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Menders of the Mind

A History of The Royal Australian and
New Zealand College of Psychiatrists,
1946–1996

W.D. Rubinstein
Hilary L. Rubinstein

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Foreword

Menders of the Mind is a fitting tribute to our College which, together with its predecessor, the Australasian Association of Psychiatrists, has reached the respectable age of half a century. While the book is an official history of a professional organisation and shows the developmental complexities of such, it also encompasses a great deal of the fascinating change in the professional climate since the Second World War and shows by example and implication the intertwining of events outside and inside the College.

Clearly, a history of the College is not the definitive history of psychiatry in Australia and New Zealand. Nevertheless, the history of psychiatry in these two nations cannot ignore the seminal part played by the College, not only as a grouping of psychiatrists, but also as a powerful force driving education and standards in the field, driving the development and practicality of various modes of service delivery, and developing a collegiate approach between its members which has spurred many initiatives. Not the least of these are academic ones, whose activities have interrelated with College endeavours and have always had at least moral support from the College.

The book will provide an accurate documentary source for those who want to understand the development of psychiatry in this part of the world. It is intended to give an analytic appraisal of events rather than be a self-serving and triumphalist narration. Nevertheless, it is a triumphal account (written with due humility) of a group of farsighted and dedicated men and women with a great vision of our profession serving its major and powerful role in the amelioration of anguish as experienced by so many of the distressed people whom we serve. The early recognition of

the need for a Guild, for that Guild to be binational and for that Guild to gather the practitioners of our art in order to effectively influence the powers that be to assist a particularly defenceless and needy segment of our populations was commendable and effective.

It is difficult, in writing a foreword such as this, to disentangle the objective from the subjective. The authors have done this well but for me it raises a plethora of memories from the 1960s and 1970s when I was the Honorary Federal Secretary of the College. The memories are not those about organisations and change or how to professionalise the College, although these were always there. The memories are about a band of great people, led in many ways by David Maddison, who worked hard, against many odds, and with no remuneration, to achieve a dream. The College did become a very professional organisation and, as this book describes, there was an inexorable development to that end. The motivation was not because the founders sought to emulate others but because they themselves were the epitome of professional people and the structures and philosophy of true professionalism were the only way they could think and operate. One of their powerful motivations was to ensure that the directions of philosophy of our emerging profession would always maintain these high-minded ideals. Thanks to them and to the College I believe that it has.

However, in addition, the members of this band were very human and their company most enjoyable. There was a powerful spirit of companionship and friendliness which facilitated the College tasks and frustrations we undertook to resolve. For many of us, as younger practitioners, there was a true apprenticeship nurtured by the friendship of great men and women and the exposure to their world views and wisdom. There are many psychiatrists now in senior positions whose careers have been touched and often directed as a result of their contact with the College, both in

its early days and, hopefully, now. Our psychiatric training teaches us to be psychiatrists whereas involvement in College activities can teach us to be part of a broad and complex community whose objectives are rarely parallel to our own and often dangerously at variance. I believe that the College has contributed to many the feeling of being able to be effective in the face of adversity instead of being helpless. This might be seen as a particularly important collegiate influence in 1996, when the environment within which the College and its Fellows operate is changing so rapidly and in such challenging ways.

This book is divided into three parts, each spanning the entire history of the College. The first is an outline history, followed by a substantial section on the internal workings of the College and finally an important section on the College and wider society. Through all these parts the authors demonstrate the ways in which the College has become an increasingly professional organisation and the continuous process of change. They point out the College's responsibility to determine standards of training, to maintain ethical and clinical standards in the behaviour of its members, and its sanctioning powers. Earlier I mentioned the concept of a Guild which essentially has a monopoly over a profession, and controls entry to and exit from it. In simplistic terms we have clearly achieved this, as this book amply shows. However, the Guild concept is an old one and now the College has a major challenge, in Australia and New Zealand, that socio-political developments appear to be questioning the concept of professional Guilds (or professional Medical Colleges).

The winds of change include a demand for greater transparency to the community of what we do and stand for. Other interests are demanding the right to set standards and are questioning both our capacity to do so and our rights in this role. In at least one of our countries there are serious questions about the monopolistic aspects of

Colleges such as ours and whether they are trade restrictive. Changes in legal determinations regarding patient treatment outcome, even when there is little question of negligence, challenges our concepts of what is 'good enough' practice.

Consistent with the long tradition of this College of amending its structure in keeping with changing external environments, I am sure that by the time this book is published the College will again have undergone a change in its priorities, repositioning itself to meet new challenges and restructuring to deal effectively with the tasks of the new day.

However, I am sure that if a history of the College's second fifty years were to be published, in 2046, it would reaffirm that, throughout its history, the College has maintained its professionalism, its integrity and its concern for excellence in the care of those members of the community who need the services of College Fellows.

George Lipton
President 1995-97

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Preface

Menders of the Mind is an official history of The Royal Australian and New Zealand College of Psychiatrists (RANZCP) written to commemorate the fiftieth anniversary of the foundation of its predecessor body, the Australasian Association of Psychiatrists, in 1946. This history was commissioned by the College in 1993 and we obtained the commission to write it, in open competition, based upon an advertisement in the *Australian*. The College made a number of points clear from the first, and it is advisable to set these out so that the nature of *Menders of the Mind* is not misunderstood.

The College was commissioning a history of itself as an institution to commemorate its half-century mark. It was explicitly stated that the work was not to be either a history of psychiatry in postwar Australasia or a history of the treatment of mental illness, worthy and important as those two topics are. A number of excellent general histories of those subjects have appeared in recent years, most notably M.J. Lewis' *Managing Madness: Psychiatry and Society in Australia, 1788-1980* (Canberra, 1988) and, for the period before the formation of the College, Stephen Garton's *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940* (Sydney, 1988). Lewis' book, in particular, is a most valuable and wide-ranging survey to which anyone interested in the development of the treatment of mental illness must soon turn. Nevertheless, as a source for the history of the RANZCP or its predecessor bodies, it is extremely cursory, dealing with the College in an intelligent way, but in less than a dozen pages. The book we were commissioned to write would trace the history of the birth and development of a specialist medical college.

Nevertheless, the commission made it clear that this book was also to be a work of social history, tracing the involvement of the College with wider society and its nexus with broader events. It would also attempt to chart the likely future of the College in relation to probable developments in the nature and treatment of mental illness in Australasia. These aims were to be accomplished within a book of 60–80 000 words — half the size, or less, of many academic monographs.

We decided that this could best be done by dividing the book into three parts. The first provides a synoptic history of the Association, the College and the Royal College, explaining the most important and salient features of its development in chapters divided by natural chronological breaks. The main theme of that part of the book is the evolution of the RANZCP from a small, collegial voluntary association founded with sixty-seven members to a large medical specialist society having all the powers and responsibilities of true professional societies, especially a monopoly on the admission of new members and realistic powers to discipline and expel members for unprofessional conduct. Part II provides much more detail on the evolution and nature of the most important internal structures and functions of the College, the branches, the committees, the training and examination process, the congresses and research, and the College's prizes and awards. Part III examines the external workings of the College and its relationship to the wider world by looking at such topics as its international links and its attitude towards drug treatments. Included here, too, are much more detailed discussions of the College's two *causes célèbres* — Chelmsford and Townsville — and the results of a wide-ranging survey of a sample of members who critically examined the College and looked to the future.

We believe that this format is easy to follow, cogent and lucid. A reader interested in, for example, the development

of a particular College committee, is able to follow this in both a general and a more detailed way in the specialist chapter without the frequent breaks in the narrative which would be imposed by the format of a single chronological discussion. The title of this book, *Menders of the Mind*, provides a short and accurate description of the work of College members which is unlikely to be forgotten and which is a conscious echo of a work by Dr John Cade — one of the College's most distinguished members — *Mending the Mind*.

The College imposed no restrictions of any kind in access to its archival material or current papers. So far as we are aware, the College maintains few confidential documents which we were not allowed to see. Similarly, in the forty or more interviews conducted virtually all interviewees were remarkably frank — sometimes extraordinarily so — in discussing their careers and relationship with the College and its members. We do not believe that there was any aspect of the College's development about which we did not have full and complete knowledge.

There were two primary sources upon which we based this work. The first was the archives of the RANZCP, then housed at the College's headquarters. The other comprised the forty or more interviews we conducted with prominent College members from mid 1993 until early 1995, undertaken with a tape recorder and extensive note-taking. These interviews proved invaluable in providing a human face and human detail to the College's written record. Nevertheless, as anyone who has undertaken oral history will be aware, the human memory is quite fallible and easily confuses, conflates or unknowingly distorts events from even the recent past, and we have been extremely reluctant to accept oral evidence without contemporary written supporting documentation. In addition, only a handful of people are now alive who clearly remember the early days of the Association. Finally, one facet of conducting oral

interviews for a history of this kind is that diminishing returns set in surprisingly quickly. We learnt, for example, an immense amount about the history and problems of the New Zealand branch by interviewing five or six senior members who lucidly expounded on these themes; we seriously doubt that we would have learnt much more if we had conducted twenty New Zealand interviews. We suspect that we would only have heard the same points made over and over again by different people.

In researching and writing this book we became indebted to many kind and helpful people. Our primary thanks must go to Dr Paul Brown, chairman of the College's History Committee, whose help and encouragement we gladly acknowledge. Dr Brown and his wife Marta became personal friends of ours during this period, an association we greatly value. Similarly, we owe a great deal to the College's History Committee, Drs Susan Brann, Eric Cunningham Dax, Jeanette Lancaster, and David Hines, to Dr Eric Ratcliff of the Publications Committee, and to the anonymous readers of the first draft of this work. We must also thank the College's Registrar and Executive Director, Dr Robert Broadbent, for his assistance and courtesy, as well as the staff at Maudsley House: Margaret Ettridge, Barbara Keyser, Mary-Rose Morgan, Ann Parker, Sheena Mathieson, Cate Cole, Kristine McDonell and Gail Rose. We must also express our debt to the College Archivist, Bronwyn Hewitt, for her knowledge and helpfulness.

As we have noted, in conducting research for this work, Professor Rubinstein undertook over forty interviews with prominent psychiatrists, including several whose memories went back to the earliest days of the Association. Most of these extremely frank interviews lasted an hour or more, and were undertaken in the homes or offices of the interviewees, or at the annual Congress at Launceston in May 1994 and the New Zealand branch conference in Dunedin in August 1994. Professor Rubinstein interviewed

the two Registrars of the College, Peter Carter and Dr Robert Broadbent, and two long-serving College professional officers, Pam Allen and Margaret Ettridge. The following members of the College were interviewed: Drs Richard Ball, Sidney Bloch, Phillip Boyce, Paddy Burges-Watson, Graham Burrows, Philip Cohen, Eric Cunningham Dax, Colin Degotardi, Douglas Drysdale, Peter Eisen, John Ellard, Sandra Hacker, Anne Hall, Wallace Ironside, Norman James, Ross Kalucy, George Lipton, Ian Martin, Tim McKergow, Russell Meares, Wayne Miles, Russell Pargiter, Gordon Parker, Bruce Peterson, Bill Pring, Carolyn Quadrio, Beverley Raphael, Eric Ratcliff, Winston Rickards, Maurice Sainsbury, Brian Shea, Harry Southwood, Alan Stoller, Noel Wilton and Karen Zelas. Dr Arch Ellis was interviewed for us by Dr Paul Brown, while we also profited from interviews with the daughter of Dr Hal Maudsley, Mrs Helen Brack, and the daughter of Dr Jack Russell, Mrs Fudge. We also benefited from the advice of a number of other persons with whom no formal interview was conducted, including Drs Piroshotima Bilimoria, John Mark Davis and Malcolm McMillan. Most regrettably, a number of senior figures in the College's history could not, for one reason or another, be formally interviewed, and in these cases we took pains to note their contributions in other ways.

As a group, the interviewees were almost always extremely interesting and most informative. After interviewing so many senior psychiatrists, it might be worth noting that while they were all highly intelligent and well-educated professional men and women, they differed remarkably in personalities, backgrounds and outlooks. We are glad to have met all of them.

The competency of the typists of this very detailed manuscript, Margaret Moulton and Frances Baensch, cannot be praised enough.

The information in this work is current as of May 1995. Any errors which are brought to the attention of the authors

will be corrected in any future editions of this work.

Professor Bill Rubinstein

Dr Hilary L. Rubinstein

PART I

The Association and the College: An Outline History

In Part I of *Menders of the Mind* the origins and growth of the Australian and New Zealand College of Psychiatrists are traced and analysed in narrative form, beginning with the formation of the Australasian Association of Psychiatrists in 1946. The transformation of the Association into the College in 1963-64, the granting of royal status in 1978, and the recent challenges faced by the College, are discussed here chapter by chapter.

1 The Australasian Association of Psychiatrists, 1946-64

The facts surrounding the foundation of the Australasian Association of Psychiatrists in 1946 are reasonably clear. It is more difficult to ascertain why the body was formed at that particular time, nearly twenty years before Britain's Royal College of Psychiatrists was formally established. The formation of the Association appears to have come virtually out of the blue, with only a few hints that its formation had been seriously discussed prior to that date.

The Australasian Association of Psychiatrists (AAP) was officially formed on 9 October 1946 at the Royal Australasian College of Surgeons' Building in Melbourne. According to the Minutes of the inaugural meeting, twenty-seven psychiatrists were actually present; the well-known list of sixty-seven foundation members of the AAP thus includes forty persons who were not actually present at the original meeting.¹ Another nine invitees sent formal apologies.² Hal Maudsley spoke first, outlining matters relating to the formation of an Association, and was immediately named Acting Chairman. It was then resolved that the twenty-six present, together with the nine absentee members, constitute themselves as the Australasian Association of Psychiatrists. The next item of business was the election of Professor W.S. Dawson as foundation President (he took the chair), Maudsley as President-elect, and A.J.M. (Alex) Sinclair as Honorary Secretary. A Council of fifteen was then formed, which met the next day (10 October 1946) and agreed upon a set of draft rules. Membership on the Council was based on a fixed ratio for the states and New Zealand, with New South Wales, Victoria

and New Zealand having three members each, Queensland and South Australia two each, and Western Australia and Tasmania one each.³ The Council met the next day with instructions to draw up a set of Rules for the Association to be presented to the next general meeting.⁴

A number of other very basic matters were also decided at the meeting. The new body was formally named the Australasian Association of Psychiatrists, whose 'object should be all embracing and should include considerations relating to the study of mental hygiene' — not, perhaps, the most precise of briefs.⁵ More significantly, membership limitations were discussed and there was agreement that it should be limited 'to legally qualified Medical Practitioners engaged in the practice of Psychiatry'.⁶ This was an extremely important decision, ruling out psychologists and others concerned with mental health who lacked proper medical training, and physicians who had an interest in psychiatry but who did not practise in that field. It also ruled out full membership by medical students or trainees — the question of associate membership was deferred for a year — or by interested lay persons. Thus, from its inception, the AAP was designed to be a fully fledged medical specialist body, on a par with the surgeons' or gynaecologists' bodies. Professor Dawson's very first words to the new Association showed this intention clearly, for he 'emphasised the importance of the Association immediately taking up the question of improvement in Post-Graduate and Under-Graduate training in Psychological Medicine'.⁷

Several crucial questions arise about the foundation of the AAP at that date and in those circumstances. Most importantly, at that time there was no British equivalent of the AAP, while — as the attendance at the inaugural conference suggests — the psychiatric profession in Australia was very small and faced all the obstacles of distance, with their attendant costs, encountered by any

would-be binational body in Australasia. The AAP was thus certainly a pioneering venture: its foundation in 1946 must seem at least mildly surprising. Indeed, had it not been founded then, the foundation of a specialist psychiatry medical body in Australasia might have been delayed for another twenty years. The AAP at that time appears to be chiefly due to the efforts of Dr Henry (Hal) Maudsley, who chaired the inaugural meeting and served as the AAP's second President. His paramountcy is agreed upon by all the significant figures in the College's early history who set down their recollections of these events. Writing in April 1964, when the AAP had just transformed itself into the Australia and New Zealand College of Psychiatrists, Dr John F. Williams (present at the inaugural meeting), stated that:

There seems to be no doubt that Dr Henry Maudsley must be given foremost responsibility, and I hope credit, for the idea of forming this Association, and this is supported by an Editorial comment in the Newsletter, Volume 4 (1952) that 'Professor Dawson informs us that he has always regarded Dr H.F. Maudsley as responsible for the inception of the AAP, and that he had brought up the proposal to Professor Dawson at his home on May 4th 1946.' Moreover Professor Bostock, speaking as Chairman for Dr Maudsley's Second Presidential Address, stated that he had been largely instrumental in starting the Association (*AAP Bulletin*, 1956).⁸

Maudsley's formative role, according to Williams, 'followed his interest as a Foundation Member in the development of the Association of Physicians which later became the Royal Australasian College of Physicians, and his ambition that psychiatrists should have a similar development of an Association and later a Royal College of their own'.

Maudsley's formative role has also been confirmed by others. Sydney psychiatrist Desmond Arnott, President of

the AAP in 1950, stated in his autobiography *50 Years in Psychiatry* that:

In February 1946 I was visited by Dr Hal Maudsley, a psychiatrist from Melbourne whom I had come to know very well during the war. As I was still in the army, he visited me at Concord.

The object of his visit was to discuss with me the possibilities of forming an Australian association of psychiatrists. The discussion took most of the morning and resulted officially in the Australasian Association of Psychiatrists. Dr Maudsley was the father of the Association, helping to found and develop it.⁹

Arnott's account, if accurate, would suggest an earlier date for Maudsley's efforts than found in other sources and a more significant role for Arnott himself. Unfortunately, he does not extend his discussion of this meeting. Nevertheless, it seems unarguable that Maudsley was central to the process of the AAP's formation. Arnott's view was echoed many decades later by Dr Ian Martin, who missed the inaugural meeting of the Association because of influenza, but who was active in the organisation from its earliest days and served as Honorary Secretary for many years. 'Maudsley initiated the whole idea', he stated to one of the authors in 1994. According to Dr Martin, the idea grew out of a dinner conversation at the Melbourne Club at which Maudsley said to Dr John Williams: 'why don't we form an Association?'¹⁰

The sequence of events between 4 May and 9 October 1946 is somewhat complex. On 6 May 1946 Dawson circulated a detailed letter to other psychiatrists noting the 'proposal to form an Australian (and maybe in due course) an Australasian Association of Psychiatrists'.¹¹ In it he noted the objects of the proposed Association — 'to promote scientific discussion and to further the cause of Psychiatry in Australia' — and its proposed membership. In Dawson's

typescript this was to be 'Primarily psychiatrists in private practice' — who constituted probably much less than half the profession in 1946 — and 'Also Departmental Psychiatrists who are engaged in teaching or in special clinical work'. However, surviving at the base of the form letter, Dawson wrote the following: 'On further consideration I do not think it will [do] to isolate ourselves in this way. Suggest psychiatrists of 3-5 years standing with higher special qualifications.'¹² Dawson also noted that meetings of the Association would be held 'from time to time in various capital cities, that there would be state sub-committees, and the question of new members would be discussed at the first meeting'. He then concluded that:

A general meeting would then be called in Sydney or Melbourne with a view to proceeding with the establishment of the Association.

I shall be obliged if you will let me know if you are in favour of the formation of an Association on these or any other lines.¹³

Two conclusions seem evident from this letter. First, the very nature and purpose of the new Association was extremely fluid, with the most basic facets of its *raison d'être* being undecided. Second, far from being a figurehead or Maudsley's puppet, Dawson emerges as a powerful formative figure with almost plenipotentiary powers, able to change the nature of the proposed Association's membership literally with a few strokes of the pen.

Professor W.S. Dawson (1891-1975) Professor of Psychiatry at the University of Sydney in 1927-51, was the only professor of psychiatry in Australia at the time. Born in the Yorkshire dales and, like Maudsley, an officer in both World Wars, he trained at the Maudsley Hospital and was a Rockefeller Fellow before coming to Australia. From the early

1950s he lived in England, dying at Oxford in March 1975.¹⁴ Russell described him as 'ever a shy, reserved, sensitive, retiring man [who] evinced outwardly little concern for his public image, and indeed had no talent at all in projecting it'.¹⁵ Known through a play on his initials as 'Whiskey' Dawson, he was perceived as a 'courtly gentleman in the real sense'.¹⁶ Nevertheless, from the very early records of the AAP he emerges as a strong and innovative leader. Some witnesses to this period, indeed, have regarded Dawson's role as nearly as significant as Maudsley's. According to Dr Harry Southwood, who was present at the inaugural meeting, the pair were jointly regarded as 'the senior psychiatrists' in Australia.¹⁷ Dr Alan Stoller, another eminent figure in the College for many decades, described them as 'the prime progenitors' of the AAP. Dawson had, it would seem, himself been actively considering the formation of an Australasian psychiatric body long before this. In 1963, Professor John Bostock recalled (but without giving the date) that he and Dawson had 'discussed plans for the setting up of an Australasia counterpart of Psychiatrists' to the Royal Medico-Psychological Association of England, probably in the 1930s.¹⁸ This is a tantalising bit of historical evidence. Nevertheless, it should be realised that neither Dawson nor Arnott acted on these discussions, and practical results had to await Maudsley's crucial activities in 1946. What one can say, however, is that Maudsley's venture found an already favourable atmosphere, and not the hostility one might have expected such an innovative suggestion to have received.

Maudsley and Dawson notified the heads of psychiatric departments of the leading hospitals about their plans. Both found very considerable support for their proposals in the circular letters they had addressed to psychiatrists. On 17 May 1946, for instance, Charles Brothers of New Norfolk, Tasmania, wrote to Maudsley to say that he had contacted

three other Tasmanian psychiatrists, all of whom 'are very keen on the formation of such an association'.¹⁹ Good advice arrived from many other quarters. John Bostock of Brisbane advised Alex Sinclair of Melbourne that 'At all costs one must avoid making the mistake of having a hereditary hierarchy' and 'it is essential that the extramural psychiatrist have at least an equal voice in the councils and often a dominant voice'.²⁰ He also insisted that 'Since a large number of psychiatrists are in the public service it is felt that there should be an equitable balance kept on all executive bodies between intramural and extramural members'.²¹ Maudsley also spoke to Drs Springthorpe, Ellery and Bostock, among others, all of whom were keen to see the formation of the Association.²²

Preliminary meetings were held in Sydney and Melbourne, and possibly elsewhere, prior to the national inaugural meeting in October 1946. A meeting of interested persons was held at BMA House, Macquarie St, Sydney, on 9 July 1946. Chaired by Dawson, it formally agreed to the formation of the AAP. At least eight other psychiatrists were present.²³ The Sydney meeting followed a similar meeting in Melbourne by about six weeks. On 29 May 1946 Maudsley convened a meeting of leading Melbourne psychiatrists at his rooms at 8 Collins St 'to discuss proposals for the foundation of an Australian Association of Psychiatrists'.²⁴ Eleven other psychiatrists were present, and it was specifically noted that 'representatives in all States' had been 'requested to convene similar provisional meetings'.²⁵

The Melbourne preliminary meeting, it should be clearly noted, did not agree to the formation of an Australian Association of Psychiatrists. Instead, it agreed 'that an Australian Medical Society be formed for the furtherance of the study of problems which are predominantly psychiatric'.²⁶ Between late May and the Sydney meeting in

early July, opinion had clearly hardened in favour of an Association rather than a study group, and while Maudsley was unable to convince his Melbourne colleagues to agree to the formation of an Association, Dawson and the Sydney group strongly favoured this course. On 19 July Dawson wrote to Sinclair that 'Dr Archdall has just rung and says that he will be getting in touch with Maudsley concerning the advisability of forming an Association independent of the B.M.A.'²⁷

However, the Melbourne meeting did recommend a number of other major points which were adopted by the Association. New Zealand would be invited to participate, qualifications of membership would be 'governed by the existing British definitions as a "specialist",' new members would be elected and the question of associate members considered later, and a further meeting would be held in Melbourne after 'a provisional chairman in each State had been contacted'.²⁸ One crucial point, however, contrasted considerably with the stance ultimately adopted by the AAP, for it was decided that membership would 'be primarily for psychiatric specialists of approved status'. The inaugural meeting of the AAP decided that membership would be exclusively for psychiatric specialists, thus ensuring that it would be the genesis of a true medical specialist body.

On 26 August Maudsley wrote to five leading psychiatrists in other states. In his letter to Professor Bostock of Queensland he first specifically put the idea that Dawson should be the first President of the new body, and even suggested the title of Dawson's presidential oration ('The Teaching of Psychiatry in the Medical Schools of Australia'). The suggestion that an eminent Sydney psychiatrist be offered the foundation presidency obviously made good sense, and was a just tribute to a man whose role in the formation of the AAP was perhaps only marginally smaller than Maudsley's own. Dawson was quite surprised by the

offer: 'The suggestion that I occupy the Presidential Chair is startling but you have mentioned such a practical and timely topic for an address that I feel in duty bound to tackle the subject. So, with some trepidation, but with a sense of the honor paid to the Sydney Chair, I have much pleasure in accepting your invitation.'²⁹

Between August and October, negotiating committees were formed in Sydney and Melbourne. These ironed out the details of the new body before the formal inaugural meeting through discussion and negotiation, although the path taken was often confusing and contradictory. For instance, at the meeting of the Sydney negotiating committee held as late as 24 September 1946, the Sydney psychiatrists, headed by Dawson, revised their former stand and requested that the name of the new body be 'The Australian and New Zealand Association of Psychological Medicine', as it was felt that 'the term psychiatrist as at present interpreted was too vaguely general'.³⁰ On the other hand, the committee sought considerable tightening of the qualifications for membership, limiting it to 'medical practitioners who are registrable in Australia and New Zealand' and who had 'a minimum of five years full time practice of psychological medicine'.³¹ Discussions and tensions such as these were probably the inevitable prelude to the formation of a totally new body such as the AAP. By 9 October, the new Association had assumed its final form.

There were several important reasons why the foundation of the AAP occurred when it did, just after the end of the Second World War. The war itself had greatly increased the demand for psychiatric services among troops suffering the psychological traumas of warfare and among discharged soldiers. Indeed, according to Alan Stoller it was the war itself which 'sparked the College'.³² Certainly that war, involving the whole of Australian society and fought for the ideals of democracy, was a remarkable catalyst for

change. Many, perhaps most, Australian psychiatrists either saw active service or were personally involved in the treatment of war-related psychiatric problems. The war crucially altered the careers of many physicians who were young at the time, orienting them toward the study of psychiatric disorders.³³ 'Reform was in the air', remembered Stoller.³⁴

There was another significant public medical issue of the day which was certainly seminal to the formation of the AAP in 1946: the question of the status of psychiatry in any Australian national health service. In 1943-49 Australia was governed by a Labor administration committed to the extension of state-sponsored social democracy. In Britain, the socialist government which took office with a large majority in July 1945 made the introduction of a national health service one of its central planks. There were many who thought that Australia would inevitably follow suit. Fears for the future of Australian psychiatry under a national health scheme were high in the minds of the AAP's founders.³⁵ 'The private boys saw their pattern of medicine changing,' recalled Alan Stoller.³⁶ As a result, one of the first resolutions adopted by the AAP on the very day of its foundation stated that 'our Association is of the opinion that no National Medical Service can be efficient unless in planning and operation due consideration be given to psychological and psychiatric implications'.³⁷

There was also pressure on Maudsley from other quarters to found a Psychiatric Association at this time, especially from Alex Sinclair and 'a whole group in the mental health services and in private practice', who were aware of the movement for change in the air at this time.³⁸ Other factors contributed to the formation of the Association at that time, for example the rapid advance of medical knowledge and

the heightened presence of psychiatry in general hospitals.³⁹

Hal Maudsley (1891–1962) was an appropriate founder of the AAP, since he was a scion of what might almost be termed the royal family of Anglo-Australian psychiatrists. His great-uncle Dr Henry Maudsley (1835–1918) was the founder of the renowned psychiatric hospital at Denmark Hill in London which bears his name.⁴⁰ He was the son of Sir Henry Carr Maudsley (1859–1944), who was knighted for his medical services to Australia's troops in the First World War and who later established the neurological and psychiatric clinic at Melbourne Hospital.⁴¹ Hal Maudsley graduated in medicine at the University of Melbourne in 1915 and received his MD in 1920, and his Diploma of Psychological Medicine at Bethlem Hospital, London in 1921. He served in both World Wars, receiving a Military Cross in the first and rising to the rank of lieutenant-colonel in the second. He was a foundation Fellow of the Royal Australasian College of Physicians. He (like his father) served as President of the Melbourne Club and of the Royal Melbourne Golf Club, and was thus a pillar of the Melbourne 'Establishment', a fact which perhaps explains something of his success. He made a name as a psychiatrist in Bendigo, successfully treating members of a number of prominent families.⁴² He was not in private practice in Melbourne until the late 1930s, when he took over his father's rooms on Collins St. He was instrumental in establishing Melbourne Hospital's psychiatric unit in the 1930s.⁴³

Maudsley was successful at networking with influential people and was at the very centre of Melbourne life. Nevertheless, his visible activism and leadership in founding the AAP was uncharacteristic and his role was a surprising one. He 'wasn't a political person ... wasn't a strutting person' and was 'always tentative', according to his daughter, and was 'ineffective' as a letter writer to the press

on psychiatric matters.⁴⁴ Moreover, he had a cleft palate and did not like to speak in public.⁴⁵ Despite these personal obstacles, it is nevertheless the case that the AAP and its successor bodies owe their existence chiefly to Maudsley's active role.

Apart from Maudsley and Dawson, there were many others who were significantly involved in the origins of the AAP and whose role was specifically noted by observers. In his account John Williams did not give Maudsley sole credit; he named other early workers in the field such as the 'dynamic and tireless Bostock, the wise and erudite Dawson, the learned Oliver Latham, the calm and deep Des Arnott, and the clear and eloquent Jack Russell'.⁴⁶ 'The list could of course be extended to many others,' he continued, naming fourteen other figures throughout Australia.⁴⁷

The inaugural meeting which established the AAP was unusually successful. It included, besides everything else, a dinner at the Australia Hotel, a presidential address by Professor Dawson, and meetings at the Travancore Development Centre and at the Royal Park Hospital. Serious issues of policy were debated at the first Council meeting held at the same time: apart from the stance on a national medical service noted above, the new Council addressed the matter of training, a recurrent issue throughout the history of the College. The Council went on record to advocate that 'immediate steps be taken to investigate the under provision of facilities in each state for post graduate training in psychological medicine' and voiced its apprehension at 'the problem of giving an adequate grounding in psychological medicine to the enormously increased number of medical students now commencing their medical studies'.⁴⁸

A number of other very basic matters to the organisation of the AAP and the College were also decided, at least by implication, at this inaugural meeting. Owing to Maudsley's

key role, the headquarters of the AAP was located from the outset in Melbourne rather than in Sydney.⁴⁹ If the AAP had been founded at a later date, it may well have been based in Canberra, although the New Zealand branch might have been likely to object to locating headquarters in Australia's capital.

There had been a New Zealand component in the AAP from the start, and a number of prominent New Zealand psychiatrists such as R.W. (Reg) Medlicott, G. Blake-Palmer and Stanley Mirams were among the leaders of the College in its early years. Nevertheless, and somewhat oddly, a New Zealand branch was not officially formed until 17 February 1955.⁵⁰

At the first Council meeting, state branches were given specific tasks to perform, for example, Victoria and New South Wales were asked to follow up and report on the two resolutions on training adopted at the first Council meeting. During its first decade or so, the AAP repeated this policy with regard to state branches. For instance, in April 1947, the South Australian branch was requested to 'prepare a report on the care of the aged and senile demented'.⁵¹ By October 1948 each of the six Australian state branches was assigned a specific project.⁵² This procedure fell into disuse within a few years: state branches, although active, were chiefly concerned with local matters.

The psychiatric profession as it existed in 1946 in Australasia was not only a tiny fraction of the size to which it would grow, but it had several social and professional characteristics which distinguish it from the specialty we know today. From the *Medical Directory of Australia 1948* it was possible to trace basic information on sixty-four of the original sixty-seven members of the Association.⁵³ As one might expect of Australian professionals at the time, the overwhelming majority were Anglo-Saxon or, occasionally, Anglo-Celtic males. Somewhat surprisingly, three of the

pioneering psychiatrists were women — Dr Christine MacMahon and Dr Irene Sebire of Sydney, and the redoubtable Dr Isobel Williams of Hobart. For decades Dr Williams was the only woman to reach a position of authority in the Association/College, and in 1967–68 served as its first female President.

Nine original members had taken their medical degrees at British universities, while all the rest had earned their qualifications in Australia, although fourteen had done advanced training or had professional medical/psychiatric experience at a British university or hospital.⁵⁴ Not one, so far as can be ascertained, had any training in a continental European university, clinic or hospital, despite the centrality of continental European psychiatric pioneers to the development of the profession, while only perhaps four or five had spent any length of time in the USA. In age, they ranged from W.E. Jones, who had taken his medical degree in 1890, to several whose first real employment occurred as recently as the few years since the end of the war; many had served in either (or both) wars. As to specialist employment, about thirteen gave their address for correspondence as a mental hospital, and another twenty or so listed a state government department, hospital or instrumentality as their professional address. Perhaps five or six were, at the time, essentially university academics, although several of these had entered university life after long experience elsewhere. The majority appear to have combined an appointment at a hospital or clinic with some private practice, and about one-third listed their primary address as a medical practice, most often in the fashionable surgeries found along Collins or Spring Sts in Melbourne, Macquarie St in Sydney, or North Terrace in Adelaide. A handful — no more than half a dozen — appear to have been exclusively in private practice, while four or five described themselves as psychoanalysts. The latter included

Dr Frank W. Graham, Director of the Psychoanalytic Clinic in Melbourne, and Dr Roy Coupland Winn, a pioneering psychoanalyst and author of works on psychoanalysis, who was, in 1931, probably the earliest practising psychoanalyst in Sydney.⁵⁵

Compared with the membership of the College half a century later, the Association in its earlier years was drawn from a much narrower, more Anglo-Australian background, and was far more state-oriented and far less engaged in private practice than was a later generation.

In its first year of existence — there is no date on the document but it clearly dates from 1946-47 — the AAP adopted formal Rules of Association which governed the body until its transformation into a College. Defining the objects of the Association as ‘the advancement of psychological medicine’, it mandated that the AAP shall consist of ‘ordinary members and of no more than ten honorary members’. A candidate for election had to be ‘a medical practitioner registered in any part of the British Empire’, had to have ‘specialised in the practice of Psychiatry for at least five years’ prior to election, had to intend ‘to continue in such psychiatric practice’, and hold an appropriate medical qualification, including a Diploma of Psychological Medicine. Office-bearing positions, including a Secretary-Treasurer, were formally constituted.

During its first ten years of existence, the AAP established a pattern of growth and development which stamped the evolution of the College for many years. There was a steady relentless rise in the number of members, to 110 ordinary and fifty-three associate members in October 1954, and to 144 ordinary, sixty-two associate and two honorary members in August 1956, making a total of 208 members after a decade of existence.⁵⁶ Each year, membership would be granted to between five and fifteen applicants, a reliable rate of growth without sudden peaks or

troughs, indicating that the AAP was becoming more widely known.

During this period, many who were destined to play towering roles in the life of the organisation joined it. Such figures include Drs Alan Stoller (October 1947) and Eric Cunningham Dax (May 1952) as well as Clara Geroe (May 1949), Arch Ellis (May 1949), Ainslie Meares (May 1950), Ian Martin (April 1957), Reg Medlicott (October 1952), Una Porter (October 1952), Wallace Ironside (May 1953), Burton Burton-Bradley (April 1954), Stanley Mirams (October 1954), Bruce Peterson (August 1955), Winston Rickards and David Maddison (both August 1955). All were significant in the development of the College, seven serving as President.

The category of associate member, discussed before the AAP's formation, was instituted in 1951. Associate membership was granted to registered medical practitioners and practising psychiatrists. Such members need not possess a senior degree such as a Diploma in Psychological Medicine.⁵⁷ Associate members were enrolled for three years and had to reapply for membership; they also had to have three years of practice, compared with five years for full members.⁵⁸ During the period of the AAP and long afterwards, the presidency of the body changed hands annually and passed to many of the figures who had been instrumental in founding the Association — John Bostock, Charles Brothers, Desmond Arnott, John Williams, H. Birch, B.F. Stafford, J.K. Adey and G. Blake-Palmer — before, uniquely, Maudsley became President of the Association for a second time, in 1956-57. Today, when reading the presidential addresses and other papers of these early figures, one is struck by the broad classical learning often demonstrated by the first generation or two of the leaders of the Association. They were just as likely to quote Shakespeare or Virgil as Freud or Jung, let alone a statistical table or biochemical study, and without affectation or

pretension. G. Blake-Palmer, the New Zealander who was President of the Association in 1955-56, asked at the close of his final presidential note:

Could we not occasionally encourage our students (and ourselves) to devote a little more time to the wider fields of literature and art and a trifle less to current fashionable specialists' text? 'Poetry works in a divine mysterious way beyond and above consciousness'...

By way of contrast, instead of the tedious and dreary statistical presentation of Kinsey, why not a few half hours with *The Greek Anthology*, Petronius Longus, the Dialogues of Arrentino, or even Burton? Coming to more recent times, Verlaine, Ellis, Gabriel Chevalier, Aldous Huxley, Scott Fitzgerald, and a dozen others come to mind.

In some fields there is almost total neglect — who today for example reads James' *Varieties of Religious Experience* or St Augustine or Wesley's *Journal*? I fear our students are perhaps not very well sign-posted to the wider literature and too many are too little read outside the strict confines of their authorised texts.⁵⁹

When Dr Preston Guy Reynolds (1907-65) of Melbourne died, his obituary noted that:

Relatively unknown as such to many professional colleagues he was one of the outstanding scholars in his profession in Australia over the last few decades. To stand in his private library was a humbling and enriching experience. Recognised as one of the best private collections of books in Australia, it contained possibly 10,000 volumes, many of them first editions and many uncommon. Astonishing as it may seem, Guy had a working knowledge of Chinese, Russian,

Latin, Greek, German and French, and also knew some Spanish.⁶⁰

Something of the sort persists to this day: many of today's psychiatrists demonstrate a remarkable range of cultural interests and knowledge apart from the professional, perhaps more than in most scientifically based specialities. Yet it is difficult to imagine a contemporary President of the RANZCP closing his or her valedictory address with a similar appeal, and something has perhaps been lost. As the poet John Wain put it: 'The wise men passed; the clever men appeared.'

During its early days the AAP had an intimate social face which was possible only because its membership was so relatively small and represented people drawn from a common background, who often felt a sense of collegiality impossible at a later time. Many early issues of the *Australasian Psychiatric Quarterly Newsletter* contained a 'Personalities' column, such as that in its September 1951-March 1952 issue:

... To Dr 'Alec' [*sic*] Sinclair (V) — our sympathy for his recent bouts of illness and our hope that he will remain in the best of health in the future.

... To Dr 'Guy' Reynolds (V) — congratulations on his recovery from a nasty attack of acute appendicitis.

... Dr W. Freeman (T) is back after six months gallivantin' in Europe and U.S.A. He linked up with Dr V. Youngman (Q) for a period in Europe and saw the same bull-fight as Dr Stoller (V) in Mexico City. All three are back in full harness.

Another feature of the early issues of the *Newsletter* was facetious doggerel poetry, such as 'The Psychiatrist Proposes' (by 'Anonymous') in the same issue. The first stanza read:

Come, my love, my sweet neurosis,
Lose yourself in love's narcosis,
In free association let our egos find rapport;
What ecstatic thrills await us,
As we give each other status.
In the jungles of the psyche we will hand in hand
explore.

Annual meetings were occasions, keenly looked forward to by many, for both camaraderie and instruction in psychiatry's latest findings. 'Both the social and educational aspects of this meeting,' noted the October-December 1949 *Newsletter* of the annual meeting in Hobart at the end of 1949, 'will remain happy memories for those who were fortunate enough to attend.' Eighteen members of the AAP (from most states) and their families attended — an insignificant number by today's standards, but at the time one of the largest gatherings of psychiatrists ever seen in Australia. Then, as now, the presidential address was possibly the highlight of the gathering. In that year it was given by Dr Charles Brothers on 'Psychiatry and Eugenics', and was followed by papers by Dr Isobel Williams on 'Hereditary Aspects of Manic Depressive Insanity', by Dr W.J. Freeman on 'Transportation and its Effects on Van Diemen's Land', and Dr R.S. Ellery on 'Trichotillomania'. An after-dinner forum centred on the problem of alcoholism and the value of insulin therapy in schizophrenia, while the business meeting elected the new body's first honorary member, Professor Alexander Kennedy of Durham University.⁶¹ Enormously expanded, today's RANZCP annual conferences follow essentially the same format. At the time, the virtual total isolation of many Australasian psychiatrists from one another and from overseas developments greatly enhanced the importance of those early conferences in the self-definition and self-confidence of the Australasian psychiatric profession.

The AAP in its early days had a number of other significant achievements to its credit. In January 1949 Dr Alan Stoller founded the *Australasian Psychiatric Quarterly Newsletter*, a publication he edited for many years until it changed its name to the *Australian Psychiatric Bulletin* in 1960. Produced single-handedly on a typewriter and then roneoed, its homely and idiosyncratic style belied its function as the primary vehicle for disseminating information and communication on the psychiatric profession in Australia. From its earliest days, it reported at length not only on events as seen from the national headquarters, but also on the activities of each local branch, incorporating each state's newsletter and a wide variety of other material ranging from presidential addresses to recent publications to forthcoming lecturers. With the AAP's Council minutes, it recorded the early history of the College, and its steady growth in size reflected the growth of the Association.

The AAP also made contact, from its inception, with equivalent bodies overseas and encouraged the visits of leading overseas specialists. In 1949 Professor Kennedy of Durham made a tour of eastern Australia — a rarity at the time — while in the same year, official contact was made with the World Federation for Mental Health (founded in 1948). Dr W.A. (Bill) Dibden of South Australia represented the AAP at the Federation's first international conference, in Geneva.⁶² In 1950, Dr Daniel Blain, Medical Director of the American Psychiatric Association, toured eastern Australia, liaising with the AAP on organisational matters and presenting a lecture to the new body.⁶³ The AAP also began an association with Australian psychoanalysis, a clinical approach underrepresented in this continent prior to the Second World War, but invigorated by the coming of psychoanalytically oriented central European refugees and others trained overseas.⁶⁴ In December 1952, the Australian

Society of Psycho-Analysts was founded in Melbourne; this was reported sympathetically in the *AAPNewsletter*. A significant minority of Australian psychiatrists have worked within the framework of psychoanalysis. For example, among the foundation members of the Australian Society of Psycho-Analysts was Dr Harry Southwood of South Australia, also a foundation member of the AAP and its president in 1960-61.

Despite all these important steps on the way to establishing itself as the representative body of the psychiatric profession in Australasia, the AAP in its early years (and perhaps for some time afterwards) clearly lacked many of the defining characteristics of a true professional association. Most sociologists of the professions regard the ability to restrict the number of new entrants to that occupation, through regulation of the examination system, as crucial to categorising a representative organisation as genuinely professional.⁶⁵ The AAP had no such powers. It had at this stage virtually no role in the examination process but was, rather, a collegial association for persons who had already achieved the status (however defined) of psychiatrist. It lacked any truly significant function in the examination process for many years. Indeed, it is no exaggeration to state that the achievement during the 1970s and later of its universally recognised role of (eventually sole) administrator of examinations to determine entrance into the Australasian psychiatric profession was congruent with the AAP's successor body achieving the status of a genuine professional umbrella organisation.

Nor did the AAP in its early days fulfil many of the other functions of a genuine professional body. It could not discipline members found guilty of unprofessional conduct: it had no realistic mechanism for doing so, and expulsion from the AAP, even if carried out, could not have made an

iota of difference to a psychiatrist's career unless accompanied by removal from the list of a state's licensed medical practitioners — a power held only by a state's medical board or council. Nor, except in the most desultory way, did the AAP lobby the government on behalf of the whole body of psychiatrists, another hallmark of a true professional body. In so far as any such lobbying occurred, it would have been carried out either privately, by a small group of influential psychiatrists, or by a state branch. Indeed, since the states (and New Zealand) were at this time almost wholly responsible for psychiatric practice, with the Australian federal government having virtually no role (repatriation and veterans' affairs being a possible exception), it is difficult to see what a national body like the AAP could have done. Only with the coming of a genuinely national health care system in the early 1970s, and with the growing power and authority of the Australian federal government in a wide range of health matters, did the College emerge as an acknowledged and powerful national voice for the psychiatric profession. As with the examination process, over the next decades the AAP attempted, albeit with success long delayed, to achieve disciplinary powers over its members and to become recognised as the profession's national voice.

In several other respects the early AAP's stance and outlook on issues differed widely from that which the College would be likely to adopt today. Not infrequently it adopted a judgmental position, closely linked with notions of eugenics which would now be discredited in most informed quarters.⁶⁶ A great deal of discussion went into the screening of migrants, then flooding into Australia from unfamiliar sources in southern and eastern Europe in record numbers. There was an often-voiced concern (although often refuted as well) that migrants were more prone to mental illness than the native-born.⁶⁷ 'Unless we are careful,

they can so easily be left to form small groups which will still tend to carry on the language and customs of their homeland,' a commentary in the *Newsletter* for January-June 1950 noted, long before multiculturalism. But it also clearly asked for sympathy for the vast number of these people who were the victims 'of persecution, concentration camps, and the loss of relations'.⁶⁸

The last seven years in the life of the AAP, before its reorganisation into the Australian and New Zealand College of Psychiatrists (ANZCP) in April 1964, in effect comprised a single period in which the affairs of the Association were all but dominated by two major issues — the question of establishing an Australia-wide Diploma of Psychological Medicine (DPM) under AAP auspices, and the drive to reorganise as a College rather than an Association. The two issues were closely linked, for it was the refusal of Queensland, in 1960-62, to recognise AAP-administered DPMs as valid which led directly to the transformation of the AAP into the ANZCP several years later.

Moves to institute an AAP-administered DPM surfaced from the earliest days of the body. In May 1950 Dr N.V. (Vincent) Youngman of Queensland moved a motion, carried at the AAP's Council meeting, that 'the Council of the AAP approach the [Australian] Vice-Chancellors' Committee ... urging them to adopt the curriculum of the DPM as laid down by the AAP.'⁶⁹ A mixed response was received from the four universities which replied to the AAP's suggestion, with the University of Melbourne responding bluntly that 'the Courses proposed were unbalanced and there was too much practical work proposed in psychology, general psychology, neurology and neuro-pathology', an ironic claim in view of the heavy emphasis eventually placed upon practical work.⁷⁰ At this time, an Australian DPM could be obtained only at the universities of Melbourne and Sydney. Residents of the smaller states were thus in the very difficult position

of having to study abroad or in Australia far from their homes, and it was from the smaller states that pressure chiefly came for an Australia-wide diploma. An early proposal was that students from smaller states work at home under AAP direction and supervision.⁷¹ The situation was especially acute in South Australia, where by 1957 'the few qualified and practising psychiatrists had been reduced in number by death, retirement, and illness', while the younger psychiatrists, about ten in number, had not been able to leave Adelaide to comply with the residential requirements for a diploma in other states and abroad. This was the crux of the matter, especially as Adelaide University had no chair in psychiatry.⁷²

At the AAP Council meeting held in Hobart on 25 November 1957 the leaders of the AAP reached the conclusion that something would have to be done. The Association's early efforts at organising its own DPM date from that meeting. Speaker after speaker highlighted the difficulties facing students in the smaller states, with Dr Bill Dibden of South Australia proposing that the Association establish 'a Board of Censors on a Federal level, in much the same way as the Board of Physicians operated'. Dr Hal Maudsley, President of the AAP, announced that he 'considered that the time had come for action in the matter'.⁷³ After the options facing the AAP were set out and discussed at great length, a subcommittee with members in each state was established and asked to report, after local consultation, on a preferred policy.⁷⁴ Various proposals were received from most states, but no progress was achieved, and in 1958 Adelaide University refused the AAP's request that a DPM be established there.⁷⁵ In May 1959, after considerable delay, some headway was made after liaison between Dr Sinclair and the Royal Australasian College of Physicians (RACP). It was decided that another small subcommittee be established under the chairmanship of

Professor W.H. Trethowan, 'to investigate the possibilities of the establishment of a DPM (RACP) and to draw up a detailed plan for presentation to this Council and the RACP if considered practical.'⁷⁶ The mills ground slowly, but in May 1960 Council finally considered a 'detailed proposal for an Australasian Diploma in Psychological Medicine'. A motion to Council from the South Australian branch that 'the AAP favours an Australia-wide DPM course and examination' was approved by nine votes to one, with two abstentions.⁷⁷ Further motions that 'the AAP shall arrange and supervise such a course, conduct examinations and grant diplomas to successful candidates' was approved by seven to three (with two abstentions), negating a proposal that the RACP rather than the College should administer a DPM. Another subcommittee to recommend on the details of the courses and examinations, headed by Dr Harry Southwood, was also approved by an identical vote.

The lengthy proposal for a DPM had been drawn up as a first draft by Professor Trethowan. It suggested a three-year course of training, divided into three parts, covering two courses of training and work in a specialist field.⁷⁸ A Board of Examiners, consisting of four Censors, was recommended. Three annual examinations, held alternately in Melbourne and Sydney (or elsewhere) were to be held, with progression possible only if the earlier examinations were passed. The examination for Part III was to consist of a thesis and a clinical and/or oral examination in a special subject.⁷⁹ Formal recommendations to the AAP's Council regarding the establishment of a College DPM were put at the May 1961 meeting and approved, with Professor Trethowan chosen as Censor-in-Chief of the Provisional Board of Censors, and Drs Sinclair, Southwood and Youngman elected as the Board's other members.⁸⁰ Professor Trethowan, who shortly thereafter emigrated to Britain, declined to stand for the official position of Censor-in-Chief at the October 1961

meeting. Instead, Dr (later Professor) David Maddison was elected, a choice which was eventually to have far-reaching consequences for the College.⁸¹ Maddison was given the privilege of selecting three persons to complete the first official Board of Censors from among a field of fourteen persons officially nominated; he chose Drs Sinclair, Southwood and Stoller, in order to give a suitable geographical and specialist balance.⁸² In May 1962 — five years after the establishment of a DPM became AAP policy — ten candidates for Part I of the new examination were examined, six from Queensland, two from South Australia, and one each from Victoria and Western Australia.⁸³ By a pattern which was to become familiar, the pass rate proved to be disappointing, with only three candidates successful at the Part I written examination.⁸⁴ In the next Part I examination, reported on at the May 1963 Council meeting, neither of two candidates was successful.⁸⁵

2 The Australian and New Zealand College of Psychiatrists, 1964-78

At the very first moment of the operation of the AAP's DPM (and notwithstanding the lack of success enjoyed by its earliest students) came a savage blow to the very concept of such a DPM, which traumatised the AAP and was directly responsible for its transformation into a College. In April 1962 the Queensland branch of the AAP received word from its solicitors, Power & Power, regarding the possibility of registering the new DPM (AAP) with the Medical Board of that state. The clear legal opinion was that this was impossible, since an Association — such as the AAP was then — was 'merely a voluntary group of individuals who may disband at any time and ... has no particular legal status'.¹ Similar advice was given to the Queensland Medical Board, to the effect that the AAP was 'not a statutory body' and not 'a legally constituted body', and should have great difficulty in gaining registration of its DPM in that state.² Ironically, in mid August 1962 the Queensland Medical Board reversed its earlier position, recognising the Association's DPM.³ The April 1962 verdict of the Queensland Medical Board came as a bombshell, according to Dr Jack Russell, its President at the time, and was the most important single factor in the decision to become a College.⁴

In the meantime, however, and building upon initiatives already instituted by Drs Jack Russell and Ian Martin, a firm decision was taken to transform the Association into a College, with legal opinion given at the May 1962 Council meeting that 'we have no chance of registering the DPM in Queensland unless we become a College'.⁵ Consequently, at

that meeting the Association's President, Dr Jack Russell, 'moved that Council resolve to take the necessary action forthwith to convert the Association into a College'.⁶ A College subcommittee, consisting of Dr Russell, Professor Maddison and Drs Ian Simpson and Bruce Peterson, was constituted, with explicit instructions 'to draw up a Memorandum and Articles of Association under the Companies Act'.⁷ By the September 1962 AGM, copies of the proposed Memorandum and Articles of Association had been drawn up and sent to all members.⁸ The name chosen for the new body — the Australian and New Zealand College of Psychiatrists — was deliberately taken 'to distinguish our initials from other Colleges' initials', and explicitly to include New Zealand.⁹ A motion at the AGM 'that this meeting approve the formation of a College' was carried unanimously. This is somewhat surprising, in view of the important legal implications of such a move. Speaking to this motion, Dr Russell and others 'outlined the advantages, tangible and intangible, particularly in status in the eyes of our colleagues and the public at large' which a College would bring, as well as the removal of the legal difficulties of the Association and the fact that as an Association another voluntary organisation could be formed, creating rival claims for recognition.¹⁰

Once endorsed, the Memorandum and Articles were submitted to various solicitors and to the New South Wales Attorney-General for approval. A year passed, however, before the new College legally came into existence. The College was officially incorporated in Sydney on 28 October 1963, and the old Association dissolved at a special general meeting of the College at AMA headquarters in Albert St, Melbourne, on Sunday 12 April 1964.¹¹ To mark the occasion, a number of special activities were undertaken, such as the presentation and publication of Dr John Williams' important paper on the history of the former body,

'The Australasian Association of Psychiatrists from Birth to Dissolution'.¹² The first formal meeting of the Council of the new College took place in Canberra (at 9.30 a.m.) on Sunday 25 October 1964.¹³ This meeting coincided with the College's first annual Congress, an event memorable for its evening inauguration at the Academy of Science, a building surrounded by a moat, almost invisible in darkness, into which fell the unsuspecting Dr J.B. Russell-Gordon, a foundation member, in formal dress.¹⁴ The inaugural proceedings were chaired by Senator (later Sir) John Gorton, then Federal Minister in Charge of Commonwealth Activities in Education and Research, who became Prime Minister four years later.

Although the formation of the College came relatively suddenly, some believe that it was anticipated from the first days of the AAP. According to Dr Youngman, last President of the Association, Dr Hal Maudsley:

envisaged our ultimately achieving the status of a Royal College in the same manner as the Physicians. Thus our line of development has diverged from that of psychiatric associations in Great Britain and America. Our criteria for full membership have always been strict and rather than a loose association of doctors interested in psychiatry we are more ... the guardians of the standards of the specialist practice of psychiatry in Australia and New Zealand.¹⁵

While Maudsley may well have had such a goal in mind, there was no discussion of such an aim in any minutes of the Association or other surviving documents before about 1960. So far as can be ascertained, the first mention of the possibility of the Association becoming a College was voiced by Dr Eric Dax at the Council meeting of 7 May 1960, when he asked that the future of the Association and the

possibility of it becoming a Royal College be discussed at a future Council meeting.¹⁶ One notable point with regard to the formation of the ANZCP is that it was formed well in advance of its British counterpart, the Royal College of Psychiatrists, which was not officially chartered until 1972, although a predecessor body, the Royal Medico-Psychological Association, came into existence in 1926.¹⁷ By a strange coincidence the British Royal College was instituted after a protracted struggle because of activities also carried out in 1960–64, including the formation of a special committee to explore the desirability of a Royal College, a postal vote in favour, and an AGM devoted to this question.¹⁸ So far as any written source in the possession of the RANZCP reveals, however, the Australian and British organisational ventures were quite independent of each other, and there is no mention in any Association or College document of institutional changes in the British psychiatric association; in any case, completion of the process of transformation from an Association to a College in Australia predated the British body's evolution by eight or nine years. Even by the 1960s, it was at least slightly unusual for an Australian body to take shape with no reference to, and ahead of, its British equivalent.

The years from 1957 to 1964 saw a number of other important developments which set the Association on the road to becoming the organisation that it is today. In 1959–60 the roneoed *Quarterly Newsletter* was replaced by an attractive printed quarterly entitled the *Australasian Psychiatric Bulletin*, like its predecessor edited by Dr Alan Stoller.¹⁹ Containing more material than the pioneering publication, it served the same basic function of communicating news and relevant information to members of the College from binational and branch headquarters. Unlike its predecessor it contained advertising, Volume 1 No. 1 presenting full page advertisements for Largactil

(chlorpromazine hydrochloride), Ritalin (methylphenidate hydrochloride), Prozine (meprobamate and promazine hydrochloride), Marplan (1-benzyl-2 (5-methyl-3-isoxazolyl-carbonyl) hydrazine), and Cemalonal ('pastel coloured phenobarbitone tablets', described by its manufacturers, Charles McDonald Ltd, as being 'as modern as the jet'). During this period, the relationship of drug companies to the psychiatric profession in Australia became an issue for the first time. In October 1961, the question of inviting drug company representatives who were doctors to scientific meetings of the College (held chiefly at the annual conference) was officially discussed at the AGM. The Council first ruled that they not be invited, a point disputed by several speakers. A vote was taken and, by a simple majority of members present, it was recommended that representatives of drug companies be invited to attend scientific sessions where appropriate.²⁰

In May 1961 the Association formed its first standing committees: earlier, it had functioned without a permanent committee structure of any kind. Noting that 'continued growth of the AAP requires a complementary growth of the Secretariat', Council established a Standing Finance Committee, a Standing Applications Committee and a Liaison Officer.²¹ The Queensland branch took charge of the Applications Committee, which dealt with new membership requests. Dr Peter Zavattaro became its first chairman. The Liaison Officer was appointed 'to deal with the correspondence between the AAP and such community-oriented mental health organisations as Council shall direct'.²² Dr Bill Dibden of Adelaide was appointed to this position. The Association went out of its way to make clear that these changes did not constitute any move towards the professionalisation of its secretariat, stating in the preamble to the motion that 'the nature of the work requires more

Honorary Officers from the membership rather than more salaried officials'.²³

In 1963 there occurred another event which set the stage for much future development within the College: the formation of its first subsection, on child psychiatry. This subsection was formed on the initiative of Dr W.S. (Winston) Rickards, widely regarded as the doyen of Australian child psychiatrists. Rickards presented a report on the first conference on Training in Child Psychiatry, held in Washington DC in January 1963 and on an international conference on child psychiatry held in the Netherlands in 1962.²⁴ In suggesting the formation of a College subsection on child psychiatry, he had in mind overseas procedure: a similar subsection existed within the Royal Medico-Psychological Association and an Academy of Child Psychiatry had been established in the USA.²⁵ At its September 1963 meeting, the Council appointed a committee to report on the formation of a child psychiatry subsection, a delay somewhat surprising in view of the warm support Dr Rickards' suggestion originally received at this meeting.²⁶ Rickards later termed the resistance to the proposal 'unbelievable', although there was a section on child psychiatry at the first meeting of the newly formed College in Canberra in 1964.²⁷ The section in Child Psychiatry was officially approved by the first annual Council meeting of the College in October 1964.²⁸

In other respects the final seven years of the Association proved constructive. In June 1957, Dr Maudsley, writing as President of the Association, perceived a sense of exhaustion and lack of direction in the body which must have been widely shared by members:

Is the Association to remain a small esoteric body, attempting certainly to increase the knowledge and professional standards of its members, but working

mainly for its own ends without any special mission, or can we visualise a future in which the Association's responsibilities can be enlarged and be regarded as arbiter of Australasian psychological medicine in its broadest sense?

The teaching of young or aspiring psychiatrists is being carried out, but only in one State is there any intensive post-graduate teaching progressing. We encourage, or would like to encourage, research, but this is mainly directed by the Mental Health departments without cooperation being sought by or from psychiatrists outside these departments.²⁹

Only seven years later, while the newly formed College still had a considerable way to go to become universally regarded as the 'arbiter of Australasian psychological medicine', it was certainly a very different body from its intimately collegial predecessor.

Apart from the changes noted already, a number of other important developments in this period merit attention. The Association had no permanent headquarters, although from its beginnings it had operated chiefly from Melbourne. Plainly, any recognised professional umbrella organisation required a permanent headquarters, but could acquire one only if its durability and status were assured and its finances were sufficient to obtain a suitable property. In 1962-63 the College acquired its headquarters, Maudsley House, clearly a most important symbol of its coming of age. In mid 1962 the Association was given the opportunity to acquire 8 Collins St, the offices used for many years by Dr Hal Maudsley, who had just died.³⁰ This site was referred to in the Association's minutes as 'Maudsley House', and a Maudsley House Committee was appointed to examine the possibility.³¹ Thus, the headquarters of the society was dubbed Maudsley House even before the two sites in

Carlton, subsequently called by that name, were acquired, or were even known to the Association. Although there was widespread support at the 1962 AGM to acquire the prestigious Collins St site, obtaining it proved to be difficult because of its cost and the uncertainty of future development in central Melbourne.³² In May 1963, however, Dr Eric Dax:

spoke of a double framed house opposite and under the control of the old Children's Hospital (now a mental deficiency hospital under the Mental Hygiene Authority). He discussed the locality, design and facilities already obtaining or readily obtainable by simple structural alterations. He outlined negotiations that he had initiated through his Minister expressing the hope that the AAP would be able to obtain this at a 'pepper-corn' rent.³³

In early 1964, the Victorian Premier, Henry Bolte, made a generous offer to Dr Dax on behalf of the Association, enabling it to acquire the site.³⁴ While the Association's Council, at its final meeting preceding the official formation of the College, approved the offer, reservations were voiced about its actual costs.³⁵ According to some, there was also considerable resentment from the Queensland branch at the headquarters being placed permanently in Melbourne.³⁶ By June 1964, however, the *AP Bulletin* was able to announce that the Council had officially inspected the site, which was redecorated free of charge by the Victorian government and made available at a nominal rental, with the College responsible for subsequent upkeep.³⁷ The pair of houses at 107-109 Rathdowne St, Carlton, was apparently built in 1870, adjacent to the manse of St Andrew's Presbyterian Church, and across the street from Carlton Gardens.³⁸ It was officially dedicated by Henry Bolte on 7 May 1965.³⁹ To Dr

Eric Dax belongs most of the credit for the College finding a permanent home in Melbourne.

The Association also took steps, albeit tentative ones, to upgrade and regularise its administrative functions. A Standing Finance Committee was appointed, consisting of Dr Bruce Peterson as Honorary Federal Treasurer and Drs Jack Russell and Ian Simpson as committee members.⁴⁰ All three were prominent Sydney psychiatrists, and for many years the financial affairs of the Association/College had been handled from Sydney.⁴¹ This was deliberately done to balance the fact that the organisation's headquarters and its secretariat were permanently in Melbourne. At the same time, a Liaison Officer, Dr Bill Dibden of Adelaide, was appointed, and an attempt to form a Standing Applications Committee in Brisbane was made.⁴² In 1956 and in May 1961, the appointment of a full-time Executive Officer was seriously discussed, but it was decided that the Honorary Secretary, Dr Ian Martin, be retained. No professional appointment was to be made, although Dr Martin's duties were to be shared with Dr Dibden.⁴³ As will be discussed, Melbourne-based Dr Martin held that position for many years, 1953-69, following two predecessors as Honorary Secretary, Dr Alex Sinclair (1946-51) and Dr Don Buckle (1951-53).⁴⁴ Dr Martin's duties consisted of 'organising meetings, preparing agendas, and conducting the business of the Council', a task he would perform 'with one of the girls' in his practice. Dr Martin took the minutes himself.⁴⁵ By the early 1960s there was a keen feeling that the Association had outgrown its amateur base, but for some time little was done to professionalise its structure.

In other ways, too, more dignity and formality pervaded the Association. In 1961 Drs Dax and Maudsley were asked to submit proposals for a formal ceremony for the inaugural part of each AGM. Under their proposal the President, followed by the President-elect, 'leads Councillors onto the

platform in academic dress. New members and associates, in academic dress, [are seated] in the front row in seats allotted in the same order as listed in the Council Agenda', and so on in a formal ceremony which climaxed when 'the retiring President inducts the incoming President and changes seats with him'.⁴⁶ The October 1961 AGM opened with this procedure.⁴⁷

The Association was thus acquiring many of the trappings of a well-established medical representative body, however far it had to go fully to achieve this aim. Its success and visibility were evidenced by the consistent and rapid growth in numbers during the last period of the old Association. In 1956, the Association had 208 members; by May 1963 this figure had grown to 351, an increase of 69 per cent in only six years, composed of 240 full members, 103 associate members, and eight honorary or retired members.⁴⁸ It was well represented in all the states, with Victoria having 106 members in all categories, New South Wales ninety, New Zealand forty-eight, Queensland and South Australia thirty-five each, Western Australia twenty-seven, Tasmania eleven, and nine resident overseas.⁴⁹

The period from the formation of the College in 1964-65 until the granting of the 'royal' prefix on 9 May 1977, and its formal adoption on 7 May 1978, forms a discrete chronological unit in the history of the organisation. In some respects it is a particularly difficult period to consider. Almost immediately upon the formation of the College there was an enormous and unprecedented increase in the volume of activities it undertook, with a proliferation in committees, meetings and paperwork. It is no exaggeration to say that by the late 1970s the College generated more paperwork in one year than it did in the whole decade of the 1950s. As the number of special interest groups, committees and sections proliferated, the autonomy of each increased, as did the essential independence of each group

from one another and from the College's central organisation and headquarters. The state (and New Zealand) branches also grew, as did the College's overall membership. Except, possibly, for a handful of persons at the very centre of the College's activities, by the time the Royal College was formed it was probably no longer possible for any single psychiatrist (or observer) genuinely to fully understand all the activities of the RANZCP, a situation which persists today, and has indeed probably worsened.

Yet in that period there was also, paradoxically, a greater sense of professional unity than before. The College took crucial steps to becoming a professional representative body — rather than a voluntary collegial association — in the proper sense. The very expansion of the College's membership — continuous, often virtually relentless — gave it a greater legitimacy, centrality and visibility than ever before. It became a force within the Australasian medical profession and in negotiations with the government, and took more visible and vocal stands (often very controversial) on public issues involving psychiatry. By the time of the formation of the Royal College in 1978 it was assuredly a professional medical representative body in a genuine sense, seen as such by the rest of the medical profession, by public bodies and by the psychiatric profession.

In 1964-78 the College was concerned with a host of issues on an extraordinarily wide range of subjects. Two matters of great importance to the evolution of the College stand out, however: the new examination system for membership, chiefly devised by Professor David Maddison in 1966-67 and taking effect as the College's sole examination system in 1970; and the extensive negotiations with the federal government over funding of medical benefits for psychiatric services, associated particularly with the introduction of Medibank by the Whitlam government in 1972-75. These negotiations were carried out by the College's executive officers, especially its Honorary

Secretary, Dr George Lipton, and in effect placed government funding for psychiatric services on the same basis (with minor exceptions) as any other medical services. Both matters contributed enormously to the legitimacy and centrality of the College as the representative body of the psychiatric profession in Australia.

While both will be examined in much more detail, it is first necessary to set out the major developments of the College's executive and administration from 1964 to 1978. In 1962-69, after much discussion, a College coat of arms was decided upon and adopted, chiefly on the instigation of Dr Eric Dax, who did much to facilitate this and other formal and ceremonial aspects of the College's new status. The suggestion that the Association have a presidential badge of office was first made in 1962.⁵⁰ In 1963 a famous medallionist, Andor Mezaros, offered to produce a professional design for this presidential badge, but the suggestion was dropped because the proposed design could not be adopted for an official coat of arms. In April 1964, when the formation of the College was under way, Dr Dax submitted three separate designs for a College coat of arms, all broadly similar, to Council for discussion.⁵¹ These were sent to the branches in August 1964 for discussion, with notes regarding their meaning. In each figure:

The central design within the circle shewing the crossed bands and central square refers to the intellect which has itself become disordered and has turned itself against itself and the body. This design shows in primitive symbolism the outer circle of the body, the disorganised inner components of the mind, and the enclosed central spirit.

Above is the symbol for Alum, to which has been attributed special mental healing powers. The symbol incorporates a Roman Cross. Its superposition is

designed to suggest that it is exerting healing influence over the disordered intellect.

The snakes entwined about the staff, which could be Caducei, were in their original design taken from a coin illustrated by Jung.

The octagon surrounding the design represents harmony attained by healing and integration.

The interlocking hooks [in the octagon] refer to the Maori sign of the two fishing hooks uniting the North and South Islands of New Zealand. The snakes could be related to Ungud, the serpent of the Aboriginal dreamtime, and as such be taken as an Australian symbol. Thus, both Australian and New Zealand symbols would be enclosed in the design.⁵²

After consultation with the branches, a final badge design was produced. In January 1965 the Bluemantle Pursuivant of Arms of the British College of Arms (the body granting coats of arms and other heraldic insignias) agreed in principle to the granting of arms and a badge to the College.⁵³ On 29 March 1966 an official (but rough) coat of arms, drawn by the Bluemantle Pursuivant of Arms, slightly modifying the original suggested badge, was received by Dr Dax and considered at a Council meeting in May 1966. The official coat of arms was finally adopted in 1969.⁵⁴

The College adopted an official motto at about the same time, another important symbolic indication of its new and higher status, although here the going was less smooth. In 1966, 'from a series of appropriate mottoes supplied by a very senior classical scholar', the words *Humanitate Progredi* ('Progress through Understanding') were chosen, but rejected by the British College of Arms (which sanctions official mottoes) as not being good Latin, despite the standing of its suggester.⁵⁵ A number of alternatives was discussed, and Dr John Cade's suggestion *Non est vivere*

sed valere vita (roughly ‘Not just to live but to value life’) was agreed upon — until the discovery that it was already the motto of the Royal Society of Medicine. Finally, Dr Scott-Orr suggested *Ex Veritate Salus* — ‘Out of truth (or understanding) comes health (or well-being)’ — which was ‘delightedly approved by everyone concerned’ and then by the College of Arms.⁵⁶ This then is the motto of the RANZCP; it expresses elegantly and concisely what the College is about, or is supposed to be about.

To many, such matters as the College’s coat of arms and motto will seem trivial, even antiquated and pointless relics. But they were important signposts of the growing maturity of the College and the measure of recognition it had achieved, which by that time had probably far exceeded the most sanguine expectations of its founders.

As throughout its history, the executive head of the College was the President. In that period two notable changes occurred in the post: in May 1975 on the initiative of Dr Pargiter the term of the presidency was lengthened from one year to two, effective from 1977.⁵⁷ This change had been frequently discussed and debated by Council over the years, from at least the November 1965 Council meeting, but had not been acted upon. At the same time it was decided that from 1977 the President-elect of the College also be elected ‘two years prior to his taking office as President’ and that the composition of the important Executive Advisory Committee (EAC) should consist of the President, President-elect, Honorary Federal Treasurer, Honorary Federal Secretary and Censor-in-Chief, which in effect became the College’s inner cabinet until professional executive officers were appointed.⁵⁸ The EAC had been established, as the Executive Committee, in October 1964, at the first Council meeting of the new College, and initially consisted of the President, President-elect, Immediate Past President, Honorary Federal Secretary and Treasurer,

Chairman of the College Committee, and Censor-in-Chief.⁵⁹ Its duties were deliberately left vague, with no formally defined existence or function, and it was 'groping towards a defined role' but was obviously intended as an inner executive cabinet.⁶⁰

Another major change to the method of selecting the President of the College was made at the October 1973 meeting of Council. In the early days of the Association the President simply emerged, being 'tapped on the shoulder' by the senior office-bearers of the College. (When asked why he was chosen President of the Association in 1960, Dr Harry Southwood replied to one of the authors that 'It was just my turn.')

⁶¹ According to office-bearers from those days, due regard was paid to such matters as rotation among the states, but with a relatively small membership, especially of senior figures, those who were, by character and reputation, presidential timbre were well-known and most such men (and one woman, Dr Isobel Williams) eventually served.⁶² When the College succeeded the Association, the Council established a President-elect Committee which functioned for a few years. In October 1973 that Committee was disbanded and henceforth the election of a President was made by Council in a preferential secret ballot after receiving written nominations two months before the May Council meeting at which the presidency would be decided.⁶³ The President of the College, in other words, was to be chosen by Council following a contested election.

This change apparently followed a good deal of grumbling by members about the lack of democracy and representativeness in the selection process. For instance, in November 1972 the President of the College received a letter from a member in Queensland which made the following points:

Why am I opposed to increasing powers for the EAC? Because it is unrepresentative of College membership. Three members (Honorary Fed. Sec., Honorary Fed. Treasurer and Censor-in-Chief) will always be from Sydney or Melbourne and invariably two of the other three members (President, President-elect, and Immediate Past President) will come from these two cities also and decisions reflect this unbalanced geographical representation ...

Furthermore with the arrangement we have for electing a President there is a danger of a clique running the College and we had the ridiculous situation where three years running the President came from Mental Hygiene Departments ... at a time when issues relating to private practice were of central concern and taken over by A and B even without EAC approval. I could imagine A being nominated as President and although the vast majority of members would be opposed to this nothing could be done to stop his election without turning the matter into a personal issue at Council ...⁶⁴

The issue of the representativeness of the EAC and other bodies central to the governance of the College was discussed at length at the May 1973 general Council meeting. The Queensland branch proposed that members from the smaller states be included in the EAC as a matter of course.⁶⁵ Ultimately, nothing was done to change the composition of the EAC.⁶⁶

The first contested election for President took place in May 1974, when Dr Arch Ellis of Western Australia defeated another candidate.⁶⁷ In May 1975 a second annual contested election took place, at which Dr Maurice Sainsbury of New South Wales defeated four other candidates. Most presidential campaigns since that date

have been contested, with Council receiving often lengthy *curricula vitae* and other information from candidates. Since voting is secret, no returns are known. While this change ensured that a tap on the shoulder was no longer sufficient to select the College's chief executive, the method of choosing a president was not strictly democratic, as only members of Council, rather than all members of the College, are eligible to vote. As nominations are made officially by state branches, however, an important element of popular choice does exist.

As noted, one of the most striking features of the College in that period was the enormous growth of its committee structure, a trend which became apparent almost as soon as the College began. Between 1965 and 1971 the College created a plethora of committees and a committee structure similar in many respects to that which exists today. By May 1967 the College had no fewer than sixteen committees, in addition to its state and New Zealand branches, the Board of Censors and its Child Psychiatry section. The sixteen committees were the Executive Advisory, President-elect, Fellowship, Evan Jones Prize, Maudsley House, Library, Gifts, Overseas Visitors, College, Secretarial, Finance, Scientific Program, Host Branch (of the annual conference), Journal, Application, and Pharmaceutical Benefits Committees.

Clearly, some of those, especially the Executive Advisory and Finance Committees, were more central and significant than others, while the work of some committees was obviously specialised, requiring only occasional close attention. This proliferation of committees was an unmistakable sign of the health and vigour of the College and its success at overseeing so much of Australasian psychiatry. Yet the trend also made profound demands on the resources of the College, which was still largely conducted by the voluntary work of its members. For much of that period — from 1969 to 1977 — an immense amount of College business was conducted from Melbourne by the

Honorary Secretary, Dr George Lipton, who was groomed by his long-serving predecessor, Dr Ian Martin, for the position.⁶⁸ When Lipton was appointed, the College employed one secretary and one junior secretary, despite the escalation of its paperwork.⁶⁹ Much of the work which would now be undertaken by its Registrar (a professional, full-time senior executive officer) was done in the early years by its Honorary Secretary, on a part-time basis.

Some increase in the staff of the College came in this period. A personal assistant (Mrs Peggy Nunn) to the Honorary Federal Treasurer was appointed in June 1965, and an honorary College Publicity Officer, Dr Warren White, responsible for liaison with the press, in early 1970.⁷⁰ In 1975 Dr Sandra Hacker, a young Melbourne psychiatrist who was encouraged by both Martin and Lipton to participate in College activities, was appointed Honorary Assistant Secretary to the College. Her tasks included replying to all correspondence, drawing up agendas and minutes of Council meetings, and highlighting issues to be raised at the Council.⁷¹ Undeniably, Dr Hacker was the first female psychiatrist to be taken into the College's innermost day-to-day circles of governance, although Dr Isobel Williams had served on the Association's Council for many years from its earliest days.

With the growth of committees also came new sections of the College. The differences between a section and a committee were not always crystal clear, although sections plainly represent broad interest groups which meet chiefly for educational and research reportage purposes rather than for a specific practical purpose, as a committee normally would. Non-psychiatrists from the relevant discipline also participate in section meetings; for example, legal figures are sometimes involved in the activities of the section on Forensic Psychiatry.

Sections are empowered to hold conferences and seminars apart from the annual binational conference devoted to the specific subject of the section rather than to a multiplicity of topics. During this period, two other groupings joined Child Psychiatry as formally constituted sections: Forensic Psychiatry in 1968-69, and Social and Cultural Psychiatry in 1973. Forensic Psychiatry, a highly specialised group slightly apart from the mainstream, was first constituted as a section in late 1968 and Dr C.L. Rolle was appointed its convenor in mid 1969.⁷² The section on Social and Cultural Psychiatry received its terms of reference in late 1973.⁷³ That section, whose first chairman was Dr Alan Stoller and whose first secretary was Dr W.E. Mickleburgh, liaised closely with the section on Transcultural Psychiatry of the World Psychiatric Association.⁷⁴ It had held preliminary discussions at the Hobart conference in October 1972, and met again early in 1973.⁷⁵

As with so much committee and sub-group activities, each committee and section of the College took on a life of its own, normally proving to be indestructible if not immortal. A unique exception to this permanency was the Overseas Visitors Committee, which dissolved itself in May 1973.⁷⁶ With the coming of inexpensive jet flights, the arrival of a prominent visitor from abroad was no longer a major event trumpeted throughout the Australasian psychiatric world; the committee also noted that it was frequently not informed of the arrival of relevant visitors, especially to universities. Left with little or nothing to do, it dissolved itself, and for its efforts 'a vote of thanks ... carried by acclamation' was proposed and carried at the May 1973 Council meeting.⁷⁷

One of the most notable changes which occurred to the role and image of the College as a facilitator of research and as a communicator of new and important scientific psychiatric studies in Australasia and internationally was the

birth of the *Australian and New Zealand Journal of Psychiatry* in 1967. The *Journal* took the place of the old *Australasian Psychiatric Quarterly Newsletter* and the *Australasian Psychiatric Bulletin* but was quite different in purpose. While retaining announcements about forthcoming College events, obituaries of prominent psychiatrists and the like, it was primarily a scientific journal, publishing research papers of merit which had undergone close peer group assessment and scrutiny before being accepted for publication. It was the first Australasian journal devoted to new scientific research in psychiatry — no previous publication by the Association or College had published scientific papers — and quickly established an international reputation. Volume 1 No. 1 of the new *Journal* appeared in 1967, edited by Dr Alan Stoller of Melbourne, one of the doyens of scientific research on psychiatry in Australia, and formerly editor of the *Newsletter* and *Bulletin*. Professor Brian Davies of the University of Melbourne and Dr Ainslie Meares of Sydney were Associate Editors and Associate Professor J.E. Cawte of the University of New South Wales was Review Editor. From the start the *Journal* had a large Editorial Board consisting of most Australasian psychiatrists who had been prominently involved in research.⁷⁸

The question of founding a psychiatric journal for scientific articles was discussed officially by the old Association as early as 1954.⁷⁹ Although quotations were obtained and guidelines for publication drawn up, nothing appears to have been done until late 1965, when a Journal Committee was formed. It met twice in early 1966 and obtained Council approval for a March 1967 launch date. All psychiatry professors in Australasia, and a variety of other specialists, were officially appointed as consultants and a brochure describing the venture was sent to all members and relevant institutions.⁸⁰ Advertising, especially from drug companies, was seen as financing the major cost of the

journal, along with library subscriptions.⁸¹ It was envisaged that the Journal would initially consist of sixty pages with 30 000 words of text per issue.⁸² Maudsley House was given as the sole address for all correspondence, with the deliberate intention of highlighting its position as the College headquarters. Very considerable thought and preparation went into every phase of the *Journal*: for instance, no fewer than 220 publishing houses were circularised with a letter requesting suitable books for reviewing.⁸³ Drs Stoller and J.L. Evans were officially appointed Editor and Assistant Editor in March 1966.⁸⁴

Before the appearance of the first issue, however, there was considerable disquiet at what some regarded as the narrow editorial base of the *Journal* in Victoria, and the May 1966 Council meeting discussed the matter at great length. Professor Maddison attacked the apparent fact that two of three key members of the proposed Editorial Committee (the Editor-in-Chief, Assistant Editor and Review Editor) 'have the power to reject any contribution to the Journal', and attacked the representativeness of the Board of Consultants.⁸⁵

It is far too psychiatric. It should have representatives from other disciplines on it. Apart from the professors, it only includes one person from outside the State of Victoria. It completely fails to give representation to the important private practice segment of psychiatry.⁸⁶

As a result, later that year an enlarged Editorial Board, consisting of an Editorial Committee plus an Assistant Editor located in each branch of the College, and a Board of Consultants, were created.⁸⁷ It was further provided that 'no paper submitted shall be rejected without the agreement of two members of the Board of Consultants'.⁸⁸

Notwithstanding these teething troubles, the *Journal* finally appeared and proved to be a great success. By May 1968 the *Journal* was receiving 'some 1200 incoming items of correspondence per annum, and at least double that number outgoing'.⁸⁹ In 1968-69 it published twenty-two original articles and ten editorial articles, and had 122 subscribers apart from members of the College.⁹⁰ In May 1968 Dr Meares resigned as Associate Editor of the *Journal*, leading to the appointment of two new Associate Editors (together with Professor Davies), Drs J.L. Evans and E.R. Seal.⁹¹ At the same time, Dr Stoller announced his intention to resign as Editor-in-Chief, with effect from the end of 1969.⁹² The Council decided to advertise for a replacement, and to ask the appointee to recommend his own choices to fill the senior editorial positions.⁹³ Dr Evans was appointed Editor-in-Chief in Stoller's place, after a postal ballot among Council members.⁹⁴ When he retired in 1972 Dr Roger Buckle of Melbourne was chosen to replace him.⁹⁵

Membership escalated continuously from 1964 to 1978; indeed, at a higher rate than ever before. There were a total of 444 members in all categories in June 1965, growing to 643 by October 1970 and 745 by October 1973. Growth escalated more sharply during the mid 1970s, reaching 830 by May 1975 and 878 by May 1976.⁹⁶ The 1000 mark was passed coincidentally with the acquisition of the 'royal' prefix, reaching 1001 members in May 1978. By August 1971 the College was the third largest specialised medical organisation in Australia and New Zealand, behind only the Colleges of Physicians and of Surgeons — an extraordinary achievement for a medical body only a quarter of a century old.⁹⁷ Three hundred new members joined the College between 1973 and 1978, a figure itself nearly six times the original total membership of the Association in 1946. When the College was formed in 1964, a category of 'Foundation

Fellows' was created, consisting of eminent psychiatrists, with provision for electing new Fellows in the future.⁹⁸ Under the provisions for fellowship drawn up by Drs Jack Russell, Ian Simpson and Alex Sinclair, consideration for election was to be based upon '(a) standing in the College; (b) distinction in literature science [*sic*]; (c) academic honours; (d) public appointments; (e) length of tenure in membership; (f) professional eminence'.⁹⁹ Thirty-nine Foundation Fellows of the College were then elected, representing the cream of Australasian psychiatry in the mid 1960s.¹⁰⁰

New South Wales	D.W.H. Arnott • A.T. Edwards • E.T. Hilliard • O. Latham • D. Maddison • C.M. McCarthy • C. MacMahon • B.H. Peterson • H.J. Prior • J.D. Russell • I. G. Simpson • C. Swanton
Victoria	D.F. Buckle • J.F. Cade • E.C. Dax • C. Geroe • F.W. Graham • J. Hurt • I.H. Martin • A. Meares • A.J.M. Sinclair • G. Springthorpe • A. Stoller • W.S. Rickards • J.F. Williams
Queensland	J.Bostock • B.F. Stafford • N.V. Youngman
South Australia	R.T. Binns • W.A. Dibden • H.M. Southwood
Tasmania	J.R.V. Foxtton • I. Williams
Western Australia	W.B.C. Gray
New Zealand	G. Blake-Palmer • A.G. Constan • W. Ironside • R.W. Medicott • S.W.P. Mirams

New Fellows were elected every year from among senior psychiatrists, who were nominated from among the ordinary members and elected by Council, normally without opposition. The College's Fellowship Committee selected those deemed worthy of the honour. By the time of the acquisition of the 'royal' prefix in May 1978 there were 143

Fellows of the College in addition to the thirty-two surviving Foundation Fellows — thirty-six in New South Wales, thirty-five in Victoria, twenty-one each in Queensland and New Zealand, nine in Western Australia, three in the ACT and two in Tasmania.¹⁰¹ During this thirteen-year period, there were often rumblings of disapproval at the two-tiered structure which seemed, to some, increasingly dated in an age of specialist experts whose distinction might be known to few or who had rendered eminent services to the College itself.

In late 1971 and early 1972 an Ad Hoc Committee on Election to Fellowship, convened by Professor David Maddison, was formed, and agreed on the defects in the system of electing Fellows, especially what it claimed was ‘a deliberate attempt ... to ensure that each branch was equally diligent in ... nomination of Fellows’.¹⁰² It also noted ‘a considerable departure from the earlier implication that real distinction within the College would be readily recognised, rather than conscientiously tracked down’, in the case of some long-serving members whose names had been circulated by the College Secretariat for advancement to fellowship.¹⁰³ The Ad Hoc Committee therefore recommended that ‘as from a date to be determined the category of Ordinary Member be abolished and that all Members at that date shall thereafter be designated as Fellows of the College’.¹⁰⁴ The abolition of the two-tiered system did not occur for many years, but was clearly in train by the early 1970s. Abolition made the College more democratic and also recognised that the highly specialised nature of modern psychiatry made distinctions of that type increasingly misleading.

Invidious distinctions among leading members of the College must be avoided in this history, but there is one man whose achievement in medical science, made while he was a senior member of the Association and popularised when he was a senior member of the College, was so

significant that it must be discussed. He was Dr John Cade (1912–80), whose discovery of the use of lithium in the treatment of manic depressive disorders arguably had the most far-reaching effects of any discovery in psychological medicine made by an Australian. While medical superintendent and psychiatrist at the Repatriation Hospital in Bundoora, Cade experimented with the use of lithium with chronic or recurrent mania, finding that it had a remarkably calming effect.¹⁰⁵ Cade's pioneering paper on this subject, 'Lithium Salts in the Treatment of Psychotic Excitement', was published in the *Medical Journal of Australia* in 1949. Cade was a foundation member of the Association in 1946 and a Foundation Fellow of the College in 1963, and served as President of the ANZCP in 1969–70. At that point he was a distinguished senior Australian psychiatrist, but one whose career was perhaps not more remarkable than any of fifteen or twenty others.

In the late 1960s, however, the Danish psychiatrist Dr Mogens Schou validated Cade's use of lithium in large-scale international trials and almost overnight Cade became world famous — probably the most famous of all Australasian psychiatrists with the possible exception of the great Adelaide-born psychiatrist Dr Aubrey Lewis (1900–75), who spent the whole of his professional career in England. In 1970 Cade was made a Distinguished Fellow of the American Psychiatric Association and received many other international awards.¹⁰⁶ In 1985 the American National Institute of Mental Health estimated that Cade's discovery had saved the world at least \$17.5 billion in medical costs.¹⁰⁷ 'Cade's discovery of lithium was viewed by many as one of the most significant discoveries in the history of pharmacotherapy', Professor Gordon Parker wrote, and he identified Cade as 'the only Australian listed for any other internationally accepted clinical advances across a wide

range of therapeutic modalities' in standard psychiatric textbooks.¹⁰⁸

Among the committees formed in this period was the Social Issues Committee. Although its work will be studied in more detail below, it is worth highlighting one of the more interesting and significant facets of the public face of the College in this period.

Before the late 1960s the College took no stand on controversial social issues which involved moral, ethical and lifestyle decisions or patterns of behaviour. College policy had dated from 1948 when it was decided that matters of medico-legal nature were to be commented upon by the Australian Medical Association.¹⁰⁹ During the late 1960s, the great change in social behaviour of a section of Australian youth, especially in sexual and reproductive matters and the use of narcotic drugs, and the growing importance of such issues in the public eye, virtually compelled the College to take a stand, placing on record the expertise and insight of the psychiatric profession. The Social Issues Committee as a rule led the way in voicing the opinions of the College on such controversial issues as abortion, homosexuality, sterilisation, the decriminalisation of narcotic drugs, and the like. Repeatedly, the stand which the Social Issues Committee took on these issues might be described as permissive or left-liberal, normally well in advance of mainstream public opinion or of the law as it stood at the time. It might be supposed that the permissive attitude demonstrated by the Social Issues Committee was the result of the personal leanings and agenda of its members, who were obviously likely to be concerned with controversial social issues to a far greater extent than most psychiatrists, presumably with a reformist viewpoint and strategy. While this was probably true, a very striking and important fact about the attitude of the Australasian psychiatric profession to controversial social issues is that when the committee's

proposals regarding official statements which the College ought to make was put to a vote of all College members, over and over again the rank and file members echoed the permissive views of the Social Issues Committee by large (and sometimes enormous) majorities. Consistently, virtually the whole membership of the College showed itself to hold attitudes on controversial social issues far in advance of mainstream Australasian public opinion.

There was no Social Issues Committee (or its equivalent) before the late 1960s. In March 1969 a motion was discussed by the EAC recommending that consideration be given to the formation of a Social Issues Committee, in order to provide a mechanism whereby the College could 'provide opinions regarding social issues such as abortion, bromurides and other drugs, tissue transplant, etc.'.¹¹⁰ This motion noted that the Victorian branch, under Dr Stanley Gold, had made a study of the abortion law, and suggested that this might be a model for the College as a whole.¹¹¹ The EAC's motion referred to a special meeting of the Victorian branch, held on 29 April 1968, which carried a resolution proposed by Dr Stanley Gold and seconded by Dr W.H. (Bill) Orchard. That resolution recommended that a registered medical practitioner not be guilty of an offence under the law relating to abortion if two registered medical practitioners terminated a pregnancy, being convinced that 'the risk to life or physical or mental health of the pregnant woman or any existing children of her family [were] greater than if the pregnancy were terminated'.¹¹²

Three members of Council, Drs John Cade, F.W. Graham and W.S. Rickards, asked Council to consider that document and define a College policy on the matter.¹¹³ In response Dr Ian Martin, the Honorary Federal Secretary, recommended that branches discuss the proposal.¹¹⁴ At the 3 August 1969 Council meeting, several branches recommended that the College adopt the position that it was competent to take

action on medico-legal matters and, as a result, its branches were given the right 'to make public statements on medicolegal or other matters of local concern after due consideration of the views of its members and after consultation with the President of the College'.¹¹⁵ At the same time, a federal Social Issues Committee was established and its terms of reference — essentially, to 'consider and advise on such matters of social concern as have relevance to Psychiatry' — were framed.¹¹⁶

In the early 1970s the Social Issues Committee considered and acted upon a range of such issues, all controversial. In late 1969 the Abortion Law Reform Committee, a subcommittee of the Victorian branch which shortly thereafter formed the basis of the Social Issues Committee, was asked by the College to conduct a questionnaire of all members on their attitude towards abortion law reform.¹¹⁷ Questionnaires were sent to 647 members of the College, of whom 270 responded. Members' attitudes toward abortion in late 1969, as shown in the poll, were as follows, along with results from a survey of members of the Australian Medical Association (AMA) carried out shortly before.

1 Would you agree that it should be the policy of the ANZCP that it encourages and supports methods for alterations in the laws on abortion, so that legally qualified medical practitioners are free to exercise clinical judgment in this as in other matters?

Yes 90% (AMA 77%) **No** 10% (AMA 23%)

2 Do you agree that the following considerations should be borne in mind in achieving this clinical judgment?

a When the continuance of the pregnancy would involve risk:

i to the life of the pregnant woman?

Yes 91% (AMA 88%) **No** 9% (AMA 12%)

ii of injury to her physical or mental health?

Yes 89% (AMA 88%) **No** 11% (AMA 12%)

iii of injury to the physical or mental health of any existing children in her family, greater than if the pregnancy were terminated?

Yes 70% **No** 30%

iv In determining the degree of risk, should account be taken of the pregnant woman's actual or reasonably foreseeable environment and her physical and mental reactions to the environmental conditions?

Yes 78% (AMA 54%) **No** 22% (AMA 46%)

b When there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be severely handicapped?

Yes 87% (AMA 80%) **No** 13% (AMA 20%)

c Termination of the pregnancy under conditions a or b should be subject to the following safeguards:

i at least two medical practitioners should have examined the woman and have each, in writing, expressed the opinion that on the balance of probabilities on the information available, the conditions of a or b are satisfied.

Yes 85% **No** 15%

ii no medical practitioner shall be under any legal duty to participate in any treatment under a or b, and no action shall lie against him for refusal to participate in any such treatment, providing he makes clear to the patient the grounds for such decision.

Yes 95% **No** 5%¹¹⁸

In May 1972 the College's Council adopted as College policy a resolution which 'strongly condemns community attitudes and laws which discriminate against homosexual behaviour between consenting adults in private'.¹¹⁹ In mid

1973, following a survey of College members, the Social Issues Committee prepared a draft position statement which, after a lengthy discussion, was approved by the Council as a clinical memorandum.¹²⁰ The Council discussion noted the results of a survey conducted in 1973 by S. Wortley of the attitudes of 110 psychiatrists and forty clinical psychologists in New South Wales, which found that 'about two-thirds endorsed the views either that "homosexuality is merely a matter of personal preference but should be kept strictly private" or "homosexuality is as natural as heterosexuality and should be freely expressed." Only one-third of Wortley's subjects endorsed the view that "there is something seriously wrong with a homosexual."¹²¹

While not officially reflecting College policy, the *ANZ Journal of Psychiatry* of June 1972 (Volume 6 No. 2) contained a lengthy Editorial Annotation by Professor David Maddison and Dr Bill Orchard on censorship and pornography. While Maddison was cautious about extreme claims that pornography was always harmless, Orchard stated that:

In my psychiatric practice, I have never interviewed a person who was significantly channelled into perverse or socially deviant activity as a result of reading a book or watching a film or play. Nor, to my knowledge, have any psychiatrist colleagues of my acquaintance had experience which differs from this. I have, of course, like other people, read of instances where a book or film has shaped the form of deviant or antisocial behaviour in a previously disturbed individual.

The notion that certain books or films may significantly corrupt flies in the face of the modern psychological view that character is largely shaped in the early years of life, that the pervert and the socially

deviant are determined long before adolescence, and that character in adolescence and adulthood is relatively immutable.¹²²

In February 1974 the Social Issues Committee released a position statement on the abolition of torture, maintaining that 'it wishes most vehemently to condemn the use of medical and/or psychiatric procedures for the purpose of political coercion of any kind', and 'joined with Amnesty International in its campaign to abolish torture'.¹²³ Plainly these sentiments were far less controversial than the others noted here, although the notion that the College should take an official stand on a political topic, even one as uncontroversial as this, was not universally shared. A questionnaire on the issue was circulated to all 659 members of the College in September 1973, of whom 423 (64 per cent) replied.¹²⁴ Eighty-eight per cent of those who responded agreed that the College should become involved in forming an opinion regarding these matters, and 86 per cent agreed that the College should issue a statement condemning the use of medical and/or psychiatric procedures for the purpose of political coercion of any kind.¹²⁵ Other calls for action also received large majorities, the exception being the statement 'I agree that the College should actively campaign with Amnesty International in their current campaign to abolish torture', which received the approval of only 52 per cent of respondents.¹²⁶

The stance taken by the College and by the majority of its members, consistently permissive and left-liberal, is thus strongly at variance with the popular image of a professional body, especially a medical professional body, as a backbone of conservatism. The image, even among scholars, of the psychiatric profession in Australasia (and elsewhere) is perhaps radically bifurcated and riddled by cognitive dissonance: psychiatry is certainly the most

unorthodox of mainstream medical disciplines, whose practitioners tend to have much more unorthodox and permissive views than other medical practitioners, but it is a medical discipline nonetheless. An Editors' Note preceding a radical critique by Robin Winkler and Una Gault of 'Psychiatry and Clinical Psychology', in a collection of essays on the professions in Australia, published in 1976, stated that:

Practitioners in the fields of psychiatry and clinical psychology do not deal with physical disability or illness in the ordinary sense but are concerned with altering individual behaviour which they consider to be inappropriate for orderly and productive functioning at work and for harmonious domestic arrangements and so on. Members of these occupations act as judges of what is normal and abnormal in society, while at the same time seeking, and often claiming, the sole right to determine what should be done to persons who come to the attention of such social control agencies as psychiatric hospitals, welfare agencies, counselling services, and so on.¹²⁷

The essay also noted the distinctive attitudinal/ideological outlook and agenda that have been the hallmark of the College, at least from the mid 1960s:

Mental health professionals generally see themselves as more liberal in their outlook than the patients they see, and in many ways, they have been. Freud was vilified for decades for his revolutionary ideas on sexual experience. In many areas, for example, alcoholism, sexual deviance, and crime, mental health professionals have fought to reduce legal concepts of deviance, replacing punishment and 'lack of

understanding' with treatment. Attitudinal surveys indicate that mental health professionals are generally more liberal in their views on issues such as homosexuality, abortion and marijuana than are samples of the general public.¹²⁸

This ideological unorthodoxy almost certainly marks out psychiatrists from the more conservative medical specialties. One assumes — but, without a great deal of detailed evidence, cannot be sure — that medical practitioners who choose to specialise in psychiatry, or students who choose to become psychiatrists, already represent a self-selected subgroup among university-educated professionals and medical practitioners. Furthermore, presumably psychiatrists hold, characteristically, more liberal and permissive attitudes on controversial social issues, a component of the *gestalt* which is also centrally interested in mental processes, cognition, deviant behaviour and so on, as opposed to the more straightforwardly organic outlook and processes of other medical specialties. On the other hand, first-hand experience with the immensely wide range of deviant behaviour and mental processes may also be productive of these permissive attitudes, or at least of the inappropriateness of condemning unorthodox lifestyles and practices on moralistic grounds.

Psychiatry's tendency towards the unorthodox should, however, probably not be exaggerated or unduly highlighted. That the psychiatric profession has thoroughly normal attitudes on material issues is best illustrated when we consider the first of what were arguably the two most important questions with which it was concerned in the 1964–78 period: medical benefits and government funding for psychiatric services, especially when Medibank was enacted by the Whitlam government. These issues are extremely complex and detailed and no point would be

served in attempting to examine more than the highlights of the changes which occurred.

Throughout Australasian history, most psychiatric services by medical practitioners were offered to patients in mental institutions, and so until the later part of the interwar period most psychiatrists were solely or chiefly in what would now be termed the public sector. Certainly, some psychiatrists were engaged in private practice, especially for a small clientele of middle-class patients, but the majority were not.

In 1958, the Association entered into an affiliation agreement with the British Medical Association (later the AMA) to negotiate over all matters related to fees, although the Association/College retained the right to negotiate on its own behalf if it was dissatisfied with the AMA's representations on behalf of psychiatry.¹²⁹ Under the national health scheme that existed in Australia at the time, a host of anomalies remained in the rebates offered for psychiatric services, owing to a lack of recognition of the time and skill spent in the essentially verbal techniques of psychiatric practice. Most of the fee had to be paid by patients.¹³⁰ Further, the scheme carried no items directly related to psychiatric practice (except for electro-convulsive therapy), and psychiatric services were lumped together with service providers who reasonably charged lower consultation fees, such as those in ancillary services (psychologists, social workers, etc.) in the diagnostic and therapeutic management of patients.

In 1964 the Anomalies Committee of the AMA approved the concept of a differentially higher fee for neurologists and (somewhat later) psychiatrists, but this was rejected by the government.¹³¹ From 1967 the Australian College of Neurologists and the College made separate submissions to the federal government, which were accepted by the Senate Select Committee responsible for the matter.¹³² While the

Minister for Health agreed that the psychiatrists had a good case, the AMA refused to put any pressure on the government for the correction of anomalies, especially the important grievance related to the time taken for psychiatric consultancies as the basis for fee rebates.

During the late 1960s, a number of key College officials, especially Drs George Lipton, Ian Martin, Russell Pargiter and John Game, negotiated almost continuously with the government and the AMA to upgrade psychiatrists' fees for non-hospital or institutionalised patients, to arrive at fair common fees for the whole profession and to equalise payments among the states.¹³³ Dr Lipton, who as Honorary Federal Secretary of the College probably deserved the most credit for these favourable changes, recalled that the AMA, 'a GP-run organisation' had great antipathy to the College's claims, and negotiations with them involved often difficult and painstaking meetings and discussions from 1968 to 1971-72.¹³⁴ There had been 'no mention of psychiatrists' in the AMA schedule of fees, and to obtain parity 'we fought and fought and fought'.¹³⁵ To boot, the federal government — now entering the health insurance field in earnest — was, according to Lipton, 'adamantly uninterested in psychiatry'. Finally, in 1972 the Ludeke Tribunal recommended placing psychiatry on an equal schedule payment basis with the other medical specialties.

A key request of the College was for a time-basis method of arriving at payments. Dr Lipton recalled being cross-examined for two days by the Ludeke Tribunal. 'Everything we asked for we got,' he noted, and in a sense the contemporary financial basis of Australian (though not New Zealand) psychiatry began at about that time. Placement of psychiatric fees on the medical benefits schedule was, according to Lipton, 'the single most important factor in getting psychiatrists out of the public sector and into the private sector,' where the majority are situated today.¹³⁶

(Another eminent psychiatrist, Dr Maurice Sainsbury, pointed out that public sector psychiatry diminished by 70 per cent in the big cities during his career.)¹³⁷ Medibank's psychiatric benefits meant that Australia was one of the few western nations — possibly the only one — where private psychiatric treatment was fully paid for by the country's national health system. Psychiatrists in training also receive medical benefits for services they provide, under certain conditions.

In the late 1960s and early 1970s the College's minutes and other printed sources were literally overflowing with memoranda and documents of every kind on the issue of fee payments. Many, especially those concerned with the AMA, have an undertone of vexation and even acrimony. Nearly all are lengthy and involved, containing page after page of minutiae and details about the precise definition of services and fees. There is, however, a clear feeling from many who were closely involved that not only was it worth all the effort, but that in some sense the College came of age during this time, or at least proved its worth. Psychiatry 'developed greater respectability within the medical profession as a whole' during this period, Dr Pargiter later recalled.¹³⁸

Next to the issue of medical benefits, probably the most important and far-reaching matter with which the College concerned itself during this period was that of the reform of the ANZCP examination system in the late 1960s, a process spearheaded by Professor Maddison. As the examination system is treated in more detail in the next chapter, only the highlights will be discussed here.

Maddison served as Censor-in-Chief of the Association and the College from October 1961 until December 1971, and twice produced basic changes in the psychiatry body's examination system. The first system, offering the Association/College's Diploma of Psychological Medicine

(DPM) to successful students, in operation until 1970, was closely based upon the DPM offered by the University of Sydney, where Maddison had been Head of the Department of Psychiatry.¹³⁹ It consisted of written examinations testing students' knowledge of physiology, psychology and psychopathology (Part I) and neurology and psychiatry (Part II).

Few students took the Association/College DPM, and there was an increasing feeling that the present state of affairs was inadequate. Perhaps the earliest and lengthiest discussion of the DPM occurred at the first Council meeting of the new College in Canberra on 25 October 1964. There was a feeling, expressed by Dr Alex Sinclair, that 'as we have a new College I think we ought to start with a fairly clean sheet'.¹⁴⁰ There was a generally expressed view that the College's DPM was intrinsically more difficult than those administered by the universities, which (as the two were very much in competition) militated against students attempting the College's DPM. Nevertheless, the College's DPM had the support of New South Wales Institute of Psychiatry, and as a result Professor Leslie Kiloh claimed that 'we ... hope to start teaching the majority of the DPM students in New South Wales'.¹⁴¹ On the other hand, in Victoria, where the University of Melbourne administered its own DPM, about forty students 'do the University DPM and one ours'.¹⁴² There was a general sense of confusion, with some hopes for the future mixed with a good deal of doubt about the success of the College DPM.

In May 1966 the College's Council passed a motion, put by the Western Australian branch, that 'the Board of Censors be asked to review the form and content of the current Diploma and forthcoming Membership Examination and be empowered to seek the opinions of State and New Zealand Branches and submit its final recommendations to Council as soon as possible'.¹⁴³ In reporting on this in the

Australasian Psychiatric Bulletin, the College's President, Dr Bill Dibden, noted that:

Some members of my own Branch have questioned whether the DPM really examines for what membership of the College implies. They have doubted the usefulness of an examination that subscribes to the old traditional scientific emphasis on neuroanatomy and neuropathology and largely ignores a consideration of competence in interviewing techniques and psychotherapy and the paramedical disciplines of sociology and anthropology.¹⁴⁴

In 1966-67, extensive discussions were undertaken by the Board of Censors on a new examination, and on 6 May 1967 Professor Maddison was able to report to a meeting of Council at Maudsley House that:

the Board of Censors were proposing an examination which would be far more relevant to the needs of psychiatry than the present DPM. There should be no necessity for the candidate to master large areas of fine detail on subjects not related to psychiatry, but there would be heavy emphasis placed on clinical examination. There would be two 3-hour written papers, as against 7 written papers in the Diploma exam. The oral examinations, requiring approximately 2 1/3 days, are equal in length to the oral examinations required by the Diploma. In addition, the presentation of case histories would be a mandatory first step prior to attempting the examination. Although non-psychiatrist examiners will be co-opted in certain areas, this examination comes much more under the control of the College and its Censors than any previous examination has ever done. We would no longer be in the hands of non-psychiatrists in

determining the standards of the examination at any level. It is proposed that there will be an accompanying Booklet for the guidance of candidates. This Booklet will contain explanatory notes to the by-laws, which in some cases are, of necessity, starkly worded.¹⁴⁵

Maddison also stated that 'the Board had given much thought to the preparation of case histories and believed that this would be a most desirable first test of the quality of the candidates' experience, aptitude, and level of training in psychiatry'.¹⁴⁶

The new proposals were discussed at great length, a number of changes suggested, and the new scheme formally adopted on 6 May 1967. Maddison and the Board of Censors were officially thanked by acclamation for an effort which deeply impressed the College Council.¹⁴⁷ The Council also resolved 'that the membership examination shall come into force on 1 January 1970 replacing the Diploma of Psychological Medicine which shall be superseded from that date'. Thus the beginning of 1970 marks a fundamental break in the role of the College as an examining body.¹⁴⁸

The emphasis that the College now placed on case histories rather than upon theoretical scientific knowledge was a major innovation. This was similar to requirements in a number of other Australasian medical colleges as well as to the examination procedure in the Royal College of Physicians, which Maddison might have viewed as a model for his changes to the College's system. On the other hand, the new approach was unique when compared with those of the other major examining bodies in psychiatry in Britain, Canada and the USA.¹⁴⁹

According to Singh, Doherty and Kalucy, Professor Maddison introduced the case histories from his 'conviction that the exercise of writing up certain specified cases make

explicit the need for the candidate to have participated in training experiences that were considered appropriate when variable standards of training were occurring in Australia and New Zealand'.¹⁵⁰ It also provided a test of the skills of a training psychiatrist much more relevant to those he or she would use in everyday practice — the ability to collect and synthesise clinical material, formulate, apply and evaluate a management plan, relate the facts of the case to the relevant literature and communicate them in writing'.¹⁵¹ Finally, it might be suggested that the emphasis on *praxis* and on the practical ability to analyse specific cases, rather than theoretical knowledge, is perhaps more characteristically Australian (or Australasian) than models of psychiatric training derived from Europe, Britain or the USA, and represent a highly original contribution to this area. By any test, Professor Maddison was one of the most significant figures in the history of the College, certainly among the half-dozen formative figures in its evolution.

While the new examination system marked a turning point in the history of the College, it is important not to exaggerate its immediate effects. In the first membership examinations held under the new system, in May 1970, only seventeen candidates entered for the examination, of whom fourteen were successful in Part I and were allowed to proceed.¹⁵² Numbers crept up to twenty-five in 1971 and then rose to forty in 1972 and fifty-four in 1973, but this partly reflects the enormous growth in College numbers which took place at that time. Similarly, while the universities which had successfully offered their own DPMs all eventually accepted the primacy of the College DPM

— a tribute to the importance of Maddison's work — that process took surprisingly long. The University of Sydney abandoned its DPM shortly after the ANZCP membership examination was established, but the University of Queensland continued to offer its own DPM until the 1990s

while, remarkably, the University of Melbourne abandoned its own DPM only in 1995, after a long and bitter debate.¹⁵³

Professor Maddison retired as Censor-in-Chief in December 1971, and was succeeded by Professor J.R.B. (Richard) Ball, from January 1972 until May 1978 and by Dr Bill McLeod, as Acting Censor-in-Chief, until the achievement of Royal status in October 1978.¹⁵⁴ The award given by the College to the outstanding candidate examined in any year, previously known as the Grey Ewan Medallion (1970-74) and the College Medallion (1975-82), was renamed the Maddison Medal in the professor's memory in 1983.

3 The Royal Australian and New Zealand College of Psychiatrists, 1978-89

Probably the final seal of approval, or at least the most visible form of official recognition, of the rising status of the College came in 1978 with the acquisition of the 'Royal' before the name of the College. The desirability of the College becoming 'royal' had occasionally been mooted long before. As early as October 1952 the Association's Council minutes noted that: 'The steps taken to obtain such an honour were outlined and the difference between Royal Prefix and a Royal Charter was discussed.'¹ While the following year Dr Maudsley stated that the matter was still being investigated, that October he 'reported that his enquiries had led him to advise that this question be postponed until the Association has acquired more stability and funds'.² The matter was raised only fitfully over the next fifteen years. In May 1960, Dr Eric Dax stated to Council that 'he had been giving some consideration to the future of the Association, and the possibility of it becoming a Royal College, etc.', and asked for the matter to be discussed at a future Council meeting.³ The question was also discussed briefly in May 1961.⁴ With the formation of the College a few years later, however, little more was heard of this proposal until the late 1960s. In August 1971, the College made an official application to the Australian government for the 'royal' prefix, cogently making a case based upon its size, functions and maintenance of professional standards.⁵ Somewhat surprisingly, the College was advised in May 1973 by the Director General of Health that there was 'no

possibility of a successful application this year'.⁶ By that time the Whitlam government had come to office, and was determined to diminish Australia's links with Britain. In October 1973 Council 'was informed that in the present political climate it would be wise to defer a further application for the prefix "Royal" for at least a year'.⁷ After the sacking of Whitlam in November 1975, however, 'royal' status returned to the active agenda, although there was little or no direct mention of that matter in the College minutes for several years. In 1977, however, the desired status was achieved as from May 1978, although approval had to be received from the Corporate Affairs Department.⁸ This involved Dr Colin Degotardi, the College's Honorary Federal Treasurer, in lengthy negotiations, and an extraordinary general meeting of the College to ratify the inclusion of 'Royal' in the name of the College was held on 7 May 1978.⁹ From the 1970s, successive Governors-General of Australia and New Zealand served as Patrons of the College, Sir John Kerr giving way to Sir Zelman Cowen in 1977 as the latter assumed the office of Australia's Governor-General.

The achievement of 'royal' status, although intrinsically a symbolic rather than a consequential change, was striking evidence of the legitimacy the College had achieved, and may be seen as the end of one era and the beginning of another — the era of the College's full maturity as an organisation universally recognised as the psychiatry profession's representative body in Australia and New Zealand. Yet, while this era of maturity produced satisfaction throughout the psychiatric world, it began with something like a period of crisis in the affairs of the College, and has been marked by as much disturbance and change as any other in the organisation's history. In considering the era after May 1978, it might be convenient to divide it into two periods — 1978-89, coinciding with the professionalisation

of the College's headquarters and other significant changes, and from 1990 onwards, an era which, because of its proximity in time, historians must treat with some caution.

A number of very important steps were taken by the College in 1978–89 in a variety of areas. Probably the most important was the professionalisation of the staff of its headquarters from the late 1970s to the mid 1980s, especially the appointment of a Registrar as the full-time executive officer of the College in 1983. The College also assumed a much more active role in its relations with the government and took its own role as the representative body of the psychiatric profession more seriously, with the institution of a College Ethics Committee in 1978. Furthermore, the College gave a lead to the initiation of the Committee of Presidents of Medical Colleges in the mid 1980s, and began a much more proactive role in workforce planning for the psychiatric profession. For the first time, the issue of gender and the role of women in Australasian psychiatry became of major concern. It was also in this period that the two most publicised scandals to affect modern Australasian psychiatry — those of Dr Harry Bailey and the Chelmsford 'deep sleep therapy', and of Ward 10B in Townsville — erupted into major issues which generated unprecedented discussion throughout the country. It will be argued that these had very significant long-term effects on the determination of the College that no repetition would be allowed to occur.

There is general agreement among members of the College closely associated with its affairs that something like a crisis point was reached in the late 1970s, probably around the time it reached 1000 members in May 1978. An organisation with so many members was simply unmanageable without a professional managerial structure in place.¹⁰ That 'there has been a continued escalation in the work undertaken by the Federal Secretariat Committee'

and other groups at the centre of the College was a continuing refrain at this time.¹¹ No such professional managerial structure existed, a reality which, owing to the competence of its honorary officers, did not have to be squarely faced until long overdue. When Peter Carter took up his appointment as the College's first Registrar in 1983, he found it in dire need of competent professional administration. Its administration was very badly organised and really languishing compared with other large medical specialist bodies, a situation which could obviously not continue indefinitely without the College eventually becoming unviable.¹²

The office-bearers realised this perfectly well, and the five years from 1978 were taken up with arriving at an acceptable scheme of professionalising the administration of the College. In May 1978 a subcommittee was appointed under the chairmanship of the Honorary Federal Secretary, Dr Sandra Hacker, to discuss issues 'relating to ... the funding of a College employee'.¹³ A draft advertisement for a full-time Executive Officer at an annual salary of \$18-22 000 was drawn up, with a job description.¹⁴ In mid 1979 College Employee Working Paper No. 3, drawn up by Dr Hacker, set out at length the justification for a professional administrator. Apart from the escalation of work, that paper highlighted 'the need for the College to develop [an] on-going political presence' in Canberra and Wellington and 'current and continuing political and governmental intervention in professional ... practice' as important reasons for such an appointment, but noted that in May 1979 Council had specified that any such appointee 'should be a psychiatrist, rather than any other professional'.¹⁵ It also canvassed alternative solutions such as a heightened role for the Honorary Federal Secretary, rejecting all of them and noting that 'maintenance of the status quo could not be

sustained'.¹⁶ This Working Paper 'strongly recommended that the College employee be a Junior Psychiatrist'.¹⁷

Little was done to implement this specific proposal. There appear to have been several reasons for the delay. Since the early 1970s the College had acquired a de facto administrative stratum. In 1973 Maudsley House appointed Margaret Ettridge (Cocks), who successively held the office of Executive Secretary, Administrative Secretary and Assistant Registrar (Fellowships). As is so often the case with positions of this kind, it would be impossible fully to describe Mrs Ettridge's duties except that, in a sense, she ran much of the nonmedical side of the College's activities single-handedly, doing everything from preparing minutes to greeting out-of-state visitors.¹⁸ With increasing seniority, she functioned as the College's institutional memory, often the only person who could recall relevant precedents. In the New South Wales branch, Pam Allen, the Branch Administrator, who has served since 1969, has fulfilled a similar role, putting out the branch newsletter, organising the local examinations, answering at least thirty phone calls a day and very definitely representing, in a personal capacity, the continuity of a branch where the Branch Chairman and office-bearers are elected annually.¹⁹ The College did appoint a full-time professional member of staff, but not to the managerial position clearly recommended. The appointee was Jenny Gormly, formerly a research officer with the New South Wales Health Commission, who became Research Officer of the College from April 1980.²⁰ There is general agreement that this appointment was unsuccessful, although Ms Gormly did produce a number of important research papers for the College. There were personality clashes, and her appointment did not address the central problem of the College, which was the lack of a proper manager with executive powers.²¹

Throughout those years, the College's executive continued to question, in the words of Dr John Grigor, its Honorary Federal Secretary after October 1981, 'how much longer the College can function with its present voluntary structure of gifted amateurs'.²² Finally, in May 1983 the Council approved the appointment of a full-time salaried executive officer.²³ On that occasion the Council approved a number of other very important ventures, including the purchase of a replacement headquarters for the first Maudsley House, directions that the Finance Committee achieve tax-exempt status for the College, and that all salaried staff, apart from those associated with the Journal Committee, be centralised in Melbourne. It also, crucially, redefined the role of General Council, mandating that it 'continue to develop as a governing rather than an executive body', that the College's management be structured 'around four major functions: education and research, finance, secretarial, and fellowships', and it abandoned any attempt to redraft the College's constitution.²⁴ Many of these innovations were proposed in an important and wide-ranging Report to RANZCP May 1983 General Council — RANZCP Organisational Review of March 1983, which was scathing about the College's structure. The report noted that 'the usual voluntary agency model tends to use voluntary labour to perform unskilled and public relations tasks, while the professional tasks and organisations of the voluntary labour are frequently placed in the hands of paid professionals', yet it was ironically the case that 'the reverse is true of medical colleges'. Moreover, the College's 'framework ... self-funded organisations, initiated, staffed and managed by Honorary professional labour ... is a most improbable form of organisation to have survived into the 1980s'.²⁵

Behind all that activity, probably long overdue, lay the fact that influence had passed to men and women who

understood the need for change and reorganisation. Chief among these were Dr Peter Eisen, then a member of the College's Federal Secretariat Committee (and its President in 1985-87), who had lucidly been arguing the case for reorganisation in a variety of cogent papers, Dr John Grigor, its Federal Secretary at the time, and Dr Peter Morse, its Federal Treasurer. The College's two Presidents during that period, Dr Brian Shea (1981-83) and Dr Beverley Raphael (1983-85), ably guided these changes through and were strongly supportive of them.

On 1 December 1983 Peter Carter became the College's first Registrar, that is, its first professional executive director. He was chosen from seven shortlisted applicants.²⁶ Carter's previous career had been chiefly in academic administration, and at the time of his appointment he was Assistant Registrar of Monash University.²⁷ He was not a psychiatrist, and the College's decision to appoint someone outside psychiatry — in contrast with its previous wish for a psychiatrist-administrator — came from advice received from professional administrators, especially Jim Potter, the Registrar of the University of Melbourne.²⁸ Carter was, in his own words, 'given a blank canvas' as to administration, and his five years were marked by a continuous upgrading of the College's administrative infrastructure. He regards several changes as the most important in his term of office. The College 'related more vigorously with government'; a new staffing structure was put in place and computerisation of records instituted; tax deductibility was finally achieved for the College, after years of failing to persuade the federal government of its merits, in 1987; research issues received heightened emphasis; and, symbolically, the College moved into a new headquarters, the second Maudsley House, immediately adjacent to the previous one.²⁹

Another important innovation of that period was the Committee of Presidents of Medical Colleges, which was

convened in May 1986 and first met on 4 July 1986.³⁰ The idea of periodic meetings of the presidents of Australasia's medical colleges was new, although meetings had been held in 1981 of the education committees of the clinical colleges.³¹ The venture was wholly an initiative of the RANZCP, having been conceived in a meeting between Dr Peter Eisen and Peter Carter in the latter's garden.³² Carter's explicit model was the Committee of Australian University Vice-Chancellors, a long-existing group. The idea was initially proposed to the Royal Australasian College of Surgeons, whose Secretary at first opposed the idea.³³ While any joint public stance taken collectively by the presidents of the medical colleges carried enormous weight as a lobbying effort, it was the newer and arguably more marginal medical colleges, such as the RANZCP, which clearly gained in prestige by being regarded by the older high status colleges (such as the Surgeons) as fully equal. Arguably, the former would also have gained most from shared information.

At the inaugural meeting of the new body, held at the headquarters of the Royal Australian College of General Practitioners in Sydney, Dr Eisen represented the RANZCP as its President. He was formally thanked by the chairman (D.G. Macleish of the Royal Australasian College of Surgeons) for suggesting the meeting.³⁴ That was the first occasion on which the heads of the eighteen specialist Australasian medical colleges had met as a group. The RANZCP officially provided the secretarial support for the meeting and continued to do so for some years.³⁵

The College's finances were also placed on a much sounder footing at that time, or soon afterwards. A College Foundation, bringing together all the funds available to the College from its assets and numerous bequests, was organised in the mid 1980s on the initiative of Drs Eisen and Morse. As a result, the percentage of the College's income

derived from members' subscriptions declined from 80 per cent to 50 per cent or less.³⁶

In 1982-85, the question of a new College headquarters also became pressing. The first Maudsley House had been let to the College at a peppercorn rent. When John Cain's Labor government came to power in Victoria in 1982, this privileged position increasingly came under threat. The new Victorian government announced that the St Nicholas Hospital site, of which Maudsley House formed a part, was to be put up for sale at the end of 1982.³⁷ In 1982-83, the College Council 'looked all over Sydney and Melbourne' for an alternative headquarters.³⁸ In March 1983 the RANZCP Organisational Review, carried out by the Executive Advisory Committee, moved that an alternative site be purchased in Melbourne.³⁹ By late 1983 an excellent new site was found, remarkably enough next door to the old headquarters, at 95-105 Rathdowne St, Carlton (now 101 Rathdowne St), a historic old Presbyterian manse constructed in 1868-69, which was listed on the Victorian Historic Buildings Register, and while 'slightly neglected' was 'in good condition'.⁴⁰ The Presbyterian Church sold it to the College for \$330 000, about \$120 000 below the expected market value.⁴¹ The building was derelict, but the Federal Secretariat discovered 'the day after the preliminary exchange of money... that we had a number of "tenants" if not prospective patients, in residence', and security patrols of the property had to be arranged.⁴²

A College Headquarters Committee, established at this time, recommended the expenditure of \$60 000 for furnishing the new building, which had to be gutted and virtually rebuilt, owing to its condition.⁴³ Restoration of the building cost \$245 380.⁴⁴ Council explicitly ruled against naming any room of the new building for a pharmaceutical company if it made donations to the new headquarters,

after approaches were made to that effect.⁴⁵ 'Maudsley House' was universally accepted from the start as the name of the new headquarters, and the College Headquarters Committee recommended naming the main meeting room 'The Dawson Room' (as in the old headquarters), and naming the second meeting room 'The Medlicott Room' after New Zealand's pre-eminent psychiatrist Professor Reg Medlicott, who was also the foundation President of the College in 1963-64. The new headquarters after reconstruction was a charming two-storey structure reminiscent of a more gracious era, and was fronted by an outstandingly attractive cottage garden. The College unsuccessfully attempted to purchase part of the former Maudsley House from the Victorian government.⁴⁶ The College's new headquarters was formally opened on 3 May 1985 by Sir Ninian Stephen, Governor-General of Australia.⁴⁷

All those changes helped to professionalise the College, and an observer of its affairs in the early 1970s who travelled forward to 1985 would have found an institution which had changed in many ways and had matured. Nevertheless, significant components of College life remained essentially untouched. In particular, while the College's headquarters and central governing body in Melbourne had professionalised in a variety of ways, its local branch and committee structure remained, for the most part, just as before, run on the voluntary efforts of honorary officers when they could spare the time from busy practices. For many years afterwards, for example, most branch and committee reports submitted semi-annually to General Council were typed on what were evidently home typewriters by committee officers who did not number professional typing among their skills. The very considerable funding required to effectively professionalise the College's centre and headquarters could only rarely be found for the College's branches and committees, and not consistently.

As at all other times in the history of the College, numbers escalated continuously during the period 1978-89, rising from 1041 members in October 1978 to 1622 in mid 1988 and over 1700 at the end of 1989.⁴⁸ The increase in College numbers was especially sharp in the early 1980s, when the number of members rose from 1154 in 1980 to 1443 in 1985.⁴⁹ The number of Fellows (as opposed to ordinary members) rose especially sharply during this period. In the College's early days, the category of Fellow was reserved for a relatively small group of the body's most eminent members. During the early 1980s, however, it became progressively easier for ordinary members to be advanced to the rank of Fellow, and the previous notion of a two-tiered system of College membership gradually lost meaning. In October 1981 approximately 100 new Fellows were created (compared with only twenty the previous year), and during each of the next few years sixty or eighty new College Fellows were created annually. In May 1979, of the College's total membership of 1090, approximately 250 were Fellows. The rise in the number of Fellows was largely brought about by the changes in the examination process introduced in 1978, moving to the introduction of a five-year training program and a Part II dissertation requirement. By May 1982, however, the remarkable situation had arisen that there were more Fellows (677) than ordinary members (527). By 1984, of the College's 1351 members 878 were Fellows, and the original intention of a two-tiered system based upon merit, with the rank of Fellow given only to those of demonstrably higher standing in the psychiatric profession, manifestly no longer applied to the College. In November 1986 the rank of ordinary member was abolished, and all members of the College became fellows as soon as they were admitted to membership.⁵⁰

During this period, for the first time the College actively addressed the question of manpower, that is, of likely future

trends in the growth of the number of practising psychiatrists in Australasia. There is no evidence that the College directly addressed this issue before the mid 1970s. In 1976 Professor L. Opit, Head of the Department of Social and Preventative Medicine at Monash University, carried out the first manpower survey of psychiatrists in Australia.⁵¹ Similar surveys were carried out by Dr P.W. (Peter) Burvill in 1980–84.⁵² From 1979 onwards, manpower questions became a matter of considerable concern for the College, with important statements on manpower issued in 1979 and a Psychiatric Developments and Manpower Committee formed in 1981.⁵³ As recently as 1970 the ratio of practising psychiatrists to the Australasian population was 1:16 830, far below the figure of 1:10 000 (or 10 800) regarded as ideal.⁵⁴

As the number of psychiatrists increased during the 1980s, however, many pertinent questions were asked by the College about the future supply of psychiatrists in Australasia, including a possible *oversupply* in the profession, that is, a number exceeding the ideal ratio.⁵⁵ The College was — and is — severely handicapped regarding manpower questions by the crucial drawback that it has no real control over the total number of psychiatrists in Australasia. Numbers of students entering all medical specialties collectively are set by the medical schools of Australasia (and are augmented by the immigration of physicians qualifying abroad), but the College cannot directly control the number of newly qualifying psychiatrists and has always tacitly accepted that the more psychiatrists, the better. From a crudely materialistic point of view, the College's success at securing increased Medibank payments for private psychiatry meant that the *private* psychiatric 'cake' was constantly rising in this period. In economic terms there was almost infinite elasticity of demand, ensuring that incomes and opportunities for new and well-

established psychiatrists certainly did not diminish. In consequence, no strong lobby or pressure group built up within the College to reduce, or even effectively control, intake, and nothing more than concern was ever expressed about the continuing growth of psychiatric numbers. Most psychiatrists welcomed the increase, seeing Australasia as containing a vast amount of untreated psychiatric disorder and disease.

Yet everyone recognised that the increase in psychiatric numbers had been very uneven. As the 1981 report put it:

A considerable maldistribution exists between psychiatrists in general and in sub-specialty practice with all of the sub-specialties being seriously short of manpower. As approximately 12 per cent of psychiatrists are in rural areas, there is a significant maldistribution between urban and rural practice. Further there is a maldistribution between states.⁵⁶

One of the major areas of maldistribution in resources was — and is — in the public/private divide, especially in terms of income. As recently as November 1981, about 51 per cent of Australasian psychiatrists were employed in the public sector and 49 per cent primarily in the private sector — a far greater percentage than in any other medical discipline.⁵⁷ Yet pay for public sector psychiatrists languished. Dr Eisen estimated that the senior public psychiatrist post in Tasmania earned only \$47 000 with no automatic rights of private practice, compared with a net income of \$57–71 000 for private psychiatrists (up to \$100 000 gross).⁵⁸ Public psychiatrists also worked much longer hours. Furthermore:

While it is claimed that private practice deals with similar populations of patients to those in the public sector, this is patently absurd. The public sector has a

far higher proportion of patients with chronic psychiatric illness, gross personality and neurotic disorders, disadvantaged and socially inert persons and people from the lower social classes. Further, public systems deal with the bulk of people with alcohol and drug dependency who see psychiatrists or mental health professionals, the intellectually handicapped and forensic 'cases.' Also in most states ... the majority of children and adolescents with psychiatric disorders are seen within the public sector.⁵⁹

There was and is no obvious remedy for this undoubted imbalance.

Other sections of Australasian psychiatry also undertook detailed manpower assessments. In September 1982 the Child Psychiatry section presented an extremely comprehensive study of its future needs, which concluded that there was 'a severe and critical shortage of child psychiatrists in Australia' which meant that 'at the present rate of training it could take 15 to 20 years to meet Australia's current needs', and that the problem was proportionately larger in the smaller states.⁶⁰

In December 1987 P.W. Burvill, chairman of the RANZCP's Manpower Committee, carried out an important Manpower Survey of Psychiatrists in Australia and New Zealand, which provided far-reaching and valuable information on many aspects of Australasian psychiatry. For instance, it surveyed the foreign languages spoken by College psychiatrists, and remarked on the surprisingly small number of psychiatrists who spoke Greek or Italian.⁶¹ This report estimated a shortfall in the number of psychiatrists in 1987 at approximately 300 in Australia (including 112 in New South Wales) and 182 in New Zealand (compared with the actual number of psychiatrists there in 1986 of 119).⁶² It estimated

that there would be 1502 psychiatrists in Australia in 1992 and 1791 in 1997, and 189 and 252 in New Zealand at those dates.⁶³ It envisaged that by 1997 the ratio of psychiatrists to population would reach 1:10 140 in Australia and 1:13 820 in New Zealand.⁶⁴

That survey was also one of the first to examine the question of non-College psychiatrists, generally those who trained abroad and never qualified for membership in the RANZCP. Burvill estimated that in 1987 there were 245 non-College psychiatrists in Australia, compared with 1181 members of the College, suggesting that about 83 per cent of practising psychiatrists in Australia in 1987 belonged to the College.⁶⁵ The percentage of non-College psychiatrists, however, varied enormously from state to state, ranging from 29 per cent in Tasmania (ten of thirty-four), 26 per cent in New South Wales (141 of 540) to none at all in South Australia, 'apparently a by-product of its Medical Specialists Registration laws'.⁶⁶ Burvill credited the sharp rise in the number of psychiatrists to private practice, noting that in Britain and New Zealand, where most psychiatrists were employed in the public sector, the ratio of psychiatrists to population was far lower than in the USA or Australia, where there was a vigorous private practice component.⁶⁷ He concluded that the maldistribution of psychiatric numbers highlighted by Dr Eisen was unlikely to change, although overall numbers were likely to grow still further, perhaps reaching as high a ratio as 1:7000.⁶⁸ In New Zealand, while 'the psychiatric manpower situation ... seems grim', hope was provided by the youthful age profile of its psychiatrists and the high number of trainees.⁶⁹

Just as the total number of psychiatrists grew strongly in this period, so the work of the College carried out by its committees grew, but perhaps with fewer dramatic changes than in the previous period. In May 1988 the Child

Psychiatry section evolved into the Faculty of Child Psychiatry, with even greater semi-autonomous powers. Three new sections were formed: Alcohol and Other Drugs in 1987, whose chairman was Dr Les Drew; Psychiatry of Old Age in 1988, headed by Dr Edmund Chiu; and Psychotherapy, formed at the end of 1989. By 1989 the College included about twenty-two committees, as well as its state branches and the Fellowships Board. Several of these committees represented important new ventures. The College became active in the area of the psychiatric traumas produced by natural disasters (such as the Darwin cyclone of 1974), a field long headed by and associated with Professor Beverley Raphael (President of the College in 1983–85). A Crisis and Disasters Committee was formed some years later. Possibly the most important of the new ventures was the Ethics Committee, which was formed in August 1978 and received its terms of reference in May 1979. From its foundation, and for the next fifteen years, its convenor was Dr Russell Pargiter (President of the College in 1973–74), who was thus strongly associated with the committee for many years.⁷⁰ The purpose of the new committee was to advise on ethical matters and to hear complaints brought by members.⁷¹

Until the Chelmsford scandal of the late 1980s, however, the committee had some deficiencies: its members never met — they communicated by correspondence — and the range of subjects it dealt with appears rather miscellaneous. In the six months from May–October 1983, for instance, it dealt with the following matters: the appropriate disposal of a deceased member's clinical records; confidentiality in cases of child abuse; a request from the Gay Rights Lobby in New South Wales that homosexuality be deleted from a glossary of mental disorders; a view on the Australian Law Reform Commission's Research Paper on Opinion Evidence; and the preparation of a paper on medical ethics for College

members.⁷² While each of these was certainly a worthy topic in its own right, they are very variegated. The Ethics Committee seldom or never dealt with matters of alleged individual misconduct by College members. Nor, remarkably, did it ever discuss deep sleep therapy or questions related to Chelmsford. As time went on, however, the Ethics Committee did examine several very vexed and weighty issues, such as in vitro fertilisation and the relationship of the pharmaceutical industry to psychiatric practice, both examined in 1987. Furthermore, it seems true that the existence of the Ethics Committee heightened the awareness of ethical issues in the College, which 'increased in geometric progression', as Dr Pargiter put it.⁷³

Another important committee or subcommittee formed during this period was the Subcommittee on Politics and Psychiatry, established about 1982. In October 1982 Council endorsed a motion proposed by that subcommittee, echoing one previously carried by the Royal College of Psychiatrists in Britain, condemning the abuse of psychiatric practice for political purposes in the Soviet Union and calling upon the World Psychiatric Association to expel the All-Union Society of Neurologists and Psychiatrists of the USSR.⁷⁴ The subcommittee (convened by Dr George Mendelson) was extremely active in highlighting and condemning the political abuse of psychiatry in the Soviet Union, a matter of international concern until the dissolution of the Union in the late 1980s. Much of the international momentum for the condemnation of Russia's 'political hospitals' was due to the South African-born Australian psychiatrist Dr Sidney Bloch, resident in England in 1977-89 (when he returned to Australia), who was instrumental in drawing world-wide attention to these abuses. In early 1979, the College subcommittee also condemned the abuse of psychiatry for political purposes by the Marcos regime in the Philippines.⁷⁵

While condemnation of the abuse of psychiatric practice in the Soviet Union would of course attract universal support, the College's attitude towards this issue was perhaps indicative of a more conservative stance on political and social issues in this period than in the previous one. Strikingly, the Social Issues Committee apparently went out of existence by 1974; in 1987 Dr A.C. McFarlane of Flinders University in Adelaide wrote a long letter to Peter Carter proposing the establishment of a Social Issues Committee, evidently unaware that such a committee had existed in the past.⁷⁶ In 1985-86 the College was lobbied by a number of psychiatrists to seek affiliation with the International Physicians for the Prevention of Nuclear War, a group which most conservatives would certainly have perceived as left-wing in the context of the Cold War. The College rejected affiliation 'on the grounds that that body has no provision for affiliation in its constitution'.⁷⁷ The Secretariat Committee of the College recommended, at the same time, that the Chairman of the Crisis and Disasters Committee of the College be designated 'an advisor on statements ... related to nuclear war', effectively removing such statements from the hands of activists.⁷⁸

In June 1989 a strongly pro-choice draft position statement on abortion, drawn up by the Dunedin psychiatrist Dr Sarah E. Romans-Clarkson, was referred back to branches for further consideration, with 'several councillors question[ing] whether it was possible or desirable for the College to have a position statement on what they saw as a moral issue', in contradiction to the College's long tradition of taking just such stances.⁷⁹ At the same meeting Council declined to endorse an immediate change of policy to make injected drugs legally available in the context of the AIDS epidemic.⁸⁰ Certainly, the College did take official stands on a variety of controversial issues, from single-parent families (1978) to the ownership of

firearms (1989) and Aboriginal deaths in custody (1989), but these tended to reflect enlightened mainstream opinion rather than the more provocative attitudes which the College adopted in the 1970s. Notably, too, members were no longer polled regarding their attitudes, as they had been by the Social Issues Committee in the previous decade; the College's stance on such issues (when it took a stance) was now more likely to be decided by General Council acting after consultation with the branches, but without a general plebiscite.

In the latter part of the period 1978-89, the College formed several new committees or groups which clearly resulted from its enhanced position. In early 1984 a Board of Research, under the chairmanship of Dr Graham Burrows, was formed. While the College had long had a Research Committee, this new board elevated the role of research and amalgamated several bodies dealing with the subject. In June 1989 the College established a Clinical Standards Committee as a revised form of the old Medical Practice Standards Committee, and flagged the possibility of a Board of Practice Standards.⁸¹ Dr John Ellard was the new committee's chairman; by its terms of reference it was to 'act on referrals from the Executive Officers or from General Council ... on matters of clinical standards of practice in psychiatry'.⁸² It was at least partly a response to the Chelmsford affair. In 1988-89 an Interim Committee for Continuing Medical Education was established.⁸³ The question of continuing medical education had long been discussed by the College; the Interim Committee recommended the voluntary adoption of guidelines on continuing education.⁸⁴ (In the early 1980s a Board of Continuing Education, headed by Professor Alan German of Western Australia, had been formed.)

During that period the College also adopted a much higher profile in relation to all aspects of psychiatry in

South-East Asia, closely paralleling the enhanced role of Australia and New Zealand in their immediate region. While other international contacts by the College certainly did not diminish, it seems clear that the old attachments of many College members to Britain and, to a certain extent, to the USA, gave way to a much greater emphasis on the Asia-Pacific region.

The College's examination system evolved in many ways during this period, but without such dramatic changes as those introduced by Professor Maddison. Nevertheless, there were some important innovations. In October 1976 General Council approved a change for candidates who started training after 1 January 1978, lengthening the period of training from three to five years, in parallel to similar changes introduced at this time by other Australasian medical colleges.⁸⁵ As well, a Section II examination was introduced in which candidates were required 'to present five additional case histories or a dissertation', while the Section I case history requirement was reduced from ten to five case histories.⁸⁶ In the late 1970s, a brief experiment with multiple choice questions proved unsuccessful, and candidates returned to two written papers.⁸⁷ Much effort in this period by the Committee of Examinations went into establishing a viable exemption policy for persons with previous postgraduate qualifications in psychiatry. Possibly the most far-reaching development occurred in May 1981, when Council resolved that there would be only one specialist vocational qualification in psychiatry recognised in Australia and New Zealand.⁸⁸ In the long term, this brought about the demise of separate university DPMs and established the College's monopoly of the examination process, a *sine qua non* for the College achieving the true and legitimate status of a specialist medical college, although the final completion of this process took many years.⁸⁹ In October 1984 the College approved the

amalgamation of the Board of Censors and the Board of Accreditation (dealing with training matters) into a Fellowships Board, responsible for both the training and examination of candidates, with effect from October 1985.⁹⁰ During this period the College had three Censors-in-Chief: Dr Bill McLeod (October 1978–October 1984), Professor Ross Kalucy (October 1984–April 1988), and Professor Bruce Singh (May 1988–May 1995).⁹¹ The Committee for Examinations expanded from eight members in May 1977 to seventeen from October 1987, reflecting the great increase in the number of candidates examined.⁹²

In some respects, to social historians, perhaps the most fundamental changes in the outlook of the College have been the alteration in the status of women and in the sensitivity of the College, and the psychiatric profession, to women's issues. Needless to say, psychiatry was always fundamentally aware of gender and sex-based differences in individual psyches and in mental illness, and many early scientific papers presented by the Association and the College analysed and discussed aspects of this most basic determining human characteristic. But for many years two things were missing from the College's response to gender issues: any appreciation that women as a very large social group (the largest of all, in fact) had particular experiences in common and were, in most spheres of life, grouped together in ways which explicitly or implicitly marked them as inferior to men, a habitual gender stereotyping which produced enormous mental health problems; and that women psychiatrists constituted a specific and growing group within the College which often had common problems and faced common obstacles. The College — reflective of nearly all professional bodies in Australasian (and western) society — showed virtually no recognition of either fact until the mid 1970s or even later.

The College's implicit assumptions about the role of women if anything lagged behind other highly educated sectors of Australasian society in many respects. Consider the following from the Report to the General Council by the committee planning the July 1974 Annual College Congress at Hobart, Tasmania, concerning what could be expected at the conference. While the (over 90 per cent male) College members would be hearing learned papers on the latest scientific research in psychiatry, the conference organisers highlighted the fact that there was also a Ladies Committee, which had:

Responsibility for the entertainment and comfort of the delegates' wives; local tours, local personality or even a stockbroker to talk, lunches, fashion parades, a palm reading afternoon ... hair and makeup demonstrations, cooking demonstrations, private entertainment, etc. Local hairdressers might also be asked to keep a few appointments available for wives of delegates ...

... The Congress should have appeal to ladies as well. The [TAA] 'Travaire' girls will also give 'packing' your case demonstrations to the [Ladies] Committee and advice on clothes, and will also compère parades free-of-charge.⁹³

To be fair, there was another side to the coin.⁹⁴ No precise figures about the number or percentage of women members of the College exist in a continuous or detailed way, but it was probably the case that compared with other medical specialist bodies in Australasia and perhaps with most other professional groups, women were almost always over-represented. Dr Isobel Williams — certainly one of Tasmania's leading psychiatrists in the early days of the Association/College — was a member of the organisation's Council from the beginning, and in 1967-68 served as the

College's first female President. (In contrast, the Royal Australasian College of Surgeons elected its first female Councillor only in 1994.)⁹⁵ While no exact figures on the number of women members of the College exist, by the 1973 Annual Conference fifteen of 158 delegates were women.⁹⁶ This percentage of women delegates — 9.5 per cent — was almost certainly greater than for other medical specialist conferences in Australasia at this time. Since the early 1970s the percentage of women fellows of the College has grown very significantly, and now probably amounts to one-third or more of younger fellows. Between 1983 and 1991 the College elected three women Presidents — Professor Beverley Raphael, Dr Joan Lawrence and Dr Karen Zelas — almost certainly a greater number than any other medical specialist body. This period also saw the development of feminist psychiatrist groups and activists, and of a much greater sensitivity to gender issues by the College, although the College's leadership is certainly still overwhelmingly male.⁹⁷

For the College and perhaps for Australasian psychiatry, the years 1978–89 may well be remembered not for these things, but for the two scandals which affected the profession and which became the focus of reporting and popular commentary throughout Australia and beyond: the Chelmsford deep sleep therapy case and the affair of Ward 10B in Townsville, Queensland. Vast amounts of press reportage and two books have appeared about these cases, which, most unfortunately, are among the few events in the recent history of psychiatry likely to be known to the average person in the street in Australia, if not perhaps in New Zealand.⁹⁸

Both cases are very complicated, and will be described in greater detail later in this book. A brief overview here notes the following facts. The deep sleep case concerns the activities of Dr Harry R.

Bailey (1922–85), long-time Fellow of the College, and Chelmsford Private Hospital in Pennant Hills, Sydney. Between November 1965 (when accurate records began) and March 1979, when deep sleep therapy ceased at Chelmsford, Bailey and his colleagues treated 1127 patients there with continuous narcosis (deep sleep therapy) techniques, that is, artificial sleep induced by the administration of drugs.⁹⁹ Twenty-four persons died from the complications of deep sleep therapy while another twenty-four patients later committed suicide.¹⁰⁰ In 1985 Dr Bailey, faced with ruin and possible imprisonment over the consequences of deep sleep therapy at Chelmsford, committed suicide. From 1988 to 1991 a royal commission, instituted by the New South Wales government and headed by Mr Acting Justice Jack Slattery, investigated the Chelmsford affair and produced a fourteen-volume report after receiving evidence from 297 witnesses.¹⁰¹ The Slattery Commission described Bailey as ‘two-faced, devious, dissembling and unprincipled’ and criticised the role of a number of Bailey’s professional colleagues, including Dr John Herron, a Fellow of the RANZCP, whom Slattery found ‘came under the spell of his mentor Dr Bailey’ and ‘was manipulative both as a witness and as a person’ at the royal commission.¹⁰² Many lawsuits and a host of legal complexities arose from the Chelmsford case.

From the viewpoint of the overall history of the College, the only questions which might be appropriately discussed here are these: what role did the College play in the Chelmsford affair, and in what respects did the College change as a result of it? It is not appropriate to treat here either the details of the College’s role in Chelmsford or the fairly basic questions of whether the College did all it could, and if not why not. An examination of these questions appears in a later chapter.

The issue of Chelmsford was never officially discussed by the national leadership of the College before 1980. According to a media statement issued by Dr Joan Lawrence (President 1987–89) in August 1988, ‘the matter [of Chelmsford] first came to the attention of the General Council’ in October 1980 ‘with the lodgement of two complaints by, respectively, the Citizens Committee on Human Rights (CCHR) and Dr John Sydney Smith (Director, Neuro-Psychiatric Institute, University of NSW)’.¹⁰³ In the same month the College’s General Council issued a Clinical Memorandum to provide guidance to members in relation to deep sleep therapy. The memorandum stated that ‘based on published clinical reports, Deep Sedation Therapy is undoubtedly a hazardous technique’, that no controlled studies confirming the effectiveness of this technique had been conducted, and that therefore ‘there would seem at present no justification for the use of this form of treatment’.¹⁰⁴

For the next four years, the College was unable to make any public statements on Chelmsford or on the activities of Dr Bailey or his associates because the whole question was *sub judice*. This fact — that the whole question was *sub judice* for much of the 1980s — was the central element in determining the College’s public attitude and stance on the affair, effectively tying its hands and precluding any public statements which its General Council might wish to make. As noted, Bailey suicided in September 1985.

In April–May 1986 the College Executive Officers sought to convene a special meeting of General Council in order to expel Dr John Herron from membership in the College ‘because his conduct has, in the opinion of General Council, been detrimental to the honour and interest of the College and the profession of psychiatry’.¹⁰⁵ Dr Herron sought an injunction in the Equity Division of the New South Wales Supreme Court to restrain the Council from considering the

expulsion motion.¹⁰⁶ Based on legal arguments rather than the merits of the College motion, an injunction was granted and the College motion could not proceed. In 1986 the New South Wales Court of Appeal stopped the New South Wales Medical Tribunal from hearing complaints against Dr Herron and two others relating to the deaths of certain patients at Chelmsford.¹⁰⁷ Between 1988 and 1991 the whole matter again became *sub judice* pending the issuing of the report of the Slattery Royal Commission. In November 1991 the New South Wales Court of Appeal, by a 2-1 majority, granted Dr Herron and two others a permanent stay of the complaints made against them on the grounds that those complaints were an abuse of due process, being prejudiced by the loss of information and evidence since deep sleep was last used at Chelmsford in 1978.¹⁰⁸ In April 1992 the New South Wales Health Department went to the High Court in an effort to have complaints against Dr Herron and two others investigated.¹⁰⁹

Any action which the College might have wished to pursue was stymied by the fact of near-continuous legal injunction and investigation, as well as by the real possibility of a successful defamation suit against the College if it took any premature action. The College's hands were tied by the framework of law and legal procedures which it had scrupulously to obey. As Dr Karen Zelas put it in her President's Letter in *News and Notes* (February 1991), suggestions made in the Slattery Royal Commission report that the College 'may have been bolder in its actions at an earlier stage' overlook the fact that 'this would have gone against legal advice received and might have risked defamation action'. The Slattery Royal Commission did, however, 'propose that the College be an independent statutory body' with greater complaints powers. These suggestions have been acted upon since the release of the Report.¹¹⁰

The matter of Ward 10B in Townsville, Queensland, came to the attention of the College much later than Chelmsford, and after the lessons of deep sleep were evident to the College. In May 1990 the Queensland government established a Commission of Inquiry into the care and treatment of patients in the psychiatric unit of Townsville General Hospital between 1975 and 1988. The commission was chaired by Mr Justice William Joseph Carter, who presented his report in February 1991.¹¹¹ The report was highly and specifically critical of Dr John S.B. Lindsay, a well-known senior Queensland psychiatrist who had been a member of the Association and the College for several decades, and, to a lesser extent, of Dr Bevan Cant, Psychiatry Registrar in the unit from January 1978 to July 1987. According to the Summary of Findings of the Carter Report:

In the period March 1975 to February 1987, during which time Dr Lindsay exercised effective control of Ward 10B either as Director of the Unit or whilst engaged by the Townsville Hospitals Board as a consultant and in the period February 1987 to May 1987, during which time Dr Cant was in charge of the ward, the care and treatment of patients was, in many respects, negligent, unsafe, unethical and unlawful.

Dr Lindsay was a committed adherent to [*sic*] social therapy in psychiatry as the preferable treatment option for all forms of mental illness and under his direction and influence Ward 10B was developed as a therapeutic community ...¹¹²

According to this Summary of Findings, Dr Lindsay in his role as director 'was firmly authoritarian, intransigent in his ideas, rude and abrasive in his dealing with many patients, their relatives and some staff and uncooperative and

demanding in his dealings with officialdom within the hospital ...'.¹¹³

The Summary found that two patients 'died because the treatment of them in Ward 10B was negligent and unsafe', and that six other patients 'all of whom committed suicide, were cared for and treated in Ward 10B in a manner which was negligent and unsafe'.¹¹⁴ It also pointed out that 'In the course of the assessment process relatives [of patients] were sometimes identified as being in need of "treatment" themselves and encouraged to accept admission together with the "identified" patient'.¹¹⁵ The Summary concluded, however, that there was insufficient evidence to prosecute anyone in respect of the death of any person or 'in respect of assaults referred to in Chapter 19 of the Report'.¹¹⁶

Even before the Carter Commission commenced, however, the College was determined not to repeat the delays and obfuscations experienced in dealing with Chelmsford. Dr Lindsay was expelled at a special meeting of the Council on 11 May 1990.¹¹⁷ (Dr Lindsay personally presented his case to this meeting.¹¹⁸) It did this even before the Carter Commission officially began its hearings, and it also took great care to assist the commission in any way it could.¹¹⁹ In 1992 Dr Lindsay published a spirited defence of his role in the Townsville affair, *Ward 10B: The Deadly Witch-hunt*, which blamed the failures highlighted by the Carter Commission on inadequate staffing in a remote and isolated psychiatric ward, and severely criticised a number of office-bearers of the College, Queensland state politicians, and the media for their role in the affair. From 1987 onwards a new administration at Townsville General Hospital ended all the abuses highlighted by the Carter Commission.¹²⁰

There seems little doubt that these two incidents, particularly Chelmsford, had a profound long-term influence on the College, on psychiatric practice in Australasia, and

arguably on medical practice here in a much wider sense. The extensive and continuing adverse media publicity generated showed Australasian psychiatrists the fact that psychiatry is widely misunderstood and even feared by sections of the population, and that there is no lack of voluble interest groups ready to attack it for any failings, real or imagined. The 'sensational nature of media reporting' of Ward 10B, Dr Joan Lawrence noted to the General Council meeting of 27 October 1990, 'was having a very serious effect on the image of psychiatry' — a sentiment with which there was universal agreement by the College's leading members.¹²¹ It is also arguable that the role of the College in exposing and stopping the improper and dangerous practices found in both cases was extremely deficient. At the time the College did not have proper or effective means of monitoring inadequate practice standards or adequate mechanisms for dealing with members engaging in such practices. There is no doubt that the College has genuinely and sincerely attempted to raise its performance in these areas since the late 1980s, chiefly as a result of Chelmsford and Townsville, but also consistent with its growing role as a medical specialist college in the true sense.

4 The RANZCP in the Recent Past, 1990-Today

It is obviously more difficult for any historian to write about very recent events than the distant past, and this fact is no less true in examining the history of the RANZCP than any other institution. The most important underlying trends or events are not yet evident; the leading personalities are still very much alive and active; every month, indeed virtually every day, brings a fresh challenge to the College and to the psychiatric profession in Australasia. There is also the sheer size of the College and its multiplicity of functions, whose growth has increased at an even greater pace than before. In describing the past half decade or so of the College's history, the historian can only paint with the broadest of brush strokes and hope that, a generation or two from now, when historians of another age reconsider this period, the history depicted will prove to be generally accurate.

In early 1988 Peter Carter relinquished the position of College Registrar after nearly five years in the job and was succeeded by Dr Robert Broadbent, who took up his duties on 6 June 1988.¹ By professional training Dr Broadbent was a research chemist with a strong interest in science education. From 1981 to 1988 he was Executive Director of the Australian College of Education in Melbourne, a national professional body of educators with a membership of 6000 and a range of interests somewhat similar to the RANZCP.² At the same time as Dr Broadbent was appointed, the College chose Barbara Keyser as its Information Officer and Sheena Mathieson as Administrative Officer (Training), to complete the centralisation of the administration of the fellowship training program. Mrs Keyser had previously been

Station Manager of Melbourne's ethnic radio station 3EA. Her position was designed to enhance the College's profile and the public's understanding of psychiatry, in the wake of Chelmsford and Townsville.³ Dr Broadbent was reappointed to his position in October 1993 for a further eight years and his post was retitled Executive Director and Registrar.⁴

It is probably easy to categorise the major issues dealt with by the College since the end of the 1980s — a group of separate but related initiatives to make psychiatry in Australasia more accountable and responsible, and to ensure that the College had a central role in this process. Several developments in particular had the aim of accountability and responsibility in directions not previously wholly pursued by the College. These included the formation of a Clinical Standards Committee and a Quality Assurance Committee, both formed in 1989, a Board of Practice Standards (begun in 1990), the amendment of the College's constitution in 1991 to give the College new and broad disciplinary powers, leading to the establishment of a Professional Conduct Committee in 1992, the promulgation of a College Code of Ethics by the College's Ethics Committee, also in 1992, and the issue of recertification, which had been occasionally discussed before but which became a major and serious issue in 1992–93. Other proposals also reflected the College's now central concern for responsible behaviour and accountability on the part of its members.

The proposal for a Clinical Standards Committee was discussed by General Council in June 1989, and its formation on a *pro tem* basis, as a committee of the College's Fellowships Board was approved at the same meeting.⁵ Chaired by Dr John Ellard, its aim was 'to provide advice in confidence to the Executive Officers' on 'matters of clinical standards of practice in psychiatry'.⁶ Dr Ellard had no doubt about why the need for such a Committee arose:

I have been involved in a number of matters in which psychiatrists have come to the notice of an assortment of statutory bodies. It is no secret that in most cases their activities are censurable, and as the findings emerge it is probable that there will be a firm and urgent necessity for psychiatry to regulate itself if it is to escape being regulated by others. For example, the Melbourne Coroner has asked me to prepare a document on psychiatry and self-regulation to be presented at a hearing that is to take place in April.⁷

Dr Ellard wished that the role of the existing Medical Practice Standards Committee be strengthened and clarified to make it proactive rather than reactive and that 'the Committee emerge from behind the arras, as it were, and become a public and substantial part of the College's structure, to make it clear that the College means business'.⁸

In May 1990, after much discussion, the College approved a Board of Practice Standards and renamed the Clinical Standards Committee the Clinical Practice Advisory Committee.⁹ The new Board of Practice Standards had four constituent committees: the Continuing Medical Education Committee, the Quality Assurance Committee, the Ethics Committee, and the Clinical Practice Advisory Committee.¹⁰ It was specifically divorced from the Fellowships Board in order 'to differentiate pre- and post-Fellowship areas as responsibilities of separate Boards', as Professor Singh put it.¹¹ The new Board of Practice Standards was to have very wide functions, especially to 'develop and recommend policy and provide advice in the related areas of continuing medical education and standards of practice and ethics of Fellows of the College and for psychiatry generally' and to 'provide a forum within the College for ... the development and implementation of policies and programs' in these

areas.¹² Dr Ellard became chairman of this important new board, and as such became *ex officio* a member of both the College's General Council and its Executive Committee, its innermost circle of governance.

To obtain new and broad disciplinary powers over members found guilty of improper practice, the College amended its constitution at a special general meeting in November 1991. A Professional Conduct Committee was established, with Dr Joan Lawrence, President of the College in 1987-89, as its inaugural chairman.¹³

Before the adoption of these revised procedures, the College had expelled a member for misbehaviour only once before, in May 1990, when it had acted against Dr Lindsay.¹⁴ Disciplinary action could, however, always be taken against a member convicted of unprofessional conduct by a state (or New Zealand) medical board or medical council. Between 1985 and 1990 Council instituted expulsion procedures against two Fellows (in 1985-86 and 1989-90). Executive Officers acted as an investigative body and the General Council as adjudicators on those occasions.¹⁵ No formal mechanism existed for a branch to hear complaints brought against members, although there were guidelines for the handling of such complaints by branches.¹⁶ The new procedures established a range of disciplinary sanctions: informal warning or counselling, censure (reprimand), suspension, expulsion, and 'any other sanction Council may determine'. Complaints against College members could be dismissed and the member exonerated.¹⁷ Formally constituted bodies at branch and central levels were set up: the Branch Professional Conduct Committees and a central Professional Conduct Committee, the latter a standing committee of General Council outside the structure of the Board of Practice Standards.

By mid 1991, General Council certainly paid far more attention to reports of complaints about allegedly improper

behaviour by its fellows than ever before. At the 18 May 1991 General Council meeting which considered the establishment of a Professional Conduct Committee, ten such matters, covering a very wide range of allegedly improper behaviour, were considered in confidential session.¹⁸ All such alleged instances of impropriety were treated with great seriousness. At the October 1993 General Council meeting, for example, Council received reports on eleven such cases, and made a point of being as informed as possible of any investigation by a responsible body of a fellow for misconduct or any related matter.¹⁹

The formation of a Quality Assurance Committee was discussed in the late 1980s at the same time as the formation of a Board of Practice Standards. In October 1989 Council approved the establishment of a Quality Assurance Committee.²⁰ In the report on this matter which was moved by Professor Singh, 'the importance of distinguishing between normative standards of practice and minimal standards, below which the practice would be regarded as unacceptable or negligent' was emphasised.²¹ This committee, which was formally constituted in 1989-90, was 'to develop and promulgate "standards" of psychiatric clinical practice', 'to consider development of Clinical Indicators for Psychiatry' and 'to develop and make available to College Fellows a QA assessment package which could be used in self-assessment by individual psychiatrists'.²² The committee was constituted as a committee of the Board of Practice Standards.²³ Professor Gordon Parker became its first chairman.²⁴ Over the next few years it instituted a number of projects and initiatives, including Guidelines for General Psychiatric Outpatient Practice and for Methadone Prescribing and Treatment of Alcohol Dependent Persons (in 1993) and Guidelines for Psychotropic Drugs in Psychiatric Practice (in 1994).²⁵ In

early 1994 a Project Officer was appointed to initiate a maintenance of practice standards process, looking at such factors as practice visits, peer review, patient satisfaction and general practitioner satisfaction, and innovative quality assurance.²⁶ In 1992-93 Clinical Indicators were tested in eight Australian hospitals, and a final list of Clinical Indicators was to be put before Council in 1995. The committee also planned the introduction of Psychiatric Clinical Indicators within the Australian Council on Healthcare Standards Accreditation Guidelines in 1996.²⁷ Interviewed in 1993, Professor Parker stated his belief that Quality Assurance Guidelines had already changed practice habits, especially in the private sphere.²⁸

In 1991 the College Ethics Committee, headed by Dr Russell Pargiter, drafted a Code of Ethics (the first in the College's history) which was approved, with some amendments, at the May 1992 Council meeting.²⁹ The Code of Ethics presented a list of nine principles of ethical behaviour incumbent upon all who engaged in psychiatric practice. The list of ethical principles began with the proposition that 'Psychiatrists shall have respect for the essential humanity and dignity of each of their patients', that 'Psychiatrists shall provide the best possible psychiatric care for their patients', and that 'Psychiatrists shall hold information about the patient in confidence', and concluded with 'Psychiatrists in their societal role shall strive to improve the quality of psychiatric services, promote the just allocation of these services and contribute to the education of society regarding mental health.'³⁰ A lengthy list of annotations to the principles followed, some of which were perhaps more controversial than the broader list of principles, such as the statement that 'Given the potential irreversibility of suicidal behaviour intervention may be justified to allow the patient both time and opportunity to reconsider their decision. However, psychiatrists shall give

consideration to the patient's autonomy in making an intervention.' The annotations grappled with the very difficult question of the disclosure of information about patients by stating:

Whilst upholding the principle of confidentiality, psychiatrists must do so within the constraints of the law and with regard to statutory requirements ... Disclosure is however mandatory under legal compulsion and psychiatrists as well as their clinical records are compellable witnesses, and in the statutory context subject to legislative requirements, e.g. reporting of child abuse or unfitness to drive a motor vehicle.³¹

The Code of Ethics also mandated, unequivocally, that 'Sexual relations between psychiatrists and their patients are always unethical', and that 'Psychiatrists shall not participate in executions.'³² The Code of Ethics was general and broad in nature and did not proscribe or condemn modes of treatment specified by name (such as deep sleep therapy), nor approaches to psychotherapy (such as the type of group therapy practised at Townsville's Ward 10B in the 1980s).

Closely allied with the spirit of these measures to raise practice standards and eliminate unethical behaviour were a number of other ventures whose aim was to ensure that Australasian psychiatrists remained familiar with developments in their profession throughout their working lives. Those developments centred on the process of continuing education and, more controversially, of recertification after a period of years.

In the late 1980s a Committee for Continuing Medical Education was formed, succeeding the Board of Continuing Education, which had been disbanded several years earlier. It reported at length in October 1990 on the types of

programs it was interested in pursuing.³³ The committee compiled an Annual Continuing Medical Education Record to be completed by all fellows, and concentrated initially on the problems of geographically isolated fellows, a matter which has been paid a good deal of attention by the College in recent years.³⁴ By 1994, the committee was closely involved in the issue of recertification or maintenance of practice standards, as well as in establishing a needs priority in defining the future shape of continuing education, and in the possible formation of an educational foundation for the College.³⁵

The most controversial and potentially far-reaching such venture which emerged during the 1990s was the issue of recertification. The College decided officially to consider the question of recertification in 1992.³⁶ In October 1993 General Council endorsed the development of a recertification scheme by the College 'as a means by which psychiatrists may be encouraged to continually improve their professional knowledge and performance'.³⁷ Under the principles of the recertification scheme devised and trialled by the College Board of Practice Standards, recertification for five years would be offered on a voluntary basis to all fellows of the College (with consideration given to extending the scheme to non-College psychiatrists).³⁸ The scheme would be initially aimed at fellows in clinical practice, with recertification awarded on the basis of points given for participation in continuing medical education and quality assurance activities.³⁹

During this period the College also issued a large number of statements and other short summaries of the official College position on a wide variety of contentious issues. The production of College statements and related position papers had begun in the 1970s, but these increased in number and variety in the 1990s. At its October 1994

General Council meeting, for instance, the College either endorsed or received and renewed the release of policy statements on mental health services, orthomolecular psychiatry, violent offending, asylum-seekers on hunger strikes, and the role of psychiatrists in disasters.⁴⁰ The College also produced a number of brief statements, intended for lay persons, explaining the nature of psychiatry and of mental illness.

These developments represented a maturation of the College and a real attempt to fulfil its role, now realistically established, as the representative body of the psychiatric profession in Australasia. In view of these radical innovations, the actual formal structure of the College has also changed somewhat since 1989, while retaining many of its traditional structures. In the mid 1990s the College was governed by a General Council, with the College Executive Committee (CEC) having an advisory executive role, just as it had been for many years. The CEC consisted of the President, President-elect, Immediate Past President, Honorary Secretary and Honorary Treasurer, the Chairmen of the Fellowship Board and Board of Practice Standards, and a New Zealand branch representative, with the Executive Director/Registrar always present but officially 'in attendance'.⁴¹ It met quarterly for one day, and dealt with very important matters for advice to the Executive Officers or transmission to the General Council, financial affairs, and issues on which the College had to decide its fundamental policy stance and direction. A broader agenda of issues was debated and discussed by the College's General Council, which met twice yearly, normally in May and October. In the mid 1990s membership of the General Council consisted of the College's officers, plus seventeen other persons representing the branches, elected for two-year terms, and a representative of the Faculty of Child and Adolescent Psychiatry. The College's Federal Councillor for Psychiatry on

the AMA was present by invitation as an observer, while the Executive Director/Registrar and Information Officer were also in attendance. Thus, a total of twenty-eight persons attended the College's General Council meetings in the mid 1990s.⁴²

As the business of the College has increased, the work of the General Council has escalated accordingly, and continues to do so every year. The agenda and supporting documents of the October 1994 General Council meeting, for instance, comprised over 400 pages, including seventy-one attachments in the form of reports of branches, committees, sections and other matters brought officially to the attention of General Council. Before the mid 1980s, Council meetings were attended by a number of non-voting observers such as the chairman of the College Committee and the Editor of the *Journal*. These observers often, according to Council members present, dominated the actual discussion.⁴³ From the mid 1980s, the restriction of attendance to Council members only, and the appointment of a College Registrar, greatly shortened the actual time of Council meetings, despite the increase in the size of Council agendas.⁴⁴

Plainly, neither the General Council nor the Executive Officers can properly function on a short-term basis as the executive arm of the College. The latter's actual executive business is largely transacted by weekly teleconferences held by the President, Executive Director/Registrar and Honorary Secretary.⁴⁵ This points to the enhanced role of the President of the College during the past twenty years. He or she is now an executive president, actively and centrally involved in the College's fundamental decision-making, and never a figurehead, even if resident in a remote place. 'There was no "power behind the throne"', New Zealand's Dr Karen Zelas (President 1989-91) recalled of her term of office. Despite her residence in New Zealand, she engaged

in weekly teleconferences with Melbourne and was directly responsible for College policy. The trend to an executive presidency apparently began in the mid 1980s, during the term of Dr Peter Eisen.⁴⁶ The need for an executive presidency has been made more difficult by the fact that all Presidents pursue, simultaneously, full-time professional careers and are extremely busy. For example, the College's President in the mid 1990s, Dr Noel Wilton, was also Director of Mental Health in the New South Wales Department of Health. Nevertheless, the College continues to function efficiently, and has almost certainly improved its performance in most vital areas during the past decade.

During the 1990s, the College's Committee structure remained largely as before, with the exception of the creation of the new Board of Practice Standards and the new committees to deal with disciplinary, quality assurance and clinical standard matters discussed above. In August 1992 the Faculty of Child Psychiatry changed its name to the Faculty of Child and Adolescent Psychiatry, more reflective of its interests. In 1992 it had 210 members, including thirty-six trainees working specifically under its direction.⁴⁷ The section of Psychotherapy was formally established at the May 1991 College conference in Adelaide, following several years of discussion.⁴⁸ Permission to form a Committee on the Political Abuse of Psychiatry and Social Issues, successor to the Social Issues Committee and to the Politics and Psychiatry Committee, was sought in 1993-94 but not approved.⁴⁹ As in the 1980s, the College's profile on controversial political and social issues appeared to be somewhat more conservative. An Ad Hoc Committee on HIV/AIDS was, however, formed in 1992-93, devoted to dealing with the psychiatric aspects of that disease.⁵⁰

During that period the College reinvigorated a History Committee. Previous efforts to form such a committee were undertaken decades before by Dr Alan Stoller, who was also

the chairman of the History Committee in the early part of the 1990s. In March 1991 the History Committee supported the proposal of the Registrar that a qualified archivist, Bronwyn Hewitt, be appointed, to catalogue the College's voluminous historical records at Maudsley House and to place them in preservative containers.⁵¹ Files containing material relating to all College Presidents and other notable figures in the organisation's history were also established.⁵² In 1993 the authors of this book were officially commissioned by the History Committee (under the chairmanship of Dr Paul Brown) to write the College's official history, and a number of other historical activities, including the presentation of papers on psychiatric history at the 1994 College conference in Launceston, were begun.

Also in 1991, the College established a Publications Committee to oversee the production of the *Australian and New Zealand Journal of Psychiatry* and all other College publications.⁵³ The *Australian and New Zealand Journal of Psychiatry* continued to expand substantially virtually every year since 1980 under its Editors, Professor Gordon Parker (1979-87), Dr Robert Finlay-Jones (1987-91) and Dr Sidney Bloch (from 1991). By the 1990s each issue published twenty or more articles, chiefly presenting the results of original research, but also more general essays on the psychiatric profession and its future. The *Journal* became increasingly internationally known and regarded. In 1993 the College began the publication of *Australasian Psychiatry* (edited by Dr Harry Minas), a glossy quarterly which contained shorter articles, chiefly of a broader and more reflective nature, about aspects of psychiatry, but also containing shorter articles detailing new research. Chiefly, however, *Australasian Psychiatry* published news about the College such as reports on General Council and other College bodies and accounts of the annual conferences, College statements on mental health issues, and comments

on government mental health policies and the like. Each issue began with a President's Letter, written by the serving President, commenting upon recent events as they affected the College and Australasian psychiatry. It replaced the briefer newsletter *News and Notes*, which served much the same function of providing general information to fellows, although with fewer reflective articles on psychiatry.

While relative stability in the College's committee structure seemed to indicate general satisfaction with its performance by RANZCP fellows, there were at least some indications of greater concern on the part of the College's branches in the states and New Zealand. The branches experienced all the growth in numbers which the College as a whole experienced, without much in the way of professionalisation. Branches had long added a surcharge, dependent on the range of activities in each branch, to the annual fellowship fee. But these charges were seldom sufficient to provide for the branches a level of professional service on par with that provided by the binational headquarters. Most branches operated on a shoestring, and depended chiefly upon honorary office-bearers as the College as a whole did before the 1980s. The situation became especially acute in New South Wales, New Zealand and Victoria. In New South Wales in the mid 1990s there was considerable concern at the branch level, caused by a growth in the branch's size (over 500 by 1994), a feeling of neglect by the Melbourne headquarters, and the loss in 1994 of the branch's long-standing right to share accommodation with the New South Wales Institute of Psychiatry as its headquarters when the Institute was forced to move to Parramatta.⁵⁴ In late 1994 the New South Wales branch, declining to act on suggestions by the College headquarters, found itself without a permanent venue and was operating from Pam Allen's kitchen.⁵⁵

The New Zealand branch went through a period in the mid 1980s when the issue of seceding from the College was actively and widely discussed.⁵⁶ This is understandable, given the fact that New Zealand is a separate country with its own system of providing psychiatric care, involving a much greater reliance on public psychiatry and fewer opportunities for private practice. It must also be emphasised that the College is a binational body, with New Zealand always recognised as a joint but separate component of the RANZCP. New Zealand's Governor-General has always been joint Patron of the College along with Australia's Governor-General. There is general agreement that, by the early 1990s, the mood of discontent in the New Zealand branch had passed and that there was by then a significant shift in attitude toward the binationality of the College in a positive direction.⁵⁷ There was hope of opening a New Zealand national office for the College, although the lack of an obvious venue remained: although Wellington is New Zealand's capital, it is slightly less populous than Auckland, while Christchurch, Dunedin, Palmerston and Hamilton are important local centres. By the mid 1990s, however, considerable disaffection had again arisen in the New Zealand branch with its status.

In Victoria, discontent with the method of choosing College office-bearers led in May 1995 to two special resolutions being presented to the College AGM. These resolutions proposed the direct election by postal votes (from all fellows of the College) of the President-elect, Honorary Secretary and Honorary Treasurer, the nomination of candidates for these posts from the whole College, and a requirement that nominees provide information about their backgrounds and views. Another resolution proposed that chairmen of the Fellowship Board and the Board of Practice Standards be denied the right to vote on Council.⁵⁸ The stated aim of these proposals was to increase democracy in

the College's governance by ensuring that all fellows are fully democratically represented, and by making all members of the General Council more directly accountable to fellows of the College.⁵⁹ These resolutions were vigorously opposed by almost all office-bearers and General Councillors of the College, including the President, Immediate Past President and President-elect.⁶⁰ Opponents presented a variety of objections: Victoria and New South Wales would dominate all direct elections; the proposed resolutions would create two methods of election of General Council members, by branch members and by the fellowship at large, with separate streams of accountability and responsibility; the resolutions would politicise and fragment the College; disenfranchising board chairmen would unduly diminish their key importance in the College.⁶¹ The proposed resolutions were defeated at the 1995 AGM, although about 40 per cent voted in their favour.

Despite these rumblings of discontent, the College continued to grow at a national level in the 1990s. Its finances were sound, with successful fiscal management ensuring a net operating surplus of \$641 172 in 1994, and holding reserves in the College's Foundation Fund of \$3 612 957 compared with \$2 971 785 the previous year.⁶² The College held \$4 388 717 in accumulated funds at the end of 1994, up from \$3 747 545 a year earlier.⁶³ By 1995 its membership had reached nearly 2000. Indeed, so large had the psychiatric profession become in Australasia that workforce studies were now aimed at a ratio of more than one psychiatrist for every 10 000 persons. By the early 1990s the College had adopted a recommended ratio of one psychiatrist to between 7500 and 10 000 persons, with an ultimate ratio of 1:7500 being found 'much easier to defend' by one 1992 study of this question.⁶⁴

However, the long-standing maldistribution of psychiatrists between geographical areas was continuing. In

the early 1990s, the College devoted much attention to one aspect of this question by focusing on the plight of geographically isolated psychiatrists, with *News and Notes* featuring psychiatrists in remote areas over four issues. It detailed the experience and practice of such practitioners as Dr Wendy Bourke, the only psychiatrist in Mount Isa, Queensland, a town of 26 000 people not only distant from Queensland's main population centres but itself covering an area of 40 000 sq. km, 'about the same size as Switzerland'!⁶⁵ Similar was the situation of Dr Jock McLaren, the only psychiatrist in the Kimberley region, 'about twice the size of the state of Victoria'.⁶⁶ Most of the geographically isolated psychiatrists appeared remarkably satisfied with their lot, although many missed the possibilities of professional involvement with other psychiatrists.

Given the ever-increasing prominence of gender issues throughout western society, it was inevitable that they should become greatly more prominent in College affairs during the 1990s. The importance of women as a distinctive group, seeking both equality and serious attention on the effects of gender in our society, grew enormously during the 1980s and 1990s, and it is fair to say that no College function can ever be undertaken without due sensitivity being shown to gender issues and sexual equality. These changes affected the College in a variety of ways. By the mid 1990s the College had already had four women Presidents, more than any other medical college in Australasia, and the President-elect for 1995-97 is a senior female psychiatrist from New Zealand, Dr Janice Wilson. The number and percentage of women psychiatrists grew steadily. In April 1990, 20.5 per cent of College fellows were women. At the same time, so were 41 per cent of College trainees, a proportion much higher than in most other medical specialties.⁶⁷ Dr Karen Zelas, then the College's President, attributed this in part to the RANZCP's

enlightened attitude to part-time training, noting that the College was the first among medical specialties 'to accept part-time training and a number of Colleges are still strongly opposed to it'.⁶⁸ There were, probably, other culturally derived reasons for the attractiveness of psychiatry to female physicians: the nurturing nature of psychiatry was suggested to the authors by a number of interviewees, for instance.

During this period forums and other bodies specifically for women psychiatrists were formed. In April 1989 an informal initial meeting of twenty women psychiatrists in Melbourne formed a Women in Psychiatry Group, which was formalised in August 1989. It was open to all women Victorian branch members.⁶⁹ The aims of the group were 'to provide a network and forum for the interaction with other women psychiatrists', 'to provide a forum for the exploration of broad political issues' and to assist the educational needs of women trainee psychiatrists.⁷⁰ A Binational Network of Women Psychiatrists, open to all College fellows, was formed at the College's May 1990 Congress in Perth.⁷¹ That conference was also the first to have an issue specifically relating to women as its central theme: The Resilience of Women in the Face of Adversity.⁷² A breakfast for female psychiatrists devoted to women's issues was also held at the conference. Women psychiatrists also held a breakfast meeting in Dunedin, New Zealand, in August 1990.⁷³ Further meetings, including a Women's Workshop at the 1992 Canberra Congress, were held throughout this period.⁷⁴

This period also saw the emergence of avowedly feminist psychiatrists, probably for the first time in Australasia. Possibly the best-known is Dr Carolyn Quadrio of Sydney, who initiated a lively debate in *News and Notes* in the early 1990s over women's psychiatric issues, and whose article 'Women in Australian and New Zealand Psychiatry: The Fat

Lady Sings', highlighted how 'gender disadvantage ... significantly affects the development of women doctors', and claimed that 'psychiatry in Australia and New Zealand has yet to articulate those issues which bear directly upon the development of its own members', among them female psychiatrists.⁷⁵ Dr Quadrio also criticised the fact that the Plenary Sessions of the College's 1988 Congress had no women speakers.⁷⁶ It seems clear that the College has had increasingly to heed this message. In 1993 General Council accepted the principle that 'where possible by [mid-1994] there be at least one female Fellow and one male Fellow on every College board and committee and, where this has not been achieved, the Chairman of the relevant committee be required to provide an explanation to General Council'.⁷⁷ How long genuine gender equality might take to achieve is a more debatable matter.

In other respects, too, the College was much more broadly representative than in the past. It had prominent fellows and office-bearers from virtually every European ethnic group, and increasing numbers of fellows of Asian background (from a variety of cultures), who were also welcomed as office-bearers, apparently meeting little or no ethnic prejudice. In this, the College probably showed itself to be more democratic than the older medical specialist bodies.

In recent years the College has also had to deal with changes to payments for psychiatric care which potentially disadvantaged psychiatrists, their patients and services. In particular, during the 1990s the method of government payment to hospitals known as 'casemix' was widely debated and widely adopted. Under casemix, hospital funding is based upon previous episodes of patient care, divided by illness classification.⁷⁸ Australian casemix formulae have adapted the American casemix system (HCFA-DRG). It is known in Australia as AN-DRG (Australian

National Diagnosis Related Groups). On the basis of the principal clinical diagnosis recorded during an episode of care, each patient is assigned to one of twenty-three groupings and then to more specific groups.⁷⁹ Many psychiatrists have expressed fears that the grouping of mental health problems is based upon extremely crude classification criteria which, in particular, do not recognise the special need for long-term psychiatric care for acute or non-acute cases. The introduction of casemix was grounded in the need by governments to curb the skyrocketing costs of hospitalisation, but also seems, to many, to threaten the basis of proper psychiatric hospital funding. This issue, and the pressures which produced them, will continue in the future.

In 1993-94 the psychiatric profession suffered another bout of what many saw as unfair and unsubstantiated bad publicity with the release of the Report of the National Inquiry into the Human Rights of People with Mental Illness, known as the Burdekin Report after its chairman, Brian Burdekin, the Federal Human Rights Commissioner. The College fully assisted that inquiry.⁸⁰ The report was frequently highly critical of psychiatrists and of the treatment of the mentally ill in Australia, which it regarded as often constituting a violation of the human rights of the mentally ill. Some aspects of the report itself, and the very high media profile sought and received by Brian Burdekin in releasing it, were criticised in turn by Australian psychiatrists. For instance, the report 'eschew[ed] any definitions of mental illness'.⁸¹ The College had great difficulty in obtaining a copy of the report when it was released in October 1993.⁸² The report was also criticised by some psychiatrists for its excessive reliance on anecdotal evidence and the often adversarial stance it adopted towards psychiatry. The net result of the Burdekin Report was thus very mixed: a wellpublicised light on the problems

of the mentally ill, which was unquestionably a good thing, side by side with criticism which many psychiatrists believed was often unfair. It is interesting, however, that there was probably less public hostility generated towards the psychiatric profession by the Burdekin Report than by Chelmsford only a few years before. Quite possibly the efforts made by the College at improving both the image and performance of Australasian psychiatry had borne fruit.

As the College entered the end of its first half-century of existence it could do so with much satisfaction. The evolution of what was, at the outset, a voluntary collegial association of the handful of practising Australasian psychiatrists into a universally recognised medical specialist College had been achieved in relatively easy evolutionary stages, accompanied by remarkable and steady growth in numbers. The final steps toward the achievement of unqualified status as a professional body were seemingly achieved as recently as the early to mid 1990s, when, within a few years, the last university rival to the College's examination system ceased. Shortly before, the College had amended its constitution to give it realistic powers to discipline or expel members found guilty of improper behaviour. It thus acquired, in full form, the powers generally regarded as requisite for any professional qualifying body: a monopoly over the entrance of new members, and the ability to discipline or expel any member guilty of unprofessional conduct.

The College had grown so much that it had to abandon Maudsley House and to move, in 1995, into two self-contained floors of a modern office building in central Melbourne at 309 La Trobe St with more than twice as much floor space. Maudsley House, because of its historic classification, could not be enlarged.

Both the College and the psychiatric profession faced new challenges during the 1990s and will look somewhat different several decades hence. Such matters as the

Australian National Mental Health Policy and Plan and workforce questions exemplified by the College's Corporate Plan and its forthcoming survey of membership loom.⁸³ College contacts with South-East Asia can reasonably be expected to increase. From the College's earliest days there have been many such contacts, although little in the way of on-going and continuing programs. In October 1993 General Council established a working group to investigate and recommend future direction and activities for the College to contribute to the development of psychiatry in the south-west Pacific region and South-East Asia.⁸⁴

Despite this solid record of achievement, there is a residual feeling that psychiatry remains the most marginal and misunderstood of medical specialties, and still suffers from the negative stereotypes and images which have for so long been attached to the discipline and its practitioners. While this may still be true, it is probably much less valid than in the past.⁸⁵ The other side of the coin is the real record of positive contribution to the improvement of the mental health of 21 million Australasians which psychiatrists and the College have made over the past half-century. While the national identities of Australia and New Zealand are now much more ambiguous than in the past, and while both societies suffer from many economic, social and ecological problems, the rate of dysfunctional behaviour of the type which psychiatry exists to ameliorate is probably lower than in most other industrial urbanised societies (the high rates of youth suicide being a significant exception). Whatever their problems, Australia and New Zealand remain among the most liveable countries in the world. While there are a host of reasons why that is so, it would be unreasonable to deny or exclude the contribution made by those medical practitioners who deal with society's most vulnerable and disadvantaged members.

PART II

The Internal Workings of the College

In Part II, closer attention will be paid to the more important internal functions of the College. We will look in detail at the evolution of the College's branches in the Australian states and New Zealand, at the important subject of the College's committee structure, at the fundamental question of its examination and training process, at its annual congresses, and its role in the furtherance of research in psychiatry.

5 The Branches of the College

The general history of the College sketched in Part I necessarily concentrated on its development as an Australasian body with a central headquarters in Melbourne, and discussed the growth of that central body and its relationship to the psychiatric profession and to Australasian society. Largely apart from the College's central governing body in Melbourne, however, are branches in the Australian states and in New Zealand. Each branch has a history and internal dynamics often distinct from the concerns of the College as the Australasian umbrella organisation of the psychiatric profession. Often, too, these branches have initiated developments or voiced concerns over matters well in advance of the College's national headquarters, and have been more closely attuned to popular opinion in the Australasian psychiatric profession.

From its earliest days, the Association of Psychiatrists viewed the creation of state and New Zealand branches as integral to its function and purpose. In its 1946 Rules of Association, the new organisation devoted considerable attention to the foundation of local committees. Under Article 21 members 'in each of the States ... and New Zealand shall elect a State Committee which shall act in an advisory capacity to the General Council on the affairs of the Association within a particular State'. Each state committee was to consist of a chairman, secretary and treasurer 'and not less than three or more than ten members', while any Councillor (i.e. branch representative to the General Council) not elected to the branch committee became, *ex officio*, a member of that committee. Members of the state committee were to be elected annually by the Association's members in that state, but were to be eligible

for re-election.¹ This provision for annual elections probably had the long-term effect of weakening the state committees, especially in the larger states, making for an arguably too-rapid turnover of state council members who barely had time to learn the ropes before their term of office ended. In New South Wales, the largest state branch, long-serving Administrative Secretary Pam Allen recalled that each year a new committee had to reinvent the wheel, often considering from scratch matters which a former state committee had already debated and settled.² In the smaller states, with far fewer local members, there was a less frequent turnover of committee members and greater continuity. Under the Rules of Association of the new organisation, state committees were also required to meet at least twice a year, the presence of five members being deemed a quorum.³

Despite the new Association's virtual insistence that local branches would be formed in the states and New Zealand, they appear to have been exceptionally slow in getting off the ground in any meaningful sense. Indeed, during the first seven years of the Association — from 1946 until about 1953 — they appear to have been virtually nonexistent, and are mentioned in the Association's minutes only fitfully and skeletally, if at all. In October 1947 the Association's General Council 'after considerable discussion' voted to keep £5 in each state account 'to cover administrative expenses'.⁴ In 1947-48 (as noted in chapter 1), each state association was given a specific project to engage its attention.⁵ In May 1949, Victoria, New South Wales, Queensland and Tasmania each presented a report on their assigned task.⁶ In November 1949, under the heading 'State Tasks for 1949' in the Association's minutes, it was noted that Professor Bostock 'gave a survey of the psychiatric in-patient facilities of the various states, collated from the

reports made by each'.⁷ This appears to be the last occasion on which anything came of projects assigned by the General Council to the state branches; thereafter, the branches were generally left alone by the College headquarters apart from occasions when they were specifically requested to give their opinions about a particular issue. Indeed, nothing more is heard of the state branches in the College minutes for nearly four years, until October 1953, when a lengthy account of the activities of the Queensland, New South Wales, Victorian and South Australian branches appears in the General Council minutes.⁸

Nevertheless, in the interim each of the state branches certainly operated and reported in virtually every issue of the *Australasian Psychiatric Quarterly Newsletter* (later the *Australasian Psychiatric Bulletin*), the organisation's periodical. The reports, however, tended to consist of accounts of psychiatric activities of interest to local members, such as lectures and seminars at universities, as well as developments in state mental health legislation and building projects, rather than the activities of the committees themselves. From the beginning, each state branch elected Councillors to the Association's General Council and took turns at hosting the annual conference.

In the early to mid 1950s, there occurred the organisation of the state branches in the proper sense, with chairmen and other office-bearers first being selected in all the Australian states (except Tasmania) in the period 1953-56 (Appendix 3 lists the chairmen of the branches from that time until the present). By 1953, most state branches met regularly, holding state AGMs, as the Victorian and South Australian branches did in 1953.⁹ In 1953, for instance, the South Australian branch met eight times between February and October, electing a state committee and discussing local psychiatric matters at length.¹⁰ By 1954, the South Australian and Western Australian branches 'expressed

disappointment' at not receiving General Council agendas and financial statements for discussion before Council met.¹¹ In 1955, full lists of branch office-bearers appeared in Council records for the first time. All states and New Zealand had selected honorary secretary-treasurers, but neither New South Wales nor Tasmania had named branch chairmen.¹²

That year marked another turning point, as several of the branches made specific suggestions to the Association's General Council, to be discussed and acted upon at a federal meeting, thus reversing the former pattern in which the central organisation assigned tasks to the states. By mid 1955, for instance, the Queensland branch officially suggested to Council 'that the Australian Postgraduate Federation bring a prominent psychiatrist to Australia', that 'accommodation at Mental Hospitals would be of great value to Interstate Visitors, if adequate notice were given', that there should be 'a Permanent Nominating Committee' of one member from each state to decide which applicants should be admitted, subject to Council approval, and, that a 'Permanent Presidential Nominating Committee consisting of all Past-Presidents' be established.¹³

During the late 1950s the relationship of the branches and the federal Council was debated by the latter, in the context of several branches seeking greater discretion to hold special meetings and take other steps outside the strict rules of the Association.¹⁴ The eve of the Association's transformation into the College also saw an important initiative by a state branch, when in September 1963 the Victorian branch moved 'the setting up of a sub-section in Child Psychiatry', the first such subsection (later termed 'section') to be mooted. The Victorian resolution led to the formation of a committee, under Dr W.S. Rickards, to report on this recommendation.¹⁵

During the mid to late 1960s most branches evolved into bodies with activities similar to those familiar to fellows today. This process was largely complete by the early 1970s. By 1965 regular branch meetings were held in all states. Often these were the venues for the presentation of scientific papers or addresses by eminent visitors. At its April 1965 branch meeting, for instance, the New South Wales branch heard papers by Dr J.G. Andrews on 'The Aetiology of Stuttering', by Dr N. McConaghy on 'Suicide and Parental Deprivation' and by Dr J.E. Cawte on 'The Cultural Factor in Psychosomatic Disturbances'.¹⁶ At its May 1965 meeting, the New South Wales branch was addressed by Dr Don Jackson, Director of the Mental Research Institute of the Palo Alto Medical Research Foundation in California.¹⁷ Also in April 1965, the New Zealand branch's semi-annual meeting, held at Hokitika on the South Island, was attended by 50 per cent of New Zealand's College membership. Five papers were presented and the assemblage toured the local hospital.¹⁸ Around the same time, South Australia held a branch meeting at which Dr Bill Dibden read a paper on 'E.E.G. Abnormalities in Relation to Behaviour Disorder of Childhood', and the Queensland branch held its AGM.¹⁹

A number of states began to produce their own branch newsletters at this time. The Victorian branch produced its own quarterly newsletter from 1967 under the editorship of Dr J.L. Evans. For financial reasons, the newsletter was discontinued in 1970, but began again on a monthly basis in 1972.²⁰ A New South Wales branch newsletter began at about the same time.²¹

By 1970, too, the larger branches, especially Victoria, developed their own subcommittee structure which functioned quite independently of the College's committees. In August 1970 the Victorian branch had five subcommittees in place, the Host Branch Subcommittee (to deal specifically with the October 1972 College Conference, held in

Melbourne), an Education Subcommittee, an Overseas Visitors Subcommittee, a Social Subcommittee, and a Subcommittee on the Uses and Abuses of LSD and Other Hallucinogenic Drugs.²²

The Victorian Branch Report of August 1970 noted that the branch had entered into correspondence with the Medical Board of Victoria on the question of the 'Registerability of M[embers of the] ANZCP' to ensure that membership of the College was 'accepted by the Federal Department of Health as an appropriate qualification for classification as a consultant specialist under the NHS.'²³ The Victorian committee thus negotiated with the government and relevant authority, on behalf of its members.

Many of the branches moved their own motions to the College's General Council, to be considered at the next General Council meeting. In October 1970, for example, the Queensland branch made several proposals to General Council: that changes be made in the form of the College Presidential Address, which they wished to be given informally and frankly at the College AGM rather than in a ceremonial public address; that a Standing Committee on fees charged in private practice be formed, with a representative from each branch; that alterations be made in the deadlines for suggesting scientific papers at the annual conference; and that draft copies of General Council minutes be submitted to state branches no later than one week after each Council meeting.²⁴ These were very typical of the types of suggestions made by branches to General Council over the years, particularly the last point, which reflects the lack of information and consultation the branches believed they had received from the College headquarters. The issue became a stock-in-trade in branch reports over the next decade or two.²⁵

Over the next quarter of a century the functions and activities of the state branches remained broadly similar to what they had become by about 1970. In essence, every branch by that time had three or four major areas of activity which they undertook on behalf of their members. Each held regular meetings, often of a social nature, at which scientific papers were delivered or prominent visitors spoke. Probably the most important means of frequent professional and social communication among Australasian psychiatrists as a group, especially in the smaller states, these meetings have served an important educational function in Australasian psychiatry as well as in enhancing professional *esprit de corps*. Indeed, for many psychiatrists the College's most visible and frequently encountered public face undoubtedly consists of the local functions organised by the state and New Zealand branches, rather than anything done by the College's headquarters.

The local branches also choose Councillors to the College's General Council — these representatives comprise a majority of members of the College Council. The branches nominate candidates for the College presidency and have an important role in determining national College policy. They also choose their own local office-bearers, including branch chairman, secretary-treasurer and local committee. The list of branch chairmen shows that while a minority became senior office-bearers in the College at the federal level, or headed important College committees, the majority were known only locally and did not make a career in the College's federal structure.

A third continuing role of the branches is to propose motions to be considered by the College's General Council. Additionally, the branches often negotiate with the governments of the Australian states or New Zealand on mental health and psychiatric issues, or with local hospitals, universities or other relevant institutions. State branches, with their local knowledge, can often do this much more

effectively than the College's federal headquarters. As the role of local governments in the mental health area has grown, this may now be the most important function. Finally, since 1993, the first-year training examinations of the College have been organised at branch level. By the 1990s a large branch, like that in New South Wales, held up to fourteen branch committee meetings each year.

In the late 1980s a new arrangement came into being for the collection of fees to support the operations of branches, as well as of faculties and sections. Under this arrangement, one subscription notice was issued annually to each member, which included all components of membership — the College's annual subscription, branch fees and other fees. Thus, the College now centrally collects the fees for the branches and other groups, then pays over the money collected on their behalf to each body. In the mid 1990s branches received a grant of \$1000 plus up to \$3000 for continuing medical education, but any funding beyond this figure is based upon a branch-determined annual fee for that year. In the mid 1990s, for instance, the New South Wales Branch received \$87 000, a figure based on the annual fee set by the branch for that year. Each branch differs markedly in the fee it requests to be collected, depending upon its estimated requirements. The amount of the fee is formally approved by the General Council as part of the budget approval process.²⁶

Before the College's own DPM became the primary or sole vehicle for obtaining College membership, the state branches transmitted all applications for admittance, with their own comments on the suitability of each request. They thus had an important role in determining Association/College membership. This was especially important during the first twenty years or so of the body's history, but became of diminishing significance thereafter.

Inevitably, several of the branches developed in different ways. In 1964-65 the New South Wales Institute of Psychiatry was established by the state government to train psychiatrists in that state. Original College members of the Institute included Professors David Maddison and Leslie Kiloh, Drs Ian Simpson, Brian Shea and Jack Russell.²⁷ Chiefly concerned with the preparation of regulations governing training programs and a suitable syllabus for candidates for the DPM (including the College DPM), it was located at the Kirkbride Complex of Rozelle Hospital until its transfer, in 1994, to Cumberland Hospital in North Parramatta. The Institute served as the centre for almost all New South Wales branch functions as well as for its secretariat, who received office space there free of charge over many years.²⁸

The New Zealand branch was founded later than those in the Australian states, in 1954-55. It has been distinguished from them in that its headquarters rotates every two years among the four largest regional centres — Wellington, Auckland, Christchurch and Dunedin — with delegates from two other large cities — Palmerston and Hamilton — having regional representatives on the branch committee.²⁹ During each two-year period, the branch's senior office-bearers all derive from the host city. The New Zealand branch meets twice annually face-to-face and twice holds teleconferences.³⁰ In the mid 1990s, plans were advanced to establish a permanent New Zealand College office in Wellington.

The College's branch in the Australian Capital Territory was not convened until August 1973. Before that, the New South Wales branch considered applications from Canberra residents who, if accepted, joined the New South Wales branch.³¹ Although an ACT branch was provisionally founded in 1973, its records are much more fragmentary than those of any other branch, and branch reports to the College's

General Council could often not be traced on a regular basis until those of the 1990s.

One final interesting branch footnote is that from October 1969, for about a decade, the College was officially represented in Papua New Guinea, and semi-annual reports, of considerable appeal to social historians of that society (which became independent in 1973) were filed throughout this period. The College's representative (as Liaison Officer) in Papua New Guinea was Dr (later Sir) Burton Burton-Bradley (1914-93), an important figure in the medical history of the new state, whose reports described such matters as local cargo cults, tribal violence and the rapid approach of independence.³²

In recent years each of the branches has increased enormously in size along with the general growth in the membership of the College. In 1994 the New South Wales branch had 535 members, more than the College's total membership in the 1960s.³³ In 1994, area portfolios, covering such topics as training issues, public psychiatry, media liaison and rural psychiatry, were allocated to the branch's incoming executive.³⁴ The expansion of branches has generated a host of new problems. In addition, ethical and training issues — of a kind acted upon only rarely in the past — have also become important matters of concern for the branches, as well as for the College headquarters. By 1994, many of the branches had established Branch Ethics, Training and Continuing Medical Education Committees.³⁵

Each branch, however, has continued to focus on a different set of issues and problems, representing separate regional concerns. The New South Wales branch was primarily concerned with securing a new branch headquarters. New Zealand regarded workforce questions as paramount, its report noting that while 'the number of psychiatrists in New Zealand has risen, the number of members of our College has remained the same. We have

reached a situation where close to half the practising psychiatrists in NZ are not Fellows of the RANZCP'.³⁶ The Queensland branch reported on a 'fruitful' meeting with the state's Minister of Health, and noted that the state's Director of Mental Health 'continues to attend Branch Committee meetings quarterly'.³⁷ Tasmania claimed that 'there have been exciting developments aiming at trialing a partial integration of private and public psychiatry'; the branch also 'entered the fray of the homosexual law reform debate', issuing a press release calling for the decriminalisation of homosexuality 'on psychological and psychiatric grounds'.³⁸ At the same time, the Victorian branch put forward motions for consideration by General Council. These called upon Council to debate the implications of the First National Mental Health Report 1993 and the Report of the Mental Health Workforce Committee on financing; requested that a working party be set up to co-ordinate the response to the first of these reports 'with particular reference to improving the appreciation of the private sector'; and asked Council to 'debate the concept of serious mental illness and its validity in the interests of universal treatment services to people suffering from mental illness'.³⁹ The Western Australian branch also put two motions to Council for consideration, relating to quite different matters. The first asked for 'a review of subscription rates to fellows who work on a part-time basis', and the second requested a review of conference and travel arrangements. Its report to Council noted concern at the closure of Heathcote public psychiatric hospital.⁴⁰ Thus, to a perhaps surprising extent, each of the branches had quite different concerns and wished to raise very different matters at the College's national level.

By the mid 1990s, however, there was also often a mood of considerable discontent about the role of the branches, making for moves towards fundamental change to the

College. The discontent often arose from the underlying problem of the branches in the modern College: that they had grown enormously in size and function without evolving a professional infrastructure as had the organisation's headquarters. Another contributing factor was the nature of the underlying relationship between the College's headquarters and its branches, often perceived by the latter as remote, even irrelevant to the day-to-day local concerns of the branches. One major branch was 'not working terribly well', according to its chairman, interviewed in 1994. He highlighted the need for longer time-frames for the development of state branch policy than those provided by annual elections, the need for much greater consultation with the College headquarters ('branches are left on their own ... they are given only snippets of information'), the prevalence of parochial issues on branch agendas, the absence of a branch institutional identity, and, probably above all else, the problem of the 'Mickey Mouse' infrastructure and secretariat of the branch, which has survived on the goodwill of honorary office-bearers. That chairman also called for regular meetings of the executives of all branches, especially honorary secretaries. This presently does not occur. One important and perhaps inevitable task of the College as it enters its second half-century will be to address these problems centrally, by moving towards the professionalisation of branch infrastructures to match that achieved by the College's headquarters.

6 The Committees of the College

In recent decades the committees of the College have come to play a crucial role in its work; they have proliferated in number and purpose in a bewildering and complicated manner. It is virtually impossible to imagine the College, or any other organisation equally large in membership and complexity, existing without them. It is therefore surprising that the Association existed for fifteen years without any standing committees whatever: the functions which would later be performed by those committees were carried out, if they were done at all, by the College's handful of honorary office-bearers, especially its Honorary Secretary.

Admittedly, during its first fifteen years the College established a number of subcommittees, but those were normally formed for a highly specific and narrow purpose, and lacked the permanence and infrastructure of the College's later committees. The first record of a subcommittee of any kind being established by the Association occurred in November 1949, when the question of the Association's attitude towards the DPM was 'referred to a subcommittee of Drs Maudsley, Youngman, Stoller, and Buckle for their recommendations'.¹ This subcommittee reported the next day, Dr Buckle 'detail[ing] general principles which should govern the policy of the AAP on Diplomas, and elaborated their ideas for an ideal curriculum'.² Their report was 'adopted and promulgated to relevant bodies'.³ Nothing more was heard of that subcommittee, which was simply an offshoot of a regular Association Council meeting, attended by eleven early fellows.⁴ In October 1951 the minutes reported on the existence of a Victorian Education Subcommittee, Council

resolving to write to the state branches, urging them to send reports of their local activities, and informing them of Victoria's efforts in this area.⁵ A year later, no replies had been received to the Secretary's request for information, and Council, on the motion of Dr Arnott, formed a subcommittee consisting of Drs Stoller, Buckle and Martin, to review psychiatric education in the Australian states, New Zealand, Britain and the USA.⁶ In October 1954, that subcommittee reported to Council that it had 'sketched the proposed plans for an intensive subcommittee investigation of DPM facilities and requirements in Australasia', but deferred its report pending the findings of Britain's Royal Colleges of Physicians and Surgeons on this question.⁷ Earlier in 1954, a committee had been established by Council, consisting of Drs Ellery, Springthorpe, Meares and Stoller, 'to investigate the possibility of commencing a journal of the AAP'; Drs Sinclair, Martin and Dax (as a proxy for Stoller) were then added to the committee.⁸ It was not a standing committee in any constitutional sense, being convened for one explicit and narrow reason. Opinion voiced at the October 1954 Council meeting was that caution should prevail on this matter, and the question was deferred for two years.⁹

Another ad hoc subcommittee, to discuss the organisation of the Association's secretariat, was formed in August 1955, while in October of that year, a small committee was also formed 'to study the Rules and their application'.¹⁰ The Rules Subcommittee took nearly three years to report, during which time the Association apparently had no committees or subcommittees of any kind; at least none are mentioned in Council's minutes.¹¹ There was again a complete hiatus in the formation of Association committees until October 1960, when a Subcommittee on Pharmaceutical Benefits and one on

Corresponding Membership were formed.¹² This situation persisted until May 1961, when circumstances began to alter in fundamental ways.

Thus, for its first fifteen years the Association operated successfully without any standing committees, let alone the wide range of bodies which were shortly to develop. It might be asked how the Association could possibly function without committees. To this question there is no clear-cut answer. The Association was of course much smaller than the College was to be, but by this time it was certainly no longer an insignificant body. In May 1961 it already had 269 members, including eighty-eight in Victoria and sixty-nine in New South Wales.¹³

Three reasons why the Association took so long to develop a committee infrastructure can be advanced. First, as an Association rather than a College it retained the voluntary collegial nature with which it had begun, and had not yet experienced the range of duties and activities which were shortly to follow, in particular the development of its own examination system. Second the volume of work was handled very efficiently by the College's office-bearers, especially Dr Ian Martin, its long-serving Honorary Secretary, and a few other key activists such as Dr Alan Stoller, the *Bulletin* Editor. Third the branches were developing a range of activities of their own. To these reasons might be added the tyranny of distance in Australasia: only a few face-to-face meetings could be held by an organisation like the Association, given the logistics and expense of travel at that time.

In 1961 this absence of a standing committee structure became untenable. At the May 1961 Council meeting, the Association's secretariat was reconstructed to contain two new standing committees, the first in the Association's history to cover finance and applications for membership.¹⁴ (On that occasion, a Liaison Officer was also appointed, for

the first time.) The Standing Finance Committee was given the responsibility 'to assume the management of all financial matters relative to the Association', and this became one of the most significant components of the Association's infrastructure, a role it continued under the College.¹⁵ The committee was deliberately placed in Sydney to balance the fact that the Association's headquarters was in Melbourne.¹⁶ Its members were also drawn from New South Wales; for many years it was headed by Dr Bruce H. Peterson.¹⁷ The Standing Applications Committee was placed in Brisbane, and was assigned to deal 'with all new applications for membership of the Association'.¹⁸

At the same May 1961 Council meeting, two subcommittees came into formal existence. A year earlier Council had voted seven-three to establish a subcommittee to recommend on details of courses and examinations of any Association DPM.¹⁹ That group, which soon became known as the DPM Subcommittee, was headed by Adelaide's Dr Harry Southwood.²⁰ In May 1961 it reported for the first time on its work over the previous year, outlining its proposals for an AAP-based DPM.²¹ At the same meeting it was also decided, in connection with this proposal, that a Provisional Board of Censors be established.²²

Shortly before the transformation of the Association into the College, two further developments occurred. In May 1963 a proposal was made by W.S. Rickards and the Victorian branch to form a subsection in child psychiatry.²³ That was the earliest suggestion that the Association formally constitute a group devoted to a specific subject area in psychiatry. In September 1963 Council gave Dr Rickards permission to convene a subcommittee to report further on the proposal.²⁴ The following April a Programme Committee was proposed to plan the Association's annual program of events in co-operation with the branch hosting

the yearly conference. Council deferred the proposal, and the Host Branch Committee (an ad hoc committee organising aspects of each Congress) was not formed until 1966.²⁵

By the time of the formation of the College — whose inaugural Council meeting was held on 25 October 1964 — many steps had thus been taken to establish an infrastructure of standing committees and other formally constituted groups, although by later standards these steps were highly tentative. Over the next two years, however, the new College made up with a vengeance for lost time, engaging in what might accurately be termed a veritable orgy of committee formation. By October 1966 it had no fewer than sixteen standing committees, in addition to a formally constituted Section on Child Psychiatry and a Board of Censors. At the October 1964 annual Council meeting, the College set up a Programme Committee, an Executive Committee, a College Subcommittee, a Fellowship Committee and a College Building Committee. It also officially established the Section on Child Psychiatry.²⁶ These departures clearly came out of a comprehensive discussion of the role of the Federal Secretariat in the newly formed College.²⁷

Of especial importance among these new committees was the Executive Committee, the predecessor body of the Executive Advisory Committee. Consisting of the College's President, President-elect, Immediate Past President, Honorary Secretary and Treasurer, Chairman of the College Committee and Censor-in-Chief, it had already met in June and July 1964, although it was not officially sanctioned by Council until the October meeting.²⁸ The College Subcommittee was intended to develop official regulations for future use by the College, especially in relation to the admission of new fellows.²⁹ Dr Jack Russell was its chairman.³⁰ The College Building Committee was constituted

to facilitate the purchase and fitting out of the first Maudsley House.³¹ The Programme Committee was established to co-ordinate programs for scientific meetings of the College.³²

At the May 1965 Council meeting more new subcommittees were established, the annotations to the agenda noting that 'experience has shown that Council, in not accepting promptly the various recommendations to set up Subcommittees in order to divide the burden of College administration, has delayed development and left an undue burden upon a few'.³³ A Secretariat Subcommittee, to assist the Honorary Federal Secretary, a Gifts, Scholarship and Endowments Committee, and a Policy Steering Committee, 'to forward recommendations to Council regarding such matters as liaison with other bodies and the public, long term planning and future development', were established on that occasion, while the Executive Committee was renamed the Executive Advisory Committee and the College Building Committee was renamed the Maudsley House Committee.³⁴

In November 1965, an Overseas Visitors Committee (convenor Dr Neville Parker of Queensland) was established.³⁵ That meeting also received the first report of the Bulletin Committee, headed by Drs Alan Stoller and J.L. Evans; the committee had been formed at the same time as the beginnings of the *Australian and New Zealand Journal of Psychiatry*.³⁶ The duties of the Fellowship Committee were merged with the Executive Advisory Committee.³⁷ The annotations to the minutes of the November 1965 Council meeting were also the first to present lists of each committee and its members, a subject of increasing complexity, and the first to present convenors' reports from the Section on Child Psychiatry and the Board of Censors.³⁸ The minutes and annotations (including committee reports) of this meeting are over fifty pages long, many times the

length of the brief reports of Association Council meetings only a few years previously. For the College, 1965 might well be termed 'the year of the committee'. Nor did this process stop in 1965, for the next year more new committees were formed: a President-elect Committee, a Library Committee, a Host Branch Committee and a Fellowship Committee.³⁹

This remarkable period of growth in the College's committee structure stopped as suddenly as it began, and over the next few years the structure underwent fewer changes. Yet committees continued to be added. In July 1968 an Education and Research Committee was established, whose aim was specifically to administer the College's Education and Research Fund.⁴⁰ Although under its terms of reference it was given the power 'to consider requests for finance for projects involving research and education in psychiatry or allied disciplines', the new committee originally had only \$4000 at its disposal, and was limited to making grants of 'up to \$500 or for such amounts as Council may from time to time decide'.⁴¹ Also in 1968, an H.B. Williams Committee, to recommend the holder of the periodically awarded H.B. Williams Memorial Fund Travelling Professor (a distinguished overseas psychiatrist), was officially constituted, with Dr R.W. Medicott as convenor.⁴² At the same time, an International Liaison Committee with Professor J.E. Cawte as convenor was established, to liaise with international psychiatric bodies such as the World Federation of Mental Health.⁴³ The College also agreed to the formation of a second section, that on Forensic Psychiatry.⁴⁴

Another spate of committee formation came several years later, in 1970-71, when in short order a number of important new bodies were established. The Social Issues Committee held its inaugural meeting in January 1970.⁴⁵ It initially acted as a spur to the College, taking an advanced

position on a variety of controversial social issues. In October that year, Council authorised the establishment of a Psychotropic Drugs Committee, a Standing Committee on Fees, and a Committee on Specialist Recognition.⁴⁶ The Psychotropic Drugs Committee, chaired by Dr Russell Pargiter, was the first committee of the Association or College ever to have an input into this obviously important subject, and exemplified the growing maturity of the College. Under its terms of reference, that committee was to advise the College on all aspects of the therapeutic use of psychotropic drugs, to liaise with other bodies and institutions involved in the assessment and provision of such drugs, and to undertake surveys of the College's membership to obtain 'a collective opinion as to the usage and value of particular psychotropic drugs'.⁴⁷ The new committee arose partly from discussions between the College, the AMA and the Federal Senate Select Committee to Review the Provision of Pharmaceutical Benefits, and partly from the realisation that the profession would increasingly be called upon to provide, and justify, expert advice about the use of psychotropic drugs by psychiatrists.⁴⁸ The Standing Committee on Fees was also established in late 1970, with Dr Colin Degotardi of Sydney as its convenor.⁴⁹ This committee took as its terms of reference the task of surveying consultant psychiatrists 'to determine the range of present fees and where anomalies exist in rebates for various psychiatric procedures', to assist in negotiations with the federal government and the AMA over fees, and to recommend the adjustment of psychiatric fees in line with other medical fees.⁵⁰ Finally, the Committee on Specialist Recognition was formed to establish the current list of psychiatric qualifications recognised by the College as constituting valid qualifications for College membership, and providing advice on any qualifications not

previously considered.⁵¹ In May 1971, Professor Issy Pilowsky was appointed convenor of that committee.⁵²

The creation of the infrastructure of committees in this period had many benefits for the College, apart from giving it one of the necessary hallmarks of a true professional umbrella organisation. It allowed expert opinion to be brought to bear or develop in the administration of highly specialised areas. It greatly increased the number of the College's actively involved fellows, allowing many more members to feel engaged in the decision-making process. It also increased the range of areas on which the College could provide expert up-to-date knowledge to the government and media.

In the wake of that intensive period of committee formation, it seems worthwhile to examine the College at ten-yearly intervals to see how its committee structure changed. Accordingly, the College is observed in 1974, 1984 and 1994.

By 1974, little had been added since the period of construction. The College's 1974 committee structure contained only a few committees which had been recently formed. Among those was a Psychiatric Developments and Manpower Committee, convened by Dr Wallace Ironside, which attempted to ascertain long-term trends in the training and employment of Australasian psychiatrists, and health care needs in the field of mental illness. There was a College Questionnaire and Survey Committee, convened by Dr P.W. Burvill, which undertook surveys of College members, especially over the controversial ethical questions raised by the Social Issues Committee. And there was a newly formed Interprofessional Relationships Committee, convened by Dr A. Shearer, which examined the relationship between Australasian psychiatry and professional workers in allied mental health fields such as clinical psychologists, social workers, remedial therapists and nurses.⁵³

A Roche Visiting Professorship Committee was formed in 1974, to administer the grant provided to the College by Roche Products to bring a distinguished overseas visitor to Australasia.⁵⁴ Several ad hoc committees also existed that year, among them an Ad Hoc Committee on the First Pacific Congress of Psychiatry, held in Melbourne in May 1975 (Dr John Cade, committee chairman); an Ad Hoc Committee on the Australian National Health Scheme and the Care of the Psychiatric Patient, convened by Dr W. Argall; and an Ad Hoc Committee on the Organisation of College and International Congresses, convened by Dr Peter Eisen, created chiefly to review the structure of the College's annual conference.⁵⁵ A College Section of Social and Cultural Psychiatry had also been recently created.⁵⁶ Many College committees continued to be based in one branch, with that branch having the responsibility of organising those committees and performing their functions. Such procedure saved travel costs and also increased the feeling of direct involvement in College affairs by the branches, especially the smaller ones.

In other respects, the College's committee structure in 1974 was much as it would be twenty years later. Nevertheless, there were a number of important differences. In particular, no committee existed to deal with any allegations of improper behaviour by fellows, and none had any responsibility to examine or define ethical behaviour by Australasia's psychiatrists, or to produce codes of proper practice standards. Arguably, the lack of structure to deal with such issues was a major and regrettable error of omission, which had grossly deleterious effects upon the reputation of Australasian psychiatry when the Chelmsford and Townsville affairs became public knowledge, to say nothing of the malign consequences for the patients caught up in those scandals. Nevertheless, it must be appreciated that there was another side to the story. The College, under Article 71 of its constitution, required General Council,

rather than a committee, to deal with disciplinary action of this type. Similarly, the College had no committees concerned with continuing education and had entered into the area of forward planning only in a fragmentary and preliminary way. The lack of any committee devoted to allegations of improper behaviour by College members was probably a result of the piecemeal evolutionary nature of the organisation's development, and of its lengthy transformation from a voluntary association of friendly colleagues to a specialist medical college in the proper sense, a transformation completed only shortly before the College reached its half-century mark. In addition, it must be noted that no such allegations were apparently made before the 1980s.

By 1984 the College's committee structure was in essence the same as it had been a decade earlier. Five new committees had been established, as well as the very important Board of Accreditation. But these had built on the foundations laid during the College's infancy and did not represent any striking new departures. The major gaps in the College's early committee structure were addressed in part and in a preliminary way by the creation of an Ethics Committee under the chairmanship of Dr Russell Pargiter, and a Board of Continuing Education, formed in 1983 as the first College venture into that important area.⁵⁷

A Board of Research, chaired by Professor Graham Burrows, had been formed in October 1983 to stimulate, promote, and encourage psychiatric research and research training, to monitor and disseminate research, and where possible to increase resources for psychiatric research.⁵⁸ Also new was the Politics and Psychiatry Committee, headed by Dr George Mendelson, which dealt with the abuse of psychiatry for political purposes in totalitarian regimes, especially the Soviet Union. A fifth, rather *sui generis*, new committee was the Presidential Appeal Committee (later

known as the College Appeal Committee), established in 1983 to raise money for the College through professional fund-raisers and fund-raising bodies.⁵⁹ Since 1974, a Board of Accreditation, to oversee training facilities for psychiatric students, had been established. And in 1984 the College was in the process of amalgamating the Board of Censors and the Board of Accreditation into a single body. In other respects the committee structure had changed little in the previous decade.

By 1994, however, the committee structure had altered quite considerably. This was partly a component of the long-term response to Chelmsford and Townsville, with the demands they produced for much greater accountability, and partly an effect of the College's further growth in numbers and complexity. It was also the outcome of greater professionalisation and specialisation in all the College's activities. As noted earlier, this decade saw the formation of a number of major committees designed to improve the delivery of psychiatric services in a variety of ways. The Board of Practice Standards under the chairmanship of Dr John Ellard, the Committee for Continuing Medical Education convened by Dr Keith Mayne, the Clinical Practice Advisory Committee chaired by Dr Ellard, the Quality Assurance Committee under Professor Gordon Parker, and a Professional Conduct Committee under Dr Joan Lawrence, all emerged from the resolve of the College not to see any repetition of Chelmsford or Townsville.

In the past decade a number of new College sections were instituted — the Section in Psychiatry of Old Age under Dr Edmund Chiu, the Section of Psychotherapy chaired by Dr Craigie Macfie, and the Section on Alcohol and Other Drugs chaired by Drs Les Drew and Stephen Jurd. As well, an Interim Section on Consultation-Liaison Psychiatry, convened by Professor Graeme Smith, held its initial meeting at the 1994 College Congress in Launceston.⁶⁰ The

Fellowships Board, under the chairmanship of Professor Bruce Singh, now consisted of a Committee for Training (chaired by Dr Jonathan Phillips), a Committee for Examinations (chaired by Associate Professor John Condon), and a Committee for Training in Child Psychiatry (chaired by Professor Robert Kosky).

Several new smaller committees were also established during the past decade, including the History Committee, the Publications Committee, a Committee on the Role of Psychiatry in the Family Court, and the Ian Simpson Award Committee. Owing to the professionalisation of the College's headquarters and the appointment of a Registrar/Executive Director and other members of the College secretariat, Council members received reports and proposals from College committees in an attractively bound thoughtfully compiled agenda. This incorporated the report of each committee, which previously was circulated in loose photocopied form. Given the enormous size and complexity of the College's infrastructure, it is difficult to appreciate how the General Council could possibly keep abreast of the bewildering range of reports it had to consider.

The loci of the origins of the College's many committees are of interest. Those original and major committees founded in 1961 and in 1965-71, as well as those of the 1989-94 post-Chelmsford period of reforms, chiefly emerged from the College's executive. They were created from above, by leaders who were aware of serious gaps in the College's structure. Other committees, especially those which have become sections, and smaller committees (for instance the Social Issues Committee and the History Committee) were instituted from below, and reflect the enthusiasm and specific areas of expertise of a wide variety of interest group areas within Australasian psychiatry. This balance has probably been healthy, and has enabled the College at once to evolve a wide-ranging infrastructure of necessary groups, to correct its former errors, and to tap

into the interests and expertise of its members. That the College's committee structure has been relatively stable and successful, yet has been able to evolve fairly rapidly and to branch into new and growing areas of psychiatric life, is surely testimony to the College's healthy state at the half-century mark.

7 The Examination and Training Process

In this chapter, the important matters of the examination and training system of the College will be examined in more detail. The possibility that the Association might create its own DPM had been discussed from that body's earliest days. In mid 1949, Dr Donald Buckle chaired a subcommittee of the AAP to deal with the question of a postgraduate DPM, and the Association's *Newsletter* presented a brief description of the content of a 'full-time refresher course in psychiatry (one month)'.¹ In 1950, the Association's *Newsletter* pointed out that 'owing to the variation in standards for the DPM in different states (Vic., NSW, and Queensland), the AAP is approaching the Vice-Chancellors Committee of the Australian Universities and the Post-Graduate Federation urging that the curriculum for the DPM as laid down by the AAP be adopted'.²

Throughout the 1950s, the Victorian branch of the AAP helped the Melbourne Permanent Post-Graduate Committee to organise a DPM course in psychiatry. With an enrolment fee of 14 guineas, the 1953 course attracted twelve students.³ In conjunction with this, the AAP held a number of all-day symposia on selected subjects. The AAP's January-March 1953 *Newsletter* presented a list of eighteen lectures arranged for the program.⁴ At the same time, the subcommittee headed by Dr Buckle reported on its proposals for a uniform DPM throughout Australia.⁵ The *Newsletter* also reported from time to time on the training requirements for psychiatrists in Australasia, and how these compared with training overseas.⁶

The first concrete attempt by the Association to create its own examination system was the Diploma of Psychological Medicine instituted by the Association in 1960-61, and existing for less than a decade before being replaced by the new examination system devised by Professor David Maddison in 1966 and implemented from 1970. The original regulations concerning the Association's DPM were approved by Council at its meeting on 13 May 1961, and it is perhaps worth placing on record what candidates for the DPM were supposed to master. The proposed regulations of May 1961 appear in Appendix 4. It will be seen that, compared with the examination today, the first Association/College DPM was far more theoretical and much less practical and, indeed, did not assess candidates on their ability to assess or treat patients with a psychiatric illness. It was not particularly successful in attracting candidates, and experienced a pass rate even lower than that of recent times. In 1962, only three of ten candidates passed Part I of the examination.⁷ The first Association DPM ever awarded went in 1963 to Dr Joan Lowrey of the Queensland branch. Over twenty years later, in 1987-89, as Dr Joan Lawrence, she served as the College's President.⁸ The probable nonrecognition by several states of a DPM awarded by a non-statutory body led directly to the transformation of the Association into the College in 1963-64.

The major innovations of the 1966-67 reforms spearheaded by Professor Maddison were as follows: first, the ANZCP Part I DPM examination was dispensed with, while the Part II examination, which remained, was given a more clinical orientation.⁹ Professor Maddison introduced his great innovation, the submission of written work in the form of case histories. As Singh and Doherty put it:

Ten case histories of patients seen during training were to be presented. These case histories would cover at least five specified cases. These were: a patient treated by psychotherapy for fifty sessions, a patient seen in the long stay wards of a mental hospital, a child or adolescent patient, a patient with an organic mental syndrome, and an acute psychiatric patient. The remaining five were to be 'free choice.'¹⁰

The aim of this innovation was to test, in a far more realistic and insightful way, the candidate's 'understanding of clinical psychiatry, his/her ability to formulate a meaningful picture of various psychiatric patients and of the issues involved in the diagnosis and treatment of common clinical problems', and the candidate's familiarity with a wide range of patient types.¹¹

The new examination also modified the written part of the test, reducing from four to two the number of written papers. The papers specifically testing a candidate's knowledge of biological and behavioural sciences disappeared, and were replaced by more general papers testing a wide range of relevant subjects.¹² The written part of the examination was also deliberately intended to serve a screening function, preventing weak candidates from proceeding to the more significant case histories.¹³ The oral and clinical parts of the examination were conducted over two days, with a third day used for a viva in the case of borderline candidates.¹⁴ It was envisaged in 1967 that the first day of the examination would consist of two sessions. In the morning, the candidate would examine a long case for sixty minutes and then be examined by two censors for thirty minutes; the afternoon routine would be similar, although a new case would be examined and two different censors would examine the candidate. The four censors

would then decide which candidates were eligible to proceed. Some candidates were eliminated at this point.

On the morning of the second day, candidates were interrogated regarding their general knowledge of psychiatry (especially in the behavioural sciences) by one censor and a behavioural scientist, while in the afternoon they would undergo an oral examination in psychiatry and medicine, with emphasis on biology, by a psychiatrist, neurologist, psychologist and general physician. Again, an assessment would be made on the candidates' abilities at this point, with some invited to appear before the Board of Censors on the third day and others invited to retire. The third day of the examination also entailed a mandatory appearance before the Board of Censors, although the final viva was reserved for borderline candidates and those exempted from other parts of the examination, usually those candidates who had practised overseas.¹⁵

This examination procedure is obviously traumatic to candidates and exhausting to the College censors, who have had to devote an intense period of concentration twice a year to examinations, upon which the careers of the candidates often depend. Professor Ross Kalucy, Chief Censor from 1984 until 1988, recalled that many promising candidates initially failed the examination, then subsequently passed 'and are very good psychiatrists'.¹⁶ One candidate sat the examination six times. The traditional wait for the handing out of sealed envelopes at the end of the Day One exam, with each candidate being told whether he or she had passed or failed, is recalled as a terrifying ordeal by many candidates. The thrust of the reforms introduced by Professor Maddison, with their de-emphasis of theoretical knowledge compared with a demonstration of clinical skills, may be quite Australasian in nature — Australasian psychiatry is sometimes described as practical and eclectic compared with models of psychiatric education

in Britain or the USA. The case history requirement is unique among international examining bodies in psychiatry, such as the American Board of Psychiatry, although it is similar to the requirements of a number of other Australasian medical specialist bodies.¹⁷

The College's training and examination process has been subject to a certain amount of criticism from members. The emphasis on practical clinical experience in the form of the case histories was, for instance, criticised by Professor Peter Burvill in an article in the *Australian and New Zealand Journal of Psychiatry* in 1988. Professor Burvill claimed that:

The major lack of the current College examination process is that the theoretical base of our discipline, both biological and non-biological, as opposed to clinical practice of psychiatry, is not adequately examined. If the College appears to downgrade the significance of this knowledge ... trainee psychiatrists, like all students, will likewise give it low priority in their preparations in their future career.¹⁸

Professor Burvill's paper attracted a good deal of commentary in response. Letters represented a range of opinions, from psychiatrists echoing his view to others labelling it 'a backward move'.¹⁹

The success enjoyed by the new system of examinations has been analysed in some detail by Dr G.W. Mellsop in an article published in *Medical Education* in 1980.²⁰ Mellsop analysed the 593 applications for membership in the College by 370 candidates in the seven years 1970-76. He found that candidates whose medical education took place in Australia were consistently more likely to pass than those educated elsewhere. The Australian-educated experienced a 51 per cent pass rate, compared with 46 per cent for those educated in New Zealand, 40 per cent in Britain, 27 per cent

in India, and 14 per cent in other Asian countries.²¹ The overall pass rate during this period was 'fairly constantly of the order of 45 to 50%'.²² Among those educated in Australia, graduates of Queensland universities performed best, with a 70 per cent pass rate, compared with only 43 per cent among graduates of the University of New South Wales, the university with the worst record.²³ Younger applicants did better than older ones. This was because, often, older applicants had sat the examination before and had failed. Mellsop's study concluded that:

The five most important [independent variables] for predicting a fail were, in order, number of applications, applicant's age, graduation from India or Sydney Medical School, and post-graduate training in England. The four most prominent positive predictors were Victorian post-graduate training, possession of an MD, New South Wales postgraduate training, Queensland post-graduate training.²⁴

In the later 1970s a number of changes were devised. Local branch examiners were introduced for Day One long cases in 1979 to save costs and to increase knowledge of the examination process in the branches.²⁵ In October 1976 a major change was introduced by General Council into the entrance examination, effective from the beginning of 1978. It raised the training period from three to five years, in line with that of other medical specialist colleges in Australasia.²⁶ In addition to the Maddisonian examinations, known now as Section I, a Section II examination was inaugurated. It required candidates to present either five additional case histories or a dissertation. These were to directly relate to the subject studied in the candidate's elective year, itself introduced as part of the lengthening of the training period. To balance these changes, the Section I

requirement was reduced from ten to five case histories in the obligatory five areas introduced in 1970.²⁷ Dissertations based either on original research, a comprehensive literature review, or a discussion of a theoretical aspect of psychiatry, came to be preferred by a majority of candidates and censors.²⁸

Data has been collated by Professor A. McFarlane, and published by Singh and Doherty, about the pass rates in the Section I component of the examination in 1980–89, that is, after the lengthening of the training period and the introduction of a Section II examination just described, which was taken by a total of 894 candidates in this period.²⁹ The failure rate among the five case histories was extremely low — 8.7 per cent among candidates for the acute case, 4.9 per cent for the chronic case, 7.7 per cent in the child psychiatry case, 5.9 per cent for psychotherapy, and 4.7 per cent in the organic case.³⁰ With the two papers, however, there was a 24.5 per cent failure rate in all, while the failure rate among the vivas was often higher still, ranging up to 34.2 per cent among candidates for the Day One viva.³¹ Among all candidates in this nine-year period, the failure rate was 41.4 per cent — very substantial, but lower than the failure rate found in the study by Mellsop of the 1970–76 period. This indicated (perhaps) that the quality of the students, or their teachers and the program, had improved over the two decades.

The rate of failure at the dissertation level was extremely low: Singh and Doherty noted that of 193 dissertations submitted in 1989–90, only 6.7 per cent failed.³² Numbers of candidates examined have risen steadily in recent years. In 1990, the Committee for Examinations conducted examinations in Perth, Dunedin and Sydney. A total of eighty-eight candidates submitted case histories, of whom eleven (12.5 per cent) failed. Of the 145 candidates who sat the written examination, forty-nine failed (33.8 per cent). A

total of 133 candidates attempted Day One of the clinical examination, of whom fifty-eight failed (43.6 per cent). In Section II, ninety-one candidates submitted dissertations and eighty-one passed (88 per cent). Of the eight candidates for the special Day One viva, three (37.5 per cent) passed. In all, ninety-four candidates completed all sections of the examination in 1990 and were admitted as fellows.³³

In December 1992 a series of major changes was introduced in the examination process, described by Singh, Doherty and Kalucy as 'the most major changes in its examination procedures since the examination was established'.³⁴ The basic philosophy underlying these changes included a greater integration of training and examinations, a greater continuous assessment, a less onerous Section I hurdle and greater opportunities for the identification of unsatisfactory candidates. These changes affected all trainees who commenced after December 1992.³⁵

By the mid 1990s these further changes had been incorporated in the examination procedure, with the introduction of a separate general medical examination; a requirement that candidates address psycho-social as well as medical issues in the patient examination; and a change in the mechanism of the examination so that all candidates would attempt both Day One and Two examinations, ending the dreaded pass/fail envelope after Day One.³⁶ These changes followed a review of the training and examination by-laws and explanatory notes which took place in 1990-91, providing a vertical structuring in the operations of the Fellowship Board which contains Branch Training Committees as subgroups of the Committee for Training. These are not part of the branch structure, but rather a devolution of the responsibility within the training and examination process which remains centrally run and co-

ordained.³⁷ As well, the specified case histories were explicitly linked with training requirements in 1991.³⁸ In the 1980s the behavioural sciences viva was renamed the consultancy viva, in order to test the ability of the candidate to 'put himself/herself into ... some of the legitimate or potential roles that a psychiatrist might be asked to fulfil', such as an expert witness to the Family Court.³⁹

One vexed question down the years has been the College's exemption policies towards prospective fellows who completed their DPM at a university which offered the diploma independently of the College, or abroad. A major element in the dilemma faced by the College in this area has been that its own examination has consistently been more rigorous than alternative methods of qualification. In practice, since the mid 1970s the College has moved from the near-automatic exemption of candidates who had gained Part I of the DPM elsewhere from the requirement to sit the College Part I examination, to a much more rigorous policy on exemptions.⁴⁰ The National Specialist Qualifications Advisory Committee accepted that the College fellowship was the only recognised specialist qualification in Australia enabling its holder to practise as a specialist/consultant psychiatrist. Other qualifications are assessed in relation to their equivalence to the College fellowship. In 1988, a special Day One flagged viva was introduced, designed to improve the Committee for Examinations' flexibility in regard to experienced consultants.⁴¹ The issue of the recognition of degrees received abroad continued to receive attention. A reciprocity agreement was negotiated with Britain's Royal College of Psychiatrists and it appears, following lengthy discussions, that similar agreements with other overseas Colleges may be negotiated.

From 1974 onwards, the Section (later Faculty) on Child Psychiatry offered a training program in child psychiatry

based on the minimal training standards developed by the section. Child psychiatry was the earliest specialist area to develop a separate section within the College, and has always been a pioneer. The development of a specific training scheme in child psychiatry probably stemmed from a realisation that only 5-6 per cent of Australian psychiatrists were trained in child psychiatry.⁴² It may also have grown out of the international experience of Dr Rickards, who had attended the First Conference on Training in Child Psychiatry in Washington DC in 1963.⁴³ By the mid 1980s the College-accredited training program in child psychiatry was available in most state capitals in Australia and in Auckland and Dunedin in New Zealand.⁴⁴ Child psychiatry training in the College was 'essentially of an apprenticeship type with extensive supervision of clinical practice as its cornerstone'.⁴⁵ Each training program in a major city comprised a Director of Training and a number of supervisory child psychiatrists, and included a formal academic component as well as clinical experience.⁴⁶

The examination of trainee child psychiatrists under this program was governed by a Subcommittee for Training in Child Psychiatry, and consisted of three senior members of the Section on Child Psychiatry and one member of the Committee for Examinations as well as the chairman of the committee. This Subcommittee has undertaken the accreditation of programs, candidates and supervisors, and the progressive assessment of candidates, and recommends candidates who have satisfactorily completed training to the Fellowships Board and then to General Council, which then awards a Certificate of Satisfactory Completion of Training in Child Psychiatry.⁴⁷ All training programs adhere to the Minimal Training Standards for Accredited Child Psychiatry Training Programme developed most fully in 1983, and revised since.⁴⁸ Even in the 1990s, the program was unique

internationally as a postgraduate course.⁴⁹ In 1991, there were thirty-one accredited trainees in the College's child psychiatry program, with ten fellows successfully completing the program in 1990.⁵⁰

Detailed information on the training of psychiatrists in Australasia is available for the period just before the introduction of the Maddisonian examination system.⁵¹ In 1967 a study by Professor Brian Davies of the University of Melbourne found major differences in training among the Australian states and New Zealand. In New South Wales, postgraduate training was carried out by the Institute of Psychiatry, a unique state-chartered body which patterned its training program along the lines of university DPMs.⁵² The Institute was in the process of altering its pattern of teaching to structure it upon the College membership examination being developed to take effect in 1970. The Institute's formerly sharp distinction between pre-clinical and clinical teaching was being abandoned to place greater emphasis on clinical psychiatry to match the new emphasis on case studies in the College examination.⁵³ In Victoria, training in psychiatry was organised by the Victorian Mental Health Authority in association with the University of Melbourne, and offered a three-year training course that led to either the University of Melbourne or the College DPM.⁵⁴ This course was available for all doctors undertaking training with the Victorian state services involving not less than a three years' engagement. Doctors were usually attached to a country hospital in the first year, and moved to the Melbourne metropolitan area in the second year, instruction then being available at the University of Melbourne and local hospitals.⁵⁵

In Queensland, training facilities for Part I of the DPM were arranged by the University of Queensland, with candidates for Part II also attending a fortnightly seminar

series organised by the university. The Queensland mental health services organised a recruitment pool among those who undertook study for the local DPM.⁵⁶ In South Australia, postgraduate training was co-ordinated by the Postgraduate Medical Committee of the University of Adelaide, with a weekly session of detailed training for registrars organised by the state's Department of Mental Health.⁵⁷ Instruction at the time was much more limited in Western Australia and Tasmania. The University of Western Australia's Department of Psychiatry did not provide instruction in physiobiology or biochemistry, although it did in other aspects of psychopathology and mental illness. Heathcote Hospital and the Royal Perth Hospital were recognised by the College as psychiatric hospitals for training purposes.⁵⁸ At the time, Tasmania had no recognised clinical training facilities in psychiatry.⁵⁹ In New Zealand, only Sunnyside Hospital in Christchurch was fully recognised for College membership training, although a DPM course was also run by the Department of Psychological Medicine at the University of Otago.⁶⁰

Thus, even in the late 1960s, training for psychiatrists was patchy and depended on the commitment of each state to a coherent program in this area. New South Wales and Victoria were clearly in advance of the other states or New Zealand. The absence of coherent central direction in Australasian psychiatric education had been criticised as early as the mid 1950s by Dr Alan Stoller, who recommended (for Australia) more uniform federal support along the lines of the National Institute of Mental Health in the USA.⁶¹ Paradoxically, this lack of wide availability of training facilities, or of uniformity or central direction in psychiatric postgraduate education in Australasia, probably left the way open for the College to impose its own training and examination program upon the Australian states and New Zealand. It is, for instance, difficult to imagine that the

Maddisonian examination system would have gained widespread acceptance so readily if a better alternative had been in place, especially one strongly supported by the national or state government.

The institution and wide acceptance of the College examination facilitated the imposition of common standards throughout Australasian psychiatry, and made it necessary for the College to create separate bodies to oversee the training and examination of candidates. In the 1960s and early 1970s, accreditation and training matters had been the responsibility of the Board of Censors. In 1975, however, Council created a Board of Accreditation under Dr John Ellard, who was primarily responsible for drawing up its terms of reference and who served as its chairman for many years.⁶² Under those terms its function was 'to advise the General Council on all matters pertaining to the accreditation of institutions and training programs' and 'to submit for the approval of General Council regulations which will determine facilities and clinical opportunities which an institution or training programme must provide for trainees before the General Council will accredit [it]'.⁶³ The Board of Accreditation consisted of a chairman and five other members, one of whom was to be the Censor-in-Chief or his nominee.⁶⁴

The task facing the new board was considerable. All training programs were reviewed annually, and took the form of agreements between individual candidates and particular institutions.⁶⁵ This was done, rather than accrediting hospitals or accrediting for longer periods, because of the diminution in quality which might result from the loss of one or two key staff, and the difficulty of the accreditation of institutions throughout Australia, New Zealand and South-East Asia.⁶⁶ Many other difficulties were encountered by the board, for example the considerable expense entailed in annual reaccreditation and difficulties in

finding qualified supervisors. It was also often difficult to distinguish between the duties and responsibilities of the Boards of Accreditation and of Censors.⁶⁷ In 1984–85 it was decided to merge the two into a Fellowships Board which included both training and examination functions.⁶⁸

As with the examination system, by-laws for training and examination were extensively reviewed by a College working party in 1992. It more closely linked the training program with the presentation of case histories, the theme which forms so large a part of the examination process.⁶⁹ Increasingly, the College has been liberal in granting permission for part-time training, which is especially useful to women with young children or to trainees with other employment or duties. In recent years much responsibility for overseeing training has devolved to the branch level, while the Committee for Training has also been concerned to encourage trainees to perform part of their training in remoter areas where there are few practising psychiatrists.⁷⁰ On-site visits to hospitals and other training facilities by the committee are regularly conducted, and are subject to strict guidelines and protocols.⁷¹ In 1982, an Association of Psychiatrists in Training was established (building on branch Associations established before), which has been active establishing branches throughout Australia and New Zealand. The College demonstrated its interest in this area by including in the Committee for Training a representative of the Association of Psychiatrists in Training.

In the 1990s the College's Fellowships Board had an elaborate committee structure, comprising the board itself, a Committee for Training, a Committee for Training in Child Psychiatry, a Committee for Examinations, and an Exemptions Subcommittee, with a total membership of thirty-four in December 1991. In that year, the Committee for Training had nine members and the Committee for Examinations had eighteen.⁷² With its secretarial and

infrastructural assistance at the College headquarters and in the branches, the examination and training process probably comprised the largest single component of College work, dwarfing all its other efforts in terms of personnel and energy. The contemporary College secretariat includes an Assistant Registrar (Fellowships), Margaret Ettridge, and an Administrative Officer (Training), Sheena Mathieson, as well as several secretary/assistants solely concerned with this area. The effort expended by the College on supporting its monopoly on the training and examination of the growing number of psychiatrists in Australasia, so long in being achieved, would have astonished and delighted the early leaders of the Association and even Professor Maddison when his seminal reforms were first proposed.

8 College Congresses and Research

For many fellows of the Association and the College, possibly its most visible public face consists of the annual meetings or Congresses which have taken place almost since the earliest days of the Association. The annual Congress serves a variety of separate but important functions. It is perhaps the major collegial social gathering for Australasia's psychiatrists, allowing them to see old friends and colleagues, let their hair down amid their professional brothers and sisters, and take their family on a holiday to another Australasian city they might otherwise be unlikely to visit. The Congress also serves as the venue for the College's annual general meeting and for a semiannual General Council meeting. It is the major ceremonial occasion in the life of the College, and one where the College's prizes are awarded. In recent years it has generated positive publicity for both the psychiatric profession and the College in the local media.

Perhaps the most important role of the Congresses, at least in terms of the percentage of time devoted to it, is to facilitate the presentation of scientific papers by members of the College. The College's Congresses are, and have long been, the showpieces of new and significant research in psychological medicine by Australasian psychiatry, and thus function as litmus tests for new and important research conducted here. The best of these papers are normally published in the College's *Australian and New Zealand Journal of Psychiatry*, in another learned journal or in a monograph, but the College offers the opportunity to present a researcher's efforts before an informed and sometimes critical audience.

The many roles served by the annual Congresses were fairly clearly defined surprisingly early in the history of the Association.

Nonetheless, it is rather difficult to ascertain just when the Association's initial annual meeting in the accepted sense was held; the most accurate verdict on this is that by the mid 1950s the Association's annual meetings were surprisingly similar to those held today, although of course they were smaller and required less elaborate planning. (A complete list of the General Meetings and Congresses of the Association and College appears in Appendix 5.) In a sense, the Association's initial formation meeting, convened by Dr Maudsley in Melbourne in October 1946, also served as its inaugural annual meeting. It was attended by twenty-seven psychiatrists from throughout Australia and conducted as a business meeting.¹ The following April, a Council meeting of the Association was held in Adelaide, while in October 1947 a General Meeting was held at Todd Hall, Sydney, attended by twenty-five psychiatrists. That occasion also saw the Association hold a Council meeting, attended by eleven members of the Council.

Thus the General Meeting of October 1947 was the first official gathering of the Association attended by a larger group of psychiatrists than the Council. Moreover, it saw the election of new office-bearers, heard a financial statement, and heard the first paper presented at an Association venue when Dr S.J. Minogue read a paper on 'Alcoholics Anonymous'.² The next General Meeting, in October 1948, held in conjunction with a Council meeting, saw an informal meeting of the Association held at the Windsor Hotel.³ Scholarly papers were read at those early Council meetings.⁴

The 1949 General Meeting of the Association was held in Hobart and was attended by seventeen fellows. An after-dinner forum held following the meeting commenced 'with

some discussion on alcoholism'.⁵ The October 1951 Annual Meeting in Sydney saw further evolution on the way to being a conference in a recognisably modern sense, it being termed 'a huge success both scientifically and socially'. That gathering, at Gladesville Mental Hospital, was noteworthy 'not only for the magnificent lunch and fine clinical meeting, but also for their splendid souvenir programme and menus printed by patients in their own O.T. workshop'. Discussions on 'the psychopath' and on 'termination of pregnancy on psychiatric grounds' were also held.⁶ The following Annual Meeting, held in Adelaide in October 1952, 'was considered by many, both in its clinical and social aspects, as being the best meeting we have ever held', and involved psychiatrists from England and the USA, as well as about twenty Australasian psychiatrists from states other than South Australia.⁷ It was the first Annual Meeting for which a scientific program survives. That program is reprinted here to show changes since those days.⁸

27	7.30	Dr H.M. Birch — Presidential Address
	October	p.m.
28	11.30	Dr S.J. Minogue — 'Psychiatry from books,
	October	a.m. not from life'
	2.30	Dr N.V. Youngman — 'My impressions of
	p.m.	American psychiatry'
	3.45	Dr A.R. Phillips — 'The role of the psychiatric
	p.m.	consultant in social case-work'
	8.00	Dr R. Mottram Torre — 'World aspects of
	p.m.	mental health'
29	10.00	Dr D.F. Buckle — 'The teaching of psychiatry'
	October	a.m.
	2.30	Symposium: 'Present-day concepts of
	p.m.	schizophrenia'
		Dr Orde Poynton — 'Aetiology of

		schizophrenia’
		Dr A. Stoller — ‘The organic approach to schizophrenia’
		Dr W.F. Salter — ‘The psychodynamic approach to schizophrenia’
	6.45	Dinner and discussion: ‘The role of the community in mental health’
	p.m.	
30	10.00	Dr R.A. Noble — ‘Abnormal behaviour in children’
October	a.m.	Dr R.T. Binns — ‘Presentation of a case of mental regression’

That Annual Meeting was also the first to feature a ladies’ committee, convened by Mrs Southwood, ‘to arrange a programme of entertainment for visiting ladies’ — a feature of conferences unlikely to be encountered today!⁹

The yearly meetings of the Association and the College followed the pattern set no later than the 1952 meeting — a mixture of scientific papers and reports, visits to local clinics, and social events, together with a Council meeting and the AGM. The 1953 meeting, in Sydney, was similar, extending over five days. It included a mixture of administrative meetings, scientific papers, social gatherings and professional visits to Callan Park Hospital and Broughton Hall Psychiatric Clinic.¹⁰

A highlight of all annual meetings was the presidential address, which was often published in the *Medical Journal of Australia*. At the time of the replacement of the Association by the College in 1964, Dr J.B. Williams produced a list of those, which is included in Appendix 5.¹¹

With the birth of the College in 1964, the name of the annual meeting was changed to the perhaps more grandiose term ‘Congress’, the title by which it is known today. The presidential address (or College address), is a major ceremonial occasion in the life of the College. Also, for

some years Semi-Annual Scientific Meetings were held as a forum for scientific papers additional to the Congress. In May 1965, for instance, a Semi-Annual Meeting was arranged at Maudsley House by the Section on Child Psychiatry.¹² These semiannual sessions were gradually replaced by programs specifically organised by a section, devoted to a specific area of psychiatry, which have been a feature of the College in recent years.

During the later 1960s, the organisation of Congresses was made much more bureaucratised, with a Scientific Programme Committee and a Host Branch Committee, responsible respectively for the selection of papers and speakers and for the social and administrative organisation of the Congress.¹³ The infrastructural side of the Congress — by that time often attended by several hundred people, including the spouses and guests of fellows — had become a major logistical exercise, requiring the booking of hotels and site venues, airline and travel reservations, and the special needs of a medical conference with regard to the availability of papers, photocopying machines and the like.

Textbook publishers and (more controversially) pharmaceutical companies had become a highly visible part of College Congresses by the 1970s. Since the mid 1960s the venues of future Congresses were decided long in advance: in 1965, the site of the 1972 Congress (Tasmania) had already been announced.¹⁴ From the mid 1960s, the plenary sessions at annual Congresses were given themes such as 'Australian Transcultural Psychiatry' (the theme of the 1965 Sydney Congress), and 'Aggression' (the theme of the 1970 Congress in Melbourne). This custom continues, with the plenary session of the 1991 Congress being on the theme of 'The Challenge of Practical Psychiatry' and the 1994 Congress in Launceston having the theme of 'Expert Systems in Psychiatry'. The sheer number of papers presented — over 100 at Congresses in the 1990s — meant

that parallel sessions had to be held, and each Congress included increased numbers of symposia and special interest meetings.

From 1950 until 1985, Congresses were normally but not invariably held in October; since 1985, May has been the normal time of Congresses, although there have been occasional variations, such as the 1992 Canberra Congress, held at the end of September and early October. A major innovation was begun with the 1978 Congress, which was held in Singapore, the first off-shore Congress; subsequently Congresses have been held in Hong Kong (1981) and Honolulu (1989).¹⁵ Although Congresses have normally been held annually, none took place in 1984 or 1993 as only eighteen months separated the preceding and succeeding events.¹⁶ Congresses rotate among the branches, normally to capital cities, and there has been a trend to smaller cities as venues with the 1994 event in Launceston and 1995 in Cairns. Because of this rotation, no single city (or state branch) need expect the considerable chore of helping to organise the Congress more frequently than every eight years or so. For example, Sydney was the venue of the 1980 Congress and did not host it again until 1988. Although the relevant Host Branch Committee is officially responsible for the organisation of a Congress, much of the administrative work is performed at the College's headquarters. Margaret Ettridge has been in charge of this since the early 1970s and several other members of the College staff are needed to assist in this time-consuming process. The innumerable details of the Congress's infrastructure are now assisted by professional conference organisers, and conferences feature lengthy, high-quality printed program brochures.

Although the annual Congress continues to be the centrepiece of the organisation's collegial life, and will probably always be so, a number of queries about its utility in the contemporary Australasian psychiatric world have

been repeatedly raised by fellows. As noted, while in the early days the General Meeting/Congress was virtually the only venue for the reading of scientific papers in psychiatry to an Australasian audience, during the past quarter of a century a variety of sections and groups within the College have held their own special interest scientific conferences. By 1989 there were five such sectional scientific gatherings.¹⁷ In particular, the Section of Social and Cultural Psychiatry and the Faculty of Child Psychiatry have held their own annual conferences for many years; these have also been carefully organised and rotate among the larger cities.

A steady stream of critiques of the College's Congresses have appeared since the early 1980s. In 1982, for example, Dr Russell Pargiter produced a wide-ranging paper entitled 'A Review of the Form, Cost, and Attendances of the Annual RANZCP Congresses', which noted criticism that 'Annual Congresses of recent years have become lavish spectacles which are to the financial advantage of those who can claim it as a tax deduction and a disadvantage to those who cannot', and that 'costs are increased because Annual Congresses are held in expensive luxury accommodation'.¹⁸ Dr Pargiter noted that registration fees for Congresses rose from \$73 in 1973-75 to \$151 in 1979-81: in other words no higher than the retail price index.¹⁹ Another point which has been raised against the College Congresses is that, in recent decades, the percentage of delegates attending has declined in relative terms and perhaps in absolute terms.

Since the College has expanded so enormously, it has probably become unrealistic to expect anything else: clearly, many fellows will be unable to attend Congresses for valid personal or professional reasons or see no benefit compared with the costs involved. Dr Pargiter found, however, that from 1972 to 1980 the percentage of College

members did *not* decline. While 22 per cent of College members attended the 1972 Hobart Congress (158 out of 710), 26 per cent attended the 1980 Sydney Congress (296 of 1154), with, respectively, 40 and 38 per cent of College associates also attending.²⁰ The higher percentage of associates attending was presumably due to the desire of younger members of the College to network with established members for professional reasons, or perhaps because more were involved in research presentations.²¹ It was also suggested that private sector psychiatrists have increased at the expense of those from the public and academic sectors, possibly because the former, often better-paid, can afford the costs or perhaps because of relative scheduling problems.

In more recent years, the annual College Congress has continued to generate controversy. The 1988 Congress was criticised by feminist psychiatrists, especially Dr Carolyn Quadrio, for its failure to include women among its plenary speakers.²² In 1989, the College discussed the future of Congresses at length, particularly the issue of expensive hotels and accommodations, with Dr Pargiter again analysing the issues and range of possibilities open to future Congresses, such as using a university venue rather than a hotel or conference centre, and dispensing with the social program.²³ In 1990 Dr Barrie Kenny, Honorary Secretary of the College, also examined the issues, recommending that the Congress should be held every second year, that it should take place during school holidays, that its continuing medical education aspects should be emphasised, and that a major function of Congresses should be to welcome newly elected fellows.²⁴ Dr Kenny also claimed that the actual cost to Congress goes was extraordinarily high, putting the time cost, including lost income, at greater than \$10 000,²⁵ a remarkable figure. He also noted that Congresses were often of little relevance to most people's clinical practices

and that alternative fora for sharing scientific research now existed.²⁶ In recent years, Congresses have gone beyond the presentation of individual scientific papers to include symposia and workshops on important issues.

Although the major purpose of the College Congresses is the presentation of scientific papers, the College's role in generating and fostering research through the provision of funding or College-based facilities has been very limited, especially before the recent past, and Australasian research in psychiatry has largely centred in other sources. Most research in Australasian psychiatry (as well as virtually all training of new psychiatrists) is apparently carried out at the university departments of psychiatry in Australia and New Zealand. Those departments in their fully developed form are relatively recent. In 1967 there were nine chairs of psychiatry or psychological medicine in Australasia, the oldest, at the University of Sydney, founded in 1923, but tenured only from 1956. In 1962 chairs were established at the Universities of New South Wales and Otago, in 1963 at the University of Adelaide, in 1964 at the Universities of Melbourne and Queensland, in 1965 at the University of Western Australia, and in 1968 at Monash University.²⁷ In the succeeding decades, although departments of psychiatry have certainly grown greatly in size, their actual number has not increased markedly, since they must perforce be attached to a university medical school and few of these have been established in Australasia since the 1960s. Although the number of universities in Australasia has grown from about thirteen in the late 1960s to nearly forty-five today, there were in the mid 1990s only two more university departments of psychiatry or psychological medicine than there were a quarter of a century earlier (at the Universities of Newcastle and Auckland). In contrast, by the 1990s there were literally dozens of university departments of psychology or health sciences.

On the other hand, the number of academic staff in university departments of psychiatry or psychological medicine has grown very significantly. In 1993-94 no fewer than thirty-one persons held chairs in psychiatry or psychological medicine at an Australasian university, while the academic staff employed at the ten universities which taught in this field numbered about 145.²⁸ Most of these — but, perhaps surprisingly, not all — were fellows of the College: of the thirty-four academics on the staff of the University of New South Wales' Department of Psychiatry in 1994, for example, twenty-four were fellows of the College; at Monash University the figure was nine of fourteen staff.²⁹ Among those holding chairs in psychiatry at an Australasian university in the mid 1990s are two former College Presidents, Drs Beverley Raphael and Basil James, as well as such well-known College figures as Drs Robert Adler, Gavin Andrews, Graham Burrows, Peter Burvill, Peter Ellis, Robert Finlay-Jones, Peter Joyce, Graham Mellsop, Gordon Parker, Issy Pilowsky, Sarah Romans, Bruce Singh, Bruce Tonge, John Werry, Chris Tennant, Robert Kosky, Scott Henderson, Ross Kalucy and David Copolov.

Despite the clear growth in the links between the College and the university community over the past few decades, highly productive scholars and researchers were confined (almost by definition) to a small percentage of the College's membership. Professor Gordon Parker, who examined this matter in detail for the period 1978-84, noted that 'despite an increase in College membership over the period, output by researchers appeared remarkably constant over the whole seven-year period'.³⁰ Looking at the eighty-nine most active researchers in Australasian psychiatry in this period (as determined by citation indexes), Professor Parker made one perhaps unexpected finding about these active researchers: that they were very disproportionately located in New South Wales, New Zealand and South Australia, with

Victoria and the other states being under-represented as venues of significant research.³¹ The academic journal which published by far the highest number of papers by researchers was the College's *Australian and New Zealand Journal of Psychiatry*, with eighty-two publications, compared with only thirty-two in the next highest, the *British Journal of Psychiatry*.³² Among the eighty-nine active researchers, 41 per cent were full-time university lecturers, 17 per cent were in full-time hospital employment with a conjoint university position, and 12 per cent were in full-time private practice, with smaller percentages employed elsewhere, such as in a teaching hospital position or a research unit.³³

Apart from university settings, the research-oriented members of the College have been active in a number of psychiatric research units. Perhaps the best-known is the Institute of Mental Health Research and Postgraduate Training in Melbourne, founded in 1956 as the Mental Health Research Institute.³⁴ Among the well-known figures who held positions with this Institute are Drs Alan Stoller (its first Director, in 1956–69), Richard Ball, John Grigor and Graham Mellsop.³⁵ A bibliography of research papers published between 1956 and 1971 which grew out of its programs included 1042 items.³⁶ In 1988 the National Health and Medical Research Council, together with Monash University and the Mental Health Research Institute, established a Schizophrenia Research Unit at Royal Park Hospital, Melbourne, whose co-directors were Professors David Copolov and Bruce Singh, both important figures in the College.³⁷

In recent years the College's direct role in fostering research has increased. A College Research Committee was established in 1975–76. Originally funded to a very limited level, its status grew significantly only in the 1980s. In May

1983 it co-hosted the first Seminar of Psychiatric Research in Australia with the Australian Society of Psychiatric Research.³⁸ During the mid 1980s the Research Committee was upgraded to become a Board of Research, with Professor Graham Burrows as its chairman, and increased its range of activities. In 1989 it funded eight research projects, produced a brochure on research and proposed a range of other activities such as research workshops.³⁹ The following year, it produced a RANZCP Directory of Research, listing the current research projects of approximately eighty fellows. By 1994, the directory had run into three editions. By the mid 1990s the board was actively attempting to redefine its role in the College.⁴⁰

One of the major vehicles for the presentation of research in recent years has been the *Australian and New Zealand Journal of Psychiatry*, which publishes the most significant scientific articles from a wide range submitted to it. In recent years the *Journal* has expanded considerably, reflecting the growth of important research being conducted by Australasian psychiatrists. By the mid 1990s it had grown into a quarterly journal which published more than twenty articles in each issue. In 1993 the average size of each issue was 183 pages, a great increase even in the space of a decade.⁴¹ While the *Journal* had increased significantly in size over the past ten years, so great has been the rise in high-quality Australasian research papers that the backlog in papers waiting for publication remained very high.⁴² The assessment of articles — which is now shared among over 100 expert referees — has always been strict.

Some information is available on the acceptance rate for the *Australian and New Zealand Journal of Psychiatry* during the 1970s. In 1974–75, forty-one papers were accepted, fifty were rejected, and seventy-one noted as ‘undecided’, presumably meaning that they might be accepted subject to revision.⁴³ The immediate acceptance rate was thus about

25.3 per cent. Among papers originally presented at the 1974 Perth Congress, fourteen of twenty-three were accepted, but of ninety-one presented at the 1975 Melbourne Congress only ten were accepted, with fifty-five undecided.⁴⁴ At present the acceptance rate is approximately the same. A Points of View column, containing 'short "punchy" pieces in which the author expresses a view regarding an important aspect of psychiatry', was introduced in the 1990s.⁴⁵

It would be quite impossible to mention more than a handful of the notable monographs and books on psychiatry which have been published by Association or College fellows, and the authors are painfully aware of how invidious and selective any such list must seem, and how galling the exclusion of many excellent works must be to their authors. Yet room must be found for mention of just a few works by College members, especially those not noted elsewhere.

Several important histories of Australasian psychiatry have been written by College figures, such as John Bostock's *The Dawn of Australian Psychiatry* (Sydney, 1968), C.R.D. Brothers' *Early Victorian Psychiatry, 1835-1905* (Melbourne, 1962), Sir Burton Burton-Bradley's *A History of Medicine in Papua-New Guinea* (1990), W.A. Dibden's *A Biography of Psychiatry: People and Events in the Development of Services for the Psychiatrically Ill in South Australia, 1939-1989* (1989) and A.S. Ellis' *Eloquent Testimony: The Story of the Mental Health Services in Western Australia, 1830-1975* (Perth, 1983). Four of these authors were Association/College Presidents.

A number of autobiographical or historical works by notable College psychiatrists have appeared, for example D.W.H. Arnott's *50 Years in Psychiatry* (Sydney, 1980), A.T. Edwards' *Patients Are People* (Sydney, 1968), R.S. Ellery's *A Cow Jumped Over the Moon: Private Papers of a Psychiatrist* (Melbourne, 1956), and E. Cunningham Dax's *Asylum to*

Community (1961). J.E. Cawte wrote several notable studies of anthropological psychiatry, especially works dealing with Aboriginal mental health, including *Cruel, Poor and Brutal Nations* (Honolulu, 1972), and *Medicine is the Law* (Adelaide, 1974). On a more popular level, one must certainly mention the best-selling works, with psychiatric themes, of Ainslie Meares (1910–86), such as *The Door of Serenity: Relief Without Drugs* and *The Wealth Within*, known throughout the world, as well as those by his son Russell Meares, such as *The Metaphor of Play* (1993).⁴⁶ John Ellard's excellently titled *Some Rules for Killing People: Essays on Madness, Murder and the Mind*, edited by Gordon Parker (Sydney, 1989), contains provocative and informative essays, and Professor Parker is the author of *The Bonds of Depression* (1978).

The work co-authored by Sidney Bloch with Peter Reddaway, *Soviet Psychiatric Abuse* (1984) (also published as *Russia's Political Hospitals*), was internationally influential. Bloch and Bruce Singh coedited *Foundations of Clinical Psychiatry* (1994), and Bloch also wrote the important *Psychiatric Ethics* (1992). Graham Burrows is the author of the *Handbook of Studies on Depression* (1977) and other works. Several College members have received *festschriften* of papers by colleagues in their honour, for instance Winston Rickards and Leslie Kiloh.⁴⁷

This brief list is only the tip of an enormous iceberg of research productivity and output, with literally hundreds of College fellows having written notable scientific papers. Some College fellows have been extraordinarily productive, with members such as Graham Burrows, Eric Dax, Gordon Parker and Alan Stoller, among many others, having written many dozens of papers, chapters and reports, as well as lengthier works, some of which have been internationally influential.⁴⁸

9 College Prizes and Fellowships

Throughout its recent history the College has rewarded meritorious achievement of various kinds by its members through a series of annual prizes. The College has also established a number of fellowships to assist Australasian psychiatrists wishing to travel overseas and to bring notable foreign psychiatrists to Australia and New Zealand.

In the period of the Association, only one prize was established, the Evan Jones Memorial Prize. In early 1948 Professor W.S. Dawson wrote to the Secretary of the Association, Dr Alex Sinclair, noting that Sir Sydney Evan Jones was gravely ill and suggesting that an appeal be launched to establish a prize in his honour. Jones was the first Superintendent at Broughton Hall Psychiatric Clinic in New South Wales, and a notable teacher of psychiatry to medical students.¹ In 1949-50, a sum of £300 was raised to endow the prize.² In November 1949 the Association established a subcommittee, consisting of Dr Charles Brothers, Professors W.S. Dawson and John Bostock, to consider what to do with this money.³ Little more was heard of the money for a surprising period of time, although Council minutes between 1950 and 1956 record that it was invested in Commonwealth of Australia bonds.

In 1952, it was decided to use the money 'to award a prize triennially for the most meritorious publication by an Australian or New Zealander' (presumably a psychiatrist) 'in the three years prior to the award'.⁴ There the matter rested, except for noting in Council minutes the fund's continued existence, until August 1956 when, at a Council meeting, Dr Maudsley asked pertinently: 'what had been done about the awarding of this prize?'⁵ It was soon

discovered that, in effect, nothing had been done in the seven years since the fund came into existence. A committee of adjudicators, consisting of Dr Maudsley, Professor Trethowan and Drs J. Williams (Victoria) and Ironside was appointed to consider entries for the prize, which was to go to the best original work in psychiatry under the terms agreed upon in 1952. Finally, in November 1957 the Evan Jones Prize was awarded for the first time, going to Dr H. Bourne of New Zealand. Seven entries for the prize had been received.⁶

In 1958 the terms of the prize were clarified so that only original work done specifically for the Prize, or an essay of the contributor's recent work, was eligible, rather than the best contribution to psychiatry written for another purpose, and it was reiterated that the prize was to be awarded every three years.⁷ In October 1960 the Evan Jones Prize was awarded for the second time, to Dr John Cawte of Adelaide.⁸ Dr Cawte received the award — £50 in cash — for his *Collected Papers, 1957-1960*, including his thesis, 'The Significance of Phenylketonuria in Australia' and ten other papers.⁹ In May 1963 the terms of the prize were again clarified and in October 1964 it was announced that Dr Cawte had again won.¹⁰ As a result — rather unfairly, it would seem — the Association decided that in future the prize would not be awarded twice to the same recipient.¹¹ In March 1969 it was discovered that no submissions had been made for the Evan Jones Prize that year, and it was also decided to award the prize biennially.¹² For reasons which are unclear, the Evan Jones Prize was not awarded again. From the late 1970s it was merged into the newly created Organon Junior (Evan Jones) Research Award.

Soon after the College was formed two other awards were established. In the middle of 1964 the College received, most unexpectedly, a gift of £A25 000 from a New

Zealand donor to establish the H.B. Williams Memorial Fund Travelling Professorship in Psychiatry in order to bring psychiatrists and related scientists to Australia and New Zealand 'in much the same way as the Sims Professorships in Medicine and Surgery'.¹³ This fund was established by Jan M. Williams of Hawkes Bay, New Zealand, in memory of her father, Heathcote Beetham Williams (1868-1961), a successful farmer and commercial investor.¹⁴ It was by far the largest gift the Association had ever received, and was evidence of the organisation's growing centrality to the Australasian psychiatric profession. Discussion ensued over how to use the money, and it was decided to ask branches and individual persons to submit the names of possible recipients of the award. Early in 1966 the first H.B. Williams Travelling Fellow, Dr T.F. Main of the Cassell Hospital, London, was appointed.¹⁵ The second recipient was the eminent psychiatrist Professor Desmond Pond of London Medical College, whose appointment was announced early in 1968.¹⁶ A shortlist of possible recipients of the next award, in 1971, drawn up by the College's H.B. Williams Committee, included such eminent figures as Erik Erikson and Jerome D. Frank.¹⁷ Professor Frank, of the Henry Phipps Psychiatric Clinic, Baltimore, was chosen as the third recipient, followed by Dr John Bowlby of the Tavistock Clinic, London, in 1973; Professor Leston Havens of Harvard Medical School (1975); Professor Chester Pierce of Harvard (1977); Professor Jolyon West of the University of California, Los Angeles (1979); Professor R.W. Kendall of Edinburgh University (1982); and Dr John Gunn (UK, 1985).¹⁸

In the middle of 1967 Roche Products provided the College with a grant, at the time limited to \$5000 annually, to provide for the appointment of a Roche Visiting Professor. This was also intended to bring distinguished overseas psychiatrists to Australia, although on at least one occasion

it was used to send an Australian overseas.¹⁹ The first Roche Travelling Professor was the American Dr Jules Masserman, appointed in 1968; he was succeeded by Professor E. Kringlen of Norway in 1969, and then by Dr Bryant Wedge (1970) and Professor Milton Rosenbaum (1972), both Americans. In 1974 Dr John Cade became the first Australian holder of this professorship. Subsequent holders have been Dr Jules Angst (Switzerland, 1976); Dr Isaac Marks (UK, 1978); Professor Griffith Edwards (UK, 1982); Professor George Vaillant (USA, 1985); Professor Alfred Freedman (USA, 1988); and Dr Julian Leff (USA, 1990).²⁰

In 1970–76 the Roche Professorship was awarded every two years, then every three years through the 1980s.²¹ From 1971, its incumbent was required to attend the annual Congress.²²

Both the Williams and Roche awards were significant in bringing important overseas psychiatrists to Australasia as well as acquainting overseas psychiatrists with Australasian society and the psychiatric profession here. From 1970 until 1990, the Squibb Co. also sponsored an academic lecture at the College Congress, known as the Squibb Academic Address.²³

The 1970s saw the College institute a number of new awards and prizes. In 1971, on the recommendation of the Board of Censors, the College created the Grey Ewan Medallion for 'the candidate of highest merit in the Membership Examination conducted during that year'.²⁴ The award was named in honour of Dr Grey Ewan, who provided the funds. It was first awarded in 1971 to the best examinees for 1970: in October 1971 the medallion was given jointly to Dr M. Serry and Dr D. Serry, both of Victoria.²⁵ The prize has been awarded annually ever since, although between 1975 and 1982 it was known as the College Medallion and, from 1983, as the Maddison

Medallion, in honour of Professor David Maddison.²⁶ Several of the recipients went on to distinguished careers in psychiatry, while the winner of the 1971 Grey Ewan Medallion, Dr Ross Kalucy, himself became Censor-in-Chief thirteen years later. A list of medallion recipients appears in Appendix 6.

In May 1978 Organon Australia presented funds for the Organon Research Award, which was to be made annually to the person who has made the most significant contribution to research in psychiatry in Australasia. It consisted of a medallion and, at the time, a prize of \$2000.²⁷ The initial recipient was Professor F.A. Whitlock of the University of Queensland, who had worked in a wide variety of research areas, ranging from the psychopharmacology of skin diseases to paranormal psychology and psychiatry.²⁸ In 1979 an Organon Junior Research Award was established.²⁹ That prize, also established by Organon Australia, consisted of an award of \$500 to the fellow or member, under the age of thirty-five, who presented what the Selection Committee deemed to be the best paper at the College's annual Congress.³⁰ (The first of the two Organon Awards was then renamed the Organon Senior Research Award.) Recipients of the Organon Junior Award include Drs Bruce Singh and Henry Brodaty (1980), Dr Wayne Miles (1983) and Dr Nicholas Keks (1986).³¹

In October 1981, the John Cade Award was established by the College, in honour of the discoverer of lithium therapy who had died in November 1980. It was a biennial award of a medal to either a member of the RANZCP or another medical practitioner who made the most significant published contribution related to clinical psychiatry.³² The John Cade Award was awarded in 1982 to Dr Eric Dax and in 1985 to Professor Issy Pilowsky.

The various major College prizes and awards were consolidated and closely reviewed in the mid 1980s, and the Senior Organon Award and John Cade Prize were merged. The Evan Jones Prize, which had fallen into abeyance, was merged with the Organon Junior Prize.³³ In May 1987 the terms of the Organon Senior Research Award were amended so that the Award 'may be made annually to the Fellow or Fellows of the College who ... [have] through psychiatric research made an outstanding contribution of international repute to psychiatry and related fields'. Further, 'the psychiatric research submitted in support of the nominations will have been published during the two years preceding the closing date for nominations'.³⁴ The terms of the Organon Junior Research Award were also changed, so that it would be awarded to fellows of not more than five years standing, based upon either their research during the previous five years or the presentation of an outstanding research paper at the Congress.³⁵

A number of other College awards and prizes were established around this time. In 1981 Professor Richard Cheetham of South Africa, an honorary fellow of the College who had been invited to the 1981 Victorian branch Congress held in Hong Kong, donated his registration fee to establish a book prize to pay tribute to Professor Richard Ball.³⁶ This prize, the J.R.B. Ball Award, was to be awarded annually to the most outstanding dissertation by the best external candidate submitting for the College membership examination.³⁷ In 1976 the South Australian branch established a trust fund to honour Dr Ian Simpson of South Australia, a former President of the College, who had just died. Towards the close of 1979 that fund was vested by General Council in the Board of Censors and the Honorary Federal President, and the Ian Simpson Prize was established to be given to applicants who, in the opinion of the Prizes and Awards Committee, have made the most

outstanding contributions to clinical psychiatry as assessed through service to patients and to the community. The award, for which applications are invited in College publications, consists of a citation and a sum of money. The Simpson Prize was not awarded until 1988, when Dr Henry Brodaty became its first winner. He was followed by Professor Derrick Silove (1991), Dr Alan Rosen (1994) and Dr Pat McGorry (1995).³⁸

Two College trust funds also exist. In 1956 the Gallipoli Trust Fund was established by an anonymous donor in honour of his late father, consisting of a sum of £9000 to the Association. By the mid-1980s, the income from the trust was used by the College for the purposes of undergraduate medical education in psychiatry.³⁹ In 1976, a memorial fund was established to honour Professor Peter Lewis of Otago University, an eminent child psychiatrist who was killed in 1974, along with his wife and three of his children, in a plane crash in Pago Pago. Administered by the New Zealand branch of the Section on Child Psychiatry in conjunction with the Honorary Federal Treasurer, its aim was to subsidise the cost each year of New Zealand trainee psychiatrists attending the College's annual Congress or for a related purpose.⁴⁰ Winners have been Dr Sarah Clarkson (1977) and Dr J. Anderson (1985).

Another New Zealand-based fund exists: the Dawn Short Trust Fund, founded in 1978, which provides grants to be applied for the advancement of medical knowledge in psychiatry, and which may be awarded only to members of the New Zealand branch of the College or to trainees in New Zealand. It may be awarded either for scholarship aid or to provide funds for research.⁴¹

A final College prize exists at the state level: the John F. Williams Prize, which is a medallion offered annually by the Victorian branch in order to encourage original work in

psychiatry in Victoria.⁴² As of 1985 it was believed to have not been awarded in several years, if at all.⁴³

Finally, in the mid 1980s the College also included among its awards the W.M. Somerville Travelling Fellowship in Child Psychiatry, named in honour of William McNaughton Somerville of New Zealand, to enable child psychiatrists, within five years of election to fellowship in the College, to complete further studies.⁴⁴

During the late 1980s and early 1990s, the award system of the College changed, with the institution of two new prizes — the College Medal of Honour and the College Citation. Both grew out of proposals made in the mid 1980s.⁴⁵ The College Medal of Honour was intended to be the College's highest award, recognising long and continuous service to the College over many years. Its recipients have included Dr Russell Pargiter (1989), Dr Bruce Peterson (1990), Dr John D. Russell (1991) and Dr John Ellard (1992). The College Citation was intended to honour those who contributed in special ways and, uniquely, could be awarded to College members or nonmembers (indeed, to non-medical persons). The College Citation has gone to Dr John Dobson (1990), Dr Jim Methven, and Dennis Cowell (1991), a Senior Nurse Educator at Wolston Park Hospital, Queensland, and to Dr Henry Bennett and Associate Professor Anne Hall (1992). All except Cowell were from New Zealand. The award to Cowell was perhaps the first made by the College to a non-medically trained person.⁴⁶

Most of the existing prizes also continued to be awarded. The Organon Senior Research Prize has gone, in recent years, to the following winners: Dr John Werry (NZ, 1979); Professor B.G. Burton-Bradley (PNG, 1980); Dr Graham Burrows (Vic., 1981); Associate Professors Gordon Johnson and Gavin Andrews (NSW, 1982); Professor Russell Meares (NSW, 1983); Dr J. Krupinski and Professor Gordon Parker (NSW, 1985); Associate Professor J.J. Wright (NZ, 1986);

Professor Chris Tennant (NSW, 1987); Associate Professor Lorraine Dennerstein (Vic., 1989); Professor Gordon Parker (NSW, 1990); Professor Gavin Andrews (NSW, 1991); Dr Robert Goldney (SA, 1992); Associate Professor Fiona Judd (Vic., 1993); and Professor Peter Joyce (NZ, 1994). It will be seen that several persons won the award twice.

The Organon Junior Research prize has been awarded to the following: Drs Bruce Singh and Henry Brodaty (NSW, 1980); Dr Wayne Miles (NZ, 1983); Dr Phillip Boyce (NSW, 1985); Dr Nicholas Keks (Vic., 1986); Dr John Condon (SA, 1987); Dr Peter Yellowlees (SA, 1988 and 1989); Associate Professor Fiona Judd (Vic., 1990); Dr Patrick McGorry (Vic., 1991); Dr Ian Hickie (NSW, 1992); and Dr Ashley Bush (Vic., 1994).⁴⁷

In 1992 plans were announced to fund a College prize for the best dissertation on alcohol and related drugs.⁴⁸ The awarding of College prizes is now centred in a Prizes and Awards Committee and College Medal of Honour Committee, chaired by the College President, whose members consist of former Presidents. In 1993, a major new award, the Lilly Psychiatry Fellowship, valued at \$35 000, was established. It was awarded in 1994 to Dr Matthew Large of New South Wales, who also received the second Lilly Fellowship in 1995 to enable him to continue his research.⁴⁹

PART III

The College and Wider Society

In Part III, aspects of the College's wider links with Australasian society and with the outside world are examined in more detail. Following that, the College's relationship with psychiatric medicine and treatment as they have evolved over the past half-century are discussed. The two well-known *causes célèbres* affecting the Australasian psychiatric profession in recent decades, Chelmsford and Townsville, are discussed in greater detail than was possible in Part I, with the aim of examining the College's role in these affairs as precisely as possible.

The final section of Part III is reflective. It examines the largely negative image of psychiatry in Australia during the past half-century, and reports the results of a survey of a random sample of Australasian psychiatrists concerning their attitude towards psychiatry and towards the College — past, present and future.

10 International Links

From its infancy, the AAP sought to establish links with psychiatrists and psychiatric bodies in other countries. The evolution of those links closely followed the evolution of Australasian society as a whole in the second half of the twentieth century. During that period, Australia and New Zealand matured from small, remote and exotic nations which could only benefit from foreign contacts, especially with Britain and the USA, to major regional states increasingly oriented towards South-East Asia, and widely respected for the quality of their education and training, as well as for their high professional standards. Throughout this half-century, however, to a surprising extent the Australasian psychiatric profession set out, through the College, on an independent path. While the RANZCP clearly has much in common with equivalent psychiatric bodies in the English-speaking world, it differs in many respects from those bodies. Also, it has refrained from expanding its direct role in the Asia-Pacific region.

As early as 1948, the AAP joined the World Federation of Mental Health (WFMH), formed that year in London.¹ Dr Hal Maudsley, who was in Britain, affiliated the AAP, paying a fee of 400 Swiss francs. The fledgling organisation was to act in an advisory capacity to UNESCO and the World Health Organisation (WHO).² New Zealand at the time had a National Mental Hygiene body, and initially joined the WFMH separately, with the Director of Mental Hygiene in New Zealand, Dr J. Russell, being appointed to its Executive Board.³ Dr Maudsley apparently acted on his own initiative in securing membership for the AAP in the WFMH; his

actions were later confirmed by the AAP at its October 1948 meeting.⁴

In May 1949 the AAP debated the matter at length and voted that in general it favoured the proposal 'to form a National Mental Health Organisation in Australia', calling upon each state branch to convene a body for this purpose.⁵ Probably, some members viewed any such body as a potential rival to the new Association. The AAP continued to play a role in the new organisation, editing an issue of the WFMH's bulletin, *World Mental Health*, in 1953.⁶ The WFMH held annual international congresses at which members of the Association were often present.

From the AAP's earliest days, its members often participated in other international gatherings, despite the time-consuming and expensive nature of such journeys. In 1950, for example, Dr Alan Stoller was a guest speaker at the Silver Anniversary Meeting of the American Rehabilitation Association in New York. He found, to his consternation, that the other guest speaker that evening, before an audience of 2000 at the Statler Hotel, was Eleanor Roosevelt, F.D.R.'s widow! 'Any nerves I might have had faded quickly before this gracious lady's address ... She prepared the way perfectly for my own more laboured and more technical address.'⁷ Several prominent members of the Association, such as Maddison, Stoller and Dr Vincent Youngman, travelled abroad regularly, reporting on their visits to international psychiatric conferences in the Association's periodicals. The Association was officially represented at several of the meetings of the Royal Medico-Psychological Association, Britain's equivalent body to the AAP at the time. In July 1953, for example, Dr John Bostock delivered an address at its annual conference in Gloucester on behalf of the AAP.⁸ Nevertheless, the AAP had no official links with its British counterpart or with any of its equivalents overseas. In 1951, the AAP officially approached

the Royal Medico-Psychological Association with the aim of attachment, only to be told that the charter of that body 'precludes any such affiliation'.⁹ So far as is known, neither the Association nor the College ever sought to affiliate with any counterpart overseas, and even from the Association's earliest days was determined to develop independently.

From the first years of its existence the Association welcomed visitors from abroad. In view of Australasia's isolation, the existence of only a handful of university positions in psychiatry here, and the fact that new developments in psychiatric theory and practice overwhelmingly came from overseas, distinguished foreign visitors were eagerly sought and treated with great respect. Given the culture cringe which undoubtedly existed, especially towards British visitors in high positions, these visitors sometimes had a significant influence on the course of Australasian psychiatry. Perhaps the most striking example was Professor Alexander Kennedy of Durham University, whose visit to Australia in 1949 was jointly sponsored by the Victorian government, the AAP, and the British Council.¹⁰ Although Professor Kennedy gave many addresses to psychiatric audiences in Australia, the main purpose of his visit was to produce a report, known as the Kennedy Report, on Victoria's mental health services. Dr Kennedy's comments on the Victorian Director of Mental Hygiene, Dr Catarinich, were unbelievably blunt and personal:

Professor Kennedy's report had numerous suggestions which were thought worthy of support by the Victorian Branch of the AAP. However, Professor Kennedy had said: 'The Director, Dr Catarinich, has acted as the sole advisor to successive Ministers. The organisation of the channels of communication allows him full liberty if he should wish to suppress any suggestion

for improvement which may emanate from junior officers.'

Professor Kennedy stated further that Dr Catarinich had restricted his contact with psychiatrists outside the Mental Hygiene Department and with physicians and surgeons in Victoria; he attended no scientific meetings and professionally 'was in a state of voluntary isolation'; he had 'fallen so far behind' in the knowledge of some aspects of his subject that he had 'difficulty in discussing the technical side of the work with other physicians owing to lack of a common language'.

These personal comments about Dr Catarinich were such that the Victorian Branch of the AAP considered it should dissociate itself from them, and steps were officially taken to carry this out in a letter to the Minister. At the same time, the Branch expressed its intense interest in the future of mental hygiene in Victoria and offered to give any assistance that might be needed.¹¹

Dr Kennedy's remarks led directly to the Victorian *Mental Hygiene Authority Act 1950*, which reformed that state's mental hospital system. Dr Eric Dax, one of the towering figures in the College's history, was appointed the first chairman of the Victorian Mental Health Authority, emigrating from Britain as a result.¹²

In 1955, in a letter to Dr Stoller, Kennedy showed that his gift for words had not been lost. He noted of Australian psychiatry: 'you are in the strong position of being able to examine British and American psychiatry and to profit from their experiments and errors before going on to make your own'.¹³ Another early visitor was Dr Daniel Blain, the first Medical Director of the American Psychiatric Association, who also visited Australia in 1950, under the auspices of the

Repatriation Commission, and who addressed the AAP's Council.¹⁴

Very few of the Association's early overseas links were with South-East Asia, where psychiatry was a profession rarely encountered. Indeed, it is not possible, from AAP sources, to identify any nexus with psychiatry in that region until the late 1950s. In March 1959 Dr Burton Bradley, later an eminent figure in Papua New Guinea, reported on the period he had spent as a Colombo Plan psychiatrist and later as Medical Superintendent of Singapore's Woodbridge Hospital in 1957-59.¹⁵ In 1960, the WHO sent Filipino doctors to be trained in Victorian mental hospitals.¹⁶ In May 1963 occurred probably the first international psychiatric conference in Asia at which the AAP was represented, a joint meeting in Tokyo of the American Psychiatric Association and the Japanese Society of Psychiatry and Neurology.¹⁷ Several Australasian psychiatrists, including Drs Youngman and Medlicott, were present, along with 400 American psychiatrists arriving on specially chartered flights.¹⁸ By the time of the transformation of the Association into the College in 1964, the organisation had also joined the World Psychiatric Association and in August that year sent a delegation to the First International Congress of Social Psychiatry in London.¹⁹ During that period, each issue of the *Australasian Psychiatric Bulletin* carried notices of six or eight overseas meetings of interest to members, chiefly in the USA and Europe.

Although at first glance it may seem strange, official contacts between the RANZCP and overseas psychiatry probably did not grow markedly during the first few decades of the College's existence; indeed, they may have decreased in number and, more markedly, as an important component of the College's activities. This was probably natural. The College grew continuously and was composed

of Australian and New Zealand psychiatrists, most of whom were educated in Australasia. Australian medical and psychiatric education was probably equal to any in the world, and no longer looked to Britain or elsewhere for leadership and instruction. As transport became faster and cheaper the mystique of foreign travel diminished, and there was rapid and ready access to overseas journals and books. The College's committee structure and its range of activities grew steadily, and these naturally reflected almost exclusively Australasian concerns, in the context of psychiatry in Australian and New Zealand society.

Nevertheless, there were developments linking Australasian psychiatry with overseas psychiatry. In general these new links were increasingly oriented towards South-East Asia, although the official sponsorship of psychiatrists from Britain and the USA has continued. Most of the holders of the H.B. Williams Travelling Fellowship and the Roche Travelling Professorship have been distinguished British or US psychiatrists. The College has held several of its annual Congresses in the Asia-Pacific region — in Singapore (1978), Hong Kong (1981) and Honolulu (1989) — while many meetings of College sections have taken place outside Australia and New Zealand. Examination of candidates for membership of the College occurred in Singapore in the 1980s.

On the other hand, the College has certainly concentrated primarily on local psychiatric issues. From 1968 the College had an International Liaison Officer (the first was Professor John Cawte). In the 1980s the International Liaison Committee collected textbooks for Chinese psychiatrists and prepared a Catalogue of Australian and New Zealand Psychiatry.²⁰ The College has long been a member of the World Psychiatric Association, and during the mid 1980s participated in the restructuring of that body.²¹ Australia has long been prominent in

exposing the abuse of psychiatry for political purposes in totalitarian countries, especially in the former Soviet Union. However, the College has not taken a direct role in international psychiatric affairs beyond these significant but indirect measures. In 1984 a recommendation from Dr Noel Wilton, as International Liaison Officer, that the College 'establish Committees of Council in each country in South East Asia and the Pacific Region in which ten or more Members and/or Fellows of the College reside' was not acted upon, and the College has no direct role or representation outside Australia and New Zealand.²² The College did, however, establish a RANZCP Travelling Professorship in the late 1980s as a biennial award in South-East Asia and the south-west Pacific.

It is useful to offer some comparisons between the evolution and functions of the RANZCP and similar bodies overseas. The College has three sister organisations in the English-speaking democracies with which it might be compared.

Canada is often said to be the country most comparable to Australia and New Zealand, and it is not surprising that the Canadian Psychiatric Association (CPA) presents many parallels to the RANZCP. The CPA was founded in May 1949 by seventy-one Canadian psychiatrists, who formed its interim committee during the Canadian Medical Association's annual meeting.²³ Among the pressures which prompted its foundation were the possibility of a National Health Insurance Plan in Canada, and the rejection of significant numbers of potential military recruits during the war on mental health grounds.²⁴ Officially founded in June 1951, the CPA began publishing its *Bulletin* in 1952, the forerunner of today's *Canadian Journal of Psychiatry*.²⁵ The CPA is officially affiliated with the Canadian Medical Association and with the American Psychiatric Association.²⁶ From 1957, the Canadian federal government funded

psychiatric services in all hospitals except provincially operated psychiatric hospitals, which continued to be funded by the ten Canadian provinces. This produced a great expansion in the delivery of psychiatric services in community general hospitals.²⁷ Since 1961 Canadian health insurance has included coverage for psychiatric illness which has made it (in Roberts' words) 'the most extensive and inclusive medical care coverage for psychiatric illness'. Roberts notes that this changed the nature of professional psychiatric care across Canada.²⁸

In many respects the growth of the CPA has been very similar to the RANZCP. In 1972 an executive committee, larger than the College Executive Advisory Committee but smaller than General Council, was instituted. On the other hand, a streamlining of the CPA's committee structure led to a decrease in the number of committees from twenty-one to four.²⁹ During the 1980s the title of the administrative head of the CPA, the executive secretary, was changed to chief administrative officer.³⁰ In a manner rather different from the evolution of the RANZCP during the 1970s, the CPA moved from an advocacy role vis-à-vis the government to responsibility for 'the setting of standards for psychiatric education and the development of position papers for Canadian psychiatrists with respect to significant medical/psychiatric/social issues'.³¹ The president of the CPA is elected annually. In 1995 it had 2400 members.³²

Britain's equivalent body to the RANZCP, the Royal College of Psychiatrists (RCPsych) is, oddly enough, considerably younger than its Australasian counterpart. Steps to found it were not taken until 1964, and it did not officially come into existence until 16 June 1971.³³ Admittedly, British psychiatrists did organise into professional societies as early as 1841 (when the Association of Medical Officers of Asylums and Hospitals for

the Insane was formed), but the psychiatrists' representative body prior to the 1970s, the Royal Medico-Psychological Association, was not a medical college and was regarded by both the government and the medical profession as a less influential organisation on psychiatric questions than the Royal College of Physicians.³⁴ Between 1960 and 1964 the British psychiatric profession debated a number of possible options, including the possibility of becoming a faculty within the Royal College of Physicians, before deciding to declare independence.³⁵ Negotiations were very long and protracted.

The psychiatric profession in Britain has always been much larger than in Australasia, and has grown enormously in recent years. There were 1063 practising psychiatrists in Britain in 1963, and over 7000 today.³⁶ In many respects, however, the RCPsych and its functions are very similar to those of the RANZCP. The RCPsych's predecessor body initiated a Diploma in Psychological Medicine in 1948 and today, as with the Australasian College, it holds examinations for new entrants — probably its major function.³⁷ It is organised into a committee structure very similar to that of the RANZCP, and has a fairly similar administrative infrastructure. Presidents of the RCPsych normally serve for five years or more, and most, like Sir Desmond Pond and Sir Martin Roth, enjoyed international renown.³⁸

The RCPsych publishes the *British Journal of Psychiatry*, one of the most eminent psychiatric journals. Geographically, the RCPsych is subdivided into ten divisions, covering major regions of Britain (and Ireland, which includes both Ulster and Eire), which each hold annual meetings and have local secretariats.³⁹ The RCPsych's headquarters, an eighteenth-century mansion in aristocratic Belgrave Square, Mayfair, might well be the second Maudsley House writ large, even the interior floorplans of

the two buildings being somewhat similar. Their respective size is likely to strike the Australasian visitor as the chief difference between the two bodies: the RCPsych has a permanent staff of fifty-five, including a Research Unit employing sixteen persons in the mid 1990s.⁴⁰ In their functions and ambience, the British and Australasian Colleges appear remarkably similar.

Somewhat like its British equivalent, the American Psychiatric Association (APA) was the successor body to an earlier group, the Association of Medical Superintendents of American Institutions for the Insane, composed exclusively or almost exclusively of heads of lunatic asylums.⁴¹ During the late nineteenth century, it had to deal with many attacks on the ethical and legal dimensions of the incarceration of the insane, led by such reformers as Dorothea Dix.⁴² Originally the organisation was very small, with a membership of only 153 in 1899.⁴³ In 1921 its name was altered to the American Psychiatric Association, and it gradually absorbed most of the new trends in psychological medicine, from psychoanalysis to occupational therapy. Such trends became enormously popular in America; many originated there.⁴⁴

The APA grew steadily in size, numbering 1000 members in 1921.⁴⁵ It professionalised much earlier than equivalent bodies overseas, employing from the early 1930s an executive secretary and several other full-time employees, as well as a permanent headquarters (originally in New York, later in Washington DC) at about the same time.⁴⁶ Growth was continuous and, by foreign standards, enormous, with membership reaching 4000 in 1944, 11 000 in 1960, 25 345 in 1980 and 31 000 in 1986.⁴⁷ In 1994 the APA had 37 380 members, over *eighteen* times as many as the RANZCP. From 1948 it also employed a full-time Medical Director, the first of whom, Daniel Blain, visited Australia and was an

honorary fellow of the College.⁴⁸ By Australasian standards, everything about the APA is gargantuan. Its budget in 1987 was \$US15 million and it employed a staff of 150. Its periodical, the *American Journal of Psychiatry*, is internationally renowned.

Apart from the APA's size, its role is vastly more complex than any of its sister bodies. It has to deal with the federal government, with no fewer than fifty state governments, and with hundreds of local units of administration, all of which are legally powerful in the field of psychological medicine. It must negotiate with dozens of medical schools and hundreds of hospitals, and it has to deal with a health delivery system notorious for the inadequate and fragmented nature of its funding structure, and with levels of violent anti-social behaviour virtually unknown elsewhere. Additionally, in cultural terms, while the American middle class has made the private analyst its own (and the subject of a thousand jokes), the treatment of the mentally ill and mentally handicapped is often scandalous. Nevertheless, the administrative tasks of the APA are broadly similar to those of the RANZCP, revolving around the lobbying of governments, the holding of annual conferences and the like.⁴⁹ There is, however, one major difference between the two: the American body does not conduct training, examine candidates or award its own qualification, while these activities are at the very heart of the RANZCP's current role.

It seems clear from even these brief comparisons that the historical evolution of the RANZCP has been most like that of its Canadian counterpart, while structurally it is probably most similar to the British Royal College. The APA is so vast and so variegated that it seems difficult to make a valid comparison with the RANZCP, although the aims of both bodies are similar. In reality, however, while the RANZCP has parallel objectives to those bodies and has good relations with them, it is not linked to them in any way.

As noted, while one might suppose that the RANZCP might have (or have had) official ties with the RCPsych, in fact there have never been any links and the Australasian body was formed and evolved separately from any British medical organisation.⁵⁰ The RANZCP is an entirely Australasian institution, which has evolved to suit local needs.

Furthermore, while unofficial and professional ties with all three similar overseas bodies are strong, the College's overseas links are increasingly with South-East Asia, a trend which is likely to increase still further in the coming decades. In this the College reflects the wider evolution of Australasian society. Yet it is also true that US, British and, to a lesser extent, Canadian standards of education, research and practice will certainly continue to be closer to those of Australasia than is the case with other parts of the world, and this will perhaps always be true.

11 The College, Psychiatric Medicine and Treatments

This chapter considers the attitude of the College towards psychiatric medicine and treatment, that is, to both the modes of clinical treatment used by Australasian psychiatrists, and to the techniques and schools (such as psychoanalysis) practised by Australasian psychiatrists. A caveat is in order. This book is not a general history of the medical treatment of mental illness since 1946, and the authors, professional historians, would not be technically qualified to write such a work. This chapter is concerned with the evolution of the College's attitude to psychiatric medicine and treatment, a subject which can appropriately be dealt with in this work in the same manner as any other aspect of the College's history.

This task is made easier by the fact that, to a remarkable degree, the College was not directly engaged in the medical aspects of psychiatry until very recently, and has been relatively uninvolved in anything to do with the specifics of treatment or with the particular approaches brought by the different schools of psychiatry to their treatment. The College has played only the most limited role, until recently, in the direct involvement of Australasian psychiatrists and their patients, or in virtually any aspect of the treatment or therapy given by its members to their patients.

There are a number of important reasons for this. First, the College has long been concerned with the examination and accreditation of new members, but once these psychiatrists qualified professionally, the College has assumed that they have been fully able to administer the best possible treatment to patients and that the methods used, subject to the wide constraints of the law and normal medical practice, were their own business. Second, the College lacked either the power or will to intrude into the details of day-to-day medical practice until very recently and, indeed, it may still be reluctant to do so. Third, of all the medical specialties, psychiatry has perhaps the widest range of therapies its practitioners legitimately view as helpful. There is presumably only one correct way for a surgeon to remove a tumour, but there are many psychiatric schools, and these offer very different approaches to common psychiatric illnesses such as chronic anxiety or

schizophrenia. Some of these schools, for example, place far greater reliance on the use of psychotropic drugs than others do. Given these differences, the College is most unlikely to wish to dictate (or even advise) what the correct specific mode of treatment might be, and any attempt to do so would very likely be resisted by a significant portion of the College's members, who might well form a breakaway organisation. (The College does publish clinical memoranda, position statements and guidelines on treatment, but it does not clearly favour one psychiatric school over another.) Australasian psychiatry has, in fact, been distinguished by a variety of approaches and is seen by many psychiatrists as eclectic in its techniques.

Additionally, the infrastructure and committee structure of the Association and the College was, for at least its first twenty-five years, too limited and haphazard to attempt any far-reaching assessment of medical therapies even if it had wished to do so. Professional misconduct or the unprofessional use of any medical treatment were, for many decades, probably regarded by the College as primarily the responsibilities of state medical boards. Lastly, there has been a sense that professional solidarity forbade any intrusion by one set of psychiatrists into the clinical behaviour of other psychiatrists, unless that behaviour was simply untenable. In this atmosphere, a variety of schools and approaches naturally grew up. On the other hand, the psychiatric education given at Australasia's various medical schools and other training facilities was similar — and became more so as the College secured a monopoly of the examination process — ensuring that the approaches adopted by Australasia's psychiatrists would broadly resemble each other.

In its early days the Association/College did little more than provide a venue for members to present their research and to liaise with other members about new techniques and approaches. Thus, for example, in 1949 a note appeared in the Association's *Newsletter* stating that 'Dr [John] Cade wishes to collate all evidence relating to' the use of 'lithium treatment of mania'. 'He especially stresses the importance of careful clinical observation when maximum doses are being employed and the need for prompt withdrawal when toxic symptoms appear'. He invited respondents to contact him at the Repatriation Hospital, Bundoora.¹ This foreshadowing of Cade's world-renowned discovery of lithium therapy was made with no more ado, the Association taking no interest in its success or otherwise.

When any involvement of the Association/College in the modes of clinical treatment was evident, it was voluntary and tentative. In

1951, for instance, the *Newsletter* noted that a 'Subcommittee of the AAP (Drs Springthorpe, Dax, Graham and Stoller) met with a subcommittee of the British Psychological Society' to discuss matters of mutual professional interest including 'the role of the clinical psychologist in diagnosis, and the still more debatable field of therapy. The possibility of the proper registration of qualified clinical psychologists was brought up.'² There is no evidence that anything came of this meeting, certainly not registration of qualified clinical psychologists in an official sense. In 1953 the Association's Clinical Meeting in Sydney discussed full-coma insulin therapy, electrotherapy in the management of neurotic illnesses, and cortical electrotherapy, without anyone present drawing any conclusions about the safety — or potential legality — of these techniques other than that full-coma insulin therapy was risky. (The presenter of what was described in the Association's *Bulletin* as the 'very excellent account' of 'the therapeutic use of electric currents applied to the brain' was Dr Harry Bailey.)³

This state of affairs continued throughout the period of the Association and into the early years of the College. The College remained extremely reluctant to become involved directly in anything which suggested that it was dictating correct medical procedures to its members. For example, in October 1970, General Council debated and *defeated* a motion that 'Council is of the opinion that electrotherapy be administered by two (2) legally qualified medical practitioners except in an emergency'.⁴ When the College was formed and its committee structure put into place, little was initially done to examine or regulate any aspect of clinical practice. In 1967, however, the College became officially involved with the Australian government's Pharmaceutical Benefits Advisory Committee, which made recommendations regarding drugs available as pharmaceutical benefits. In May 1967 Dr Russell Pargiter of Tasmania was appointed by General Council to convene a committee of the Tasmanian branch to enquire into the matter. That committee led directly to the College's Psychotropic Drug Committee and its earliest involvement in passing judgment on the use of psychotropic drugs and eventually on other medical techniques.⁵ In October 1964 the College made its first official recommendations to the government on the inclusion of drugs in the pharmaceutical benefits scheme, calling, for instance, for the inclusion of 'Pencyazine (Neulactil) tablets, injection and syrup as a Pharmaceutical Benefit'.⁶

Dr Pargiter played a leading role in this process, which marked an important step in the evolution of the College.

In 1968 Dr Pargiter prepared a major report regarding Drugs under Consideration as Pharmaceutical Benefit Items. This consisted of three parts. In the first, all forty-six drug firms known to be manufacturing psychotropic drugs were surveyed as to the amounts of such drugs used in state institutions and the amounts sold by these firms.⁷ Usable data were received (concerning 1967–68) from twenty-two drug companies. By type of drug, it was found that the most widely prescribed were as follows — barbiturates: Amylobarbitone, 1 816 000 g; Butobarbitone, 1 739 000 g; non-barbiturate hypnotics: Methagualone, 336 000 g; major tranquillisers: Chlorpromazine, 1 913 000 g; anti-depressants: Amitryptiline, 980 000 g.⁸

The College had no committee specifically to deal with the use of drugs in psychiatric practice until October 1970, when Dr Pargiter was asked to draw up terms of reference for a Psychotropic Drug Committee.⁹ At that time the AMA was in the process of making a submission to the Senate Select Committee on Pharmaceutical Benefits. The College decided to make its own submission via the AMA to the Senate Committee on pharmaceutical benefits relating to psychotropic drugs.¹⁰ This must be seen as an important milestone along the path of the College's independence. At about the same time, the College also made a lengthy submission to the House of Representatives Select Committee on Pharmaceutical Benefits.¹¹

The Psychotropic Drug Committee formally adopted its terms of reference in March 1971. It was to consist of a convenor, three members in the same state as the convenor, and one liaison member from each branch. Its purpose was to advise the College on all aspects of the therapeutic use of psychotropic drugs, to liaise with other bodies involved in the assessment and provision of these drugs, and to conduct surveys of the College membership for its collective opinion regarding the use and value of particular psychotropic drugs.¹² The committee noted that it had already made a survey of the use of sin-gle-tablet combinations of anti-depressant and tranquilliser drugs.¹³ In 1971, the Victorian branch established a subcommittee on the use of hallucinogenic drugs (then of world-wide popular interest during the flower power years of the 1960s). The subcommittee's report concluded: 'It goes without saying that any non-therapeutic use of these drugs, either by doctors or patients, is

unethical, immoral, and illegal.’ But it endorsed their use for therapeutic purposes in highly restricted situations.¹⁴ A clinical memorandum on this topic was subsequently published by General Council.

In 1972 the Psychotropic Drug Committee under Dr Pargiter embarked upon a major survey of psychotropic drug use by College members. The committee sent out 613 questionnaires and received 497 duly completed, an overall response rate of 85 per cent.¹⁵ That survey of drug use remains one of the most comprehensive and searching studies of its kind ever carried out by the College. It revealed a remarkable variation in psychotropic drug use by College members. Asked ‘Do you prescribe barbiturates?’, 254 (51 per cent) of respondents replied ‘yes’ and 243 (49 per cent) replied ‘no’. A considerably higher percentage of senior members of the College — those who had been qualified for ten or more years — prescribed barbiturates than junior members with fewer than ten years of membership (58 per cent compared with 39 per cent).¹⁶ Psychiatrists in Tasmania (85 per cent of respondents), Western Australia (64 per cent) and Victoria (56 per cent) were the likeliest to prescribe barbiturates, psychiatrists in New South Wales (45 per cent) least likely.¹⁷

Among non-barbiturate hypnotics the drugs preferred by College members were (in descending order) nitrazepam, mandrax and methaqualone. Asked whether members ‘prescribe single tablet antidepressant/tranquilliser combinations’, 134 (27 per cent) replied ‘yes’ and 363 (73 per cent) replied ‘no’.¹⁸ Only 12.5 per cent prescribed ‘simultaneous MAOI [monoamine oxidase inhibitors] and Tricyclics’, with 87.5 per cent not prescribing this combination.¹⁹ Asked ‘do you prescribe sympathomimetics?’, 146 (29.4 per cent) replied ‘yes’, 351 (70.6 per cent) replied ‘no’. Among drugs preferred for the aged by respondents, the most popular were: amitryptiline (as an anti-depressant), diazepam (minor tranquilliser) and thioridazine (major tranquilliser). These three drugs were also the most widely prescribed for children, although it should be noted that only 272 (54.7 per cent of respondents) prescribed drugs for children.²⁰

The picture derived from this survey, suggesting perhaps greater caution in the use of prescription drugs than one might expect, is enhanced by the finding that a further ninety-one respondents (18.3

per cent) had used barbiturates but no longer did so, while twenty-seven (5.4 per cent) no longer used MAOIs.²¹

This part of the Psychotropic Drug Committee’s report was coupled with another involving data on the number of prescriptions written per week for each drug. The picture was much the same — one of surprising caution. In the categories of minor tranquillisers and tricyclic anti-depressants, prescriptions per week were as shown in Table 11.1.²²

Table 11.1: Prescriptions per week

	0	1-10	11-20	21+
<i>Minor tranquillisers</i>				
Total number: 1988 (4 named drugs)	1005	711	180	92
Percentage	50.6	35.8	9.1	4.6
<i>Tricyclic anti-depressants</i>				
Total number: 4483 (9 named drugs)	2572	1460	329	122
Percentage	57.3	32.6	7.3	2.7

The Committee’s report was accompanied by a lengthy College statement on Tricyclic Anti-depressants in the Treatment of Depression (dated June 1972), which noted that ‘tricyclic antidepressants are a major contribution to the treatment of depressive illness’ but that ‘they should be used with discernment, a full knowledge of their side effects and individual properties in conjunction with other treatments such as counselling, psychotherapy, and environmental manipulation’, that ‘large quantities of these drugs should not be supplied’, dosages should be supervised and ‘in severe depression it should be remembered that ECT is often the more rapidly effective treatment’.²³ As worthy and important as a College statement of this kind was, it should be remembered that the College had no realistic way of ensuring that its members followed such guidelines, or indeed that they even read them. This would remain the case for years to come.

The College has continued to issue clinical memoranda and position statements on a wide variety of topics, many of which relate to the use of psychotropic drugs or other aspects of clinical practice. Yet there was occasionally a feeling that this good advice fell on deaf

ears. In October 1975, for instance, the report of the Psychotropic Drug Committee stated that it:

can appreciate the chagrin of the small minority of the College membership who have represented their views and needs to the ... Committee only to find that little has resulted ... It is not generally recognised that the College as a whole cannot always speak with a single voice on Psychotropic Drug matters and indeed there is a substantial minority in the College membership who have grave doubts as to the validity and even morality of psychotropic drug treatment.²⁴

Nevertheless, the Psychotropic Drug Committee has continued to meet regularly, and some of its typical activities might be noted here. In the months before March 1980, for instance, it met to consider the Clinical Memorandum on Deep Sleep Therapy then being drawn up by the College as a result of concerns raised by the Chelmsford affair. It also formed a working party to consider the long-term use of antipsychotic drugs and the recognition and management of tardive dyskinesia. It liaised with the Pharmaceutical Benefits Advisory Committee and helped to prepare a booklet on psychopharmacology training.²⁵ In July 1980 the Psychotropic Drug Committee reported that it had met with the Pharmaceutical Benefits Committee to consider the listing of mianserin hydrochloride and of larger dose formulations of anti-depressants and anti-psychotic drugs. It also noted that it was concerned at the rising prescription rates of MAOIs. Finally, it put the finishing touches on the position statement on deep sleep therapy, noting unequivocally that 'there is no justification, at present, for the use of this treatment'.²⁶ Six years later, in its Report to the General Council of March 1986, the committee noted that it had reopened discussions with the Pharmaceutical Benefits Committee on the availability and prescribing of psychotropic drugs, and was considering undertaking another national survey on psychotropic drug use by psychiatrists.²⁷ At that time, the Psychotropic Drug Committee was headed by Associate Professor Gordon Johnson, with three other members in New South Wales and liaison members in the other states and New Zealand.²⁸ At its November 1986 meeting, on the recommendation of the Psychotropic Drug Committee, General Council changed its

guidelines concerning the use of benzodiazepines.²⁹ Council now recommended that great care should be exercised in their use.³⁰

It will be seen from this overview that Australasian psychiatry as it evolved over the first four postwar decades was marked by a considerable diversity in its modes of practice, with a mainstream making judicious but determined use of psychotropic drugs but a strong minority eschewing the use of those drugs, turning instead to psychoanalytic and other techniques. (It is notable that, in the 1970s, it was apparently the College's younger members who were disproportionately reluctant to prescribe psychotropic drugs.) This pattern probably reflected the historical evolution of Australasian psychiatry, which was initially heavily influenced by the largely organic school predominant in British psychiatry, but which from the 1930s on became more open to other types of psychiatric practice such as psychoanalysis.³¹

The strong variations in the patterns of treatment used by Australasian psychiatrists emerged strongly from surveys of the work of Australian psychiatrists in the mid 1980s conducted by Dr Gavin Andrews of the University of New South Wales and others.³² Andrews and Hickie made a detailed study of the twenty most recent patients of forty-nine randomly chosen psychiatrists in Sydney. They found that the psychiatrists surveyed:

spent a third of their time with patients with psychotic illnesses, a third with patients with neurotic conditions and most of the remainder with patients troubled by personality disorders. The predominant treatments were drug therapy for the psychoses, and psychotherapy for the neuroses and personality disorders.³³

Andrews and Hadzi-Pavlovic then undertook a detailed Australia-wide postal sample of 167 Australian psychiatrists in 1986, as part of the College's Quality Assurance Project.³⁴ Those psychiatrists were asked, *inter alia*, about the treatments provided to their twenty most recently seen patients, under the headings of drug therapies, psychotherapies and other treatments. The results of this part of the survey were as shown in Table 11.2.³⁵

It can be seen from Table 11.2 that a wide variety of primary treatments were employed by the Australian psychiatrists surveyed. Twenty-nine per cent of patients received drugs, 60 per cent psychotherapy, and 11 per cent some other treatment. Nine per cent

were described as being in insight or intensive psychotherapy, and 20 per cent as receiving supportive psychotherapy, guidance and counselling, or ventilation, comfort and support. Perhaps surprisingly, group therapy accounted for only 2 per cent of treatments, and family, marital and conjoint therapies a further 3 per cent.³⁶

Table 11.2: Primary treatments for patients consulting psychiatrists

	All patients (%)	Adults 17 and older (%)	Children 0-16 years (%)
<i>Drug therapy</i>			
Anti-depressants	11	12	1
Anxiolytics	1	1	0
Anti-psychotics	6	6	2
Unspecified	9	9	4
Other drug	2	3	4
All drug therapy	29	31	11
<i>Psychotherapy</i>			
Insight	9	9	3
Support	20	21	9
Behaviour	3	3	5
Unspecified	19	19	15
Family, marital, group	5	5	14
Other (hypnosis)	4	2	3
All psychotherapy	60	59	49
Other treatments	11	10	40

By psychiatric illness, the principal types of treatment offered were as shown in Table 11.3.³⁷

Table 11.3: Principal types of treatment

	Schizophrenia (%)	Personality disorders (%)	Depression or manic (%)	Neurotic depression (%)
No. of patients	188	240	331	243
<i>Drugs</i>				
Neuroleptic	42	—	—	—
Anti-depressant	—	—	46	5
Unspecified	27	—	15	—
<i>Psychotherapy</i>				
Insight	—	27	—	17
Supportive	—	24	10	32
Not specified	—	34	10	26
Family etc.	—	6	—	—

It is apparent from Table 11.3 that a wide variety of treatment therapies were used by Australian psychiatrists. Nevertheless the authors expressed concern with 'the frequency with which supportive psychotherapy is used as a principal treatment ... and the rarity with which behavioural psychotherapy is actually used in the treatment of neuroses'.³⁸ They attributed this to 'the rigidity of the medical benefits schedule ... Most behaviour therapy techniques require long sessions of therapy over a short term'.³⁹ They concluded on the following note:

Psychiatry is distinguished from the other medical specialities by the use of psychotherapeutic techniques. Whilst there have been virtually no developments in drug or physical therapies in psychiatry in the past 25 years, there have been a number of new developments in the psychotherapies, both in terms of techniques, the availability of training, and in proof of efficacy for the simpler forms of therapy. It is essential that the College ... develops an active program of psychotherapy evaluation and peer review ... We must ensure that our patients are able to receive the benefits of these new developments.⁴⁰

A consideration of Australasian psychotherapy shows that it was probably the primary mode of treatment by only a minority of psychiatrists. The exact (or even imprecise) percentage is, however, a matter of dispute, since no good figures exist. In 1973 R.H. Hook sent a survey to a representative sample of College psychiatrists. He found that fifty-five of 112 respondents had a special interest in psychotherapy, with ninety-five respondents indicating that they had practised some psychotherapy. But 59 per cent of respondents also noted that they tried to achieve a balance between organic and dynamic aspects of psychiatry, with 35 per cent stating that they were more concerned with the dynamic aspects.⁴¹

But a handful of psychoanalysts were to be found in Australia during the early years of the Association and College; for instance Drs R.C. Winn, F.W. Graham and Harry Southwood, and the Hungarian emigré Dr Clara Geroe, who arrived in Melbourne in 1940 and was the first training analyst with the newly formed Melbourne Institute of Psychoanalysts.⁴² Dr Geroe was noted for her profound mastery of the Freudian fundamentals of psychoanalytic theory, derived from her training in Budapest under Dr Michael Balint.⁴³ Her obituary, however, made clear that she had 'to labour under the great burden of having been the only training analyst in Melbourne for about twenty years', a 'frustrating and difficult situation for her and for her students'.⁴⁴ Australasian psychiatry was almost completely isolated from European schools of psychoanalysis, since Australia and New Zealand received comparatively many fewer refugees and emigrés than the USA, but, as noted, drew very largely on the more practical, organically oriented British traditions of psychiatry. The profession in Australasia never developed a popularly based tradition of psychoanalysis as happened in the USA, where psychoanalysis has become a virtual fixture in American culture, at least on the east and west coasts.

Perhaps for that reason, the records and publications of the College contain remarkably few items relating to psychoanalysis, and it is no exaggeration to say that in most years it is not mentioned at all in the College's surviving records and documents. However, papers reflecting a psychoanalytical viewpoint were certainly offered at the College's Congresses, and a minority of psychiatrists would have regarded themselves as primarily oriented to this tradition. Organisations such as the Australian Society of Psychoanalysts (later the Australian Psychoanalytical Society, a component of the

International Psychoanalytical Association) were eventually established, but they were largely if not wholly outside the College's matrix of interest groups. In 1953 the Association's *Newsletter* carried a brief item noting that the Australian Society of Psychoanalysts had just been founded in Melbourne.⁴⁵ Periodic announcements about its activities appeared, but little more. Dr Harry Southwood, a founding member of the Association and its President in 1960–61, virtually abandoned any significant role in the Association or College after the early 1960s as his interest in psychoanalysis increased.⁴⁶

In October 1989 the College established a Section of Psychotherapy, which held its first meeting in Adelaide in May 1991.⁴⁷ The section was deliberately broad in its inclusion of psychological therapies and did not concentrate on psychoanalysis alone. Remarkably, it provided the earliest forum for psychotherapy as a separate, formally constituted group within the College. While the College's publications contained virtually nothing over many years about psychoanalysis or related approaches, the *Australian and New Zealand Journal of Psychiatry* in 1989 published a wide-ranging attack on 'Psychoanalysis: A Creed in Decline' by Professor Paul Mullen of the University of Otago. Mullen claimed that 'its methods disbar it from serious consideration as a natural science and its claims to therapeutic efficacy are in tatters'.⁴⁸ This article, not surprisingly, was greeted with a volley of critical letters, chiefly by College members, countering Mullen's attack. Psychoanalysis clearly has many supporters within the College, perhaps an increasing number.⁴⁹

Changes in the College's attitude towards playing a direct role in psychiatric practice came in the 1980s. They accelerated in the 1990s, in the wake of the Chelmsford and Townsville affairs, which revealed that anything but an active stance was often detrimental to the interests of psychiatry. Moreover, the evolution of the RANZCP into a true medical specialist college, with the active power to discipline wayward members, was certainly significant. A significant and influential positive step — perhaps the most important one — was the report prepared in 1984 by the College's President, Dr Beverley Raphael, concerning a national mental health policy for Australia. The federal government set up an inquiry into this matter in 1987–88 which produced another report, culminating in the adoption of a National Mental Health Policy in mid 1992. This policy

has been endorsed by all state and territory governments in Australia and now forms the basis of current funding and approaches to mental health services. Dr Raphael's original report, centring on community-based care and an integrated approach to the provision of services, was at the core of the strategy adopted by Australia's governments.

From the early 1980s onward, the College made a significant effort to influence, at least voluntarily, the treatments offered by psychiatrists for specific disorders in the direction of world best practice. From 1982 until the late 1980s the *Australian and New Zealand Journal of Psychiatry* published a series of articles, produced by the College's Quality Assurance Project, presenting treatment outlines for agoraphobia, depressive disorders and the management of anxiety states, schizophrenia, obsessive compulsive disorders and somatoform disorders.⁵⁰ This was a major world-leading undertaking which sharply upgraded the profile of the College in psychiatric practice.

From the late 1980s those efforts accelerated further with the growth of such measures as quality assessment, peer review programs, discussions of recertification and the like, which would certainly have an effect upon clinical practice. The College also took a greatly increased role in explicitly stating medical practices, especially in the use of psychotropic drugs, which were no longer deemed appropriate or which were unsafe.⁵¹ In an article assessing a Peer Review Pilot Study carried out by the College in Victoria in 1992, in which sixty-three psychiatrists participated, the authors (Drs Barbara Knothe and Shirley Prager), specifically stated that:

The great majority of participants felt that the process had an effect on their clinical practice. Amongst the effects noted were the following:

- Record keeping improved.
- Increased self assessment, i.e. critical review.
- Improved clinical standards.
- Change of style in therapy.
- Clinical improvement in patients.
- Medication use reviewed.
- Psychotherapy in organic cases reviewed.

By the mid 1990s, it seemed clear that the role of the College in clinical practice standards and procedures would inevitably increase,

perhaps to become one of the College's primary functions. Whether this could be done without undue intrusion, and without constraining independent and even unorthodox but possibly valuable modes of clinical practice, seemed likely to become a serious long-term issue.

All these changes occurred against the backdrop of what is known as the deinstitutionalisation of the mentally ill. A one-sentence description of the treatment of the mentally ill in Australasia (and elsewhere) in modern times could do worse than to note that treatment has been a continuing process of confinement in institutions being replaced by treatment in the community.⁵² An account of that process is largely beyond this work, but some remarks should be made about the College's role in it.

From the outset, the AAP included a great many psychiatrists who were employed by mental institutions and other state instrumentalities, but it also comprised a disproportionate number of private practice psychiatrists. Today, the majority of Australasian psychiatrists (in Australia at any rate, if not New Zealand) are in private practice and public psychiatry is often regarded as second best. The College appears to have had little direct role in this development, neither augmenting nor deterring it. The transformation was primarily the result of two factors: the discovery of new psychotropic drugs and medical techniques, allowing the safe release of psychiatric patients into the community; and governmental pressures, generally dictated by economics or by media depictions of the horrors of 'snake pit'-like mental institutions, to decrease their size or close them entirely. The growth of private psychiatry has been augmented in Australia (though not in New Zealand) by the medical benefits provided by public health insurance and also, perhaps, by the growth of a newer middle-class clientele. These trends have been evident, in one form or another, throughout the world during the twentieth century, and the history of deinstitutionalisation is far older than many realise.

If the College has had any perceptible bias in this process — and it is not easy to discern any — it has been in the direction of responding more vigorously to the interests of Australasian psychiatrists in the private sector, while neglecting the residual public sector, including the standards of institutionalisation provided in public mental hospitals. Nevertheless, the College has merely reflected a trend which commenced before its foundation and has been present in all industrialised societies. But the College went on record, in April 1992, in warning against the Australia-wide policy of

'deinstitutionalising' the seriously mentally ill unless it was accompanied by much greater resources and higher standards of community support services. Describing deinstitutionalisation as a miserable failure, RANZCP President Dr Norman James signalled the College's heightened concern with the issue.⁵³

12 Chelmsford and Townsville

In this chapter the two great scandals involving fellows of the College will be examined in more detail than was possible earlier. Even so, this chapter obviously cannot be a comprehensive account of these affairs, and must focus on the role the College played in them.

From the vantage point of this work the Chelmsford affair essentially revolves around the activities of Dr Harry Bailey and a handful of his colleagues, and the treatment technique known as prolonged narcosis (deep sleep therapy), and how these interacted with the College. Harry Bailey's links with the Association and College appear, to historians working from College records, to be both infrequent and unremarkable. Bailey became a member of the AAP in October 1952, along with five other persons admitted at the same time to full membership and twenty admitted to associate membership.¹ So far as can now be determined, Bailey gave only one account of his psychiatric research to the Association/College. This occurred at a clinical meeting in Sydney in October 1953, when he gave the following account of cortical electrotherapy, as reported in the *Australasian Psychiatric Quarterly Newsletter* for October 1953:

Cortical electrotherapy — a critical appraisal

Dr H.R. Bailey (NSW) gave a very excellent account of the therapeutic use of electric currents applied to the brain. He pointed out that Benjamin Franklin (1706–1790) had experimented with electronarcosis whilst, as early as 1870, the value of E.C.T. had been demonstrated by Arndt. His review was a critical one

from then till the present day, including early experiments in electroanaesthesia, consideration of the standard Cerletti-Bini technique, the Strauss-McPhail 'Plexacon', the 'Reiter' apparatus, the Brief Stimulus Technique, and others.

Dr Bailey argued that there was a 'non-specific factor' entering into the favourable response of depressive and paranoid syndromes and a narrower 'specific factor' which is 'responsible for the differences seen in the responses of these two syndromes to E.C.T.' He postulated that the 'second factor could easily be a function of some variable associated with therapy, such as wave form'.

He went on to discuss the physiology of the therapeutic response and mentioned a 'growing tendency to regard the convulsion as an epiphenomenon rather than the healing force in E.C.T.' The bulk of the current traverses subcortical and diencephalic regions and attention is being focussed on the importance of the diencephalic (thalamic) reticular formation, which activates the cortex and so produces the convulsion. He pointed out that sub-convulsive stimulation has a hypothalamic response, as shown by a marked fall in circulating eosinophils.

Dr Bailey himself is interested in investigating microsecond pulses, the variables of which he hopes to be able to control and reproduce accurately. If so, electrolyte changes in the nerve-cell (possibly Potassium), produced by electrical discharge, might give significant results with these controlled pulses.

This, of course, being dependent on the changes in the nerve-cell occurring quantitatively.

Dr Bailey finished by stating: 'The full force of electronic research is available to us; we have only to learn sufficient of the electronic and communication

engineer's language to make our demands intelligible, and it is here that the disc line of cybernetics will prove so valuable' ... 'Let us have E.E.G.s and photic stimula and the rest — but we must have more observation and recording by the clinical psychiatrist. One small but accurate series of observations may be of more worth than a car load of pseudo-analytic and sesqui-pedalian hypotheses'.

In a final demonstration, he showed a pulse generator and modulator capable of producing square pulses, continuously variable from 0.5 to 50 microseconds in duration, at frequencies from 10 cycles to 10,000 cycles. Coupled with a suitable power amplifier and monitoring devices, this instrument formed the basis of a new research electrostimulator. The generator produced micropulses displayed on a cathode-ray oscillograph. For comparison, a 50 cycle sinusoidal (AC) wave was shown on the oscillograph.

Two model miniature E.C.T. apparatuses were shown, the Mark II model incorporating 'glissando' and unidirectional (rectified) current. The timing device was of the dial type, controlling a sensitive relay.

A demonstration of photo-metrazol stimulation was given, myoclonic responses being provoked in an epileptic boy.²

Ironically, Dr Bailey's critical talk on cortical electrotherapy was given just after a discussion on full-coma insulin therapy — a predecessor technique to full deep sleep therapy — presented on the same occasion by Dr G. Flanagan of Victoria and Dr Ian Simpson of New South Wales.³ Bailey took no part in this discussion. As far as can be ascertained, there is no further mention of Harry Bailey or his activities in any College source for over twenty-five years. Although he was certainly controversial in the context

of Sydney psychiatry, in the College's records he was professionally indistinguishable from hundreds of other psychiatrists.⁴ Further, there is apparently no mention in any College source of deep sleep therapy and certainly no alarm or criticism concerning it.

Deep sleep was a well-known, if perhaps infrequently used, form of therapy dating back to the 1920s. In Australia, it was used as a technique by such pre-eminent psychiatrists as Dr Alex Sinclair and Dr Eric Dax. Before coming to Victoria, Dr Dax 'used prolonged narcosis on up to 1300 patients in Britain'.⁵ Prolonged narcosis was also practised in the mid 1950s at Larundel Hospital in Bundoora, Melbourne.⁶ In 1989 the New South Wales Royal Commission noted that Dr Sinclair began using a form of sleep therapy in Melbourne soon after the war and continued until the late 1970s.⁷ It was widely accepted that in experienced hands, the death rate under prolonged narcosis was 0.5 per cent, but that this rate increased to at least 2 per cent among patients who did not receive adequate nursing care.⁸ What distinguished Dr Bailey and the Chelmsford Hospital was, centrally, the fact that safeguards designed to limit mortality were not practised: 'not one of [the] accepted procedures was in place', according to Bromberger and Fife-Yeomans.⁹

There is also universal agreement that Harry Bailey was a bizarre character, whose charismatic personality was a veneer over a twisted interior.¹⁰ Bailey 'could talk the leg off an iron pot'. He was a 'terribly important-looking man' who 'charmed the relatives' of his patients.¹¹ Bailey was a 'manic depressive' but unquestionably had charisma, a senior psychiatrist explained, representing a consensual viewpoint.¹²

So far as the College's nexus with the Chelmsford affair is concerned, there are a number of key questions which must

be addressed in assessing its role and in deciding whether it acted in a responsible fashion. First, when did leading Australasian psychiatrists become aware of Chelmsford? Second, when did the College begin to act? Third, if the College did not take any radical measures against Bailey and others guilty of malpractice, why was this not done? In retrospect, how should the College's behaviour be viewed? Finally, what did the College learn from Chelmsford?

Concerning the first of these questions, there have been suggestions that many leading psychiatrists in Sydney had heard that something was amiss at Chelmsford towards the conclusion of the period of deep sleep therapy (which ended in 1978). There is no evidence, however, that very much, if anything, was known to the College's leading officials and office-bearers before Bailey's activities became the subject of official investigation, and the evidence is certainly very contradictory. Although Bailey's early career had been in isolation from the profession at large, by the mid 1970s he was certainly a well-known figure in the Sydney psychiatric world (although not in the activities of the College).¹³ Bailey's biographical notice appeared in every edition of *Who's Who in Australia* from 1962 (when he was barely forty) until his death in 1985 (seven years after Chelmsford became a matter of public knowledge). He was probably among the wealthiest psychiatrists in Sydney, boasting of an income of \$250 000 by the late 1960s, a colossal figure.¹⁴ He frequently appeared in court to give medico-legal evidence. Even before the Chelmsford scandal entered the public arena, he had been involved in several sexual affairs which were common knowledge.¹⁵ One of his mistresses committed suicide, leaving Bailey as the sole beneficiary of her \$100 000 estate.¹⁶ Even apart from deep sleep, Bailey had been sailing exceedingly close to the wind in a variety of ways for many years: Bromberger and Fife-Yeomans

concluded that by 1967 'Bailey should have considered himself lucky to still be practising medicine'.¹⁷

In 1973 Bailey published an article in the *Medical Journal of Australia* which was refereed by eminent psychiatrist Professor Leslie Kiloh of the University of New South Wales, who recommended that it be rejected. Kiloh was surprised when the article was published.¹⁸ Letters critical of the article by Dr S.E. Williams of the Psychiatric Research Unit at Callan Park and by Dr John Sydney Smith were also published, which resulted in a decrease in the number of psychosurgical operations carried out at Prince Henry's Hospital.¹⁹ Professor David Maddison was also publicly critical of Bailey's approach to psychosurgery on an ABC *Four Corners* program broadcast in March 1974.²⁰ Doubts about Bailey's methods, especially his administration of drugs, were also evident to officials of the New South Wales Health Department.²¹

In 1978 various serious complaints about Bailey and Chelmsford were made by former patients and staff nurses.²² At that time many of Chelmsford's medical records were apparently destroyed.²³ Also, and even more seriously, the unusually high mortality rate of the deep sleep techniques practised at Chelmsford began to come to light.²⁴ In 1978, several Sydney newspapers began to take up the case — the *Sunday* newspaper headlined a story "'Zombie Room" outrage at Hospital' — and the Church of Scientology redoubled its anti-psychiatry public relations efforts with attacks on Bailey.²⁵ In 1983 the Channel 9 program *60 Minutes* brought national attention to the affair with an award-winning documentary entitled 'The Chelmsford File'.²⁶

Despite all this, it seems that senior Australian psychiatrists, even in Sydney, knew surprisingly little about Bailey's deep sleep procedures before those procedures

came to the public's attention. The criticism voiced about Bailey's 1973 *Medical Journal of Australia* article related to psychosurgery, not to deep sleep. Dr Russell Pargiter (based in Tasmania) was not aware of anything amiss at Chelmsford when he was President of the College in 1973-74.²⁷ Dr John Ellard of Sydney, who probably did more than any other psychiatrist to expose Bailey, realised that the latter was a crooked figure, but knew nothing of the details until they were publicly exposed.²⁸ There was, however, apparently a sense that 'people knew that something bad was going on', as Dr Richard Ball expressed it.²⁹

There is no record in any College source of any involvement by the College in the Chelmsford affair, of either an official or unofficial nature, before March 1979. On 5 March 1979 Dr Brian Boettcher, a consultant psychiatrist in Sydney, who had patients hospitalised at Chelmsford, wrote to Dr Noel Wilton, chairman of the College's New South Wales branch, in order 'to inform the College of events that I feel should be of interest to them'. Dr Boettcher outlined the meeting in November 1978 between Dr Herron and six other doctors, following the exposure of the hazards of deep sleep in the local press. As a result of that meeting Dr Boettcher and four other doctors who had used the Chelmsford clinic ceased doing so.³⁰ Dr Boettcher stated that 'it was determined at this meeting that the doctors using this therapy [at Chelmsford] namely Dr Heron [*sic*] and Dr Bailey would not stop using it and that the hospital would not nor could not stop them'.³¹ He suggested that 'such strong action' — the withdrawal of five psychiatrists from Chelmsford — 'should not go unnoticed by Aust. & NZ College of Psychiatrists', and also suggested 'that a Position Paper be prepared regarding the use of deep sedation therapy, because if you don't the media will very soon bring the matter to the public's attention with the

College in a totally unprepared state. In fact this has already happened'.³²

As noted, no written evidence of any kind exists which implies that the College or its officials heeded Chelmsford before this date (or were asked to). In October 1980 the matter first came to the attention of the General Council with the lodgment of complaints by the Citizens Committee on Human Rights and Dr John Sydney Smith (Director, Neuro-Psychiatric Institute, University of New South Wales).³³ In the same month the College made its first statement on deep sleep, issuing a clinical memorandum 'to provide guidance to members in relation to this form of treatment'.³⁴ This clinical memorandum was proposed by the College's Psychotropic Drugs Committee, based upon a recommendation by General Council in response to a letter about the issue written by Dr Brian Boettcher. The memorandum stated that 'Deep Sedation Therapy is undoubtedly a hazardous technique' and concluded that 'there would seem at present no justification for the use of this form of treatment'.³⁵ The complaints were initially considered in October 1980 and legal advice subsequently sought by the College before reconsideration by the General Council at its next meeting, in May 1981. There was great confusion and obvious ignorance about both the College's powers and the infrastructure of the College which dealt with disciplinary action. Moreover, there seemed to be a feeling that the College's responsibilities lay with isolating and punishing Dr Bailey. On the other hand, the College seemed just as strongly to be responding to adverse television and media criticism.

With these considerations in mind, historians are able to address, at least tentatively, the question of why so little was done until after deep sleep therapy ceased at Chelmsford. The most important reason by far was that no realistic procedure existed to enable the College to take any

action. The College had no binational committee to deal with allegations of unprofessional behaviour by its members. The reason why no such committee existed was that while the RANZCP had established a monopoly or near-monopoly over the examination process for new fellows, it had not yet instituted a realistic means of disciplining unprofessional fellows. In theory, disciplining was supposed to be left to the branches, but their appropriate mechanisms appear to have been even more skeletal and primitive. While the College, under its constitution, did indeed possess the formal power to discipline unprofessional conduct, the power had never been used.

There were additional reasons. Most basically, little or nothing was known of the abuses at Chelmsford, even to other psychiatrists associated with it let alone to those who were not associated, and until the late 1970s there was no reason why anyone should have known. Dr Richard Ball, the College's President in 1979–81, later stated that 'the College as a College was not told until the last minute of Chelmsford', there being no official complaint. 'Then everything failed.'³⁶ Deep sleep therapy was regarded as a risky but nevertheless medically acceptable technique which had been widely used internationally and was referred to in psychiatric textbooks as recently as 1972.

More telling for the College was another motive for inaction mentioned by some psychiatrists involved in the RANZCP at that time: 'Nobody is very critical of their peers.'³⁷ In the absence of any established mechanism for adjudicating complaints of unprofessional behaviour, few psychiatrists were likely to intrude into the professional careers of their colleagues except in the most extreme and clear-cut circumstances — and with good reason, as a failure to prove alleged unprofessional behaviour would certainly result in a defamation suit being brought against the

complainant. This reluctance to criticise professional colleagues is fully shared by the rest of the profession.

What certainly did not occur — and this cannot be emphasised too strongly — was any kind of a deliberate cover-up or any attempt by the College or its office-bearers to hide the situation at Chelmsford or to sweep it under the carpet once it became known. Any such suggestion would be quite false and unsupported by any evidence which the authors have seen. Rather, an infrastructural failure in the framework of the College as it existed then was primarily to blame. At the time, the College made searching and extensive enquiries through its solicitors concerning its power to take action.

The College's involvement with Chelmsford and its consequences was, for the next decade, continuing and direct, although it was hamstrung by legal obstacles to further action. In May 1981 the College Council, after taking legal advice, 'resolved that the complaints [against Drs Bailey and Herron] be referred to the relevant Medical Board', and Bailey and Herron were 'advised that the complaints had been forwarded to the Medical Board of NSW.'³⁸ During the next three years 'it became clear to the Executive Advisory Committee that a number of legal actions ... made the matter *sub judice* for a period of time extending into 1984'.³⁹

From 1978 onwards a new element entered the College's considerations — attempts by the so-called Citizens Committee on Human Rights (closely associated with the Church of Scientology) to expand its long-standing anti-psychiatry campaign by pinning some of the blame for Chelmsford on the College or the psychiatric profession generally. The Citizens Committee (later the Citizens Commission) wrote to the College in 1978 and 1980, pointing out the Chelmsford abuses.⁴⁰ In the late 1980s the commission redoubled its effort in a highly visible manner.

In August 1988 it presented the College with a 'Compensation Bill' for \$100 million 'on behalf of victims of deep sleep treatment'. That sum represented 'the estimated income of Australian psychiatrists in one year'.⁴¹ A press release was issued by the commission at the same time, resulting in stories about the claim appearing in various newspapers.⁴² The commission staged a wellpublicised media event at Maudsley House during which they confronted the Registrar.⁴³ The College was forced to retaliate with a strongly worded letter to the commission threatening legal action over possible defamation. Additionally, the College President, Dr Joan Lawrence, immediately issued a press statement setting out as accurately as possible what the College's involvement in Chelmsford had been.⁴⁴ At that time the media image of the College was arguably at its lowest ebb, and a mood of pessimism and deep concern gripped many employees of the College and leading psychiatrists. Dr Lawrence stated that, in 1988, 'ongoing negative images' of psychiatry were 'before the public, whether rightly or wrongly, for most of the year', and that 'the forces inimical to psychiatry tried to capitalise on this'.⁴⁵

Because many aspects of Chelmsford were *sub judice* for most of the 1980s, the College could do much less than it wished to against those who participated in its harmful aspects. Following an announcement that the Complaints Unit of the New South Wales Health Department would lodge a complaint concerning the competence of Dr Bailey, in August 1985, the College held a special meeting of the General Council 'to consider matters raised by this case and the case of *Hart v. Herron*'.⁴⁶ As a result, Council 'determined to consider whether use of the expulsion power was warranted but the matters remained *sub judice* because of an appeal pending in the *Hart v. Herron* case'.⁴⁷

In April 1986, when it became clear that *Hart v. Herron* would not proceed further, the executive officers of the College decided to initiate expulsion procedures against Dr Herron.⁴⁸ A resolution to that effect was prepared and was to be moved by the College's executive officers at a special meeting of the General Council on 18 May 1986, but Dr Herron successfully blocked its progress in a court injunction.⁴⁹ In the late 1980s there followed the New South Wales Royal Commission into Chelmsford, to which members of the College, especially Dr Maurice Sainsbury, gave extensive evidence. (Dr Sainsbury, a former College President, was consultant psychiatrist to the Slattery Royal Commission; his 503 page report comprises Volume 11 of the official Royal Commission Report.) The fact of the Slattery Royal Commission also delayed any further action.

The whole of the Chelmsford affair, with its rather unsatisfactory conclusion, caused great and genuine consternation to the College. 'Fear was floating around,' Peter Carter, the College's Registrar, recalled.⁵⁰ It was 'very threatening — very frightening', according to Margaret Ettridge, the College's Assistant Registrar.⁵¹ In retrospect, there are two schools of thought about the College's involvement with Chelmsford. The majority negative view is highly critical of the College. The College was 'impotent' and 'did nothing'; it was at the time an 'amateurish organisation'; the College's officers were too 'timid'. 'We failed.'⁵² Those are among the views the authors of this book heard frequently expressed by senior psychiatrists about Chelmsford. Most senior psychiatrists interviewed about the subject still deeply regret these events, typically exhibiting a mixture of embarrassment and vexation about the College's inactivity and impotence.

There is, however, another school of thought which claims that, given the realities of the situation, the College 'acted reasonably well', as Dr Robert Broadbent, the

College's Registrar (who had no involvement in College activities until 1988) put it.⁵³ Once it 'became obvious that [College] intervention was subject to legal advice' and had to await the outcome of the courts, nothing could be done.⁵⁴ Probably both points of view have strong elements of truth, though anyone must regret that no adequate infrastructural channels for monitoring unprofessional behaviour by College members were in place until after Chelmsford.

Perhaps the fairest verdict on the College's role is that, after about 1980, it did everything legally open to it to counteract Chelmsford's abuses, but that it did little or nothing before then and does not emerge from the Chelmsford affair covered in glory. On the other hand, the College learnt a great deal from Chelmsford, genuinely reforming its constitutional provisions and committee structure dealing with abuses of this kind. It is at least improbable that there could now be a repetition of Chelmsford, and very unlikely indeed that any abuses of psychiatric practice analogous to Chelmsford could continue for any long period without being officially and critically investigated by the College.

There were a number of other inquiries into the use of deep sleep therapy as a result of Chelmsford, outside New South Wales. In 1990, at the request of the New Zealand Minister of Health, the New Zealand Department of Health appointed Professor Graham Mellsop, a fellow of the College, and Michael Radford, a lawyer, to inquire into allegations concerning the use of deep sleep therapy in New Zealand hospitals.⁵⁵ The inquiry was prompted by allegations made by the Citizens Commission on Human Rights.⁵⁶ The report, submitted in January 1991, found that deep sleep therapy was indeed used in New Zealand, especially at Cherry Farm Hospital in the 1970s, but that since 'a high standard of general nursing care' was always given, no serious harm came to any patient, in contrast to

the situation at Chelmsford.⁵⁷ In 1991, the Victorian Health Services Commissioner, Dr Ian Siggins, claimed that 'modified deep-sleep therapy' had been used in Victoria, 'often with staff inadequately trained to respond to life-threatening emergencies'.⁵⁸ Dr Siggins was careful to note that 'the reported cases in Victoria could not compare with the Chelmsford Hospital experience. It is nothing on the scale of Chelmsford. There is no conspiracy of silence but people are not talking about some of the forms of treatment'.⁵⁹

Although the Chelmsford affair overlapped chronologically with the scandal of Townsville Hospital's Ward 10B, by the time 10B surfaced as an issue for the College, the lessons of Chelmsford had been learnt, and infrastructure and procedure reinforcing the College's powers were in place to deal with such occurrences. There were also substantial differences between the two affairs, especially the amount of direct evidence about Ward 10B available to the College compared with Chelmsford and the absence of any legal actions which constricted the College's response. The College dealt firmly and speedily with the Townsville scandal, despite the fact that the man at the centre of the case, Dr John Lindsay, had been a respected member of the College for many decades. From mid 1988 the College closely monitored 10B, and officially noted it at General Council meetings in June and October 1989. This followed very closely on Dr Lindsay's taking leave as head of the ward in February 1987, and on the raising of the issue with Queensland officials by Dr Lindsay's successor, Dr Johann Schioldann-Nielsen, in May 1987-February 1988.⁶⁰ According to Dr Lindsay, Dr Schioldann-Nielsen wrote to the President of the RANZCP, Dr Joan Lawrence, on 16 March 1988, giving his version of events.⁶¹

It is clear, however, that (somewhat like Chelmsford) any action by the College had to follow the official investigation

of Townsville by the state Medical Board. At the College's General Council meeting of October 1989, it was noted that 'The investigation of these matters [10B] by the Queensland Medical Board was proceeding slowly. The College had formally registered its interest in being kept informed of progress ... The CEC [College Executive Committee] had expressed concern about the rate of progress with the Board's investigation and had formed the view that a special meeting of General Council might be required to be held in Perth in May 1990 in association with the scheduled Council Meeting ...'.⁶²

Dr Lindsay was present on that occasion. The account of the meeting given in its minutes is as follows:

'THAT Dr John Spencer Bonar Lindsay be expelled forthwith from membership of the College because his conduct has, in the opinion of General Council, been detrimental to the honour and interest of the College and the profession of psychiatry and has tended to bring the College and the profession of psychiatry into contempt, disrespect and loss of esteem.'

Moved: Dr J. Lawrence
Seconded: Dr B. Kenny

Dr Zelas [President of the College] referred members to the written statement by Dr Lawrence in support of the resolution which had been circulated with the Registrar's memorandum of 27 April 1990. The President then introduced Dr Lindsay to all members of General Council and drew attention to a written statement from Dr Lindsay which had been received on 10 May 1990 and distributed to members at the commencement of the meeting.

Dr Zelas announced that the order of proceedings for the meeting would be as follows:

1. Dr Lawrence to read her statement supporting the resolution.
2. Dr Lindsay's rebuttal to be presented.
3. Right of reply by Dr Lawrence.
4. Questions from members of General Council.
5. General Council to consider and vote on the resolution.

At the invitation of the President, Dr Lawrence read her statement in support of the resolution.

At the conclusion of Dr Lawrence's statement the President invited Dr Lindsay to respond. Dr Lindsay indicated that he had prepared a written response to the matters raised by Dr Lawrence and he commented on this document which had been distributed to all members. The President emphasised to Dr Lindsay that Councillors had not yet had the opportunity to read his submission and invited him to read the submission to Council. Dr Lindsay declined to do so and expressed agreement when Dr Zelas indicated her intention to read his submission to the meeting. Dr Lindsay requested leave from the meeting whilst this reading occurred, indicating his intention to return when the reading was completed.

Dr Lindsay returned to the meeting at the conclusion of the reading of his submission. He presented additional documentation to the President in the form of copies of articles from a number of daily newspapers of 11 May 1990 and, at Dr Lindsay's request, these articles were read to the meeting by the President. Dr Lindsay said that he had no further comment to make at this stage.

Dr Lawrence then exercised her right of reply.

Following this, the President invited members of General Council to submit to her in writing any questions they wished to address to either Dr Lawrence or Dr Lindsay. These questions were asked

by the President who invited a response from the relevant person and any comment from the other party.

At the conclusion of questions Dr Lawrence, Dr Kenny, Dr Lindsay and the Registrar, Dr Broadbent, withdrew from the meeting. General Council then debated the matter after which the resolution was put in a secret ballot with the result: 20 votes in favour, nil against, one abstention. The President *declared the motion carried* in accordance with the requirements of Article 71 of the Memorandum and Articles of Association.

The meeting was closed at 5:50 pm.⁶³

The effects of Townsville, both upon the College and in the mind of the general public, were certainly much less dramatic than were the effects of Chelmsford. It is noteworthy, for example, that senior psychiatrists interviewed for this book almost never raised the Townsville affair, although Chelmsford was often and regularly mentioned spontaneously and is regarded by many as traumatic and unforgettable. Townsville surfaced in the wake of Chelmsford, when the College's procedures for handling such affairs had been carefully examined and the experience of Chelmsford had been internalised. It should also be noted that while Chelmsford occurred in Australasia's largest city, the Ward 10B scandal took place in a remote regional centre in far north Queensland where Dr Lindsay was often the only practising psychiatrist. Indeed, one of the themes to emerge from analyses of the Ward 10B affair was that an isolated psychiatric ward was in particular jeopardy owing to its lack of a large staff.⁶⁴ Ward 10B lacked a central figure with Harry Bailey's colourful notoriety as well as more than minimal involvement by the highly visible Scientologists. As a result of all these factors,

the media paid much less attention to Townsville than to Chelmsford. It is at least hopeful that no affair similar to either has occurred since.

13 The Image of Australasian Psychiatry: Past, Present and Future

In this concluding chapter, the history of the College will be related to a wider topic, the image of psychiatry in Australasia as it has developed over the past half-century. Additionally, something of whether there is an Australasian 'school' of psychiatry and how the College's own fellows view the current activities of the College will be expressed from the results of a random sample survey of College fellows conducted for this book.

There is widespread agreement among both psychiatrists and members of the public that the profession of psychiatry suffers from a negative image problem, founded in ignorance and misunderstanding of the nature of psychiatry, of psychiatrists and of mental illness. That image problem takes many forms and guises, and has many causes. Perhaps its most basic cause lies in the singular fact that mental illness is seemingly the only socially shameful disease in which the stigma affecting its victims also attaches to the doctors who treat them. It would be absurd to suggest that the physicians specialising in the treatment of other socially stigmatised illnesses, from leprosy to AIDS (and, in the case of AIDS, medical scientists specialising in research) are regarded by the general public with anything but great respect. Yet throughout modern times there has been the totally illogical but pervasive notion that physicians who specialise in the treatment of mental illness must somehow themselves be abnormal: 'crazy people treating crazy people' is the often-heard refrain.

Behind this primary aspect of psychiatry's image problem lies an equally widespread public ignorance about

psychiatry itself. Many, perhaps most, persons in Australia and New Zealand do not know what a psychiatrist is: in particular, they are almost certainly unaware that a psychiatrist is a qualified medical practitioner who has received further rigorous specialist training in mental illness and its treatment. Very significant numbers of even well-educated persons confuse psychiatrists with psychologists, or assume that all psychiatrists are psychoanalysts, or conflate psychiatrists with the white-coated attendants in mental asylums, or make some other assumption about psychiatry detrimental to the profession, based on ignorance and misinformation.

Two particular misleading images of psychiatry are still surprisingly common. The first is that of the psychiatrist as nineteenth-century lunatic asylum keeper, someone who incarcerates the mentally ill in horrifying conditions with quasi-medieval restraint devices. This image is still extremely widespread, even among people whom one assumes would be much better informed. For instance, in 1989 the *Law Institute Journal* (the respected monthly organ of the Law Institute of Victoria) published a serious study of 'The Process of Civil Commitment under the Mental Health Act 1986' by Neil Rees. The article was illustrated by a photograph showing 'the back view of a man wearing a straitjacket being escorted by two men in white coats who are holding him quite firmly'.¹ Four psychiatrists wrote in protest, pointing out that straitjackets have not been used in Victorian psychiatry in many years, and that the representation could only have an adverse effect upon potential patients seeking treatment.² Anyone familiar with lowbrow tabloid advertising on television or in newspapers will be aware that 'crazy people' are still depicted in similar images.

Psychiatry is also often seen by many people in terms of the popular image of the cartoon Freudian psychoanalyst,

the patient on the familiar couch telling his or her life story to a bearded psychiatrist taking notes. This situation is the butt of a thousand jokes, and probably every comedian and comic writer of the twentieth century has cracked a 'psychiatrist joke' at one time or another (example: Sam Goldwyn's apocryphal remark 'Anyone who sees a psychiatrist should have his head examined'). The psychiatric profession has no real recourse. During the past fifty years, while negative stereotypes of ethnic and religious minorities and grossly sexist depictions have become not merely unfashionable but possibly illegal in some states, there are no remedies for the defamation of a profession, even if the charges brought against it are wildly misleading or even mendacious.

A final source of bias against psychiatry comes from within the medical profession itself. There has in all likelihood always been an underlying current of uneasiness or even hostility towards psychiatry from other medical specialties, especially, perhaps, the old-established ones such as surgery. This is because psychiatry often eschews the physical treatment of illness in favour of more nurturing approaches. In Australasia and probably elsewhere, psychiatry has attracted a disproportionate number of relatively disadvantaged groups, for example women, who comprise a much higher percentage of psychiatrists than they do of old-established medical specialties such as surgery. There has long been a well-publicised school of thought among other physicians and academics who argue that the very concept of 'mental illness' is misleading and is normally a euphemism for any form of behaviour which society deems unacceptable, rather than constituting organic disease in the same sense as pneumonia or lung cancer.

There is no doubt that a combination of all these factors, augmented by the horror and even luridness of mental illness *per se*, remain powerfully entrenched in the media,

even in well-informed and responsible sources. A 1988 cover story on mental illness in the *Bulletin*, the leading Australian weekly news magazine, was entitled 'How to Tell if You Are Going MAD and What Will Happen when You Do'. The section of that feature dealing with psychiatry was headed 'What We Think about Shrinks'.³ Although well-researched and basically serious, the story began with a *de rigueur* psychiatrist joke (Patient: 'Doctor, I have continual, nameless dread.' Psychiatrist: 'Don't worry! We have names for everything!'), made prominent note of how 'we stereotype psychiatrists, portraying them as eccentric, mad Viennese as mad as their patients, or as "headshrinkers" — our equivalent of witchdoctors'. Most of the article dealt with the difficulties facing psychiatry and psychiatrists, and concluded by asking: 'Considering the anger it arouses, does psychiatry have a future?'⁴ The *Bulletin* returned to the same subject, in the same manner, three years later, with an article entitled 'Psychiatry: A Very Peculiar Practice', again beginning with the mandatory psychiatrist joke, and having as its theme the 'criticism of the profession following the "Deep Sleep" affair'.⁵ The Australasian media, it seems, rediscovers psychiatry and its 'peculiarities' every few years.

That psychiatry has often been viewed in a dark light in the past is amply demonstrated in historical accounts of psychiatry written by Australasian psychiatrists. To a remarkable extent, their message varies little, regardless of when written. R.S. Ellery, a foundation member of the AAP, who began his career as a psychiatrist in Melbourne just after the First World War, observed in his 1956 autobiography how marginal psychiatry and the treatment of mental health were in the early 1920s:

In the year 1923 medical practice was accomplished without the aid of psychiatry. Mental disorder

belonged to the asylum where it was shut off from the main body of medicine like an encysted abscess. There it went and, so far as the medical profession was concerned, there it remained. Madness was generally without interest to the general practitioner ... Psychiatry was now on the map in Melbourne — but only just. For some years its influence was hardly felt. To the layman it was still sternly suspect. You went to the psychiatrist ... only if you were crazy.⁶

Among the College's records is an exchange of letters dating from early 1964, between Dr C.M. McCarthy, also a foundation member of the AAP, and J.D. Rimes, Under Secretary for Psychiatric Services in the New South Wales Department of Public Health. Dr McCarthy protested at a newspaper article and television documentary in which the New South Wales department allowed reporters access to psychiatric patients. *Inter alia* Rimes gave as one reason the fact that (according to him):

There is, as you know, a considerable prejudice against psychiatry, psychiatrists, and, particularly, against mental health care. It is our view that articles such as those you mention assist in breaking down much of the prejudice which exists in the minds of the public and encourages people to adopt a more realistic and rational view towards psychiatric treatment.⁷

Today's psychiatry suffers from much the same image problem. In the course of the interviews of prominent College psychiatrists undertaken in preparation for this book, the authors were told many anecdotes illustrative of this. One man, who was 'nearly engaged' to a nurse, was told by her that psychiatry 'was not proper doctoring' and would be 'the waste of a good doctor'. Many other

psychiatrists repeated that psychiatry was the most marginal of the medical specialties.

Although the College has taken measures to combat this negative image, it cannot be said that it has ever launched the far-reaching proactive campaign to better inform the public about psychiatry which might have helped to counteract negative images. The first forty years or so of the organisation's history were chiefly taken up with establishing the College examination, becoming recognised by the government and other medical specialist bodies as Australasia's representative psychiatric body and, more recently, with establishing better practice standards. Given the difficulty of these tasks, it is perhaps natural that no massive campaigns have been launched to improve psychiatry's image, although the College's Information Officer and other College officials have certainly had some effect. Changing the image of a profession is enormously difficult, but the legitimacy the College has achieved, not least among other medical specialties, has probably assisted this process.

Yet one of the major tasks which the College might wish to set itself, over the coming decades, is the transformation of psychiatry's negative image, a task which must be founded in educating the general public in Australasia about the real nature of psychiatry and its achievements. One relevant factor is whether the College is viewed by its own fellows as doing its own work satisfactorily. To a surprising extent, the answer is probably yes.

In an attempt to ascertain the grassroots opinions of College fellows towards a number of vital issues affecting it, a postal survey was undertaken in 1994 of a random sample drawn from two groups of College fellows — those with fewer than five years' membership, and those with ten or more years' membership. A total of forty-five fellows, randomly selected from the College's membership lists, were sent a four-page open-ended questionnaire. Forty-one

replies were received, twenty-two from the younger group and nineteen from the older group. This survey was perhaps not large enough to be statistically accurate to within the very small margin of error preferred in such surveys, but its results are probably accurate enough, especially if they point to a clear verdict. Apart from information about their careers, respondents were asked to 'write a brief account of your association with the RANZCP' as well as to provide information about any College offices held or conferences attended.⁸ They were also asked their views on the College examination process and what changes they would wish to make in it. The survey also asked whether fellows 'should be required to reaccreditate regularly after, say, ten or fifteen years?' A question was asked as to whether the RANZCP 'is doing its job properly' and how it might improve. Finally, a general question was asked about the likely evolution of psychiatry in Australasia. For all questions, respondents were told that they could write as much or as little as they wished.

Perhaps the most interesting and surprising result in this survey was in the answers to the question 'Is the RANZCP doing its job properly?' Only three respondents (7 per cent) out of forty-one answered 'no' with fifteen (24 per cent) answering with an unequivocal 'yes', thirteen (32 per cent) basically answering 'yes' but suggesting some changes, and ten (24 per cent) respondents declining to answer or having no response.⁹ The very strong apparent degree of satisfaction with the College's performance might surprise those aware of the rumblings of discontent among some fellows at the very time (mid 1994) that this survey was administered. Moreover, and perhaps more surprisingly, younger fellows appeared to be more generally satisfied with its performance than more senior fellows. The number of respondents who indicated dissatisfaction with the College's examination and training process certainly

exceeded the percentage who were dissatisfied with the College *per se*.

Those respondents who indicated dissatisfaction with the College noted that:

For me, the RANZCP. has not fulfilled my interests. For many, some aspects are of use, while for others it is their central focus. It is a body with status, which conveys status ...

The College presumes to carry out an accrediting role not only in regards to admission to membership but also with regard to clinical facilities ... It is quite inappropriate that the College sees itself as an industrial advocate and contends with the Govt. over fees and conditions ...

I do not feel ordinary members, particularly women, are really encouraged to participate. Sometimes a closed club atmosphere.

Should be more responsive and proactive in social issues such as child abuse, domestic violence, and Aboriginal health.

The College's satisfied fellows made remarks such as these about its performance:

Overall, I think it is [doing its job properly]. As a registrar there were supportive people when information was needed ... I feel that the College is essentially approachable and accessible.

Whenever I have had to call the office, the staff are friendly and efficient and certainly seem able to answer queries. The material put out by [the] College

(e.g. position statements) are generally good, well thought out and helpful ...

I have no complaints at present.

A number of respondents endorsed this positive view of the College, but added suggestions to improve its performance:

It could be more proactive, with a public profile, in promoting community awareness of mental illness, defending attacks from 'anti-psych.' groups and advocating on behalf of doctors and patients.

I like the Journal and conferences [but] I have no idea what else the College does.

The attendance of general meetings of the College is not good — There does not seem quite enough lively communication between 'office bearers' and clinicians.

Perhaps a service such as referrals for psychotherapists could be handled by [the] College. It is very difficult to find a psychotherapist with vacancies.

A somewhat unexpected disclosure by the survey is that a large percentage of the psychiatrists who participated appear to have had much direct association with the College, although these may have been chance results. Seventeen respondents (41 per cent) had a great deal of association with the College, eleven (27 per cent) had a moderate amount, and thirteen (32 per cent) had little or no contact. Those in the first category were fellows who held an official position with the College or any of its committees or branches at the federal or state level. Respondents with little or no association are simply passive fellows who pay

their dues but seldom or never participate directly in College activities. The 'moderate' category includes those who have attended several College conferences, but have never been members of any College committee.

Since the College currently has about 2000 fellows, it may seem surprising that such a large proportion of those surveyed have held an official position in the College. This figure may well be an overestimate. Nevertheless, in view of the plethora of College committees and branches, at any one time there are probably up to several hundred people who are members of a College or branch committee — a number which, over fifteen or twenty years, must be multiplied by three or four because of personnel turnover. Of those with little direct association with the College, nine of the thirteen are younger fellows while only four out of the seventeen members with a great deal of association with the College are younger fellows, just as one might expect.

Given the expansion in College membership, whether or not in the future as many fellows will participate directly and officially in College affairs is debatable. There is, in any organisation, what the French sociologist Robert Michels termed the 'iron law of oligarchy' wherein leadership devolves upon a tiny percentage of the membership who virtually monopolise that organisation's positions of authority; no large organisation is ever truly democratic. Certainly the history of the RANZCP bears this out: the twenty or thirty most prominent fellows turn up again and again on virtually every committee and in an extraordinary variety of leadership positions. This was certainly true when the College was small and it is also true, although to a lesser extent, today. Nevertheless, it would seem that there are surprisingly ample opportunities to become officially involved in the College's affairs. Nor should it be forgotten that many fellows, especially the younger ones who are establishing themselves, have no wish to become involved with the College's activities. It would appear that the

College's record in engendering participation by fellows is much better than one might suppose.

The survey asked two important questions about the training and examination process. The first asked respondents for 'your views on the examination, training, and qualification process'. The responses were distinctly less sanguine than those to previous questions. Only seven respondents (17 per cent) were unreservedly happy with the examination process, while twelve (29 per cent) were critical. Fifteen (39 per cent) held mixed feelings about it, often suggesting improvements. Seven (17 per cent) held no opinion or did not answer this question. Among younger fellows, to whom the current examination process was a recent memory, four were happy with it and nine were critical.

Those who considered the examination system satisfactory made remarks such as:

This has progressed to a much higher standard and level of professionalism.

I support it in [its] current and proposed form.

I believe the present process to be well-rounded and highly satisfactory.

Those who were critical made remarks such as:

Training in psychological therapies, especially CBT and BT, is grossly inadequate.

The exams do not appear to test core knowledge, but rather an ability to function under pressure. Although the latter is important, facility with the former is *more* important.

Too much of a dichotomy between being trained in a general hospital and a psychiatric hospital. There should be a greater breadth of training.

... I think the present restrictions on the number of doctors allowed to present themselves for the exam harms public psychiatry when more doctors are needed.

... although the College has an examination function on which it bases the granting of membership it does not have any inherent skills in teaching, education, and training, nor is it able to provide on its own behalf any clinical facilities.

The training supplied was inadequate to pass the exams. The exam bore little relationship to clinical practice. Trainees [were] used as cheap labour in psychiatric hospitals. [The] whole process seems to be unnecessarily cruel and sadistic — it is viewed by most graduates as the worst experience of their lives.

Those who had very mixed views about the process made comments such as:

Strong training, but difficult examination process ...

... I believe it is important to correct the predominant 'organic' bias, but believe that psychotherapy makes special demands which not all candidates can cope with.

It is a necessary evil that is conducted as fairly as possible. It definitely enhanced my own practice and development as a clinician.

Respondents were also asked to suggest what changes should be made in the examination process. Classifying the responses here as well as possible, it would appear that five respondents (12 per cent) explicitly stated that no changes should be made in the current process; thirteen (32 per cent) suggested a few changes, generally in one particular dimension of the examination process; six (15 per cent) suggested significant changes; and two (5 per cent) wholesale changes. A very large number — fifteen respondents (37 per cent) — did not answer this question or stated that they were unqualified to do so. It can be seen that while many respondents were dissatisfied with the examination process, very few indeed suggested making dramatic alterations to it.

Most respondents who were satisfied with the present system simply made this clear without further comment, but one respondent (who qualified in the 1990s) noted that:

I wrote my views to the College at the time I finally passed and funnily enough the changes in the exam system do seem to be similar to what I suggested.

Those who wanted some alterations in the system tended to recommend changes in a few areas which were commented upon several times. The views expressed by one respondent were to be found in many comments:

Some form of continuous assessment throughout the training years related to clinical skills and ability to relate to both patients and colleagues.

These sentiments were echoed by such remarks as:

Less emphasis on Part I and Part II examinations.
Greater emphasis on continual assessment.

The essence of psychiatric skills is contained in the clinical interview or

examination. I strongly believe and would recommend that this interaction between candidate and patient be *directly* observed by the examiners.

... Perhaps [a] reduced emphasis on *one* lot of exams with a better spread over the years would be helpful.

I feel the emphasis should be on an examination of the interactive capacity of the examinee. A return to the supervision of a patient seen for at least 50 sessions is a good way to access this and teach interactive communications.

The message is that the examination process should be continuous and test how, realistically, the candidate interacts with patients. (In 1992 the College had enacted changes to its examination by-laws that accord with these sentiments.)

Those who recommended what might be termed more far-reaching changes made such suggestions as:

... I would prefer [the] performance of candidates as assessed by examiners be used as the final assessment — not further evaluated in a committee procedure.

It is most regrettable that the postgraduate teaching function of educational institutions has been usurped by the College. It is surprising how many recent 'graduates' to fellowship describe themselves as consultant psychiatrists.

Those who recommended far-reaching changes suggested that:

A diploma in clinical psychology, emphasising cognitive testing, projective testing, neuropsychological testing, scientific method, behavioural psychology, [and] cognitive-behavioural psychology should be embedded in the fellowship course.

... cases [are] not [a] very useful assessment tool — everyone (or at least most) reads cases of recently successful colleagues and tends to regurgitate the same formula — very few original or challenging cases, more ones that are 'safe'.

On the controversial question of recertification or reaccreditation, opinion seems sharply divided, with fourteen respondents (34 per cent) believing that recertification should be required, thirteen (32 per cent) unequivocally opposed, and another thirteen (32 per cent) adopting an ambiguous stance generally indicating agreement with some sort of reaccreditation process under certain circumstances. (Only one respondent — 2 per cent of the sample — failed to answer this question.) Several respondents unequivocally opposed to reaccreditation did, however, agree that a 'points' system of continuing medical education might be acceptable.

Most 'yes' respondents made no further comment, although some remarks are worthy of note:

I hate to admit it, but Yes.

[Reaccreditation] would be advantageous [but] updating has to be made interesting and not too difficult to obtain if fellows are to be motivated.

Those opposed to reaccreditation made comments such as:

I doubt if much is gained. Those who take their work seriously will look after their own learning; and those who don't can escape doing what is most important ...

Who will accredit the accreditors? The old boys club perhaps!

No — some of the worst psychiatrists in Victoria are professors, so academic adeptness is not necessarily an indication of clinical ability.

Those who tentatively but ambiguously agreed with the notion of reaccreditation made such comments as these:

Some process of accountability, minimum professional standards, review by peers would be useful.

I feel it is necessary for continuing education to be compulsory to ensure 'up to date treatment' modalities. I feel strongly that there should be no re-examination process.

All right if you live in a major centre but a definite disincentive for those who wish to practise in smaller centres.

The survey asked, finally, the views of respondents about the future of psychiatry and the psychiatric profession in Australasia: 'Do you think the basic direction of psychiatry will change, or ought to change, over the next few decades?' An enormously wide variety of responses were received, and it is difficult to point to a single area in Australasian psychiatry about which there is consensus. Answers touched upon twenty separate topics, while ten (24 per cent) respondents failed to answer this question. Two areas of concern were mentioned more than any other — the public/private dichotomy in psychiatry, and the likely

increase in public scrutiny of the profession. Six respondents (15 per cent) mentioned the public/private dichotomy, generally regretting the lack of resources in the public sphere:

The pay and conditions in the public sector need to massively improve — to attract people to work there [these] need to be at least equal to private practice.

It would be good to see more fellows staying in public psychiatry but this is unlikely given the difference in remuneration.

Another five responses (12 per cent) mentioned heightened public scrutiny of psychiatry. A typical comment was:

I think by its very nature, that psychiatry will gradually evolve and change ... This will be to the good of psychiatry. I am afraid, however, that this progress may become distorted by the increasing intrusion of power-hungry politicians and their accompanying bureaucrats into the doctor-patient relationship.

Other responses covered such matters as the dichotomy between academics and clinicians, rural services, the role of patients, increased specialisation, increased medical knowledge, deinstitutionalisation, competitive pressures from other mental health professionals, decreased funding, access to services, moral values, local problems, and the image of psychiatry. None of those was mentioned by more than two psychiatrists. Among the more interesting responses were such comments as:

It is likely that the treatment of hardcore mental illness will change dramatically due to further advances in medicine and medical science. On the

other hand it is doubtful if the human experience in response to its environment will alter substantially.

Economic factors will be the main determinant of [change]. It will be important to develop further biomedical credibility if we are to continue to receive funding ...

I am concerned that the basic direction is *too* much oriented toward research and computers and that academics are dictating their views. There is too little concern for the therapeutic relationship, family dynamics, and the humanistic side of psychiatry.

Curiously, psychiatry's poor image was mentioned by only one respondent:

Psychiatry is perceived in the community as a frightening, distant, untouchable (and intangible) aspect of medicine. We would do well to reduce the myth and stigma of our profession, along with the rest of medicine [which] we are here to practise and service.

One comment of a local nature is worthy of note:

I live in NZ — psychiatry is in a sad state. We need to be much more politically active. We need to get more than basic services in lots of areas. We have to be advocates for our patients and to support voluntary organisations. More social awareness — less biologism. Need to educate GPs about psychiatry. (Perhaps I should get involved in the College.)

That there is no clear consensus about some issues facing psychiatry is illustrated by these comments from different respondents:

I think there may be more demand expressed for a psychotherapeutic type of approach but if psychiatrists do not provide it, others may try to do it.

I think less psychotherapy will be done because of eventual changes in Medicare and that's a shame.

No respondent specifically mentioned the College by name as a likely instrument of change.

Psychiatry has now been established in Australasia for over 100 years, and the AAP and the RANZCP for half a century. Australia and New Zealand are no longer colonies or outposts of another country, and one key question which bears closely on the issue of future directions is whether a specific school of psychiatry is evolving in Australasia, different from that characteristically found in Britain, the USA and Europe. While there is no consensus on this matter, from the interviews conducted with leading psychiatrists in compiling this book and from other sources, a widely held view emerged that Australasian psychiatry is distinguished by being eclectic. It borrows the best features from foreign models and adapts them to Australian and New Zealand society producing a mixture of organic and psychotherapeutic models suitable for societies with perhaps fewer sharp social divisions than elsewhere. Whether this is accurate or not, it seems clear that by the mid 1990s Australasian psychiatry had reached adulthood. The RANZCP had taken half a century to evolve into a true medical specialist college. Now mature and well-established, it is in a position to lead as well as follow.

Appendix 1

Presidents and Honorary Secretaries of the Association and the College

Australasian Association of Psychiatrists

- 1946 William S. Dawson
- 1947 Henry F. Maudsley
- 1948 John Bostock
- 1949 Charles R.D. Brothers
- 1950 Desmond W.H. Arnott
- 1951 John F. Williams
- 1952 Hugh McIntyre Birch
- 1953 Basil R. Stafford
- 1954 John K. Adey
- 1955 Gordon Blake-Palmer
- 1956 Henry F. Maudsley
- 1957 Cedric Swanton
- 1958 Ernest John Thompson
- 1959 Alec J.M. ('Alex') Sinclair
- 1960 Harry M. Southwood
- 1961 John D. Russell
- 1962 N.V. (Vincent) Youngman

Australian and New Zealand College of Psychiatrists

1963 Reginald W. Medlicott
1964 Eric Cunningham Dax
1965 William A. Dibden
1966 Ian G. Simpson
1967 C.I.A. (Isobel) Williams
1968 Stanley W.P. Mirams
1969 John F.J. Cade
1970 Alan Stoller
1971 Bruce H. Peterson
1972 Wallace Ironside
1973 Russell A. Pargiter
1974 David C. Maddison
1975 Arch S. Ellis

Royal Australian and New Zealand College of Psychiatrists

1977-79	Basil James
1979-81	Richard Ball
1981-83	Brian J. Shea
1983-85	Beverley Raphael
1985-87	Peter R. Eisen
1987-89	Joan M. Lawrence
1989-91	Karen Zelas
1991-93	Norman James

1993-95 Noel Wilton
1995- George Lipton
(Dr Janice Wilson was President-elect in 1996)

Honorary Secretaries of the Association and the College

Australasian Association of Psychiatrists

1946-51 Alec J.M. ('Alex') Sinclair
1952-53 Donald F. Buckle
1953-63 Ian H. Martin

Australian and New Zealand College of Psychiatrists

1963-69 Ian H. Martin
1969-77 George L. Lipton

Royal Australian and New Zealand College of Psychiatrists

1977-81 Sandra M. Hacker
1981-87 John M.L. Grigor
1987-91 Barrie M. Kenny
1991- Michael W.N. Epstein

Appendix 2

Foundation Members of the AAP

This list of sixty-seven foundation members is taken from a plaque on the wall of the College's headquarters. It is not necessarily complete — there were certainly other practising psychiatrists in Australia and New Zealand in 1946 — and as explained in Part I, only a fraction of those named here actually attended the College's earliest meetings. Nevertheless, these sixty-seven are officially regarded as the Association's foundation members.

J.K. Adey

N.Z. Albiston D.W.H. Arnott W.E. Audley F.H. Beare

J. Bentley

R.T. Binns

H. Mcl. Birch G. Blake-Palmer J. Bostock

C.R. Boyce

C.R.D. Brothers D.F. Buckle J.F.J. Cade A.G. Couston P.G. Dane

W.S. Dawson W.A. Dibden A.T. Edwards K.F. Edwards R.S. Ellery G.L. Ewan

G. Farran-Ridge W.J. Freeman F.W. Graham W.B.C. Gray J.H.B. Henderson E.T. Hilliard J.T. Hurt V.P. Johnson S.E. Jones

O. Latham

R.E.G. MacLean C.H.M. MacMahon H.F. Maudsley C.M. McCarthy J.A. McGeorge D.G. McLachlan S.J. Minogue G.B.V. Murphy H.M. North

H.H. Nowland W.R. Page

A.R. Phillips J.O. Poynton F.M.G. Prendergast P.G. Reynolds G.A. Ross

J. Russell

I.B. Sebire A.J.M. Sinclair H.M. Southwood H.L. Spearman
G.H. Springthorpe B.F.R. Stafford H.J.B. Stephens C. Swanton
E.J.T. Thompson P.C.C. Tresise J.A.L. Wallace R.R. Webb
C.I.A. Williams J.F. Williams R.G. Williams R.C. Winn
G.B.R. Wooster N.V. Youngman

Appendix 3

Chairmen of the Branches

This list is drawn largely from the College's Council minutes and other records at its Melbourne headquarters and is probably incomplete. Names, including initials, are as given in these sources. All were physicians and their names should, in all cases, be preceded by 'Dr'. Dates are approximate in some cases, and are usually the year of election, meaning that the term of office of the chairman named continued into the following year.

New South Wales

E. Hilliard, 1956; Bruce Peterson, 1966; H.J. Prior, 1967-68; Carl Radeski, 1968; Issy Pilowsky, 1969-70; H.P. Greenberg, 1971-72; Colin Degotardi, 1972; Warren Argall, 1973-75; Noel Wilton, 1975-79; Anthony Williams, 1979-82; Henry Brodaty, 1982-84; Bryanne Barnett, 1984-85; Michael Pasfield 1985-86; Michael Giuffrida, 1986-87; Yvonne White, 1987-91; William Andrews, 1991-93; Phillip Boyce, 1993-95.

New Zealand

G. Blake-Palmer, 1958; Henry E. Bennett, 1966-69; D.F.M. McDonald, 1969-75; John Dobson, 1975-79; Basil James, 1979-83; R.J. (Jim) Methven, 1984-86; Allen R. Fraser, 1986; Les Ding, 1987; Peter Joyce, 1989; Sarah Romans-Clarkson, 1990; Janice Wilson, 1992; Wayne Miles, 1994.

Queensland

G.B. Murphy, 1954; C.R. Boyce, 1958; Gordon Urquhart, 1964; Howard Tait, 1966; P. Zavattaro, 1968; Neville Parker, 1969; W. Hamilton, 1970; Frank A. Whitlock, 1971; Joan M. Lawrence, 1972; L. Proctor, 1973; R. Apel, 1974; Ben Steinberg, 1975; B. King, 1976; J. Edwards, 1977; A. Shearer, 1978; John Slaughter, 1979; Larry Evans, 1981; John Price, 1982; D. Somerville, 1983; Martin Nothling, 1984; Donald Grant, 1986; Ben Steinberg, 1988; Tom George, 1989; Jim Rodney, 1991.

South Australia

Harry M. Southwood, 1953; William A. Dibden, 1956; H.M. Birch, 1958; R.T. Binns, 1965; Rayner W. Smith, 1966; L.C. Hoff, 1968; J.D. Litt, 1970; P.D. Grivell, 1972; R. Gillen, 1975; Peter Eisen, 1977; John Litt, 1979; Graham Barrow, 1980; Robert Goldney, 1981; Andrew Czechowicz, 1982; David Ben-Tovim, 1989; John Couper-Smartt, 1991; Johanna Lammersma, 1992.

Tasmania

Isobel Williams, 1958; John R.V. Foxton, 1966; John R.C. Weatherley, 1967; T.H.G. Dick, 1969; Russell Pargiter, 1970; Eric Dax, 1971; T.H.G. Dick, 1971; Isobel Williams, 1974; John R.C. Weatherley, 1975; D.W.K. Kay, 1977; Eric Ratcliff, 1982; John R.C. Weatherley, 1983; Eric Ratcliff, 1986; Ian Sale, 1992; David Weidmann, 1994.

Victoria

Charles Brothers, 1954; Alex J. Sinclair, 1958; Winston S. Rickards, 1966; J.V. Ashburner, 1968; Jack L. Evans, 1969; J.R.B. (Dick) Ball, 1971; A. Nicholson, 1972; John Cone, 1974; Denis O'Brien, 1976; John Grigor, 1977; Graham Burrows, 1979; John Tiller, 1980; Graham Burrows, 1982; George Szmukler, 1989; Graham Burrows, 1992.

Western Australia

E.J.T. Thompson, 1954; F. Prendergast, 1956; S.P. Derham, 1966; P.J. Zeck, 1967; E.R. Csillag, 1968; E.J. Harrison, 1969; E.R. Csillag, 1970; Peter W. Burvill, 1971; Arch S. Ellis, 1972; H.J. Blackmore, 1974; Andrew Zorbas, 1976; Henry Smyrna Jones, 1979; Peter W. Burvill, 1983; David Jacobs, 1986; Paul Skerritt, 1987; John Penman, 1989; David Jacobs, 1990; Bill Walker, 1992; Suzanne Dobson, 1993; Hugh Cook, 1994.

Australian Capital Territory

H. Merrifield, 1973; R.C. McDonald, 1974; W.E. Mickleburgh, 1976; B.J. Hughson, 1984; Patrick Tancred, 1988; John Saboisky, 1990.

Appendix 4

The Association's 1961 Proposed Regulations for an AAP Diploma in Psychological Medicine

The Australasian Association of Psychiatrists Diploma in Psychological Medicine (AAP): Recommendation to Councillors

The Provisional Board of Censors of the Australasian Association of Psychiatrists who have drawn up the regulations for the examinations realise that there will no doubt be many minor points which could be discussed. It is also realised that there must necessarily be imperfections which can only be discovered when the rules are put into practice. However, there is no reason why various amendments to the rules and regulations should not be made from time to time according to how they work out in practice. Because of this and because of the fact that a great deal of time and discussion has already been spent in drawing up these regulations, the Board of Censors are anxious that they should be passed by the Council of the AAP without much time-wasting discussion over trivial details, which could easily be endless. It is hoped, therefore, that Councillors will accept this principle in the spirit with which it is enunciated.

I Regulations

- 1 There shall be a Diploma in Psychological Medicine to be granted by examination by the Australasian Association of

Psychiatrists.

- 2 Examination for the Diploma in Psychological Medicine will be conducted by a Board of Censors appointed by the Association.
- 3 The Examination shall be conducted in two parts, known as the Part I Examination and the Part II Examination.
- 4 A candidate for the *Part I Examination* will be required to produce evidence that he or she:
 - a is a medical practitioner eligible for registration in one of the Australian states or in New Zealand who
 - b has spent at least two years in medical practice since graduation, one year of which must have been spent as a Resident Medical Officer in a general hospital approved by the Board of Censors.
- 5 A candidate may enter for the *Part II Examination* only after having passed both sections of the Part I Examination and, at the time of entry, after having produced attested evidence of having spent no less than three years in full-time psychiatric practice in such various psychiatric units as are approved by the Board of Censors. This shall include:
 - a a period of at least twelve months in general psychiatric hospitals approved by the Board of Censors, in which experience has been gained with adult male and female patients suffering from acute and chronic psychiatric disorders;
 - b attendance at a Child Psychiatric Unit approved by the Board of Censors, for at least 30 half-day sessions;
 - c attendance at the psychiatric out-patient department either of a general hospital or of a psychiatric clinic approved by the Board of Censors for at least 50 half-day sessions for the purpose of obtaining experience in the diagnosis and treatment of patients suffering from neurotic disorders.

- 6 The *Part I Examination* shall, subject to any necessary variation in procedure which the Board of Censors may, from time to time, recommend, consist of examinations in:
 - a *The Structure and Function of the Nervous System*, in which the examination will comprise two written papers of three hours' duration and one oral examination;
 - b *Psychology and Psychopathology*, in which the examination will comprise two written papers, each of three hours' duration and one oral examination.
- 7 The written examination, which shall precede the oral examination by at least four weeks, may be taken in the capital city of any Australian state or, in the case of New Zealand, at such places as the Board of Censors may from time to time decide.
- 8 Only those candidates who, in the opinion of the Board of Censors, reach a required standard in the written examination will be invited to attend the oral examination.
- 9 The oral examination of those candidates who reach the required standard in the written examinations will be held in such places in Australia or New Zealand as the Board of Censors decide and determine at a date prior to the written examination.
- 10 In order to complete the Part I Examination candidates will be required to pass in all parts of both subjects at the one examination.
- 11 The *Part II Examination* shall, subject to any necessary variation in procedure which the Board of Censors may from time to time recommend, consist of examinations in:
 - a *Neurology* (including Neuropathology), in which the examination will comprise one paper of three hours' duration, together with a clinical and oral examination;

b *Psychiatry*, in which the examination will comprise two papers of three hours' duration together with an oral examination and a clinical examination which will consist of the examination of at least one case in detail and discussion of this with the examiners.

12 The same provisions which pertain to the Part I Examination (see paragraphs 7, 8 and 9) shall also be applicable to the Part II Examination.

13 In order to complete Part II of the Diploma Examination candidates will be required to pass in all parts of both subjects in the one examination.

14 The fee for the Part I Examination will be 20 guineas and for the Part II Examination will be 30 guineas. These fees shall be paid to the Secretary for Examinations in each state no less than four weeks prior to the date of the first written examination in each instance.

15 In the case of those candidates who, having paid the statutory fees, are prevented by misfortune from attending either the written or oral examinations a proportion of the fees paid may, at the discretion of the Board of Censors, be refunded.

16 In the case of those candidates who, in the opinion of the Board of Censors, do not reach the required standard in the written examination and who are not therefore invited to attend for the oral examination no fees paid, or any part thereof, shall be refunded.

II Additional Information for Candidates

Candidates are required to be familiar with the necessary qualifications for admission to each part of the examination as set out in the Regulations. The Secretary for

Examinations in each state will advise prospective candidates on any matters in which they may be in doubt.

A list of hospitals and Psychiatric Units approved by the Board of Censors and referred to in paragraph 4b and paragraph 5 of the Regulations may be obtained from the Secretary for Examinations in each state.

Because the list of approved hospitals and Psychiatric Units may necessarily be incomplete any candidate who has obtained experience at a hospital or Psychiatric Unit not on the approved list may, after giving details of such experience, apply for approval of this to the Censor-in-Chief, such application being made, in the first instance, to the Secretary for Examinations in the state in which the candidate resides.

In regard to the payment of fees according to paragraph 14 of the Regulations, these should be paid to the Secretary for Examinations in each state by cheque made payable to the Australasian Association of Psychiatrists, Board of Examiners.

Appendix 5

Annual Meetings and Presidential Addresses

Association Meetings

1946 (October)	Formation meeting in Melbourne
1947 (April)	General meeting in Adelaide
1947 (October)	General meeting in Sydney
1948 (October)*	Melbourne
1949 (November)	Sydney
1950 (October)	Melbourne
1951 (October)	Sydney
1952 (October)	Adelaide
1953 (October)	Sydney
1954 (October)	Melbourne
1955 (October)	Canberra
1956 (August)	Brisbane
1957 (November)	Hobart
1958 (October)	Perth
1959 (October)	Sydney
1960 (October)	Adelaide
1961 (October)	Melbourne
1962 (September)	Brisbane
1963 (September)	Wellington

* This was the date of what was known as the 'General Meeting' until 1961, when its name was changed to the 'Annual Meeting'. The 'General Meeting' and 'Annual Meeting' always included the Association's scientific program and, by 1952-53, were virtually identical in format to the College's annual Congress.

College Congresses and Themes

1964 (October)	Canberra: First annual Congress of the ANZCP
1965 (November)	Hobart
1966 (October)	Sydney
1967 (October)	Perth
1968 (October)	Adelaide
1969 (October)	Surfers Paradise
1970 (October)	Melbourne
1971 (October)	Auckland
1972 (October)	Hobart
1973 (October)	Sydney <i>Youth in a World of Change</i>
1974 (October)	Perth <i>Therapy in Psychiatry</i>
1975 (May)	Melbourne — held with the First Pacific Congress of Psychiatrists
1976 (October)	Adelaide
1977 (October)	Brisbane <i>Psychiatry and the Family</i>
1978 (October)	Singapore <i>Urbanisation East and West — Psychiatry in Challenge</i>

- 1979 (October) Queenstown, New Zealand
Off the Edge
- 1980 (October) Sydney
Australasian Psychiatry
- 1981 (October) Hong Kong
*Asian Pacific Psychiatry — Common
Grounds Common Solutions*
- 1982 (October) Perth
Politics, Technology and Mental Health
- 1983 (October) Adelaide
*Towards the Pursuit of Excellence in All
Areas of Psychiatry*
- 1984 Not held
- 1985 (May) Hobart
*Intimacy and Isolation — The Young
Adulthood of Psychiatry*
- 1986 (May) Brisbane
The Neuroses
- 1987 (May) Auckland
Running with the Wind
- 1988 (May) Sydney
*Psychiatry in a Changing World —
Towards the Year 2000*
- 1989 (May) Honolulu, Hawaii
*Psychiatric Research and Clinical
Practice: East meets West —
Intercollaboration*
- 1990 (May) Perth
*The Resilience of Women in the Face of
Adversity*
- 1991 (May) Adelaide

The Challenge of Practical Psychiatry

- 1992 (September- Canberra
October) *The Science of Clinical Practice?*
Subtheme: *Applied Science?*
- 1993 Not held
- 1994 (May) Launceston
*Expert Systems in Psychiatry — The
Clinician, Computers and Genetics*
- 1995 (May) Cairns
Rediscovering Psychotherapy
- 1996 (May) Wellington
Psychiatry in a Multicultural Context
- 1997 New South Wales
- 1998 Victoria
- 1999 Western Australia
- 2000 South Australia

Addresses by Presidents of the AAP

- 1946- Professor W.S. Dawson
47 Medical Education in Psychiatry in Australia. *Med J Aust* 1946; 2:721.
- 1947- Dr H.F. Maudsley
48 Some Ideals for a Psychiatric Service. *Med J Aust* 1948; 1:581.
- 1948- Professor J. Bostock
49 A Psychiatric Centenary (1848-1948). *Med J Aust* 1948; 1: 763.
- 1949- Dr C.R.D. Brothers
50 Psychiatry and Eugenics. *Med J Aust* 1950; 2:211.
- 1950- Dr D.W.H. Arnott

- 51 Bringing Up Children. Med J Aust 1951; 1:569.
1951- Dr J.F. Williams
- 52 Psychiatric Facts and Fantasies. Med J Aust 1952;
1:25.
1952- Dr H.M. Birch
- 53 Psychiatric Disorders in General Practice. Med J Aust
1952; 1:813.
1953- Dr B.F. Stafford
- 54 Synergistic Psychiatry. Med J Aust 1954; 1:551.
1954- Dr J.K. Adey
- 55 Not published.
1955- Dr G. Blake-Palmer
- 56 Group Prejudice. Med J Aust 1956; 2:813.
1956- Dr H.F. Maudsley
- 57 The Winding Road. Med J Aust 1957; 1:561.
1957- Dr C. Swanton
- 58 Physical Absolution: Pills, Partisans and Perspectives.
Med J Aust 1958; 2:373.
1958- Dr E.J.T. Thompson
- 59 Not published.
1959- Dr A.J.M. Sinclair
- 60 Not published.
1960- Dr H.M. Southwood
- 61 The Psychiatrist and the Public. Med J Aust 1961;
1:771.
1961- Dr J.D. Russell
- 62 Personal Reflections. Med J Aust 1962; 1:285.
1962- Dr N. V. Youngman
- 63 Psychiatry, Medicine and the Community. Med J Aust
1963; 1:604.

Appendix 6

Recipients of the College Examination Award

Grey Ewan Medallion

- 1970 Drs M. and D. Serry (Vic.)
- 1971 Dr R.S. Kalucy (NSW)
- 1972 Dr P. Morse (NSW)
- 1973 Dr J. Phillips (NSW)
- 1974 Dr G. Oppenheim (Vic.)

College Medallion

- 1975 Dr J. Donsworth (SA)
- 1976 Dr B. Stagoll (Vic.)
- 1977 Dr H. Brodaty (NSW)
- 1978 Dr E. Sebel (NSW)
- 1979 Dr R.J. Barrett (SA)
- 1980 Dr D.L. Bassett (SA)
- 1981 Not awarded
- 1982 Not awarded

Maddison Medal (renamed Maddison Medallion in 1993)

- 1983 Dr P. Burnett (SA)

1984 Dr J. Condon (SA)
1985 Dr B. Westmore (Qld)
1986 Dr S.J. McLean (SA)
1987 Dr D. Blood (SA)
1988 Dr I. Hickie (NSW)
1989 Dr J.M. Wright (NSW)
1990 Dr P. Brown (Qld)
1991 Dr P. Jungfer (NSW) and Dr C. Jackson (Vic.) jointly
1993 Dr A. Loughlin (SA)
1994 Dr M. Germain (NSW)
1995 Not awarded

Images



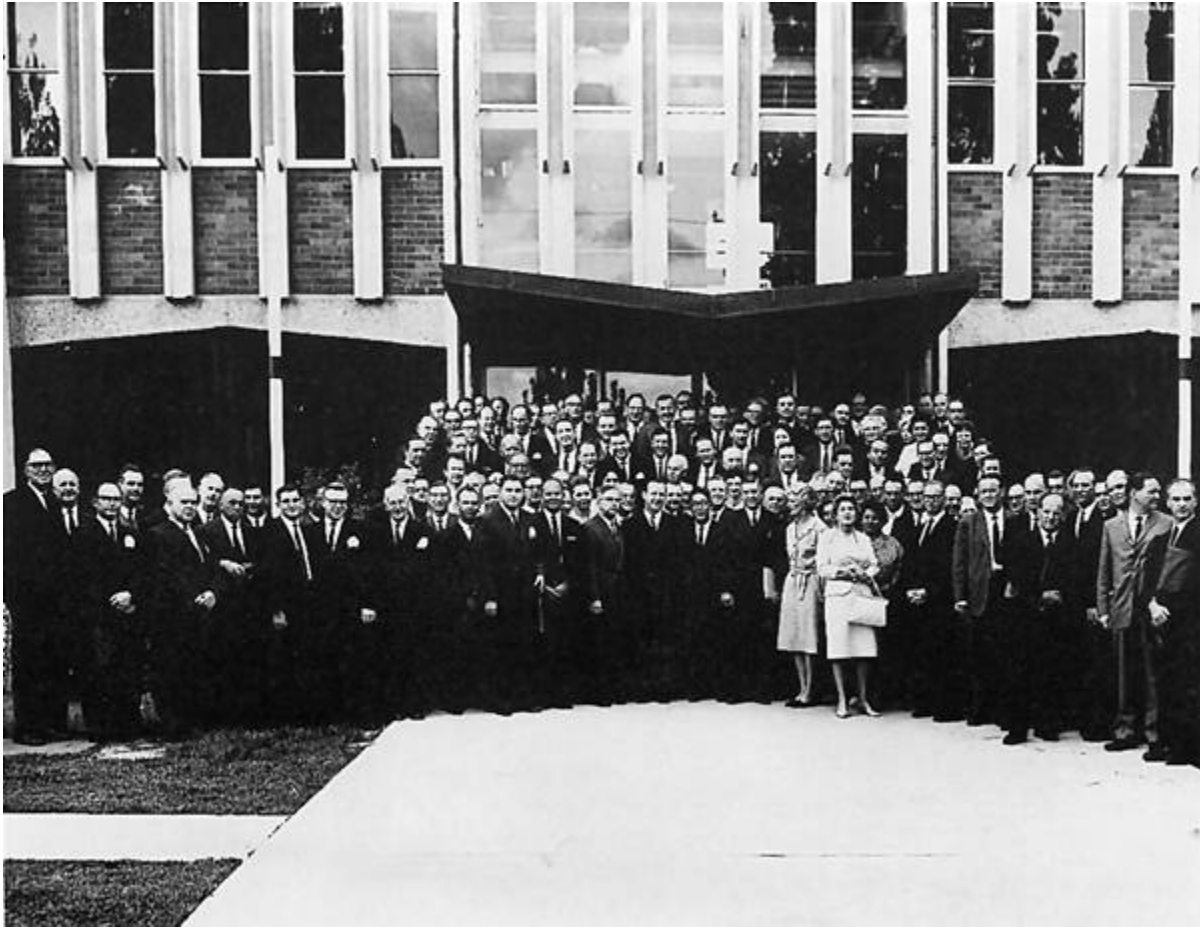
Council meeting of the Australasian Association of Psychiatrists, 1951, at Indooroopilly Golf Club, Queensland. Standing (L-R): J. Bostock, W. Dawson, H. Maudsley and V. Youngman. Seated (L-R): D. Arnott, and Daniel Blain, visiting speaker from the USA. Photo courtesy V. Youngman.



College Headquarters since 18 December 1995. Levels 1 and 2 plus entry foyer of 309 La Trobe Street, Melbourne.



Last Annual Meeting of the Australasian Association of Psychiatrists held in Wellington, New Zealand, 1963.



First Annual Congress of the Australian and New Zealand College of Psychiatrists, held in Canberra 1964.

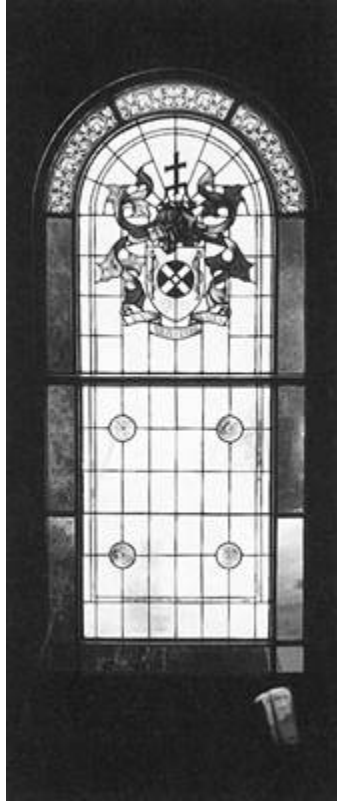


The first Maudsley House, 107-109 Rathdowne Street, Carlton.
Opened as College headquarters on 7 May 1965.
Photo taken 1963-1964.



The second Maudsley House. Built in 1868-69 as a manse for the St. Andrew's

Presbyterian Church and now classified by the National Trust. Opened as College headquarters on 3 May 1985. From a pen and ink drawing by Bettina B. Guthridge, 1985.



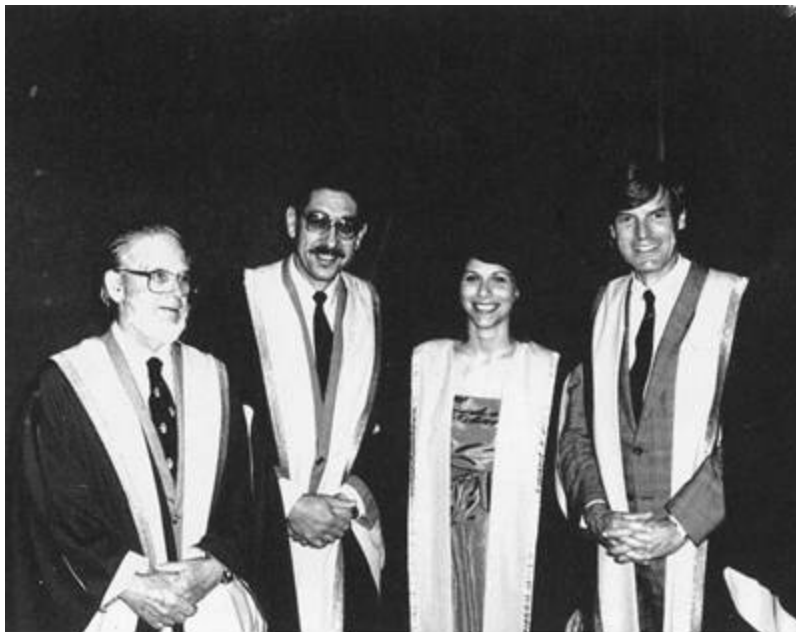
Stained glass window depicting the College Arms, seen here at Maudsley House, 101 Rathdowne Street, Carlton. Later transferred to College Headquarters, 309 La Trobe Street, Melbourne.



Earliest known photo of the Australasian Association of Psychiatrists taken at Millbrook Rise Hospital for World War I Veterans, New Norfolk, Tasmania, November 1949. Standing (L-R): F.M.G. Prendegast, D.W.H. Arnott, C.R.D. Brothers, O. Latham, Hospital Matron, J.F. Williams, J.T. Hurt, H.F. Maudsley. Seated, back (L-R): J.O. Paynton, C.I.A. Williams. Seated, front (L-R): R.S. Ellery, C.M. McCarthy, J. Bostock, G.H. Springthorpe, A.J.M. Sinclair, W.J. Freeman, J. Youngman, Photo courtesy V. Youngman.



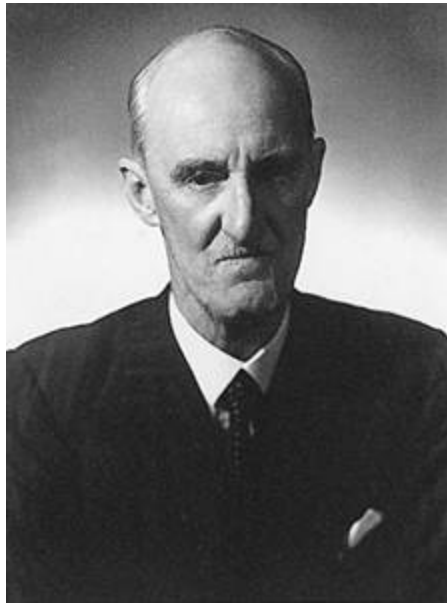
Dr Joan Lawrence (then Lowrey). The first person awarded the College's Diploma in Psychological Medicine, 1964.



The first four Honorary Federal Secretaries. (L-R): Dr Ian Martin, Dr George Lipton, Dr Sandra Hacker, Dr John Grigor.



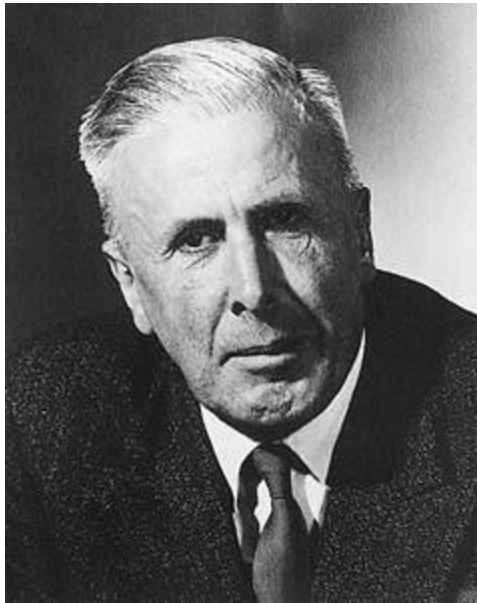
W. S. Dawson 1946



H. F. Maudsley 1947 and 1956



J. Bostock 1948



C. R. D. Brothers 1949



D. W. H. Arnott 1950



J. F. Williams 1951



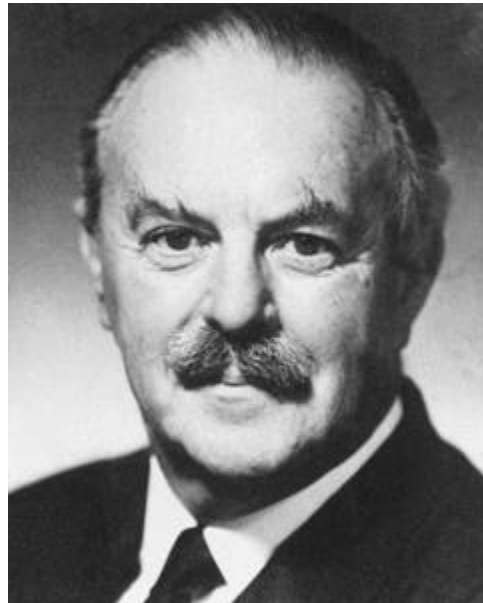
H. McL. Birch 1952



B. F. R. Stafford 1953



J. K. Adey 1954



G. Blake-Palmer 1955



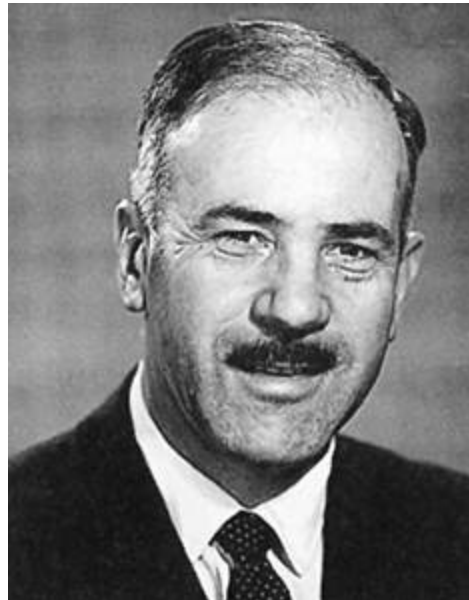
C. Swanton 1957



E. J. Thompson 1958



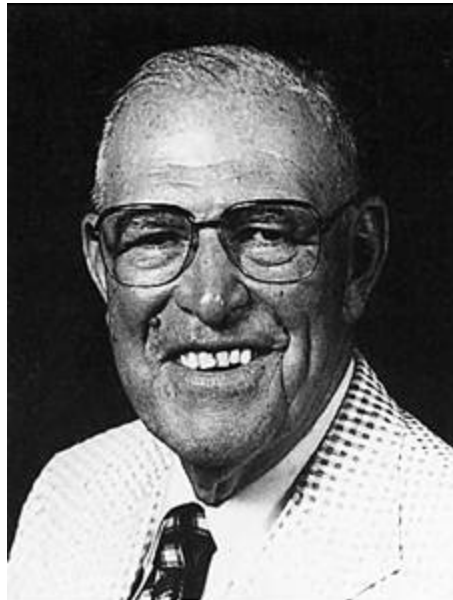
A. J. M. Sinclair 1959



H. M. Southwood 1960



J. D. Russell 1961



N. V. Youngman 1962



R. W. Medicott 1963



E. Cunningham Dax 1964



W. A. Dibden 1965



I. G. Simpson 1966



C. I. A. Williams 1967



S. W. P. Mirams 1968



J. F. J. Cade 1969



A. Stoller 1970



B. H. Peterson 1971



W. Ironside 1972



R. A. Pargiter 1973



D. C. Maddison 1974



A. S. Ellis 1975



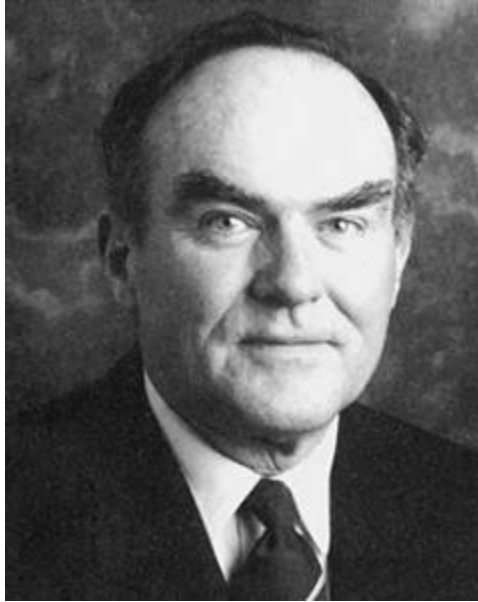
M. J. Sainsbury 1976



B. James 1977-79



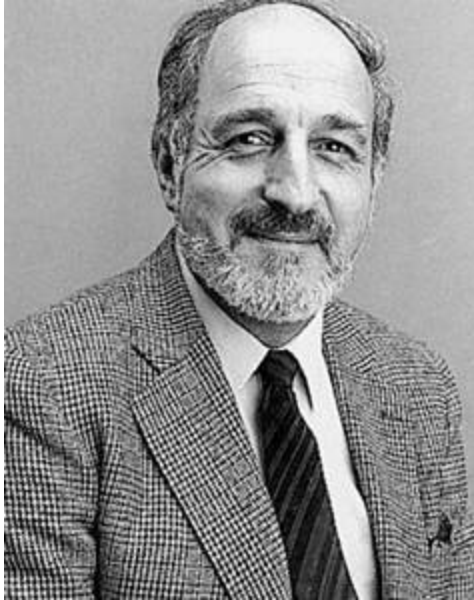
J. R. Ball 1979-81



B. J. Shea 1981-83



B. Raphael 1983-85



P. R. Eisen 1985-87



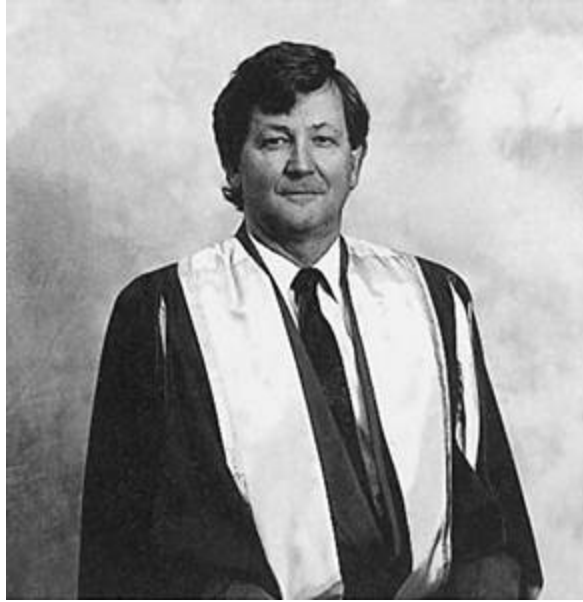
J. M. Lawrence 1987-89



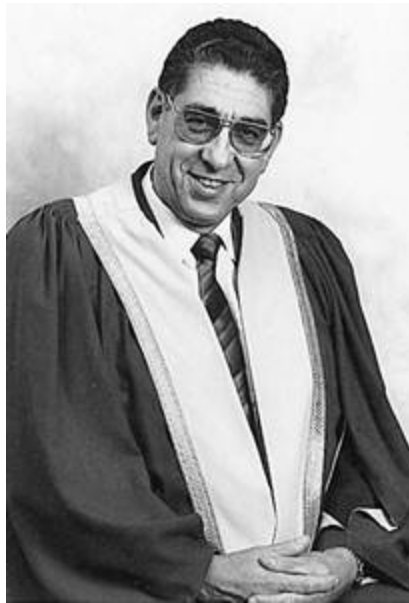
K. D. Zelas 1989-91



N. Mcl. James 1991-93



N. M. Wilton 1993-95



G. L. Lipton 1995-

Notes

1 The Australasian Association of Psychiatrists, 1946-64

[1](#) 'Minutes of the Meeting of Psychiatrists. Held on 9 October 1946 for the purpose of the formation of an Australasian Association of Psychiatrists,' AAP minutes, 1946-63, Series 6, 10. The list of sixty-seven is actually an enumeration of 'those present and those invited but absent, including four from New Zealand'. John Williams 'The Australasian Association of Psychiatrists from Birth to Dissolution' (typescript, 1964), p. 5. It is, in other words, a list of most (but not all) practising psychiatrists in Australia.

[2](#) Those present were (in the order given in the minutes): Professor W.S. Dawson, Drs H.F. Maudsley, A.J.M. Sinclair, J.K. Adey, J.F. Williams, Springthorpe, Swanton, Arnott, Ewan, Birch, Southwood, Professor Bostock, Drs Stafford, W.B. Stephens, Buckle, Albiston, Dane, Reynolds, Cade, Johnson, Phillip, Graham, McLean, Webb, McCarthy, Wishaw, A. Williams. Apologies were received from Drs Ellery, Paton-Ridge, Brothers, Prendergast, Brown, McLachlan, Russell, Lewis and Gray. In late 1994 only Drs Southwood and Russell were still alive; the latter passed away before the end of the year.

[3](#) *ibid.* The General Council elected at the inaugural meeting, which held office for one year, consisted of: Victoria — Adey, J. Williams, Springthorpe; NSW — Swanton, Arnott, Ewan; SA — Birch, Southwood; Qld — Bostock, Stafford; WA — Prendergast; Tasmania — Brothers; NZ — McLachlan, Blake-Palmer, Gordon Couston.

[4](#) *ibid.* Ten Council members and officebearers were present at the inaugural meeting of the Council, held the next day (10 October 1946) at the Council rooms of the Victorian branch of the British Medical Association: Dawson, Maudsley, Springthorpe, Bostock, Stafford, A. Williams (representing Brothers), Ewan, Birch, J. Williams, Sinclair and Arnott.

[5](#) *ibid.*

[6](#) *ibid.*

[7](#) *ibid.*

[8](#) John Williams, 'The Australasian Association of Psychiatrists from Birth to Dissolution', unpublished typescript in the file 'Documents *Re* Foundation of the Australasian Association of Psychiatrists in 1946', pp. 1-2, Maudsley House. A printed version of this page appeared in the *Australasian Psychiatric Bulletin*, Vol. 4, No. 2, June 1963. In the *Australasian Psychiatry Quarterly Newsletter* for June-September 1952 (p. 9) appeared the following: 'Inception of AAP — At last we have, authentically, what many of us have guessed and have known. Professor Dawson (NSW) informs us that he has always regarded Dr H. Maudsley (Victoria) as responsible. Dr Maudsley brought up the proposal to Professor Dawson at his home on 4 May, 1946.'

[9](#) D.W.H. Arnott, *50 Years in Psychiatry* (Sydney, 1980), p. 39. In a letter from Dr Arnott to Dr Maurice Sainsbury (President of the College) dated 28 July 1977, Dr Arnott also noted that 'The birth of the Australian [*sic*] Association of Psychiatrists ... occurred on a hot morning in February 1946 at Concord Hospital when Hal Maudsley came to see me (I was still in the army) and suggested forming an Australian Society of Psychiatrists.

I had got to know him very well during the war and also in a very personal way. He first suggested to me a society just of those psychiatrists in private practice but I reminded him that the vast majority of the psychiatrists in NSW were in the mental hospitals and we agreed to include all psychiatrists. So Hal and I assisted in its conception and later in its birth. Thus the flame was lit.

We then agreed that he approach Dawson.' (College Archives. We are grateful to Dr Robert Broadbent for this reference.)

[10](#) Interview with Dr Ian Martin, Melbourne, 3 June 1994.

[11](#) Typescript circular letter from W.S. Dawson, dated 6 May 1946, in Series 25 'General Correspondence of the Honorary Federal Secretary, 1946-65,' Maudsley House records. There is unfortunately no clue as to whom the circular letter was sent.

[12](#) *ibid.*

[13](#) *ibid.*

[14](#) 'W.S. Dawson', typescript obituary notice by Dr Jack Russell, in the possession of Dr Maurice Sainsbury of Sydney; Stephen Garton, 'William Siegfried Dawson (1891-1975)', *Australian Dictionary of Biography*, Vol. 13 (Melbourne, 1993), p. 596.

[15](#) *ibid.*

[16](#) Interview with Dr Ian Martin, Melbourne, 3 June 1994.

[17](#) Interview with Dr Alan Stoller, Melbourne, 16 August 1994.

[18](#) Professor J.V. Bostock, 'The Australian [*sic*] Association of Psychiatrists and Its Gestation', *Bulletin*, Vol. 4, No. 1 (March 1963), p. 15. Bostock believes that Dawson 'took a major part in creating the vital shuttle service from ... New South Wales and Queensland ... to Victoria', crediting Maudsley

with directing 'the southern blade of the forceps' (ibid.). There is no evidence, however, that Dawson (in contrast to Maudsley) was active in organising an Association prior to Maudsley's work early in 1946.

[19](#) Unpublished letter from C.R.D. Brothers to Maudsley, 17 May 1946, Series 25, Maudsley House op. cit.

[20](#) Unpublished letter from Bostock to Sinclair, 20 June, 1946, ibid.

[21](#) ibid. Bostock's advice was never taken. Bostock's letter contains a lengthy list of similar points.

[22](#) Comment by an anonymous reader of the first draft of this work.

[23](#) Namely S.E. Jones, Edwards, S.J. Minogue, W.E. Audley, D.W.H. Arnott, J.A. McGeorge and C. Swanton, who comprised a state subcommittee. Audley was elected Honorary Secretary. ('Minutes of a Meeting of Interested Persons ... 9 July 1946', Series 25, Maudsley House.) [24](#) Williams, op. cit., p. 3.

[25](#) ibid. Those other psychiatrists present were J.K. Adey, G. Springthorpe, D.F. Buckle, R.S. Ellery, G. Reynolds, H. Stephens, A.J.M. Sinclair, Paul Dane, N.A. Albiston, A.R. Phillips and J.F. Williams. Apologies were received from R. Webb. Maudsley was elected chairman of this group and Sinclair secretary.

[26](#) ibid.

[27](#) Unpublished letter, Dawson to Sinclair, 19 July 1946, Series 25, Maudsley House.

[28](#) Williams, op cit., pp. 3-4.

[29](#) Unpublished letter, Dawson to Maudsley, 30 August 1946, Series 23, Maudsley House.

[30](#) 'Meeting of the Negotiating Committee ... 24 September 1946', Series 10, Vol. 1, Maudsley House. It also said that 'If the original name is retained a definition of psychiatrist should be decided upon.' The term 'psychological medicine' was also chosen 'because the role of psychiatrist was not as acceptable to the professor', according to an anonymous commentator on the first draft of this College history.

[31](#) 'Meeting of the Negotiating Committee ...', *ibid.*

[32](#) Interview with Dr Alan Stoller, Melbourne, 11 September 1993.

[33](#) This was clear from numerous interviews by one author with today's very senior psychiatrists, who time and again remarked on the crucial role of the war in their career choice.

[34](#) Interview with Alan Stoller, 16 August 1994.

[35](#) *ibid.*

[36](#) *ibid.*

[37](#) 'Minutes of the Meeting of Psychiatrists Held ... on 9 October 1946', *op. cit.*

[38](#) Interview with Alan Stoller, 16 August 1994.

[39](#) Comments by an anonymous reader of the first draft of this history.

[40](#) Henry R. Rollin, 'Whatever Happened to Henry Maudsley?' in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (Royal College of Psychiatrists, London, 1991); Dr George I. Szmukler, 'Maudsleys of the Melbourne' (unpublished typescript, n.d.).

[41](#) K.F. Russell, 'Sir Henry Carr Maudsley (1859-1944)', *Australian Dictionary of Biography*, Vol. 10.

[42](#) Interview with Mrs Helen Brack (daughter of Hal Maudsley), Melbourne, 12 July 1994.

[43](#) *ibid.*

[44](#) *ibid.*

[45](#) Interview with Alan Stoller, 16 August 1994.

[46](#) Williams, *op. cit.*, p. 2.

[47](#) 'Medlicott and Blake Palmer and Mirams in New Zealand, Charles Brothers and Isobel Williams in Tasmania, Thompson and Prendergast in W.A., Southwood, Dibden, and Binns in South Australia, Youngman and Stafford in Queensland, and here in Victoria the bulk of the early work was carried by Alex Sinclair' (*ibid.*). Williams also mentioned the 'almost imperturbable and unflustered' Ian Martin. The role of Dr R.S. Ellery should also be noted.

[48](#) 'Minutes of Council Meeting ... on 10 October [1946],' p. 2.

[49](#) This might also have been a factor in the choice of Professor Dawson as the first President of the Association.

[50](#) *Australasian Psychiatric Quarterly Newsletter* (hereafter *APQ Newsletter*), Vol. 6, No. 21 (March 1955), p. 5. There is some confusion about when the New Zealand branch was formally constituted. Formal steps to organise a New Zealand branch were not taken until 1952-53 ('Minutes of the Council Meeting ... of 9 October 1954', p. 7 and 'Minutes of the Meeting of the Council ... of 20 August 1955', p. 3). In the latter source Dr Sinclair moved that 'this meeting accepts that New Zealand has been inaugurated as a Branch this year [i.e. 1955]' ('Minutes of the Council Meeting ... 27 October 1952', p.6). Reg Medlicott was not officially elected a member of the AAP until 1952.

[51](#) 'Minutes of the General Meeting ... 30 April 1947'.

[52](#) For instance, Queensland was assigned the 'preservation of historical records' and Western Australia 'psychiatric aspects of immigration'. (Minutes of the Council Meeting ...

19 October 1948', p. 3). Some branch-based committees have continued to be appointed, particularly where frequent meeting is needed. The most obvious example is the H.B. Williams Committee in New Zealand.

[53](#) The other three were presumably either New Zealand or deceased in the two years since the formation of the College.

[54](#) A disproportionate percentage of the very prominent early psychiatrists appear to have had some component of their training or professional experience in Britain, including Drs Maudsley, Dawson, Sinclair, Springthorpe, Swanton, Bostock, Birch and all very prominent early leaders of the Association. A small but not insignificant percentage of these early psychiatrists were Roman Catholics, among them John Cade and H.H. Nowland. This is at least slightly unexpected, given the sectarianism of Australia which placed obstacles in the path of Catholics joining the professions. Additionally, the Catholic church at the time is often said to have been hostile to some forms of psychiatry, especially psychoanalysis. Despite the prominence of Jews in the history of psychiatry only one of these sixty-seven was Jewish: Dr A.E. Phillips, a product of the prominent Melbourne Jewish family which produced E. Phillips Fox the painter and a later President of the College, Arch Ellis. This contrasts with the prominence of Jews in Australasian psychiatry some decades later; five post1970 Presidents of the RANZCP have been of Jewish descent.

[55](#) 'Manpower Document — Australian Psychoanalytic Society' (January 1978), with 1978 College minutes and documents. Dr Clara Geroe, the Hungarian-born pioneer of psychoanalysis in Melbourne, did not join the Association until some years later, while neither of the two other European-trained analysts who came to Sydney as refugees

— Dr S. Fink and Dr A. Peto — had yet joined the Association.

[56](#) 'Minutes of the Council Meeting ... 9 October 1954', p. 1; 'Agenda for Council Meeting ... 20 August 1956', p. 2. There do not appear to be annual membership totals prior to about 1954.

[57](#) 'AAP General Statement', *APQ Newsletter*, October 1953, p. 3.

[58](#) *ibid.*

[59](#) *APQ Newsletter*, Vol. 7, No. 26 (July 1956), p. 3.

[60](#) O.N.D. Blomfield, 'Obituary — Preston Guy Reynolds', *Australasian Psychiatric Bulletin* (hereafter *AP Bulletin*), Vol. 6 No. 3 (September 1965), p. 28.

[61](#) *APQ Newsletter*, Vol. 1, No. 4 (October–December 1949), p. 4.

[62](#) *APQ Newsletter*, July 1949, pp. 10–12.

[63](#) *APQ Newsletter*, January–June 1950, pp. 2–3.

[64](#) Probably the most significant pioneering psychoanalyst in Australia was the Hungarian-born Dr Geroe, a refugee who arrived shortly before the war and who introduced a generation of Australian psychiatrists to Freudian concepts. She was also one of the formative women psychiatrists of her time.

[65](#) See Robert Dingwall and Philip Lewis (eds), *The Sociology of the Professions: Lawyers, Doctors and Others* (London, 1983); Philip Elliott, *The Sociology of the Professions* (London, 1972), esp. ch. 3.

[66](#) See, e.g., the presidential address of Dr C.R.D. Brothers, 'Psychiatry and Eugenics', as in the *Newsletter*, October 1949: 'Marriage guidance councils could extend their work to control marriages in order to prevent racial decline; this

should include complete physical and mental examination of prospective partners' (p. 2).

[67](#) See, e.g., 'Annual Report (1950-51) of Inspector-General Mental Hospitals', *Newsletter*, June-September 1952, p. 4.

[68](#) 'Presidential Note (2)', *Newsletter*, January-June 1950, p. 10.

[69](#) 'Minutes of the Council Meeting ... [of] 29 and 31 May 1950', p. 1.

[70](#) 'Minutes of the Council Meeting ... [of] 27 October, 1952', p. 3.

[71](#) 'Biennial Council Meeting ... [of] 29 April 1954', p. 4.

[72](#) 'Minutes of Council Meeting ... [of] 25 November 1957', p. 3.

[73](#) *ibid.*, p. 3.

[74](#) *ibid.*, p. 5. This important subcommittee had as its members Drs Youngman, Parker and Goldman (Qld); Prof. Trethowan, Drs Edwards and Dawson (NSW); Stoller, Sinclair and J. Williams (Vic.); Southwood, Dibden and Binns (SA); I. Williams and Foxton (Tas.), with Dr Ironside to convene a meeting in New Zealand and Dr Gray in Western Australia. Dr Alex Sinclair probably spoke at greater length about this topic at the meeting than anyone else, with Drs Brothers, Stafford, Russell, Swanton and Martin also participating in the discussion although not named to the subcommittee.

[75](#) 'Minutes of the Council Meeting ... [of] 13 October 1958', p. 2.

[76](#) 'Minutes of the Council Meeting ... [of] 30 May 1959', p. 3.

[77](#) 'Minutes of the Semi-Annual Council Meeting ... [on] 7 May 1960', p. 2. There is no record of which Council members did not vote in favour. According to Dr Jack Russell

(President 1961–62) Dr Southwood ‘in particular ... merits especial mention’ in this matter. ‘He kept the matter of an Australasian Association of Psychiatrists’ Diploma in Psychological Medicine persistently before Councillors. Indeed in his uncompromising zeal and the many epistles he wrote at that time reminded me ... of St Paul’ (J. Russell, ‘The Present: The Birth of the Australian and New Zealand College of Psychiatrists’, typescript of paper read 12 April 1964, p. 1, College Archives).

[78](#) ‘AAP Semi-Annual Council Meeting ... Agenda ... [of] 7 May 1960’, p. 2. Part I of the course of training covered the physiology of the nervous system, neuroanatomy, psychology and psychopathology. Part II covered neurology, neuropathology (practical work), applied (clinical) psychology and psychiatry, including child psychiatry.

[79](#) *ibid.*, pp. 2–3. The date of the document prepared by Professor Trethowan was March 1960.

[80](#) ‘Minutes of the Semi-Annual Meeting ... [of] 13 May 1961’, pp. 3–4.

[81](#) ‘Minutes of the Annual Council Meeting ... [of] 15 October 1961’, p. 6.

[82](#) *ibid.* Those unsuccessfully nominated were Drs J. Russell, Swanton, C. Edwards, Prior, Youngman, Rickards, Kingston, Cade, Ironside, N. Parker and I. Simpson.

[83](#) ‘Minutes of the Semi-Annual Council Meeting ... [on] 27 May 1962’, p. 8.

[84](#) *ibid.*

[85](#) ‘Semi-Annual Council Meeting ... [of] 4 May 1963’, p. 4.

2 The Australian and New Zealand College of Psychiatrists, 1964–78

[1](#) 'Presidential Note', *AP Bulletin*, Vol. 3, No. 2 (June 1962), p. 2.

[2](#) *ibid.*

[3](#) 'Presidential Note', *AP Bulletin*, Vol. 3, No. 3 (September 1962), p. 1.

[4](#) J. Russell, 'The Present: The Birth of the Australian and New Zealand College of Psychiatrists (incorporated 28 October 1963)', typescript of paper read 12 April 1964, p. 2, College Archives.

[5](#) 'Minutes of the Semi-Annual Council Meeting ... [of] 27 May 1962', p. 9.

[6](#) *ibid.* Dr Russell notes that 'immediately following on this October 1961 Council meeting your Federal Secretary — Dr Ian Martin — and I decided that the time had at last arrived when we could make some preliminary enquiries about how a College is established'. Dr Russell then held 'informal talks' with the Royal Australasian College of Physicians and the College of Pathologists and Radiologists in Sydney 'in late 1961 and early 1962' (Russell, *op. cit.*, p. 1).

[7](#) *ibid.* All the members of this subcommittee came from Sydney. This was apparently done deliberately to facilitate the subcommittee's work.

[8](#) 'AAP Minutes of the 17th Annual General Meeting ... 26 September 1962', p. 1.

[9](#) *ibid.* It was also meant to copy the style of the College of Physicians.

[10](#) *ibid.*, p. 2. The last point was made by Dr N.V. Youngman.

[11](#) 'AAP Minutes ... [of] 11 and 12 April 1964', p. 1; *AP Bulletin*, Vol. 4, No. 4 (December 1963), p. 5.

[12](#) First read at the AAP annual meeting in Brisbane in September 1962 and published in the *AP Bulletin*, Vol. 4, No.

2 (June 1963).

[13](#) 'ANZCP 1st Annual Council Meeting, 1964', p. 1.

[14](#) Private information from Dr Eric Dax. Other senior members who have recounted this story to the authors have claimed that several other members (in formal dress) also fell in.

[15](#) 'Presidential Note', *AP Bulletin*, Vol. 4, No. 4 (December 1963), p. 1.

[16](#) 'Minutes of Semi-Annual Council Meeting ... [of] 7 May 1960', p. 4. In October 1952, however, in the context of a discussion of a possible 'Royal Charter' for the Association, 'the question of whether we should seek to become a Royal Association or a Royal College was raised', but without, apparently, any further discussion ('Minutes of Council Meeting ... [of] 27 October 1952', p. 5).

[17](#) John G. Howells, 'The Establishment of the Royal College of Psychiatrists' in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (Royal College of Psychiatrists, London, 1991), p. 118. An Association of Medical Officers of Asylum and Hospitals for the Insane was founded as early as 1841 (*ibid.*).

[18](#) *ibid.*, pp. 120ff. Many British psychiatrists were reluctant to do more than form a faculty within the Royal College of Physicians (*ibid.*, p. 121).

[19](#) Volume 1 No. 1 of the *AP Bulletin* bears the date July 1960, but two undated and unnumbered issues of the *Bulletin* were published prior to its first numbered issue.

[20](#) 'AAP 16th Annual General Meeting, 16 October 1961', p. 2.

[21](#) 'AAP Semi-Annual Council Meeting ... [of] 13 May 1961', 'Supplementary Annotations to Council Agenda', p. 20 and p. 14.

[22](#) *ibid.*, p. 20.

[23](#) *ibid.*

[24](#) 'Minutes of the Semi-Annual Council Meeting ... [of] 4 May 1963', pp. 4-5. On Dr Rickards' distinguished career see *Festschrift for Winston S. Rickards* (Department of Child and Family Psychiatry, Royal Melbourne Hospital, Melbourne, 1985), especially I. Maurice Eisenbruch and Patricia M. Leaper, 'Winston Selby Rickards: A Portrait', pp. ix-xi.

[25](#) *ibid.*, p. 5.

[26](#) 'Minutes of the 18th Council Meeting ... [of] 22 September 1963', pp. 1-2.

[27](#) Interview with Dr W. Rickards, Launceston, 18 May 1994. Some of those opposed to the creation of a child psychiatry subsection 'wanted a solid College before too many sections' were formed (comments by an anonymous reader of the first draft of this College history).

[28](#) '1st Annual Council Meeting ... [of] 25 October 1964', p. 3.

[29](#) 'Presidential Note', *APQ Newsletter*, Vol. 8, No. 29 (June 1957), p. 1.

[30](#) 'Minutes of the 17th Annual General Meeting ... [of] 26 September 1962', p. 1.

[31](#) *ibid.*

[32](#) *ibid.* and 'Minutes of the Semi-Annual Council Meeting ... [of] 4 May 1963', p. 4. One delegate at the 1962 AGM wished the Association to acquire a Canberra headquarters. Mrs Maudsley and her family offered considerable financial help to acquire the Collins St site, but this proved insufficient.

[33](#) 'Semi-Annual Conference Minutes', *ibid.*, p. 4.

[34](#) 'Minutes of the 18th Semi-Annual Council Meeting ... [of] 11 April 1964', p. 9.

[35](#) *ibid.*

[36](#) Private information.

[37](#) 'College H.Q.', *AP Bulletin*, Vol. 5, No. 2 (June 1964), p. 7.

[38](#) E. Graeme Robertson, *Carlton* (Adelaide, 1974), pp. 30-2.

[39](#) 'College Notes and News', *AP Bulletin*, Vol. 6, No. 2 (June 1965), p. 7.

[40](#) 'Minutes of the Annual Council Meeting ... [of] 15 October 1961', p. 2.

[41](#) Interview with Dr Bruce Peterson, Sydney, 23 March 1994.

[42](#) 'Minutes ... [of] 15 October 1961', *op. cit.*

[43](#) 'Semi-Annual Council Meeting ... [of] 13 May 1961', p. 21.

[44](#) Interview with Dr Ian Martin, Melbourne, 3 June 1994.

[45](#) *ibid.*

[46](#) 'Agenda of the Semi-Annual Council Meeting ... [of] 15 October 1961, Annotations', p. 2.

[47](#) 'Minutes of the 16th Annual General Meeting, 16 October 1961', p. 1. According to one anonymous reader of the first draft of this work, Dr Maudsley presented the college with a gavel and bowl and Dr W.S. Maclay (an honorary member) presented it with a mace. 'Their disappearance is one of the college mysteries.'

[48](#) 'Semi-Annual Council Meeting Agenda ... [of] 4 May 1963, Annotations', p. 2.

[49](#) *ibid.*

[50](#) Dr E. Cunningham Dax, 'The College Arms', *Australian and New Zealand Journal of Psychiatry* (henceforth *Journal*), Vol. 5, No. 4 (December 1971), pp. 234-5.

[51](#) *ibid.*

[52](#) *ibid.*, p. 234. 'Caducei' were the staffs of Caduceus, the emblematic staff with two serpents coiled around it, traditionally used as a symbol of the medical profession.

[53](#) *ibid.*, p. 235. At the same time, the College of Arms declined to include 'supporters' (figures, usually of a knight, animal or mythical creature at each side of the coat of arms — the lion and unicorn are the supporters of the British coat of arms) to the coat of arms 'owing to the recent foundation of the College' (*ibid.*). One wonders what these 'supporters' might be — two people in white coats, perhaps!

[54](#) *ibid.*

[55](#) *ibid.* An alternative motto was proposed by the Garter King of Arms, the head of the College of Arms, but was unacceptable to the College.

[56](#) *ibid.*; Minutes, October 1968.

[57](#) 'Minutes of the May 1975 General Council Meeting', p. 22. The first President elected for a two-year term, Dr Basil James, was also the first President of the Royal College. Dr Maurice Sainsbury, the last President of the College before the granting of its 'royal' prefix, served one year, 1976-77.

[58](#) *ibid.*

[59](#) '1st Annual Council Meeting ... [of] 25 October 1964', p. 4.

[60](#) *ibid.* The name of the EAC was later changed to College Executive Committee (CEC).

[61](#) Interview with Dr Harry Southwood, Adelaide, 28 March 1994.

[62](#) Based on interviews with Drs Ian Martin, Alan Stoller, Eric Dax, etc.

[63](#) 'Minutes of the October 1973 General Council Meeting ... [of] 13-14 October 1973', pp. 17-18.

[64](#) Letter dated 2 November 1972, with October 1973 'Minutes and Supporting Documents' file at the RANZCP Series 1, Files 18-20. We have deleted the names of the five persons named in this letter as several are still alive. It should also be noted that, when this letter was written, at least two recent Presidents of the College came from smaller states (with many others spending lengthy periods of their careers there), although it would seem that the notion that the College was run by a Melbourne-Sydney clique was widespread in the smaller states.

[65](#) 'Minutes of the May 1973 General Council Meeting ... [of] 6 May 1973', pp. 38-45.

[66](#) The author of the letter quoted above, who was a Councillor on the ANZCP Council from Queensland, led the discussion of this issue. Several years later he resigned from the College.

[67](#) See the nomination material and *curricula vitae* in the College file for the May 1974 Council meeting. The defeated candidate was the author of the letter quoted above.

[68](#) Interview with Dr George Lipton, Launceston, 18 May 1994.

[69](#) *ibid.*

[70](#) 'Minutes of the 2nd Annual Council Meeting ... [of] 7 November 1965, Annotations', p. 2. Mrs Nunn resigned in May 1970 and was replaced by Loretta Stokes ('Annotations to Agenda of 12th Council Meeting', March 1970, p. 4). Mrs Nunn was a paid employee of the College, but Drs White and Hacker were honorary officers.

[71](#) Interview with Dr Sandra Hacker, Melbourne, 18 August 1994.

[72](#) 'Annotations to Agenda of 9th Council Meeting [October 1968]', p. 22; 'Minutes of the Executive Advisory Committee ... [of] 3 August 1969', p. 8.

[73](#) 'The ANZCP Section of Social and Cultural Psychiatry', 7 August, 1973, typescript with the October 1973 minutes and supporting documents, ANZCP files.

[74](#) *ibid.*

[75](#) 'Report to May 1973 General Council ... of the Ad Hoc Social and Cultural 1973 Congress Committee', received 29 March 1973, typescript with May 1973 Council minutes and supporting documents. Apart from Dr Stoller (convenor), the members of the Ad Hoc Committee were Drs J. Cawte, F. Weston and M. Kidson.

[76](#) 'Minutes of the May 1973 General Council Meeting ... [of] 6 May 1973', p. 39.

[77](#) *ibid.*

[78](#) A Journal Committee, consisting of Dr Ellery (Chairman), and Drs Martin, Meares, Sinclair, Springthorpe and Stoller (with Dr Dax as his proxy) was appointed by Council in April 1954 and met three times that year ('Memorandum from AAP Journal Subcommittee', typescript in possession of Dr Alan Stoller, Melbourne).

[79](#) Apart from those named, the Editorial Board in March 1967 consisted of N. Colbert (Business Manager) and seven Assistant Editors: Dr J.L. Evans (NSW), Dr O.D.H. Blomfield (Vic.), Dr S.W.P. Mirams (NZ), Dr N.E. Parker (Qld), Dr H.M. Southwood (SA), Dr A.S. Ellis (WA), and Dr Isobel Williams (Tas.). There was also a Board of Consultants of nineteen persons, and nine other Special Consultants. Dr Cawte

replaced the original choice for Review Editor, Dr Carrick McDonald, at some stage prior to publication.

[80](#) 'Report of the ANZCP Journal Committee, for Discussion by E.A.C. on Sunday 13 February 1966', typescript in possession of Dr Stoller.

[81](#) 'Memorandum to ANZCP Council *Re* Australian and New Zealand Journal of Psychiatry', roneoed memorandum, written by Alan Stoller and J.L. Evans late 1966, p. 1, in possession of Dr Stoller.

[82](#) *ibid.*

[83](#) 'Minutes of the ANZCP Journal Committee Meeting ... [of] 9 February 1966', p. 2; Stoller Papers.

[84](#) 'ANZCP Memorandum ... *Re* The Australian and New Zealand Journal of Psychiatry', roneoed memorandum, 2 March 1966, p. 2; Stoller Papers.

[85](#) 'Minutes, 4th Council Meeting, 1 May 1966', p. 9.

[86](#) *ibid.* Professor Kiloh, Dr Youngman and others supported Professor Maddison (*ibid.*).

[87](#) 'Minutes of the 5th Council Meeting ... [of] 16 October 1966', p. 8.

[88](#) *ibid.*

[89](#) 'Annotations to the Agenda of 8th Council Meeting [5 May 1968]', p. 11.

[90](#) 'Journal Committee' in 'Annotations — 11th Council Meeting', to the 'Minutes of the Executive Advisory Committee Meeting ... [of] 3 August, 1969', item 4.10.

[91](#) *ibid.*

[92](#) *ibid.* and 'Minutes of 9th Council Meeting ... [of] 22 October 1968', p. 9.

[93](#) '22 October 1968 Council Meeting', *ibid.*, pp. 8-9.

[94](#) 'Annotations — 11th Council Meeting', op. cit.

[95](#) 'Journal Committee — Report to Council, August 1972' with October 1972 Council minutes and supporting documents. Two candidates applied for the position.

[96](#) Council meeting minutes, *passim*.

[97](#) 'Submission to Support Application for the Prefix "Royal" By the ANZCP' (typescript, 18 August 1971), p. 1. Series 53, College Archives.

[98](#) 'Minutes of the First Annual Council Meeting ... [of] 25 October 1964', item 11.

[99](#) *ibid.*

[100](#) *AP Bulletin*, Vol. 6, No. 4 (December 1965), p. 6. Three of the Foundation Fellows were women: Drs Clara Geroe, Christine MacMahon and Isobel Williams. About half of them had also been among the sixty-seven founding members of the Association in 1946. At least eight were still alive at the end of 1994.

[101](#) 'Federal Secretariat Report to May 1978 General Council', p. 1. There were also at this time 802 ordinary members of the College and twenty-four honorary and corresponding members.

[102](#) 'Ad Hoc Committee on Election to Fellowship', undated (typescript received 17 February 1972), p. 1, with May 1972 Council minutes and documents.

[103](#) *ibid.*

[104](#) *ibid.* Dr Bruce Peterson of the Ad Hoc Committee dissented from this recommendation, while another member, Dr H.P. Greenberg, expressed strong reservations.

[105](#) Wallace Ironside, 'John Cade (1912-1980)', *Australian Dictionary of Biography, Vol. XIII, 1940-1980* (Canberra, 1983), p. 330.

[106](#) *ibid.*

[107](#) *ibid.*, p. 331.

[108](#) Gordon Parker, 'The Australian Contribution to Psychiatry' in David Copolov (ed.), *Australian Psychiatry and the Tradition of Aubrey Lewis* (NHMRC Schizophrenia Research Unit, Melbourne, 1991), p. 31. According to one anonymous reader of the first draft of this work, Parker's comments should be amended to include the research of Sir Norman Gregg and others on the relationship of German measles to mental deficiency, which 'is quoted in every textbook and is one of the greatest discoveries in the mental deficiency field'.

[109](#) This statement was made at the AGM of 24 October 1968 in Adelaide ('Annotations' to 11th Council Meeting, 3 August 1969, p. 10(1)). Council policy on this matter was made by the old Association on 19 October 1948 when it was agreed 'to consult the BMA before taking any medico-political action', *ibid.*, p. 10(2), from a letter to Dr D.N. Scott-Orr from Dr Ian Martin, dated 18 July 1969.

[110](#) 'Minutes of the Executive Advisory Committee Meeting ... [of] 16 March 1969', p. 2.

[111](#) *ibid.*

[112](#) 'Memorandum Submitted to Council at its 8th Meeting in Sydney on 5 May 1968 — *Re: Law Relating to Abortion*', typescript with 1967-69 Council minutes and supporting documents. This memorandum had other clauses, including a 'conscientious objection' clause noting that no medical practitioner could be forced to participate in an abortion.

[113](#) *ibid.*

[114](#) 'Memorandum *Re. Law Relating to Abortion*, 11 June 1968', typescript to branch secretaries by Dr Martin, with *ibid.*

[115](#) This motion had actually been passed by Council somewhat earlier, on 4 May 1969 ('Annotation', 3 August 1969 Council meeting, p. 10(3)). Some state branches were evidently unaware of this.

[116](#) *ibid.*, p. 10(5).

[117](#) 'ANZCP Social Issues Committee' (typescript memorandum of first meeting of this Committee, n.d. but after 22 January 1970, the date of the first meeting), p. 1.

[118](#) A number of questions asked in this poll have been omitted. The results of these questions were very similar to those cited in the text.

[119](#) *ANZCP Federal Secretariat Bulletin No. 5* (July 1972), p. 2.

[120](#) 'Minutes of October 1973 General Council meeting ... [of] 13-14 October 1973', item 13.

[121](#) *ibid.*, p. 6, citing S. Wortley, 'Attitudes and Therapeutic Goals', unpublished Master's thesis, University of New South Wales, 1973.

[122](#) 'Censorship (2)', *ANZ Journal* Vol. 6, No. 2 (June 1972), p. 80.

[123](#) 'ANZCP Position Statement No. 8 — Abolition of Torture', memorandum of February 1974, with May.

[124](#) *ibid.*, Appendix I, p. 2.

[125](#) *ibid.*

[126](#) *ibid.*, p. 3.

[127](#) 'Editor's Note' to Robin Winkler and Una Gault, 'Psychiatry and Clinical Psychology' in Paul Boreham, Alec Pemberton and Paul Wilson (eds), *The Professions in Australia: A Critical Appraisal* (Brisbane, 1976), p. 169.

[128](#) Winkler and Gault, *ibid.* pp. 171–2. It is not clear whether the authors had the attitudes of Australasian psychiatrists (as opposed to psychiatrists overseas) specifically in mind, or were familiar with the College's stance on the issues discussed above. Both authors are university lecturers in psychology.

[129](#) 'National Health Scheme Benefits — Rebates for Psychiatry Patients', remarks by Dr George Lipton, 'ANZCP Minutes of 12th Council Meeting ... [of] 3 May 1970', pp. 6–7. Lipton's outline of the history of rebates for psychotherapy patients is an excellent summary.

[130](#) *ibid.*, p. 6.

[131](#) *ibid.*, p. 9.

[132](#) *ibid.*

[133](#) The situation in New Zealand remained quite different, with no government payment for private or non-institutionalised patients until very recently.

[134](#) Interview with Dr George Lipton, Launceston, 18 May 1994.

[135](#) *ibid.*

[136](#) *ibid.* Charges for patients in mental hospitals had been abolished in 1948.

[137](#) Interview with Dr Maurice Sainsbury, Sydney, 21 March 1994.

[138](#) Interview with Dr Russell Pargiter, Melbourne, 28 October 1993.

[139](#) Bruce S. Singh and Peter Doherty, 'The First Twenty Years of the RANZCP Examination, 1970–1990', *Australasian Psychiatry*, Vol. 1, No. 1 (April 1993), p. 8. This, and the accompanying article in the same issue — Bruce Singh, Peter Doherty and Ross Kalucy, 'The Components of the

Fellowship Examination 1970-1990' — are excellent accounts of this subject. Professor Singh was Censor-in-Chief in 1988-92, Dr Doherty was Chief Co-ordinating Secretary of the Committee for Examinations from 1987 and Professor Kalucy was Censor-in-Chief in 1984-88.

[140](#) 'Minutes of 1st Annual Council Meeting ... [of] 25 October 1964, Item 10, 'Educational Activities'.

[141](#) *ibid.*

[142](#) Remarks of Dr Harry Southwood, *ibid.*

[143](#) 'Presidential Note', *AP Bulletin*, Vol. 7, No. 2 (June 1966), p. 3.

[144](#) *ibid.*, p. 4.

[145](#) 'Minutes of the 6th Council Meeting ... [of] 6 and 7 May 1967 pp. 1-2.

[146](#) *ibid.*, p. 3.

[147](#) *ibid.*, p. 5.

[148](#) *ibid.*

[149](#) Singh, Doherty and Kalucy, *op. cit.*, p. 16.

[150](#) *ibid.*

[151](#) *ibid.*

[152](#) '12th Council Meeting, 2 May 1970, Report of the Board of Censors' (typescript with 1970-71 minutes and supporting documents).

[153](#) Singh and Doherty, *op. cit.*, p. 10.

[154](#) Singh and Doherty, *op. cit.*, Table 4, p. 15. Additionally, Dr Alex Sinclair was Acting Censor-in-Chief from May 1964-July 1965, and Professor Bill Cramond was Acting Censor-in-Chief from July-November 1968. Professor Ball served as Acting Censor-in-Chief from May 1977-May 1978, until a

replacement could be found for him. Dr McLeod was officially appointed Censor-in-Chief of the RANZCP in October 1978, serving until October 1984 (ibid.). A full list of Censors-in-Chief, members of the Committee of Examination, and Chief Co-ordinating Secretaries may be found in Singh and Doherty.

3 The Royal Australian and New Zealand College of Psychiatrists, 1978-89

[1](#) 'Minutes of the Council Meeting ... [of] 27 October, 1952', p. 5.

[2](#) 'Minutes of the Council Meeting ... [of] 2 May 1953', p. 4; 'The Australasian Association of Psychiatrists Minutes Council Meeting, 24.10.55', p. 3.

[3](#) 'Minutes of the Semi-Annual Council Meeting ... [of] 7 May 1960', p. 4.

[4](#) 'AAP Semi-Annual Conference Meeting ... [of] 14 May 1961, Agenda, Annotations', p. 2.

[5](#) 'Submission to Support Application for the Prefix "Royal" By the ANZCP' (typescript, dated 18 August 1971). This grew out of a motion passed at the May 1971 Council meeting that 'the Council instructs the College Committee to prepare a submission for obtaining the "Royal" prefix for the College ('Agenda of [1] May 1971 Council Meeting', p. 7).

[6](#) 'Minutes of May 1973 General Council Meeting ... [of] 5 and 6 May 1973', p. 30.

[7](#) 'Minutes of October 1973 General Council Meeting ... [of] 13 and 14 October', p. 20.

[8](#) 'Minutes of the General Council Meeting ... [of] 6 and 7 May 1978', p. 24.

[9](#) ibid.

[10](#) That the College became 'unmanageable' when it reached 1000 members is from Dr Sandra Hacker, interview in Melbourne, 18 August 1994.

[11](#) 'Report to the October 1979 General Council Meeting — Federal Secretarial Committee', p. 2, with October 1979 minutes and supporting documents.

[12](#) Interview with Peter Carter, Melbourne, 29 November 1994.

[13](#) 'Working Paper No. 2 — College Employee', minutes of meeting on 18 August 1978 in Adelaide, with Dr Brian Shea and Professor P. Eisen, with October 1978 Council minutes and supporting document.

[14](#) *ibid.*

[15](#) 'College Employee Working Paper No. 3' (c. mid 1979), with October 1979 Council minutes and supporting documents.

[16](#) *ibid.*, p. 3.

[17](#) *ibid.*, p. 7.

[18](#) Interview with Margaret Ettridge, Melbourne, 1 December 1994. Since the appointment of a full-time Registrar, Mrs Ettridge has been in charge of the administrative side of College examinations, its annual conferences, and visiting professors.

[19](#) Interview with Pam Allen, Sydney, 3 August 1994.

[20](#) 'Minutes of the May 1980 General Council Meeting ... [of] 31 May and 1 June 1980', p. 20; *ibid.*

[21](#) Interview with Peter Carter, 29 November 1994.

[22](#) 'Federal Secretariat Committee — Report to the May 1982 General Council Meeting', p. 2, with May 1982 General Council minutes and supporting documents.

[23](#) 'Minutes of the May 1983 General Council Meeting ... [of] 13 May 14, and 15, 1983', p. 2.

[24](#) *ibid.*, pp. 2-3.

[25](#) This important document is anonymous, but was apparently drafted chiefly by Ms Gormley under the oversight of Dr John Grigor, the College's Honorary Secretary (information provided by Dr Peter Eisen).

[26](#) 'The Honorary Federal Secretary's Report to the October 1983 General Council Meeting', p. 2, with October 1983 Council minutes and supporting documents.

[27](#) Interview with Peter Carter, 29 November 1994.

[28](#) *ibid.*

[29](#) *ibid.*

[30](#) 'Presidents of Medical Colleges — The Inaugural Meeting ... on 4 July 1986', typescript, with October 1986 Council minutes and supporting documents.

[31](#) 'Minutes of the Meeting of the Combined Education Committee of the Clinical Colleges Held at the Royal Australian College of Obstetricians and Gynaecologists ... Melbourne, on Friday 20 November 1981', typescript with May 1982 Council minutes and supporting documents. Drs John Grigor and William McLeod represented the RANZCP. A previous meeting had been held on 10 April 1981.

[32](#) Interview with Peter Carter, 29 November 1994.

[33](#) *ibid.*

[34](#) 'Presidents of Medical Colleges ...', *op. cit.*, p. 2.

[35](#) *ibid.*, p. 7. Mr Carter was present at the inaugural meeting as an observer, the only non-President in attendance.

[36](#) Interview with Dr Peter Eisen, Melbourne, 11 November 1993.

[37](#) 'The Federal Secretariat: Report to the October 1982 General Council Meeting', p. 8; 'Minutes of the EAC ... [of] 4 and 5 February 1982', p. 1.

[38](#) Interview with Peter Eisen, 11 November 1993.

[39](#) 'Report to RANZCP May 1983 General Council — RANZCP Organisational Review, March 1983', p. 2.

[40](#) 'The Honorary Federal Secretary's Report to the October 1983 General Council Meeting', p. 3, with October 1983 General Council minutes and supporting documents. Margaret Ettridge, the College's Executive Secretary, handled much of the dealings for the new building.

[41](#) *ibid.*, p. 3.

[42](#) *ibid.*, p. 3. Another site, the Psychiatrist Superintendent's House at Royal Park, Brunswick, was also seriously considered. Dr Jack Evans was specifically thanked by the secretariat for his help (*ibid.*, p. 2).

[43](#) 'RANZCP College Headquarters Committee' (typescript, n.d.) with 1984 Council minutes and supporting documents. The committee consisted of Drs Peter Eisen (chairman), Colin Degotardi, Wallace Ironside, Eric Ratcliff and Jim Carson ('College Headquarters Committee Progress Report on ... Maudsley House', typescript dated 8 March 1985, p. 1, with May 1985 Council minutes and supporting documents). Tony Mussen was the project architect for the building's restoration. He won the commission from among three shortlisted architects (interview with Dr Eric Ratcliff, 1 April 1995).

[44](#) 'College Headquarters Committee', *ibid.*, p. 1.

[45](#) 'RANZCP General Council Meeting [Minutes] ... [of] 13 and 14 October 1984', p. 11.

[46](#) 'RANZCP General Council ... [Minutes] [of] 4 and 5 May 1985', p. 15.

[47](#) 'RANZCP Opening of Maudsley House — 3 May 1985' (brochure), in College Archives.

[48](#) 'General Council Meeting GC 1/89 — Branch Funding Options — A Discussion Paper', typescript dated 19 April 1989, p. 2, with June 1989 General Council minutes and supporting documents. Series 1, files 69 and 70, College Archives. Precise annual statistics of the College's membership become much more fragmentary after the mid 1980s.

[49](#) *ibid.*

[50](#) 'RANZCP General Council Meeting ... [Minutes of] 1 November 1986', p. 17. The Fellowships Committee, which recommended new fellows, was abolished at the same time (*ibid.*).

[51](#) P.W. Burvill, '1987 Manpower Survey of Psychiatrists in Australia and New Zealand', p. 1, typescript dated December 1987, with April 1988 General Council minutes and supporting documents.

[52](#) *ibid.*

[53](#) Peter Eisen, 'Report to General Council of the Psychiatric Developments and Manpower Committee', typescript dated 31 July 1981, with October 1981 General Council minutes and supporting documents. Dr Eisen was convenor of that committee.

[54](#) *ibid.*, p. 2. This figure was first recommended by the American Psychiatric Association.

[55](#) The 1981 Report however, believed that there would continue to be a shortfall for ten years (*ibid.*, p. 9).

[56](#) *ibid.*, p. 8.

[57](#) Dr Peter Eisen to Dr J.R.C. Weatherley (hon. secretary, Tasmanian branch, RANZCP), 'Public-Private Sector Issues', letter dated 19 November 1981, with May 1982 General Council minutes and supporting documents.

[58](#) *ibid.*, p. 2.

[59](#) *ibid.*, pp. 2-3.

[60](#) 'RANZCP Manpower Needs in Child and Adolescent Psychiatry in Australia — Revised September 1982', p. 39, with October 1982 General Council minutes and supporting documents.

[61](#) Burvill, *op. cit.*, p. 9. Only seventeen psychiatrists spoke Italian and nine Greek, compared with sixty who spoke French, forty-eight German and twenty-six Cantonese. This presumably reflected the ethnic backgrounds of those who entered psychiatry in Australasia up to that time, as well as required school languages and the locus of immigration. On the other hand, Australasian psychiatrists spoke a remarkably wide range of languages, including at least one speaker of Balasa, Flemish, Foochow, Ga, Hak, Hon, Nepali, Swahili and Xhosa.

[62](#) *ibid.*, Table 12, p. 17.

[63](#) *ibid.*, Table 17, p. 22.

[64](#) *ibid.*

[65](#) *ibid.*, Table 18, p. 24. No figures were available for New Zealand.

[66](#) *ibid.*, p. 24.

[67](#) *ibid.*, p. 31.

[68](#) *ibid.*, p. 33.

[69](#) *ibid.*, pp. 32-3.

[70](#) The other original members of the committee were Drs Bruce Peterson and Stanley Mirams. 'Memo from Dr R. Pargiter to Dr Sandra Hacker', dated 18 August 1978, with October 1978 General Council minutes and supporting documents.

[71](#) Interview with Dr Russell Pargiter, Melbourne, 28 October 1993.

[72](#) 'RANZCP Ethics Committee. Report to General Council Meeting, October 1983', with October 1983 General Council minutes and supporting documents.

[73](#) Interview with Russell Pargiter, 28 October 1993.

[74](#) 'Minutes of the October 1982 General Council Meeting ... [of] 9 and 10 October 1982', p. 15.

[75](#) 'Minutes of the Executive Advisory Committee ... [of] 10 February 1979', p. 3.

[76](#) Letter from Dr A.C. McFarlane to Peter Carter, dated 8 July 1987, with October 1987 General Council minutes and supporting documents.

[77](#) 'RANZCP Proposed Position Statement on Nuclear War', dated 4 April 1986, with May 1986 General Council minutes and supporting documents.

[78](#) *ibid.*

[79](#) 'Minutes of the General Council Meeting ... [of] 3-4 June 1989', p. 8.

[80](#) *ibid.*

[81](#) *ibid.*, pp. 13-14.

[82](#) *ibid.*, p. 14.

[83](#) *ibid.*, p. 13.

[84](#) *ibid.*, p. 13.

[85](#) Singh and Doherty, op. cit., p. 10.

[86](#) *ibid.*

[87](#) *ibid.*, p. 11.

[88](#) *ibid.*, p. 12.

[89](#) *ibid.*, p. 12.

[90](#) 'Proposed Amalgamation of the Board of Censors and the Board of Accreditation: Proposal by the College Executive Committee', typescript with October 1984 General Council minutes and supporting documents; 'RANZCP General Council [Minutes of] 13 and 14 October 1984', p. 5.

[91](#) Singh and Doherty, op. cit., p. 15. Professor Singh was Acting Chief Censor from May–October 1988.

[92](#) *ibid.*

[93](#) 'Report to the General Council — Re: T.A.A. Convention Planner's Convention Held on 29–30 July 1974, Wrest Point, Hobart, Tasmania', p. 2, with October 1974 Council minutes and supporting documents.

[94](#) The role and status of women in the College, and other issues of gender, will be discussed in more detail in a later chapter.

[95](#) Interview with Peter Carter, Melbourne, 29 November 1994.

[96](#) 'Notes on Ninth Annual Congress: Hobart and Launceston', p. 1, with May 1973 Council minutes and supporting documents.

[97](#) These questions will be discussed in much greater detail in a later chapter.

[98](#) For instance, when one of the authors (Prof. W.D. Rubinstein) told a colleague in another state, a distinguished history professor at a leading university, that

he was engaged in writing the official history of the RANZCP, the first thing his colleague asked was whether the book would get to the bottom of why so many people died — an obvious reference to Chelmsford. In our opinion a similar response, even from very highly educated people, is likely to be regrettably common.

[99](#) 'Harry Richard Bailey', in *Report of the Royal Commission into Deep Sleep Therapy* (henceforth *Slattery*), Hon. Mr Acting Justice J.P. Slattery, Royal Commissioner (Sydney, 1990), Vol. 2, *The DST Doctors*, pp. 1-134; Brian Bromberger and Janet Fife-Yeomans, *Deep Sleep: Harry Bailey and the Scandal of Chelmsford* (Sydney, 1991), pp. 45-6, 105.

[100](#) Slattery, op. cit., Vol. 4, The Deaths, pp. 25-44, 'The Statistics'; Simon Pinder, 'Exposing the Chelmsford Horror', *Adelaide Advertiser*, 18 August 1991.

[101](#) Slattery, *ibid.*, Vol. 1, 'Introduction', p. 13; Bromberger and Fife-Yeomans, op. cit., p. 164.

[102](#) Slattery, *ibid.*, Vol. 2, *The DST Doctors*, pp. 14, 166-7; Bromberger and Fife-Yeomans, *ibid.*, p. 168.

[103](#) Joan M. Lawrence, 'Action by The Royal Australian and New Zealand College of Psychiatrists in Relation to the Conduct of Two of Its Members, Dr Harry Bailey and Dr John Tennant Herron, Associated with Chelmsford Hospital, Sydney, New South Wales', media statement, 10 August 1988, p. 1. The CCHR is generally regarded as closely linked to the Church of Scientology, well-known for its opposition to psychiatry.

[104](#) *ibid.*, p. 2.

[105](#) *ibid.*, p. 3, citing part of the resolution to be moved at a special meeting of General Council on 18 May 1986.

[106](#) *ibid.*

[107](#) 'High Court Bid in Chelmsford Doctors Saga', *West Australian*, 8 April 1992.

[108](#) *ibid.*

[109](#) *ibid.*

[110](#) 'President's Letter', *News and Notes* (quarterly College newsletter), No. 24, (February 1991), p. 4.

[111](#) Hon. W.J. Carter QC, Commissioner, Commission of Inquiry into the Cause and Treatment of Patients in the Psychiatric Unit of Townsville General Hospital between 2nd March 1975 and 20th February 1988, *Report Vol. 1: 'Summary of Findings, Recommendations and Commissioner's Report'*, Brisbane, 1991 (henceforth Carter). As with Chelmsford, the Ward 10B affair will be discussed in more detail in a later chapter.

[112](#) Carter, *ibid.*, p. iii.

[113](#) *ibid.*, p. iv.

[114](#) *ibid.*, p. viii.

[115](#) *ibid.*, p. v.

[116](#) *ibid.*, p. xi.

[117](#) Letter from Dr R.F. Broadbent (College Registrar) to Hon. William J. Carter, dated 7 June 1990, copy with November 1990 General Council minutes and supporting documents.

[118](#) 'Minutes of General Council Special Meeting 11 May 1990', with May 1990 General Council minutes and supporting documents.

[119](#) *ibid.*

[120](#) John Ellard, 'The Lessons from Townsville', *News and Notes*, No. 27 (November 1991), pp. 23-25.

[121](#) 'Minutes of General Council Meeting ... [of] 27-28 October, 1990', p. 5.

4 The RANZCP in the Recent Past, 1990-Today

1 'New Appointments', *News and Notes*, June 1988, p. 12. Carter took up a business position in New South Wales and later became Secretary of the Royal Australasian College of Surgeons (interview with Peter Carter, Melbourne, 29 November 1994). Dr Broadbent was selected from several shortlisted candidates. Chris Miller, the College's Deputy Registrar, left after one year in this position at the time of Dr Broadbent's appointment (*News and Notes*, June 1988).

2 Interview with Dr Robert Broadbent, Melbourne, 1 December 1994; 'New Appointments', *ibid.*

3 'New Appointments', *ibid.* Sheena Mathieson was appointed at the same time as Administrative Officer (Training). This left Margaret Cocks (Ettridge) (Assistant Registrar/Fellowships) and Mary-Rose Morgan, the College's Financial Administrator, as its 'old hands'.

4 'Minutes of General Council Meeting ... [of] 15 and 16 May 1993', p. 3; 'RANZCP Agenda — General Council Meeting ... [of] 22, 23, 24 October 1993'. Barbara Keyser and Sheena Mathieson were reappointed at the same time.

5 'Minutes of the General Council Meeting ... [of] 3-4 June 1989', p. 14. It should also be noted that a Committee for Equality for the Psychiatrically Ill, chaired by Dr John Grigor, was established in May 1986 and met frequently over the next few years. It dealt with such topics as federal and state mental health policies, standards for psychiatric facilities, deinstitutionalisation, and civil liberties issues concerning the mentally ill. See, e.g., 'Committee for Equality for the Psychiatrically Ill — Report to General Meeting No. 1/87 [1987]', with May 1987 General Council minutes and supporting documents. This committee was disbanded in February 1988, but the New Zealand chapter of the committee continued specifically as a New Zealand branch

activity and the Social Issues Committee developed further policy in this area ('RANZCP Report to the General Council meeting 1/88 — Committee for Equality for the Psychiatrically Ill', dated 1 March 1988, with 1988 General Council minutes and supporting documents.) [6](#) *ibid.* Dr Ellard was at the time chairman of the Medical Practice Standards Committee. He discussed the proposal for such a committee extensively with Professor Bruce Singh (letter from Dr Ellard to Dr Robert Broadbent, College Registrar, dated 3 February 1989, with June 1989 General Council minutes and supporting documents).

[7](#) *ibid.*, p. 1. Both Chelmsford and Townsville were also discussed extensively at the College's General Council meeting which approved the creation of the committee.

[8](#) *ibid.*, p. 2.

[9](#) 'Minutes of the General Council Meeting ... [of] 12-13 May 1990', p. 5. Professor Singh led this discussion.

[10](#) *ibid.*

[11](#) *ibid.*, p. 4. See also Robert Broadbent, 'RANZCP Board of Practice Standards — Proposed Terms of Reference', with May 1990 General Council minutes and supporting documents.

[12](#) *ibid.*, Point 4 'functions'.

[13](#) 'Minutes of General Council Meeting ... [of] 18 May 1991', p. 7.

[14](#) R.F. Broadbent, 'RANZCP Disciplinary Powers and Procedures — Summary of Proposed Revisions', dated 25 February 1991, with May 1991 General Council minutes and supporting documents; A discussion paper on this matter had been considered by General Council in 1990 (comments by Dr Broadbent to the authors).

[15](#) *ibid.*, p. 1.

[16](#) *ibid.*

[17](#) *ibid.*

[18](#) 'Minutes ... [of] 18 May 1991', pp. 17-18.

[19](#) 'Minutes of General Council Meeting ... [of] 15 and 16 May 1993', pp. 30-2, with October 1993 Agenda — General Council Meeting.

[20](#) 'Minutes of General Council Meeting ... [of] 28 October 1989', pp. 7-8.

[21](#) *ibid.*

[22](#) 'RANZCP Quality Assurance Committee: Proposed Terms of Reference', pp. 1-2, with May 1990 General Council minutes and supporting documents.

[23](#) *ibid.*, p. 1.

[24](#) Minutes of General Council Meeting ... [of] 12-13 May 1990', p. 5.

[25](#) 'Report from QA Committee to General Council', with 'Agenda — General Council Meeting ... [of] 14-15 May 1994', Attachment 58.

[26](#) *ibid.*

[27](#) *ibid.*

[28](#) Interview with Professor Gordon Parker, Sydney, 1 October 1993.

[29](#) 'Minutes of General Council Meeting ... [of] 16 May 1992', p. 21.

[30](#) 'The RANZCP Code of Ethics — Principles', p. 2, with May 1992 General Council minutes and supporting documents.

[31](#) *ibid.*, 'Annotations to the Principles', pp. 3, 5.

[32](#) *ibid.*, pp. 3, 7.

[33](#) Dr Keith Mayne (NSW) has been its chairman.

[34](#) 'Report to General Council Meeting ... [of] 27 October 1990/Committee for Continuing Medical Education', with October 1990 General Council minutes and supporting documents.

[35](#) 'Agenda — General Council Meeting ... [of] 14-15 May 1994', Attachment No. 54.

[36](#) 'Report to General Council 1/92 from the Committee for Continuing Medical Education', with May 1992 General Council minutes and supporting documents.

[37](#) Dr Robert Broadbent, 'The Principles and the Process', *Australasian Psychiatry*, Vol. 2, No. 1 (February 1994), p. 29.

[38](#) *ibid.*

[39](#) *ibid.*

[40](#) 'RANZCP Agenda — General Council Meeting ... [of] 22-23 October 1994', p. 3. The College also withdrew an opinion statement on Sensory Deprivation as a Therapeutic Technique, as that technique 'is no longer in use' (*ibid.*).

[41](#) See, e.g., 'RANZCP College Executive Committee Meeting [Agenda] ... [of] 2 September 1994', p. 1.

[42](#) See, e.g., 'RANZCP Agenda — General Council Meeting ... [of] 22-23 October 1994', p. 2. Of these twenty-eight persons, eight were women. (The College's CEC had no women members in the mid 1990s, although it did have women members in the past, in the person of the President/President-elect/Immediate Past President.) The College General Council had three New Zealand members, two from South Australia, Queensland and Western Australia, and one from Tasmania.

[43](#) Interview with Dr Eric Ratcliff, Melbourne, 1 April 1995.

[44](#) *ibid.*

[45](#) Interview with Dr Robert Broadbent, 1 December 1994. The Honorary Secretary (who currently lives in Melbourne) also holds face-to-face discussions with the Executive Director/Registrar on Wednesday afternoons.

[46](#) Interview with Peter Eisen, 11 November 1993.

[47](#) Dr H. Julie Jones, 'Faculty of Child Psychiatry. Report to the General Council of the RANZCP Meeting, September 1992', with September 1992 General Council minutes and supporting documents.

[48](#) Dr Craigie Macfie, 'Section of Psychotherapy Established', *News and Notes*, No. 26 (August 1991), p. 8. Dr Craigie Macfie was its chairman and Dr Ron Spielman its secretary.

[49](#) 'Agenda — General Council Meeting ... [of] 22, 23, 24 October 1993', p. 4.

[50](#) 'Report of Ad Hoc Committee on HIV/AIDS for GC2/93', with *ibid.*, Attachment No. 3.

[51](#) 'Memorandum to Council, September 1991; RANZCP History Committee', with November 1991 General Council minutes and supporting documents.

[52](#) *ibid.*

[53](#) 'RANZCP Minutes of General Council Meeting ... [of] 18 May 1991', p. 4.

[54](#) Interview with Dr Phillip Boyce (NSW branch chairman), Sydney, 5 August 1994.

[55](#) Pam Allen has been the branch's administrative secretary for many years.

[56](#) Interview with Dr Wayne Miles (chairman, New Zealand branch), Dunedin, 24 August 1994. This movement was associated with a paper advocating secession written in 1984 by Dr Bob Large, 'Cutting the Chord'.

[57](#) Interview with Wayne Miles, 24 August 1994.

[58](#) 'Notice of Annual General Meeting ... [of] 10 May 1995, Agenda and Special Resolutions', pp. 2-7. The statement in support of these resolutions was prepared by Drs John Buchanan, George Halasz and Shirley Prager.

[59](#) *ibid.* pp. 4, 6.

[60](#) *ibid.*, p. 7, where it was noted that the 'no' case was supported by twenty then-serving office-bearers and General Councillors.

[61](#) *ibid.*, pp. 6-7.

[62](#) 'Financial Statements', pp. 9, 13, in RANZCP Annual Report 1994.

[63](#) *ibid.*, p. 10.

[64](#) P.W. Burvill, 'Looking Beyond the 1:10,000 Ratio of Psychiatrists to Population', *Australian and New Zealand Journal of Psychiatry*, Vol. 26, No. 2 (1992), p. 268.

[65](#) 'Isolated Fellows Special Feature', *News and Notes*, No. 25 (May 1991), p. 9.

[66](#) 'Gifs [Geographically Isolated Fellows] Get a Go', *News and Notes*, No. 24 (February 1991), p. 20.

[67](#) Karen Zelas, 'President's Letter', *News and Notes*, No. 21 (April 1990), p. 3.

[68](#) *ibid.*

[69](#) 'Women in Psychiatry Group Sets Up', *News and Notes*, No. 19, November 1989, p. 6. Drs Manuela Hrasky and Sandra Hacker were contact persons.

[70](#) *ibid.*

[71](#) Zelas, *op. cit.*; 'Women's Bi-National Network Formed', *News and Notes*, No. 22 (August 1990), p. 8.

[72](#) *ibid.*, p. 4.

[73](#) 'Women Psychiatrists Breakfast in New Zealand', *New and Notes*, No. 23 (November 1990), p. 14.

[74](#) 'Women's Workshop', *News and Notes*, No. 31 (November 1992), p. 27.

[75](#) In *Australian and New Zealand Journal of Psychiatry*, Vol. 25, No. 1 (March 1991), p. 95.

[76](#) 'Reflections on RANZCP Congress 1988' (letter) in *Australian and New Zealand Journal of Psychiatry*, Vol. 22, No. 4 (December 1988), pp. 340-2.

[77](#) 'Agenda Item 5.2: Female Representation on the College Executive Committee', with 'RANZCP Agenda — General Council Meeting ... [of] 22, 23, 24 October 1993', Attachment No. 8. This document dealt specifically with the fact that CEC then had no female member.

[78](#) A good introduction to this subject is David I. Ben-Tovim and Robert H. Elzinga, 'Casemix: A Clinician's Starter Pack', *Australasian Psychiatry*, Vol. 1, No. 2, (June 1993), pp. 68-70.

[79](#) *ibid.*, p. 69.

[80](#) Michael Epstein, 'What You Always Wanted to Know About Mental Illness ... But were Afraid to Ask!: A Review of the Burdekin Report', with 'RANZCP Agenda — General Council Meeting ... [of] 14-15 May 1994', p. 1, Attachment No. 3. The commission took evidence from seventy psychiatrists and Professor Beverley Raphael, former College President, assisted the Inquiry.

[81](#) *ibid.*, p. 3.

[82](#) 'Minutes of the General Council Meeting ... [of] 22-23 October 1993', p. 4, with 'RANZCP Agenda — General Council Meeting ... [of] 14-15 May 1994'.

[83](#) See, e.g., 'Australian National Mental Health Policy and Plan' in 'Minutes of General Council Meeting ... [of] 16 May 1992', p. 5.

[84](#) 'College Links with Asian and Pacific Regions' in 'RANZCP General Council Meeting ... [of] 22, 23, 24 October 1993', Attachment No. 5. Dr Victor Storm became the convenor of this working group. He has been very active in this area.

[85](#) The popular image of psychiatry in Australasia will be examined later.

5 The Branches of the College

[1](#) Article 22, 'Election of Members of the State Committee', in the AAP's Rules of Association.

[2](#) Interview with Pam Allen, Sydney, 4 August 1994.

[3](#) Article 24, Rules of Association.

[4](#) 'Minutes of the Council Meeting ... [of] 22 October 1947', pp. 2-3. Dr Southwood moved this resolution.

[5](#) In October 1948, Victoria's project concerned 'post-graduate training in psychiatry with particular reference to the DPM'. New South Wales was assigned 'under-graduate training in psychological medicine'; Queensland the 'preservation of historical records'; South Australia the 'care of senile and chronic cases'; Tasmania 'psychiatric problems relating from isolation'; and Western Australia 'psychiatric aspects of immigration'. (No New Zealand branch was formally organised until 1954-55.) The minutes give no clue as to what each branch was supposed to do with each of these assignments, and a project (for instance) on the 'care of senile and chronic cases' would surely have required a significant research budget ('Minutes of the Council Meeting ... [of] 19 and 20 October 1948', p. 3).

[6](#) 'Minutes of the Council Meeting ... [of] 24 May 1949', p. 1. At this time, South Australia was not yet in a position to forward a report.

[7](#) 'Minutes of the General Meeting of Members ... [of] 29 November 1949', p. 1.

[8](#) 'AAP Minutes of Council Meeting held ... on 10 October 1953', pp. 2-5.

[9](#) *APQ Newsletter*, Vol. 5, No. 16 (July 1953), p. 2.

[10](#) 'AAP Minutes of Council Meeting ... [of] 10 October 1953', p. 3.

[11](#) 'AAP Minutes of Council Meeting ... [of] 9 October 1954', p. 2. This theme was frequently reiterated over the next decade.

[12](#) 'AAP Agenda for Council Meeting ... [of] 20 August 1955', p. 2.

[13](#) *ibid.*, p. 3.

[14](#) 'AAP Minutes of Council Meeting ... [of] 12 October 1959', pp. 3-4.

[15](#) 'AAP Minutes of the 18th Annual Council Meeting ... [of] 22 September 1963', pp. 1-2.

[16](#) 'Branch News Letters — New South Wales', *AP Bulletin*, Vol. 6, No. 2 (June 1965), p. 19. This was the first branch meeting held at Prince Henry Hospital.

[17](#) *ibid.*

[18](#) *ibid.*, p. 26.

[19](#) *ibid.*, pp. 28, 31.

[20](#) 'ANZCP Victorian Branch — Report to Federal Council — August 1970', p. 1, with October 1970 General Council minutes and supporting documents; Victorian branch

'Report to Federal Council, August 1972', p. 2, with October 1972 Council minutes and supporting documents.

[21](#) New South Wales branch, 'Report to General Council, August 1972', p. 2, with October 1972 Council minutes and supporting documents.

[22](#) 'ANZCP Victorian Branch — Report to Federal Council, August 1970', with October 1970 Council minutes and supporting documents. The Education Subcommittee arranged a College evening course on Aspects of Psychiatry for trainees and a combined meeting with the College of General Practitioners.

[23](#) *ibid.*

[24](#) 'Report of the Queensland Branch to the 13th Council Meeting — 18 October 1970', with October 1970 Council minutes and supporting documents.

[25](#) Of the proposal to circulate Council minutes earlier, this Queensland report noted that 'this branch has been bringing this matter to Council's notice for a number of years' (*ibid.*).

[26](#) Interview with Pam Allen, Sydney, 3 August 1994; information provided by Dr Robert Broadbent, 18 May 1995.

[27](#) 'Branch Newsletters — NSW', *AP Bulletin*, Vol. 6, No. 2 (June 1965), p. 19.

[28](#) Interview with Pam Allen, 3 August 1994; 'Institute of Psychiatry', *AP Bulletin*, Vol. 7, No. 1 (March 1966), pp. 30-2.

[29](#) Interview with Dr Wayne Miles, Dunedin, 24 August 1994.

[30](#) *ibid.*

[31](#) 'AAP Minutes of Council Meeting ... [of] 30 May 1959', p. 4.

[32](#) Burton-Bradley, who was born in Sydney, received numerous international awards for his research, including

the Benjamin Rush Bronze Medal of the American Psychiatric Association in 1974.

[33](#) 'RANZCP New South Wales Branch Report to Federal Council 2/94', with 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 24.

[34](#) *ibid.*, p. 1.

[35](#) For the activities of the New South Wales branch in these areas, see *ibid.*, p. 2.

[36](#) 'Report to General Council from the New Zealand Branch — August 1994', p. 1, with 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 25.

[37](#) 'Report on Branch Activities — Queensland Branch', p. 1, with 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 26.

[38](#) 'Tasmanian Branch Report', 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 27.

[39](#) 'Victorian Branch — Motions for GC 2/94 from the Victorian Branch', with 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 28.

[40](#) 'Western Australian Branch — Motion to Council/Report to Council', with 'Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 29. There were no reports from the South Australian or ACT branches.

6 The Committees of the College

[1](#) 'Minutes of the Council Meeting ... [of] 28 November 1949', p. 3.

[2](#) *ibid.*, p. 4.

[3](#) *ibid.*, p. 1.

[4](#) *ibid.*

[5](#) 'Minutes of the Council Meeting ... [of] 29 October 1951', p. 4.

[6](#) 'Minutes of Council Meeting ... [of] 27 October 1952', p. 3.

[7](#) 'AAP, Minutes of Annual General Meeting ... [of] 12 October [1954]', p. 1.

[8](#) 'AAP Biennial Council Meeting ... [of] 29 April 1954', p. 3.

[9](#) 'AAP Minutes of Council Meeting ... [of] 9 October 1954', p. 5.

[10](#) 'AAP — Agenda for Council Meeting ... [of] 20 August 1955', p. 3. Drs Stafford and Youngman comprised the secretariat subcommittee; 'AAP — Minutes — Council Meeting — 24/10/55', p. 2; 'AAP Annual General Meeting, 26.10.55', p. 1.

[11](#) The recommendations of the Rules Subcommittee were tabled by Dr Dax at the Council meeting of 13 October 1958 ('AAP Minutes of Council Meeting ... [of] 13 October 1958', p. 4).

[12](#) 'AAP — Minutes of the 15th Annual Council Meeting ... [of] 17 October 1960', pp. 3, 5. The Pharmaceutical Benefits Committee consisted of Drs Southwood, Sinclair and Martin, and was concerned to examine the range and scale of pharmaceutical benefits then granted by the government. It was thus similar in some respects to later standing committees. The latter committee consisted of Drs Sinclair, Springthorpe and Maudsley.

[13](#) 'AAP Semi-Annual Council Meeting ... [of] 13 May 1961', Annotations, p. 2.

[14](#) 'Supplementary Annotations to Council Agenda' with 'AAP Semi-Annual Council Meeting ... [of] 13 May 1961 ... Agenda', p. 20.

[15](#) [ibid.](#)

[16](#) This was decided after Council debated the merits of siting the Treasurer in the same branch as the Secretary. Dr Maudsley proposed that the Finance Committee be based in Sydney. This was seconded by Dr Dax ('AAP Minutes of the Semi-Annual Council Meeting ... [of] 13 May 1961', p. 1).

[17](#) 'Supplementary Annotations to Council Agenda' with 'AAP Semi-Annual Council Meeting ... [of] 13 May 1961 ... Agenda', p. 2. The other members of the Standing Finance Committee were Drs Jack Russell and I.G. Simpson.

[18](#) [ibid.](#) This committee consisted of Drs Zavattaro, Stafford and Matchett, of whom the first served as chairman/secretary.

[19](#) 'Minutes of Semi-Annual Council Meeting ... [of] 7 May 1960', p. 3.

[20](#) Its other members were Professor Trethowan and Drs Stoller, Youngman, Williams, Ironside and an unnamed member of the Western Australian branch.

[21](#) 'AAP Minutes of the Semi-Annual Council Meeting ... [of] 13 May 1961', p. 6.

[22](#) [ibid.](#), p. 3.

[23](#) 'AAP Minutes of the Semi-Annual Council Meeting ... [of] 4 May 1963', p. 5.

[24](#) 'AAP Minutes of the 18th Annual Council Meeting ... [of] 22 September 1963'.

[25](#) 'AAP Minutes of the Semi-Annual Council Meeting ... [of] 11 April 1964', p. 8.

[26](#) 'ANZCP — 1st Annual Council Meeting ... [of] 25 October 1964, Agenda', Annotations, pp. 1-3, 9; 'ANZCP Minutes of 1st Annual Council Meeting ... [of] 25 October 1964', pp. 3, 14-15.

[27](#) 'ANZCP — 1st Annual Council Meeting ... [of] 25 October 1964, Agenda', pp. 2-3.

[28](#) *ibid.*, p. 3; 'ANZCP Minutes of 1st Annual Council Meeting ... [of] 25 October 1964', p. 3.

[29](#) 'ANZCP — 1st Annual Council Meeting ... [of] 25 October 1964, Agenda', p. 9.

[30](#) 'ANZCP — Minutes of 1st Annual Council Meeting ... [of] 25 October 1964', p. 2.

[31](#) 'ANZCP — 1st Annual Council Meeting ... [of] 25 October 1964, Agenda'.

[32](#) There was apparently some delay in officially constituting this committee, for it was not formally approved until May 1965, though it had been convened before. Dr Bill Dibden was its chairman. 'ANZCP Minutes of 1st Annual Council Meeting 1965 ... [of] 9 May 1965', p. 3.

[33](#) 'ANZCP — 1st Semi-Annual Council Meeting 1965 ... [of] 9 May 1965', Annotations, p. 2.

[34](#) 'ANZCP Minutes ... [of] 9 May 1965', pp. 2-3. The chairmen of these committees were: Secretariat Committee, Dr Ian Martin; Maudsley House Committee, Dr Dax; Gifts, etc. Committee, Dr R. Medlicott; Policy Steering Committee, Dr W.B.C. Gray (WA). The Policy Steering Committee was renamed the Objects Committee later in 1965.

[35](#) 'ANZCP — Minutes of 2nd Annual Council Meeting ... [of] 7 November 1965', p. 10.

[36](#) *ibid.*, p. 12.

[37](#) *ibid.*, p. 13.

[38](#) *ibid.*, Annotations, pp. 12-23.

[39](#) The President-elect Committee is first mentioned in the 'Minutes of the 4th Council Meeting, 1 May 1966', p. 4; the Library Committee in the 'ANZCP — Minutes of Executive

Advisory Committee ... [of] 17 July 1966', p. 2; and both the Fellowship Committee and Host Branch Committee in the 'ANZCP — Minutes of 5th Council Meeting — October 1966', pp. 2, 7. There is no indication of when precisely some of these committees came into existence; several, like the Library Committee, appear in the minutes fully constituted. The Programme Committee was renamed the Scientific Programme Committee in October 1966. The Library Committee may have originated after Dr John Cade collected funds in memory of Dr Charles Brothers, which were in part to be used for shelving a library in the Charles Brothers Room on the first floor of the old College building in Rathdowne Street. (Information from the comments of an anonymous reader of the first draft of this history.) [40](#) 'ANZCP Minutes of 8th Council Meeting ... [of] 5 May 1968'. p. 4.

[41](#) 'Annotations to Agenda of 9th Council Meeting' [n.d., October 1968], p. 9. Dr Ian Simpson was its convenor and the committee consisted of a member of the Board of Censors and of the Finance Committee. The first appointees to this committee were Drs John Ellard and Bruce Peterson.

[42](#) *ibid.*, p. 11.

[43](#) *ibid.*, p. 21.

[44](#) *ibid.*, p. 22.

[45](#) 'Report of the Social Issues Committee' with 'ANZCP — Minutes of 12th Council Meeting ... [of] 3 May 1970' supporting documents.

[46](#) 'List of Motions Carried at the 13th Council Meeting ... [of] 18 October 1970', p. 5.

[47](#) 'Psychotropic Drug Committee — Composition and Terms of Reference', dated March 1971, with May 1971 Council minutes and supporting documents.

[48](#) See, e.g., 'ANZCP — Report of Executive Advisory Committee ... [of] 7 March 1971', p. 4.

[49](#) 'List of Motions Carried at the 13th Council Meeting ... [of] 18 October 1970'.

[50](#) 'Report to Council Meeting in May 1971 — The Committee on Fees', with May 1971 Council minutes and supporting documents, pp. 1-2.

[51](#) 'Committee on Specialist Recognition', (typescript, n.d.), with May 1971 Council minutes and supporting documents.

[52](#) 'ANZCP Minutes of May 1971 General Council Meeting', p. 4.

[53](#) On the terms of reference of this committee see the letter from Dr Ben Steinberg (honorary secretary of the Queensland branch, where this committee was organised), to Dr G. Lipton, Honorary Federal Secretary of the College, dated 8 March 1974, with May 1974 Council minutes and supporting documents and the reports of the other two committees mentioned here.

[54](#) 'Resolutions of the May 1974 General Council Meeting', pp. 28-30, with May 1974 Council minutes and supporting documents; 'Roche Visiting Professor Committee Report to May 1974 General Council Meeting', with May 1974 Council minutes and supporting documents. Dr Arch Ellis was chairman of this committee. The Roche Visiting Professorship funds were originally provided in 1967 but no College committee to administer them was established until 1974.

[55](#) See reports of each Ad Hoc Committee with May 1974 Council minutes and supporting documents.

[56](#) 'Resolutions of the May 1974 General Council Meeting', pp. 27-8. Dr W. Mickleburgh was appointed secretary of the section *pro tem*.

[57](#) 'RANZCP Report of the Board of Continuing Education', with May 1984 Council minutes and supporting documents. Professor G.A. German of Western Australia was its chairman.

[58](#) 'Board of Research', document with May 1984 Council minutes and supporting documents, p. 4.

[59](#) 'RANZCP Presidential Appeal — Summary of Recommendations,' with May 1984 Council minutes and supporting documents. Dr George Lipton was chairman of this committee, which appears to have been shortlived.

[60](#) 'RANZCP — Consultation-Liaison Psychiatry Interest Group — Minutes of Business Meeting ... [of] 16 May 1994' with 'RANZCP — Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment 35.

7 The Examination and Training Process

[1](#) 'Post-Graduate Diplomas in Psychological Medicine', *APQ Newsletter*, Vol. 1, No. 3 (July 1949), p. 9.

[2](#) 'Diploma in Psychology Medicine', *APQ Newsletter*, Vol. 2, Nos 4, 5 (Jan.-June, 1950), p. 7. No surviving source states what the AAP 'curriculum' was.

[3](#) 'Educational Matters: (a) DPM Course', *APQ Newsletter*, Vol. 5, Nos 14-15 (January-March 1953), p. 10.

[4](#) *ibid.*

[5](#) 'Proposal for Uniform DPM', *APQ Newsletter*, p. 11.

[6](#) See, e.g., 'Training of Psychiatrists,' taken from a paper by Professor Trethowan of the University of Sydney, *APQ Newsletter*, Vol. 8, No. 28 (March 1957), pp. 5-6.

[7](#) 'AAP Minutes of Semi-Annual Council Meeting ... [of] 27 May 1962', p. 8.

[8](#) 'Personalities', *AP Bulletin*, Vol. 4, No. 3 (September 1963), p. 17.

[9](#) Bruce S. Singh and Peter Doherty, 'The First 20 Years of the RANZCP Examination: 1970-1990', *Australasian Psychiatry*, Vol. 1, No. 1 (April 1993), p. 9.

[10](#) *ibid.*

[11](#) *ibid.*

[12](#) *ibid.* All aspects of science which made 'no known contribution to the understanding of psychiatry' were deliberately eliminated from the examination (*ibid.*).

[13](#) *ibid.*

[14](#) *ibid.*

[15](#) *ibid.*, p. 10.

[16](#) Interview with Professor Ross Kalucy, Launceston, 19 May 1994.

[17](#) Bruce S. Singh, Peter Doherty and Ross Kalucy, 'The Components of the Fellowship Examination: 1970-1990', *Australasian Psychiatry*, Vol. 1, No. 1 (April 1993), p. 16.

[18](#) Peter W. Burvill, 'Editorial Comment — Is it Time to Revamp the College Training and Examination Process?', *Australian and New Zealand Journal of Psychiatry*, Vol. 22 (1988), p. 354.

[19](#) See 'Letters to the Editor,' *Australian and New Zealand Journal of Psychiatry* Vol. 23, No. 2 (June 1989), pp. 148-52.

[20](#) G.W. Mellsop, 'The First Seven Years of the Examination for Membership of the Royal Australian and New Zealand College of Psychiatrists', *Medical Education*, Vol. 14 (1980), pp. 50-5.

[21](#) *ibid.*, Table 1, p. 51.

[22](#) *ibid.*, p. 51.

[23](#) *ibid.*, p. 52.

[24](#) *ibid.*, pp. 52-3.

[25](#) Singh and Doherty, *op. cit.*, p. 10.

[26](#) *ibid.*

[27](#) *ibid.*

[28](#) *ibid.*

[29](#) *ibid.*, pp. 13-14.

[30](#) *ibid.*, Table 2, p. 13.

[31](#) *ibid.*

[32](#) *ibid.*, p. 14.

[33](#) Bruce Singh, 'Committee For Examinations', *RANZCP Annual Report 1990*, p. 12.

[34](#) Singh, Doherty and Kalucy, *op. cit.*, p. 16.

[35](#) *ibid.*, pp.16-21; information from Dr Robert Broadbent, 18 May 1995.

[36](#) Dr John Condon, 'Committee for Examinations — Report to General Council (October 1994)' in 'RANZCP Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Attachment No. 47.

[37](#) Bruce Singh, 'Fellowships Board' in *RANZCP Annual Report 1990*, p. 10; *RANZCP Annual Report 1991*, p. 9; information from Dr Robert Broadbent, 18 May 1995.

[38](#) Singh, Doherty and Kalucy, *op. cit.*, p. 16.

[39](#) *ibid.*, p. 20.

[40](#) Singh and Doherty, *op. cit.*, pp. 11-12.

[41](#) *ibid.*, p. 12.

[42](#) George Lipton, 'The Current Status of Child Psychiatry in Australia with Special Reference to Training in General

Psychiatry', *Australian and New Zealand Journal of Psychiatry*, Vol. 12 (1978), p. 157; information from Dr Robert Broadbent.

[43](#) 'AAP Minutes of Semi-Annual Council Meeting ... [of] 4 May 1963', p. 4. His proposal for a Section in Child Psychiatry was made at the same time as his report on this visit.

[44](#) See the Letter from Dr R.J. Methven (Chairman, Federal Executive, Section on Child Psychiatry) to P.J. Carter, Registrar of the RANZCP, dated 26 August 1986, which presents a history of the College training program in child psychiatry in the context of a formal application by the Section on Child Psychiatry to become a Faculty of the College, with 1986 General Council minutes and supporting documents. College Council had approved a training program in child psychiatry in 1973.

[45](#) *ibid.*, p. 2.

[46](#) *ibid.*

[47](#) *ibid.*

[48](#) *ibid.*, p. 3.

[49](#) Professor Robert Kosky (Chairman, Committee for Training in Child Psychiatry), 'Committee For Training in Child Psychiatry', *RANZCP Annual Report 1991*, p. 10.

[50](#) *ibid.*

[51](#) For a study of the medical education of Australian psychiatrists, with special emphasis on the overseas contribution, see William A. Cramond, 'The Overseas Contribution to Australian Psychiatry 1950-1980', *Australian and New Zealand Journal of Psychiatry*, Vol. 15, No. 3 (September 1981), pp. 199-204.

[52](#) Brian Davies, 'The Training of Psychiatrists in Australia and New Zealand in 1967', *Australian and New Zealand Journal of Psychiatry*, Vol. 2, No. 2 (June 1968), p. 61.

[53](#) *ibid.*

[54](#) *ibid.*

[55](#) *ibid.*, p. 82.

[56](#) *ibid.*

[57](#) *ibid.*

[58](#) *ibid.*, p. 63.

[59](#) *ibid.*, p. 62.

[60](#) *ibid.*, p. 63.

[61](#) *ibid.*, p. 63, citing Alan Stoller, *Mental Health Facilities and the Needs of Australia* (Canberra, 1955).

[62](#) Dr John Ellard, 'Board of Accreditation — Report to Council — October 1984', with 1984 Council minutes and supporting documents; John Ellard, 'Confidential Draft — Submissions to be Made to Council — October 1975 by the Chairman of the Board of Accreditation', with 1975 Council minutes and supporting documents.

[63](#) Ellard, 'Board of Accreditation — Report... 1984'.

[64](#) *ibid.*

[65](#) *ibid.*, p. 2. The College's attitude contrasts with that adopted by other medical colleges. (We are grateful to Dr Robert Broadbent for this point.) [66](#) *ibid.*

[67](#) *ibid.*, p. 3.

[68](#) 'Proposed Amalgamation of the Board of Censors and the Board of Accreditation', with 1984 Council minutes and supporting documents.

[69](#) 'Minutes of General Council Meeting GC1/92-16 May 1992', pp. 17-19.

[70](#) Dr Jonathan Phillips, 'Committee for Training — Report to General Council, March 1992', with 1992 Council minutes and supporting documents. According to Professor Richard Ball, former Chief Censor, in the training process 'We enforced rotation to ensure variety of experience including a period in general hospital-consultation-liaison work, and matching time in hospitals specializing in medium and longer term care (Richard Ball, 'On College Presidents — With the Report of One Case', presidential address, c. 1981).

[71](#) 'RANZCP Committee for Training — Guidelines for Inspection to Training Programs', dated March 1993.

[72](#) *RANZCP Annual Report 1991*, p. 36. Series 5, College Archives.

8 College Congresses and Research

[1](#) 'Minutes of the Meeting of Psychiatrists Held ... on 9 October 1946 for the Purpose of the Formation of an Australasian Association of Psychiatrists'.

[2](#) 'Minutes of the General Meeting of the Australasian Association of Psychiatrists ... [of] 22 October 1947'.

[3](#) 'Minutes of Informal Discussion Held After Dinner at Hotel Windsor on 20 October 1948'. This informal discussion agreed to urge the necessity for not less than half of official visitors of state mental hygiene departments being trained psychiatrists and to investigate the possibility of inviting an expert from England to report on the mental hospital position.

[4](#) 'Minutes of the Council Meeting ... [of] 24 May 1949', p. 1. It is possible that this refers to meetings of state branches of the Association. The papers are collected in Series 55, 'Published Material of the AAP', College Archives.

[5](#) 'Minutes of the General Meeting ... [of] 29 November 1949', p. 3.

[6](#) *APQ Newsletter*, Vols 3-4, Nos 9-11 (September 1951-March 1952), p. 8.

[7](#) *APQ Newsletter*, Vol. 4, Nos 12-13 (June-September 1952), p. 2. An anonymous reader of the first draft of this work has pointed out the article 'Less Health and More Language' in *News and Notes*, No. 8 (March 1987), in which the author comments: 'I am immediately reminded of an Australasian Association of Psychiatrists Annual Meeting in Adelaide in 1952 when I was invited to be the after-dinner speaker. By good fortune our meeting happened to be held during "wine week" in which one hotel each night was provided with free wine. The announcement that ours was the one chosen coincided with the beginning of the first course. You can imagine the success of the after-dinner speech. To be truthful I have no recollection of what I said and I am comforted by knowing that neither had anyone else.'

[8](#) *ibid.*, p. 3.

[9](#) *APQ Newsletter*, Vols 3-4, Nos 9-11 (September 1951-March 1952), p. 9.

[10](#) *APQ Newsletter*, Vol. 5, No. 16 (July 1953), p. 5.

[11](#) From J.B. Williams, 'The Australasian Association of Psychiatrists From Birth to Dissolution' (typescript, 1964), p. 7.

[12](#) *AP Bulletin*, Vol. 6, No. 2 (June 1965), p. 9.

[13](#) See, e.g., W.A. Dibden, 'Presidential Note', *AP Bulletin*, Vol. 6, No. 4 (December 1965), p. 4, for an account of the Scientific Programme Committee.

[14](#) *AP Bulletin*, Vol. 6, No. 4 (December 1965), p. 24.

[15](#) The 1975 Congress in Melbourne was also the occasion of the first Pacific Congress of Psychiatrists.

[16](#) The 1983 Congress was held in October in Adelaide, but the 1985 Congress took place in May in Hobart. Similarly, the 1992 Congress took place in September–October in Canberra, and the 1994 Congress was held in Launceston in May.

[17](#) ‘Minutes of the General Council Meeting ... [of] October 1989’, p. 11.

[18](#) Dr R.A. Pargiter, ‘A Review’, with 1982 General Council minutes and supporting documents, p. 4. Dr Pargiter was at the time Congress Advisory Officer to the College. His conclusion was that some criticisms of the costs of the College were justified, others not. A revised version of his paper, ‘Are Congresses an Outdated Luxury?’, appeared in *ANZ Psychiatric News*, No. 21 (June 1982).

[19](#) Pargiter, ‘A Review’, with 1982 General Council minutes and supporting documents, p. 6.

[20](#) *ibid.*, Table, p. 8.

[21](#) Pargiter notes, however, that some ‘Associates’ were actually the non-College spouses of members (*ibid.*, p. 9).

[22](#) Dr Carolyn Quadrio, ‘Letter to the Editor’, *Australian and New Zealand Journal of Psychiatry*, Vol. 22, No. 4 (December 1988), pp. 340–4.

[23](#) Dr R. Pargiter, ‘Report to GC1/89 — Congress Options’, dated 29 March 1989, with June 1989 General Council minutes and supporting documents.

[24](#) Dr B. Kenny, ‘Report to May 1990 General Council — College Congresses’, with May 1990 General Council minutes and supporting documents.

[25](#) *ibid.*, p. 1.

[26](#) *ibid.*

[27](#) (Professor) Brian Davies, 'Editorial — Medical Students, Psychiatry and Medical Psychology', *Australian and New Zealand Journal of Psychiatry* (September 1967), Table 1, p. 113. In 1964 the holders of these chairs were, respectively, Professors David Maddison, Leslie Kiloh, Wallace Ironside, William Cramond, Brian Davies, Frederick Whitlock and Ian Oswald. (The chair at Monash had not then been filled.) [28](#) See the relevant listings in the *Commonwealth Universities Yearbook, 1994* (London, 1994). This data is current for mid-late 1993 and should be regarded as fairly approximate, with some double-counting and the inclusion of practising psychiatrists holding part-time academic appointments. The total also includes a number of full-time research fellows and the like.

[29](#) *ibid.* These figures are probably understatements, as some academics do not list all of their post-nominal initials. On the other hand, it is rather odd to find any university lecturers in psychiatry in Australasia who are not fellows of the College.

[30](#) Gordon Parker, 'Research by Psychiatrists in Australian and New Zealand, 1978--1984', unpublished report, dated March 1986, with May 1986 Council minutes and supporting documents.

[31](#) *ibid.*, pp. 9-10 and Table 2.

[32](#) *ibid.*, Table 1. The journal impact factor of the College's *Journal* was, however, much lower than for overseas journals, i.e. articles published there were themselves cited by other published research papers in psychiatry much less frequently than those published in the USA or Britain.

[33](#) *ibid.*, p. 7. Parker also notes the increasing trend to lengthy lists of coauthors of scientific papers, and cites a 1964 editorial in the *New England Journal of Medicine* that

'the publication of a long list of authors' names after the title is a little like having all a vessel's ballast hanging from the masthead, as if to counterbalance the barnacles'! (p. 16).

[34](#) See 'Organisation and History' in Jerzy Krupinski, Alan Mackenzie and Rachelle Banchevska (eds), *Psychiatric Research in Victoria: The History and Achievements of the Mental Health Research Institute, 1956-1981* (Melbourne, 1981), p. 3.

[35](#) 'Past and Present Professional Staff' in *ibid.*, pp. 217-18.

[36](#) *ibid.*, pp. 127-206.

[37](#) David Copolov, 'The Schizophrenia Research Programme at Royal Park' in David Copolov (ed), *Australian Psychiatry and the Traditions of Aubrey Lewis* (Melbourne, 1991), pp. 21-4.

[38](#) Peter Beumont (Convenor, Research Committee), 'Report to May 1983 General Council Meeting', with May 1983 General Council minutes and supporting documents.

[39](#) Dr Edmond Chiu (Honorary Secretary, Board of Research), 'Board of Research — Report to Council Meeting 1/89', with June 1989 General Council minutes and supporting documents. There appears to be some confusion about when the Board of Research was established. It definitely submitted reports to Council under this name by 1989, yet in mid 1994 there were references in Council minutes to the 'newly constituted Board' (see, e.g. 'Agenda of 22-23 October General Council Meeting', Item 9.1, p. 10).

[40](#) See 'Minutes of Board of Research, 25 August 1994', with 'RANZCP Agenda — General Council Meeting GC2/94 ... [of] 22-23 October 1994', Item No. 57; *RANZCP Annual Reports, 1990 et seq.*

[41](#) Sidney Bloch, 'Report on the ANZ Journal of Psychiatry, August 1993', with 'Agenda — General Council Meeting GC2/93 ... [of] 22, 23, 24 October 1993', Attachment No. 35.

[42](#) *ibid.*

[43](#) Roger C. Buckle, 'ANZCP Journal Committee — Report to October 1975 General Council Meeting', with October 1975 General Council minutes and supporting documents.

[44](#) *ibid.*

[45](#) 'Report on A.N.Z. Journal of Psychiatry, August 1994', RANZCP General Council Meeting GC2/94 ... [of] 22–23 October 1994', Attachment No. 37.

[46](#) See Herbert Bower, 'Obituary — Ainslie Dixon Meares', *Australian and New Zealand Journal of Psychiatry*, Vol. 21 (1987), pp. 251–2.

[47](#) Gavin Andrews (ed), *Festschrift in Honour of Leslie Gordon Kiloh* (Sydney, 1986).

[48](#) M.D. Neilson, 'Classification of Depression: A Co-Citation Index' in *ibid.*, charts precisely the extraordinary influence of one 1963 paper by Kiloh and R.F. Garside, 'The Independence of Neurotic Depression and Endogenous Depression', which was cited in 407 other published psychiatric papers around the world between 1972 and 1982.

9 College Prizes and Fellowships

[1](#) Awards and Prizes File, with May 1985 RANZCP General Council minutes and supporting documents.

[2](#) *ibid.*

[3](#) 'Minutes of the Council Meeting ... [of] 28 November 1949', p. 3. The only previous explanation of this fund

occurs in the 'Minutes of the Council Meeting ... [of] 19 October 1948', p. 1, where it was stated that 'the Evan Jones Memorial Fund at 30/9/48 had reached £233/10', including £50 'from the NSW Public Services Medical Officers Association'.

[4](#) 'Minutes of the Council Meeting ... [of] 27 October 1952', p. 2. This decision came from the fund's official trustees, 'explained by Dr Arnott'.

[5](#) 'AAP — Council Meeting ... [of] 20 August, 1956 ... Minutes', p. 3.

[6](#) 'AAP Council Meeting ... [of] 25 November 1957 — Annotations', p. 2.

[7](#) 'AAP Council Meeting ... [of] 26 April 1958', p. 2.

[8](#) 'AAP Minutes of the 15th Annual Council Meeting ... [of] 17 October 1960', p. 2.

[9](#) *AP Bulletin*, (n.d., 1960 issue), pp. 9-11.

[10](#) 'AAP Semi-Annual Council Meeting ... [of] 4 May 1963 ... Agenda', Annotations, p. 2; 'AAP Minutes of 1st Annual Council Meeting ... [of] 25 October 1964', p. 5.

[11](#) 'Minutes 4th Council Meeting, 1 May, 1966', p. 3. This change was proposed by Professor Kiloh, who argued that 'academics would be in a strong position to win the prize year after year, whereas it was intended that this prize should be for the purpose of encouraging younger psychiatrists who were establishing themselves' (p. 4).

[12](#) 'ANZCP Minutes of Executive Advisory Committee Meeting ... [of] 16 March 1969', p. 4; 'ANZCP Minutes of Executive Advisory Committee Meeting ... [of] 3 August 1969', p. 1.

[13](#) R.W. Medlicott, 'Presidential Note', *AP Bulletin*, Vol. 6, No. 3 (September 1964), p. 3.

[14](#) 'The H.B. Williams' Memorial Fund Travelling Professorship', *AP Bulletin*, Vol. 6, No. 2 (June 1965), p. 18.

[15](#) 'ANZCP Minutes of the Executive Advisory Committee Meeting ... [of] 13 February 1966', p. 2.

[16](#) 'Annotations to the Agenda of 8th Council Meeting' [5 May 1968], p. 8. Professor Pond later became President of the Royal College of Psychiatrists and is regarded as one of the most eminent British psychiatrists.

[17](#) 'Annotations to Agenda of 9th Council Meeting' [October 1968], p. 11.

[18](#) See, e.g., Addendum 1 to letter from W.D. Wilson (Medical Director, Ashburn Hall, New Zealand) to Dr Sandra Hacker of the RANZCP, dated 18 March 1980, with 1980 General Council minutes and supporting documents.

[19](#) In 1974, Dr John Cade of Melbourne was appointed Roche Travelling Professor.

[20](#) List of holders of Roche Travelling Professorship, based on letter from John Spencer to Peter Carter (College Registrar), 25 February 1986, with 1986 Council minutes and supporting documents and complete lists from the file maintained by Margaret Ettridge, College headquarters.

[21](#) *ibid.*

[22](#) 'ANZCP Minutes of the 12th Council Meeting ... [of] 3 May 1970', p. 13.

[23](#) 'Annotations to Agenda of 12th Council Meeting' [3 May 1970], p. 3.

[24](#) 'ANZCP Executive Advisory Committee — Report of Meeting held 1 August 1971', p. 5; 'Grey Ewan Medallion — Terms of Reference', with EAC Series 34, Folder 3, n.d. (c. 1972).

[25](#) 'ANZCP Minutes of October 1971 General Council Meeting ... [of] 17 October 1971', p. 16.

[26](#) Bruce Singh and Peter Doherty, 'The First 20 Years of the RANZCP Examination: 1970-1990', *Australasian Psychiatry*, Vol. 1, No. 1 (April 1993), p. 7. The College Medallion was not awarded in 1981 or 1982.

[27](#) *RANZCP Bulletin*, No. 15 (August 1979), p. 7; see also RANZCP File on Awards and Prizes, with May 1985 General Council minutes and supporting documents.

[28](#) *RANZCP Bulletin*, No. 15 (August 1979), pp. 7-8.

[29](#) Letter from Margaret Cocks (Administrative Secretary, RANZCP) to Horst Bendes of Organon (Australia) Pty Ltd, dated 20 February 1980, with 1980 Council minutes and supporting documents. The College maintains a file of award winners which is largely but not wholly complete.

[30](#) Awards and Prizes File with May 1985 General Council minutes and supporting documents.

[31](#) *ibid.*

[32](#) *ibid.*

[33](#) 'Attachment II — Action Sheet (After Council Ratification)', on College Prizes, with May 1986 General Council minutes and supporting documents.

[34](#) 'Organon Research Awards — Summary of Recommendations', with May 1987 General Council minutes and supporting documents.

[35](#) *ibid.*

[36](#) Awards and Prizes File, with May 1985 General Council minutes and supporting documents.

[37](#) *ibid.*

[38](#) *ibid.*; complete lists from file maintained by Margaret Ettridge, College headquarters.

[39](#) *ibid.*

[40](#) *ibid.*

[41](#) *ibid.*

[42](#) *ibid.*

[43](#) *ibid.*

[44](#) 'W.M. Somerville Travelling Fellowship in Child Psychiatry', with October 1987 General Council minutes and supporting documents.

[45](#) 'A Review of the Prizes and Awards of the RANZCP', with May 1986 General Council minutes and supporting documents.

[46](#) *RANZCP Annual Report 1990*, p. 20.

[47](#) Complete lists of winners from the files maintained by Margaret Ettridge, College headquarters.

[48](#) 'Minutes of the General Council Meeting GC1/92 ... [of] 16 May 1992', p. 24.

[49](#) Information from Dr Robert Broadbent, 18 May 1995.

10 International Links

[1](#) 'World Federation of Mental Health', *APQ Newsletter*, Vol. 1, No. 1 (January 1949), p. 2.

[2](#) *ibid.*

[3](#) *ibid.*

[4](#) 'Minutes of the Council Meeting ... [of] 19 October 1948', p. 3.

[5](#) 'Minutes of the Council Meeting ... [of] 24 May 1949', p. 3.

[6](#) *APQ Newsletter*, Vol. 5, Nos 14-15, (January-March 1953), p. 16. The subcommittee to edit this publication consisted of Drs Phillips, Lewis and Stoller; *APQ Newsletter*, Vol. 5, No. 16 (July 1953), p. 4.

[7](#) 'Editorial Note', *AP Bulletin*, Vol. 3, No. 4 (December 1962), p. 2.

[8](#) *APQ Newsletter*, Vol. 5, No. 17 (October 1953), pp. 6-7.

[9](#) *APQ Newsletter*, Vol. 3, Nos 7 and 8 (Jan.-June 1951), p. 10.

[10](#) 'Visit of Professor Kennedy', *APQ Newsletter*, Vol. 1, No. 3 (July 1949), p. 10.

[11](#) *APQ Newsletter*, Vol. 2, Nos 4 and 5 (Jan.-June 1950), p. 4. It does not appear that Dr Catarinich was ever a member of the AAP.

[12](#) 'Congratulations', *APQ Newsletter*, Vol. 6, No. 21 (March 1955), p. 7. Dr Kennedy was made the AAP's first honorary member. He died in 1960.

[13](#) *APQ Newsletter*, Vol. 6, No. 22 (June 1955), p. 4.

[14](#) 'Dr Blain's Visit', *APQ Newsletter*, Vol. 2, Nos 4 and 5 (Jan.-June 1950), p. 2.

[15](#) B.G. Burton-Bradley, 'Psychiatry in Singapore', *APQ Newsletter*, Vol. 10, No. 34 (March 1959), p. 10.

[16](#) *AP Bulletin*, (n.d., mid 1960), p. 19.

[17](#) *AP Bulletin*, Vol. 4, No. 1 (March 1963), p. 7. The cost (depending on length of stay) ranged from £436 to £735.

[18](#) *AP Bulletin*, Vol. 4, No. 4 (December 1963), pp. 25-6.

[19](#) *AP Bulletin*, Vol. 4, No. 3 (September 1963), p. 9.

[20](#) Dr Noel Wilton was then International Liaison Officer. See his 'Report to General Council, May 1982', with May 1982 General Council minutes and supporting documents.

[21](#) See, e.g., 'Report to General Council — November 1986' by Dr John Grigor, Convenor, Task Force on Restructuring of the World Psychiatric Association, with 1986 General Council minutes and supporting documents.

[22](#) Noel Wilton, 'South East Asia and Pacific Region — Committee of Council', with 1984 General Council minutes and supporting documents.

[23](#) Charles A. Roberts, 'The Canadian Psychiatric Association' in T.P. Morley (ed.), *Medical Specialty Societies of Canada* (Toronto, 1991), p. 400.

[24](#) *ibid.*, p. 399.

[25](#) *ibid.*, p. 401.

[26](#) *ibid.*, p. 402.

[27](#) *ibid.*

[28](#) *ibid.*, p. 405.

[29](#) *ibid.*, p. 406. They are the Management Council, the Liaison Council (for liaison with the provincial psychiatric associations and governments), the Scientific Council, and the Professional Standards and Practice Council.

[30](#) *ibid.*, p. 407. The first two holders of this position were women.

[31](#) *ibid.*

[32](#) Letter to Professor Rubinstein from Sharon Petrie, Communications Officer of the CPA, dated 25 January 1995.

[33](#) Henry R. Rollin, *The Royal College of Psychiatrists* (London, 1987), p. 14.

[34](#) John G. Howells, 'The Establishment of the Royal College of Psychiatrists' in German E. Berrios and Hugh Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London, 1991), pp. 118-119.

[35](#) *ibid.*, pp. 120-1.

[36](#) *ibid.*, p. 119; Rollin, *op. cit.*, p. 14.

[37](#) *Royal College of Psychiatrists — Annual Report 1994*, pp. 9-10. About 200 successfully pass all parts of the RCP examination each year. A Certificate of Efficiency in Psychological Medicine existed from 1885 to 1948.

[38](#) The RCP was in 1995 headed by its first female President, Dr Fiona Caldicott.

[39](#) *Annual Report 1994*, pp. 16-18; interviews with Mrs V. Cameron (Secretary) and Dr Thomas Bewley (former President), London, 29 September 1994. Series 5, College Archives.

[40](#) *Annual Report 1994*, p. 23; interviews with V. Cameron and Thomas Bewley, 29 September 1994.

[41](#) Walter E. Barton, *The History and Influence of the American Psychiatric Association* (Washington DC, 1987), p. 39. We are grateful to William E. Baxter, Director of the Library and Archive of the APA, for sending us this work.

[42](#) *ibid.*, pp. 61-7.

[43](#) *ibid.*, p. 88.

[44](#) The organisation was also known as the American Medico-Psychological Association from 1894 to 1921.

[45](#) Barton, *op. cit.*, p. 168.

[46](#) *ibid.*

[47](#) *ibid.*, pp. 255, 257-8.

[48](#) *ibid.*, p. 248. Several later Medical Directors, including Dr Matthew Ross (in 1961) and Dr Melvin Sabshin, also visited Australia, as have several APA Presidents.

[49](#) The annual meeting of the APA, its Assembly, elects a presiding officer known as the Speaker of the Assembly, and

also a Recorder of the Assembly.

[50](#) Many Australian psychiatrists, especially in the early days, were British-trained. Another notable link was that Dr Hal Maudsley, the founder of the Australasian body, was the great-nephew of Sir Henry Maudsley, one of the most distinguished British psychiatrists.

11 The College, Psychiatric Medicine and Treatments

[1](#) 'Insertion-Lithium Treatment of Mania', in *APQ Newsletter*, Vol. 1, No. 4 (October–December 1949), facing p. 12.

[2](#) 'Clinical Psychologists', *APQ Newsletter*, Vols 3–4, Nos 9–11 (September 1951–March 1952). The British Psychological Society, it should be noted, was an Australian body, despite its name.

[3](#) *APQ Newsletter*, Vol. 5, No. 17 (October 1953), pp. 4–5.

[4](#) 'ANZCP Minutes of 13th Council Meeting ... [of] 18 October 1970', p. 16. This motion was proposed by Professor Issy Pilowsky and seconded by Dr Colin Degotardi.

[5](#) 'ANZCP Minutes of 6th Council Meeting ... [of] 6 and 7 May 1967', p. 15; 'ANZCP Minutes of 7th Council Meeting ... [of] 8 October 1967', p. 12.

[6](#) 'Minutes ... [of] 8 October, 1967'.

[7](#) 'Pharmaceutical Benefits Advisory Committee' in 'Annotations to Agenda of 9th Council Meeting' [October 1968], pp. 30–2. Of these companies, eleven did not reply and another thirteen declined to cooperate, claiming that the information was confidential. Companies which declined to co-operate included Lilly, Ciba and Beechams.

[8](#) *ibid.*, pp. 31–2.

[9](#) 'ANZCP Minutes of 13th Council Meeting ... [of] 18 October 1970', p. 20.

[10](#) 'ANZCP May 1971 General Council Meeting ... [of] 1 May 1971 [Agenda]', p. 4.

[11](#) 'ANZCP Submission to House of Representatives Select Committee on Pharmaceutical Benefits, 10 May 1971', with May 1971 General Council minutes and supporting documents.

[12](#) 'Psychotropic Drug Committee — Composition and Terms of Reference', March 1971, with May 1971 General Council minutes and supporting documents. The original committee consisted of Dr Russell Pargiter (convenor), and Drs R.C. Simpson, W.E.L. Crowther and C. Boland.

[13](#) *ibid.*

[14](#) 'Report of the Sub-Committee — ANZCP *re* The Uses and Abuses of L.S.D. and Other Hallucinogenic Drugs', Appendix B, pp. 9–10, with May 1971 General Council minutes and supporting documents.

[15](#) 'Psychotropic Drug Committee', with October 1972 General Council minutes and supporting documents. 81.1 per cent of questionnaires sent out were usable (*ibid.*, p. 1). This report was distributed to College members in 1973 as Russell A. Pargiter, 'A Survey of the Prescribing Habits of Psychiatrists in Australia and New Zealand'.

[16](#) *ibid.*, p. 2.

[17](#) *ibid.*

[18](#) *ibid.*, p. 3.

[19](#) *ibid.*

[20](#) *ibid.*, p. 4.

[21](#) *ibid.*, p. 5.

[22](#) *ibid.*, Appendix A, p. 2. Dr Pargiter's 'Survey of Prescribing Habits' noted that prescribing habits differed little between Australia, which at the time severely restricted the drugs listed as pharmaceutical benefits under the National Health Scheme, and New Zealand 'where there is no such restriction on the availability of psychotropic drugs'.

[23](#) *ibid.*, pp. 3-4.

[24](#) Russell A. Pargiter, 'Psychotropic Drug Committee — Report to General Council Meeting, October 1975', p. 4, with October 1975 General Council minutes and supporting documents.

[25](#) 'Report to Council ... From Psychotropic Drug Committee, March 1980', with May 1980 General Council minutes and supporting documents. Associate Professor G. Johnson was convenor of the Psychotropic Drug Committee at this time.

[26](#) 'Report to Council ... From Psychotropic Drug Committee, July 1980', with October 1980 General Council minutes and supporting documents.

[27](#) 'Report to the Council ... From Psychotropic Drug Committee, March 1986', with May 1986 General Council minutes and supporting documents.

[28](#) *ibid.*

[29](#) 'RANZCP General Council Meeting ... [of] 1 November 1986 [Minutes]', pp. 20-1.

[30](#) Letter from Associate Professor Gordon Johnson (convenor) to Peter Carter, (College Registrar), 29 August 1986, with November 1986 General Council minutes and supporting documents.

[31](#) On this historical evolution see Milton Lewis, *Managing Madness: Psychiatry and Society in Australia, 1788-1980*

(Canberra, 1988), especially pp. 49–73, which discuss this evolution in an illuminating way.

[32](#) Gavin Andrews and C. Hickie, 'The People Seen by Sydney Psychiatrists', *Australian and New Zealand Journal of Psychiatry*, Vol. 20 (1986); Gavin Andrews and Dusan Hadzi-Pavlovic, 'The Work of Australian Psychiatrists, Circa 1986', *Australian and New Zealand Journal of Psychiatry*, Vol. 22, No. 2 (June 1988).

[33](#) Andrews and Hickie, *ibid.*, cited in Andrews and Hadzi-Pavlovic, *ibid.*, p. 154.

[34](#) *ibid.*, p. 155.

[35](#) *ibid.*, Table 3, p. 156.

[36](#) *ibid.*, p. 157.

[37](#) *ibid.*, Table 6, p. 159.

[38](#) *ibid.*, p. 164.

[39](#) *ibid.*, p. 165.

[40](#) *ibid.*

[41](#) R.H. Hook, 'Psychotherapy: Practice and Training — Opinions of Members of the Australian and New Zealand College of Psychiatrists', *Australian and New Zealand Journal of Psychiatry*, Vol. 7 (1973), pp. 87–96.

[42](#) F.W. Graham, 'Obituary: Clara Lazar-Geroe', *Australian and New Zealand Journal of Psychiatry*, Vol. 14, No. 3 (September 1980), p. 223.

[43](#) *ibid.*, p. 224.

[44](#) *ibid.*, p. 223.

[45](#) 'The Australian Society of Psycho-Analysts', *APQ Newsletter*, Vol. 5, Nos 14–15 (Jan.–March, 1953), p. 7.

[46](#) Interview with Dr Harry Southwood, Adelaide, 28 March 1994.

[47](#) Dr Sidney Bloch, 'Section of Psychotherapy', *News and Notes*, No. 22 (August 1990), p. 4; Dr Craigie Macfie, 'Section of Psychotherapy Established', *News and Notes*, No. 26 (August 1991), pp. 8-9.

[48](#) Paul E. Mullen, 'Editorial Comment — Psychoanalysis: A Creed in Decline', *Australian and New Zealand Journal of Psychiatry*, Vol. 23, No. 1 (March 1989), p. 17.

[49](#) 'Psychoanalysis: A Creed in Decline' in 'Letters to the Editor', *Australian and New Zealand Journal of Psychiatry*, Vol. 23, No. 2 (June 1989), pp. 155-61. Letters on this article continued to appear for the next year.

[50](#) See, for instance, 'Treatment Outlines for the Management of Schizophrenia', *Australian and New Zealand Journal of Psychiatry*, Vol. 18 (1984), pp. 19-38.

[51](#) For instance, in 1989 the College Psychotropic Drugs Committee issued a position paper noting that in its opinion 'there is no place for the intermittent administration of intravenous barbiturates for the treatment of chronic anxiety'. This followed an adverse finding in such a case by the Victorian state coroner (*News and Notes*, No. 19 (November 1989), p. 4).

[52](#) On this process in Australia see Lewis, op. cit., especially pp. 75-98 and 123-42; Eric Cunningham Dax, 'The First 200 Years of Australian Psychiatry', *Australian and New Zealand Journal of Psychiatry*, Vol. 23, No. 1 (March 1989) and 'The Evolution of Community Psychiatry', *Australian and New Zealand Journal of Psychiatry*, Vol. 26, No. 2 (June 1992); John Ellard, 'The Future of Psychiatry in Australia', *Australian and New Zealand Journal of Psychiatry*, Vol. 13, No. 1 (March 1979).

[53](#) RANZCP media release issued 30 April 1992.

12 Chelmsford and Townsville

[1](#) 'Minutes of the Council Meeting of the AAP ... [of] 27 October 1952', p. 5. He was admitted at the same time as Dr Reg Medicott, the pioneering New Zealand psychiatrist. For further biographical information on Bailey see Hon. Mr Acting Justice J.P. Slattery, *Report of the Royal Commission into Deep Sleep Therapy* (henceforth Slattery), Vol. 2, *The DST Doctors*, pp. 1-134, which presents a full account of his career; and Brian Bromberger and Janet Fife-Yeomans, *Deep Sleep: Harry Bailey and the Scandal of Chelmsford* (Sydney, 1991), pp. 1-41.

[2](#) *APQ Newsletter*, Vol. 5, No. 17 (October 1953), pp. 5-6.

[3](#) *ibid.*, pp. 4-5. Dr Simpson and others described this therapy as 'risky' (*ibid.*, p. 4.) Another paper presented at the same time was one by Dr David Maddison on 'electrotherapy in the management of neurotic illness' (*ibid.*, p. 5).

[4](#) On the other hand, it should be noted that he played no active role in the affairs of the College after the early 1950s. This was perhaps a reason why his controversial activities were unnoted by the College.

[5](#) Paul Daley, 'Deep Sleep Slowly Gives Up its Dead', *Sunday Age* (Melbourne), 9 August 1992, p. 6. Bailey was chosen to open and supervise the Neuropsychiatry Unit at Callan Park, New South Wales. The authors owe this information to an anonymous reader of the first draft of this book.

[6](#) *ibid.*, citing Dr Alan Stoller's 1955 Report 'Mental Health Facilities and Needs of Australia'.

[7](#) Slattery, *op. cit.*, Vol. 3, *DST and ECT*, p. 18.

[8](#) Daley, *op. cit.*

[9](#) Bromberger and Fife-Yeomans, *op. cit.*, p. 49.

[10](#) Slattery, op. cit.; Bromberger and Fife-Yeomans, op. cit., chs 1-3 for details of Bailey's personal character and life story.

[11](#) Interview with Pam Allen, long-serving administrative officer of the New South Wales branch, Sydney, 3 August 1994. Slattery states (Vol. 2, p. 13) that 'he was many things to many people'.

[12](#) Interview with Dr Philip Cohen, Melbourne, 3 November 1994.

[13](#) Quotation from Bromberger and Fife-Yeomans, op. cit., p. 42.

[14](#) *ibid.*, p. 44. See also Slattery, op. cit., Vol. 2, pp. 77-81. Bailey's entry in *Who's Who in Australia* noted that he was Foundation Vice-President of the New South Wales Association of Mental Health and a member of the American Electro-Shock Research Association.

[15](#) Bromberger and Fife-Yeomans, op. cit., pp. 56, 70-5.

[16](#) *ibid.*, p. 77; see also Slattery, op. cit., pp. 81-101.

[17](#) Bromberger and Fife-Yeomans, op. cit., p. 81.

[18](#) *ibid.*, p. 89.

[19](#) *ibid.*, pp. 89-90.

[20](#) *ibid.*, p. 90. Bailey declined to appear on the show. According to Slattery (op. cit., p. 10), Bailey 'had personal antipathy towards Professor Maddison'.

[21](#) Bromberger and Fife-Yeomans, op. cit., pp. 81-2.

[22](#) *ibid.*, pp. 96-120. A crucial meeting of Chelmsford psychiatric staff was held on 20 November 1978 (p. 119).

[23](#) *ibid.*; interview with Dr Maurice Sainsbury, Sydney, 21 March 1993, revealing that 1500 Chelmsford nursing notes and case histories were missing.

[24](#) *ibid.*, p. 119.

[25](#) *ibid.*, p. 140.

[26](#) *ibid.*, p. 142; Toni Eatts, 'The Chelmsford Affair: How Barry Hart Beat the System', *Weekend Australian*, 24-25 May 1986.

[27](#) Interview with Dr Russell Pargiter, Melbourne, 28 October 1993.

[28](#) Interview with Dr John Ellard, Sydney, 1 October 1993. Dr Ellard first became aware of Bailey's crookedness when his wife, a librarian, reported that Bailey never returned the books he had taken out! In his suicide note, Bailey named Drs Ellard and three other medical practitioners, describing them as 'egocentric crazies' (Slattery, *op. cit.*, p. 133).

[29](#) Interview with Dr Richard Ball, Melbourne, 22 December 1993.

[30](#) Letter from Dr Brian Boettcher to Dr Noel Wilton, 5 March 1979, quoted in Slattery, *op. cit.*, Vol. 3, p. 225.

[31](#) *idem.*

[32](#) *idem.*

[33](#) Joan M. Lawrence, 'Action by The Royal Australian and New Zealand College of Psychiatrists in Relation to the Conduct of Two of Its Members, Dr Harry Bailey and Dr John Tennant Herron, Associated with Chelmsford Hospital, Sydney, New South Wales', media statement dated 10 August 1988, p. 1. Sometimes the commission styled itself 'committee': *vide* various documents bearing its letterhead in the College's archives.

[34](#) *ibid.*, p. 2.

[35](#) *ibid.*

[36](#) Interview with Dr Richard Ball, Melbourne, 22 December 1993.

[37](#) Interview with Dr Maurice Sainsbury, op. cit.

[38](#) Lawrence, op. cit., p. 2. The complaints were indeed forwarded to the New South Wales Medical Board, but returned to the College on the technicality that the College was not the complainant, and hence the board could not accept the complaint. The College then advised the individual complainants to lodge the matter directly. (Information from Dr Robert Broadbent.) [39](#) *ibid.*

[40](#) Letter from Ms Jan Eastgate of the Citizens' Commission on Human Rights to the RANZCP, dated 8 August 1988, College Archives. See also the letter from this body to the College dated 28 October 1980, in which 'evidence of Dr Bailey's signature on a pre-paid list of drugs and dosages so that unqualified nursing staff could fill in the name of any patient they chose' was presented.

[41](#) *ibid.*

[42](#) See, e.g., 'Big Claim Over Deep Sleep', *West Australian*, 11 August 1988.

[43](#) 'RANZCP General Council Meeting GC2/88 ... [of] 15-16 October, 1988', pp. 4-5; 'RANZCP — NSW Royal Commission into Mental Health Services, Including Chelmsford ...', College report, with October 1988 General Council minutes and supporting documents, pp. 1-2. See also Barrie Kenny, 'Honorary Secretary's Report', *News and Notes*, No. 15 (December 1988), p. 4.

[44](#) *ibid.*, p. 2. As a result, the solicitors acting for the Citizens' Commission 'agreed to desist from any further demonstrations'.

[45](#) 'President's Letter', *News and Notes*, No. 16 (February 1989), p. 3.

[46](#) Lawrence, op. cit., p. 2.

[47](#) *ibid.*

[48](#) *ibid.*

[49](#) *ibid.*, p. 3.

[50](#) Interview with Peter Carter, Melbourne, 29 November 1994.

[51](#) Interview with Margaret Ettridge, Melbourne, 1 December 1994.

[52](#) Interviews (not necessarily in this order) with Dr Richard Ball, Melbourne, 22 December 1993; Dr Peter Eisen, 11 November 1993; Dr John Ellard, Sydney, 1 October 1993; Dr Sandra Hacker, Melbourne, 18 August 1994.

[53](#) Interview with Dr Robert Broadbent, Melbourne, 1 December 1994.

[54](#) Interview with Dr Brian Shea, Adelaide, 28 March 1994.

[55](#) 'New Zealand Inquiry into the Use of "Deep Sleep Therapy"', *News and Notes*, No. 25 (May 1991), p. 7.

[56](#) *ibid.*

[57](#) *ibid.*

[58](#) Paul Conroy, Andrew Bock and Alex Messina, 'Clinics Still Using Sleep For Therapy', *Age* (Melbourne), 5 April 1991.

[59](#) *ibid.* Prominent RANZCP psychiatrists were quick to condemn deep sleep therapy. For instance, Professor Bruce Singh of the University of Melbourne was quoted in the article as saying 'I don't see any place for it in psychiatry.'

[60](#) John Lindsay, *Ward 10B: The Deadly Witchhunt* (Qld, 1992), p. 162.

[61](#) *ibid.*, p. 163.

[62](#) 'RANZCP Minutes of General Council Meeting GC2/89 ... [of] 28 October 1989', pp. 3-4.

[63](#) *ibid.*, p. 2. Dr Lindsay has given his own account of this meeting in *Ward 10B* (op. cit.), pp. 174–210.

[64](#) Dr John Ellard, 'The Lessons From Townsville', *News and Notes*, No. 27 (November 1991), p. 24. See also Joan M. Lawrence, 'What Do Commissions of Inquiry Achieve?', *Modern Medicine of Australia*, August 1991, pp. 17–18.

13 The Image of Australasian Psychiatry: Past, Present and Future

[1](#) Dr Michael Epstein, Letter to the Editor, *Law Institute Journal*, June 1989, p. 454.

[2](#) *ibid.*

[3](#) *Bulletin*, 19 July 1988, p. 118.

[4](#) *ibid.*, p. 119.

[5](#) Glennys Bell, 'Psychiatry: A Very Peculiar Practice', *Bulletin*, 12 February 1991, pp. 80–5.

[6](#) R.S. Ellery, *The Cow Jumped Over the Moon: Private Papers of a Psychiatrist* (Melbourne, 1956), pp. 87, 89.

[7](#) Letter from J.D. Rimes to Dr C.M. McCarthy, 17 March 1964, in College file on the early history of the RANZCP.

[8](#) The survey promised anonymity, although there was room for respondents to provide their names and addresses if they wished.

[9](#) In the covering letter attached to the forms, Professor Rubinstein made explicitly clear that the answers received were to be used only for this book, and that the authors had no other connection with the RANZCP than being commissioned to write its history.

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