ely, Cambs., England.

POSITIONS WANTED

S.E. ASIA

FAR EAST. British G.P., M.B., D.R.C.O.G., 33, married, casualty, paed., 3 yrs. in Far East, looking for an opening in Singapore, Hong Kong, Malaysia, Long or short term. Avail. Jan., 1970. Reply: Box GDH, Rikerservice.

POSITIONS AVAILABLE

SOUTH AUSTRALIA

SOUTHERN SUBURB (Adel.), near city, 2 mls. Excellent practice grossing $60,000 p.y., netting $52,000 p.y. 2 fully equipped, air conditioned surgeries. Third partner required. Reply: Box FWV, Rikerservice, or 'phone 46 2626 or 65 2780 (Adel.).

WEST COAST. Practice avail., 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., Elliston, S.A. 5670.

QUEENSLAND

COUNTRY. Assistant with view to replace retiring partner in opposed country practice handy to Bris. All facilities avail. in city. G.C.T. exceed $50,000. Salary $200 p.w. Early equal share of partnership. Reply: Box FTE, Rikerservice.

FOURTH AUSTRALIAN GENERAL PRACTITIONERS' CONVENTION

BRISBANE, MAY 17-23, 1969

The theme of the Scientific Programme of Convention will be "THE CHANGING FACE OF GENERAL PRACTICE." The Convention will be staged at the University of Queensland. First class accommodation will be available. Registration fee for Convention for a member and his wife is $30.00.

Further details may be obtained by writing to the Secretary, Fourth Australian General Practitioners' Convention, P.O. Box 1498, Brisbane, Qld. 4001.

The Australian College of General Practitioners
N.S.W. FACULTY

"ETHICAL PROBLEMS"

Seminar: Sunday, 30th March, 1969.
Commencing: 9.15 a.m.

The Seminar deals with topics such as GOING INTO PRACTICE, PATIENT REFERRAL and the TERMINATION OF PREGNANCY.

COLLEGE HEADQUARTERS
43 LOWER FORT STREET, SYDNEY

Registration and Lunch—$4.00

To DR. M. V. AARONS
58 PITT STREET, MORTDALE 2223

PARTNERSHIPS & PRACTICES

POSITIONS AVAILABLE

BRISBANE. Old established 3-man practice requires assistant with view to full partnership after 6 months. Salary $160 p.w. plus petrol. Man with higher degree considered. Reply: Box FTH, Rikerservice, or 'phone 96 2141 (Bris.).

BRISBANE. Exc. opportunity for young doctor wanting g.p. as career. Assistant to 2-man family practice with view partnership in 6 months. Good salary and easy terms. Reply: Box FWT, Rikerservice.

LARGE CITY CLOSE TO BRIS. G.P. Assistant view partnership with 4-man Protestant group (2 G.P.'s, 2 specialists). Full hosp. facilities avail. Comfortable working conditions. Reply: Box FZF, Rikerservice.

WESTERN SUBURBS (BAYSIDE AREA). 4th partner required for busy established practice, pref. with anaes. exp. Good income assured. Exc. hosp. services avail. and roster system. Accommodation can be arranged. Starting 24th March, 1969. Reply: Box GDA, Rikerservice.

WESTERN Q'LD. Solo practice avail. No ingoing required. Gross income $20,000. Home, surgery all provided. Scope avail. to pursue specialist interests. For further enquiries write to: Box GDT, Rikerservice.

VICTORIA

MELBOURNE CITY. Half share, industrial lock-up city practice. Alternatively, suite to let with secretarial/reception facilities edge of redevelopment area inner Melb. Reply: Box FXX, Rikerservice.

S.E. SUBURBS (Melb.). Assistant with view, solo practitioner. Obstets. and anaes. advantage. Protestant. Furnished house avail. Reply: Box FTF, Rikerservice.

TO USE RIKERSERVICE

Closing date for RIKERSERVICE April issue is Friday, 14th March

Write your advertisement in the coupon on the back page, and mail it today! If you do not wish your name to appear, we can have your replies directed to a box number (simply tick the square in the coupon). All replies will then be forwarded to you (unopened) as soon as they are received.

POSITIONS AVAILABLE

GIPPSLAND COAST. An adventurous third partner is required for an expanding and unusual g.p. which serves some of the off-shore oil development. Any special interest can be catered for, but the applicant must be prepared to travel by helicopter or go into a decompression chamber. A high income and challenge is assured. Good hosp. facilities. Good climatic and recreational cond. Easy terms. Reply: Box FMA, Rikerservice.

GIPPSLAND GROUP requires fifth partner after short assistantship. Exc. premises and hosp. with teaching hosp. affiliation. Opportunity for any special interest. Adequate roster, leave and long service leave every 5 yrs. Reply: Box FTG, Rikerservice.

EASTERN SUBURBS (Melb.). Partnership in group of 5. Modern clinic. 2 yrs. hosp. exp. required. Large district hosp. facilities. Surgical or other special interest catered for. Reply: Box FSW, Rikerservice.

NORTHWEST VIC. — no ingoing, pleasant country practice, no opposition. G.C.T. $20,000. 35 mids, 10 bed hosp., new 4 bedroom brick house $10 p.w. Close to inland city with all specialist facilities. Reply: Box FTO, Rikerservice.

ASSISTANT with view required. Vic. city — 2 hospitals, all facilities. Reply: Box FRE, Rikerservice.

PROVINCIAL GROUP has a vacancy for assistant with view to equal partnership after 6 months trial period. Anaes. exp. an advantage. First class clinic with exc. hosp. and supporting services. Reply: giving full curriculum vitae to Box FXV, Rikerservice, or 'phone Morwell 42011.

MELB. AREA. Part time assistant required, for g.p. 6 mls. from G.P.O. Morning or afternoon sessions plus alternate Friday evenings and Sat. mornings. Reply: Box FXZ, Rikerservice.

SEMI-RURAL solo practice in Dandenongs requires assistant view partnership. Reply: Dr. W.H. Hardy, Mt. Evelyn, Vic. 3796 or 'phone Mt. Evelyn 393.

AUSTRALIAN CAPITAL TERRITORY

PARTNERSHIP REQUIRES 3rd MEMBER. Equal one third partnership to general practitioner after short assistantship in growing practice. Exp. in obstets. and paed. desirable. Reply: Box DGM, Rikerservice.

NEW SOUTH WALES

SYD. METROP. AREA. Half share. Very modern solo practice, gross in excess of $50,000, well equipped surgery. Pleasant area. Only well qualified man with g.p. versatility and solid financial backing will succeed. Reply: Box FZR, Rikerservice.

INNER WESTERN SUBURB (Syd.). Assistant required. Exc. working conditions. No weekend work. Reply: Box FRF, Rikerservice.

POSITIONS AVAILABLE

SYD. HILLS DISTRICT, Assistant with or without view to partnership. Anaes. exp. preferred. Exc. home avail. Salary depending on exp. Reply: Box GBG, Rikerservice.

OUTER WESTERN SUBURBS (Syd.). G.P. surgeon requires long term assistant with definite anaes. training and capabilities. Very attractive terms and conditions will apply, including no night or weekend work, and replies with full details are invited to Box FFG, Rikerservice.

COUNTRY. Third man required for 2-man unopposed country practice — grossing $100,000. Expanding. Prefer surgeon with post. grad. degree. Reply: Box FZX, Rikerservice.

WOLLONGONG. Assistant with view wanted as soon as practicable. Expanding area. Reply: Box FXH, Rikerservice.

NEWCASTLE. Assistant with view to partnership for 4-man group, situated around shores of Lake Macquarie. High schools and university in neighbourhood. Exc. income, ideal living conditions for family man interested in g.p. Reply: Box FXF, Rikerservice, or 'phone Newcastle 59 1235.

NORTHERN N.S.W. COASTAL PRACTICE. Exp. energetic g.p. with surgical ability required as assistant view partnership to form with principal the nucleus for a new medical centre. Modern air conditioned premises to be erected in the near future and completed by end of July, 1969. Reply: Box GDO, Rikerservice.

MEDICAL OFFICER, STUDENT HEALTH SERVICE. The Service is mainly diagnostic in the areas of physical and preventive medicine and is not intended to replace private and community health services where chronic or continuing conditions are diagnosed. Within these limits therapeutic medicine is practised. The Service is supported by the specialist facilities of the University's teaching hospitals and a well qualified counselling unit. The present staff consists of the Medical Director, a qualified nursing sister and secretary. Applicants must possess a degree registrable in the State of New South Wales and have extensive exp. in g.p. The upper age limit is preferably 50 yrs. Salary: $7,600 range $8,750 p.a. Commencing salary according to qualifications and experience. Further information may be obtained from Dr. M.A. Napthali, Director, Student Health Service. Applications should be lodged with the Appointments Office, P.O. Box 1, Kensington, N.S.W. 2033.

UNITED STATES

ANAESTHESIOLOGIST, University centre, exc. stipend, benefits. Fringe benefits. Teaching research. Age 40 and under. Lic. any state. Reply: Box GDK, Rikerservice.

FOR SALE

QUEENSLAND

BRISBANE G.P., busy northern suburb, established 23 yrs. $3,000 goodwill. Reply: Box FXP, Rikerservice, or 'phone 6 5417 or 67 3706 (Brisb.).

SOUTH AUSTRALIA

COUNTRY PRACTICE. Solo unopposed, 100 mls. north of Adel. Sea port, good beach. Exc. Gov. Hosp. Surgery for sale or rent. Exc. large family home. Reasonable goodwill. Reply: Box GDV, Rikerservice, or 'phone Wallaroo 232.

A.C.T.

CANBERRA CITY. Old established solo practice. Rented surgery complete with furniture and equipment. No obstets no surgery. Reply: Box FZC, Rikerservice or 'phone 4 2644 (Canb.).

VICTORIA

SOLO UNOPPOSED. Gross cash take $20,000 p.a. Could be increased by surgeon. Mids 45 p.a. Exc. hosp. facilities. Good arrangements for time off. Terms. Reply: Box FLC, Rikerservice.

MURRAY VALLEY. Half share unopposed practice netting over $26,000, in growing township, 3 hours by road from Melb. 22 Bed hosp. good facilities, 140 mids yearly. Remaining partner competent surgeon & Physician. Large attractive air-conditioned surgery, good high school, excellent sporting facilities. Reply: Dr. D. Tellesson, P.O. Box 109, COHUNA. VIC. or 'phone Cohuna 6 or 26.

PLEASANT PROVINCIAL CITY. Ophthalmic practice for sale in area with large district population. Exc. hosp. fully equipped for ophthalmic surgery. Reply: Box FXA, Rikerservice.

SOLO PRACTICE, COASTAL TOWN, with beautiful surroundings and delightful climate. Gross $24,000. Mids 60-70 and increasing. New district hosp. with well equipped and air conditioned theatre plus labour wards. Most emergency surgery and obstets. done here and therefore suit a keen young doctor who wishes to practise medicine in all its aspects. Co-op. opposition for time off. Very little out of hours or weekend work. Twice weekly air services to Melb. Terms by mutual arrangement. Reply: Box GDC, Rikerservice.

NEW SOUTH WALES

SOUTHERN SUBURB (SYD.). Solo practice in young expanding area. Urgent Sale. Reply: 'Phone 520 9612.

SOLO PRACTICE. Large modern surgery suite, centrally situated, 1½ hours from Syd. GCT $28,000 with further expansion inevitable. District Hosp. facilities for surgery, obstets, & anaesthetics. Suitable for one or more practitioners. Principal intends to specialise. Reply: Box FTL, Rikerservice.

RYDE (SYD.) AREA. Solo practice, G.T. $17,000. Established 21 yrs. Goodwill $5,000. Reply: Box FWO, Rikerservice.

PARTNERSHIPS & PRACTICES

FOR SALE

INNER SOUTHERN SUBURB (SYD.). Solo practice, ground floor position with dentist & chemist in same block. Established 14 yrs. No weekends or nights, 30 hrs/week. Rent $12 weekly. Spacious rooms. G.T.O. $10,000, good will and chattels $3,200. Reply: Box FXG, Rikerservice or 'Phone 660 6774 or 55 1408 a.h. (Syd.).

MONA VALE. Solo G.C.T. over $30,000 without surgery and obstets. For sale at $7,500 plus equipment at valuation. With the practice, detached from surgery unit, a four bedroom house with two toilets and showers, lounge, dining, kitchen, bath & kitchenette for sale at $21,000. Reply: Box FXL, Rikerservice.

FAIRFIELD DISTRICT (SYD.). Presently run only as a branch surgery in "Off Peak" hrs. GCT Approx. $7,500 with no mids or surgery. Room for considerable expansion. Equipment includes ECG. Bad Debts less than 2%. Walk in Walk out $1,500. Reply: Box FZB, Rikerservice.

UPPER NORTH SHORE SYDNEY. ½ share medical practice adjacent shopping centre and station. Reply: Box GBH, Rikerservice.

FAR NORTH COAST N.S.W. Solo general Practice. Beautiful area. Rapidly growing town 20 miles from nearest city with good medical facilities. Reply: Box FZK, Rikerservice.

DARLINGHURST AREA (Syd.). Solo practice recently established inner city area. Minimum goodwill and rental. Reply: Box GBX, Rikerservice.

SYD. SOLO PRACTICE for sale or 2 yr. lease, in rapidly expanding south eastern suburb (Syd.). 4 bedroom house with surgery attached. G.C.T. $18,000 p.a. House $18,500. Goodwill and equipment $5,500. Finance available. Reply: Box GDN, Rikerservice.

SESSIONAL ROOMS TO LET

NEW SOUTH WALES

CREMORNE. Consulting rooms avail. at new shopping centre. Suitable for specialist practice. Reply: 'Phone 43 1161 or 95 5098 a.h. (Syd.).

KINGSFORD (Syd.), at shopping centre. Avail. 2 afternoons. New building. A prestige suite comprising waiting room, toilet and shower recess, surgery with sliding glass doors, overlooking private garden and fountain. Tastefully furnished in accordance with interior decorators specifications. Reply: Box FKS, Rikerservice, or 'phone 663 2178 (Syd.).

MACQUARIE STREET (Syd.). Lease front room avail, or sessional rooms. Reply: Box FTC, Rikerservice, or 'phone 37 0436 (Syd.).

SESSIONAL ROOMS TO LET

BEST POSITION, BONDI JUNCTION (Syd.). Suite of 3 rooms in new building. Parking avail. Suit. Pathologist or specialist. Reply: 'phone 38 1230 (Syd.) mornings only.

DEE WHY (Syd.), air conditioned central rooms avail. on sessional basis for specialist use. Especially suitable for surgeon, physician, ENT, derm., anaes., or urologist. Reply: 'Phone 982 3333 (Syd.).

BONDI JUNCTION (Syd.). Sessions avail. afternoons. Suit orthopods, surgeons or physicians. Reply: Box FWP, Rikerservice.

LANE COVE SHOPPING CENTRE (Syd.). Sessions avail. Full secretarial services. Low rental. Buses from Chatswood, Mosman and city pass door. Suit path. orthal. or derm. Reply: Box FSZ, Rikerservice.

WANTED TO BUY

QUEENSLAND OR NEW SOUTH WALES

WIDELY EXP. DOCTOR with higher qual. seeks semi-retirement in warm climate. No night work. Reply: Box FTS, Rikerservice.

NEW SOUTH WALES

A GENERAL PRACTICE in Syd. area. Reply: Box FTZ, Rikerservice.

SYD. EASTERN SUBURBS. Doctor with cash wants to buy a small g.p. Share in group practice or part-time permanent assistantship could be considered. Reply: Box FZS, Rikerservice, or 'phone 36 1887 (Syd.).

WANTED TO LEASE

NEW SOUTH WALES

SYD. AREA. Solo practice by exp. g.p. recently arrived from England. Reply: Box FXC, Rikerservice.

LOWER NORTH SHORE (Syd.) Doctor's rooms, fully furnished and equipped alibi phone, completely self contained with garage, etc. Suitable branch surgery nucleus practice. Suit g.p. or specialist. Moderate rental. Reply: Box FTJ, Rikerservice, or 'phone Dr. Collins, 95 2847 (Syd.).

BEXLEY (Syd.). Lock up rooms in main street. Good position in densely populated area. Very suitable for g.p. To arrange inspection write to: Box FTD, Rikerservice.

DISIPAL...

DISIPAL is an anti-Parkinson drug that also has a mild psychotropic 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.

DOSAGE:

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

POSITIONS WANTED

TASMANIA

2nd YR. GRAD. avail. for 2 weeks April to May. Own car. Reply: Box FWB, Rikerservice.

TASMANIA OR VICTORIA

SEMI-RETIRED EXP. DR. with own car and bag open for engagements weekly or sessional in Vic. or Tas. Reply: 'Phone 783 8626 (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 FTB, Rikerservice or 'phone 439 7304 (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 81 4540 (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., 20 yrs. exp. requires long locum. Working hours 8.30 a.m. to 6.00 p.m. No weekends. $180 p.w. Reply: 'Phone The Entrance 72.

POSITIONS WANTED

NEW SOUTH WALES

WOMAN GRAD. (1962) exp. in g.p. avail. part time or sessional work and emergency day work. Own car and bag. Reply: 'Phone 89 0706 (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 FGF, Rikerservice.

CITY AND EASTERN SUBURBS (Syd.). 4th yr. grad. avail. for night and weekend locums. Considerable locum exp. Own car and bag. Reply: Box FZT, Rikerservice.

NORTH SHORE OR MANLY-WARRINGAH, 1965 grad. with 2 yrs. hosp. and 2 yrs. g.p. exp., seeks long or short term locums. No obstets. Own car and bag. Avail. now. Desperate for work. Reply: Box FSC, Rikerservice.

SYD. GRAD. (1961) M.R.A.C.P. requires locum during all or part of March to May inclusive. Own car and bag. Will require accommodation. Reply: Box FZL, Rikerservice.

POSITIONS WANTED

EASTERN SUBURBS (Syd.). Locum/assistantship wanted for all or part of March to June, any period of length or period of time considered. Full time or sessional. Married, 2 yrs. teaching hosp. grad. Living locally. Reply: 2/32 Cook Road, Centennial Park, N.S.W. 2021.

NORTH SHORE OR MANLY-WARRINGAH AREA (Syd.). Exp. g.p. own car and bag, avail. weekend and evening locums. Regular basis, alternatively, would consider part time assistantship. Reply: Box FZH, Rikerservice.

LIKE AN AFTERNOON OFF? Exp. locum 3rd yr. grad., avail. to do afternoon surgery and calls 1 afternon p.w. Prefer St. George area, but other area would do. Reply: Box FXK, Rikerservice, or 'phone 57 7964 (Syd.).

SYD. AREA, North side, East or near west and southern suburbs pref. Locum or assistant without view from April 1969 to Jan. 1970. Reply: Box FXJ, Rikerservice.

LOWER NORTH SHORE (Syd.). pref. Hosp. registrar with post. grad. degree, avail. for evening surgeries and weekend calls. Reply: Box GDB, Rikerservice.

POSITIONS AVAILABLE

QUEENSLAND

NORTH Q'LD. Locum orthopaedic surgeon required 3 to 4 months, July-Oct., 1969. Busy hosp. and private practice. Qualifications to comply with Q'ld. Specialist Register. Further details enquire: Box GBO, Rikerservice.

VICTORIA

WEEKEND LOCUM WANTED every 2nd or 3rd weekend, 6.00 p.m. Frid. or 8.30 a.m. Sat. to 10.00 p.m. Sunday. Live in essential. Suit post. grad. student. No mids or surgery unless desired. Salary by arrangement. Minimum term 6 months. Reply: Box FTA, Rikerservice.

POSITIONS AVAILABLE

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BURWOOD (Syd.). Locum wanted for 2 weeks from 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 solo g.p. from Monday 12th May to midday Sat. 17th May. No obstets. or surgery. $150. Reply: stating exp. and qual. References essential, to Box FXB, Rikerservice.

FAIRFIELD DIST. (Syd.). Regular weekend locum required for every third weekend for solo practice. From Sat. 2.00 p.m. till 11.00 p.m., and next day, Sun. from 9.15 a.m. to 10.00 p.m. Quiet weekends. Ideal for studying, relaxing. Salary $34 plus meals provided. Reply: 'Phone 72 2170 (Syd.).

RYDE AREA (Syd.). Part time locum wanted from 9.00 a.m. to 1.00 p.m. Mon. to Fri. To start at end of April for 5 months. Reply: Box FWN, Rikerservice.

CRONULLA (Syd.). Locum required for March-Oct. (approx.), 1969. Group practice. Good facilities and conditions. Reply: Box FJJ, Rikerservice or 'phone 523 6677 (Syd.).

MID WEST SUB. (Syd.). Locum required for solo practice, 8 mls. G.P.O. Syd. from 1st Aug. 1969 for 4 weeks. Live out. No night or weekend work. Reply: Box FTP, Rikerservice.

WESTERN 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 easily found in district. 2 week day afternoons off and only 1 weekend worked in 3. Hardly any night work. Minimum mids and if preferred no surgery at all. Reply: Box GBW, Rikerservice, or 'phone 72 2170 (Syd.).

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 Whyalla Hospital, South Australia, or 'phone Whyalla 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 ½—infants 1/10th.

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Reply to Dr. D. A. Brown or Dr. M. V. Aarons, Australian College of General Practitioners, 43 Lower Fort Street, Sydney, N.S.W. 2000.

PEN FRIENDS

GIRLS

(9½) — Katrina Duthie, Dundarg Deveron Road, Yurriff, Aberdeenshire, England.
(10) — Hope Plavin, 457 Pepper Ridge Road, Stamford, Connecticut 06905, U.S.A.
(11) — Lise Morin, 625 Glover Road, Lake Charles, La. 70601, U.S.A.
(12) — Patrice Morin, 625 Glover Road, Lake Charles, La. 70601, U.S.A.
(13) — Ann Wehrle, 2849 Forest Lane, Merced, Calif. 95340, U.S.A.
(14) — Laura Herrlin, 50 Pine Street, Garden City, N.Y. 11530, U.S.A.
(14) — Iselin Juland, Tasenveien 49, Oslo 8, Norway.
(14) — Anne Challoner, The Bay Hotel, Towyn, Merionethshire, North Wales, UK.
(15) — Tone Lystad, Tingstoveien 16, Bestum, Oslo 2, Norway.

GIRLS

(15) — Arnbild Clemens, 9700 Lakselv, Pinnak, Norway.
(15) — Liz Houghton, Cecil Lodge, Spa Road, Llandrindod Wells, Radnorshire, Wales, UK.
(16) — Jay Robb-Smith, Chaucers House, Woodstock, Oxford.

BOYS

(9) — Revindra Midha, Gorwydd Lodge, Gowerton, Swansea, Glam., Wales, UK.
(10) — Michael P. Horan, 58 Windsor Ave, Lurgan, Co. Armagh, N. Ireland.
(11) — Paul Midha, Gorwydd Lodge, Gowerton, Swansea, Glam., Wales, UK.
(18) — Roderick Davies, 'Boschetto' 20 Melfort Rd, Newport, Mon, S. Wales, U.K.
(18) — Luis Coutinho Ferreira de Vasconcelos, Santa Cristina do Couto, Santo Tirso, Portugal.

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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. Aarons, Australian College of General Practitioners, 43 Lower Fort Street, Sydney, N.S.W. 2000.

PEN FRIENDS

GIRLS

(9½) — Katrina Duthie, Dundarg Deveron Road, Yurriff, Aberdeenshire, England.
(10) — Hope Plavin, 457 Pepper Ridge Road, Stamford, Connecticut 06905, U.S.A.
(11) — Lise Morin, 625 Glover Road, Lake Charles, La. 70601, U.S.A.
(12) — Patrice Morin, 625 Glover Road, Lake Charles, La. 70601, U.S.A.
(13) — Ann Wehrle, 2849 Forest Lane, Merced, Calif. 95340, U.S.A.
(14) — Laura Herrlin, 50 Pine Street, Garden City, N.Y. 11530, U.S.A.
(14) — Iselin Juland, Tasenveien 49, Oslo 8, Norway.
(14) — Anne Challoner, The Bay Hotel, Towyn, Merionethshire, North Wales, UK.
(15) — Tone Lystad, Tingstoveien 16, Bestum, Oslo 2, Norway.

GIRLS

(15) — Arnbild Clemens, 9700 Lakselv, Pinnak, Norway.
(15) — Liz Houghton, Cecil Lodge, Spa Road, Llandrindod Wells, Radnorshire, Wales, UK.
(16) — Jay Robb-Smith, Chaucers House, Woodstock, Oxford.

BOYS

(9) — Revindra Midha, Gorwydd Lodge, Gowerton, Swansea, Glam., Wales, UK.
(10) — Michael P. Horan, 58 Windsor Ave, Lurgan, Co. Armagh, N. Ireland.
(11) — Paul Midha, Gorwydd Lodge, Gowerton, Swansea, Glam., Wales, UK.
(18) — Roderick Davies, 'Boschetto' 20 Melfort Rd, Newport, Mon, S. Wales, U.K.
(18) — Luis Coutinho Ferreira de Vasconcelos, Santa Cristina do Couto, Santo Tirso, Portugal.

FOR SALE

VICTORIA

COT, fly wire (meat-safe) with innerspring mattress. As new. Complete $18. Reply: 'phone 42 4494 (Melb.).

INSTRUMENTS. Extensive range of general and gynaecological surgical instruments, in excellent condition at reasonable prices. Reply: 'phone 63 1766 (Melb.), or inspect at 61 Collins Street, Melbourne, Vic.

1968 VE VALIANT SAFARI. V8 motor, automatic box. White duco, tan upholstery. 4,000 mls. on clock. Showroom condition throughout, mechanically perfect. Owner posted unexpectedly overseas. Vehicle now in storage in Melb. Price $2,800 o.n.o. Reply: Dr. A. J. Ridings, 7 Jalan Ahmad Bin Kasa, Hillside, Penang, Malaysia.

ELIZA MICROSCOPE, with light. Perfect condition. Eyepieces x 5 x 10 x 15. Objectives x 4 x 10 x 40 x 100 (oil immersion). Price $75. Reply: 'phone 842 3660 (Melb.).

MICROSCOPE, Carl Zeiss. Movable stage. Oil immersion lens. Reply: 13 Walbundry Avenue, North Balwyn, Victoria 3104, or 'phone 85 1437 (Melb.).

3 EXAMINATION COUCHES, E.C.G. (Both), U.V. (Mercury) Ray-lamp (table-model), scales, 2 office desks, and a varied selection of medical and surgical instruments for g.p. Reply: 'phone 94 2828 (Melb.).

LANCIA AURELIA V6 Gran Turismo 2500 coupe. Body by pininfarina. Superb condition. Excellent performance $2,000. Also Aurelia Saloon. Good condition $975. Reply: 397 Punt Road, Richmond, Victoria 3121, or 'phone 42 8079 (Melb.).

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2-WAY RADIO, base and one mobile set. Good working order, suitable country area. 60 kc band width frequency 80,43 megs. Reply: Dr. W. Sewell, Main Street, Mornington, Victoria 3931, or 'phone Mornington 52146.

NEW SOUTH WALES

NEW AKAI XIV RECORDER with 1 pair of 10 ins. Akai speakers for sale. Reply: 'phone 40 1014 (Syd.).

ANAESTHETIC MACHINE. Portable airmed TFX head, all circuits possible with fluothane vaporisor complete. Carrying case and many extras. Owner has given up specialty. Reply: B. S. Zilliacus, North Ryde Psychiatric Centre, North Ryde, N.S.W. 2113, or 'phone 88 0281 (Syd.).

OPERATING MICROSCOPE. Beck Binocular on heavy mobile counter-balanced floor stand. Perfect condition $200. Reply: 'Occupier', 38 Olola Avenue, Vaucluse, N.S.W. 2030, or 'phone 37 1197 or 28 9840 (Syd.).

SURGERY COUCH, etc. Reply: 'phone 90 2809 after 5.00 p.m. — if unanswered 43 4972, after 5.00 p.m. (Syd.).

1 KROMEYER LAMP $100. 1 galvanic unit $75. 2 infrared lamps $15 each. 1 ultra violet therapy lamp $60. 1 full length exercise mirror $10 or near offers. Reply: Box FWA, Rikerservice, or 'phone 27 2865 (Syd.).

MARK 7 BIRD RESPIRATOR, excellent condition. $300 or near offer. Reply: Box FTM, Rikerservice.

CABIN TRUNKS—3 metal fitted with padlocks and keys. Syd. area. Reply: Box FWK, Rikerservice.

CARDIOTRACE ink mark E.C.G. unit in good condition $150. Reply: Dr. Niedzinski, 'phone 36 5933 (Syd.), evenings.

BRAND NEW EXAMINATION COUCH, with matching stool — sliding cupboards underneath and drawer, teak finish. Price $72. Reply: 'phone 72 6200 (Syd.).

MICROSCOPE, monocular (German) complete with 5 x 10 x 40 x 100 x objectives 8 x 15 x eyepieces. Mechanical stage. In case and in very good order. Reply: Dr. Niedzinski, 'phone 36 5933 (Syd.) evenings.

PAKO RAPID DRYER suitable for rapid drying of X-ray films. This unit is in perfect order and is only offered because it has been replaced by automatic processor. Reply: 'phone 41 3173 (Syd.).

MICROSCOPE. Olympus, monocular, 4 objectives inc. oil immersion, mechanical stage, $95. Reply: 'phone 28 1807 (Syd.).

THIRD AUSTRALIAN CLINICAL TUBERCULOSIS CONFERENCE

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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 Abrahams, M.D., M.R.C.P.
Director of Tuberculosis
Department of Health
63-79 George Street
BRISBANE, Queensland 4000
OR
Dr. Gwyn Howells, M.D., M.R.C.P.
Director of Tuberculosis
Department of Health
CANBERRA, A.C.T. 2600

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MAH-JONGG. Complete set wanted for children. Reasonable price. Reply: Box FXD, Rikerservice, or 'phone 7 4433 (Adel.).

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JAGUAR SP. 100. Any Marque sports car. Please indicate price and condition. Also for sale or part exchange. Almost finished Turner Sports car. B.M.C. 'A' stage II tune. Reply: Box FZG, Rikerservice, or 'phone 32 8348 (Maitland).

ITALIAN. Linguaphone. Cheap. Reply: Box FWC, Rikerservice, or 'phone 660 2772 (Syd.).

'TIP' FOR GREENHEART. Blackfish rod. Reply: Dr. Matheson, 33 Wakeford Rd., Strathfield, N.S.W. 2135, or 'phone 642 3787 (Syd.).

NOVEL 'PAPA MARTEL'. By Robichaud Gerard. In reasonable condition. Reply: Dr. Matheson, 33 Wakeford Rd., Strathfield, N.S.W. 2135, or 'phone 642 3787 (Syd.).

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SOUTH AUSTRALIA

YACHT, 25 ft. LOA, dragon sails, simplex marine engine, recent refit, lying at R.S.A.Y.S. Sell $2,000 o.n.o. Reply: Dr. Alan Cotton, 14 Baliol Street, College Park, South Australia 5069, or 'phone 63 2136 (Adel.).

VICTORIA

CABIN CRUISER. Hartley design, 20 ft. flying bridge, stern drive, hydraulic trim tabs. Sleeps 4, electric bilge pump. Electric toilet pump. Gas stove, gas and electric lighting. Tandem trailer with brakes. Max. speed 27. Cruise 20. Materials $4,700, labour 1200 hrs. Finished 3 months. Price vicinity $4,500. Reply: Dr. McIlroy, Orbost, Vic. 3888, or 'phone Orbost 295.

UPRIGHT PIANO, German. Excellent condition and tone. Price $200. Reply: Dr. M. Milecki, 707 Barkly Street, West Footscray, Vic. 3012, or 'phone 68 5028, 9.00 a.m.-6.30 p.m. (Melb.).

OIL PAINTING. Cliff Pugh original. Small still life (mushrooms), 1954. $250. Also Aylward painting of aboriginal girl about 3'-4' $150. Reply: Box GBD, Rikerservice, or 'phone 52 2507 (Melb.).

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H.M.V. RECORD PLAYER with few classical records. Both machine and records completely new (stereo machine). Cost $80, will accept $50. Reply: Box GBV, Rikerservice.

YACHT, Payne design, 35' x 8' 6" x 6'. Raised deck cutter with dog house. 5 h.p. Simplex. Gas stove. Blake toilet. 4 berths. Synthetic and canvas sails. Cover and sun awning. Sister ship to Hobart winner. $6,000. Reply: Box FXM, Rikerservice.

FOR SALE

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HEAD SAIL — 115 sq. ft. Suit "vivacity" or similar yacht. $45 o.n.o. Reply: 'phone 43 1767 (day) or 95 3689 (home) (Syd.).

ANY STATE

FIRST PAPUAN PAINTER, still living, but incurably ill, his life work — 43 Aquarell paintings on approx. 1 sq. ft. each — native frames, film protection. Painted in usual landscapes, ceremonial objects, sacred patterns, also copying some Medieval Missionary Bible (Spanish?), no perspective. For sale for $1,000. As landmark in Papuan culture will raise enormously in few years. Good investment if you can spare wall big enough to accommodate treasure. Reply: Box GDE, Rikerservice.

LAND

FOR SALE

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PINE PLANTATION. Forty six acres Thorpdale area. 9 roomed house, S.E.C. Phone. Dams & access roads, orchard, grazing for ponies. Half share or whole for sale. Reply: Box FWD, Rikerservice.

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BEST COASTAL VIEW IN AUSTRALIA. High over Kilcare Beach. Impossible to be built out. Kerbed, guttered, tarmac road. Obliged to sell reluctantly because of commitment elsewhere, 50 ft. frontage to Manly View Road, and not another block avail. in this street. Reply: Box FZO, Rikerservice, or 'phone 2 2328 (Penrith).

AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Western Australia Faculty

Continuing Advanced Training Courses, Fremantle Hospital, Tuesdays, 8 p.m. Princess Margaret Hospital, Wednesdays, 7.30 p.m. Swan District Hospital, Thursdays, 8 p.m.

These weekly courses will continue indefinitely. Enrolments to replace members unable to attend regularly are invited. Further details from the Secretary, Australian College of General Practitioners, 8 King's Park Road, West Perth, W.A. 6005.

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HOUSE AVAIL. return G.P. duties Wed. from 1.00 p.m. Sat. 9.00 a.m. to 12 noon. Suit married woman grad. Reply: Dr. Roxburgh 76 6785 (Syd.).

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ADELAIDE SUBURB. Large, well-furnished house to let. 6-12 months. Lessee. Can have practice. Free. Semi-retired. Reply: Box FZA, Rikerservice, or 'phone 65 6819.

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BROADBEACH. A 2 bedroom home unit overlooking water, fully furnished manilla cane furniture, television, washing machine, cutlery etc. Delightfully comfortable $35 weekly. Reply: Box FXR, Rikerservice, or 'phone 6 5417 or 67 3706 (Bris.).

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MANLY. Opposite ocean beach, mod. upstairs, furn. flat, 1 bedroom, large lounge, w.w. carpets, tiled shower, mod. kitchen, laundry, b.i.r., h.w.s. lease 1 year, $21 p.w. Reply: Box FSX, Rikerservice.

EASTERN SUBURBS. Furnished house for 6 months from May 1969. Two bedrooms, separate lounge/dining/sunrooms. Nice garden with panoramic ocean views. Reply: Box GBC, Rikerservice.

BELLEVUE HILL (Syd.). Doctor's residence, fully furnished, harbour view. Large sitting room, 2 bedrooms, study, dining room, etc. 7 months from mid March 1969. 2-3 adults. Rent by arrangement. Reply: Box GBP, Rikerservice.

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BROADBEACH. Lovely 2 bedroom brick home unit set in spacious grounds overlooking water. Unit is completely and artistically furnished. $9,500. Reply: Box FXO, Rikerservice, or 'phone 6 5417 or 67 3705 (Bris.).

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NEW SOUTH WALES

ST. GEORGE DISTRICT (Syd.). 2 storey brick home suitable as doctor's surgery and residence, near busy shopping centre in well populated suburb without resident g.p. For private sale. Best offer. Reply: Box GBT, Rikerservice or 'phone 54 1115 (Syd.) after 6.00 p.m. or weekends.

S.W. SUBURBS (Syd.). Doctor's residence for sale — brick and tile. New building, with private surgery room and laboratory. Largest and busiest street of suburb. Very good professional potential. Modern adaptation and swimming pool. Doctor going overseas. No goodwill. Price walk in walk out $23,000. Good opportunity for doctor moving city. Reply: Box GDF, Rikerservice, or 'phone 661 1920 (Syd.).

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YOUNG MARRIED COUPLE. Reg. Royal Adelaide Hospt. seek house or flat. Pref. partly furnished in Adelaide from April. Reply: Dr. R. F. Henderson, 32 Kent Road, Rose Bay, Syd. Or 'phone 37 6389 (Syd.).

VICTORIA

KEW (VICTORIA) AREA. A two bedroomed furnished flat or house for rent for one year. Reply: P. Harrisson, Flat 45, No. 6 Williams Rd., Windsor, Victoria or 'phone 669 2641.

PARKVILLE AREA. Doctor and engineer husband require 2-3 bedroom house minimum 6 months from March. No children or pets. Reply: Box GBE, Rikerservice.

MELBOURNE. Young doctor & wife require a two bedroom flat or small house in vicinity South Yarra, Toorak or Caulfield. For 12 months from March 69. Rental to $25 p.w. Reply: Box FWX, Rikerservice, or 'phone 49 4666.

TOORAK. Free one bedroom flat, Toorak. Modern, suit registrar in return for some light after hrs. work for group. Reply: Box FXE, Rikerservice.

NEW SOUTH WALES

STRATHFIELD AREA. By doctor & family. 3 bedroom house, lounge, separate dining with or without family/sunroom. Reply: Box FWJ, Rikerservice.

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NEWPORT (Syd.). Holiday resort 4 bedroom home for sale $19,500. On transport. Handy to schools, beach and hotel. Reply: Box GBA, Rikerservice, or 'phone 99 1822 (Syd.).

HOLIDAY HOME, ULLADULLA. 2 storey 12 square modern aluminium minimum maintenance home with 30 ml. ocean view. All conveniences. Price $12,000. Reply: Dr. K. M. Doust, 33 Foley's Road, Gwynneville, N.S.W. 2500, or 'phone Wollongong 2 4064.

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GOLD COAST. Superb position. Magnificent outlook on beach. Ideal facilities. Mention unit 15, Park Towers, Goodwin Terrace, Burleigh Heads.

BROADBEACH. 3 bedroom fully furnished (ex linen), 11 square, first floor unit right on beach front with extensive views. Avail. for rent including Easter. Reply: Box GDP, Rikerservice.

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GIPPSLAND LAKES. Ideal yachting & fishing. Mod. well-equipped house, takes 8, large lounge & sheltered sundeck with fine views of Lake King & Bancroft Bay. Oil fire, elec. h.w.s. and large frig., mains water, indoor toilet. Near hotel, stores & public jetty. Till end of April $75 p.w. after that $55. Reply: Dr. R. A. Cameron, Metung, Vic. 3904 or 'phone 333.

NEW SOUTH WALES

SUSSEX INLET. Modern waterfront cottages. Indoor septics and carports. Accomodate 2-8 persons. Peaceful and relaxing area. Reply: Dr. M. H. Waters, 'phone S.I. 77.

SNOWY MOUNTAINS. Old Adaminaby in the heart of the trout fishing country. Well appointed family holiday cottage. 3 bedrooms, large living room with panoramic lake and mountain views. All elec. kitchen, hot water serv. and septic tank. Everything supplied, but linen. 5 minutes walk from hire boats. $75 p.w. Reply: Box FGW, Rikerservice, or' phone 428 1418 (Syd.).

MONA VALE (Syd.). Surf front cottage. Sleeps 6, large outdoor entertaining area. Avail. from Feb. Long or short term. Reply: Peter James, 'phone 99 4241 (Syd.).

INTERNATIONAL

DENMARK

WANTED — "Deep Sea Racing" by C.F. Mason in English. Publishers sold out. Reply Knud Erik Srensen, M.D., Vesteraa 23, 9000 Aalborg, Denmark.

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STAMPS — send me 40 from your country and I will send 40 from mine. Daire Robins, 52 Parkmore Drive, Terenure, Dublin, Ireland.

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STAMPS — Please send 50 used stamps and I will send 50 British and Irish in exchange. Mrs J. O'Donoghue, 1 Reddish Ave, Whaley Bridge, via Stockport, Cheshire, SK12 7DP, England.

UNITED STATES

FOR SALE — Medical Clinics of North America, complete May 1955 to January 1967; Annals of Internal Medicine, complete 1957; Wintrobes Clinical Hematology; Year Book Medicine, 1956-57, 57-58, 58-59; Samson Wright's Applied Physiology, 1952. Best Offer — Reply Box GDJ Rikerservice.

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WANTED — Various medals, ribbons, decorative awards, copies or originals and sources of information. Reply Box GDS Rikerservice.

COINS — Must sell part of coin collection. Cents thru half dollars, Mint errors, sets and rolls, many bargains — send S/A envelope for list to Stanley Gittelson, M.D. 1445 Merrick Avenue, North Merrick, N.Y. 11566.

WANTED — Old brass microscope and other old medical equipment, skeleton, skull regardless of condition. Send description and price. Also will buy or trade Colonial Currency or Broken Bank Notes. Stuart Danoff, M.D., 1867 Summer Street, Stamford, Conn. 06905.

BALLENTYNE, J.W. Want books by this turn of the century Scottish Perinatal Pathologist. Send title, condition and price. M.G. Freeman, M.D., 69 Butler St, S.E., Atlanta, Ga. 30303.

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 20.5.69	Registration and Introduction	Basic Principles	Private Entertainment
Wednesday 21.5.69	The application of nuclear medicine to organ pathology		
Thursday 22.5.69	The production and availablity of radio nuclides	Combined meeting of nuclear medicine seminar and Haematological Society	Combined dinner

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
Hon. Sec. State Committee
Cytology Laboratories
The Queen Elizabeth Hospital
WOODVILLE, S.A. 5011

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COT, fly wire (meat-safe) with innerspring mattress. As new. Complete $18. Reply: 'phone 42 4494 (Melb.).

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For further details reply to:

Dr. Ellis Abrahams, M.D., M.R.C.P.
Director of Tuberculosis
Department of Health
63-79 George Street
BRISBANE, Queensland 4000
OR
Dr. Gwyn Howells, M.D., M.R.C.P.
Director of Tuberculosis
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CANBERRA, A.C.T. 2600

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BOOKS. Buchanans Manual of Anatomy 1st edition 1919. Adel. Med. Stud. Soc. Review, 1920 and 1921. Education Gazette South Aust. Vol. 38, 1922. Report Aust. Assoc. Adv. Science, Perth meeting 1926. Please state price. Reply: Dr. B. Christophers, 366 Church Road, Richmond, Vic. 3121, or 'phone 42 1269 (Melb.).

U.F.O. REPORTS for survey. Include all relevant details. Reply: Dr. P. Zeck, 254 St. Georges Terrace, Perth, Western Australia 6000, or 'phone 21 5413 (Perth).

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Appendix II
MAR 1969

A DOCTOR'S BUSINESS REVIEW

VOL. 7, No. 2 MARCH, 1969

A Service Newsletter to the Medical Profession From NICHOLAS PTY. LTD.

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"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's 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 nearly 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 — 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.

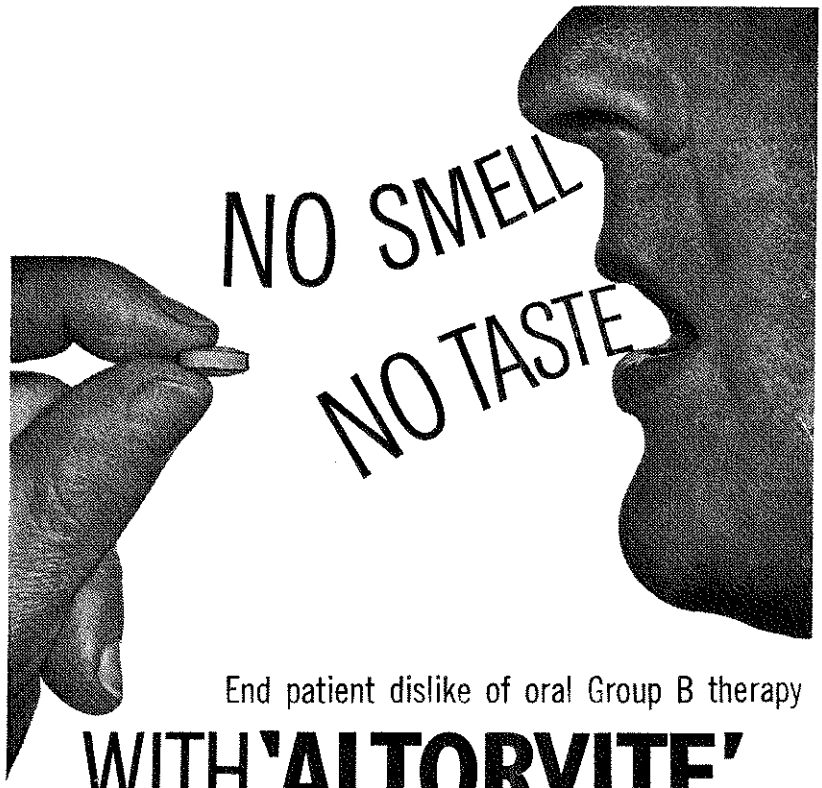
Section 50 in particular states in effect that where a deduction or part of a deduction relates directly to a class of income that deduction shall be made first against that class of income, and if the deduction is not fully absorbed against that class, it shall be made successively against the other 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 outgoings of capital, or are incurred in relation to the gaining or production of exempt income."

From this it is clear that for a deduction to be allowable the loss or outgoing must be incurred in gaining or producing assessable income, or necessarily 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 expenses to be taken into account in assessing motor



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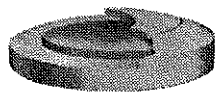
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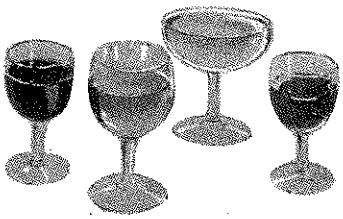
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Wine for Health Part 1

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 misproportion 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 cure 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 incipient 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 in to, 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 Lolli, 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 Lolli has still to discover.

(Continued May issue)