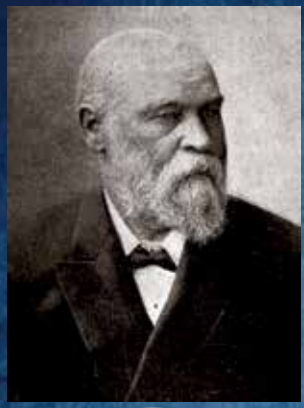
Rx Medical Philanthropy p.r.n.

[as the need arises]

The Victorian Medical Benevolent Association 1865–2011

Emma Russell & Vicky Ryan



For 145 years the 'Medical Benevolent' has helped hundreds of distressed practitioners and their families. However, recipients have been a small percentage of the profession - with 812 registered doctors in 1892, and 22,000 in 2010, there has rarely been more than three dozen beneficiaries at any given time, often far fewer. How can something endure for so long when there appears to be so little need for it?

This book searches for the answer by considering the characteristics of charitable giving; concerns and issues raised by practitioners in the medical press; cases that came before the committee; and the Association's attitudes towards these doctors and their families.

Ultimately, benevolence for doctors by doctors matters to the medical community. The best explanation for the longevity of the Victorian Medical Benevolent Association is that doctors are a community unto their own and empathy is best found amongst colleagues.

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Publication information

Editor: Katherine Steward, Writers in Residence
Designer: Jenn Falconer, Onto Printed Pages
Printer: Ellikon Certified Green Printing, Melbourne

ISBN 978-0-646-56075-5

Front cover image: Dr Smith, Surgeon, Geelong. *Courtesy of Pictures Collection, State Library of Victoria*

Front flap images: Top – William Henry Cutts (1828-1897) from In Memorium, printed memorial, 1897. *Courtesy of Rare Books, State Library of Victoria*
Middle – Dr Godfrey Howitt, 1872. *Courtesy of Pictures Collection, State Library of Victoria.*
Lower – Dr Lawrence Martin, *Courtesy of Monash University Library Rare Books Collection*

Back cover images: While homeopathy was intensely disliked by many doctors it was widely accepted and practiced by the general public, with many households stocking medicines and books such as *The Homeopathic Guide for Family Use* c. 1857. This domestic homeopathic kit was distributed by Bell and Huntley, a homeopathic pharmacy in George St, Sydney.
Courtesy of Monash University Library Rare Books Collection

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Acknowledgements

We would like to thank the members of the Steering Committee responsible for this book for their advice and guidance. These people are Dominic Barbaro, Sandra Hacker, George Santoro and George Tippett.

They also consented to be interviewed, which gave us a much better understanding of the philosophy of philanthropy and insight into the changes that have taken place within the Association and amongst the medical profession over the last several decades. Jo Grant and Chris Roff were also interviewed and provided the 'non-medico's' compassionate and thoughtful insight into the more recent history of the Association. Paul Woodhouse provided his input by answering our questions in writing when arranging an interview time proved too difficult. We would like to thank these people for their time and consideration.

Many others who are not associated with the Victorian Medical Benevolent Association were very helpful.

We would like to thank AMA staff Jane Stephens and Judith Clark for providing access to the VMBA archives. Richard Overell, Librarian and Stephen Herrin, Assistant Librarian at the Rare Books collection, Monash University provided considerable assistance with research and with gathering the images sourced from their collection. Additional images and information were provided by Susie Shears, Curator, Medical History Museum at the Brownless Library, Melbourne University; Elizabeth Milford, Royal College of Surgeons archive; Robyn Waymouth, Royal Women's Hospital Archives; Stephen Due, Editor of the Australian Medical Pioneers Index; and the staff at the State Library of Victoria. Image identification and credits are listed with each caption.

We would also like to thank Katherine Steward, editor, Max McMaster, indexer, and Jenn Falconer, designer, for their valuable and professional assistance in bringing this manuscript to publication stage.

It has been a pleasure to work with members of the medical profession who have a strong sense of the importance of their history to the way they operate today. A strong vein of collegial compassion runs deep amongst medical colleagues and we hope that this book inspires readers to keep it flowing freely.

Emma Russell & Vicky Ryan
History@Work

Foreword

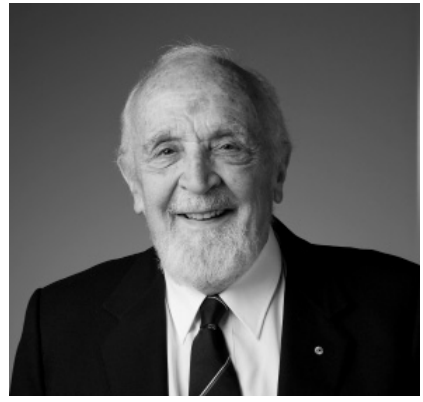
Dr George Tippett, AM FAMA KStJ

For ten years it was an honour and a challenge to use a lifetime of experience in the field of medical practice to help one's colleagues with their misfortunes.

Socioeconomic changes, and the political rigour of government and the Medical Board of Australia, caused many new stresses. I was fortunate to enlist the assistance of Group Captain Chris Roff who was my guide when I was President of the Victorian branch of the Royal Flying Service and he was CEO.

Chris's contribution to VMBA's fiscal management, and negotiations with stock brokers and financial advisers enabled us to maximise the opportunities of the economic boom, increase our core assets dramatically and even eliminate our need to pay tax on investments. I was sorry when the time came for us both to move on.

Management became more difficult as a result of having council members mentor specific cases for ethical reasons and the conflict of clinical opinion and the laws of privacy. At the same time, there was a need for increasing the range of skills, including computer and communication competence, to maintain reliability and transparency. Life is not without its problems even with the best of ideals.



The philosophy of philanthropy is to balance the aims of the benefactors and the needs of the beneficiaries, without stimulating learned dependency and neglecting other sources. It was not just financial need, but often special medical and legal considerations that had to be processed. Fortunately our social worker had a wide range of human skills and a lifetime of experience with the human state and its frailties and a compassion for life's misfortunes.

My councillors were very supportive and a joy to work with, ever ready with sage counsel and wisely observant of the changing times and the need to adjust responses when necessary. As with all philanthropy there must always be the opportunity for spiritual growth of the philanthropist.

Dr Dominic Barbaro AM, President, VMBA

I am delighted to have been asked to contribute to this Foreword following on the appraisal of events over the past ten years by former President, Dr George Tippett. We, and the Association, have also benefitted from the previous President's, Dr George Santoro, contribution as outlined in the Association's first edition of its history Caring for the Carers (1865-1999).

Having served the Association since 1998 I have been able to consider the myriad needs of our fellow colleagues in times of crisis, as well as the demographic evolution in the composition of our beneficiaries – increased females, part-time workers and foreign graduates.

Notably the Association has helped colleagues afflicted with personal and family problems, accidents, financial difficulties and generally stressful situations such as dealing with the Medical Board and Victorian Doctors Health Program, particularly in matters of substance abuse and psychiatric problems. The Association is pleased to have considered measures leading to prevention and early intervention of stressful situations amongst our colleagues by giving support to the Doctors Peer Support Telephone Service established by AMA – Vic.

I consider it an honour to have been entrusted with the leadership of the Association by the Committee in 2009 and I pledge to continue and expand on the services needed within our medical fraternity. These include the challenges brought about by the ever changing composition of the medical workforce, and the introduction of National Registration in July 2010.

I am fortunate to have the support of a dedicated Committee and staff in conducting the work of the VMBA, including management of its funds and collaboration with other organizations. AMA - Vic has been particularly supportive of all our endeavours. Our specific collaboration and work with the Victorian Doctors Health Program deserves a special mention.

Our rewards are the many letters of thanks from the people we endeavour to help and the knowledge that our assistance has in some way contributed to their wellbeing, their diminished suffering and, in some cases, their aspired rehabilitation back into the medical workforce. The medical profession can be very proud to have such a worthy organization to assist its members in need!

Dr Harry Hemley, AMA Victoria President

The publication of a revised history of the Victorian Medical Benevolent Association provides the perfect opportunity to reflect on the Association's past achievements and the challenges that lie ahead.

Impressive though it is, the greatest achievement of the VMBA is not having survived for 146 years. Rather, it is the many acts of charity provided to doctors and their families over that time. The legacy of the VMBA will not be grand monuments or artefacts but instead can be found in the lasting effect of many individual acts of support and compassion.

For an organisation such as the VMBA whose work is necessarily discreet and isolated, history is particularly important. It allows us to review the good deeds of the VMBA and be reminded of those whose efforts and generosity made them possible.

Medicine is a profession rich in history — today's medical profession is built upon the lessons learned by our predecessors. The greatest diagnostic tool a doctor has is his or her patient's history. So too can the VMBA of today learn lessons from its past.

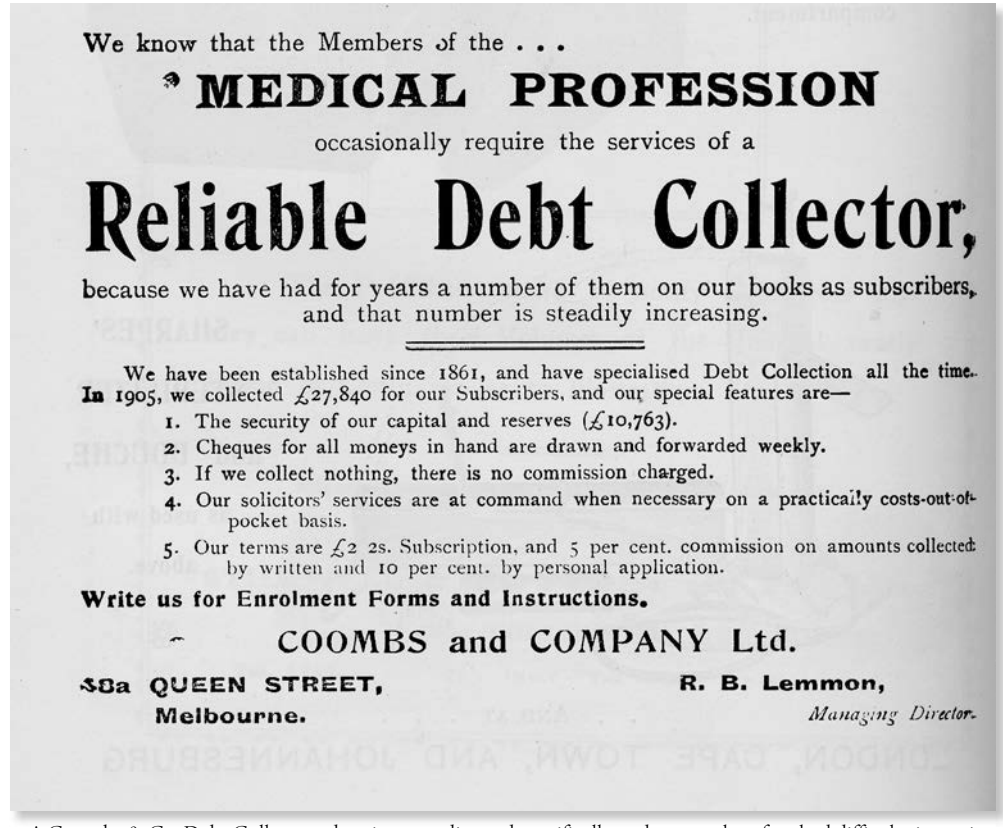
Refusing charity to doctors who fell afoul of the law or were victims of addiction, as the VMBA once did, seems harsh by contemporary standards. The VMBA must endeavour to not only remain relevant to a rapidly changing

profession, but also to assist those in our ranks who society is unwilling or unable to help.

The medical profession and inturn the VMBA will face new challenges moving into the 21st Century. As society becomes more litigious and Governments more aggressively regulate our profession, an increasing number of doctors may find themselves in difficult circumstances. Additionally, the profession is becoming increasingly diverse — both demographically and vocationally. These present new reasons why doctors may be in need of the helping hand that the VMBA has historically been so willing to extend.

The VMBA's history portrays the profession at its best and at its worst. It involves members of our profession who have faced difficulties — both personal and professional. But throughout its 146 year existence the VMBA also presents doctors at their best, selflessly giving up their time and resources to help their peers.

On behalf of AMA Victoria I would like to thank the current and former committees of the VMBA, the Presidents who have lead this association, and in particular all of those who have donated their time and resources over the past 146 years.



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A Coombs & Co. Debt Collector advertisement directed specifically to doctors who often had difficulty in getting paid for their services. Published in 1908 it explains that the company has had members of the medical profession as subscribers for many years and that their number is rising. *Courtesy of Monash University Library Rare Books Collection*

Introduction

'aiding necessitous persons'

Relieving Victorian doctors 'under severe and urgent distress occasioned by sickness, accident or any other calamity'[1] was the reason for the establishment of the Victorian Medical Benevolent Association in 1865. This philanthropic organisation still exists today, nearly 150 years later, and its purpose hasn't changed in all that time. It was dependent on subscriptions and donations at first, although these were unreliable and not easily come by. This was despite the Association making itself available to every registered medical practitioner in the state regardless of whether they contributed or not, which is still the case today. There has been only one minor and one major donation of funds, the latter coming more than one hundred years into VMBA's history and enabling it to feel comfortable for the first time about its long-term future and ability to support doctors in distress.

A few years after founding they were able to establish a permanent fund for investments. The returns on these were directed towards the widows and children of doctors who had died 'untimely' and left inadequate savings or assets to cover the living expenses of their wives and the educational expenses of their children. The only requirement was that a doctor had subscribed to the Association for three years. The VMBA was, in effect, an insurance policy for any Victorian doctor and his family. This remains the case today, although the permanent fund is no longer set aside only for widows and children, and doctors are no longer required to subscribe for three years to benefit from the permanent fund.

Throughout its history there have been fewer than one hundred people serving on the committee, all of them established and often leading medical professionals. These

people have been responsible for the management of the Association and of its funds, and for tackling the myriad moral and ethical dilemmas that come with charitable decision making. A member of the committee has invariably visited applicants for relief in their homes in order to understand fully their circumstances and the reasons for their distress. In the last fifty years or so this work has been increasingly aided, and more recently taken over, by a professional social worker employed by the Association.

The VMBA's administrative records and history of recipients reveal a constant demand for, and provision of, financial relief. This has been given in the form of one-off grants and loans for emergency assistance, and regular payments to assist with school fees, rents, bills, health insurance payments, medical registration fees and other essentials. Although the Association was only formed to provide financial relief, its committee has always been free with advice or referrals when financial assistance was not deemed necessary. Such assistance has also been more common in recent years under the guidance of a professional social worker and since beneficiaries have been faced with increasingly complex circumstances and problems.

The VMBA was formed at a time when the medical profession in Victoria was still struggling to establish itself. Doctors were confronted by many issues in the towns and rural districts of nineteenth-century Victoria: isolation, remuneration, collegiality, training and registration. As part of what was a very difficult world, many of them had their own personal struggles in establishing a viable livelihood. The profession has been well established in Victoria for more than a century now, but the numbers of doctors whose professional expertise does not extend to the world of business or financial management is no more or less than in the general community. And those issues facing the profession 150 years ago remain, even if cast in a different light. The ability of doctors to self-medicate, combined with their detailed knowledge of drugs and ability to access them, has helped create problems of substance abuse. Narcotic addiction has always been present within the medical fraternity but in recent decades illicit substance abuse amongst a younger cohort of professionals, with the complex and varied difficulties

associated with such a state, has become more common. Alcoholism, of course, is another disabling factor that has appeared in the case books since the very early years.

Over the previous 145 years the 'Medical Benevolent', as it is fondly called, has helped many hundreds of distressed practitioners and their families, while the number of refusals over the years has been negligible. However, the recipients are still a very small percentage of the Victorian medical population – there were 812 registered doctors in 1892, and 22,000 in 2010, and there have never been more than three or four dozen recipients at any given time, often far fewer. How can something endure for so long when there appears to be so little need for it? This question is considered by chronologically discussing some of the professional concerns and issues raised by practitioners in the medical press, surveying the cases that have come before the committee and studying the attitudes and concerns of the Association towards these doctors and their families. As Australian doctors adjust to a system of national registration imposed in mid-2010, the histories of medical benevolent organisations across Australia are being considered and the question asked: 'Is it time for medical benevolence to become a nationwide endeavour and, if so, how can this best be achieved?' Benevolence for doctors by doctors cannot be fully understood and appreciated without some knowledge of the characteristics and politics of charitable giving, discussed in the next chapter. Ultimately, however, the best explanation for the longevity and endurance of the Victorian Medical Benevolent Association is that doctors are a community unto their own and the empathy required to deal with their particular problems is best found amongst their colleagues.

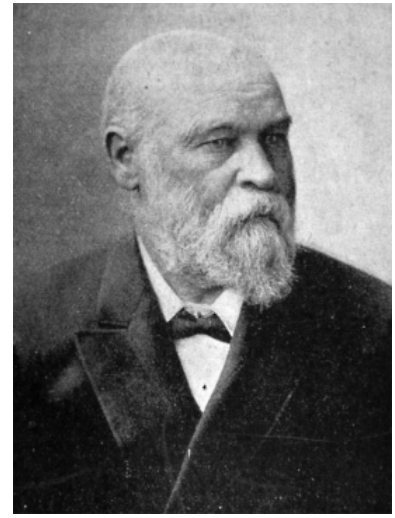
Puddling for gold in Sandhurst (Bendigo) c. 1861. Life on the goldfields was extremely harsh, especially as not all hopefuls were lucky. Many of the medical men quickly returned to medicine after their experience on the goldfields. *Courtesy of Pictures Collection, State Library of Victoria*

Chapter one

The politics of benevolence

> *The lure of gold brought to Australia many reckless medical adventurers, who later became derelicts, drifting from State to State, and town to town, nearly all of them heavily weighted by addiction to alcohol, who applied again and again for succour, before they were finally engulfed in oblivion. The early records are filled with the sad, and often sordid, stories of these incapables, and the efforts, not always without result, to rescue them.*

This miserable scenario was vividly described in the Association's annual report many years later in 1933. In Australia, and more particularly Victoria, the enormous number of immigrants who poured into the colony after the discovery of gold in the 1850s stretched the resources of the fledging society. A number of cases listed in the Association's minutes reflect the growing number of doctors working in the goldfields, and their particular plights. The manner in which these 'incapables' were rescued is the subject of later chapters, but it is interesting to consider why the Medical Society of Victoria (MSV) did not pass the initial motion, proposed by Dr William Cutts in 1864 and supported by several other prominent doctors, to establish a relief fund for the medical profession. The reason was that their membership base was only a fraction of the profession and they believed a benevolence fund ought to be available to the entire profession; the Society felt unable to help anyone outside their membership because the MSV was established



William Henry Cutts (1828-1897)
In 1865, with Drs Neild, Tracy, Gillbee and others, he founded the Victorian Medical Benevolent Association, on which he served as Treasurer for 27 years and President for 13 years until his death in 1897. Dr Cutts arrived in Victoria in 1852 and after a short time proceeded to the 'diggings' at Bendigo, where he supplemented his professional work with the quite profitable occupation of gold buying for the banks. The rough life of the goldfields soon lost its attraction and he returned to Melbourne, where he practiced successfully and was a vital member of the medical community.
In Memorium, printed memorial, 1897 State Library of Victoria

for other purposes. Cutts subsequently asked the Society for money to help the fund become established but this was not successful either, with opposition from Mr William Gillbee and with 'lukewarm support' from Dr Gerard Fetherston.[2] The fund went ahead independently, organised by Cutts. Gillbee was in attendance at the Victorian Medical Benevolent Association's inaugural meeting on 20 March 1865, and later that afternoon was elected an ordinary member of the first committee. He, like others from the Society, opposed the extension of the MSV's activities to include charity but clearly supported both the principal and the practice of a medical benevolent fund.

The politics of benevolence is a history in its own right. However, some understanding is required to place the establishment and development of the VMBA within the context of wider society. Six years after the Association was founded the Daily Telegraph published a report on its progress suggesting that:

> *The idea of associating for benevolent objects is the product of the oriental mind transmitted to the West through a Christian medium, and it is certainly one which the West, especially in these modern days, has cultivated with an assiduity all of its own. Through ill report and through good report the principle has worked its way to a front rank among the working forces of society, and whether it is to send blankets to Boorioboolagah [sic], or bread to starving Parisians, nobody thinks of dispensing his charity except through some association or other.*[3]

With the rising number of struggling doctors in Victoria and the precedence of medical benevolence associations in the United Kingdom and in Ireland, it became clear that a similar organisation in Victoria should be established as a standalone association. Despite the existence of government institutions such as those established under the Poor Law Amendment Act in Britain, it was still common practice for charity to be provided through private associations, often relying on membership subscriptions, and this was encouraged by government.[4] In Australia, initially founded as a convict settlement with government resources largely directed towards transportation and gaols, social welfare was mainly left in the hands of the public. The Port Phillip

The Melbourne Hospital, established in 1848, was funded through private charity and government support c. 1863-1870.
Engraving by George Nichols. Courtesy of Pictures Collection, State Library of Victoria.

I cannot consider it the business of Government to provide a General Hospital for the town of Melbourne.

District, renamed Victoria in 1835, was not a convict settlement. However, left mostly to its own devices, it also developed a laissez-faire and individualist approach to social relationships. This meant that individuals and subscription-run associations assumed most of the responsibility for charitable or philanthropic care.[5] Indeed, Melbourne's first hospital, the Melbourne Hospital (later the Royal Melbourne Hospital) was established in 1848 and the negotiations over the financing of this institution were an indication of the colonial government's attitude towards public charities. Governor Gipps wrote in a reply to Superintendent La Trobe's request for assistance that 'I cannot consider it the business of Government to provide a General Hospital for the District of PP or even for the town of Melbourne. Such institutions are properly the objects of private charity.' So the citizens of Port Phillip took charity into their own hands and decided to finance the hospital voluntarily. In the end the government provided a site and a building grant to match the amount raised by subscriptions.[6]

When the public are largely responsible for providing funds to the needy, whether directly or via an institution established for a particular purpose, it is inevitable that moral judgements become part of the assessment and distribution decisions. In the western Christian world, nineteenth-century charity was a moral or religious duty. However, in what has been described as the principle of 'selectivity', the giving of money or other benefits was often conditional.[7] In 1865 Mr Richard Stephenson from Berwick, a public vaccinator, applied to the VMBA for relief 'stating the extreme poorness of his circumstances, the smallness of his practice and the difficulty he experienced in maintaining his family'. Dr William McCrea, the vice president of the Association, undertook to make enquiries and received a character reference from a Berwick resident stating that 'Mr Stephenson … is a person of very intemperate habits, otherwise with ordinary presence he need have no occasion whatever of applying to any charitable institution for pecuniary relief.' The committee decided that as Stephenson's 'misfortunes are due to his own irregularities' they would reluctantly decline to grant him any assistance.[8] The committee may well have regretted this decision some years

later as the difficulties faced by Mr Stephenson and his family proved to be real and dire. He had immigrated to Victoria by 1858 and married in Castlemaine before moving to Sandhurst the following year, which was the heart of the goldfields. The pursuit of gold was clearly his purpose as he did not register as a doctor until August 1862, by which time he had given up gold digging and moved to Berwick where he became the first doctor in that district. A year after his application for relief was refused he applied for insolvency citing the pressure of creditors and the purchase of a practice that was less valuable then he had been led to believe. That year, 1866, he moved to Donnybrook with his family of four small children. Richard and his wife Anne had one more child before he died the following year at the age of thirty-five.[9]

An image of the ship *Dallam Tower* in which Dr Nugent originally travelled to Australia.
Dallam Tower, *Courtesy of Brodie Collection, Pictures Collection, State Library of Victoria*

I appeal as a friendly stranger and brother physician

The following year Dr Nugent, a ship's surgeon during the voyage of the *Dallam Tower* from England, applied for assistance to return home as:

> *I left Liverpool on the 13th of September last as surgeon in the ship Dallam Tower in perfect health, but on the voyage was completely deprived of the sight of the right eye with greatly diminished vision of the left one. In consequence of my blindness I fell down a hutch which was left open and … sustained such contusions and so great a nervous shock that I was confined to bed for a week and am still suffering severely … Knowing no one in this country and totally destitute of money, I appeal as a friendly stranger and brother physician … for means to send me home to my poor family.*

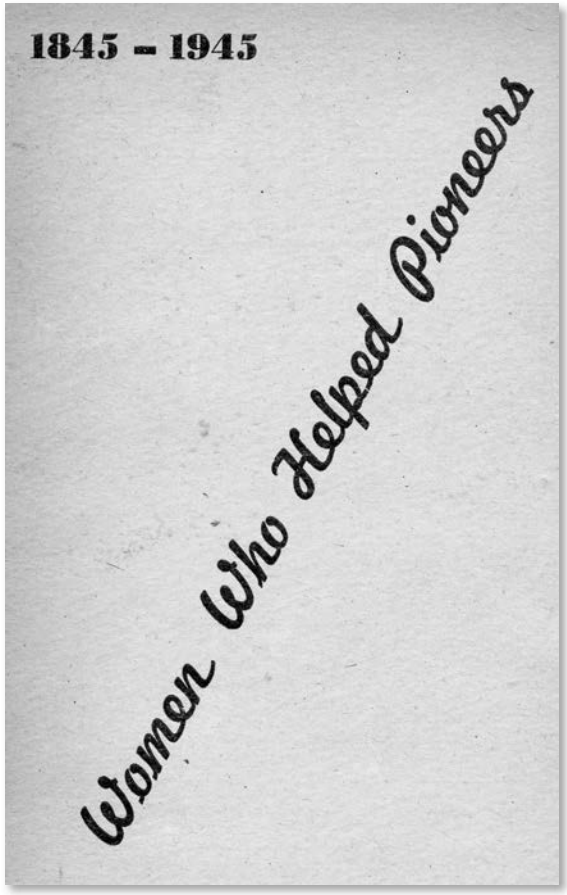
This story became less heart rending when, far from 'knowing no one in this country', a letter was received from the good doctor's son in Adelaide enquiring about his health. This was followed by one from the shipping agents who said 'Dr Nugent's conduct during the voyage had been the reverse of satisfactory. His habits had been generally intemperate and he had neglected his duties.'[10] While the committee could perhaps have made further enquiries to confirm the situation, the evidence before them did seem to reduce the validity of the surgeon's claim and they 'declined to entertain the application'.

Good behaviour was not the only condition upon which assistance was provided. When Mrs Stewart, the widow of a medical man, applied for assistance, it became apparent that Dr Stewart had never practised in the colonies so she was refused relief on those grounds.[11] While it was not necessary to be a subscriber to the Association for a doctor or his family to be eligible, it was not enough to have just been a member of the medical profession anywhere in Australia. You had to be registered as a doctor in Victoria, which was still very much an immigrant society during the 1860s and 1870s, and many doctors found it hard to establish themselves and fulfil this condition.

The Charity Organisation Society, which was founded in 1887, promoted new 'theories of systematic charity for properly assessed deserving cases'.[12] It believed it would overcome what it saw as indiscriminate giving by institutions like the Ladies'

Benevolent Society and the twenty other registered benevolent associations operating in Melbourne at the time. There was also a belief 'that direct social provision by the State, and especially cash benefits, undermined self-reliance and initiative on the part of the individual and encouraged *pauperism*'.[13] However, from the very beginning the VMBA offered urgent relief in the form of single cash benefits as well as loans to enable people to establish themselves more securely. In September 1867 Mr Stone of West Melbourne, having already applied successfully for relief twice, applied yet again saying that his furniture was in danger of being seized in lieu of rents owed. His accounts showed that for thirty-six weeks his average receipts had been £2.14 but for the last sixteen weeks they had dropped to £1.12 per week. His wife was near her confinement and he owed £13.4 for sixteen weeks rent. Mr Stone's difficulties were not that far removed from those of his colleague Richard Stephenson, yet there was no reference to intemperate behaviour and the committee resolved to offer him another £5 on top of the £12 he had already received, declaring that 'the fact of Mr Stone having been twice before relieved did not serve as a reason for declining further assistance'.[14] Indeed, in the spirit of the Ladies Benevolent Society, established in 1851 and at its strongest during the 1880s and 1890s, the VMBA considered that any 'deserving' cases would always be deserving of assistance.

By the turn of the century some of the politics and philosophies that shaped charitable assistance were beginning to be characterised by 'universalism',[15] whereby minimum rights became an expectation even for inebriates like Dr Nugent and Mr Stephenson who had been refused help in the past. This was provided, or partially provided, by the state in the form of welfare payments. In the early twentieth century discussions about the introduction of an old age pension abounded; however, Victorian politicians were reluctant to introduce a universal pension system and the debates in parliament whittled down the numbers of those who were eligible for a pension. It was the needs of the 'deserving poor' rather than the 'rights of all aged people' that were considered.[16] Nevertheless, these important discussions and debates, held



In Recognition OF THE WONDERFUL SPIRIT OF UNDERSTANDING SHOWN TO THE FLOTSAM AND JETSAM OF HUMANITY THAT PIONEERED OUR SHORES, THIS BOOK IS DEDICATED TO

THE FOUNDERS OF THE MELBOURNE LADIES' BENEVOLENT SOCIETY

☆

Foreword

The work of Social Service is one which, however necessary to the community, rarely finds its annals classed with those of the "best sellers". Yet, in perusing the records of The Melbourne Ladies' Benevolent Society—which date from 1845—one finds in their pages (so methodically inscribed in the flowing Italian hand of the period) much of interest.

That very human document is a portrayal of early days in which poverty went hand in hand with the wealth that, in many instances, arrived so quickly and—in the spirit of "light come, light go"—vanished almost as quickly.

Women who helped the Pioneers. A history of the Ladies Benevolent Society, 1845-1945 – a centenary booklet.
The Ladies Benevolent Society was one of the first organised groups to assist those in need in Victoria during the 19th century.
Courtesy of Monash University Library Rare Books Collection

across Australian drawing rooms, newspapers and parliaments, reflected a growing understanding or recognition that personal circumstances may often have nothing to do with an individual's behaviour and characteristics. The 1890s depression, a widespread and very damaging drought in 1902, worldwide inflation and the First World War left many people reeling. No matter how respectable or self-improving you were, there were greater forces at work that wielded a power beyond any individual's control and which could be the undoing of the most honourable of citizens.

The gradual evolution of state sanctioned welfare may have had something to do with the declining fortunes of the VMBA during the early decades of the twentieth century; however, there were many other explanations for this that were much closer to home, such as accusations of funds mismanagement during the 1890s depression. Certainly their records show that subscriptions plummeted: in 1902, as individuals and families were still counting the cost of the depression they had recently lived through, there were only eight subscribers to the Association and not one was outside the committee! Fortunately, this situation was not to last, as although support for the Association has ebbed and flowed over the years, it has not once been without doctors or their widows and children to consider.

As the twentieth century progressed, the links between the benevolent actions and attitudes of an organisation such as the VMBA and those of wider society become more tenuous and difficult to associate. The 'selective' approach of the nineteenth century, whereby charity was provided to the deserving poor by the responsible and able middle classes, was recognisable in VMBA's records. There were certainly judgements made by the givers, and conditions and expectations placed on the receivers, but the process was far from righteous or overbearing. In the twentieth century 'selectivity' gave way to 'universalism', or welfare in the form of a state funded basic wage, old age pension, invalid pension or war veteran's pension; and, in the years after the Second World War, was eventually superseded by 'socialism' which advocated 'distributional justice for all'.[17] The availability of private health insurance schemes, for example,

as ... families were still counting the cost of the depression they had recently lived through, there were only eight subscribers to the Association and not one was outside the committee!

initially accessed through the many friendly societies that originated in the nineteenth century, was joined by a universal national health insurance scheme in 1975 with the introduction of the Medibank (renamed Medicare in 1984). In 1976 the VMBA resolved in principal that 'payment of contributions on behalf of beneficiaries to benefit organisations [such as private medical insurance schemes] are to be discontinued, but that allowances should be increased to enable each beneficiary to take out the type of insurance which suited his or her individual requirements'. The many private life insurance and superannuation schemes that evolved during the twentieth century ensure that those who choose to pay the premiums have assistance in shoring up their futures. At the same time, the twentieth-century machinery of state or federal funded social welfare provision expanded gradually, guided largely by the impact of broader social and financial influences on voters' thinking. The detailed workings of this social welfare machine – who could receive how much benefit under what circumstances – were decided on by the prevailing governments.

While state funded benevolence increasingly dealt with larger and larger numbers of faceless and unknown people – those who fitted into a category – within the VMBA the politics of benevolence was a personal endeavour still associated with individual faces and individual circumstances.

Whether through philanthropy or welfare, caring for those who need assistance is a vital part of maintaining a contented and supportive community for all. The inaugural Medical Benevolent committee, and every committee since, has made benevolent decisions based not only on the prevailing social attitudes, but also on an understanding of what it is to be a doctor working within the conditions of his or her own time.

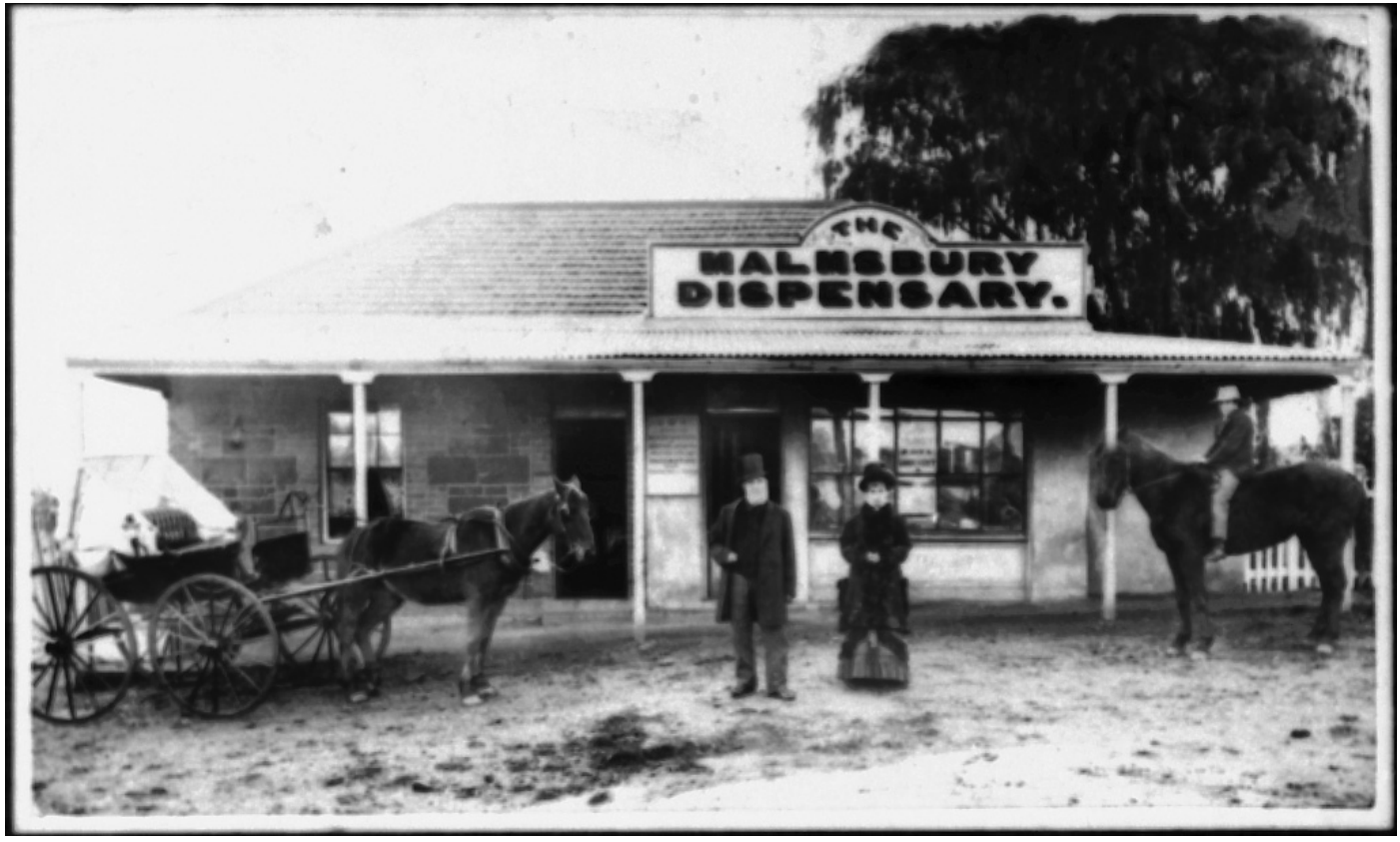
Chapter two

A profession establishes itself

I almost lived on horseback, and I was at all times prepared to … attend a patient any distance under 80 miles.

Pioneering colonial doctors in the Port Phillip District (Victoria) carved out the beginnings of a system of western medical care largely on horseback, over long distances and in isolation from colleagues for many years. In 1865 Dr David John Thomas wrote to a friend in England describing his professional experiences in the colonies over the previous twenty-six years. This was reprinted in the *Medical and Surgical Review*.[18] The first part of his letter explains that:

> *I came to [Port Phillip District] twenty-six years ago [in 1839]; we then had a scattered population, and my whole time was taken up with the active duties of my profession. Indeed, I almost lived on horseback, and I was at all times prepared to start to attend a patient any distance under 80 miles; this I would do and return in about 16 hours … This distance was not at all uncommon, and I continued at this sort of work for ten years, when, in 1849, the town had so much increased in dimensions and population that I limited my practice to [Melbourne] and the suburbs. So you can imagine that I had but little time for study. In addition, the community were fast, and it was impossible not to join with the custom. I got at last an attack of colonial fever (bilious remittent), my system being made susceptible from overwork. This shook me terribly, and I went to Europe, where I remained seven years, travelling about, and endeavouring to improve myself in my profession …*



Dr Edward Davy and his wife with their horse and buggy outside their Malmsbury Dispensary, c. 1870.
The long black coat and top hat were typical of doctors of the time who were sometimes referred to as 'the black coats'.
Country doctors would commonly visit their patients by buggy or horseback, as vividly described by Dr Thomas in his letter.
Courtesy of Pictures Collection, State Library of Victoria

It was on the backs of doctors such as this one that the medical profession gradually established itself in the colonies. The formal registration of medical practitioners commenced in New South Wales in 1838. It was extended to the Port Phillip District in 1844 where the first roll of legally qualified medical practitioners held the names of seven physicians and five surgeons. The roll did not always include every doctor practising in the colony as registration was initially voluntary. Some had retired from practice, others were unqualified or their qualifications were not considered adequate, some did not bother to register and others were in prison, the army or the navy.[19]

After considerable lobbying for several years, the *Medical Practitioners Act* was passed in the Victorian Parliament in June 1862. Its passing was probably aided by the fact that some members of the medical profession were establishing themselves amongst the higher echelons of society. At the time of the Act's passing there were six Victorian doctors in parliament. The legislation ensured that all legally qualified doctors in the colony could be registered but, significantly, it also allowed unregistered practitioners to work as long as they did not adopt a formal medical title, sue for unpaid fees or hold medical appointments in public institutions. It was not until 1900, with the passing of the *Amendment Act* to the *Medical Practitioners Act*, that all medical practitioners were required to be registered and so prove their qualifications.[20] In the meantime, the freedom for unqualified and unregistered people to practice medicine caused considerable hardship amongst some of those who were legitimate doctors.

These legitimate colonial doctors missed interaction with colleagues overseas and were frustrated by their isolation from research and the hard-to-access publications from England. They quickly established forums to support their desire for collegiate discussion on issues important to the profession and the promotion of medical knowledge. In Victoria the first such forum, the Port Phillip Medical Association (PPMA), was based on the British Medical Association and formed in 1846:

> *The primary role of this [Port Phillip Medical] Association shall be the promotion of medical knowledge and a more free professional intercourse. The more special objects*

It is impossible to imagine surgery of any sort being conducted in such a building, but for 'Dr Smith, Surgeon', as the sign to the left of his doorway reads, these were the facilities available to him in Geelong in the 1860s. *Courtesy of Pictures Collection, State Library of Victoria.*

shall be the formation of a medical library and museum, the reading of original papers on medical subjects, the introduction of a code of medical ethics and the establishment of a greater uniformity in professional charges.[21]

The PPMA was initiated by three of the leading doctors in the colony: Dr Patrick Cussen, who performed the first known surgical operation in Victoria; Dr William Wilmot, the coroner; and Dr Godfrey Howitt.[22] The Association rapidly established ethical standards, a scale of fees and began a library. Although its meetings, held in the homes of members or at the Prince of Wales Hotel in Flinders Lane, were said to be 'more convivial than scientific', many provided an avenue to hear about particular cases first hand and to learn about new techniques and discoveries. David Thomas, the 'doctor on horseback' and author of the letter describing early medical practice in Victoria, was one of PPMA's founding members. He reported at a meeting in September 1847 on his use of ether anaesthesia during the amputation of a patient's forearm. This was less than a year after the first public demonstration of the use of ether; at Massachusetts General Hospital during surgery to remove a neck tumour. Thomas was the first doctor in Victoria to use this new drug:

Mr Thomas read a very interesting paper on the inhalation of Ether. He also exhibited an inhaler which he had, with considerable trouble, got constructed in Melbourne according to the more improved principles. Mr Thomas also read some highly interesting cases in which he had used the Ether with success. The different members present complimented Mr Thomas for the zeal and industry displayed by him in the paper he had just read … .[23]

After a series of disagreements over the library and various rules and regulations, it was clear that 'the end of the Association, later described by James Neild as death from inanition, was rapidly approaching' and so the Association dissolved in 1851.[24] Still, the need for some sort of association was clearly vital and in the following year the Victoria Medical Association (VMA) was formed with some of the former members of the PPMA. It rules and regulations pointedly stated that:

Dr Godfrey Howitt, 1872.
First president of VMBA (1865-1873). Although he was perhaps most notable for his absence from committee meetings for the whole nine years of his presidency, the Committee admired him greatly, recording the following appreciative statement in the VMBA minutes after his death. 'During the year [1875] the Bronze Medallion, voted to the memory of Dr. Godfrey Howitt, our first president, has been set up in our meeting room, as a memento of his great services to the Association.'
Courtesy of Pictures Collection, State Library of Victoria.

REGISTER OF MEDICAL PRACTITIONERS FOR 1901.

THE subjoined copy of the Medical Register is published in accordance with the provisions of the *Medical Act 1890*, section 5.

Medical Board of Victoria,
Melbourne, 16th January, 1901.

G. H. FETHERSTON,
President.

List of Medical Practitioners Registered under the provisions of Act No. 158, Act No. 262, or Act No. 1118.

No. of Certificate and Date of Registration. No.	Date.	Name.	Address.	Qualifications.
1469	Aug. 3, 1888	Abbott, Thomas Eastoe	137 Macquarie street, Hobart, Tasmania	L.S.A. Lond. 1880
77	July 30, 1862	a'Beckett, William Goldsmid	119 Wellington street, St. Kilda	M.R.C.S. Eng. 1850; L.S.A. Lond. 1861
1764	Nov. 10, 1891	Abernethy, James	Millicent, S.A.	M.B. *et* Ch.B. Melb. 1891
1484	Sept. 7, 1888	Abramowski, Otto Louis Moritz	Mildura	M.D. Berlin 1876; Staats Examen 1876
1897	Dec. 29, 1893	Acton, Frederick Charles	Yackandandah	M.B. Melb. 1893
1471	Aug. 3, 1888	Adam, Basil John ...	Daylesford	M.B. *et* Ch.M. Glas. 1886
993	Nov. 7, 1879	Adam, George Rothwell Wilson	84 Collins street, Melbourne	M.B. *et* Ch.M. Edin. 1878
861	April 7, 1893	Adams, George Thomas Cooke	58 Collins street, Melbourne	L. *et* L.Mid. R.C.P. *et* R.C.S. Edin. 1892; L.F.P.S. Glas. 1892; Ch. M. *et* M.D. Queen's Univ. Canada, 1892
1530	April 5, 1889	Adams, John	119 Glenferrie road, Hawthorn	L. *et* L.Mid. R.C.P. *et* R.C.S. Edin. 1888; L.F.P.S. Glas. 1888
2186	Sept. 7, 1900	Agassiz, Alfred ...	Melbourne	M.R.C.S. Eng. 1863
2030	Dec. 31, 1896	Agnew, James Francis	18 Erin street, Richmond	M.B. *et* Ch. M. Glas. 1896
1199	Dec. 7, 1885	Aitchison, Alexander Smith	Victoria avenue, South Melbourne	M.B. 1883, Ch.B. 1884, Melb.
1166	Dec. 7, 1883	Aitchison, Roderick ...	Bay street, N. Brighton	M.B. 1883, Ch.B. 1884, Melb.
1237	Sept. 4, 1888	Aitken, William Blair ...	Jamestown, S.A. ...	M.B. *et* Ch.M. Glas. 1883; M.R.C.S. Eng. 1884
1985	Dec. 24, 1895	Aitken, William Lewis ...	Stawell Hospital ...	M.B. *et* Ch.B. Melb. 1895
1889	Nov. 17, 1893	Alexander, Lilian Helen	17 Murphy street, South Yarra	M.B. Melb. 1893
2046	Aug. 6, 1897	Allan, Edward Buller ...	Maldon	M.R.C.S. Eng. 1891; L.R.C.P. Lond. 1891; M.D. Lond. 1896; M.D. Melb. 1898 (*a.e.g.*)
814	June 2, 1876	Allen, Harry Brookes ...	Melbourne University ...	M.B. 1876, M.D. 1879, Ch.B. 1879, Melb.
2074	Jan. 7, 1898	Allester, Edwin Marston	Traralgon	M.B. Melb. 1897
1902	Dec. 29, 1893	Alsop, Charles James ...	Princess street, Kew ...	M.B. Melb. 1893
849	April 6, 1877	Alsop, Thomas Osmond Fabian	Auburn road, Hawthorn	M.B., Ch.M. *et* L.Mid., Edin. 1874; M.R.C.S. Eng. 1874
1106	Dec. 7, 1883	Altmann, Charles August	Bright	M.B. 1883, Ch.B. 1884, Melb.; M.R.C.S. Eng. 1889; F.R.C.S. Edin. 1889
1346	Dec. 10, 1885	Amess, James	287 Church street, Richmond	M.B. 1885, Ch.B. 1886, Melb.
1333	Dec. 10, 1886	Anderson, Alfred Victor Millard	Greville street, Prahran	M.B. 1886, Ch.B. 1887, M.D. 1892, Melb.
1060	Dec. 9, 1881	Anderson, Eugene Wilton	Burwood road, Hawthorn	M.B. 1881, Ch.B. 1887, M.D. 1888, Melb.; L. *et* L.Mid. R.C.S. *et* R.C.P. Edin. 1883
1714	Mar. 6, 1891	Anderson, John ...	Braxholme	M.D. *et* Ch.M. Aberd. 1885
1551	May 3, 1889	Anderson, Thomas Cochrane	Puckle street, Moonee Ponds	M.B. *et* Ch.M. Aberd. 1882
2006	April 2, 1896	Anderson, Thomas Lyncwolde	681 King street, West Melbourne	M.B. Melb. 1896
858	Aug. 3, 1877	Andrew, John Edward...	Hepburn street, Hawthorn	L.S.A. Lond. 1877; M.R.C.S. Eng. 1878; L. *et* L.Mid. R.C.P. Edin. 1878
747	May 1, 1874	Andrews, Arthur ...	Albury, N.S.W. ...	M.R.C.S. Eng.; L.S.A. Lond. 1869
1299	May 7, 1886	Andrews, William ...	2 Wellington parade, East Melbourne	M.B. 1886, Ch.B. 1888, M.D. 1889, Melb.
1896	Jan. 6, 1893	Angwin, Stuart Letcher	St. Arnaud	M.B. Melb. 1892
711	Dec. 23, 1873	Annand, George ...	169 High street, St. Kilda	M.B. 1872, M.D. 1875, Ch.B. 1879, Melb.; M.R.C.S. Eng.; L. *et* L.Mid. R.C.P. *et* R.C.S. Edin. 1876
1707	Jan. 2, 1891	Argyle, Stanley Seymour	"Drayton," Wellington street, Kew	M.B. 1890, Ch. B. 1891, Melb.; M.R.C.S. Eng. 1892; L.R.C.P. Lond. 1892
1751	Nov. 10, 1891	Armstrong, George ...	Shelford	M.B. *et* Ch.B. Melb. 1891
1838	Nov. 21, 1892	Armstrong, George Wm.	Canterbury	M.B. 1892, Ch. B. 1892, Melb.
1899	Dec. 29, 1893	Ashworth, Louis Naish	Aramac, Queensland ...	M.B. 1893, Ch. B. 1895, Melb.
1416	Nov. 4, 1887	Astles, Harvey Eustace	98 Collins-street, Melbourne	F.R.C.P. Edin. 1879; M.D. St. And. 1883; M.D. Adelaide 1885 (*a.e.g.*)
2179	Sept. 7, 1900	Atkins, Thomas Edward	Traralgon	L.A.H. Dublin 1877
361	July 3, 1865	Atkinson, Harry Leigh	37 View street, Bendigo	L.S.A. Lond.; M.R.C.S. Eng. 1855; M.B. *et* M.D. Melb. 1863
741	Jan. 29, 1874	Backhouse, Charles ...	Melton	L.R.C.S. Irel. 1863; L.K.Q.C.P. Irel. 1864
987	May 6, 1881	Backhouse, John Burder	Bay street, Brighton ...	M.B. *et* Ch.B. Melb. 1881
1901	Dec. 9, 1881	Bage, Charles	117 Toorak road, South Yarra	M.B. *et* Ch.B. 1881, M.D. 1884, Melb.
1536	Mar. 1, 1889	Bagshaw, Thomas Washington	Orient Co.'s Office, Melbourne	M.D. Cambridge 1885
1512	Dec. 19, 1888	Baird, John Chalmers ...	Healesville	M.B. 1888, Ch.B. 1889, Melb.
2099	July 1, 1898	Baldwin, Gerald Robert	166 Victoria street, North Melbourne	L.R.C.P. Lond. 1893; M. 1895, F. 1894, R.C.S. Eng.
2029	Dec. 31, 1896	Balfour, Lewis John ...	Kew	M.B. 1896, Ch.B. 1897, Melb.
796	Dec. 3, 1875	Bails-Headley, Walter ...	4 Collins street, Melbourne	Ch.M. 1865, M.D. 1868, Camb.; M. 1886, F. 1888; R.C.P. Lond.; M.D. Melb. 1876 (*a.e.g.*)
1408	Oct. 27, 1887	Barker, Walter Herbert	Ararat Asylum ...	M.R.C.S. Eng. 1875; L. *et* L. Mid. R.C.P. Edin. 1880.
1960	April 3, 1895	Barr, Valentine Herbert	Coalville	L.S.A. Lond. 1892; M.R.C.S. Eng. 1894; L.R.C.P. Lond. 1894
1823	Nov. 21, 1892	Barrett, Edgar Alfred ...	"Bronte," Glenferrie road, Hawthorn	M.B. *et* Ch. B. Melb. 1892.
239	Oct. 3, 1862	Barrett, James	97 Howe crescent, South Melbourne	L.S.A. Lond. 1853; M. *et* L.Mid. R.C.S. Eng. 1858; M.B. 1871, M.D. 1873, Sydney
1006	Dec. 9, 1881	Barrett, James William	127 Collins street, Melbourne	M.B. 1881, Ch.B. 1882, M.D. 1887, Ch.M. 1888, Melb.; M. 1884, F. 1887, R.C.S., Eng.
2140	Dec. 29, 1899	Barrett, William Amherst Henry	Portarlington	L.S.A. Lond. 1884; L.R.C.P. Lond. 1886; L.R.C.S. Edin. 1890
1642	May 2, 1890	Barrington, Arthur Ebenezer	Benalla	M.B., Ch.B., B.A.O., Dubl., 1888

MEDICAL ACT 1890.

54 VICTORIA, No. 1118.

An Act to consolidate the Law relating to Medical Practitioners Dentists and Chemists and to adopt and continue the British Pharmacopœia.

[10th *July*, 1890.]

"*Medical Practitioners Statute* 1805."

BE it enacted by the Queen's Most Excellent Majesty by and with the advice and consent of the Legislative Council and the Legislative Assembly of Victoria in this present Parliament assembled and by the authority of the same as follows (that is to say):—

Short title commencement and division.

1. This Act may be cited as the *Medical Act* 1890, and shall come into operation on the first day of August One thousand eight hundred and ninety, and is divided into Parts and Divisions as follows:—

PART I.—Medical Practitioners.
- Division 1.—Medical Board of Victoria ss. 3–8.
- Division 2.—Legally Qualified Medical Practitioners ss. 9–14.
- Division 3. — Medical Witnesses ss. 15–19.
- Division 4 — Schools of Anatomy ss. 20–37.

PART II.—Dentists.
- Division 1.—Dental Board and Officers ss. 39–45.
- Division 2.—Register ss. 46–51.
- Division 3.—Registration ss. 52–62.
- Division 4.—Examination ss. 63–65.
- Division 5.—Miscellaneous ss. 66–71.

PART III.—Chemists.
- Division 1.—The Pharmacy Board of Victoria ss. 73–80.
- Division 2.—The Pharmaceutical Register of Victoria ss. 81–87.
- Division 3. — Registered Pharmaceutical Chemists ss. 88–92.
- Division 4.—Miscellaneous ss. 93–98.

PART IV.—Adoption of the British Pharmacopœia s. 99.

The primary objects of this Association shall be the promotion of medical knowledge, a more friendly professional intercourse and, in general, the whole interests of the profession.[25]

In 1855 the VMA merged with the Medico-Chirurgical Society and formed the Medical Society of Victoria (MSV). In the following year, 1856, this organisation was responsible for establishing the *Australian Medical Journal*, which was the forerunner to the current *Medical Journal of Australia*. This was both a professional and a scientific journal that included news and notes on local topics, correspondence, opinion pieces, personal notices relating to members of the profession, occasional book reviews, as well as scientific papers. The latter including many written on local conditions, problems and achievements, as well as those reprinted from overseas journals.[26]

While informal professional development was improving through the journal and Society meetings, in 1863 a huge leap forward was made with the opening of the University of Melbourne's Medical School. This school offered a longer course of training than that commonly found (five years instead of the more usual three or four years in the United Kingdom and Europe), and one that was more theoretically based. Its graduates were often criticised for their lack of clinical and bedside training:

The [Melbourne] graduates are turned out with a fair amount of book knowledge, but are very ignorant of real bed-side clinical work; and of such trivial things as diseases of the eye, or ear … they are very ignorant. As for using the opthalmoscope … why it is doubtful if they ever saw anything of the kind.[27]

However the Medical School gradually produced more and more home-grown graduates so that by the twentieth century Australian doctors were as much a part of the profession as overseas doctors. While it would be Australian doctors who moved the profession through the developments of the twentieth century, it was British doctors who established it in the first place.

Within thirty years of European settlement in the Port Phillip District, the medical profession could already boast a Medical Register, a Medical Practitioners Act, a hospital, a journal, a strong and influential Medical Society of Victoria, and a Medical

School at the University of Melbourne. The history of medicine in Victoria is littered with successful and worthy names associated with these and other achievements; members of the profession who have played large parts not only in medicine but in the wider social, cultural and political landscape. It would not be difficult to write a history of the contribution that doctors and surgeons have made to Victorian politics, society and education since the doctor George Bass first landed at Western Port Bay in January 1798, giving rise to the possibility of a permanent settlement on these shores. Only a few of the nineteenth century doctors have become famous, and usually for things other than medicine: Beaney for his diamonds and champagne while performing surgery; Neild for his acerbic tongue and theatre reviews; von Mueller, originally a pharmacist but much better known for his work as a botanist, and others. But many doctors, less well known, were influential and determined men who devoted much energy and time to such things as addressing public health issues to prevent disease. Doctors led public debates about the need for clean water, improved sanitation and drainage, as well as the establishment of hospitals for the rapidly growing township of Melbourne. One such example was in 1859 when the MSV sent a letter to the secretary of the Commission of Sewerage and Water about the risk of lead poisoning, successfully encouraging the commission to notify users to run water before consuming.[28]

But not everyone was successful, or satisfied. Away from the inner sanctum of the medical world, 'land grabs' during the 1830s and 'gold grabs' during the 1850s were the order of the day, and the provision of a service, such as medical care, was considered less admirable than the attainment of riches. In 1836 Dr Alexander Thomson was sent by the Governor of New South Wales to the Port Phillip District to serve as government medical officer. He found this decidedly hard going and, recognising that he stood a far better chance of securing a future through squatting, resigned from his post and moved west to establish a run on land that was to later become the township of Geelong. Thomson proved to be far more successful and powerful as a pastoralist then he could ever have been as a doctor, and was one of many in the profession who chose a change

a remote epoch belonging to the medieval period ...

of career.[29] Many years later James Neild, prominent doctor and editor of the *Australian Medical Journal*, remembered the 1850s gold rush years as 'a remote epoch belonging to the medieval period, abundant in mud and dust, and fiery nobblers, and long boots, and flashy diggers; with a general character of discomfort and high prices, and incivility, and hail-fellow-well-mettishness'.[30]

Those that stayed true to their profession were often left wondering why. In his letter to England David Thomas continued to bemoan:

> *when I returned to my practice again [in 1859] … I found matters very much altered. We have now a very different population, the status being inferior to that which formerly existed; therefore it is very unpleasant to practice here as a rule. There are an immense number of clubs, which are tendered for, and the lowest tender, of course, is taken. A large number of this class of patients complain dreadfully of the fees, and they may probably have received gratuitous advice in England, and never paid a fee in their lives; and an immense number of well-doing persons … have lost so much self-respect as to apply at the hospital for medical relief. The standard of the profession is far below what it was when I formerly practiced here. We had some very good men at that time … With such men as these for competitors, it was most delightful to work; but now there is an overweening jealousy, and each is ready to cut the other's throat, were he not sure that he would be hanged for it. The fact is, the profession here is over-crowded; there is not a corner here where you will not find a medical man; and the means many adopt to gain patients is laughable. This is a capital country for quacks; the regular practitioner has no chance with them. I have a namesake here who advertises most unmercifully, which is many hundred pounds a year out of my pocket … This is Sunday and Christmas Day … I have just received a telegraphic message to go 160 miles into the country. This now can be done, thanks to the railways, in six hours.*[31]

The fact is, the profession here is overcrowded … and the means many adopt to gain patients is laughable

'This is the age for founding benevolent associations'

So despite the advances of the previous thirty years many in the medical profession were doing it tough, and this was recognised by one William Henry Cutts. Cutts was

a successful practitioner himself and a sensitive and kindly man with a strong social conscious. While increasingly prominent and influential within his profession, he was also a layman in the Wesleyan Methodist church, a magistrate, honorary medical officer at the South Carlton Refuge, and served on the Denominational Schools Board and the 1882 Royal Commission on Education.[32]

It was Cutts who first proposed the idea of a medical relief fund to help those doctors who were struggling financially. This he did at an MSV meeting in August 1864, but the motion was not passed. He was not deterred and called a public meeting of practitioners who strongly supported his proposal. Cutts, with Drs James Neild and Lawrence Martin, then proceeded to draw up a draft set of rules based on those of the Irish Benevolent Fund that had been forwarded to him. These were revised at the inaugural meeting of the Victorian Medical Benevolent Association on Monday 20 March 1865. Twenty-seven medical men attended the meeting.[33] This was around six per cent of the entire Victorian medical profession at the time, when many were living too far from Melbourne to be able to travel there for a meeting.

The minutes of this meeting hint at some of the teething problems of former medical societies. Cutts was pleased with the almost unanimous agreement to establish a benevolent or relief fund for the profession, but the simplicity of the rules he proposed was objected to by many. Cutts argued for such simplicity by saying he:

> *had found by experience that many useful projects in this city had failed from their being too elaborately organized in their commencement. He thought considerable latitude should be permitted to the managing committee which should not be bound to abide by an absolutely literal interpretation of the rules.*[34]

He seemed to have won his argument as the rules that were passed that day were no more than nine, a favourable comparison to those of the Port Phillip Medical Association nineteen years earlier, which had numbered fifty.[35] This was fortunate as one of the important and lasting characteristics of the VMBA has been its ability to review each case on its own merits and to use the combined knowledge and

understanding held by the committee members of the time to inform their decisions.

Only six years later the *Daily Telegraph* published an article on VMBA's progress, exclaiming:

> *This is the age for founding benevolent associations, just as the time before the Reformation was a time for founding monasteries … One of not the least successful examples of the service [such an association] is capable of doing to society has just been given in the report of the Medical Benevolent Society, established for the purpose of aiding necessitous persons connected with the profession. The funds of the society have so far outgrown the demands upon them that the committee are placed in the unusual predicament of bewilderment at their own success.*[36]

Postcards of Collins Street, Melbourne c. 1908. For many of Melbourne's early doctors, Collins Street was the location of their home and practice and where early VMBA meetings were regularly held. Today, there are still specialists and medical rooms in the top end of the street.

Courtesy of Monash University Library Rare Books Collection

Rules of the Victorian Medical Benevolent Association, 1865

i. That this Association shall be called the Victorian Medical Benevolent Association.

ii. That the Association shall consist of all legally-qualified medical men in Victoria on payment of an annual subscription of one guinea.

iii. That donations be received both from medical men and others, such donations, along with the surplus of subscriptions to go to form the permanent invested fund of the Association.

iv. That the objects of the Association shall be to relieve medical men in Victoria under severe and urgent distress, occasioned by sickness, accident or any other calamity; to relieve widows and children of deceased medical men; and to advise and assist those in the profession whom temporary misfortune may have rendered unable to pursue their avocations; but that a discretionary power shall be allowed to the Committee to extend the benefits of the Association to such special cases of medical men and their families as many not strictly come within this rule.

v. That the Association shall be managed by a Committee in Melbourne to consist of nine subscribing members, including a president, two vice-presidents, a treasurer, a secretary and four ordinary members who shall be annually elected by the subscribers.

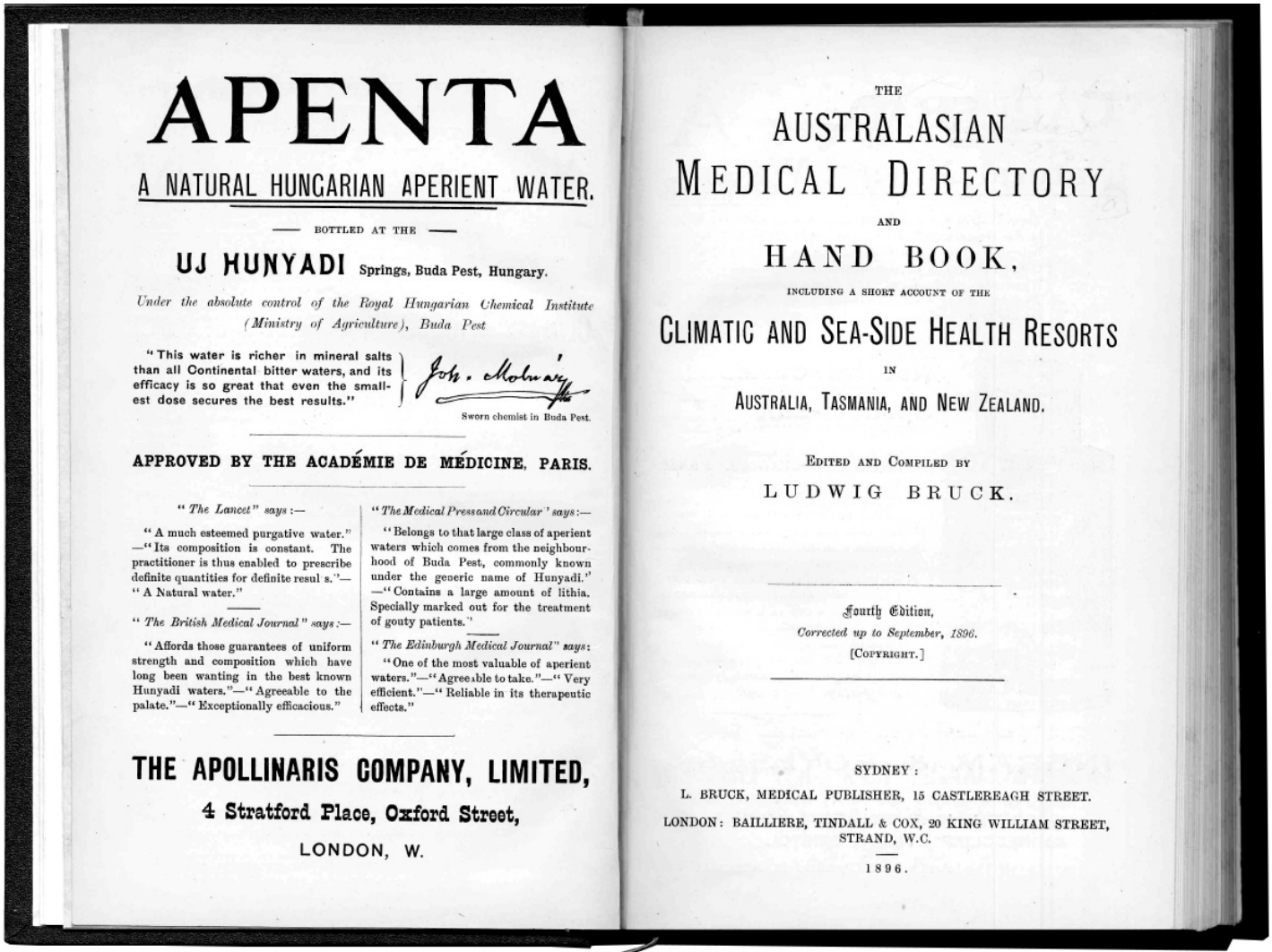
vi. That the Committee shall meet once a month; shall receive applications for relief and reports from correspondents; shall decide on all cases brought before it; and generally manage the affairs and disburse the funds of the Association.

vii. That the subscribers and contributors shall have the privilege of recommending cases to the Committee, and that no case shall be entertained without such recommendation.

viii. That the intervals of the meetings of the Committee, its members shall severally have a discretionary power to relieve cases of immediate and urgent necessity, by giving an order upon the Treasurer; provided however that such relief shall not exceed the sum of two pounds, and that all such cases shall be reported to the next meeting of the Committee which shall thereafter deal with them.

ix. That on the various gold fields and other centres of population , where it is thought desirable, the Committee shall appoint correspondents, who shall make known the object of the Association in their respective districts, collect subscriptions and donations on behalf of the Treasurer, and forward them to him as early as possible; receive applications for relief and report upon them to the Committee.

The original Rules of the Victorian Medical Benevolent Association, 1865.



APENTA

A NATURAL HUNGARIAN APERIENT WATER.

— BOTTLED AT THE —

UJ HUNYADI Springs, Buda Pest, Hungary.

Under the absolute control of the Royal Hungarian Chemical Institute (Ministry of Agriculture), Buda Pest

"This water is richer in mineral salts than all Continental bitter waters, and its efficacy is so great that even the smallest dose secures the best results."

Joh. Molnár

Sworn chemist in Buda Pest.

APPROVED BY THE ACADÉMIE DE MÉDICINE, PARIS.

"The Lancet" says:—

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THE

AUSTRALASIAN MEDICAL DIRECTORY

AND

HAND BOOK,

INCLUDING A SHORT ACCOUNT OF THE

CLIMATIC AND SEA-SIDE HEALTH RESORTS

IN

AUSTRALIA, TASMANIA, AND NEW ZEALAND.

EDITED AND COMPILED BY

LUDWIG BRUCK.

Fourth Edition,

Corrected up to September, 1896.

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SYDNEY:

L. BRUCK, MEDICAL PUBLISHER, 15 CASTLEREAGH STREET.

LONDON: BAILLIERE, TINDALL & COX, 20 KING WILLIAM STREET, STRAND, W.C.

1896.

Dr Ludwig Bruck's Australian Medical Directory, 1896.
Courtesy of Monash University Library Rare Books Collection.

Chapter three

'Ruinous reverses'

Dr Ludwig Bruck was a German immigrant and medical instrument maker and importer living in Sydney. He was also a medical journalist and so had a certain profile within the profession. Bruck compiled the first five editions of the *Australian Medical Directory*, and his finger was on the pulse of medical happenings in this country. Nearly thirty years after the VMBA was established Bruck published an article in *The Australasian Medical Gazette* entitled 'The present state of the medical profession in Australia, Tasmania and New Zealand', in which he provided some revealing figures based on his third edition of the *Directory* published in September 1892.

Statistically speaking, the medical profession in Victoria that year consisted of 812 registered doctors, the most in any colony (New South Wales was second with 691 registered doctors). There was one doctor to every 1,441 residents, the lowest ratio of all the colonies; five female practitioners; and forty-three registered practitioners with 'no fixed abode', which meant they could be travelling as medical referees to life assurance companies, temporarily absent from Australia, doing locum tenens work, or 'waiting for something to turn up'. Victoria had a lower number of 'unsettled' doctors than New South Wales as, due to the higher density of its population, insurance companies and their agents were able to employ local practitioners to conduct health checks.

Bruck's figures for the whole of Australia show that there were 2,410 registered doctors in the colonies in 1892 and approximately 12 per cent, or 291, had graduated from colonial universities. Almost all of these, 222, were graduates of the Medical School at the University of Melbourne, which had opened thirty years earlier. Bruck

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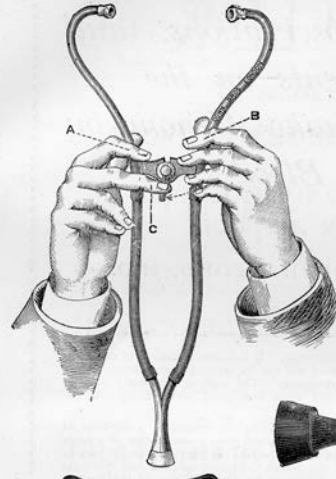

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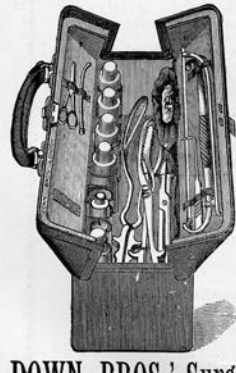

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Advertisement for Downs Bros' Surgical Instrument Manufacturers in the *Intercolonial Quarterly Journal of Medicine and Surgery,* 1896.
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suspected that an equivalent number of Australian doctors returned to the United Kingdom for their degrees, but were born and bred colonials, so that approximately 25 per cent of Australian doctors were born locally. This was a far cry from the days when David Thomas first arrived in Australia in 1839, and even from the time his letter to friends in England was written in 1865.

The 812 doctors in Victoria, caring for a population of 1,170,000, were not evenly distributed, however. The city of Melbourne (excluding suburbs) had a population of 72,500 with 110 doctors, so a ratio of 1:659. Amongst the large towns (Ballarat, Bendigo and Geelong), the suburbs of Melbourne, and the rest of Victoria the ratio of doctors to population varied between 1:1,230 and 1:1,600.

Bruck explained that this ratio, heavily in the favour of the major city, was not uncommon across Australia for a number of reasons. Firstly, specialists and those with official positions in government, hospitals or life insurance companies congregated in the central district for convenience. Secondly, while many city doctors had suburban patients, by living and practising in the city they made themselves accessible to country patients who 'constantly flock to the metropolis' for second opinions or operations. And, lastly, many found that working in the suburbs and elsewhere meant submitting to or competing with the friendly societies, otherwise known as benefit lodges or clubs, which were heavily subscribed to by the middle classes as well as the poor.

This explanation was followed by a diatribe, common enough in the nineteenth and early twentieth-century medical press, against this 'pernicious club system' that provided insurance for the 'working poor' of Australia. The clubs were both the livelihood and the bane of doctors who deplored the low fees they received as employees of the lodges, but were reliant on them for business. The medical profession was to eventually gain a foothold against the friendly societies in 1913, but the medical press and the VMBA minute books reveal the difficulties faced by many practitioners, city and rural, in negotiating a livelihood until that time.

By the turn of the century, the problems facing medical practitioners in Australia

continued to be twofold: establishing themselves as a legitimate and reliable provider of medical care (although this had already begun as medical science became more rigorous and, in Victoria at least, legislation allowed for the prosecution of unregistered practitioners assuming medical titles, although they were still allowed to tout for and provide medical services); and assuring a viable future for their practice, themselves and their families. This last was extraordinarily difficult for many in the face of expenses incurred in maintaining a practice, the friendly societies' grip over the provision of medical care to their subscribers, and competition from 'imposters', unregistered practitioners and each other. There was also often doubt in people's minds over the advantages of seeking a doctor when the local pharmacy offered diagnosis (however

A M Palmers Pharmacy Ballarat c. 1880. Often people chose to seek advise and remedies from their local pharmacy, rather than risk the possibility of a doctor's diagnosis, which could result in much feared surgery.
Courtesy of the Medical History Museum, Brownless Library, University of Melbourne.

imprecise) and remedies on the spot, and well-founded fear if the possibility of any form of operation or surgical procedure was likely.

Bruck claimed that 'a wrong impression exists in the minds of the public, who imagine that every medical man makes a fortune', when in actual fact the average annual income at the time was 'probably between £700 and £800' (approximately $70,000 to $80,000 in the early twenty-first century).[37] This had to cover rents and wages, as well as the provision of drugs to patients whose set fee for service included any required medications.

The overall effect of these difficulties on the conditions of life and practice for nineteenth-century Victorian doctors was arduous at the least and dire at worst. Bruck claimed that 'the club system in Australia, and the unenviable life in most of the bush towns, which induce many practitioners to indulge to excess in alcohol and narcotics, are largely answerable for the appalling death rate amongst medical men in these colonies'.[38] He calculated that the death rate amongst medical men was about double that of the rest of the population, while in Victoria doctors were dying at a rate of 26.67 per 1,000 compared with 16 per 1,000 deaths in the mean population. The consequence of this was made clear when he explained that of the 312 deaths in the previous six years that he was able to obtain an age for, seventy-two or over 23 per cent died in their thirties. Another 37.5 per cent died under the age of forty. Many of these doctors would have been married with young children.

Untimely deaths were a sad and often enough cause for approaching the VMBA. In their second committee meeting after forming in 1865, Cutts spoke of an application made to him on behalf of Mrs Jackson who was within four months of her confinement, already with 'several children', and completely destitute. Her husband had practised for four or five years in Geelong and then been appointed to the position of House Surgeon of the Dunolly Hospital. This had proved unsuccessful; the records do not explain why but it is likely he was an alcoholic as, when shortly afterwards he decided to move to Tasmania to work, he 'committed suicide by throwing himself overboard while

the club system … and the unenviable life in most bush towns induce practitioners to indulge to excess in alcohol and narcotics

Lawrence J Martin (1826-1879) settled in Melbourne after working his way to Australia as a ship's surgeon. He began working in a small cottage in Russell Street and eventually built up a successful practice. He became one of Melbourne's most well respected obstetricians.
He was an inaugural committee member of VMBA and remained a member until his death in 1879.
Etching from The Illustrated Australian News, 1879. Courtesy of Monash University Library Rare Books Collection; and R. Waymouth, Royal Women's Hospital Archives.

labouring under an attack of delirium tremens'. The Reverend Mr Thomson, who had been assisting the family, wrote that 'it was proposed to send her home to her friends in England if the sum of forty pounds could be raised'. Friends had already collected £28 and the VMBA was asked if it could supplement this amount. This was done, with £5 and a decision to apply to Bright Brothers, the shipping agents, for a remission on the passage money. Later that month the VMBA met again, and Dr Martin reported the family were leaving for England the next day and that £56 had been raised for them. The passage home had not been reduced and necessary expenses had left very little available for when they arrived home. The committee members were asked to increase their grant but, innately cautious, decided that as the number of cases they would need to consider over the year was unknown and the extent of their financial resources uncertain, they were not in a position to supplement it further.

Job Phillips, a surgeon in Prahran, died in 1865 leaving his wife Emma 'with a family of six children, quite unprovided for'. His practice had begun in a tent pitched on Commercial Road before he was able to move to a building near High Street.[39] After Phillips died his practice was bought by Dr Gerald Fetherston, who remained in Prahran for the rest of his working life and was the Health Officer for the City of Prahran. Fetherston was at the founding meeting of the VMBA and a member of the committee from 1873 to 1877. He rarely attended meetings, although this was probably because he was a busy man rather than disinterested in benevolence. He held honorary positions at the Lying-In Hospital and with the Benevolent Asylum, the Blind Asylum and the Deaf and Dumb Asylum.[40] His son, Richard, followed in his footsteps and was to become more prominent in the VMBA as vice-president (1930–33) and president (1933–43). The Phillips family, in the meantime, had been assisted by friends who had collected £30 towards education, clothing and expenses. A year later, however, the money had run out so Mrs Phillips applied to the VMBA for assistance in March 1866, and was provided with £10 'as the case appeared to be a deserving one'. Community support in the form of donations after a death can often be seen in the VMBA minute

books. In December 1867 the Fetherstons, the Phillips and the VMBA came together again when Mrs Fetherston wrote on behalf of the eldest Phillips daughter, Ellen, to request assistance in the completion of her studies towards a Certificate from the Board of Education. Ellen was hoping to be able to support herself and help a younger sister with her own education. The VMBA provided £5, and it appears that she was able to eventually earn a reasonable income for her family as the Phillips do not appear again in the minute books.

Some, however, reappear many, many times. Before government pensions, unemployment benefits and other forms of social security were available, those down on their luck were reliant on the many charitable bodies that existed in the cities and country towns. Mrs Spilling was the first person to apply to the VMBA for relief in April 1865, and she continued to be assisted for twenty-two years. She was the widow of a medical man who had practised in Collingwood. Nothing is known about Dr Spilling except that the committee were confident that he possessed a legal qualification. She made sixteen applications to the Association over the years for small amounts of money, usually towards furnishings to enable her to establish and maintain a boarding or lodging house. On her third application, in November 1866, the committee voted to grant her £3 but in their discussions thought it was 'undesirable as a rule to encourage a repetition of applications'. She reapplied successfully six years later, however, when four of the five men involved in the previous discussion were again making the decision. This time Mrs Spilling had asked for assistance to 'move into a better house so as to secure a better living' and William Cutts had exercised his discretion and given her £2. Later that year she called upon committee member Dr Lawrence Martin who gave her £1 as she was 'in most urgent need and almost entirely destitute'. In 1873 the VMBA began receiving letters on her behalf from the maverick philanthropist, prison reformer and evangelist, Dr John Singleton of the Collingwood Free Medical Dispensary (today known as the Singleton Medical Welfare Centre in his honour). Singleton was a man who thought outside the square; he was an early campaigner for women doctors, and

Mrs Spilling is in most urgent need and utterly destitute'

THE LATE DR. SINGLETON.

By 1873 Dr John Singleton, a medical practitioner, was well known for his work as a Christian philanthropist, evangelist and passionate reformer. He founded the free Collingwood Medical Dispensary as well as a Night Shelter for Women, a Home for Fallen Women and Model Lodging for men. The work of the Medical Dispensary started by Dr Singleton continued for over 100 years. The dispensary gave free attention to the poor and provided spiritual guidance from religious tracts.

Courtesy of Pictures Collection, State Library of Victoria

suggested in one letter that funds could be raised for Mrs Spilling by holding a concert for her at the Polytechnic if the VMBA would donate £4 towards the expenses. The committee thought this 'scheme was utterly absurd', but they were concerned by her developing a double cataract which was causing her to go blind and thought she would be better off being admitted to the Benevolent Asylum where she could be cared for by Mr Pay. This did not eventuate and she seemed to have been able to continue running her boarding house, although in July 1878 she was forced to apply again to pay off arrears in her rent and save her furniture from being seized. There were a few more requests until the final one in March 1887 when the Treasurer, Dr James Jamieson, reported he had given her £1.

Of course, the VMBA did not only help widows and children of doctors. The difficulties brought about by competition from colleagues and those masquerading as doctors, the isolation if living out of the main townships, and the inherent difficulties of maintaining a practice were real and deeply felt. Dr William Finlayson McLean arrived in Victoria in 1873 at the age of twenty-eight, having graduated in Glasgow two years before with a Bachelor of Medicine and Master of Surgery. He found employment as an assistant to Mr Curtis of Northcote 'but as he had to defray the cost of his own board and lodging and had not received any payment for his services he was reduced to considerable straits'. He had been told there was need for a doctor in Terang in south-west Victoria, but needed money to buy respectable clothes and to pay for his journey. Cutts and Neild had already met with the applicant and were able to report that his story seemed straightforward and 'he did not look like a drunkard', so eventually the committee agreed to lend McLean £6. Three months later, they received a letter from him asking if he needed to repay the loan as soon as possible or if he could have a little more time. He thought the committee would like to hear how he had fared to date:

> *I am doing fairly, of course I have had a good many things to get besides, within three months, having engaged myself to pay £23 for drugs, stoppered bottle, scales etc, the effects of my predecessor which were in the hands of Mr Anderson. This I will be able*

to do at least within a week or so of the time. The next large sum I will have to pay will be for a horse, saddle and bridle. The schoolmaster up to this time has kindly lent me his, but one cannot trespass on good nature too far. I would like if you would let me know if I should return the money to you before buying a horse, whichever way you may decide I will abide by as I have not told anyone here that I had to borrow money to come. I hope should you meet Mr Anderson at anytime you will not mention it.

I have had one fatal case of Diphtheria. I have been appointed public vaccinator and Medical Officer to the Sons of Temperance Benefit society. The members number about 25, I get £1.1 per member per annum. I find that as I am becoming known I am getting more to do, and I have always had sufficient ready cash to pay everything as I go along, including some instruments and medical books with personal necessaries which I stood in need of so that no one but the Wesleyan clergyman with whom I live know I was so hard up. Hoping to hear from you at your convenience.

It was resolved not to ask McLean to repay the money for the present and there is no other reference to him in the VMBA minute books so it is possible he was never able to repay it. McLean's experience is like that of so many nineteenth-century doctors trying to establish themselves and set up a viable practice. This was made harder still when pride wouldn't allow them to share their troubles with colleagues, friends or neighbours. It seems he left Terang within a few years, as he next appears in the public records in 1882 in Wilcannia, far to the north in New South Wales, where he died from heart disease at the age of thirty-seven. The inquest recorded the 'Value of property' for Dr McLean was '£3.7.0 found on body'.[41]

Dr Charles Stillwell sailed from Liverpool to Melbourne on the *Allison* as ship's surgeon, arriving in February 1853. He intended to make his fortune on the goldfields by setting up in practice and investing in gold, as did so many other doctors. He settled in Sandhurst where he practised successfully for quite a while. However his mining ventures were less successful, causing him to suffer 'loss both of position and fortune'. He returned to England but soon came back to re-establish himself and was recorded

£3.7.0 found on body

... once practised with much success on one of the principal goldfields, but suffered ruinous reverses

on the Medical Register as living in Raywood, near Bendigo, in 1865. Within a few years he had been offered a position as Medical Officer at Dr William Crooke's short-lived Brompton Lodge Sanatorium in Keilor at £50 per year, which he took up in July 1868. Unfortunately Dr Crooke became insolvent the following year and was unable to pay Stillwell.

At this point Stillwell resorted to appealing to the VMBA for help as he had an opportunity to establish a practice at Phillip Island but needed to cover expenses. The committee loaned him £5 towards this purpose. His intentions were to combine the practice of medicine with his appointment by the bishop as a lay-reader, which he thought would provide him with a 'small but sufficient livelihood'. The records do not show what happened to this practice but in 1873 the Medical Directory recorded his address as Runnymede, near Bendigo. Stillwell was a specialist in 'mental derangement' and he published an article on the 'Rational treatment of insanity' in 1878, but neither his specialty nor his efforts to combine medicine with another job were enough to ensure him a viable future. The VMBA heard from him again in 1881 when he applied for assistance to 'fit himself for undertaking the duties of locum tenens to a practitioner in the country'. By this time he was seventy-six years old 'but still vigorous', and the committee granted him £10. He died five years later at Sandhurst having never fully managed to make a success of himself or to settle and make a home.

In the VMBA's annual report for 1881, Stillwell was described as having 'once practised with much success on one of the principal goldfields, but [then] suffered ruinous reverses'. He was one of many to have done so during the nineteenth century. The fortunes, misfortunes and conditions of life for so many doctors were subject to many fluctuations and influences beyond their control, and the VMBA was often the final recourse for assistance. Approximately 200 different individuals applied to the Association during the nineteenth century, some of them several times over. The majority received financial assistance in the form of a grant or loan, or contribution to a community-raised fund. In several cases the members of the committee undertook

to seek other means of assistance, such as putting them in touch with the Melbourne Benevolent Asylum, seeking reduced fees to return to England, or liaising with established doctors to find a permanent or locum tenens position. In those cases that were refused assistance, it was usually because the doctor had not practised in Victoria, did not possess a legal qualification or the applicant was not thought deserving enough. These people were usually shown to have had enough means to support themselves, or were considered to have habits of intoxication or a disreputable character and could not be relied on to either repay a loan or make good use of the money granted.

The committee met irregularly, from three to twelve meetings a year, although most years they met at least every second month or more. Their decisions were rarely, if ever, made lightly. Often a discussion at a meeting would be followed by one or other offering to make further enquiries by visiting the applicant or writing to referees or associates. These were medical men who were, almost without exception, successful in their own right and highly regarded by colleagues and by those outside their profession. Like Dr Gerald Fetherston, they had experienced few 'ruinous reverses' of their own. On the contrary, many of them had honorary positions in the hospitals or benevolent associations or with the MSV. They held medical and non-medical positions such as public health officer, coroner or magistrate, contributed to the medical literature in Australia and in England, were influential in the university and the legislature, and crusaded for hospital and public health reforms. None of this was apparent during their evening discussions but it was their broad experience, combined with often lengthy service on the committee and the 'corporate memory' that tends to come with such dedicated service, that proved invaluable in forming considered decisions.

Aside from their ongoing core business of assisting individual cases, the committee were well aware of how quickly the wider world in which doctors' practise can change. They were determined the Association would last as a reliable avenue for any eligible doctor in Victoria and their family who needed it in the future. Cutts, the instigator of and inspiration for the Association, had drawn up the original rules with this purpose

in mind and they were forward looking, flexible, simple and efficient. However such documents are rarely perfect, these rules included, and several times over the years the committee discussed their revision. Of the three main concerns they had during these first decades, one was a professional concern and two were to do with the long-term future of the Association.

The 'contamination' of homeopaths

In July 1873 an application was made on behalf of Dr John Walcot, who had arrived in Melbourne from Blackpool, England, the year before, registered as a doctor and established a homeopathic practice in Emerald Hill [Port Melbourne]. He was an old man, partly paralysed, and had left his practice in England hurriedly to emigrate to Australia on the urgent persuasions of his second wife who 'gave him no peace'. He had lost several hundred pounds that had been lent to someone who subsequently became insolvent, and the unfortunate Walcot was now 'broken down both in mind and body'. His friends were attempting to raise a fund that would pay for his return passage to England as they felt that was the best thing for him, and application was made to the Association to supplement this with £10.

Cutts supported this application 'because the man was legally qualified and was a gentleman'. However he was aware that recognition of homeopathic practice was anathema to the majority of medical men. Walcot, although qualified as a surgeon, had been practising as a homeopath in England and in Melbourne, and his became a test case for what was a consuming and hotly debated issue for the committee that year. Eventually it was unanimously resolved at the July meeting to vote him the £10 required towards his passage home, but also 'that this question of relief to homeopathic practitioners be specially alluded to in the Annual Report and that the committee recommend a reconsideration of the fourth rule at the Annual Meeting'.[42]

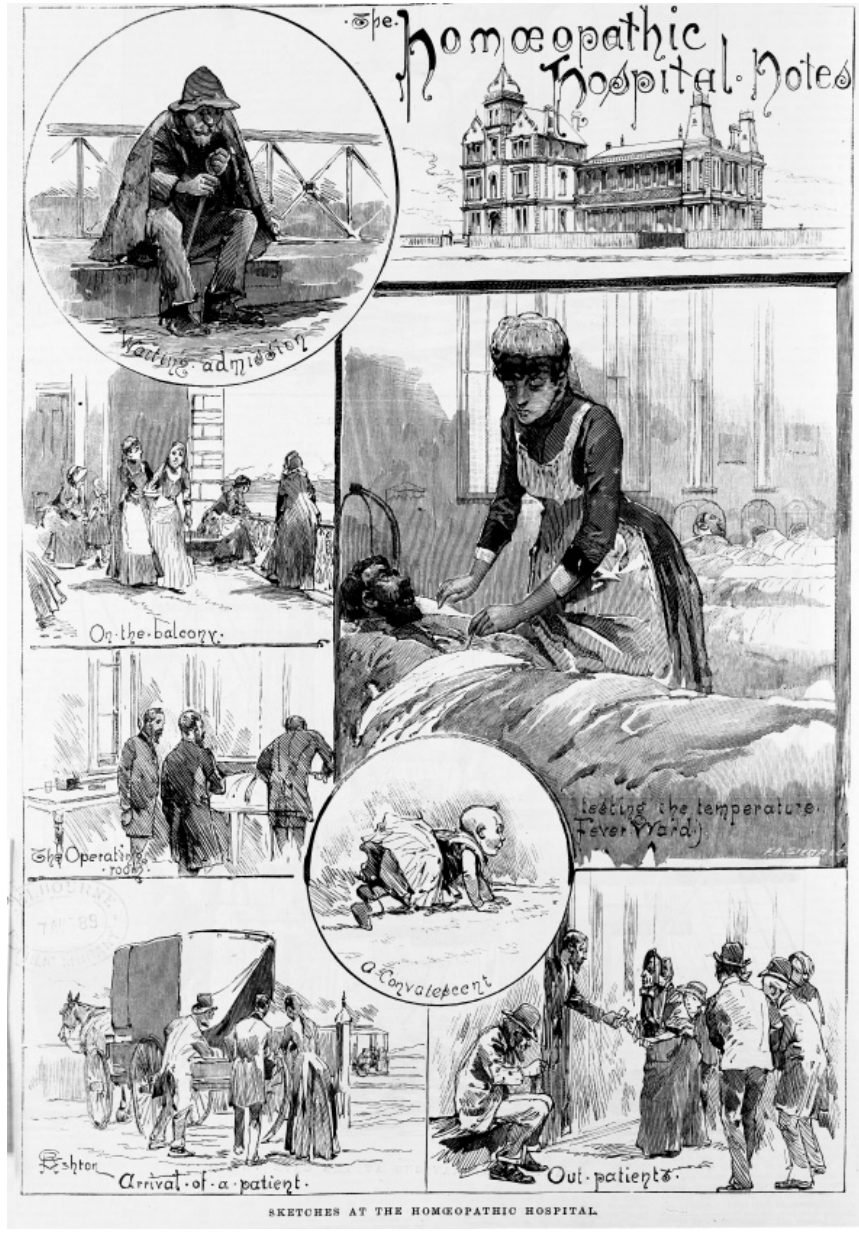
The subject was the main focus of discussion at the annual general meeting, and at a subsequent special meeting of members called for this purpose alone. Aside from

Dr William Whitcombe, who put his argument in support of homeopaths in a letter from Ballarat with the words 'any of us might become homeopaths', and Dr Bernard Lilienfeld, who considered the Association to have subscribers 'who are worse than homeopaths and more objectionable' and believed that charitable societies should accept 'from all quarters', every one of the nineteen men involved in the debate was resolutely against the idea. It was 'an absurd system not founded in science' fumed Dr David Wilkie, who was willing for the amount received from homeopaths since the Association was founded to be calculated and returned with interest in order to 'have done with them'. Dr Hermann Jonasson supported any move to amend the rules 'so as to guard the Association from any such contamination' from homeopathy. Dr Joseph Black considered the whole affair an 'embarrassment' and wanted to receive no further subscriptions from homeopaths and inform current homeopathic subscribers they could no longer belong.

The more objective of those in attendance argued that homeopaths had been supporting the Association since its inception with their subscriptions and Dr Tharp Girdlestone pointed out that £600 was due to them alone. Indeed, Robert Ray, who had recommended Walcot's case to the committee in the first place, was a homeopath and had paid his subscription annually since 1865. Cutts remembered there was a lengthy discussion about homeopaths at the first meeting and it was decided at the time to admit them 'to the benefit of the fund'. Although Neild and Martin also remembered that discussion they lamented it was not recorded in the minutes as the Association was in a 'chaotic inception state' at the time. Dr Robert Knaggs suggested limiting the vested interest to the few who had already subscribed and refusing any homeopathic money in the future, but he thought it would be 'low, mean and dishonourable' to refuse Walcot.

The fact that some homeopaths were registered and legally qualified medical men could not be ignored, and therein lay the problem. They may engage in the 'practice of quackery and humbug' but the public were accepting of them, even though it was possible to practise without a qualification; as Jonasson pointed out, 'a blacksmith

it is an absurd system
not founded in science!

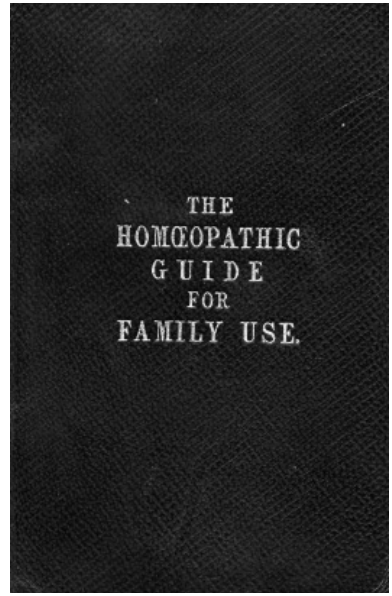


SKETCHES AT THE HOMŒOPATHIC HOSPITAL.

The Homeopathic Hospital was featured in The Illustrated Australian News in 1889 showing patients waiting admission, on the balcony, in the operating room, convalescing, arriving at the hospital and in outpatients. It operated successfully as a homeopathic hospital until 1934 when it became Prince Henry's Hospital.

Courtesy of Picture Collection, State Library of Victoria

might be a homeopath'. Dr John Blair sarcastically suggested they 'exclude watercourse men or spiritualists' as well before insisting it would 'be better to avoid the appearance of persecution and leave Homeopathy to die out'. Neild was inclined to agree because homeopathy was 'a thing of no science: while other vagaries of practice, spiritualism and so on were not openly paraded, the homeopaths were constantly flinging about Galileo and other discoveries to bolster up their delusive system and secure public sympathy by the cry of persecution'.



While homeopathy was intensely disliked by many doctors it was widely accepted and practiced by the general public, with many households stocking medicines and books such as 'The Homeopathic Guide for Family Use' c. 1857.

This domestic homeopathic kit was distributed by Bell and Huntley, a homeopathic pharmacy in George St, Sydney.

Courtesy of Monash University Library Rare Books Collection

While the spirited discussion and the freedom of unguarded expression that was a hallmark of their time is entertaining and makes it clear what the doctors thought of homeopathy, it was the ever reliable and sensible Cutts who put his finger on the pulse when he said 'the fact was, we sought to exclude homeopaths because they were successful'. In the end the principle of exclusion was agreed upon but no alteration to the rules was made. The 1874 Annual Report no longer listed any of the homeopathic doctors who had been subscribing to date, including Robert Ray who had recommended Walcot's case. The subject was raised again twenty years later when Vice-President Mr James Rudall suggested a revision of the rules to define more clearly who was eligible to subscribe. He had been a subscriber himself at the time of the 1873 homeopathy discussion but had not participated in any of the meetings. Neild, who was honorary secretary at the time and still in 1894, reminded the committee of the discussions and it was resolved to leave the matter in Rudall's hands to draft an appropriate alteration and submit it to the committee for consideration. Again, this

our purpose is outside all differences in medical treatment ... and that purpose is Charity.

was never done. As much as the profession lamented those they considered a threat to their practices and to their standing within the profession of medicine in the public mind, it was not the role of the Association to be the vanguard for advocacy or change. In the words of William Cutts again during the original debates, 'our purpose in this Association is outside all differences in medical treatment ... and that purpose is Charity.'

Placing 'widows above the reach of want'

In 1869 Cutts, then treasurer of the Association, presented the financial statement to the annual general meeting. He reminded the twelve gentlemen present that 'it ought not be forgotten that part of the scheme of the Association was to make permanent provision for those in need'. He looked forward to the fund 'growing sufficiently large to enable the Committee to educate the children of deceased destitute medical men, and to place their widows above the reach of want'. This scheme, which was inscribed in Rule 3 and involved 'limiting the expenditure as much as possible during the earlier years', was justified frequently in annual reports as it 'cannot fail to secure, eventually, a degree of success and prosperity for this Institution, which will be highly creditable to the Medical profession in the colony'.

Two years later, in 1871, the permanent fund, separate from the account used for regular loans and grants, was instigated in a form that would last for the next hundred years. At the annual general meeting, a sub-committee was appointed of Drs Cutts, Neild, Martin and Tracy to make plans for the establishment and purpose of the fund. Subscribers had to be appeased in the annual report as some were known to 'entertain objections to the increase of this fund, as being beyond the original purpose of the Association'. However the committee was determined to proceed in the belief that eventually it would be needed to ensure against limited subscriptions and to provide broader and more efficient relief in the future. The first meeting of this sub-committee resolved to apply the interest from this fund preferentially towards the widows and

orphans of doctors who had subscribed, and that this decision would take effect as soon as the fund reached the sum of £500. This happened shortly after when Cutts, anxious to take advantage of the increased value of government debentures, sold and reinvested them in the Fourth Victorian Permanent Building Society for one year at 7 per cent interest. His eagerness was such that he advanced the £14 short of the £500 required to establish the fund out of his own pocket. Drs Cutts, Knaggs and Gillbee were appointed trustees at a special meeting of subscribers called the following month in September, at which the 'principle of limitation' to widows and orphans was also resolved.

The permanent fund continued to be opposed by some subscribers who referred to it as 'hoarding'. Cutts reported at the 1872 annual general meeting that he had heard this expression used by some subscribers who believed the committee should be more liberal towards applicants. Dr Richard Tracy reminded members that the Association had a dual purpose to relieve cases applying each year, and to 'lay a foundation for the help of the relatives of medical men in future years'. In this, as in most of the Association's decisions regarding the fund over the years, it was consideration of the long-term needs of doctors and their families that won the day. The permanent fund remained and arguments about liberality were always countered with the explanation that each case was considered carefully and on its own merits. Subscribers were regularly reminded that by making three annual subscriptions they entitled their family to relief from the permanent fund if and when needed. Every year the committee felt the need to justify the accumulation of this fund and the existence of the Association itself: 'it must always be remembered that the chief aim and object of such a charity as this, is to make provisions ... for the widows and the orphans of those medical men who have practised or may in future practise in Victoria';[43] such an Association relieves the medical profession from 'the solicitation of persons whose circumstances they do not know, and into which they cannot inquire ... one of the prominent reasons for establishing [the Association was] a desire to procure some organised method of getting at the truth of the representations made by the many casual demands referred to them'.[44]

William Gillbee Esq. Surgeon (1825-1885). Gillbee was a founding VMBA committee member and served for nearly 20 years in various roles until his death in 1885. Gillbee was operating at Melbourne Hospital when Lister published On the Antiseptic Principle of the Practice of Surgery in 1867 and was one of the first to apply and advocate Lister's principles.
Engraving by H.S. Sadd, c. 1855. Courtesy of Pictures Collection, State Library of Victoria

Despite the committee's justifications, subscribers did have some cause to be annoyed. As the Association moved towards the end of the nineteenth century the interest from the permanent fund, by now twenty-nine years old, was yet to be drawn on, with grants for the year ending 31 December 1900 totalling only £58/12/0. Three of the committee members including the president were not on the subscribers list printed in the annual report! These three facts alone would have discouraged anyone considering donating their own money. It is hardly surprising that subscribers had fallen to twenty-three and would continue to drop.

The 1880s was the time of Melbourne's land boom, a rapid and 'ultimately disastrous' period of expansion when real estate speculation was rife.[45] The VMBA invested nearly £1800 in the Australian Deposit and Mortgage Bank, one of the most reputable land banks that had started during this time. However, as with all booms, there comes a crash; and by 1892 the depression had taken its toll on the assets of the VMBA, with its major investment in the Australian Deposit and Mortgage Bank under threat. The VMBA was advised at a special meeting that the bank would be forced into liquidation, and they were offered two choices with regards to their investment. They chose to redeposit their investment as preferred shares for five years, hoping that all would be well at the end of that time. However this was not to be, and eventually they would lose £800 principal and interest over 27 years when the money was frozen.[46]

'disheartened but I will try again'

The VMBA relied on annual subscriptions both to accumulate available funds and to support the permanent fund; however, the subscribers themselves were often not happy with the decisions made about the distribution of these funds. In 1872 the committee discussed at length the problem of justifying to subscribers 'any vote in favour of a claimant who was clearly outside the scope of the Rules' when they received an application on behalf of a medical man's daughter. Miss Curling's father had practised as a surgeon in England and never worked in Victoria. However, she had striven to obtain

qualifications as a midwife and was able to produce a certificate in Midwifery and Diseases of Women from the Ladies' Medical College in London. She and her mother had immigrated to Melbourne for health reasons and Miss Curling endeavoured to set up a midwifery practice in St Kilda. Having lost an otherwise reliable income of £90 a year through 'misconduct on the part of a relative', she was finding it very hard to support herself and her aged and invalid mother, and wanted to move to the country where they had a friend who would assist them. She asked for a loan of £10. The committee discussed this application at length; some considered Miss Curling to be a 'most deserving, worthy and respectable' lady and pointed out that she and her mother were the daughter and widow of a medical man. Others on the committee argued that she was not a qualified practitioner and her father had never practised in Victoria or subscribed to the Association. As it was known that she was in 'real distress' the committee decided to vote £2 to the mother, as she 'might be considered eligible' as the widow of a medical man. This was later increased to £5 when Dr Cutts visited Mrs Curling and was convinced that more was needed to cover the costs of moving to the country.

In cases such as Miss Curling's the principle of benevolence took precedence over that of financial caution or the VMBA's responsibility to subscribers. However, it did not seem to matter what the influence was behind their decisions, there was limited support for the Association from the medical profession at large. The committee tried several times to provoke interest in the Association from their colleagues. The approach encapsulated in Rule 9: 'That on the various gold fields and other centres of population where it is thought desirable, the committee shall appoint correspondents who shall make known the objects of the Association in their respective districts, collect subscriptions and donations on behalf of the Treasurer, receive applications for relief and report upon them to the Committee' was very important for both the Association and for the doctors in country towns and districts. The correspondents' role was to be a conduit for isolated doctors and to make applications on their behalf, as well as encourage subscriptions and provide the committee with knowledge of applicants and

on the various gold fields and other centres of population the Committee shall appoint correspondents who shall collect subscriptions and receive applications for relief

their situations. This was considered the best means of encouraging both interest and support from the medical profession.

At the third committee meeting on 19 May 1865, six 'particularly eligible' doctors were nominated as correspondents: Mr Pincott of Geelong, Mr McGilliveray of Sandhurst, Mr A'Beckett of Creswick, Mr Preshaw of Castlemaine, Dr Dempster of Beechworth and Dr Richardson of Ballarat. Richardson was to become better known as Richard Mahony, the fictional doctor in *The Fortunes of Richard Mahony*, a novel written by his daughter Ethel Richardson under the pseudonym Henry Handel Richardson. In the book Richard Mahony explains to his future brother-in-law, 'over a biscuit and a sherry':

> *a rough outline of the circumstances that had led to his leaving England, two years previously, and of his dismayed arrival in what he called 'the cesspool of 1852'.*
>
> *'Thanks to the rose-water romance of the English press, many a young man of my day was enticed away from a modest competency, to seek his fortune here, where it was pretended that nuggets could be gathered like cabbages – I myself threw up a tidy little country practice ... I might mention that medicine was my profession. It would have given me intense satisfaction, Mr Turnham, to see one of those glib journalists in my shoes ... There were men aboard that ship, sir, who were reduced to beggary before they could even set foot on the road to the north' ... Having had his say, Mahony scamped [avoided] the recital of his own sufferings: the discomforts of the month he had been forced to spend in Melbourne getting his slender outfit together; the miseries of the tramp to Ballarat on delicate unused feet, among the riff-raff of nations ... He scamped, too, his six months' attempt at digging – he had been no more fit for the work than a child. Worn to skin and bone, his small remaining strength sucked out by dysentery, he had in the end bartered his last pinch of gold-dust for a barrow-load of useful odds and ends.*[47]

The fictional Mahony, or the real Richardson, set up as a shopkeeper for a couple of years before finding his way back into medicine. But it was no easier to make a living as a doctor in those days as:

... in these and like accidents the unfortunate doctor might whistle for his fee

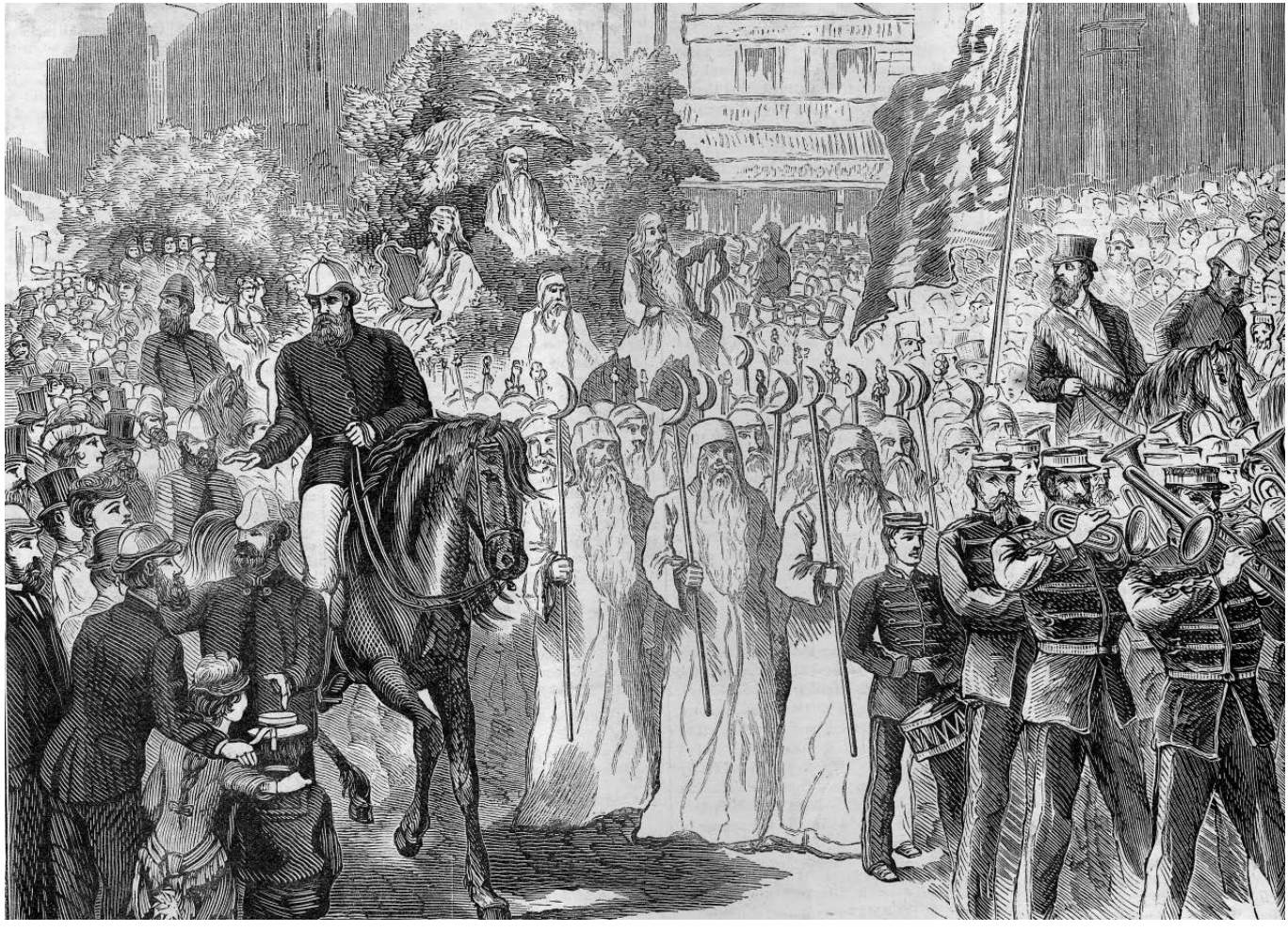
The distances to be covered – that was what made the work stiff. And he could not afford to neglect a single summons, no matter where it led him. Still, he would not have grumbled, had only the money not been so hard to get in. But the fifty thousand odd souls on Ballarat formed, even yet, anything but a stable population: a patient you attended one day might be gone the next, and gone where no bill could reach him ... or his wooden shanty had gone up in a flare – hardly a night passed without a fire somewhere. In these and like accidents the unfortunate doctor might whistle for his fee.[48]

So Richardson, like others, had the experience and eventually the contacts to make them empathetic and reliable correspondents. They were on a commission of 7.5 per cent but it was a hard job. Richardson's successor as correspondent in Ballarat, Dr Whitcombe, explained to the committee that 'I have asked for money from one or two and met with refusals, and was thereby disheartened but I will try again'.[49]

Cover of *The Fortunes of Richard Mahony*. Dr Walter Lindesay Richardson (c. 1826-1876) was the inspiration for H H Richardson's character Richard Mahony. Dr Richardson became a respected obstetrician in Ballarat, helped with the founding of its hospital and was a prominent Freemason.
Courtesy of Monash University Library Rare Books Collection

Indeed, he was not the only correspondent to be disheartened. In 1897 the committee decided to stop using correspondents in order to save money and took on the role themselves. Subscriptions did rise that year, from sixty-two to eighty-nine, which shows the value of direct solicitations, but proceeded to drop again in the following years and more considerably than ever before.

Throughout the Association's first thirty-five years the number of subscribers was usually around the eighties, with only three years when more than one hundred medical men subscribed: in 1888 there were 104; 1889, 105; and in 1891, 118 subscriptions were received. With between 812 and 1200 qualified practitioners on the Victorian Medical Register during these years, there was cause for despair for the disregard their colleagues showed the VMBA. During the latter years of the nineteenth century, there were frequent accusations of mismanagement, or at the very least of 'hoarding' the funds, and



Druids Friendly Society parade, 1880. Engraving published in *The Illustrated Australian News*, April 1880. There were many friendly societies in operation at this time, offering welcome work to doctors. However, their remuneration for doctors was low and the work was demanding. These factors became issues of disagreement, which would escalate over the next 30 years. *Courtesy of Monash University Library Rare Books Collection.*

doctors acted on these by refusing their support. The VMBA continued to meet, review cases and assist doctors and their families financially, but Rule 2 – 'That the Association shall consist of all legally-qualified medical men in Victoria on payment of an annual subscription of one guinea' – appeared to be of little value. In 1900 only twenty-three doctors subscribed, and at the dawn of the twentieth century there were only eleven subscribers, ten of whom were committee members.

What went wrong?

This was very disheartening for the committee, some members of which had served the Association for many, many years. The VMBA had done a great deal of good work over this time and helped many doctors and their families out of trouble. However, benevolence is needed by doctors in immediate distress, and such people are often not able to wait until the next committee meeting and an enquiry into their circumstances. If the Association was deemed to be ungenerous during such times of need, it was unlikely to receive subscriptions from those in a position to give. Perhaps if the Association were to have cast itself in the guise of an insurance society, with a guarantee to subscribers, rather than a benevolent society, it would have found greater success and been more appreciated. There is no doubt as to the good intentions of the founding doctors, and when they spoke of the broader scope they envisaged for the Association's future, it was with such an idea in mind. Even at their lowest the committee was positive. In the 1896 report, they still imagined a future where perhaps they would expand to embrace 'some of the purposes of an insurance society'.[50] However, it is possible that with their constant refrain of the need to accumulate VMBA funds for the future, and reassurance that doctors could refer requests for assistance to the Association instead of dealing with them themselves, the Association did itself a disservice. These two justifications alone were not enough to attract the support of a profession busy with securing its own standing, and of individuals able to receive assistance from other forms of community support that did not expect subscriptions.

Chapter four

Securing a future

In 1900 the British Parliament passed legislation to allow the six Australian colonies to govern in their own right as part of the Commonwealth of Australia, and Edmund Barton became Australia's first prime minister, with his ministry sworn into office on 1 January 1901. Until this time, there had been no reason to consider a national medical representative body, and in Victoria the various medical societies, unions and associations had a history of competing for the right to represent the state's medical profession.

In 1901 a solution to the inherent competitiveness amongst Australia's medical organisations was put forward at the Intercolonial Medical Congress, where a resolution was passed calling for the formation of an Australian Medical Association. Not surprisingly, disagreements arose about whether amalgamation would be best under the British Medical Association (BMA) or the newly proposed Australian Medical Association (AMA). The various BMA branches and the medical section of the Royal Society of Tasmania refused to appoint representatives so ultimately the committee never assembled, but the discussions did begin the ball rolling towards cooperation at a state level.[51]

In Victoria, the MSV and the BMA started to work towards their amalgamation. Eventually a scheme was adopted whereby the two organisations finally merged in 1907 under the name of the Victorian Branch of the BMA. (It was not until 1962 that it became known as the Victorian Branch of the AMA). This new organisation was to have important ramifications for the VMBA's profile, subscription levels and ability to manage trust funds for beneficiaries in future years. When the Victorian branch of

the BMA was first established in 1879 many of the original VMBA committee left the MSV, including Drs Cutts, Gillbee and Neild, and joined the BMA. In subsequent years, the groups competed for members and there was much antagonism between them.[52] However, their successful union in 1907 marked 'the end of the "old guard" of British-trained doctors and the emergence of a new order of young, enthusiastic Australian-trained men who took control of the united BMA'.[53] Under the guidance of Dr Harry Allen, this new Victorian BMA began a concerted effort to extend its membership to include all state medical practitioners and thus control medical knowledge and the direction of medical services within the state, including the forthcoming struggle with Victoria's friendly societies.[54] A federal body of the BMA was not created until 1911 and initially it was not a particularly influential body; however, it did coordinate future medical congresses, provide a permanent link between the federal government and the states, and most importantly adopted Australia's first national code of medical ethics.[55]

The new century would bring revolutionary changes in the practice of medicine, but the future was not as bright for the VMBA. By 1902 the number of VMBA subscribers had shrunk to a mere twelve, despite there being 1,178 registered medical practitioners in Victoria.[56] The committee wondered if the medical profession believed 'there was no need for such a society', as from time to time various excuses were put forward for refusing to support the charity, the principal of these being that of mismanagement by the Committee.[57] They felt aggrieved at this but insisted that such objections were never definite, nor proved, and were completely unfounded. They admitted to the fact that sometimes beneficiaries may have been found undeserving but justified it by explaining all charities were troubled by similarly isolated cases. The committee reiterated its commitment to developing the permanent fund and thus guaranteeing a regular income for the future. They described the Association realistically in the 1901 Annual Report as:

> *... only a small organisation, of necessity limited in its area of operations, but its transactions, although on a small scale, have frequently conferred valuable benefits upon those receiving them.*

we will endeavor to revive some interest in an institution which, although it has fallen somewhat upon evil days, has not died out as yet

In 1903 the funds invested with the Australian Deposit and Mortgage Bank were still frozen from the days of the 1890's depression and the bank's collapses. Chairman of the bank's directors, Mr R Murray Smith, stated at the August shareholders' meeting that he 'did not see that anything more could be done to promote the sale and realisation of the bank's assets than had been done in the past year'. It would not be until seventeen years later, in 1920, that the VMBA finally received a settlement of £1200 from the bank.

However, the optimism of the committee remained strong and with only eight subscribers they noted '…we nevertheless hope for the best and although the expression of such hope is only a cold kind of comfort, we are not unwilling to go on and do our best, endeavouring to revive some interest in an institution which, although it has fallen somewhat upon evil days, has not died out as yet'. They occasionally circulated explanations and descriptions of their work amongst the medical profession in an attempt to attract interest and support, and in 1909 even reduced the annual subscription to five shillings instead of £1/1/- in the hope of attracting more subscribers. This had little effect, but their belief in the original aims of the Association never waivered and maintained the committee through several decades of very meagre income.

In 1904 the committee recorded their disappointment at Dr Neild's resignation as honorary secretary. He was the last remaining of the original committee members, had worked tirelessly contacting and dealing with all the beneficiaries, and had regularly provided his home at 21 Spring Street for meetings. His death two years later was recorded in a minute written by Drs Syme and Gault celebrating his life:

> *The Committee of the Victorian Medical Benevolent Association desires to place on record its sense of the great devotion and self-denying labours of the late Dr James Edward Neild during the many years of his connection with the Association. One of the founders of the Association he acted as Secretary for over forty years, until failing health obliged him to retire from that office two years ago. During the whole of that period he gave ungrudgingly of his time and energy to the work. It is largely to his efforts, and those of the late Dr Cutts, that the Association holds in trust such a*

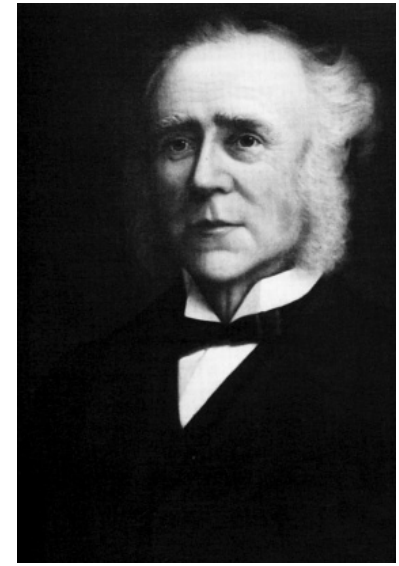
considerable sum of money for benevolent purposes. He was vigilant over the funds of the Association, tactful in the investigation of cases applying for relief, and kind and sympathetic in his relations with those to whom grants were made. His death is a great loss to the Association, but his influence will long continue to guide and inspire those who are charged with the duty of carrying on its work.[59]

Straitened circumstances

Unfortunately, Dr Neild's generous commitment to others did not protect his own family against hard times. Although applications from the widows and families of medical men were frequently recorded in the minutes, Mrs Neild was the first widow of a VMBA committee member to seek assistance through the Association, having found herself and her family in straitened circumstances after her husband's death.[60] In July 1908, a grant of £1 per week was made to Mrs Neild, which the VMBA continued for several years. Then in 1911 a letter was received from a family friend, Dr Morrison, who sought additional assistance for Mrs Neild and her family as her son was now married which meant:

a financial loss to Mrs Neild and all that she and her daughters have to live on at present is the money received from two boarders, whom they take, I believe, at a very low rate & make hardly anything out of. So far as I know, they have no other source of income and I am told by a lifelong friend of Mrs Neild, that they have nothing whatever in the Bank or savings of any sort …

The committee promptly provided a grant of £21 to Mrs Neild and further support in 1912. She died several years later, having made no more claims on the Association. A brass tablet was installed at the Independent Church of which she had been a member for nearly eighty years. At the ceremony the Reverend James outlined her contributions to society as a longstanding member of the church, and her involvement in the foundation of the Women's Hospital and several other public movements for the benefit of women and children. He preached the text 'They shall bring forth fruit in old age' from the Bible and explained that old age 'was not a thing that people liked … It involved the decay



James Edward Neild (1824-1906) Dr Neild was one of the founders of VMBA. His work and interests encompassed diverse fields – forensic pathology, drama critique, medical education and journalism. He was described by a contemporary as 'personally a delightful man, courteous and obliging … of wide reading and culture, but also a keen fighter for what he thought to be right … beloved by his friends, and most cordially hated by his particular enemies, of whom he has a good many'. (ADB online)
Courtesy of Australian Medical Association (Vic) Archives

of physical powers, an inability to do things we once did, and a feeling of comparative uselessness. Old folks had naturally to depend more and more on others, and grew more and more lonely as the years passed by.'[61] Many of the cases that were coming before the VMBA committee reflected this biblical teaching. A successful medical practice such as Dr Neild's was no surety of longstanding income and the committee knew that a flair for medicine did not always equate with an ability to manage business and financial concerns. Mrs Neild's case was similar to several others during the early years of the twentieth century, where the widows of long-practising medical men had been left in precarious financial circumstances.

Prior to Federation, the provision of welfare for the aged was primarily left to family members or charities such as the VMBA. However, at the turn of the century the lingering effects of the 1890s depression had left many older members of the community with little or no savings. There was a growing realisation that the elderly population was too great a responsibility for families and charities alone. In 1900 both the New South Wales and Victorian governments introduced an old age pension, which in 1909 was taken on by the Commonwealth.[62] Around this time, the committee reconsidered the manner in which its relief was handed out and decided to sometimes grant regular payments over a longer period rather than larger one-off payments. Although this was not necessarily the committee's preferred choice of support, it often proved more beneficial for the older doctors or doctors' widows and children.[63]

Dr Dan Gresswell, who became president of the VMBA in 1897 after the death of Dr Cutts, had a public profile in Victoria. He was appointed the medical inspector of the new Victorian Board of Public Health in 1899 and was thus responsible for the sanitary state of Melbourne. 'His handling of the influenza epidemic raging in Victoria when he arrived [back from Europe] in March 1890, won him the gratitude of the premier, the respect of the medical profession and the lasting confidence of the public.'[64] His recommendations on sanitary conditions, employment of public health officers and promotion of good sanitary practices to the public meant that in 1900 Melbourne

Drs. Gresswell and Elkington fighting the plague, 1900. The character Hamlet represents Dr Dan Gresswell, medical inspector for the Victorian Board of Public Health. The first case of plague in Melbourne was reported to him on 8 May 1900, less than two weeks before this drawing appeared. It was Gresswell's responsibility to plan for a potential outbreak of plague. An expert in public health, he advocated quarantine stations, the fumigation of houses, clearing of drains and public inoculations.
Dr John Elkington is depicted as Horatio and was responsible for carrying out fumigation and inspecting ships as they arrived at Melbourne.
Courtesy of the National Archives of Australia (CP567/1:8832596)

Mrs Gresswell is penniless having the misfortune of being duped of her money

suffered minimal effects from the plague, particularly when compared with Sydney where over 303 cases were reported and 103 people died.[65] In October 1904 Gresswell resigned as VMBA president due to the 'pressure of other duties'; however, he died only two months later from septicaemia and complications from a severe attack of jaundice from which he had never fully recovered. He was only fifty-one years of age.[66]

Ten years later the minute books record a letter from Miss Violet Benjamin on behalf of Mrs Gresswell, requesting assistance for her as 'she is penniless having the misfortune of being duped of her money'. Miss Benjamin put her case personally to Dr Gault outlining that Mrs Gresswell had 'lost all her money through the imposition of unscrupulous persons and was now penniless'. The committee initially provided support for two months in order to investigate her situation, and then granted an ongoing 15 shillings a week to supplement her old age pension and support she received from the Hall Bequest. She was assisted by the committee for many years, often with visits from members of the committee to check on her wellbeing, until her death in 1923.

Widows of doctors who requested assistance were not always older women. Mrs Newcombe, who applied for assistance in 1912, was supported in her application to the committee by Dr Mackeddie from the Alfred Hospital. She was only thirty-eight years old and a recent widow. Her husband, Dr Newcombe, had started his career as an assistant to Dr Altmann at Bright for two years, after which he had worked as a medical missionary in South Africa and later in India, where he died as a result of malaria and dysentery. Mrs Newcombe had one little girl and had been left £500 insurance and 10 shillings a week from her husband's friends towards support of her daughter. Gault advised the committee that she was 'quite unable to do anything to maintain herself owing to ill health caused by Fibroid Phthisis [a tubercular infection], chronic depression and fever' and the committee agreed to support her with a grant of £5.

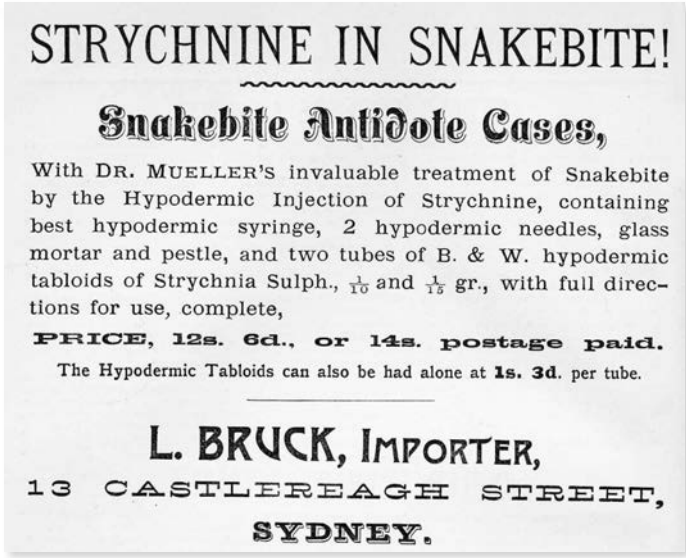
Mrs Rumney was the daughter of late Brigade-surgeon RJ Quinnell. She applied to the committee on behalf of her family explaining that her husband was of ill health and also suffering from malaria, and he had been eight months without work. They had four

children, the youngest being only two years of age, and were completely destitute and stranded in Melbourne. The committee granted an immediate £5. However, they felt the need of this family was beyond the sole resources of the Association and therefore decided to assist them further by placing a letter of appeal in the newspaper for 'A Family in Distress', hoping to raise an amount to assist them with travelling expenses to Brisbane where their friends had promised them 'any necessary further assistance and where employment is offered for her husband'.[67] The letter explained that 'all their furniture would be required to meet the rent, which a generous landlord had allowed to accumulate' and was signed by Gresswell with the editor noting that *The Argus* would be happy to collect any donations. To whatever sum was raised through this avenue, a further sum was promised by the VMBA, in order to make up what was needed to get to the family to Brisbane. During the first twenty years of the last century, the committee's support for wives, widows and children of medical practitioners far exceeded that of doctors assisted through the Association.

'the wave of ruin in our countryside'

> *Ah my sunburnt brothers! Sons of toil and of Australia! … I love and respect you well, for you are brave and good and true. I have seen not only those of you with youth and hope strong in your veins, but those with pathetic streaks of grey in your hair, large families to support, and with half a century sitting upon your work-laden shoulders. I have seen you struggle uncomplainingly against flood, fire, disease in stock, pests, drought, trade depression and sickness and yet have time to extend your hands and ears in true sympathy to a brother in misfortune and spirits to laugh and joke and be cheerful.*
>
> Miles Franklin, *My Brilliant Career*, 1901

Although these words of Miles Franklin glorify the men of the outback, they also vividly describe some of the hardships and struggles of those living in the Australian countryside. These severe conditions were often reflected in requests to the Association from the widows of country practitioners. As early as 1892 Ludwig Bruck, editor of the



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Snake bite remedy from *Australasian Medical Directory* 1896. While Mr Webb's horse died from snakebite, treatments were often advertised in the medical journals of the 19th century. This one, an injection of strychnine devised by Dr Mueller, could be bought from Mr L Bruck, importer, the same Mr Bruck who wrote the *Australian Medical Directory* and 'The present state of the medical profession in Australia'. *Courtesy of Monash University Library Rare Books Collection*

Australasian Medical Directory and Handbook, recognised the severe pressures that doctors were under, particularly county doctors.[68] Conditions of life in Victoria's countryside were extremely hard and frequently uncertain. Rural doctors not only had to deal with competition from friendly societies, but also with the harsh conditions of life on the land which often enough led to an uncertain financial situation for their patients and in turn themselves. The sufferings of one such family who came to the VMBA for assistance were described in a public appeal to the editor of *The Argus*:

> *Sir, I venture to make an appeal through your columns for assistance in a case of distress which, I am sure, there are plenty of people in Melbourne willing and able to relieve if it is brought under their notice. An educated lady, with five young children, the widow of a doctor, is stranded in Melbourne in a position of absolute destitution. Her late husband, coming from another state four years ago, started a practice in one of the then prospering townships in the heart of the Mallee country. He gained the respect and confidence of the settlers, but the wave of ruin that desolated the whole district under the calamitous drought brought him, like all about him, to starvation point. After four years' struggle, with hope deferred, he contracted influenza, on which brain fever supervened and a few months since he died in the local hospital. Though there was a fair amount on his books, nothing could be collected, no one would think of buying his practice, and the family was destitute. An appeal to the Mallee Relief Fund was*

fruitless, on the grounds that the money collected was for stricken farmers. The household furniture had to be sold to pay the local tradesmen, and to move the family to some more hopeful spot. While money was wanted for daily rations and seed wheat, no one could invest in furniture and the sale was disastrous, the few pounds realized barely sufficing to clear accounts and transfer the stricken family to Melbourne. The widow is anxious to work, but what can she do with such a handicap as five children? She is a good housekeeper, and the hard experiences of late years have made her a good cook, but she could not go out to service unless she was willing to throw her family on the state, which she is not. 'The Queens Fund' has supplied such moderate assistance as their quarterly distribution permitted. What is required is to raise a sufficient sum to enable her to furnish a small house, and take lodgers until it is possible to find some more congenial work for her.[69]

The family was that of Dr Samuel Eadon, who had lived and practised in Hopetoun for four years. Life in the Mallee was extremely hard at the best of times; however, the Eadon's arrival in Hopetoun in 1898 was right in the middle of several years of severe drought that did not end until 1902, the year of his death. Some months later the committee received an urgent request from Mrs Eadon for assistance but without particulars of her case. They forwarded £3 as temporary relief while Vice-President Dr James Ryan followed up her case with a friend of his from Hopetoun. In June they forwarded another grant of £5 before the publication of the above letter and the subsequent positive response from the public. The letter's author, Mr H Gyles Turner, a banker, historian, littérateur and sometimes humanitarian, reported personally to the VMBA committee meeting in August 1903 that now:

Mrs Eadon had engaged a board and lodging house in East Melbourne … where she had apparently some prospect of succeeding. 'A practical woman' was assisting her in her arrangements, and with the money she had received from the committee added to the subscriptions evoked by his appeal to the public … there appeared to be some likelihood of her getting out of her immediate difficulties.

the wave of ruin that desolated the whole district under the calamitous drought brought him to starvation point

Dr George A Syme (1859-1929) Dr Syme was a successful surgeon who also represented the medical community on a number of institutions such as the BMA (Vic), Medical Defence Association of Victoria and the Australian Medical Congress. He served in the AIF during WW1 and was instrumental in the formation of the Royal Australasian College of Surgeons.
Courtesy of the Royal Australasian College of Surgeons

Mrs Eadon continued to be supported with small grants from the committee during the next few years. As with many of the widows, particularly younger women supporting children, continued support was a necessary fact of life. Years later, even up to the First World War when the committee met rarely, the majority of their support remained for the widows, sisters or daughters of medical men.

The war effort

Various members of the committee contributed personally to the war effort during the First World War such as Dr George Adlington Syme, who enlisted in the AIF with the rank of Lieutenant-Colonel and served with the 1st Australian General Hospital in Egypt. He was then appointed surgeon consultant to the hospital ship Gascon. He was eventually invalided back to Australia in 1916 after contracting septicaemia through operating, and established himself back on the committee almost immediately. Dr George Cuscaden (later Sir George Cuscaden) was appointed Principal Medical Officer in Victoria at the outbreak of war, and in early 1918 he became Director-General of the Medical Services of the Commonwealth. Dr Charles Ryan was made Assistant Director of Medical Services, 1st Division, AIF, and served in Egypt and Gallipoli. In his youth he had been a surgeon with the Turkish Army in the Russo–Turkish war of 1877 where he received a Turkish decoration for his services. Dr Murray-Morton tells a story of Dr Ryan, that 'when he was on Gallipoli … a temporary truce was arranged on one occasion, and when the opposing forces met during the truce the Turks were surprised and delighted at seeing an Australian Officer wearing a ribbon of a Turkish decoration'.[70] Later members of the committee, such as Richard Fetherston and William Upjohn, also served prominently during the First World War.

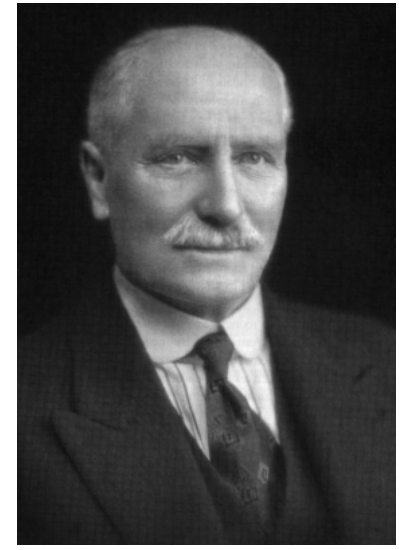
The VMBA also supported the war effort through a specific donation of £100 to the Belgian Doctors and Pharmacists Relief Fund in 1915. This society was formed to assist Belgian doctors and pharmacists who had fled to England in the early days of the war, and then later funded relief in Belgium itself through the Aide et Protection

aux Medecins et Pharmaciens Sinistres Belges. In Australia, in order to assist raising finance for the war effort, the Commonwealth Government established a series of war loans which the VMBA supported. In 1915 the committee moved £350 from the Bank of Victoria to invest in war loans, and in 1918 another £500 was invested from its Commonwealth Bank account. In 1920 the Treasurer, Dr Cuscaden, asked for permission to invest £1200 in Commonwealth Peace Loans at 6 per cent. This was the sum the VMBA had received from the liquidator of the Australian Deposit and Mortgage Bank in final settlement of its investment, owed to them since the 1890s depression.

Before the start of the war, a more pressing issue had caused disruption within the medical fraternity. It was an issue that had been brewing for many years and with the consolidation of the medical profession in Victoria under the Victorian branch of the BMA, this dispute finally came to a head in 1918 with the strike of the medical profession against the friendly societies in Victoria.

'deep inroads into doctors' private practices'

The establishment of friendly societies in Victoria began in the late 1830s and would, in time, have a major impact on the conditions and standing of the medical profession working for such institutions in Victoria. Also known as benefit lodges, they became a vital component of Victoria's nineteenth-century social and community landscape, and by 1873 the government statist estimated that around one-third of Victoria's population was obtaining medical care through one of these societies.[71] Members paid a subscription on behalf of themselves and their dependants and this money went into a common fund, which contributed to the sick pay, funeral costs and subsidised medical care required by members and their families.[72] The societies also filled a huge social and emotional need for their members during the turbulent years of the gold rushes and the subsequent rapid development and expansion of Melbourne. These fraternal organisations not only provided assistance to families settling in Victoria, but also 'fellowship and



Dr (Sir) George Cuscaden (1858-1933). Dr Cuscaden took an interest in local government while maintaining a private practice. He was a member of the Port Melbourne Council and the Melbourne City Council. He was honorary surgeon to the Women's Hospital for many years. At the outbreak of war in 1914 he was appointed the principal medical officer in Victoria and in 1918 became Director-General of the Medical Services of the Commonwealth.
Courtesy of the Australian Medical Association (Vic) Archives

the abuses of the doctor's services by the friendly societies, the public hospitals and the State government

friendship', mutual responsibility and strength in community.[73] The names of societies such as Manchester Unity, the Rechabites, the Australian Natives Association and the Independent Order of Oddfellows still resonate more than a century later.

Initially, the medical profession accepted the societies as they allowed the working class access to medical care and provided doctors with an otherwise unattainable source of income, as these workers were often not in a position to afford doctors' private fees.[74] However, membership of the societies was not means-tested, and with their enormous growth in late 1800s the medical profession quickly changed its mind. The fundamental problem was that the benefit lodges tended to appoint a doctor for their members at fees that undercut those of non-lodge doctors.[75] In 1898 the Medical Defence Association of Victoria (MDAV) conducted a survey of lodge doctors. Some 89 per cent were unhappy with their contracts, believing wealthier society members were taking advantage of the lodges.[76] The MDAV put the profession's complaints directly to the societies, and proposed that anyone earning over £200 per year should not be permitted as a member, but this proposal was rejected. They also developed a Model Agreement for doctors to use should they take on an appointment as a lodge doctor; however, these guidelines were also often rejected by the societies.

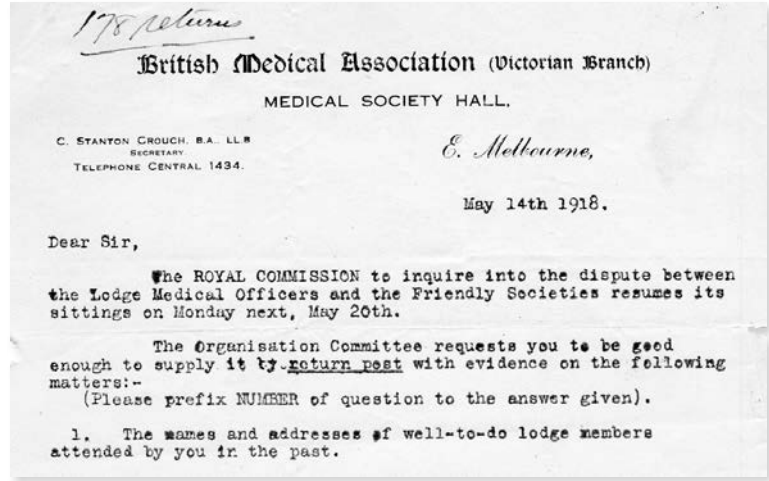
In 1907 Dr R Worrall, from the New South Wales branch of the BMA, addressed the Association members 'in a stirring speech' where he heatedly 'proclaimed the profession to be overcrowded and pointed to the abuses of the doctor's services by the friendly societies, the public hospitals and the State government'.[77] During the first decade of the twentieth century there was an unprecedented rise in the number of medical practitioners in Australia, this caused competition within the profession and Worrall was keen to compel the friendly societies to remove inequities from their lodge contracts. In Victoria, the number of registered doctors had jumped from 743 in 1901 to 1,283 in 1911.[78] Lodge doctors were paid around 14 to 15 shillings per member each year and were expected to provide consultations, surgery, anaesthetics and medicines.[79] By 1910 the friendly societies were at their peak and making 'deep inroads into doctors'

private practices', with over 142,000 members in Victoria.[80]

By 1913, however, the Victorian branch of the BMA had increased its membership considerably and was resolute in its promotion of a new agreement with the societies. It met with society representatives and called for the introduction of an 'income limit clause' of £208, the per capita rate to be raised to 20 shillings per member in the cities and 26 shillings in the country, and the number of items requiring extra payments to be increased.[81] The friendly societies, worried about losing members, continued to refuse the doctors' demands and thought the rates requested were excessive. In August 1914, the BMA and the Victorian Friendly Societies Association met to again negotiate fees. During this conference the outbreak of war was declared and the friendly societies requested the BMA to 'waive their demands until the end of the national emergency'.[82] Shortly afterwards the BMA Council formally recommended to its members 'that in view of the commercial depression resulting from the war and the need for mutual self-help, the introduction of the new agreement between medical men and their lodges be deferred for the present'.[83]

By 1917, with about one-third of the medical profession in the military, the BMA represented around 80 per cent of medical practitioners in Victoria. It was time to re-open negotiations. The BMA took a strong stance with its president Professor Berry stating that the Association had 'elicited much evidence of the gross abuse of lodge contact practice. It has now determined that it shall cease, and on this point it is adamant.' On the 31 January 1918, 408 lodge doctors simultaneously resigned their friendly society contracts.[84] This major disruption to medical services in the state, and the subsequent pressure from the Victorian BMA for doctors not to meet with society officials, resulted in the state government's intervention. Victoria's new premier, Harry Lawson, appointed a Royal Commission to settle the dispute, which in due course ruled in favour of the medical profession.[85]

This victory for the medical profession eventually brought a welcome end to the dominance of the friendly



178 returns

British Medical Association (Victorian Branch)

MEDICAL SOCIETY HALL,

C. Stanton Crouch, B.A., LL.B
Secretary
Telephone Central 1434.

E. Melbourne,

May 14th 1918.

Dear Sir,

The ROYAL COMMISSION to inquire into the dispute between the Lodge Medical Officers and the Friendly Societies resumes its sittings on Monday next, May 20th.

The Organisation Committee requests you to be good enough to supply it by return post with evidence on the following matters:-
(Please prefix NUMBER of question to the answer given).

1. The names and addresses of well-to-do lodge members attended by you in the past.

With a Royal Commission inquiring into the dispute between the Friendly Societies and the Lodge Medical Officers in 1918, the BMA (Vic) issued a series of questions to members asking for details of their engagement with the Lodges.
Courtesy of Monash University Library Rare Books Collection

societies in Victoria. By 1921, although the number of doctors in Victoria had decreased, the majority remained as BMA members giving the Association a continued representation of around 80 per cent of doctors in Victoria.[86]

there is much evidence of the gross abuse of lodge contract practice. We have determined that it shall cease, and on this point we are adamant

'the growing magnitude of claims'

The new found security experienced by the medical profession did not make doctors more inclined to subscribe to the VMBA, however. Although this lack of support was discussed at several meetings during the 1920s, it wasn't until the height of the Great Depression in 1932 that the committee decided at their annual meeting that it was time to align itself with the Victorian BMA and seek their assistance. The Secretary drew the committee's attention 'to the growing magnitude of the claims made on the Association and the need for augmenting the funds'. Unfortunately, due to the death of Sir George Cuscaden, the VMBA committee didn't formally discuss this again until the following year (under the new presidency of Dr Richard Fetherston) when it was reported that:

> *Dr Upjohn was of the opinion that wider publicity should be given to the work of the Association and suggested that the Council of the BMA should be asked to endorse and post to the members of the Association a brief statement of the objects and work of the VMBA … the statement should be accompanied by an appeal for membership. It was thought that many would be willing to add an additional 5/- to their cheque for their annual subscription.*[87]

Their request was heard and an invitation to subscribe to the VMBA was sent out by the BMA Council to its members with their annual report and BMA subscription. It was a spectacular success with two-thirds, or some 350 doctors, deciding to support the VMBA. In the 1933 Annual Report Dr Fetherston was profuse in his appreciation of the BMA and felt 'assured that a new era of usefulness has opened for the Association'.

a new era of usefulness has opened for the Association

In 1934, as the city councillors planned to celebrate the centenary of European settlement of Melbourne, it seemed to some that there was little to celebrate. The financial strains of the First World War, the Great Depression and the resulting

unemployment undercut the claims of Melbourne's positive progress. At the same time the Association now felt itself in a reasonably sound financial position. With a substantial permanent fund of over £8,000 and a new healthy membership contributing yearly subscriptions, the committee could be more generous with its assistance and feel more confident about its future.

Claims on the Association during the 1930s presented a rise in requests from doctors in difficulty, as opposed to the predominance of requests from widows and family members that the committee had previously received. The pressures on doctors resulted in some turning to drugs and alcohol, affecting their ability to maintain ongoing employment or even to obtain any work at all. The committee tended to view these doctors with a more measured approach but usually assisted. Ongoing support for a number of widows and families of doctors was frequent, suggesting that even with the availability of old age and invalid pensions there were still many needing additional support. In 1929 the Association's own auditor for many years, Dr Peter Bennie, was referred to the committee as 'beyond the old age pension he had no source of income and … he had nearly come to the end of his resources and none of his children were in a position to render financial assistance'. He was granted £1 a week. In 1930 the Commissioner of Invalid and Old Age Pensions queried the reason for his benevolence payments: 'is it on account of illness, infirmity or old age?' and was informed 'Dr Bennie is thus situated in consequence of infirmity and age.' The Commissioner seems to have accepted this explanation, allowing him to receive both a pension and a benevolent payment, as the following year the committee voted to continue his grant of £1 a week for another year.

Dr Grimshaw, a thirty-six year old who had contracted haemoptysis while a resident medical officer at the Alfred Hospital, returned to Australia in very poor health in 1934 after working in Switzerland and England 'and is now a complete invalid at his home under the care of Dr Tallent'. Tallent referred him to the VMBA who supported him for some two and a half years with £2 a week. When his breathing became more difficult

and it was clear he was not going to be able to work they considered the possibility of applying for an invalid pension as well, although that may have compromised his benevolence payments. In the end their concerns were no longer an issue when, in March 1939, he died.

Balancing the regulations associated with receipt of limited social security pensions and the need to top them up with benevolence payments was often difficult. It would not be until 1946 that Dr Cyril Dickson informed the committee that more liberal concessions were finally being considered by the government in connection with old age and infirmity pensions, which would enable pensioners to receive a larger income from other quarters, such as the VMBA, without a deduction from their pension.[88]

The committee worked hard in these between war years, with several meetings a year dealing with noticeably more requests and cases. They introduced the idea of giving small financial Christmas gifts to beneficiaries, which were provided on top of their regular payments. The committee also revised the Association's rules in 1934, removing the restriction listed in Rule 14 from 1871, which stated that 'the interest of the permanent fund should be devoted to the relief of the widows and orphans of legally qualified medical men, who had been subscribers to the fund for any three years previous to applications'. This allowed the committee freedom to distribute funds to deserving cases as they saw fit. The twenty years of peace seemed brief, however, when Prime Minister Robert Menzies announced to the Australian people on 3 September 1939: 'It is my melancholy duty to inform you officially that in consequence of a persistence by Germany in her invasion of Poland, Great Britain has declared war upon her and that, as a result, Australia is also at war.'

During the Second World War the VMBA again missed several members of its committee while they served in the forces overseas. Alfred Derham joined the AIF in 1940, but was captured by the enemy and only welcomed back to the committee in 1946 after his release from a POW camp in Asia. James Major joined the AIF in 1941, returning in 1943 when he took over as president after the death of Richard Fetherston.

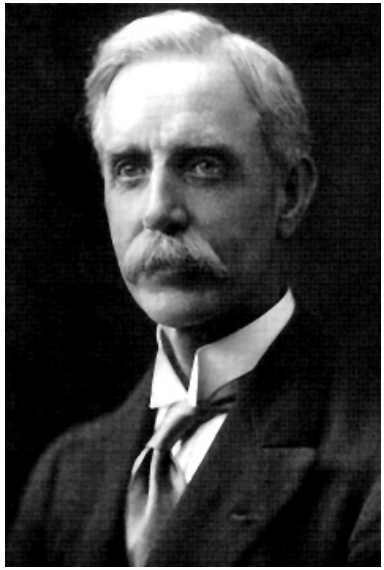
The Association paid tribute to Fetherston's active work for the VMBA and, in particular, his part in obtaining the cooperation of the BMA in publicising the work of the committee. Fetherston did more than just promote the VMBA, he secured its future as a viable charity. In his will he bequeathed 'the capital and income from his estate to the VMBA upon the death of the last survivor of his three children'.[89] The Association did not receive this bequest until 1972; however, it gave the VMBA knowledge that it would have a secure future.

In 1944 Dr Gault's annual report impressed upon subscribers the ways in which the VMBA had been able to assist doctors and their families:

> *Monthly allowances, some of £4, others of £8, to 8 persons have been made. In several instances these allowances have been maintained for several years. They have blunted the sharp edge of poverty and brightened the declining years of aged and afflicted members of the profession and have enabled others to meet successfully critical financial situations. Widows have been helped to educate young children and fit them to enter on the race of life with lessened handicap. One boy recently reported to the Secretary with pride after he had received his Wings with the Air Force and has now left for the Front. Two, of another family, were enabled to take a high school course. One of these is now working in a munitions factory and the other expects to pass the Leaving examination at the end of the year. A recent graduate, the victim of tuberculosis, has been greatly helped and enabled to enjoy a prolonged rest. This has led to such improvement in his health that he has been able to resume light professional duties.*

In 1949 Dr Edward Leslie Gault retired as honorary secretary of the VMBA committee, on which he had served for an remarkable forty-five years. He had commenced his general practice in 1896, specialising in eye, ear, nose and throat work—one of the earliest practitioners to do so. During his working years he gradually built up his work in ophthalmology, the area in which he eventually specialised. He also delighted in his teaching at the Alfred Hospital. He worked 'to make people's

monthly allowances have blunted the sharp edge of poverty and brightened the declining years of aged members of the profession



Dr Edward Leslie Gault (1863-1954) Dr Gault was an extremely well respected, kind, hard working doctor who specialized in eye, ear, nose and throat work medicine while maintaining a general practice. His generous nature was reflected in the many years of work that he devoted to assisting beneficiaries of the Victorian Medical Benevolent Association where he was secretary for forty-five years.
Courtesy of the Australian Medical Association (Vic) Archives

eyes safe in the hands of the general practitioner and to encourage others to enter this speciality'.[90] A man of extensive energy, at the age of eighty during the Second World War he took on work examining troops at Royal Park, treating eye patients at the Austin and running his two practices without a motor car.

The profession of medicine

The professional status of medical practitioners was firmly established by 1930, with the Victorian BMA confirmed as the primary medical body representing medical practitioners in the state. The longstanding threat presented by the friendly societies was gone and there was a growth in the demand for medical services, particularly with exciting developments in medical science and the acquisition of greater skills.[91] Discoveries such as penicillin in the 1940s would prove to be extremely effective against bacterial diseases such as spinal meningitis, pneumonia, gonorrhoea and syphilis, giving doctors the so-called 'magic bullet' to fight these previously often fatal infections.[92] Other discoveries in science and technology, such as new anaesthetics, enabled doctors to perform operations on the heart and lungs, something that would not have been considered before. Not only did these medical discoveries give doctors greater knowledge, tools and expertise in their field, but they also distanced the medical profession as a whole from the practice of 'alternative' practitioners. Developments in surgical techniques and procedures together with scientific research into new treatments also widened the knowledge gap between the doctor and patient. These developments in the science of medicine also had one other effect: they encouraged doctors to specialise. Before this, doctors who specialised in a particular field were usually general practitioners who tended to have extensive experience in one area of medicine, like Edward Gault in ophthalmology, or Gerald Fetherston who eventually specialised in obstetrics and gynaecology after working for many years at the Women's Hospital.

Practising benevolence

The generosity of the Fetherston bequest allowed the committee to plan for the future with some confidence. This gift would also make a difference to the lives of those who looked to the VMBA for assistance. The VMBA could now be more generous in their support with the knowledge that the Association would not have to rely on subscriptions and donations alone to increase its permanent account. Although the committee had received individual donations from doctors or families of doctors over the years, none provided the sort of security granted by the Fetherston bequest. The Association now saw their future with certainty.

The committee of the day was guided by its rules certainly, but essentially it was comprised of doctors who made their decisions based on their intimate knowledge of other doctors and of medical practice, and their beliefs as benefactors. There had been many changes in the profession over the previous eighty years, and just as many in the VMBA. The committee had ridden through misfortunes and fortunes, and its members had retained their integrity and remained true to their beliefs and to those of the founding doctors. Changes were to come at a faster pace over the next sixty years, but the practice of benevolence would forever be the driving concern.

A doctor tending to a soldiers neck wound in the trenches at Gallipoli, 1915.
T P Bennet. Courtesy of Pictures Collection, State Library of Victoria

Chapter five

Changing times

'Once upon a time we paid for half the funeral, with a bunch of flowers, and maybe the social worker would go and have a cup of tea after twelve months. Or else maybe we would pay the rates ...'

The postwar years are a cliché for many: 'static, complacent and monocultural, or, for conservatives ... prosperous, unified and satisfyingly middle class'.[93] Clichés have a tendency to hide the nuances, textures and colours experienced in reality, but for many in the medical profession monocultural and satisfyingly middle class may have been apt:

> *It was rude to practise from a shop, or from a business area, because [a general practitioner] had to be available the whole time ... He did not have to earn too much money, and it was perfectly acceptable for a doctor to retire reasonably without luxuries ...*
>
> *... a red light, a brass plate, and standing there tending the roses on the weekend and talking to friends over the fence.*
>
> *... and the wife had a twinset, and a grey skirt, and a string of pearls.*[94]

'a red light, a brass plate and the wife had a twinset'

These doctors had come back from the battlefields of the Second World War to restart their careers and lives. The broader field of medicine and medical science was certainly not static or complacent; there were many exciting developments taking place in all fields. However, behind the brass plates, the fences and the roses, many doctors

HBA Advertisement c. 1965. The VMBA frequently assisted families of deceased doctors to maintain their health insurance coverage.
Courtesy of Monash University Library Rare Books Collection

and their families were struggling. They hadn't managed to become financially secure, and the honorary system of hospital medicine, which continued for another thirty years or so after the war, left many with financial problems. There are some on the committee today who remember several instances of doctors widely recognised as wonderful and successful practitioners, but 'success with patients and success in the medical practice wasn't, in the '60s, '70s and '80s, equivalent to having any money ... and they wouldn't talk about money, and they left their wives virtually destitute'.[95]

Alongside the economic difficulties, injuries, illness and war-related post-traumatic stress disorders (although generally not recognised as such at the time) were behind many requests for help received by the VMBA during the 1950s and 1960s. President Dr Herbert Furnell gave some hint of this when he wrote in the 1961 Annual Report that 'in recent years ... demands on the Association have increased and will continue to do so ... formerly ... virtually limited to elderly widows ... today ... sought by the dependants of younger members of the profession who have died untimely'.[96] A quick glance through the minute book for the 1960s shows at least eight widows of doctors who had 'died untimely', with more than eighteen school-age or younger children between them. For these families a founding intention of the committee, namely 'to educate the children of deceased destitute medical men', was still paramount. Apart from the part payment of school fees or

other educational expenses, health and insurance payments were provided, as were grants and loans for general living expenses. So the nature of the charitable giving had not changed much in nearly one hundred years.

'the type of docs we are likely to help'

Dr George Tippett, president from 2000 to 2009, well remembers the problems that faced previous generations but believes that today 'we've got doctors who are suffering from the real complexities of life'. Pride, idealism, bad luck, illness, addiction, self-medication, a reluctance to tell another doctor they are sick, isolation, cultural differences, the impact of the Medical Board's role to protect the public (and 'they don't mind how many [ethical] doctors they might disadvantage in doing that'[97]) – all of these have been suggested as reasons for eventually seeking assistance from the VMBA. In recent decades the deliberations of the committee and the tasks of the social worker have adjusted to meet the changing characteristics of the profession, generally put down to drugs, feminisation of the medical workforce and increasingly complicated or dysfunctional lives.

today we've got doctors who are suffering from the real complexities of life

Is addiction an illness?

The problems created by drug abuse have increased dramatically in recent decades and they often begin at medical school. Thirty or forty years ago 'most medical students looked after their brains extremely carefully and didn't actually engage much ... in a marijuana culture. If they were going to abuse anything it was more likely to be alcohol ... the younger cohort of people (today) may be on a variety of drugs that were not around before ... ecstasy, ice, etc. I have heard registrars discussing the weekend "trip" and you wonder about how well they function. But it's those sorts of issues that we now see, I think, as a considerable shift in the sorts of people Medical Benevolent is assisting.'[98]

This naturally gives rise to issues of an ethical nature that need to be resolved around the committee table when decisions regarding beneficiaries are being made. In

he had been found to be a morphomaniac and an incurable inebriate

the case of an ill doctor, the primary goal has always been to enable the beneficiary to get back on their feet and to continue, or return to, practice and that is still the aim of the VMBA. There is no one on the committee today, for example, who would disagree with that goal, although there are differences of opinion as to the causes of addiction and the extent to which help is beneficial or deserved. Is addiction an illness? President Dr Dominic Barbaro believes they need to ask 'will this person be a suitable medical practitioner one day? Is he going to put our patients at risk ... And that's a dilemma for us because ... we should be able to help them as much as we can.' However, an addiction to drugs may not lend itself to a responsible and successful medical practice, so to what extent is the VMBA ethically entitled to assist? This view is countered by the one that drug addiction, whether ecstasy or pethidine, whether at medical school or early in a career, is a medical disorder and that 'only certain sorts of people use these drugs for particular reasons to the degree that they run into difficulties',[99] in which case Medical Benevolent is both entitled and tasked to assist them.

This was not always the case. In 1891 Dr Otto Gmelin approached the Association for temporary relief. He was given £2 and the next day he called upon Dr Neild to request another £3, 'but as he was drunk, the application had been refused'. Some few months later Neild reported he had heard that Gmelin had been admitted to the Melbourne Hospital after attempting to poison himself. 'He had been found to be a morphomaniac and an incurable inebriate'. When he applied yet again in May 1892 his behaviour on his last visit was remembered and he was refused. By July 1893 his life had spiralled out of control as he 'had recently been sent to gaol ... for stealing a skull from the public library and selling it to a pawnbroker for five shillings ... Gmelin was a morphomaniac and the magistrate had sent him to gaol out of a merciful desire to remove him from the temptation of indulging in morphia and other narcotics'.[100] Today, however, whatever the ethical concerns regarding substance abuse, it would seem from the sparse minutes regarding individual cases that it has been a very long time since the VMBA has turned away an applicant on the grounds of addiction.

Feminisation of the medical workforce

Victoria has a strong and proud history of women in medicine beginning with the first female students at the University of Melbourne Medical School in 1887, and the founding of the Queen Victoria Hospital in 1896, which was 'For Women By Women' only.[101] Since that time women doctors have increased exponentially in numbers and played many important roles in speciality and general medicine. However, the VMBA did not receive any applications for help from women medicos for a long, long time, apart from a small handful of widows who had had some experience in nursing.

The first clear reference in the minutes to a female doctor was in 1947 when Dr Gault reported that Dr Ethel Parnell, an ophthalmologist, was no longer able to practise due to ill health and that she had few financial resources. It turned out that assistance by the VMBA was not needed. It is not always clear if a beneficiary is a woman unless the full name is provided; however, there appears to have been only four other female doctors receiving assistance prior to 1996. Dr M, in 1962, received a grant of £100 to help her and her three children sail for England after the sudden death of her husband, who was a doctor at the Royal Children's Hospital. Dr McK began receiving assistance in 1974 with her HBA payments, school fees and an allowance. Although there is no information regarding her circumstances, she continued to receive assistance for twelve years. In 1978 Dr T was referred by the NSW Medical Benevolent Society, who had been helping her for several years. She must have moved from New South Wales to Melbourne but there is no other information about her circumstances. She received rental assistance until 1990. That year Dr W was referred to the Association but 'there has been no further contact' so she appears to have been able to manage.

So by 1996, after one hundred and thirty years, a total of only five women doctors appear to have been referred to the VMBA, two of whom did not require assistance, one received a single grant and the other two were assisted for twelve years each. By 2009 the social worker, Josephine Grant, had been maintaining contact with at least fourteen women doctors over just the previous two years. This huge increase in the number of

the average man who works as a GP, he's usually got a wife to support him at home, whereas the average female doesn't have anyone

women on the VMBA books has been put down to the 'feminisation of the medical workforce'. However, that really means that just as the medical profession is considerably more gender balanced then it once was, so are the list of VMBA beneficiaries. Jo Grant has a theory that medicine has 'been a profession that's been dominated by men, and the women don't have as much of a support group ... as the men have had. Also, for the average man who goes out and works as a GP, he's usually got a wife to support him [at home], whereas for the average female they don't have anyone, or they might have a predatory husband. I've had a few of those ... they see them as a meal ticket ... it's just awful.' One recent beneficiary was struggling with a messy divorce and a partner attempting to obtain sole custody of their child and receive child support from her.

Financial issues and illness prohibiting work are the two most common reasons for doctors to need VMBA support and this is no different for female doctors. The potential for work related stress leading to poor mental or physical health is greater when there are children involved. However, the 'feminisation of the medical workforce' has undoubtedly brought into perspective the fact that doctors are more than just workhorses who care only for their patients. Although it is still the norm that women doctors, particularly GPs, will work fewer sessions than their male counterparts in order to also run a home and care for their children, increasingly 'the blokes want to be home with their littlies, they don't want to be running the sort of practice that they used to run where the patients were more important than their families and their marriages broke down'. 'They want to have a life, like everyone else in the community, and I agree; I think we overdid it.'[102]

The complexity of a medical life

But whether you're a female or a male doctor it is still too easy to 'overdo it', as one doctor wrote in 'Confessions of a medical mother':

> *The daycare centre will never know. Three-hourly paracetamol through the night at double the recommended dose, a couple of shots of chlorpheniramine and a bit of leftover*

amoxycillin from the last bout of otitis media thrown in (never mind that it was for a different child). This medical mother is free to face the fully-booked day ahead.[103]

The temptation to do whatever is necessary in order to continue doctoring is strong and there are many theories as to why doctors are particularly susceptible to such temptations. In a 2004 issue of the *Medical Journal of Australia* devoted to doctors' health and lifestyle, Dr Geoffrey Riley writes that:

There is general agreement in the medical literature that some degree of obsessionality of personality is extremely common in doctors. This quality, combined with high intelligence, generally results in conscientiousness and commitment, which are considerable assets in any endeavour. However, in doctors, it is also a source of vulnerability. An excessive obsessional trait results in dysfunctional perfectionism, inflexibility, overcommitment to work, isolation of affect, dogged persistence and an inability to relax. These overly obsessional individuals have an intense perceived need to control their environment.[104]

These pre-existing personality traits can lead to problems that affect the day-to-day ability of a doctor to carry out his or her work and that may bring them before the Medical Board. The intensity and consistent stress of the occupation is often posited as another reason for doctors landing themselves in trouble. In a 1998 study of occupational stress amongst Australian metropolitan general practitioners with 296 participants, 60 per cent believed their experience of stress arose from their 'job context', not their 'job content'. The major causes for this were workload, economic factors such as income and running a business, medico-political factors such as involvement with professional associations and government pressures, clinical factors and the effect of work on their outside life.[105] However, whether through personality or stress, doctors 'are more likely than the average person to suffer from one or more of "the three D's" – drugs, drink and depression (including suicide)'.[106]

It is the 'job context' problems that are seemingly insoluble and high on the list are medico-legal and medico-political factors. Patients today are more educated,

some degree of obsessionality of personality is extremely common in doctors

better informed, and more likely to present as consumers as well as patients. The concept of 'informed consent', formalised in a High Court of Australia judgement in the case of *Rogers v. Whitaker* in 1992, introduced consumerism to the world of medicine. The editor of *Defence Update* at the time summarised one of the main points of the finding by explaining that 'In the past the standard of care was determined by the profession ... However the new standard resulting from this case was that the Court would decide what information [any significant material risks] a "reasonable person" could be expected to require.'[107] Legislation has also shaped the standard of care and both the Transport Accident Commission and Workcover 'have been much more aggressive in forcing practice changes and imposing onerous reporting arrangements, which makes these patients more difficult to look after'.[108]

While professional development is now compulsory, and increasingly expensive, for all medical practitioners, 'the content of undergraduate courses worries doctors who question whether they have the depth of basic knowledge in anatomy for example to practise safely'. Educators, on the other hand, 'who have not benefited from increased resources', are teaching larger and larger numbers of undergraduates.[109] Overseas trained doctors and rural doctors have their own set of problems that arise from cultural differences, isolation and travel.

Looking back at the VMBA's beneficiaries in the nineteenth century, many of these issues sound familiar.

'Now, about my operation and my Informed Consent. These friends of mine have come to see that you get it right.'

Some of the stresses that doctors face. Cartoons courtesy of *Defence Update*, MDAV Newsletter, various issues.

Indeed, a recent study of issues raised in the *Australian Medical Journal* in the 1870s has confirmed that very little actually has changed in over one hundred years.

The political issues confronting doctors in the 1870s included:

- The number of doctors entering the colonies with questionable qualifications and uncertain language skills, and the failure of medical boards to control this;
- Poor remuneration for general practitioners and control of doctors' remuneration by health funds (lodges and friendly societies);
- Specialist intrusion replacing general practice;
- Inadequate funding of the public and charity hospitals;

most doctors never get into strife, like most of the population doesn't get into strife either

» Competition from pharmacists and alternative medicine; and
» Litigation, an unfair legal system and poor expert witnesses.[110]

Whether in the 1870s, 1970s or 2010s, these are all issues of a systemic nature that individually or cumulatively create dissatisfaction, sometimes at a deep level. The reality as far as the VMBA is concerned is that:

> *most doctors never get into strife, like most of the population doesn't get into strife either … Doctors are extremely unlikely not to be working, so employment is not an issue for them … they by and large make a sufficient amount of money … doctors look after themselves well. If you go to a medical reunion nobody smokes, people don't drink much … they've got a lot of social hidden advantages, if you like, they can have holidays if they choose to … If you ask most doctors whether they like doing what they're doing, most of them think it's a rewarding career, an emotionally rewarding career … and that's good for your mental health … doing the things you like doing is good for you.*[111]

And while doctors are often dissatisfied with their work there are very few who actually choose to change careers. Although systemic occupational stresses have increased, 'remuneration is better [and doctors can] choose to work shorter hours and get [a] better work life balance. [They] increasingly understand that they don't have to be 'god' and see that others in the system have responsibilities to them – it is not a one way street anymore'.[112]

For the VMBA it is not those who are dissatisfied with the system, but the 'troubled' and 'impaired' doctors who need their help. The troubled doctors being those 'significantly affected by stress, although their disability may not be such that they cannot practise', while impaired doctors are those with a mental illness or who misuse and abuse drugs, fortunately a relatively small number.[113] These are the doctors whose lives become overly complicated and dysfunctional.

'… a pie in his letterbox'

The VMBA today is assisting about forty doctors, a mere 0.18 per cent of the Victorian

medical population. The number is insignificant but their troubles are not – for them, their families or their patients – although unfortunately 'we often don't hear about them until they're so far down the hole we can't really rescue them, but we can mitigate it a bit'.[114] In a discussion about a telephone help line and other means of providing support for doctors the comment was made 'if you save one life in a year, it's only $25,000 a life. That's cheap.'[115]

when they're so far down the hole we can't really rescue them, but we can mitigate it a bit

Market garden c. 1890. In early Melbourne, many families, including those of doctors, supplemented their income by tending market gardens to supply the growing population.
Courtesy of Pictures Collection, State Library of Victoria

So while the VMBA was ostensibly established to provide financial support their benevolence has always extended much further than that.

In their first year the committee received a request from Mr Webb Richmond of Brighton. He had been practising in Brighton for sixteen years while supporting a large family, but the 'present receipts from his practice did not amount to more than fifty pounds a year' due to the recent increase in doctors in his neighbourhood. He had diversified into market gardening with the assistance of his sons 'but his cart having become damaged beyond the power of repairs and his horse having died from the effect of a snake-bite, he had been unable to prosecute this occupation any longer'.

Professor Halford offered to travel out to Brighton, no mean feat before trains and proper roads, to discuss his circumstances. He found the family almost starving and while Richmond's conduct was impeccable his wife was 'addicted to habits of intemperance'. Halford authorised £3 and visited the local butcher, baker and grocer, requesting them to continue supplying the Richmonds until further notice. He also proposed a further grant to replace the horse and cart. On hearing elsewhere that Richmond was also prone to the bottle the committee made more enquiries. This was not to decide whether or not to provide him with the money, but whether it would be best to give the money directly to him and risk it being spent on drink, or to use it for the direct purchase of necessities. They spoke to the police who confirmed that it was only his wife who imbibed and agreed to provide him with £20 and to pay the accounts at the butcher, baker and grocer. Halford again travelled out to Brighton to take him the money and pay the shopkeepers.

Dr Cutts later reported that he had bought a horse and cart for £12 and that Drs Barker and McCrea had 'together made up a set of harness', and the various accounts had been settled. Halford had also purchased some clothing. All of this took place over the course of three or four months following which they received another letter from the poor man stating that his second horse was now dead. No explanation as to a snakebite or other cause was given but it is possible that only a few pounds was not enough to

ensure a reliable beast. The committee decided that they had given enough out of the VMBA funds, but as Mr Richmond assured them another horse could be purchased for only £2/10 Dr Tracy offered to contribute a pound of his own money.[116]

This level of enquiry, assistance and generosity may seem surprising, but it has been a hallmark of the committee's endeavours throughout their history. It is no accident or quirk of circumstance as to who serves on the committee; Past President George Tippett is straightforward when he explains:

> *that the [politics of philanthropy] is structured on the highest of ethical principles … and the [doctors] who are over-sighting [the VMBA] are, amongst doctors, the most likely to be experienced in the nature of mankind, the nature of living. We've all done everything: we've all held their hands as they've died; we've all looked at the errors, and horrors, and terrors of life. So it's appropriate that they have special people looking after philanthropy for doctors.*[117]

Committee members have always voluntarily fulfilled this role, often to the extent the first committee did for Mr Richmond. But they, as with all doctors, came to have less and less time on their hands and saw the need for a more focussed attention on beneficiaries. In 1982 the VMBA employed Mary Bush part-time as social worker and financial assessor.[118] Josephine Grant replaced her in 1989 and has since worked closely with Chris Roff, the Secretary for the past ten years. Although Jo and Chris are not doctors, they are usually the main contact with the Association as far as the beneficiaries are concerned. Chris Roff remembers one fully retired doctor and the day he 'had to leave a pie in his letterbox … he was starving. Poor old fellow. A fine line between genius and madness.' Jo Grant describes her relationship with the clients as one of trust. 'I get to know them really well … and you have to try to walk a mile in their shoes, to be effective, to help them.' Since the VMBA was established the Association itself has come a long way in its understanding of troubled doctors and their circumstances:

> *We now, I think, have a much better acknowledgement that doctors are ordinary boring human beings, who ordinary boring things happen to – like they get depressed,*

Dr Richard Fetherston (1864 -1943) was born at the Melbourne Lying-in Hospital (Royal Women's) where his father Dr Gerald Fetherston was resident surgeon. Following in his father's footsteps Richard became resident medical officer at the Women's Hospital and then honorary gynaecologist to the Melbourne Hospital. He served as Director General of the Australian Army Medical Services during WW1 and was remembered for his 'sound advice and sensible help'.
Courtesy of the Royal Women's Hospital Archives, Melbourne; F M C Forster, ADB, 1981.

or they get addicted, or they're bad at managing their money, or they gamble – they are people who have all sorts of day to day type problems, they're not special people, they're not above and beyond the normal frailties of ordinary human beings. Once you accept that, I think then you are more likely to say well there are going to be all sorts of people who end up needing assistance, and they mightn't be the sorts of people who have simply fallen on hard times.[119]

doctors are ordinary boring human beings, not above and beyond the normal frailties of ordinary human beings

The business of charity

The committee must be concerned with more than their clients, however. In recent decades issues of investments, taxation and incorporation have had an important impact on the business of the VMBA.

Dr Richard Fetherston became a member of the committee in 1927, vice-president in 1930 and president in 1933, a position he filled until his death in 1943. He was the son of one of the early committee members, Dr Gerard Fetherston. The family connection with the VMBA became a lasting one in 1972 when the Association received shares with a face value of $29, 076, in accordance with Richard's bequest.[120] An additional, unexpected sum was received in 1985 when it was discovered the trustees of the Featherston fund had been continuing to pay benefits to the widow of one of the children. The VMBA received approximately $62,000 in cash, stocks and shares and agreed not to pursue recovery of the benefits paid in error to the widow during the intervening years.[121] The first bequest introduced the world of the stock market to VMBA's permanent fund which until that point had only invested in government securities and bonds. The committee began engaging expert advice regarding re-investments to make the most of their windfall, and was able to be more generous in its payments to beneficiaries, many having their allowances increased by 20 per cent that year. Today a professional fund manager takes care of the Association's share portfolio.

The business of being a charity can sometimes be a difficult one, particularly with regard to the taxation department. In 1981 the Australian Taxation Office informed

the VMBA they were no longer exempt from paying income tax. 'The major ground for rejection of our submission was that most of the beneficiaries were not "necessitous persons" within the meaning of the Income Tax Assessment Act. A subsidiary reason was that the assistance from the Fund was restricted to a select group of persons and not the community as a whole.'[122] 'Necessitous persons' are considered to be unable to afford the essentials of life such as basic food and clothing, gas and power. Later that year the ATO reviewed their records and withdrew tax deductibility for people giving donations or subscriptions, leading to a drop in subscriptions of $14,000 the following year. These have never recovered and today 'we haven't had any donations for a long time. Nor do we expect any ... because we're not tax deductible'.[123] These decisions were very frustrating for the committee and they tried many times to have them overturned. Exasperation with the ATO was still evident many years later when President George Santoro wrote 'of recent years the association has been involved with incorporation [and] costly and fruitless discussion with the Taxation Department'.[124]

The issue of incorporation had been another headache and time consuming concern which the Association set about addressing in 1993, partly to safeguard committee members should legal action ever be taken against the VMBA, and partly to try to resolve one or both of the tax deductibility and income tax exemption problems. Eventually the VMBA became incorporated on 14 September 1994, although it was not until 2000 that they were exempted from having to pay income tax.[125]

The business of charity has also been affected by expectations that the committee have placed on themselves in the last ten years by raising the level of transparency and accountability. The very nature of associations like the VMBA demands the highest level of tact and sensitivity, both when communicating directly with beneficiaries and when discussing them around the committee table. The issue of privacy is acutely important and has often meant that not even those on the committee are fully aware of the circumstances surrounding their beneficiaries.

Despite the importance of dealing with beneficiaries in a sensitive manner, it

most of the beneficiaries were not necessitous persons within the meaning of the Income Tax Assessment Act

is still critical that the committee are able to make an informed judgement of the beneficiaries' circumstances. This is becoming more possible with thorough records of each beneficiary and descriptions of any ongoing involvement now being brought to the committee table.

During his term as president in the first decade of the twenty-first century, George Tippett attempted to reintroduce the practice of committee members occasionally taking responsibility for serious cases themselves. Tippett's intention was to go back to the days when the doctors on the committee were not only responsible for assisting their clients, but were able to build an affinity and understanding of circumstances that can only be developed through discussions and visits. This has been hard to implement as the doctors on the committee have their own full working lives that make finding the time for such visits almost impossible, and because it would require a complicated balance with the role the social worker fulfils in her own involvement with these clients.

Over and above the importance of record keeping and beneficiary relationships, has been the move during the past ten years to clearly define the role that the VMBA plays within the medical fraternity. Since the VMBA was founded in 1865 the vast majority of beneficiaries have been assisted with single or occasional payments. There have always been those who needed more assistance and frequent guidance, but the number of beneficiaries who receive regular payments has increased many times over in the last few decades. This is partially due to the VMBA's increased financial security arising from the Fetherston bequest in 1972; and the freedom, since 1934, from the constraints of the permanent fund to only provide for widows and children of doctors who had subscribed for three years.

Another factor contributing to the increase in regular payments is, of course, the nature of benevolence – it is very hard to say 'no' when your purpose is to help people. However this gives rise to two concerns: the benevolent purse may not always be full enough, however well invested; and dependent people should not be encouraged to become totally dependent and unable to help themselves or to search for help in the

right places. Tippett's approach to these problems in recent years has been to define the VMBA's role as one of 'getting people over the hump that is in their way' and to let others do the job of social welfare. After all, there are many and varied avenues for assistance both within and without the medical profession.

You must drop your egos | And pull up your socks | Coz now is the time | To visit those Docs!

This is the last verse of a song written by Monash University medical students in 2008, encouraging their student and professional colleagues to 'get a GP' and seek help because doctors are 'a support, which all of us need, for when we are lonely, or starting to bleed'.[126]

One of the striking characteristics of the medical profession in recent decades has been the growth of professional support services, by doctors for doctors. During the nineteenth century doctors worked together to establish their profession by forming medical societies, initiating a journal, establishing a medical school, legislating for registration of medical professionals and for public health reforms, and advocating for adequate remuneration and public respect. One hundred years later doctors still regard themselves as a community, albeit a disparate one, with the ability to care for each other better than the general and wider community may be able to.

At the turn of the nineteenth century Victorian doctors had the British Medical Association, the Medical Defence Association of Victoria, the Victorian Medical Society, the Victorian Medical Women's Society and the VMBA to draw upon for professional support. A century later the Doctors' Health Advisory Service, the Victorian Doctors Health Program, the Rural Doctors Association of Victoria, colleges and groups supporting medical students, different specialists, overseas trained doctors, families of doctors and many other constituencies have joined this medical community network, mostly within the last thirty years.

The expansion of the 'for doctor by doctor' network in Victoria has provided the VMBA with opportunities to work with other groups such as the Victorian

Get a GP!!!

Whether you're stressed,
Or struggling to wee,
If you're a doctor,
You need a GP!

She can help you stop smoking,
Or help you lose weight,
He can help with your depression,
Or just be your mate.

Having a GP,
Does not indicate,
That as a doctor,
You're not first rate.

It is more of a support,
Which all of us need,
For when we are lonely,
Or starting to bleed.

Even if you think,
Your English is correct,
It is always beneficial,
To have your essays checked.

Even an eye specialist,
Needs his own GP,
To pick up his lung cancer,
Or his HIV.

You must drop your egos,
And pull up your socks,
Coz now is the time,
To visit those Docs!

Written by Monash University Medical Students

Doctors Health Program. This opens doors to engage in prevention, as well as crisis management, particularly as the background of many requests for help is complicated by substance abuse. To this end the committee has contributed money towards a number of studies and programs. Another reason for engagement within the medical network is the concern that the VMBA 'still appears to be one of the best-kept secrets in Victoria', a tongue-in-cheek reference to the lack of subscriptions and donations from the medical profession.[127] Engagement with the 'for doctor by doctor' network can only assist with a broader understanding of and support for the VMBA.

However, the real benefit of this network of medical support and advocacy exists for the 22,000 practitioners in Victoria. In relation to the small percentage of doctors that are actually assisted by the VMBA, the introduction to this book posed the question 'How can something endure for so long when there appears to be so little need for it?' The answer is that the medical profession is a caring one and 'perhaps (these groups) are a natural extension ... perhaps doctors can recognise a problem and have a capacity to provide direct relief'.[128] If one person's life can be improved or saved by empathetic colleagues with a special understanding of his or her difficulties, the numbers are not important.

Conclusion

'the only societies ... are those where people look after each other'

As the medico-political landscape becomes more complex and the pressures on practitioners more onerous, there is a constant need for the VMBA to consider the circumstances of their colleagues and the nature of the requests that may come before them in the years to come. While judgemental decisions today are rarely a part of philanthropic decision making, the increased regulatory role of the Medical Board and the government have presented new issues: if, for example, a doctor is unable to pay for his or her own personal blood testing or other commitments imposed by the Board, or overseas trained doctors are required to undergo additional training or sit extra examinations, should the VMBA assist or would that risk introducing the role of a 'branch of government'? 'The ethics come into it in helping the client, but also in managing the money that's given to us under trust, and not to just spend it at someone else's whim.'[129] The problem of how long a person should be supported and how much can be given to any individual has cropped up many times over the years and perhaps can never be fully resolved.

Exploring new ways of helping people or adjusting and improving on current ways has been part of the committee's role for some years now, and this will be increasingly important as the future of medicine becomes ever more exciting and complex and stressful. 'In an era where social

Current VMBA Committee members: (left to right)
Back row: John Fletcher, George Santoro, Alan Kermond, George Tippett, John Mathew
Front row: Jo Grant, Dominic Barbaro, Sandra Hacker
Absent: Harry Hemley, Julian Keogh, Paul Woodhouse, Chris Roff (former Committee member)

security and pensions are accepted without shame or a feeling of debt to the community, our future lies with extra assistance ... even in the face of repeated recidivism.'[130]

One thing that has not changed for the VMBA however, from the first committee to the last, is the philosophical approach to their *raison d'être*. When the dispute over homeopathic practitioners erupted in the 1870s the then Treasurer, William Cutts, insisted that 'our purpose is outside all differences in medical treatment, our purpose is charity'. One hundred and forty years later Past President George Tippett believes 'that the quality of any organisation, or any community, or any culture, depends on its philanthropy. Philanthropy means the love of people, the love of [the] human state ... The only societies that exist are those where people look after each other.'

It is with these thoughts that the VMBA is increasingly looking towards a policy of prevention rather than cure for the twenty-first century. Opportunities are being sought to engage further with other medical organisations and to support efforts through research or through practical exercises that attempt to fend off the 'ruinous reverses' that still prey on vulnerable and stressed members of the medical profession.

VMBA and the Victorian Doctors Health Program

Dr Kym Jenkins

MB, ChB, FRANZCP, MPM, MEd.,
Medical Director, Victorian Doctors' Health Program

The Victorian Doctors' Health Program (VDHP) and the VMBA are complementary organisations: both having been established with a commitment to the welfare of doctors and medical students.

VDHP was set up in 2001 by the Medical Practitioners' Board of Victoria (MPBV) and the Australian Medical Association (Victoria) (AMAV) with the aim of facilitating access to appropriate health care for doctors and medical students whose own health may be compromised or may lead to a compromise in their ability to practice medicine. Since then VDHP and VMBA have on many occasions worked collaboratively when a doctor's health problems have caused financial hardship. VMBA also had an association with the Doctors' Health Advisory Service (DHAS), which provided confidential advice and assistance to medical practitioners prior to the establishment of the VDHP.

The VMBA was very supportive of the establishment of the VDHP and recognised along with the MPBV and AMAV the merits of separating a Doctors Health Program from the regulatory authority. The VDHP under the guidance of its own Board of Directors is independent of all other organisations including the Medical Board and other regulatory authorities. However the VDHP is reliant upon annual funding through the Medical Board equivalent to about $25 for each registered medical practitioner each year.

VDHP is an independent legal entity that provides a confidential and compassionate environment for medical professionals to get help for medical issues ranging from stress and anxiety through mental and physical illness to substance abuse.

Though not a treating organization per se, VDHP offers a range of services including a ready listening ear for distressed doctors, the assessment and triage of their problems, support, referral and accelerated access to appropriate treatment, case management, liaison, return to work programs, and if needed, ongoing monitoring.

In its first few years a large proportion of VDHP's work was with doctors who had alcohol and other substance abuse problems. VDHP was (and still is) able to arrange detoxification and rehabilitation programs for these participants, and if needed, to negotiate time off work before a graduated return to work. This process of getting well often necessitates a drop in income and extra expenditure to fund the repeated and ongoing testing that ensures recovery is maintained and that the doctor is not impaired in their medical practice. In more recent years VDHP still does as much work with doctors who have addiction problems but as the overall workload has expanded this represents a much lower proportion of the workload. These days the majority of medical professionals consulting VDHP have stress and mental health problems. Generally, though there is still much stigma and it is very hard for doctors to allow themselves to become the receivers of care, doctors are tending to present earlier and take actions to look after themselves before any health issues lead to major problems in functioning and an inability to practice medicine.

On many occasions the VDHP and VMBA have worked together. VDHP holds a "float" of VBMA funds that can be used at VDHP's discretion for doctors with short term and small financial needs. For doctors with more complex financial problems VDHP refers them to VMBA for evaluation of their needs by the VMBA panel and help from the VMBA social worker.

The VMBA is a member of VDHP's Consultative Council, a body of interested parties and stakeholders in doctor's health, which meets at least annually to outline future directions for VDHP.

The VDHP charter not only includes helping doctors on a direct clinical basis, but also includes education and supporting research into doctors' health. VDHP recently has investigated the outcomes of its own case management programs and results suggest that the work of VDHP is on a par with world's best practice. A new VDHP research project (instigated by and predominately the work of medical student Hope Gates-Scovelle) investigating how doctors perceive their own chronic health problems is being sponsored by VMBA. This heralds a new era of collaborative work for the VDHP and the VMBA. In the future both organizations will be more focused on a proactive rather than a reactive approach to doctors' health: supporting research, providing education projects, and encouraging doctors to take both primary and secondary preventative approaches to their own health.

VMBA History: Where to now?

Jane Stephens,

Chief Executive Officer, Australian Medical Association Victoria Ltd

Doctors are the custodians of society's health and wellbeing. With this unique responsibility come many challenges and possible hardships. For more than 140 years the VMBA has recognised this and helped doctors and their families in their times of greatest need.

The VMBA has changed dramatically in its long existence. As the profession has evolved, so too has the VMBA. The medical profession is becoming increasingly diverse both demographically and professionally. Moving forward the VMBA must ensure that it serves all doctors – regardless of their country of origin, employer, specialty or gender.

Increasingly, individuals are taking measures to protect themselves from financial hardship. It would be uncommon today for doctors not to have superannuation, health insurance and a life insurance policy. The Government also provides compensation for workplace injuries, victims of crime, road accidents and movements are afoot to introduce a National Disability Insurance Scheme.

In this context, many of those who historically would have been the beneficiaries of the VMBA's generosity will be taken care of in other ways. It is unlikely that a deceased or injured doctor's spouse or children would be left destitute today.

Despite this, the profession is an increasingly challenging one. There is a growing body of evidence that shows that doctors are at greater risk of mental illness and are more susceptible to substance abuse. The VMBA will have to continue to tailor its programs to reflect this. By working with other organisations in recent years such as AMA Victoria or the VDHA, the VMBA has been able to extend its reach and ensure that it is responsive to the needs of the profession.

It has been encouraging to see the VMBA helping to prevent problems that doctors encounter, in addition to assisting doctors once issues arise. For example, the VMBA worked with AMA Victoria to launch the Peer Support Program, an anonymous telephone support line provided for doctors by doctors.

The VMBA plays a valuable role in the Victorian medical community. It must find ways to not only stay financially viable and organisationally strong but also relevant to the profession that it seeks to serve.

On behalf of AMA Victoria and its members I congratulate the VMBA on its longevity and thank its members and volunteers for the help it has provided to doctors and their families. AMA Victoria looks forwards to working with the VMBA well into the future.

Benevolence across Australia

'My colleagues will be my sisters and brothers' is a line from the international medical profession's influential code of ethics. The Declaration of Geneva was adopted by the World Medical Association in 1949 and amended or revised from time to time, most recently in 2006.[131] It is regarded as the modern version of the Hippocratic Oath.

Although caring for colleagues has been enshrined in western medicine's code of ethics for some 1500 years, it has only been within the last couple of hundred years that the medical profession has formally associated to ensure the right care is provided where needed. As with much of Australian history, the formal provision of medical benevolence derives from earlier examples in the United Kingdom. The Royal Medical Benevolent Fund in England was founded in 1836, followed shortly after by the Royal Medical Benevolent Fund Society of Ireland in 1842.[132] These associations were specifically created for the temporary relief of medical men and their families. In the first edition of the *Association Medical Journal* in 1853, the English fund passionately described its goal to:

> *step in where no other society can be available; to give that aid which shall rise the sinking practitioner from crushing difficulties – shall rescue the widow from indigence – shall snatch the family from starving – shall foster those provident feelings which secure independence to the broken spirit, and afford time for the restoration of the fallen fortunes of the distressed, by means of their own industry, directed by their restored energy and integrity of character.*[133]

Associations across Australia

Across the continent, Australian doctors have taken on a commitment to help those of their professional colleagues in need. There are currently five medical benevolent associations in Australia. As in Victoria, not only do these organisations assist medical families financially, but many work in close collaboration with other medical support bodies, such as the Doctors' Health Advisory services, peer support programs, rural doctors' projects and the state medical associations.

Throughout their history they have had infrequent contact and discussions with each other. The records of the VMBA indicate occasional liaisons with other states in order to assist doctors who have moved interstate. On occasions the Associations' social workers have communicated regarding issues such as best practice procedures and appropriate guidelines in their support of beneficiaries. However, the Australian history of geo-political borders has meant relatively few connections amongst the medical profession from one state to the next, benevolent or otherwise. Generally speaking, each state's benevolent association has developed separately, and often with little knowledge, of the others. This has sometimes led to duplication or a lack of resources in some states. There has never been a formal process whereby these state associations could meet on a regular basis, or have regular contact regarding the work they carry out.

Despite this, each state association is similar in structure; working primarily on a volunteer basis, largely unrecognised, assessing each request for assistance on its own merits, and with a lasting commitment to 'aiding necessitous persons connected with

the profession'. However, they have each developed at different periods in their profession's establishment and so out of different socio-medical climates. Like Victoria, they have important stories to tell about the circumstances that give rise to 'ruinous reverses' in changing times for medical practitioners. When the politics of benevolence is understood it becomes clear that geo-political borders have little to do with who needs assistance and who is able to provide it. Because of this a history of the Victorian Medical Benevolent Association could not be complete without briefly studying the development of similar associations in other states.

New South Wales (incorporating ACT)

Although the doctors of Victoria established an association for assisting colleagues in distress early in Port Phillip's history, it was New South Wales that began the first medical benevolent fund, the Australian Medical Association Benevolent Fund, as part of the first Australian Medical Association (AMA) in Sydney in 1859.[134] Although this original AMA would last only ten years, the fund would continue for well over sixty years until 1934. Its aims were very clearly defined: to render 'pecuniary aid to those in distress who are or have been Fellows of the Association, their widows or orphans'.[135] The AMA Benevolent Fund was established by a number of extremely dedicated men who, for many years, continued to oversee the distribution of funds to its members and the families of its members. The fund maintained close relationships with the existing medical bodies of the time: the AMA (NSW) and then the NSW branch of the BMA, and the Medical Benevolent Fund of NSW, a separate organisation established in 1896 with very similar purposes.

When the original AMA folded in 1869, it was decided that its Benevolent Fund objectives be carried out by three trustees, and that the balance of the AMA funds be amalgamated into the Benevolent Fund.[136] This arrangement continued until 1934 when the fund finally ceased to operate once all the Fellows and their wives were no longer living and none of their family members were in need of support.[137] Its remaining funds, a substantial £2,578, were transferred to the Medical Benevolent Fund of NSW.[138]

This Medical Benevolent Fund of NSW, formed in 1896,was the second such association created by New South Wales medical practitioners specifically to aid all medical colleagues and their families who were suffering difficulties. Margery Scott-Young's history of the Association suggests its establishment may have been inspired by an article written by Dr Neild on the history of the Victorian Medical Benevolent Association, which was published in the Intercolonial Medical Journal of Australasia in 1896.[139]
By this time the VMBA had been operating in Victoria for more than 30 years. However, although Victoria had over 1000 names on the Medical Register, the Association had less than ninety subscribers.140 Neild's article was primarily a call to the medical profession in Victoria to support the Association in a time of financial crisis; however, if it had the added effect of inspiring the creation of the Medical Benevolent Fund of NSW, Dr Neild and the Victorian Association would have been well pleased.

From its inception, the Medical Benevolent Fund of NSW established a close relationship with the BMA (NSW) and held its annual meetings immediately after that of the BMA, thus 'the fledging organization was not only provided with a venue but also rendered reasonably certain of an audience', therefore increasing the likelihood of financial support and longevity.[141]

Dr Neild's article reasserted that medical benevolent societies were 'for the purpose of affording money-help to members of the profession, and their families, when from various circumstances they might happen to need it'.[142] His article expressed an underlying generosity of spirit which all the associations appeared to possess. Neild emphasised the need for kindness to the deserving but, at the

same time, reassured donors that the Association strived to ensure that it was only the deserving who received assistance:

> *It is not insisted that everyone of about five or six hundred recipients of relief has been entirely deserving, or that they have all properly employed the funds with which they have been furnished; but this may be taken as certain, that every case has been investigated most carefully, and that quite as many applications have been rejected as approved.*[143]

In a similar vein, Scott-Young proposes that the work done by the NSW fund was the 'work of a thoughtful, kindly, independent group' of men within the NSW branch of the BMA, who felt impelled to assist in the aid of their less fortunate colleagues.[144]

Although there are few early records, the annual meetings and treasurers' reports were published in the *Australasian Medical Gazette* from 1897. It appears that this New South Wales body was run on very similar lines to its Victorian counterpart, inviting all members of the BMA (NSW) to subscribe as well as encouraging donations from the state's medical practitioners. In 1926 the committee drew up new rules in lieu of its six basic principles and formed today's association, the **Medical Benevolent Association of NSW** (MBA of NSW). In 1937, after a re-examination of its rules, MBA of NSW was incorporated.

Until the 1940s all requests for assistance were assessed and approved by the committee. However, in 1941, with great foresight, they agreed that 'the service of an experienced almoner (social worker) be used when needed, not only to obtain accurate information about the position of beneficiaries and applicants for aid but also to investigate the possibility of securing additional help for applicants from other sources'.[145] Katherine Ogilvie OBE, Head of the Almoner's Department at Sydney Hospital, was the first to assist the Association on a voluntary basis. Then, in 1947, almoner Nancy Mackay was employed on a regular part-time basis to assess those being assisted by the Association, attend meetings to clarify any issues, and advise the committee regarding any questions about beneficiaries. However, in 1964, after many years of work with the Association, Mackay returned to full-time work and recommended Mary Doughty, an extremely capable social worker, to the committee. Doughty immediately put in place regular reviews and assessments, case histories and income statements of the beneficiaries, and in the 1970s she also took on the role of executive secretary to the committee. Doughty worked tirelessly for the MBA of NSW for over forty years and in 1997 she was appointed a Member of the Order of Australia in recognition of her work for the Association. In 2007 Mary Doughty resigned and Meredith McVey accepted the position of social worker.

In 1944, the Association's solicitor advised the committee that the Commissioner of Taxation would be unlikely to allow tax deductibility 'unless and until the Association registered as a public charity'.[146] Around this time some beneficiaries expressed embarrassment at being the recipients of 'charity' and it was decided to rename the beneficiaries' cheque account as the 'Jones Trust' in order to remove any stigma associated with receiving assistance from a charity.[147] Nothing was attempted in regards to the charity status of the Association until 1956 when Dr Yeates presented the committee with the motion:

> *That the Medical Benevolent Association of New South Wales apply forthwith for registration under the Charitable Collections Act 1934–1941.*[148]

The motion was passed and, after legal advice, they applied and received formal approval in April 1957 to be registered as a public charity.

At the time, the MBA of NSW wrote to the honorary secretaries of the Medical Benevolent Associations in South Australia, Victoria and Western Australia to investigate their respective positions in

this matter. Victoria and South Australia advised that they were in much the same situation as New South Wales. Western Australia, on the other hand, had solved the problem by having its subscription payments paid to the BMA (WA) Branch, thus allowing the full subscription to be tax deductible. When, in November 1957, the taxation department rejected the Association's request to allow income tax deductions for donations, the MBA of NSW investigated whether a similar arrangement to Western Australia's could be made with the BMA (NSW), but regrettably this was not permitted by the Australian Taxation Office.

In her history of the MBA of NSW, Scott-Young ascribes the favourable conclusion to this problem to the skilful diplomacy of Dr Jim L'Estrange, who in 1977 was elected honorary secretary and immediately embarked on a series of informal, personal discussions with an officer of the taxation department.[149] The Articles of Association Clause 3(b) were reworded so that assistance could be provided to any 'necessitous' member of the medical profession; the MBA of NSW was advised in November 1977 'that gifts of $2.00 and upwards to the Medical Benevolent Association of New South Wales are allowable deductions for income tax purposes under Section 78(1)(a)(iii) of the Income Tax Assessment Act'.[150]

In the 1980s the Doctors' Health Advisory Service (DHAS) was formed by the AMA (NSW). Its purpose was to ensure that medical professionals be encouraged and enabled to seek medical assistance when needed. The council of the MBA of NSW agreed to assist the DHAS by providing the services of its social worker, Mary Doughty, and financial assistance until the DHAS could bear the cost of its own administration, thus creating a valuable liaison between both services.[151] This ongoing relationship has continued with the MBA of NSW maintaining representation on the DHAS management committee and providing support through provision of the services of its social worker, Meredith McVey.

In the past all requests for assistance to MBA of NSW were assessed and approved by council; however, since 1964 assessment of requests has been done by the Association's social worker. The introduction of an income and expenditure form from that time has assisted with assessment and recommendations. The MBA of NSW constitution allows assistance to family members of registered medical practitioners and other persons at the discretion of council. For many years the Association has chosen to give financial support by way of payment of essential accounts rather than monthly payments. The MBA of NSW Council currently has twenty seats and members are registered medical practitioners from various fields and other persons at the discretion of the council.

South Australia

The permanent establishment of a medical society in South Australia took several attempts. There are no extant records of the first medical society created; however, there is a reference to its dissolution in 1856 when all its medical books were donated to the public library.152 The state's second medical body, the South Australian Medical Society, also had a short life, commencing sometime prior to 1872 and winding up in 1881. At its closure, however, the balance of its funds, £197, was used to establish the Medical Benevolent Association of South Australia (MBA of SA).153 As with Victoria and New South Wales, the MBA of SA's rules were directed towards the assistance of medical men and their families who were in distress, as indicated in its Rule no. 2:

> *That the objects of the association be to relieve distress occurring in the families of medical men practising in the colony of South Australia; and to aid in educating and bringing up their children; and to form bursaries for the assistance of medical students, the sons of medical men. Claimants who are the sons of subscribers shall have preference.*[154]

The first Committee of Management consisted of Drs

Clindening, Gosse, Paterson, Wylde, and the honorary secretary Dr Cleland: medical men who were committed to the development of their profession in South Australia. In 1879, Dr Gosse was instrumental in creating a branch of the British Medical Association in South Australia and was elected its first president. The Association's historian, Dr Hayward, considered that:

> *The founders of the Branch did well to elect Dr Gosse as their leader for, at the time when the brotherhood of man was not conspicuous among members of the medical profession, he was universally respected. He was refined, gentle in manner, extremely courteous and always the picture of a typical English gentleman.*[155]

The MBA of SA was similar to other medical benevolent associations of the time, with financial support coming largely from subscriptions, donations and life memberships. Historically, the MBA of SA supported medical men and their families with long-term assistance 'to families of either incapacitated or deceased doctors, mainly to assist with education or medical expenses, or by monthly allowances to supplement income'.[156] However, in more recent years, particularly due to changes in the welfare system, support is more frequently given in the form of one-off or short-term payments to assist immediately with financial difficulties.[157]

Unlike New South Wales and Victoria, the MBA of SA has never employed a social worker to assist with the assessment of beneficiaries, largely because the number of requests for assistance has always been relatively small. Although early financial support came primarily from subscriptions and some life memberships, recently the MBA of SA has been receiving support from the Chinese Medical Association of South Australia; a vast difference from a century ago when Chinese medicine and Chinese doctors were amongst the 'quacks and charlatans' legislated against.

While the profile of those whom the MBA of SA now assists has changed, the reasons for requiring assistance – incapacitation, death, living and family expenses – are much the same as always, as the following report written in the 1990s reveals:

- Weekly allowance to a young doctor (who suffered a cerebral haemorrhage) and his family, pending the granting of an invalid pension;
- Living expenses, wheel chair and car maintenance for a permanently incapacitated doctor and his wife;
- Payment of $7,000 to alleviate the short-term financial stress of a widow with a young family;
- Living expenses for a doctor's family during his short-term illness;
- Living expenses during the last six months of a young doctor's life;
- Gift of $5,000 to assist in immediate re-clothing of a widow and children whose home had been destroyed;
- Gift of $3,500 to help with funeral expenses and school fees of a widow and young family;
- $5,000 to a young doctor to fund an unrelated bone marrow donor search (Although the search was successful, the doctor tragically rejected the transplant and died 4 months after the operation);
- $12,700 to a young doctor to pay off some debts and to supplement living expenses three months prior to death;
- $7,000 to the widow of a doctor to assist with funeral and house maintenance expenses following the death of her husband from a long term illness.[158]

Queensland

The Medical Benevolent Association of Queensland was founded in 1967 by members of the Queensland medical profession. Dr Evan Thomson was the inaugural president and Dr Harold Palethorpe the Association's first secretary. Originally created as a legal

charitable organisation under Letters Patent, it was decided in 2007 to incorporate the Association as a public company. With a similar approach to the other states, the MBA of Queensland is a charitable organisation with the primary objective of assisting members of the medical profession in times of need.

The MBA of Queensland acknowledges that 'tragedy is unpredictable and may strike at any age in the life of a medical professional' and so offers limited financial assistance to members of the profession if they request assistance and meet the criteria for a grant from the Association.[159] They also acknowledge that there are many demands on the financial resources of a medical professional and sometimes these can become overwhelming. The MBA of Queensland believes that younger colleagues often have mounting commitments to home and practice, loan repayments and various other recurring expenses such as school fees. Meanwhile, various expenses of daily living continue such as food, clothing, rates, electricity and telephone bills, which must also be provided for. Similarly, older colleagues may see the value of their savings diminish over time because of the effects of inflation and thus require assistance.

Risks exist for medical practitioners at all stages of life and a medical career is not always a guarantee of financial success. Periods of absence from work through illness, injury or disability may precipitate emotional as well as financial distress. Although all practitioners are encouraged by the medical associations to have insurance in an effort to insulate themselves from situations that may arise, this measure sometimes fails or cannot be of assistance. In such instances the MBA of Queensland can often provide some financial support for colleagues to get through a crisis.

In 2007 the Association was incorporated as a public company limited by guarantee and registered with ASIC. The Committee of Trustees 'felt that a company structure would give the Association more credibility and transparency for its future operations'.[160] At the company's inaugural Board of Directors meeting, Dr Bob Brown was appointed chairman, Dr Paul Gray, secretary and Dr Thomas McEniery, public officer. The nine members of the Board of Directors include both general practitioners and specialists, legal and financial experts, and their secretariat services are provided by AMA (Qld).

Western Australia

There is little information available about the original Medical Benevolent Fund in Western Australia except that it was administered by the Council of the AMA (WA). This early benevolent association, however, is mentioned occasionally in the VMBA minutes. In the early 1950s the VMBA committee discussed support for a young doctor. Married during his war service, he was discharged fit in 1946. However, he subsequently developed MS and as a result was unable to earn an income. By this time, 1949, he had two small children as well as his wife to support. The VMBA initially assisted with a grant of £100, and then in 1955 it was noted in the minutes that he had moved to Western Australia and the VMBA committee decided to approach the Medical Benevolent Fund of WA to ascertain whether they would share in any assistance provided to the family. It was decided by both associations to share payment of the doctor's life assurance premiums, which they did cooperatively until the 1970s.[161]

The current **AMA (WA) Medical Benevolent Fund** was established in 1998 and its first board members from the AMA (WA) were Dr Brian Lloyd, Dr Robert Elphick and Dr Rosanna Capolingua. The fund is formally structured with the AMA (WA) as trustee, and secures all its funding through donations from doctors. Similar to other states, assistance is assessed on a case-by-case basis and determined by the governing Board of Management, which includes practising doctors, both general practitioners and specialists, government medical officers and AMA (WA) executives.

The fund does not employ a social worker.

The focus of the current fund is to ensure that a doctor's family, particularly dependent children and their education, are supported in a manner consistent with the doctor's expectations for them. Typical cases where the fund has assisted have involved the provision of school fees and associated expenses for children of deceased doctors. Doctors with long-term illnesses, unable to obtain support from their families, have also been supported. The original fund was primarily designed to support the families of AMA members, whereas the current fund (under the present chair Dr Rosanna Capolingua) supports the families of all doctors.

Looking to the future, the current Board of Management is concerned about the ongoing problem of attracting sufficient funds to meet its continuing commitments. Record numbers of suicides in the profession are currently being recorded which the committee feels may be indicative of the types of future demands the fund will face.

Medical collegiality

… into the future, working nationally

A new National Registration and Accreditation Scheme for the health professions was implemented across Australia in July 2010 by an equally new federal agency, the Australian Health Practitioner Regulation Agency.[162] In the past, any doctor who immigrated to Victoria was eligible for support from the VMBA as soon as he or she had registered with the Medical Board in Victoria. Much the same arrangement has been in place in all the states. However, the introduction of federal registration may provide an impetus for change that could bring about greater efficiencies for all state associations, encouraging them to work more closely together. The resources, histories and experiences of each could be harnessed into a formidable philanthropic force for those doctors in the future who will require assistance.

Biographies of the VMBA Committee

Dominic Anthony Barbaro AM

VMBA President
MB BS (Melb), Dip. Obst. RACOG, FRACGP

Dominic Barbaro was born in Italy in 1946 and immigrated to Australia 1961. He graduated from the University of Melbourne in 1970. Dr Barbaro established his own general practice with Dr. A J Portelli in Lalor in 1973, which expanded into a practice with five GPs and FMP trainees (1973-88 and 1993-95). Dr Barbaro was Area Coordinator for the Family Medical Program from 1976-1988 through which established ongoing continuing medical education for GPs at PANCH and Reservoir Private Hospital.

Together with the other partners in the Lalor practice, Dr Barbaro has been providing care for the residents of the San Carlo Home for the Aged since it opened in 1975 (and board member from 1982-1987) and more recently, the St Francis of Assisi Hostel (board member 1992-1995). He has supported many Italian service organisations for example as a board member of Co.As.It., an Italian welfare organisation since 1985, a member of the planning committee for care of Italian Aged, a member of the taskforce for Italian Aged Care in Victoria and a board member of the Central Health Interpreters Service Victoria since 1992. Dr Barbaro has also been involved in various health promotions and educational activities for the Italian community.

Dr Barbaro has had various professional roles with a range of health and aged care committees and organisations. He is well-known as one of the early leaders in the Divisions of General Practice Program in Victoria, having been the Chairman of Northern Melbourne Division from its establishment, taking a leading role in the many debates about the purpose and potential of the program in its early days. He has been a member of the AMA Victorian Council and the AMA representative to the Victorian Medical Postgraduate Foundation. He has served on many committees and groups including Executive Director of the Northern Divisions of General Practice (1993-2000), the Medical Advisory Board Northpark Hospital (1990-2002), the RACGP Panel of Examiners (since 1985), State Assessment Panel (1992-1996) to name just a few.

In 2008 Dr Barbaro became a Member of the Order of Australia (AM) for services to medicine as a GP, through professional roles with health and aged care organisations and to the Italian community and in the same year received Italy's equivalent recognition Cavaliere Ordine al Merito Della Republica Italiana. He has been a committee member of VMBA since 1988 and was elected President in 2009.

Sandra Hacker AO
Committee member
MMBS (Melb), RANZCP, FRANZCP, FAMA, FAICD

Sandra Hacker graduated from the University of Melbourne in 1969 and worked as an RMO at the Royal Melbourne Hospital before becoming a registrar in psychiatry at Prince Henry's Hospital. In 1975 she began private practice as a psychiatrist with a special interest in psychotherapy. She worked as a sessional psychiatrist at Prince Henry's, a coordinator of Psychotherapy Services at Royal Park Hospital and medical administrator for Ramsay Health Care Victoria.

As well as her private practice she worked as assistant psychiatrist at the Alfred Liaison Service in 1989 and from then has worked as Psychiatrist to the Heart-Lung Transplant Unit at the Alfred Hospital as well as working as Psychotherapy Supervisor at the Clarendon Clinic. She is also an Adjunct Senior Lecturer at Monash University, Alfred Hospital.

Medical politics has always interested Dr Hacker and she has served on many committees including RANZCP, in particular as College Secretary, a Censor, and on their Clinical Practice Advisory Committee. Her AMA positions included President of AMA Victoria and Federal Vice-President. She has convened and been a member of many advisory groups for various aspects of medical practice such as Ramsay Health Care Medical Advisory Panel, Medical Benefits Review, the Coroner's working party on suicide, chair of the Australian Health Ethics committee, chair of the Australian Institute of Health and Welfare and chair of the Mental Health Research Institute Board. Dr Hacker was also chair of the board of Northern Health, Melbourne from 2005 to 2010.

She is a psychiatrist in private practice and her primary area of clinical interest is in severe psychological trauma. Her clinical work involves mostly long-term psychotherapy with adults affected by severe childhood sexual assault. Dr Hacker was appointed an Officer of the Order of Australia (AO) in 2005 for her services to the medical profession. She has served on the VMBA Committee since 1995.

Harry Hemley
Committee member
MMBS (Melb), FAMA

Harry Hemley graduated from the University of Melbourne in 1980 after completing electives at the Singapore General Hospital and the San Diego University Hospital. Dr Hemley undertook his internship and residency at the Western Hospital in Footscray. He commenced working in private practice at a group practice in the

inner city following which he commenced and developed practices in Spotswood and Northcote. Nominated to the AMA Victoria Board in 2006, Dr Hemley is a former president of the Melbourne Division of General Practice. He also worked for the Commonwealth Government's General Practice Think Tank on the development of Divisions of General Practice.

Dr Hemley is the current President of AMA Victoria and the AMA Victoria representative on AMA Federal Council. His general practice work has primarily been in the inner city. He is currently principal GP at his group practice in Northcote. As well as running his general practice Dr Hemley has, for the past 30 years, been actively involved with St Vincent de Paul Ozanam Day Centre working with homeless people. He has served on the VMBA committee since 2007.

Dr Hemley has a keen interest in issues faced by rural GPs in Victoria, having sat on the board of the Rural Workforce Agency of Victoria. He is also passionate about healthy eating and exercise. Dr Hemley is married to Denise, who is also his practice manager and has five children.

Julian Keogh

Committee member

MBBS (Melb), FRCS

Dr Julian Keogh has been a member of the VMBA Committee since 2007.

Alan Kermond

Vice-President

MBBS (Melb), RANZCR

Alan Kermond was born in 1935. He attended Melbourne High School and graduated from the University of Melbourne in 1958. He then went on to study Diagnostic Radiology at the Royal Melbourne Hospital. Dr Kermond became a member, and subsequently a fellow, of the Royal Australian and New Zealand College of Radiologists.

After fellowships in London and San Francisco, he returned to private practice in Victoria, being the senior partner in Medical Imaging Australia. To solve the problem of increasingly expensive equipment in private practice (such as CT, MRI, PET scanners and sophisticated isotope equipment) the group united with a similar group in Sydney and in 2002 amalgamated with practices in all over Australia to form Medical Imaging Australasia, Australia's largest imaging group, now listed on the Australian Stock Exchange. The practice expanded to all the mainland states and began branches with PET scanning in the United Kingdom.

Dr Kermond has been an examiner for the Royal Australian and New Zealand College of Radiologists and served as a state councillor. He served on finance committees of the Frankston and Dandenong Hospitals and a subcommittee of the National Health and Medical Research Council. He has been a committee member of VMBA since 2007.

John Mathew

Committee member
MBBS (Melb), RACP, FRACP, FAMA

John Mathew attended Scotch College, Launceston and Melbourne after which he commenced his medical degree at the University of Melbourne, graduating in 1959. Dr Mathew became a member, and subsequently a fellow, of the Royal Australasian College of Physicians.

After graduating, Dr Mathew spent several years working in Melbourne hospitals including the Alfred Hospital, the Royal Women's Hospital and Fairfield Infectious Diseases Hospital before travelling overseas in 1964. He worked at New England Deaconess Hospital in Boston Massachusetts, Australia House in London and for the Australian Embassy in Vienna.

On his return, he briefly worked in general practice in North Fitzroy and as a registrar at the Alfred and then Queen Victoria Memorial Hospitals. In 1970 he commenced working at Western Hospital, Footscray as a Senior Physician in charge of a busy General Medical Unit. In the mid 1980s he initiated the establishment of a Diabetic Unit at the hospital and he worked there until 1998. At the same time, during the 1970s and 1980s, he was also Assistant Physician at the Queen Victoria Memorial Hospital.

Dr Mathew also maintains a private practice as a Consultant Physician, which he started in 1970. His special interests are General Medicine, Endocrinology, Diabetes and Counselling. Dr Mathew has been active on many medical boards and committees. He is currently on the Victorian Doctors' Health Advisory committee, AMA Branch Council and the Medicare Participation Review committee. He has been a member of the VMBA Committee since 2001.

George Romano Santoro AO

Committee member & Past-President
MB BS (Melb), FAMA

George Santoro was born in Melbourne in 1935 and attended Xavier College. He graduated from the University of Melbourne in 1962 after which he worked as an intern at the Queen Victoria Hospital followed by several years as a locum in country Victoria before eventually establishing a general practice in inner city Richmond in 1965.

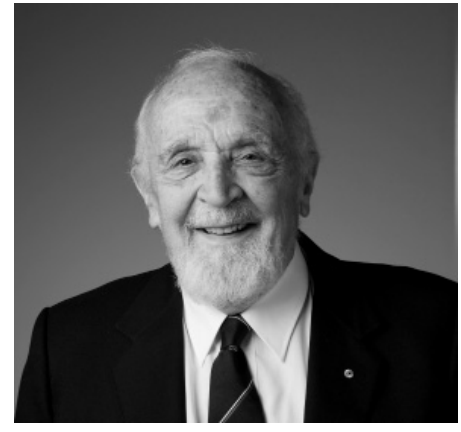
During his long career as a general practitioner, Dr Santoro has held many committee positions - Treasurer and President of AMA Victoria and member of the Federal AMA Council, Director of the Medical Society Trust Company of

Victoria, Director of the Hospital Benefits Association of Victoria, board member of the Asthma Foundation of Victoria, board member of the Academy of General Practice, inaugural President of the Italian medical Society, Director of the Medical Publishing Company and Chairman of the Lord Mayor's Fund for Metropolitan Hospitals and Charities. He was also Medical Officer for the Italian Consulate General in Melbourne for thirty years, council member of the Medical Defence Association of Victoria, Chairman of St Carlo Village Italian Homes for the Aged, Treasurer and Chairman of the Melbourne Division of General Practice, editor of Melbourne GP magazine and a member of the Faculty of Medicine Board at the University of Melbourne.

Dr Santoro is renowned in the medical world and greater community for his dedication to the provision of medical services to ethnic communities. He was the driving force behind the development of the Italian, Greek and Chinese Medical Associations, which aim to ensure that people of these cultures have access to quality health care through doctors who understand their language and ethnic origins. The Italian government recognised Dr Santoro's work over thirty years with three separate awards the Cavaliere dell'Ordine della Stella della solidarietà in 1977, Ufficiale Ordine al Merito in 1985 and Commendatore Ordine al Merito in 1995. Similarly in Australia, in 1990 he was appointed a Member of the Order of Australia (AM) and in 1994 he won *Australian Doctor Weekly's* 'GP of the Year' award.

In 2002, Dr Santoro retired from his general practice after 37 years. However, he continues to serve the needs of this community and was recently elevated to an Officer of the Order of Australia in 2010. Dr Santoro is a current VMBA committee member and has served on the committee for over 35 years in the positions of Treasurer, Vice-President and President.

George Henry King Tippett AM FAMA KStJ Past President, MB BS (Melb) DA (Lon) MFARCP&S (Lon)



George Tippett was born in Melbourne and attended school at Geelong College. He studied Metallurgical Engineering but transferred to Medicine with the assistance of a Queens College scholarship. After graduating from the University of Melbourne in 1957, Dr Tippett worked as an RMO at Wollongong Hospital and then a senior medical officer at Darwin Hospital. He was then appointed Medical Officer Native Service, which included responsibility for the Aerial Medical Service Central Australia.

Based in Alice Springs, the wide demands of this position led to an interest in anaesthetics and welfare for disadvantaged communities; interests that would be prominent throughout his life.

After several years in general practice in Sydney, Dr Tippett trained in anaesthetics at the American University Beirut and St. Thomas's England and qualified with a Diploma of Anaesthetics. On returning to Australia, Dr Tippett founded the Dandenong Anaesthetic Group and held various positions including Medical Director of Surgicentre Dandenong. He also developed Australia's first registered and accredited day surgical hospitals in Victoria and New South Wales.

Dr Tippett has dedicated much time and effort to international service for medicine especially in Asia, for which he was awarded an AM for International Service in Medicine in the Order of Australia honours. He worked at a Nepalese cataract eye camp before establishing a dental health service for Tibetan refugees in Northern India which, in time, expanded to include other health professional activities. Similar services were set up in Vietnam, Thailand, Indonesia and Cambodia.

Similar services were set up in Vietnam. He was also recognised by Melbourne Rotary, Rotary International, awarded a Dunlop Asia medal and received a Knight Order St John for his voluntary service in disadvantaged communities. He has worked hard for AMA Victoria in a number of roles, and has devoted considerable time and effort to other non-profit and voluntary organisations.

Dr Tippett established the Aerial Medical Service at Alice Springs and has been President of the Royal Flying Doctor Service in Victoria. He represented the Victorian Medical Benevolent Association on the council of AMA Victoria and was president of VMBA from 1999 until 2009.

Paul Woodhouse

Treasurer

BMedSc, MBBS (Tas), MBA (Melb), DBA (RMIT), MRACMA, FAMA

Paul Woodhouse completed his Bachelor of Medical Science in 1981 and his MBBS in 1984 at the University of Tasmania. He then undertook a Master of Business Administration in 1989 and completed his doctorate in 2004. His thesis was entitled: 'Making privatisation work: A framework for the development and operation of concession contracts in Australian hospitals'.

Dr Woodhouse has primarily worked as a clinician and within public hospital administration, firstly at St Vincent's Hospital, Melbourne and then at the Victorian Department of Human Services. In 1993 he became the Deputy Director of Medical Services at the Geelong Hospital. He has been a member of AMA Victoria since 1993 and in 1995 joined the organisation as Director of Policy. Dr Woodhouse has served as a representative of the AMA in a number of advisory roles, including to the Department of Human Services Medical Workforce & Training Committee and the Rural Workforce Agency's Rural Assessment Program, on which he was Chair.

He has significant experience in health policy development and analysis, strategic planning and policies and health administration and management. He has worked very hard to highlight the importance of the health and well-being of doctors. Dr Paul Woodhouse has been part of the VMBA committee since 1996 in the role of Secretary and now as Treasurer.

Chris Roff
Past VMBA Secretary

Chris Roff served in the Royal Australian Air Force for 32 years. He had a long and successful career in the armed forces from which he retired in 1986 as a Group Captain.

Following his career in the Air Force, Chris Roff served as CEO, Victorian Section, Royal Flying Doctor Service of Australia (RFDS), where he held responsibility for the Kimberley region until 1999. During his time with the RFDS he oversaw the development of the Kimberley operation into an efficient unit, utilising sophisticated technology. He later oversaw the merging of all Western Australian operations under the one company. He retired from RFDS in 1999.

In the same year he commenced as Secretary of the VMBA where he worked closely with Jo Grant in supporting the beneficiaries of the VMBA and the VMBA committee. He retired in December 2010.

Jo Grant
VMBA Social Worker
BSW (Hons) (Monash)

Jo Grant graduated as a social worker in 1978 from Monash University. She then undertook practice as a protective social worker, primarily with children and families at risk followed by four years as a medical social worker, dealing with family violence, children at risk and marital problems. She also completed additional courses in family therapy and marital therapy. She also participated in a consultancy panel on the management of children and families at risk.

Jo then held the position as Director of a counselling centre in the eastern suburbs. She spent twenty years running a family therapy training program, which included the major therapeutic approaches to assisting families, dealing with difficult adolescents and working with clients referred through the police and with victims of crime. She has also completed training in neuro-linguistic programming and hypnotherapy, which included approaches to dealing with depression and various other problems.

Jo Grant's private practice has included supervision of other professionals, marital and couple therapy and presentations to various professional groups. Jo Grant has worked with the Victorian Medical Benevolent Association for the past twenty years. Her work for VMBA was originally a quite a small part of her practice but has now become a much larger component of her work.

Douglas John Fletcher

VMBA Secretary, TPTC (Melbourne TC), BA, BEd (Latrobe)

John Fletcher completed his teacher training at Melbourne Teachers College in 1956. He began his teaching career as a replacement teacher in the Victorian countryside. He developed his teaching skills through his many years working in education as head teacher, Education Research Officer, Principal and Senior Education Officer. He retired from the State Education Department in 1992. However, after a 6-month retirement, he began working with the newly formed North East Valley Division of General Practice based at the Austin Health in Heidelberg where he worked for over 15 years.

On 3rd February 2011 he was appointed Secretary of VMBA.

VMBA Presidents (left to right):
George Santoro, past-President; George Tippett, past-President and Dominic Barbaro, current President

VMBA Executives past and present

Presidents

Dr Godfrey Howitt (Died 1873)	1865-1873
Mr Robert Knaggs (Died 1890)	1874-1879
Mr William Gillbee (Died 1885)	1879-1884
Dr William Henry Cutts (Died 1897)	1884-1897
Dr D A Gresswell (Died 1904)	1897-1904
Dr James Patrick Ryan (Died 1918)	1904-1918
Dr William Moore (Died 1927)	1918-1925
Dr J Talbot Brett (Died 1929)	1925-1929
Sir George Cuscaden (Died 1933)	1929-1933
Dr Richard Herbert Fetherston (Died 1943)	1933-1943
Dr James Perrins Major (Died 1962)	1943-1961
Dr Herbert Giblin Furnell (Harry)(Died 1974)	1961-1974
Dr Stanley W Williams (Died 1985)	1974-1985
Dr J Eric Clarke (Died 1995)	1986-1990
Dr George R Santoro	1990-1999
Dr George H K Tippett	1999-2009
Dr Dominic A Barbaro	2009-----

Vice-Presidents

Dr William McCrea	1865-1868
Mr Robert Knaggs	1865-1874
Dr Ferdinand Jakob Von Mueller	1868-1869
Mr William Gillbee	1869-1879
Dr J G Black	1874-1879
Dr Hermann Jonasson	1879-1894
Dr James Thomas Rudall	1879-1896
Dr D A Gresswell	1895-1897
Dr J P Ryan	1896-1904
Dr W Moore	1898-1918
Dr J T Brett	1904-1925
Sir George Syme (Died 1929)	1928-1929
Dr AVM Anderson (Died 1932)	1928-1932
Dr R H Fetherston	1930-1933
Dr George Howard (Died 1934)	1933-1934
Dr J P Major	1933-1941
Dr William George Dismore Upjohn	1934-1963
Dr Fay Maclure	1944-1949
Dr Archie S Anderson	1949-1968
Dr Stanley W Williams	1963-1970
Dr C Douglas Donald (Died 1979)	1968-1978
Dr R S Lawson	1970-1976
Dame Joyce Daws (Died 2007)	1978-2006
Dr J Eric Clarke	1981-1986
Dr George Santoro	1988-1990
Dr Tom E Antonie	1991-1995
Dr Paul Woodhouse	1996-2007
Dr Alan Kermond	2008- ----

Treasurers

Dr William Henry Cutts	1865–1882
Dr James Jamieson	1883–1889
Dr William Henry Cutts	1888–1897
Dr J T Brett	1898–1901
Dr W L Mullen	1901–1909
Dr George Cuscaden	1911–1933
Dr Leonard Mitchell	1933–1955
Dr J Eric Clarke	1955–1976
Dr George Santoro	1976–1994
Dr J Anthony Horgan	1994–1999
Dr Paul Nisselle	1999–2001
Dr Paul Woodhouse	2002–––––

Secretaries

Dr James Edward Neild	1865–1904
Dr L J Martin (Joint)	1868–1879
Dr George Graham (Joint)	1879–1891
Dr Augustus Leo Kenny (Joint)	1894–1898
Dr W L Mullen (Joint)	1899–1901
Dr Edward L Gault	1904–1949
Dr Leonard Mitchell (Joint)	1928–1933
Dr Newman (Joint)	1937–1940
Dr C H Dickson (Joint)	1945–1966
Dr A W Burton (Joint)	1961–1975
Dr W M G Leembruggen (Joint)	1966–1980
Dr J S Richardson (Joint)	1975–1978
Dr W H Ryall (Joint)	1978–1984
Dr R R Hastings (Joint)	1981–1994
Dr BE Williamson (Joint)	1984–1996
Dr Paul Woodhouse	1996–1999
Mr Chris Roff	1999–2010
Mr John Fletcher	2011–––––

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Medical Journal of Australia
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VDHP newsletter

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Note: Page numbers in bold refer to illustrations.

Emma Russell is a professional historian and sole partner in History@ Work. She has authored or co-authored histories of the Queen Victoria Memorial Hospital, Fairlea Women's Prison, marketing education at Monash, the Peter MacCallum Cancer Centre, gastroenterology in Australia, and the Medical Defence Association of Victoria. Emma's work includes oral history, commissioned history, medical history, memoirs, exhibitions and museum work, contributions to journals and The Encyclopedia of Melbourne, and as alternate historian on the Heritage Council of Victoria.

Vicky Ryan is a professional historian with a Masters in Public History. Since completing her studies in 2005, she has undertaken several research projects for various institutions, oral histories and some exhibition and museum work. Her publications include 50 Years Serving the Community for the Rotary Club of Prahran, a history of the Medical Defence Association of Victoria with Emma Russell and, also with Emma, a history of the Boroondara Libraries is in progress.

The 'contamination' of homeopaths- the debate goes on

In 2011 Dr MacLennan from the University of Adelaide insisted in *The Age* newspaper (30 May 2011, p.3) that 'the government should not be wasting the public's money subsidising something that is basically a religion without an evidence base'. This cry against alternative medical treatments is not new. In a heated debate amongst the VMBA Committee 140 years earlier their Treasurer, Dr Cutts, gave a reason for this when he said 'the fact was, we sought to exclude homeopaths because they were successful'.

The debate was over a Dr Walcot who was an old man 'broken down both in mind and body'. His friends were raising a fund for his return passage to England and applied to the Association to supplement this with £10. Cutts supported this application as 'the man is legally qualified and is a gentleman', but he was opposed by others on the VMBA Committee because Walcot practised homeopathy. This alternative form of treatment was anathema to most medical men and Walcot became a test case for a hotly debated issue.

'Any of us might become homeopaths' argued Whitcombe, while Lilienfeld considered that some doctors were 'worse than homeopaths and more objectionable' and that charitable societies should accept requests 'from all quarters'. But it was 'an absurd system not founded in science' fumed Wilkie. Knaggs suggested refusing homeopathic money in the future, but thought in this case it would be 'low, mean and dishonourable' to refuse Walcot.

While doctors lamented those practicing outside orthodox medicine, it was not the role of the 'Medical Benevolent' to be the vanguard for advocacy or change. As William Cutts said in the heat of the debate 'our purpose in this Association is outside all differences in medical treatment... and that purpose is Charity'.

ISBN 978-0-646-56075-5