A Genealogy Of Patient Rights

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Contents

Synopsis

The following ‘genealogy of patient rights’ attempts to understand the phenomena of patient rights from the point of view of a ‘history of the present’. It is inspired by the historical and contemporary questionings of the transformative capacity of rights in modern political systems, and the resonance of those queries with the argument that modern forms of power seek to ‘govern through freedom’. By engaging with a historiography of medicine in the nineteenth and twentieth centuries, the study shows patient rights to be crucially imbricated in the devolution of medical strategies that are designed to achieve successful medical management of the population. This observation unsettles the notion that rights in medicine originate directly from the demands of resistant and oppositional interests. Instead, it suggests that patient rights are an effect of the exercise of medical power.

In Chapter one, ‘Problematising patient rights’, the emancipatory guise of rights in the liberal tradition is examined in conjunction with Bentham’s critique of rights and Marx’s analysis of rights as political alienation. There follows a discussion of the conceptualisation of power, Foucault’s representation of rights as a form of disciplinary power, and the rights analyses that appear in the field of governmentality. The theme of patient rights as a model of empowerment is explored in the sociological literature that has sought to understand the field of medicine and medical power. The chapter closes with a discussion of the methodology of genealogy.

Chapter two, ‘Liberty, poverty and rights’, links the development of the liberal philosophy of rights in Britain in the nineteenth century to the shifting practices and rationales that sought to manage the ‘natural forces’ of population. This chapter discusses the management of poverty in the early century, the management of sanitary improvement in the mid-century and the management of the problem of venereal disease in the latter half of the nineteenth century. The chapter argues that in establishing the propriety of a medical management of illness and disease, questions of individual liberty and rights in medicine were designated as matters of medical discretion.

Chapter three, 'The right to motherhood', illustrates the overwhelming Australian concern with population expansion at the beginning of the twentieth century. This concern was expressed in the vilification of 'interference with procreation'. The restriction of abortifacient substances, the regulation of midwives and the extension of medical obstetric supervision were justified in terms of a woman's right to safe childbirth. This specific dialogue in rights borrowed from the women's suffrage movement to represent a women's ultimate contribution to the nation, her highest civic duty, as the 'right' to motherhood.

In Chapter four, 'The right to liberty', the focus is switched to the United States of America where the discovery of the first typhoid carrier prompted the development of preventive health strategies that employed a multiple rights discourse to enforce the adoption of hygienic health behaviours in the 'responsibilised' population. These developments are important because the American experience influenced the management of the carrier in Australia.

Chapter five, 'The right to medical privacy', shows how the medical management of prostitution and venereal disease in Australia, ultimately resulted in the deployment of strategies that privileged the doctor/patient relationship in terms of a right to privacy.

Chapter six, 'A child's right to health', outlines the medical recognition of the problem of the carrier in Australia and the ways in which the strategy of preventive medicine extended surveillance beyond the sick, to the ostensibly healthy. The elaboration of the medico-administrative complex was designed to lay the domestic sphere open to medical intervention. The 'rights of the child' were invoked in order to ensure an active compliance from the population.

Chapter seven, 'The right to be free from infection', discusses the emerging recognition that the infectivity of tuberculosis was both hidden and widespread. This meant that strategies to encourage the entire population toward hygienic practices that protected the community from carried infection were necessary. In this instance, the population was enjoined toward responsibility in terms of every citizen's right to be free from infection. This leant validity to the systems of universal medical surveillance that were implemented following the Second World War.

Chapter eight, ‘Social medicine’, argues that the nature of the various rights in health that characterised the first half of the twentieth century was fundamentally altered by the statistical displacement of the direct relationship between poverty and disease. This opened the way for an elaboration of rights in health in the different register of psychology.

Chapter nine, ‘The right to truth’, shows how the inclusion of the rationales of psychiatry in general medicine presented the problem of truth. The medical elaboration of the right to truth shows how a psychological assessment of the patient became included in the ordinary clinical calculation.

The analysis in Chapter ten, ‘The right to autonomy’, illustrates the argument that the nature of rights changed, by examining the historical questions of rights that circulated around medical terminations of pregnancy. This chapter shows how women’s rights came to be construed in terms of the psychological attribute of autonomy. In this instance, autonomy was posed as a crucial aspect of responsible motherhood.

Chapter eleven, ‘the right to rights’, shows how the designation of patient autonomy in Australia was reflected in the establishment of administrative systems for receiving patient complaints. In the wake of a series of medical scandals, this recognition of patient autonomy was deployed to impose a form of regulation upon medicine that did not offend the medical principle of autonomy nor intrude directly on the established sanctity of the doctor/patient relationship.

The study concludes, in ‘The power of rights’, with a discussion of the nature of power. It argues that the genealogical analysis of the deployment of rights in medicine shows how patient rights are deeply implicated in medical programs and strategies. It also highlights the tripartite nature of governmental power, demonstrating how the interaction of the different forms of power (sovereign, disciplinary and governmental) combine to form a comprehensive management of the population through practices of truth.

That a delicate shuttle should have woven together the heavens, industry, texts, souls and moral law - this remains uncanny, unthinkable, unseemly (Latour, 1993:5).

Introduction: From bedlam to order

Like beasts, like maniacs, the people fell on them. Many saved themselves by presence of mind; others were rescued by the resolute Communal Guards who in those days patrolled everywhere; some were seriously wounded or maimed; and six were most unmercifully murdered. There is no more dreadful sight than such popular anger thirsting for blood and throttling its defenceless victims… In the Rue Vaugirard, where two men were killed who had white powders on them, I saw one of those unfortunates when he was still breathing and the old hags were just pulling the wooden shoes from their feet and beating him on the head with them till he was dead. He was quite naked and bloody and mashed; they had torn off not only his clothes but his hair, his sex, his lips and his nose, and one ruffian tied a rope to the feet of the corpse and dragged it through the streets, shouting constantly 'Viola le Cholera-morbus!' Poet Heinrich Hein observing the cholera epidemic in Paris in 1832 (Porter, 1999:403).

Historical narratives

In the early nineteenth century the cholera pandemic swept through Europe bringing havoc in its wake. The disease progressively breached *cordon sanitaires* and continued its incessant march, arriving in Paris and then Britain. In the 1832 outbreak, seven thousand people died in London, mostly amongst the poor (Porter, 1999:403). The coming of cholera coincided with an emerging recognition that the health of the people, especially the rapidly expanding urban communities, was in decline and there followed a burgeoning effort to retrieve 'health'. Medicine places its claim as 'the greatest benefit to mankind' in this quest (Porter, 1999). Despite the emphasis given to the discoveries of science in medical historiographies, the retrieval of health did not begin with the conquering of disease through medical discovery and scientific progress. As the civil disruption in cholera stricken Paris illustrates, the effort to achievement of health in the population was historically centred on the management of people. How the population is to be known and managed in the name of health, is a medical preoccupation that both predates the era of scientific discovery and effective technological innovation and continues to exert a profound influence in the present. This form of medical knowledge, however, tends to be subsumed within heroic accounts of the scientific medical effort. Nevertheless, the imperative to manage the health of the population has shaped, not only the development of medicine, but also the tenor of political regimes.

In a comprehensive historical comparison of the public health regimes deployed throughout Europe, Baldwin concludes that while there are some differences to be discerned in the 'politics of prevention' between different political regimes, these cannot be attributed to an adherence to principles of enlightened liberalism in some regimes, or to a tendency toward totalitarianism in others. On the contrary, he suggests that the imperatives of 'geo-epidemiology' not only shaped the preventive precautions that were adopted in different countries, but 'determined their very political traditions' (Baldwin, 1999:563). Despite their usual marginalisation, therefore, the medical rationales that are spun around the management of the health of the population are crucial to both the understanding of medicine, of medical politics and broader political themes. In highlighting the management of the people in the effort toward health, the connections between rationale and practice, other than those of a positivist medical science, are brought to the fore.

In recent decades, the phenomenon of patient rights has preoccupied medical, political, public and sociological thought. In these deliberations, patient rights are almost universality assumed to represent the intrusion into medicine of a political phenomenon generated externally and in opposition to medicine. In the light of an analysis that emphasised the interconnections between medical strategy and politics we are invited us to consider afresh the historical question of how patient rights has come to occupy a foremost place in contemporary medical politics.

Contemporary medical politics

In May 2001 in Melbourne, the second Medicine and Law Conference jointly convened by the Law Institute Victoria (LIV) and the Australian Medical Association Victoria (AMA Vic) and entitled *Patient Rights/Patient Responsibilities-where does the balance lie?* resonated with a growing sense of crisis. Explicitly, the forum hoped to find points of reconciliation between what were seen as the contradictory forces of the patient's autonomy and medical responsibility. In the months preceding the conference representatives of medical profession, concerned about the expanding rate of medical litigation cases and rising insurance costs has sought dialogue with lawyers and the insurance industry with a view to identifying possible avenues of reform in October 2000 (Mark, 2000:1). This conference was aimed at a further explication of the 'crisis in medical litigation'.

For many of the doctors present, the spectre of untempered litigation showed that 'patient rights' had proved to be, as medicine had long warned, an errant social phenomenon. According to this view, patients in the past had trusted in the medical encounter and accepted the occurrence of 'medical mishap' as matters of chance or fate. In the present, however, patients come to the medical encounter with unreasonable expectations and a suspicious attitude. If the procedures or treatment that they were offered failed, the patient looked for acknowledgment of the individual medical fault. In the hands of willing lawyers, this took the form of unprecedented rates of legal action in medical negligence. For example, according to Dr. Nisselle, the Chief Executive of the Medical Indemnity Protection Society,

> …. in the past, litigation against doctors was rare, in part because medical care was seen to be hazardous and the results imperfect. Failure of cure, or treatment that actually made the patient worse was seen to be 'bad luck'- an Act of God. But God doesn't pay damages. An increasingly litigious society

> thinks ‘fault’ is behind every adversity. The twin catch-cries of modern society are: ‘It’s somebody’s fault’ and ‘Somebody’s got to pay’. (Nisselle, 2001:12)

In created a dangerously litigious mood amongst the patient community, patient rights had imposed a misplaced burden upon the medical community. Doctors argued that a great deal of effort and cost was consumed in adversarial litigation, and as the number of ‘adverse events’ genuinely based in negligence was small, an alternate system of compensation needed to be found.

In this frame, doctors blamed the legal conduct of adversarial litigation for an imposition of silence on the medical profession. As any unfortunate or unexpected medical occurrence was a potential legal battle, doctors were actively prevented from providing the reassurance, explanation and apology that should rightfully be afforded to any patient who experienced an ‘adverse event’. Patient rights, translated into legal principle and driven by aggressive lawyers, were not only interfering with patient care, they were destroyed the doctor- patient relationship. The dangers of untempered litigation were further underscored by recent experience in New South Wales where three exceptional damages payouts had forced a doubling of the insurance premium for obstetric practice. Patient rights, taken to this extreme, would inevitably accelerate the cost burden of medical insurance, further hampering the already beleaguered health system.

From the lawyer’s point of view the medical assertion of a crisis in litigation was unfounded. While there were more consumer complaints, these deserved both recognition and effective administration. For example, Judge Wodak described the operation of the new Medical Division of the Damages List in the civil jurisdiction of the County Court. This division, formed in 1998, aimed to deal efficiently and expeditiously with the proceedings concerning ‘medical negligence’ (Wodak, J, 2001:1). While the division was generally functioning well, his honour was critical of obstructive practices adopted by some medical defence organizations in the conduct of cases.

> At a time when medical defence organizations are conducting a very public campaign about the cost of insurance for doctors, and about the legal costs associated with litigating medical negligence claim, the adoption and maintenance of such tactics on the behalf of some defending parties in this type of litigation seems to be a cynical exercise, one which detracts from the credibility of complaints about costs of litigation (Wodak, J, 2001:7).

Similarly, the medical claim that many complaints were unfounded or vexatious was challenged by the Victorian Health Services Commissioner whose office receives complaints from consumers about the provision of medical services. In the experience of the Commission, the percentage of complaints that proceed to litigation represent only a small proportion of the claims received by the Office, many of which are dealt with effectively through mechanisms of mediation and conciliation. For the Commission, the medical claim to a litigation crisis, represents a refusal on the part of some doctors to acknowledge the fundamentally legitimacy of patient complaints.

While disagreement surrounded the question of the proper administration of patient complaint, common ground was found in the concept of patient responsibility. For example, medical defence representatives sought to explore ways in which the worst effects 'patient rights', could be modified within medicine existing of legal frameworks and rationales. How could the law accommodate or promote the principle of 'patient responsibility'. Where did the limits of the law of consent lie? In what instances might the principle of contributory negligence be evoked? According to Dr. Paul Niselle, legal rights should represent both duties and responsibilities.

> There is a balance between Man as an entirely self reliant and self- responsible individual and Man as a passive holder of rights, but not responsibilities [1]. The Law seeks to define a balance between doctors' duties and to their patients, and

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[1] As espoused by Ayn Rand in Atlas Shrugged (1957)

> those patients' right (duty?) to be responsible for their own health care decisions. (Nisselle, 2001:12)

Similarly, the Executive Director of the Health Issues Centre, Meredith Carter, saw consumer responsibility as a panacea for crisis. In her view, patient responsibility could be harnessed, especially within the institution, to the crucial task of quality assurance. By adopting an actively involved stance in their own care, each patient, as a responsible citizen, could directly monitor medical and institutional practice, and thereby participate in an immediate 'accountability loop'. Patient responsibility was presented as the key to cost containment. With patient vigilance, hazards would be immediately recognised, 'adverse events' minimised and litigation avoided.

Furthermore, this process would enhance patient involvement in medical decisions, thereby reducing the patient's propensity to sue. This position was supported by studies that showed patients commenced compliant or litigation processes because they were seeking explanations for the incident, because they were concerned with standards, because they sought compensation, especially where children were concerned, and because they were concerned with accountability. Patient responsibility, both as consumer and as complainant would achieve transparency in the delivery of medical services. This theme resonated with the medical claim that constant threat of litigation imposed silence upon doctors. Not only were they prevented from discussing the matter openly with their patients, doctors were restricted in their ability to conduct open forums that would provide the opportunity to identify and rectify problems, especially inadequate systems or procedures. According to Dr. Michael Sedgley, President of AMA (Vic).

> In order to allow frank and open discussion of adverse outcomes in hospitals and amongst doctors, there has to be a statutory immunity to being sued as a result of the discussion (Sedgley, 2001:6).

This argument suggests that in order to promote the patient's right to a fair explanation, and to properly organised hospital systems, doctor's legal responsibilities should be modified. The introduction of a ‘no fault’ medical negligence system would enable doctors to learn from their mistakes.

The mounting emphasis on patient responsibility, transparency, accountability and cheaper administration of negligence claims, however, lost its sureness in the face of another set of dramatic events. In the weeks leading up to the conference senior obstetric staff at the Royal Women’s Hospital in Melbourne had resigned in protest over untoward interference with medical decision making by the hospital management. Not only was the medical right to professional discretion abrogated, the ‘quality assurance process’ imposed on hospital practice, ostensibly in the name of patient rights, was preventing particular patients from exercising their right to appropriate medial care.

Conclusion

A startling feature of contemporary medical politics in Australia is the central position accorded to the concept of patient rights. In this dialogue, patient rights are presented as both the cause of a profound crisis in medicine and as the basis of a number of different solutions. Patients in the present have rights, but this was not always the case (Bartholome, 1993). The prominence of patient rights in the contemporary medical discourse, therefore, lead us to question how is it that patients have come to have rights. Although pervasive, the concept of rights presented here is also opaque. What rights have been allocated and how are these to be exercised? Given the emphasis on patient responsibility, to what extent does the medical allocation of rights accord with the notions of empowerment or autonomy? How is the concept of patient rights itself being moulded or reinterpreted in the contours of this debate?

The object of the following inquiry is to dissect the historical conditions that have rendered the ‘patient with rights’ and set this phenomenon as a central problem for contemporary medicine. It starts with a consideration of the theoretical appraisal of rights.

Chapter 1: Problematising patient rights

> The "right" to life, to one's body, to health, to happiness, to satisfaction of needs and beyond all oppressions or "alienations", the right to rediscover what one is and all that one can be, this "right"-which the classical juridical system was utterly incapable of comprehending- was the political response to all those new procedures of power which did not derive …from the traditional right of sovereignty. (Foucault, 1979:145)

Introduction

The notion of 'rights' is invested with an enduring, almost impenetrable, opalescence. In the present, the social movements with which we have become familiar, such as the civil rights movement, the women's rights movement, the patients' rights movements, the prisoners' rights movements, and the claims for children's rights and fathers' rights, carry themselves in the light and language of rights. By invoking rights, these movements place themselves within a political tradition that assumes the ability of sovereign government to allocate or enforce legal rights, but also lays claim to a broader humanitarian tradition that is thought to shape civil political government in modern democracies, through the frame of human rights. By the inferred invocation of human rights, therefore, contemporary social movements link themselves to the ideals at the heart of the political formations of liberalism and to the historical project of enlightened humanitarianism. The persistent association of all rights and rights movements with an unquestioned humanitarianism, however, is a narrative that is sustained by the excision of analyses that question the emancipatory promise of rights. Consideration of these alternate presentations of rights challenges the sureness of the contemporary reliance on rights as a primary strategy for progressive social change.

Natural rights

Contemporary human rights movements locate themselves within a history that seeks to chart the progressive evolution of the classical principles of natural law into the modern constructs of the social contract, democracy and juridical apparatus of the rule of law. A line is drawn from the classical conception of 'natural' law, as representing those principles of justice and right reason that were unalterable and eternal (Shestack, 1998), to the medieval conception of Christian natural law as the law of god, to the pre-enlightenment philosophers who saw that the purpose of organized society was to protect the 'moral' rights of the individual (Honderich, 1995:328). In the enlightenment, these ideas a distilled to form a 'modern' concept of natural rights. For example, John Locke (1632-1704) described the 'social contract' as obliging the government to protect the natural rights of life, liberty and property (Shestack, 1998:207). Locke's work was a powerful influence upon the development of both the American and French revolutionary movements and his ideas are clearly reflected in the content and language of the French Declaration of the *Rights of Man and of Citizens* (1789) and the American *Declaration of Independence* (1776) (Wokler, 2000:xi). Much of the power and imagery of contemporary rights language derives from this close association with the revolutionary movements of the late eighteenth century.

The enshrinement of rights within the progressive narrative of modernity is reflected in the philosophical requirement of individual liberty and autonomy that developed in the nineteenth century. John Stuart Mills' wrote in *On Liberty* published in 1859,

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physically or morally, is not sufficient warrant (Honderich, 1995:569).

In the first half of the twentieth century, the historical continuity of this 'effort toward freedom' in western liberal regimes was stridently affirmed in much of the literature that appeared in the post-Nazi era. The propensity of totalitarian regimes to abuse the principles of life, freedom and dignity was repeatedly stressed. It was thought that the practices of government in such regimes was mobilized by an unrestrained utilitarian calculus and an absolute disregard for the rights and freedoms of individuals. The profound revulsion against Nazism fuelled a philosophical effort to re-identify the immutable principles upon which universal political stability could be based (Shestack, 1998:215). Articulation of the principles of Universal Human Rights by the international community in the post war period is taken to represent the triumph of liberalism, and the true heart of contemporary progressive politics.

It is assumed that the proliferation of 'new rights' theories in the second half of the century is spored from this centre. For example, John Rawls' *A Theory of Justice* (1971) is regarded as a pivotal philosophical expression of the fundamental rights and freedoms inherent in the progressive liberalism of the post war period. Rawls formulated a strongly egalitarian form of liberalism that posed racial, sexual, and religious discrimination, and many forms of social and economic inequality as unjust. For Rawls, rights have a prior and independent quality. Utilitarianism is rejected on the basis that pursuing the maximum total good may impose unfair disadvantages on minorities[1]. The common theme amongst the 'new rights' theories is the assertion that the core postulate of any just and universal system of rights must include some recognition of the value of individual freedom and autonomy (Shestack, 1998:216). In accordance with this principle, individuals are seen as transcendental subjects who are capable of autonomous will. Rights are presumed to flow from the autonomy of an individual who chooses his or her own ends, provided they are consistent with a similar freedom for other individuals.

The narrative that supports the moral validity of contemporary rights theory, therefore, can be seen to rest on the twin pillars of historical continuity and the valorization of an ontological constant in the form of an autonomous, but culturally opaque, individual. This narrative is not easily sustained, however, in the light of analyses that challenge both the historiography of the progressive account and the ontological representations they imply. From the moment that Locke's enlightenment principles found a translation into the practices of revolutionary political movements, strident criticism arose from prominent proponents of nineteenth century social reform.

Rights on Stilts

Jeremy Bentham, for example, was highly critical of the way in which the concept of natural rights was used to justify the political forms of French revolutionary movement. He criticised the French *Declaration of the Rights of Man and Citizen* for using language that appeared to be citing existing rights, when it was in fact merely suggested what rights there ought to be. Bentham thought it naive to suppose that the rights that were 'declared' actually existed. For Bentham, 'real rights' could only be produced by 'actually existing' systems of law.

> Right is a child of law; from real law comes real rights, but imaginary law, from laws of nature, come imaginary rights....Natural rights is simple nonsense: natural and imprescriptible rights, rhetorical nonsense, -- nonsense on stilts. (Jeremy Bentham, The Book of Fallacies (1824) cited in (Shestack,1998:217).

Bentham's criticism derived from his theoretical commitment to founding a perfect system of law and government based on legislation. He was highly critical of the common law because he believed it hampered by a reliance on precedent, custom and history [2]. Bentham's concern with the practical realization of what constitutes good government led him to a deep consideration of the meaning of abstract concepts, or 'fictional entities', such as rights. He believed it a supreme nonsense to assert that it would be possible to discern a correct and universal set of rights that would be unalterable, indefeasible and imprescriptible. Instead, he thought it imperative that each particular system of rights be analysed in order to discern what rights were actually conferred and whether legislative amendment was required (Harrison, 1995:87). He argued that a 'right' should be understood as a benefit that is conferred on someone by the imposition of duties on others. 'Real rights', therefore, could only be conferred by legislation and were unlikely to be couched in the obvious language of rights. In contrast, 'counterfeit rights' were produced by rhetorical evocations of entities such as natural rights.

Bentham's scathing criticism of declared rights invites a consideration of whether the rights to which we refer and make claim in the present are rhetorical or real. Bentham's analysis suggests that the proliferation of rights discourse, especially where it is based in the quasi-legal apparatus, denotes a field of rhetorical rights. Real rights, if they exist, will be found enshrined as duties in

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[1]. Rawls also posed a new form of contract theory that invites us to image ourselves in a hypothetical position of equality so that just decision making could take place under a 'veil of ignorance'.

[2] Sir William Blackstone (1723-1780) published the celebrated *Commentaries on the Laws of England* from 1765 to 1769. The work set out the structure of English law and explained its major principles. Blackstone believed that civil obedience rested on the existence of an implied agreement between the citizen and the state (Harrison, 1995:87) and supported the view that the principles of natural law were the foundation of the traditions of English jurisprudence.

substantive systems of law. The relevance of Bentham' s perception of an inherent schism in the conferment of rights is amplified by its resonance with Marx's analysis of bourgeois rights.

Bourgeois Rights

According to Brown, Marx's critique of bourgeois rights is most clearly represented in his essay *The Jewish Question* (Brown, 1995:100). Brown argues this writing provides one of the earliest articulations of Marx's theory of alienation and shows his fundamental concern with articulating the limits of political emancipation. In particular, he seeks to show the way in which discourses of freedom subjugate the people that are supposed to be liberated because liberal freedom is structurally, as well as definitionally, ambiguous (Brown, 1995:106). Marx uses a parallel analysis to his critique of religion to draw a distinction between real men and their ideal representations. For Marx the ruse of power peculiar to liberal constitutionalism centres upon the granting of freedom, equality and representation to abstract, rather than concrete, subjects (Brown, 1995:106). He saw that by creating an 'ideal' image of man, the state could liberate itself from certain constraints, without man himself really being liberated. The state could simply declare freedom.

The political emancipation that resulted freed the individual only from a politicised identity. The individual is thus released from a particular social identity that forms the basis of a deprivation of suffrage, rights or citizenship. Marx considered this freedom to be an abstraction because it does not liberate the individual from the real considerations of constitutive or reiterative identity. He interpreted the right to liberty as the right to separation; the right to property as the right to self-interest; and the right to equality as having no significance. This is because liberal equality guarantees that everyone will be treated as if they are sovereign and isolated individuals. It guarantees that the state will regard it subjects as all equally abstracted from the social powers that constitute existence, and all equally decontextualised from the unequal conditions of their lives (Brown, 1995:110).

For Marx, the substitution of abstract political subjects for actual ones both forfeits the project of emancipation and resubjugates people. This is achieved by the emancipation of abstracted substitutes, and the naming that process 'freedom' (Brown, 1995:106). A formally free and equal human being is practically subordinated through this idealist disavowal of the material constituents of personhood, which constrain and contain freedom.

> The state liberates the ideal of man and abandons actual man to the powers that construct, buffet and subject him (Brown, 1995:107).

Marx argues that although man is anointed sovereign, his sovereignty is ghostly, alienated and finally punishing, because its effect is to cast the isolated creature as fully accountable for himself (Brown, 1995:108). This occurs because civil society remains striated by forms of social power that the state has declared politically insignificant. This form of social power is reinforced, and tacitly legitimated, precisely by being removed from political discourse (Brown, 1995:109). Nevertheless, Marx supported the pursuit of civil and political rights because it represented a 'stage' in emancipation. He envisaged that the failure of rights would be made manifest in the inevitable experience of un-freedom and alienation and that this would encourage the development of new forms of (revolutionary) association (Brown, 1995:114).

Brown concludes that if Marx is correct and the bourgeois constitutional state is premised upon depoliticised in-egalitarian social powers, and upon an abstract representation of equality and community, then rights are the modern political form that secure and legitimise these tendencies (Brown, 1995:110). Rights emblematise the vapid sovereignty of the unemancipated individual in modernity.

> Rights encode rather than emancipate us from the social powers and social formations that are the conditions of our un-freedom (Brown, 1995:110).

According to Brown, Marx's interpretation of rights relies upon an understanding of the domination and alienation entailed in capitalist social relations as simultaneously reiterated and obscured by the political life they generate (Brown, 1995:111). Modalities of social and economic domination are not eliminated but depoliticised, by the declaration of formal equality. On this reading of Marx, the historical emergence of the 'rights of man' serves to naturalize and entrench historically specific, but unavowed social powers. The kind of liberty that bourgeois rights discourse cast as natural is actually the effect of historically specific elements constitutive of life in civil society.

> Through rights discourse, bourgeois social relations are reified to represent the very nature of 'true' man and rights are misapprehended as required by the 'natural' man who is produced by this discourse (Brown, 1995:113).

Following Brown, the rights claims that are made in the present by various disenfranchised groups are properly viewed as retaining the inherent paradoxical quality identified by Marx. In seeking the allocation of political rights from the state, rights claims can only emancipate an ideal representation of the subject. This process removes from political consideration the material circumstances of the individual. Rights discourses therefore serve to reinforce the perception that all individual qualities are internal, personal attributes rather than the effect of social relations that iterate class, sexuality, race and gender (Brown, 1995:115). By focussing on political emancipation, 'real' social power remains unfettered at the same time as autonomous identity becomes reinforced and inscribed as natural. Brown argues that historically, rights emerged in modernity both as a vehicle of emancipation and as means of privileging an emerging bourgeois class within a discourse of formal egalitarianism and universal citizenship. Rights served both as a means of protection against the arbitrary use and abuse of sovereign and social power, and as mode of securing and naturalizing dominant social powers such as class and gender. Rights discourses, operate to both emancipate and dominate, to protect and regulate (Brown, 1995:99-100).

The nineteenth century analyses of rights, therefore, provide a compelling critique of the nature of rights claims in the contemporary world and invite us to critically evaluate the progressive rights narrative. They reiterate the basis of a longstanding socialist disquiet that the notions of rights are welded to liberal moral humanism and are an aspect of the ideology of bourgeois individualism (Rose, 1986a:210). Political rights, when wielded by the state, serve to subjugate, rather than liberate. Contemporary critiques of rights similarly focus on the paradoxical effect of political rights that are awarded by the state. For example, Brown has argued the contemporary relevance of Marx' s analysis of rights in relation to her concern with the political conditions of the effectively disenfranchised in America, despite the formal granting of political and civil rights. Similarly, critical analysis of the form of liberalism that is dominant in Australia, has attributed the development of a legalistic discourse in rights to a historical adherence to the specific principles and practices of 'rights based liberalism' through the work of Hobbes and Locke, rather than the 'civic liberalism' of Rousseau (Davidson and Spegele,1991:ix). Rights based liberalism assumes individuals to be essentially solitary beings with needs and interests separate from, and often in opposition to other individuals (Davidson and Spegele, 1991:43). Rights must therefore be prioritised and apportioned by the legal system. As that system is itself steeped in the mythologies of rights based liberalism it operates as a strategic political discourse, while appearing to offer justice. Davidson and Spegele argue that civic liberalism, in contrast, would imagine the goals of security, freedom and tolerance as achievable through mutual empathy and respect (Davidson and Spegele, 1991:42).

While these contemporary analyses echo the paradoxical nature of rights noted by both Bentham and Marx, they remain fixed within a conception of power that sees the state as the source and fulcrum of the law and of rights. As contemporary thought has challenged the saliency of that conception, principally through the work of Michel Foucault, the question of how the nature of rights might be conceptualised within an alternate understanding of power is raised. The contemporary relevance of these critiques must be considered in the light of an alternate conception of power.

Models of power

Hindess describes the western tradition, both Marxist and liberal, as adopting an understanding of power that conceptualises a force emanating from a central source. Power is seen as a transferable, cumulative commodity. Primarily repressive, it is wielded by one group over another (Hindess,1996) . This framing of power allows various modes of repressive domination to be identified. Economic, ideological, patriarchal, political or military power, control others through processes of exclusion or repression (see Lukes, 1974; Mann, 1986; Mann, 1993). Within this model the appearance of rights discourse or the assertion of rights is assumed to indicate a process that necessarily constitutes a challenge to the dominant force. The traditional conception of power, therefore, correlates with the progressive rights narrative. It necessarily equates rights with ‘empowerment’ and therefore the domination or subordination of the previously dominant force. For example, the phenomena of a ‘patient rights’ is usually interpreted in the frame of emancipatory politics. It is assumed to represent the successful assertion of patient or consumer power, and the corresponding diminution of medical power. The work of Michel Foucault, however, has encapsulated an analysis of power that radically departs from the traditional model. Foucault conceived power as a productive force with generative capacity, rather than a force that is dedicated to repression and destruction. He saw power as a diffuse phenomena embedded in the structures of society, rather than as a thing that could be gathered and wielded over others. Most importantly he conceived power as constructing and being constructed by knowledge (Hindess, 1996:18). This conception of the operation of power invites a reconsideration of the historical role of rights discourse.

Foucault's analyses of power can be seen as a critical reaction against the conceptualisation of power as a macro-structure closely related to the state, displayed through the major public institutions of the police, the law and the church, for the purpose of supporting industrial capitalism. Instead Foucault was concerned to show power as a historical and contingent relationship that is 'localised, dispersed, diffused and typically disguised through the social system' (Turner, 1997:xi). The development of an idea of power as productive and inextricably linked to knowledge is located in Foucault's elaboration of disciplinary power (Foucault, 1961; Foucault,1973; Foucault, 1977). Within hospitals, schools, prison workshops and military barracks, the intertwining of knowledge and the day-to-day practices of discipline founded a form of domination that sought to extract economic utility from the human body by insisting on regulation and uniformity. Discipline was practiced through a detailed observation that sought to correct deviation. In the regimes of disciplinary power that have their roots in the detailed order of institutional practices, the work of teachers, psychologists, psychiatrists and social workers differentiates, quantifies and ranks individuals according to their capacity to conform to the norms of disciplinary technology. Processes of normalisation, therefore, are the instrument of disciplinary power and constitute its distinguishing feature (Foucault, 1977:157). While the concept of disciplinary power has found a deep resonance in analyses on the modern condition, Foucault refined his analysis of power by describing the nature and effect of liberal government as a mentality of rule or a 'governmentality'.

Governmentality

Foucault explained governmentality as the rise of a peculiar constellation of power that emerged from a series of continuities and disruptions in the historical practice of power. His analysis rested on a comparison between the pastoral power of antiquity; the doctrines of government that assembled around the ideas of the reason of the state, the police state in early modern Europe, the beginning of liberalism in the eighteenth century, and the present forms of western neo-liberal thought (Gordon,1991:3). The salient features of the first three provide the core of his analysis of the present. Most prominently, they explore different approaches to the government of populations and the relationship of that knowledge to government of the individual subject.

Foucault observed that in the sixteenth century a wealth of literature was concerned with the benevolence of sovereign rule. This literature identified the three essential components of government as government of the self, connected with morality, government of the family as a fundamental element of the economy, and the rule of the state. Following the demographic explosion in the eighteenth century the statistical information that had previously been gathered for administrative purposes revealed that the population had its own regularities, its own cycles of death and disease, of labour and wealth, its own intrinsic aggregate effects that were irreducible to the family. The effects of this knowledge were twofold. First, it established the demarcation of the economy as an area of reality. Second, it rooted the wealth and power of the state in the strength and productivity of its population (Foucault, 1991b:99). Foucault associates these re-orientations with the emergence of early modern 'police' power. The task of government retained its profound interconnectedness between the act of government and the government of the self, but became understood in terms of developing the elements of individual lives that were economically useful in order to foster the strength of the state (Foucault, 1991b:99). In police power, government attempted a detailed accounting of reality that was characterised by the collection of inexhaustible detail and the construction of endless lists and classifications. These lists were to provide the basis for an array of specific and detailed regulations and decrees that were aimed at the allocation of an economically useful role to each member of the population (Gordon,1991:10).

The vision of perfect detailed control, however, gave way to the recognition of its impossibility. In contrast to police power, liberalism newly recognised its power as limited. It focussed on accomplishing tasks that lay within the scope of its power and sought to relinquish control over areas beyond its capacity. This pivotal transformation in the rationalities of government is marked by Adam Smith's conception of the 'invisible hands' of the economy (Smith, 1776 [1976]). In contrast to the detailed control of police power, the recognition that both the economy and the population were ordered by intrinsic processes, required of liberal government an active mode of both regulation and abstention in order to allow the play of these 'natural' forces. In contrast to the interpretations which surround the concept of *laissez faire*, liberalism represents a 'recoding of the politics of order' rather than a 'bonfire of controls' (Gordon,1991:26).

The principle object of liberalism's order was the achievement of 'security', understood as the ability to continue over a period of time. The idea of security was intimately entwined with the emergence of the knowledge of populations. For Foucault the 'problem' of government first emerged in the sixteenth century in the form of an explosion of discussion about the basis of benevolent sovereign rule. This led to the development, throughout the seventeenth century of a range of administrative techniques and strategies aimed at the management of subjects (Foucault, 1991b:87). The demographic expansion of the eighteenth century inserted the ‘problem of population’ into this new regime and provided the catalyst for the profound transformation in the exercise of power that followed. Foucault argued that it was through the problem of population and its links with the notion of economy, that the science of government first came to be thought, reflected and calculated outside the juridical framework of sovereignty. Ironically, it was the administrative tools of advanced sovereign rule, in the form of statistical formulations that defined the specific phenomena of the population.

> Statistical analyses revealed that the population had its own regularities, its own rate of deaths and diseases, its cycles of scarcity; statistics showed that the domain of the population involves a range of intrinsic, aggregate effects, such as epidemics, endemic levels of mortality, ascending spirals of labour and wealth; and lastly statistics showed that through its shifts, customs and activities population has specific economic effects (Foucault, 1991b: 99)

The problem of population encapsulated a new orientation toward the concept and practices of ‘government’. For Foucault, it was the phenomena of population that provided a new site for government activity and intervention and it was through the emergence of the problem of population that the art of government found fresh outlets (Foucault, 1991b: 99). Foucault argues that in seeking to apply the art of government to the phenomena of the population an immediate tension was established. The population became both the (unaware) object of government intervention, at the same time, as it remained its subject. Interest had to be counted at the level of the conscious individual and at the collective level of the population, regardless of the interests and aspirations of individuals (Foucault, 1991b:100). Liberalism was confronted with a contradiction between the non-totalizable multiplicity of the individual and the unity of the aggregate. The task of government required a new complexity and a subtlety in order to take account of this fundamental tension (Foucault, 1991b:100). Within this dilemma, liberalism ‘discovered’ economic man as the subject of government whose self-interest perpetually outflanked the limitations imposed in a governmental domain. Liberalism thus aimed to reconcile the contradictory interests of the individual and the population by delegating the regulatory oversight of government to the proximately distributed micro-level of individual enterprise. In this way, liberalism reflected the peculiar interdependence of economic order and public order that it inherited from police power, but aimed to govern by shaping the conduct of persons or groups of persons. This mode of distally delegated government has been aptly described in the secondary literature as the 'conduct of conduct' (Gordon,1991:3) or more accurately 'governing at a distance' (Burchell, 1993:267)[3].

The conception of individual economic enterprise was intimately entwined with an understanding that the vitality of the population, and the health and life of the people. In calculating the security of the population, vital life processes were emphasised. Matters of heredity, reproduction, sexuality, physical development and life habits became paramount. This appreciation allowed the insinuation of medical rationales within all aspect of government. Medical rationalities and solutions came to structure the ways in which the task of government was conceived and managed (Rose, 1994:49). At the same time, liberalism construed medicine as the appropriate site of distally delegated government. In that role, medicine proceeded with the task of knowing and managing the individual within the population (Foucault, 1991a:85). It did so by deploying the 'freely' constituted individual as a tool through which the prosperity and well being of the population can be maintained (Burchell, 1993:267). As Rose had observed, rooted in the attempt to tame and govern the undesirable consequences of industrial life, wage labour and urban existence, by the early twentieth century the 'authority of expertise' had became inextricably linked to the formal political apparatus of rule (Rose, 1993:284).

The focus on the individual, as subject to an authority of expertise that is welded to the task population, points to Foucault's major objective

> of creating a history of the different modes by which, in our culture, human beings are made subjects. (Foucault, 1982:208).

For Foucault, the contours of subjectivity are articulated by specific governmental practices, techniques, and rationales. He saw subjective identity as produced by three different 'modes' of objectification that have operated throughout the modern period. The first mode is designated by the confinement of the poor and insane into hospitals in the seventeenth century, the classification of disease and the associated practices of clinical medicine in the early nineteenth century, the rise of modern psychiatry throughout the nineteenth and twentieth centuries, and the medicalization, stigmatisation, and normalisation of sexual deviance (Rabinow, 1984:8). This mode of objectification is characterised by the deployment of specific 'dividing practices', such as the

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[3] For example see Rose 1992a; Rose 1994; Rose 1993; Miller &Rose 1993; Barry 1993; Osborne 1993; Dean

increasingly sophisticated classifications of the social sciences, to draw the individual from an undifferentiated mass of population (and later from highly preselected populations). These dividing practices claim a special legitimacy by virtue of their linkage to the humanitarian rhetoric of reform and progress (Rabinow, 1984:8). The second mode of objectification is characterised by the historical process by which the discourses of' 'life, labour and language' became structured in disciplines with a high degree of internal autonomy and coherence (Foucault, 1983). These discursive practices create relations of knowledge and power that shape the individual subject. (Rabinow, 1984:9). The third mode is characterised by the processes and techniques through which a person initiates an active self-formation. This effort entails a process of self-understanding that is historically derived from the act of religious confession and continues to be mediated by an external authority figure such as a doctor or psychoanalyst (Rabinow, 1984:11). Foucault's subject is therefore, not repressed by a power from which it might be liberated but is created within a matrix of 'force relations' and 'truth effects'. Different facets of subjectivity are forged within the matrix of dominant discourses and knowledges, and by the governmental rationalities and techniques that are deployed around them (Barry & Osborne, 1993).

Foucault conceived governmentality, therefore, as a highly complex and productive form of power that presupposes the formation of specific subjectivities within shifting matrices of power (Foucault, 1991b:87). The complexity of governmental is underscored by Foucault's insistence that while governmental power became pre-eminent in modern times, it displaced, but did not extinguish, sovereign and disciplinary power (Foucault, 1991b:102). For Foucault

> Governmental power is the peak of a triangle that comprises sovereignty, discipline and governmentality (Foucault, 1991b:102).

Foucault's concept of governmental power has inspired a field of study that has further elaborated the contours of governmentality. As a genre, studies in governmentality are characterised by a desire to dissect the links between the domain of politics, the exercise of authority and the rules of conduct in society, and to assess the mentalities, strategies and techniques by which we are governed and through which we govern ourselves (Barry & Osborne, 1993:265). Following Foucault, they seek to identify the interconnectedness of power and knowledge, and in doing so mirror his concern to understand the act of government as an activity that proceeds in 'name of

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&Hindess, 1998.

truth'. For example, Burchell describes the salient task as one that locates the dialogues and discourses that arise at the interface between the dual imperatives of autonomy and domination, thereby constituting the construction of 'truths' by which we have come to be governed (Burchell, 1993:267). The act of government, understood as the shaping of conduct, occurs at the point at which techniques of domination intersect with the 'techniques of the self' (Burchell, 1993:267). It is the interface between the imperative of domination and the imperative of autonomy in modern societies that creates a conceptual space within which individuals are to be governed. This appreciation of power, both presupposes the subject's capacity as an agent, and poses government as an openly strategic and shifting game. It also conceptualises a space, inhabited by technologies of truth and power, in which a strategic interlacing of conflicting social imperatives is achieved.

It follows from this analysis of governmentality as a complex form of power that produces subjects who are to be governed, and who govern themselves, that the phenomenon of rights can be understood as both a technology of power and as the effect of power. Although there are references to rights in Foucault's work, rights were not the principle object of his inquiry. Nevertheless, a specific conceptualisation of rights can be observed in his work.

Rights as a technology of power

According to Foucault, the language of rights first entered the political lexicon in conjunction with the enlightenment notion of the freedom and liberty of the citizen. Freedom was imagined in terms of an absence of interference and regulation. Rights were therefore conceived as a political mechanism that would protect 'natural' human dignity from the excesses of sovereign rule, and define a private sphere of independent action. According to Foucault, however, the discourse of rights and liberties that was so prominent in the seventeenth century was irrelevant to the new techniques of disciplinary power that emerged during the same period. Alongside the proliferation of political freedom, disciplinary power arose from a range of techniques and apparatuses that operated outside sovereignty (Foucault, 1980). The principles and practices of disciplinary power were opaque to the discourse of political rights. In distinguishing between political rights in law emanate from the power of the sovereign, and the disciplinary apparatuses, Foucualt was able to conceive the individual as being produced by these procedures, rather than from the political inscription of rights and liberties upon the common man. This distinction stands in critical opposition to the positivist tradition jurisprudence that sees human conduct as dictated by laws emanating from the power of the sovereign and constituted in the two elements of rules and sanction (Hunt and Wickham, 1994:43). Instead, Foucault seeks to show that power exists in a multiplicity of different forms, most of which do not manifest themselves in coercion. For Foucault, the delineation of the modern subject was not achieved through political franchise, but was initiated by the powerfully individualising effect of anonymous disciplinary power (Foucault, 1977:193).

Crucial to Foucault's analysis of disciplinary power was the recognition of a historical reversal from sovereign power to modern social formations (Hunt and Wickham, 1994:43). Despite the passing of monarchical rule, Foucault saw that law and sovereignty had remained central to the self-understanding of the modern forms of state power. In modernity, the shell of monarchical forms is retained, while 'real' power operates through disciplinary procedures. This leads Foucault to conclude that

> The essential role of the theory of right, from medieval times onwards was to fix the legitimacy of power;….my general project has been….to show the extent to which, and the forms in which, right (not simply the law, but the whole complex of apparatus, institutions, and regulations responsible for their application) transmits and puts in motion relations that are not relations of sovereignty, but of domination (Foucault, 1980:95-6).

In redirecting the study of power way from substantive law and toward the effect of the disciplines in modern government, Foucault does not merely displaces the law as the object of analyses, but offers a conception of law and political rights as ruse of power that clearly echoes and extends Marx's analysis of rights.

Hunt and Wickham are critical of Foucault's 'expulsion' of the law and persistent characterisation of rights as a mode of domination. They argue that the theoretical conception of law as emanating from the sovereign fails to take account of the complexity and multiplicity of modern legal forms, particularly the entrenched rights that correspond to the advancing constitutionalisation of citizenship (Hunt and Wickham, 1994:67). By affecting an unexplored 'slippage' between the concept of sovereign right and modern discourses in rights, Hunt and Wickham charge Foucault with attributing all rights the general function of legitimation.

> This slippage from ‘right’ to ‘rights’ had serious consequences; it leads Foucault, like many other recent radical thinkers to disparage the transformative capacity of right in modern legal systems…. (and) takes no account of the struggles for civil and political rights, which have traversed all the field of Foucault’s own studies, whether of prisons, mental institutions or hospitals (Hunt and Wickham, 1994:45).

While Hunt and Wickham concede that Foucault is correct in identifying rights and freedom as practices, they insist that rights should not be dismissed as mere ‘rhetorical flourishes’. Instead, they argue it is possible to maintain a critical stance that acknowledges the flawed effectivity of the law, without dismissing the relevance of legal strategies for social change (Hunt and Wickham, 1994:45). While criticising Foucault for failing to acknowledge the complexity of modern law and modern rights, however, Hunt and Wickham similarly fail to recognise different elements within the proliferation of modern rights discourses. In particular they fail to distinguish between the rhetorical invocation of natural or human rights and the realisation of legal or substantive rights, or to recognise the historically contingent nature of rights. If these factors are taken into consideration, Foucault’s theoretical marginalisation of rights in disciplinary power is strengthened, and his treatment of rights in the later elaboration of governmental power is less easily dismissed as prevarication or obfuscation.

For Foucault, disciplinary strategies produced a new subject who was meticulously contained within the details of new inventions, practices and rationalities. By the close of the eighteenth century the individual who had been etched by the practices of disciplinary administrations become more firmly placed within the purview of government by the newly discerned link between the well being of the people and the wealth and security of nations. In the *History of Sexuality*, Foucault identified the proliferation of multiple discourses in rights as peculiar feature of the new procedures of power that characterise modern society. Foucault understood the emergence of rights around the vital life processes as a product of the knowledge of populations and of a politics that connected these processes to issues of national policy and power. He argued that in this form of power, bio-power, the ancient right to take life has been replaced by the power to foster life, and that life had become the focus of political struggles (Foucault, 1979:138).

> The ‘right’ to life, to one’s body, to health, to happiness, to the satisfaction of needs and beyond all oppressions or ‘alienations’, the ‘right’ to

> rediscover what one is and all that one can be, this 'right'-which the classical juridical system was utterly incapable of comprehending- was the political response to all those new procedures of power which did not derive.....from the traditional right of sovereignty (Foucault, 1979:145).

In this formulation, Foucault maintains his distinction between the law as an emanation of sovereign power and the workings of disciplinary power by suggesting that discourses in rights, specifically discourses that centre around the body and the self, are the product of disciplinary procedures and not an allocation or redistribution of sovereign right as liberal political theory might suppose. Foucault acknowledges that these rights appear in both a rhetorical sense and in substantive form, and materialise in a contested political context. The brief treatment of rights in bio-power, therefore, alludes to Foucault's acknowledgement of a crucial interaction between law and disciplinary practices (cf Hunt and Wickham). The interaction between law and the disciplines can be reflected in the colonisation of law by the logics and rationales of the new disciplinary sciences, such as psychiatry (Foucault, 1978), or in the recoding or 'juridification' of the disciplines such that non-legal forms of discipline acquire legalistic characteristics (Hunt and Wickham, 1994:48). Foucault's elaboration of governmental power itself can be seen as an attempt to characterise the engagement between law and the new disciplines by bringing the nexus between disciplinary procedures, subjective identity and political imperatives into focus.

The significance of the multiple discourses of rights that emerged in the human sciences in the second half of twentieth century especially in medicine remained largely unexplored in Foucault's work. The idea that the appearance of rights denotes crucial shifts in the operation of governmental power, however, has been the object of several studies in the 'governmental ' field. In particular, the emergence of 'social rights' at the close of the nineteenth century has provided fruitful ground for analysis. Gordon argues, for example, that the governmental imperative of security was reflected in the effort to reconstruct the population of the poor according to a model of collective economic citizenship. These efforts produced a radical recasting of liberalism's politico-juridical heritage in terms of a political language of rights (Gordon, 1991:31). This involved dissolution of the conviction that the law was transcendent, and its replacement with a perception of the law as a relative emanation and expression of society. At the same time, legal theory and the human sciences questioned the founding legal status of autonomous individual will. Gordon argues that this dialogue mediated between the two poles of the state and the individual by striving to construct a governable legal status that correlated with the governmental delegation of power to distant bodies. Through this dialogue, liberalism posed the institution as the source of social rights, and the individual as the subject of right only through the institution. Administrative law dispenses with the concept of 'natural right' by conferring an entitlement to compensation and withholding a right to inculpate the state at the level of its sovereignty (Gordon, 1991:33).

Donzelot's (1993 [1984]) study of the development of 'insurantial' rationalities epitomizes the transformation described by Gordon. For Donzelot, the technology of insurance was a response to the problem of government experienced by a liberal industrial economy when it was confronted with both the exploitation of workers and their resistance to that exploitation. Providing monetary compensation for industrial injuries, rather than making the work-place safe, ensured maximum production at the same time as it maintained worker compliance. By disconnecting the spectre of injury, disease and death from the juridical idea of fault, the conflicting economic and social imperatives were made compatible. In this discussion, Donzelot makes a critical connection between the emergence of social rights and statistics. He describes social rights as being established in the '... homogenous language of statistics'.

> By supporting itself on the new language of statistics, social right can claim to substitute the mechanism of a reduction of the risks of all and the simultaneous argument of the chances of each, for the original opposition between (sovereignty) and classical rights (Donzelot, 1993 [1984]:405).

For Donzelot the principle of 'a promotion of the social' through the technique of insurance, underpinned by statistical language and knowledge, argued for an increase in the 'chances of each' through the reduction of the 'risks for all'.

Similarly, Ewald (1991) saw that the impulse toward future security as dependent on the epistemological development in statistical thought permitted by the apprehension of 'laws' of social causality. This knowledge gave rise to a range of insurance technologies that aimed to manage 'social' problems by redistributing the economic burden of a calamitous event across time and amongst groups of contributors. For example, friendly societies, banks and life insurance schemes were first made legal at the start of the nineteenth century. These strategies exhorted individuals to prepare for the future possibilities of unemployment, injury or death of a breadwinner. The ethical effect of such programs was to instil an orientation toward calculated future risk and insurance practice at the level of the individual. The development of insurance therefore correlated with a transformation of social morals as well as the transformation of an individual's relation to him or her self, to the future, and to society (Ewald, 1991:210). In this account, the right to individual safety and recompense is replaced by the right to insurance, as a condition of both personal being and of national security.

According to Nikolas Rose, these examples illustrate the proliferation, toward the late nineteenth century, of techniques of social rights. Social rights, and their embodiment in administrative and institutional mechanisms, correlated with the subordination of individual rights as a mechanism of rule that had dominated the nineteenth century. For Rose, the simultaneous relativisation of the state and the individual that was entailed in these techniques casts the private domain as a virtual public sphere (Rose, 1987). In this way, liberalism is able to achieve its desired stance of being activist at the same time as it was disengaged. The dual technologies of insurance and population thus combined to form 'welfarism' as a unique phase of liberalism that emerged in the first half of the twentieth century and is characterised by the proliferation of social and public health programs whose form reflected the quest for 'scientific government'. Nevertheless, the huge extension of the political apparatus of the nineteenth and twentieth century was possible precisely because it was 'entangled' in the aspirations of the people themselves and the development of a 'will to health'. The will to health was instilled as a duty during the early twentieth century, through the practices of education and the routines of domesticity that sought to instil hygienic and eugenic habits within each member of the population (Rose, 2000:15). For Rose, the complex array of disciplinary and tutelary machines that characterised welfarism, provided the essential pre-conditions for the neo-liberal transformation that emerged in the second half of the twentieth century.

The unique quality of neo-liberal thought, according to Foucault, is the expansion of a definition of economy to encompass all purposive conduct, or all conduct that entails strategic choices. In this way neo-liberal economics became an approach that was capable of addressing the totality of human behaviour (0'Malley, 1999:43). The economic agent that was conceived in liberalism was subtly recast as one who exercises the fundamental human faculty of choice, but who is also perpetually responsive to modifications in his environment. Human capacity was deemed to comprise the skills, aptitudes and competencies that are drawn from the innate component of bodily and genetic equipment and the acquired aptitudes adhered from environmental stimuli (Gordon, 1991:44). According to Gordon, it is this revision that renders the individual peculiarly inseparable from his or her capacities, but also insists that the individual is an 'enterprise of themselves'. The heightened focus upon an individual who is exhorted to care for themselves by the exercise of rational choices constitutes ‘the ethic of the self’ which is seen as the prominent feature of neo-liberalism (see also Foucault, 1984b; Burchell, 1993; Cruikshank, 1993). Analyses of the ‘duty to be well’ are prominent in the governmental literature. (see Rose, 1990; Rose, 1993; Rose, 1994; Armstrong, 1993; Nettleton, 1992; Gane & Johnson, 1993; Petersen & Bunton, 1997; Lupton, 1995a; Petersen & Lupton, 1996; Fox, 1998; Greco, 1993). These studies reflect a concern to articulate the practices that constitute the neo-liberal strategic of self conducted freedom and represent an understanding that this new set of political formulae and programmes entails a major retraction of social rights and the ideal of a welfare state (Dean, 1999:145).

The task of advanced liberal government, therefore, is aimed at reproducing the subjective conditions, the forms of self-mastery, self-regulation and self-control necessary to govern a nation made up of free citizens (Rose, 1993:290). Accordingly, the task of government is centred upon the management the complexity and diversity of the relations between authorities and individual subjects who care for themselves ‘as free subjects’ (Rose, 1993:288). It has been argued in the governmental literature that this orientation had given rise to a range of technologies that are concerned with deploying the agency and capacity of individual and populations. Cruikshank (1993) (1996) has identified ‘technologies of citizenship’ as the multiple techniques of self empowerment, consultation, and negotiation used in, for example, community action programs community development programs, and health promotion (Dean, 1999:147). In this view, consumer action that seeks to assert, for example, ‘patient rights’, is represented as the effect of those technologies of agency that have been deployed in order to transform designated groups into active, self managing citizens.

Nikolas Rose provides an analysis of the phenomena of rights in psychiatry that similarly sees rights as one of the strategies deployed in the contemporary world in the construction of the contractual self (Rose, 1986a:212). He argues that the imposition of a legalistic notion of rights in psychiatry has fundamental limitations for mental health reform because, rather than empowering patients, the invocation of rights merely reorganises relations between different forms of professional expertise (Rose, 1986a:178). Although rights discourse promises potent resolutions to political questions about the power and obligations of the state, moral questions about human conduct and technological questions about the social regulation of each, the re-contractualisation of the relations between the state and its citizens that rights entail, merely demarcates a sphere of social and personal relations that are not the legitimate concern of social authorities (Rose, 1986a:212).

> No longer is the state construed as having an overriding duty to use its powers to protect a set of moral values, or to advance the happiness and well being of its citizen. Rights seek to establish and police a border between a public domain that is the concern of the state and a personal domain that is the space of private choice and contractual relations (Rose, 1986a:212).

This view offers an interpretation of modern rights as a governmental technique that not only polices the boundaries between the designated realms of the public and the private, but also provides a strategic technology that is able to negotiate or manufacture shifts in the contours the private domain according to the imperatives of social policy.

In a more recent analysis of the phenomena of rights in health care, Rose similarly emphasises the effects of an intersection between technologies of freedom and medical imperatives (Rose, 2000). He sees the ethic of the self in neo-liberalism as bringing a new alliance between political aspirations, and the hopes and fears of individuals, in terms of biological destiny. This was because the advent of biotechnology had the effect of integrating knowledge and belief about ones biological and genetic compliment into the complex choices that prudent and responsible individuals must make in their life strategies. The imperative of autonomous self government, coupled with the abandonment by formal government an attempt to organize a heterogeneously conceived social body, resulted in the formation of a highly contested realm in which disputes about the value to be accorded to life itself, reflected in such as abortion, euthanasia and gene therapy, predominate (Rose, 2000:17). With obvious resonance with Foucault, Rose poses the kind of rights debates that coalesce around the issues of life as an ‘etho-politics’, that is, as the inevitable effect of the government of ‘vital’ populations. Rose goes on to argue, that the link established between individual endeavour and aggregate phenomena gives rise to a ‘bio-politics of risk’ where the identification of aggregate levels of harm are based on indices of statistical probability (Rose, 2000:8). The bio-politics of risk demands the identification of the biologically risky or at risk individual in terms of predictive or pre-symptomatic risk and in the name of pre-emptive intervention that takes the form of transformative techniques including biological or molecular treatment (Rose, 2000:9). At the same time, the ethic of transformation in bio-politics gives rise to the formation of groups and organizations of 'at risk' individuals who make claim to the deployment of medical and biomedical resources in the name of rights. Paradoxically, therefore, individuals who would previously have been subject to tacit exclusion or detention, demand human rights in the form of recognition, respect, resources, research and control of over medical resources (Rose, 2000:17). 'Empowerment' within bio-politics, therefore, brings new constellations of subjectivity. Bio-politics continues to value autonomy, choice and individual will, but the ethic of corporeal transformability transmutes the demand for autonomy away from the liberation of ones inner essence and toward the right to experiment with ones corporeality without constraint. In this analysis, Rose suggests that the phenomenon of patient rights is positioned within an ethical realm that has reversed the conceptual relationship between a universalising presumptive moral code and individual ethical judgment. Instead of ethics being dictated authoritatively from the pronouncements of committees, codes and conventions, it is now shaped by an alliance between clinicians and their patients who knowingly manipulate their own bodies with techniques and knowledges developed by entrepreneurial research (Rose,2000:19).

Roses' analysis of the emergence of a new form of patient rights in the contemporary milieu illustrates the principles that rights should be understood as historically contingent and as the effect of disciplinary practices. It also shows how rights delineate the boundaries between the public and private realms, in this instance by negotiating a return of clinical decisions to the semi-private realm of the physician patient consultation, rather than the procedural forums of ethics committees. In this analysis, the subject who is produced by these new regulatory norms is entrenched, as much as liberated, through the political recognition and acquisition of rights (Brown, 1995:118). Rights have merely affected a shift, that continues to hold the subject within a matrix of power relations, albeit ones that are differently composed.

Rose analysis is also significant because it provides an example where the invocation of legal rights has contradicted the trend toward 'proceduralisation'. Proceduralisation refers to the observation that in late modernity legal regulation has become deeply involved in the detailed governance of many forms of social relations and institutions. In this role, the law acquires an increasingly particularistic character, laying down detailed rules and procedures for a host of specialised areas of activity. Rather than setting positive rules to control activities, this form of legal regulation lays down procedures for how decisions should be made, including in some instances what interests are to be consulted (Hunt and Wickam,1994:67). It is usual to construe the formal recognition of procedures and interests as promoting the capacity of the law to recognise previously marginalised groups or interests. The analysis of rights in governmentality suggests, however, that a far more complex equation is at work. This conclusion in reiterated in Brown's recognition that emancipatory function of formal or procedural rights cannot be adjudicated in abstraction from the bureaucratic juridical apparatus through which rights are allocated. She sees the pursuit of rights declarations in the courts as subjecting the claimant

> to intense forms of bureaucratic domination and regulatory power even at the moment that we assert (rights) in our defence (Brown, 1995:121f/n41)

This underscores the necessity of making the effectivity of rights and rights practices the subject of analysis.

The weight of literature reiterates the idea that rights are embedded in the rationalities of liberal government at a fundamental level. In the governmental literature, however, rights are problematic. Their emancipatory potential, is not so much denied as reinterpreted as a discipline of the self. If sovereign and disciplinary power are recognised as a constant feature of governmental power, however, it follows that there are likely to contradictions, interconnections and continuities between these different forms (Burchell, 1993:267). In this light, it can be assumed that rights as technologies of power will not appear as uniform or stable entities, but will manifest in different forms and with multiple effects, depending on the specific historical constellations they inhabit. To pose rights as the object of inquiry requires a methodological approach that takes account of these complexities. Such an inquiry is best served by the construction of a genealogy of rights.

Genealogy as Method

The methodological approach that is referred to as 'genealogy' emerged from the work of Michel Foucault. This approach follows from Foucault's analysis of power and aims to explicate the effects of power. As a methodology, the principles of genealogy are gleaned from Foucault's research, the details of his methodological discussion and their application in the subsequent field of governmental study. In combination, these sources suggest that genealogical method rests upon five broad principles.

First, a genealogical method necessarily assumes that power constitutes a productive force that permeates the fabric of social existence and is thus articulated at 'the capillaries', in a multitude of relations and activities. This characterisation of power enables an analyses of the ways in which governmental rationalities shape the existence of our everyday lives and encompasses a consideration of the specific but inconstant subjectivities that are formulated within shifting matrices of power. This perception of power dictates that a genealogical approach must attempt a peculiarly extensive and innovative inquiry. A genealogy tries to uncover relations and heritages that have been lost, forgotten or taken for granted. It invites consideration of the continuities and discontinuities in both discourse and practice and the interaction between them. It aims to allow the silences or absences in historical juxtapositions to speak as eloquently as concrete activity and obvious phenomena. In this regard, it approaches 'evolutionary' historiographies with suspicion because it assumes a greater complexity than is reflected in a linear approach. A genealogical method must therefore be inspired and creative at the same time as it rests itself upon the weight of evidence.

It follows that genealogical method implies an historical approach that has been called in the governmentality literature as a 'history of the present'. Genealogy seeks to shed a different light upon accepted or 'taken for granted' historical relationships, highlighting a series of transformations that underpin current understandings of problems. A central tool in achieving this critical reorientation is to focus upon the production of 'truth'. A genealogy seeks to trace the ways in which certain events, phenomena or behaviour come to be described as 'problems'. These highly contextual 'problematisations' give rise to specific sets of policies and activities that might be activated at the level of government or at points of distal organization that correspond with governmental thesis that government occurs at arms length or 'from a distance'. Therefore, a genealogy seeks to identify the knowledge and practices that are employed to describe or 'know' a problem in order to manage it. In conjunction these principles describe an approach that seeks to identify the 'conditions of possibility' of contemporary phenomena. While these principles accurately reflect the general structure of a 'genealogy', they fail to accentuate the importance of the methodology as a tool for uncovering the production of truth as a moral force.

Foucault regarded his own work as constantly returning to aspects of his major project of constructing a 'genealogy of morals' which would trace the lines of transformation of what Foucault called 'moral technologies'. In his consideration of mental illness (Foucault, 1961) and prisons (Foucault, 1977) Foucault was not concerned to delineate categories of mental illness or punishment, but to study how these divisions operate in society (Foucault, 1991b:74). His target was not institutions, theories or ideologies themselves, but practices. Foucault argued that the critical shift in analytic focus should be toward practice. Concrete practices in everyday life reflect the intersection of the multiple discourses that construct a problematisation with the mundane or practical considerations that influence the actual shape of the proffered solutions. Following Foucault, Rose has also argued that philosophical events are necessarily grounded in material practice (Rose, 1994:62). For example, the fundamental proposition in western medical thought that the body defines the boundaries of disease is based in the medical practices of observation, measurement and calculation (Rose, 1994:62). In addition, ways of thinking, or 'intellectual technologies' must also be considered as having the quality of material practice (Rose, 1994:63). Foucault's aim, therefore, was to grasp the conditions that make a set of practices acceptable at a given moment in history (Foucault, 1991b:75). According to Foucault

> (I)t is a question of analysing a 'regime of practices', understood as the place where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted, meet and interconnect (Foucault, 1991b:75).

Foucault aimed to understand the complex intersection of ideas, beliefs and knowledges that surround a particular practice, or set of practices, giving it credence and authority. He also sought to demonstrate the way in which changes in either practice, belief or knowledge then altered the stability of a particular constellation making way for another, equally contingent, set of practices, beliefs and knowledges. Foucault sought to demonstrate that practices that seem self-evident or 'natural' (and therefore 'right' or immutable) are in fact precarious. He sought to make visible, not the arbitrariness of certain phenomena, but the complex interconnection between a multiplicity of historical processes that gave rise to it. Foucault was particularly concerned with the process of rapid social change during some periods of history. Rather than seeking to identify a buried stream of continuity that Foucault associated with conventional historical method he aimed to identify the transformations that made these hurried transitions possible (Foucault, 1991b:75).

Foucault described the methodological technique he employed to achieve this analysis as 'eventalisation' (Foucault, 1991b:76). The three critical aspects of this technique are, first, that it aims to show the particularity of a historical moment. Second, that it aims to rediscover the connections, encounters, supports, blockages, interplays of forces, and strategies that subsequently count as being self-evident and universal. Third, that it aims to analyse an event according to the multiple processes that constitute it (Foucault, 1991b:76). Eventalisation thus works by constructing around a singular event ... a 'polyhedron' of intelligibility, the number of whose faces is not given in advance and can never properly be taken as finite. (Foucault, 1991b:77). Foucault contrasted his approach with both Marxist accounts of the inherent contradictions in capitalism and Weberian accounts of the irrationality and rationality of capitalist society (Foucault, 1991b:78). Both these accounts seek to assess phenomena in terms of an absolute against which they can be evaluated. Foucault prefers to examine how forms of rationality, in practice, play a role in the codification of rules and procedure, on the one hand, and on the other, how they determine a domain of objects about which it is possible to articulate true or false propositions (Foucault, 1991b:79). Foucault sees the production of truth, or how certain phenomena become accepted as 'true', as informing the way in which populations of people are governed. The production of 'knowledge' is therefore given central importance in Foucault's schema. For Foucault the most general political problem is one of truth.

> My problem is to see how men govern (themselves and others) by the production of truth...or.... the establishment of domains in which practice of true and false can be made at once ordered and pertinent. I would like... to resituate the production of true and false at the heart of social analysis and political critique (Foucault, 1991b:79).

In this way Foucault links his project of a 'genealogy of morals' to the production of truth in the sense that what becomes accepted as 'the truth' shapes the policy decisions of government and of people in their everyday lives.

Writers who have followed Foucault's work closely have sought to further elucidate Foucault's methodological approach. Castel (1994:237) describes Foucault's sense of 'eventalisation' as a 'problematisation'. He regards this as Foucault's most essential methodological contribution. Castel identifies Foucault's methodological starting point as the assumption that the present bears a burden from the past. Problematisation therefore provides a means of utilising history as an account of the present. For Foucault, a process of problematisation is not the representation of a pre-existing object, nor the creation through discourse of an object that does not exist. It is

> the totality of discursive and non-discursive practices that brings something into the play of truth and falsehood and sets it up as an object of the mind (Foucault 1984 quoted in Castel 1994:238).

According to Castel, Foucault's phrase 'discursive and non discursive practices' refers to an array of administrative institutions, regulations or measures, architectural arrangements as well as scientific, philosophical and moral propositions. For example psychiatry can be understood, in Foucault's terms, as an apparatus comprising scientific claims, specific institutions, specialised personnel, professional mythologies and special laws and regulations (Castel, 1994:238). This complex apparatus in essence constitutes a debate about truth and falsehood. For Foucault, it is this quality that accords the apparatus its social significance. He saw the programs of conduct that are generated by apparatuses such as psychiatry as having both a prescriptive and a codifying effect. For example, Foucault saw the search for an effective, measured and unified penal mechanism as a response to the failure of the institution of judicial power to comprehend new economic forms and urbanisation. These programs, however, produce real effects, crystallising into institutions and informing individual behaviour. Thus, 'they act as grids for the perception and evaluation of things' (Foucault, 1991b:81).

Castel distinguishes a 'history of the present' from classical historical analysis by arguing that a history of the present displays its own intelligibility while remaining consistent with historical accounts (Castel, 1994:240; 251). A 'problematisation' does not merely sensitise a reading of the past to a particular issue but operates as a 'diagnostic' that is turned upon the present in order to guide a decoding of history along this line of understanding. For example, in *Discipline and Punish* (Foucault, 1977) Foucault was seeking to understand the present scientific and legal codes from which the power to punish derives its bases, justification and rules (Foucault, 1977:23). A problematisation does not consist of lifting a question out of the context of a past period, rather it is about identifying the forerunners of a current question. For example, Foucault's analysis of confession offers an understanding of the technology of confession as important condition of the exercise of power today as evidenced by modern psychiatric practice and, by extension, the dynamics of the doctor/patient relationship. Apart from Foucault's seminal work, the development of the genealogy approach in relation to medicine is most closely associated with the work of Nikolas Rose.

Rose regards Foucault as consistently seeing medicine as being bound up with the delineation of the unique human being. Medicine was the first positive knowledge to take the form of an expertise in which the human being became known by being the subject of calculated regimes of reform and transformation (Rose, 1994:49). Foucault therefore encourages us to attend to the heterogeneity of the events with which medicine has been engaged - the diversity of medical values, the diversity of interventions carried out in the name of health and the diversity of ways of relating the language of medicine to the language of politics (Rose, 1994:50).

For Rose, a methodological technique that reflects this understanding must first begin with an act of 'decomposition', that is, it must dissolve the 'great certainties'. Rose includes amongst these the valorisation of health, the sanitation of suffering, the powers ascribed to medical personages in relation to the disquiets of the body as well as of the soul and social order, and the sense of ourselves as perfectible through the application of medical techniques. Following the process of decomposition the historian of the present must seek to identify 'truth practices' by a detailed analysis of practice and discourse. This dyadic is critical because a historian of the present cannot conceive of separating the context of, for example, an epidemic from the sites within which it is identified, charted and policed. She cannot conceive of distinguishing the discourses of clinical medicine from the structuring of the medical spaces in which it is deployed, nor the technologies of diagnosis and intervention to which it is fused, nor the positions of doctor and patient in which it is embodied. As Rose points out, it is not a question of 'discourse/meaning' on the one hand and 'power/domination' on the other. Instead, it is a matter of meticulous investigation of the varied and complex ways in which 'practices of truth situate persons in particular relations of force' (Rose, 1994:53). For Rose, the task is

> to trace out, from the point of view of a problem that concerns one today, the diverse connections and liaisons that have brought it into existence and given it's saliency and its characteristics (Rose, 1994:53).

It follows from these propositions that a genealogical approach is central to the task of unravelling the complex constellations of power that position medicine in its influential place in the formation of the contemporary world.

The current inquiry proposes to adapt a genealogical method for the investigation of the 'problem' of patient rights. Patient rights presents itself as a phenomena of interest and importance in the present, not merely because of its prominence throughout the latter half of the twentieth century, but because the phenomena of patient rights, is consistently understood, regardless of the mode of analysis adopted, as reflecting fundamental relations of power. Patient rights, therefore, present as a pertinent 'diagnostic' for a genealogical study of power. Following Rose, a genealogy is properly preceded by an act of 'decomposition'. An inquiry into the phenomenon of patient rights must begin, therefore, with a consideration of the theoretical traditions that underpin the assumption that the advent of rights in the medical field denotes the 'empowerment' of the patient.

Patient rights as empowerment

The appearance of patient rights as a substantive ethical principle in medicine is generally interpreted through the frame of emancipatory politics. The apparent recognition of patient rights in terms of formal and informal alterations in medical practice, and in the establishment of both legal and quasi-legal mechanism of redress are hailed as products of the patient rights' movement. In this view, the prominent 'grass roots' social movements of the 1960's and 1970's identified and successfully opposed the excessive exercise of power by traditional authorities. In an effort to challenge the repressive power of patriarchal medicine, the women's movement and the consumer movement combined to form the patient rights movement (lrvine, 1996). For example, Rothman argues that an analysis of the legal challenges to medical decision-making in America supports the conclusion that medical authority has been made subordinate to a legal authority that has demanded medical recognition of individual patient rights (Rothman 1991; Macklin,1993). In Australia a similar subordination has been attributed to active lobbying by community groups and more formal organizations such as Health Forum and the Health Issues Centre (Baldry,1992). In large part, these interpretations rely upon two related features of the narratives in sociological thought. These are the medical dominance thesis and the privileged position that has been accorded to the doctor/patient relationship as the site of the exercise of medical power.

The doctor/patient relationship has occupied a central place within the dominant narratives of the sociology of health and illness since the Talcott Parsons functionalist analysis of the 'sick role' (Parsons, 1951a) described medicine as deeply implicated in the maintenance of social norms and the containment of social deviance (Gerhardt, 1987). Parsons' presented medical power as unproblematic because it was effectively constrained by responsibilities imposed upon the practitioner by the corresponding medical role. From the 1960's critical responses to this orthodoxy in sociology reflected a deep disquiet about the social effects of medical power. A subsequent stream of studies showed how medical knowledge and practice stigmatised and excluded any individual categorized as ‘deviant’ (For example see Lemert,1951; Goffman, 1961; Becker, 1963; (Scheff, 1966; and Conrad & Schneider, 1980). This literature re-framed medicine as a central institution of social control (Zola, 1972), and there has remained in the Sociology of Health and Illness a profound concern with the dynamics of medical power (For example see Oakley, 1980; Oakley, 1984; Ratcliff, 1989; Willis, 1998).

Feminist perspectives added an appreciation of the disproportionate impact of patriarchal medical dominance upon women by highlighting the strictly gendered understandings of psychological and biological ‘deviance’ that proliferated within medicine (for example see Ehrenreich & Ehrenreich,1974; Ehrenreich & English, 1978; Broom, 1991). Explorations of the ways in which medical power distorts or hinders the therapeutic encounter enriched this perspective (for example see Habermas,1979; Mishler, 1984; Silverman, 1987). The inherent dangerousness of the medicine was highlighted by the spectre of iatrogenic illness (see Illich, 1976; Taylor, 1979). Some voices highlighted the fundamental futility of the therapeutic project itself (McKeown, 1979; McKeown, 1988).

The concern about medical dominance extended into a consideration of the source and strength of medical professional dominance. The professional dominance of medicine has been persuasively illustrated in America and Australia (see Freidson, 1970a; Freidson, 1970b; Johnson, 1972; Starr, 1982; Larkin, 1978; and Willis, 1989[1983]). Much of this analysis links medical power either directly or indirectly to the power of the state, and extends the implications of medical power toward the economic organization of health care systems. In some accounts medicine is directly implicated in the maintenance of capitalist class relations. (For example see McKinlay & Stoeckle, 1988; Mechanic, 1976; Doyal, 1979; Navarro, 1988; Willis, 1989[1983]).

The cumulative weight of several decades of sociological inquiry suggested that the professional and political dominance of medicine was complete. Voices of dissent argued, however, that the increasing levels of general education and the impact of information technologies would result in an undermining of the status of medicine as individual patients challenged medical authority (Haug, 1973; Haug, 1988). Coupled with the emerging interest in ‘alternate therapies’ these arguments suggested a ‘demedicalisation’ of society (Strong, 1979). The continued influence of the women’s health movement, the consumer health movement, the patient rights movement and the formal recognition of an increasing number of natural or alternate practitioners added weight to this argument (see Willis, 1993; Baldry, 1992; Doyal, 1994). Changes in the organization of health care (Elston, 1991), and the emerging professionalization of the allied health occupations, such as nurses (Witz, 1994), further consolidated the argument that medical power was in decline (For example see Gabe,1994; Bunton, 1998).

This observation prompted a range of responses. For example, Parsons decried the loss of medical authority as detrimental to the fundamental relationship of mutual obligation between the physician and patient (Parsons, 1975). (See also Lupton, 1996; Bury & Gabe, 1994; Baker &Yaels, 1996). In contrast, Freidson observed that the evident changes in contemporary conditions represented merely an increased stratification within medicine. This stratification represented an entrenchment of medical power and authority at the higher levels of professional organization at the cost of some reduction in medical authority at the level of the general practitioner (Freidson, 1994). Australian sociological comment largely accepted the thesis of medical professional decline. The phenomena of 'patient rights' or 'patient empowerment' and the link between these concepts and the rise of community health education and alternate therapies was taken to represent evidence of the transference of power away from medicine toward the consumers of health care (for example see Baldry , 1992; Willis, 1993; Irvine, 1996). The observation that the final decades of the twentieth century were characterized by a vibrant discourse in 'patient rights', the formal involvement of consumer lobby groups in the organization of health care services, the promulgation of patient charters, the establishment of systems of independent health service review, as well as significant legislative reform all contributed to this view (Germov,1995). By the close of the century, however, the rhetoric of patient rights increasingly appeared in conjunction with reports of abuses of medical power (Walton, 1998) and the limitations of the concept of 'patient empowerment' began to be considered (Crossley, 1998; Charles & Redko, 1998).

Despite a series of adjustments and modifications, therefore, the medical dominance thesis has struggled to maintain its coherence in the face of a rapidly changing health field. This failure arises primarily from an uncritical acceptance of the progressive narrative of rights, and from the theoretical reliance upon a traditional model of power. Shifts in the tenor of medical ethics, the activities of ethics committees, the publication of 'patient charters' and the successes of some patient rights lobbies have been accepted as evidence of the ascendancy and actualisation of autonomous individuals. This conclusion denies the validity of research that has shown that an implicit or direct denial of patient autonomy, particularly where there is a 'conflict of interest', is representative of the standard interaction between patients and their practitioners in Australia (Walton,1998).

Roach Anleu argues that the failure to address the notion of rights in contemporary sociology arises from an uncritical acceptance of human rights as a universalistic notion. Universalistic claims and assumptions about human rights, and rights discourse generally, has encouraged an acceptance of rights as a vehicle for, and marker of, citizenship in the global community (Roach Anleu, 1999:198)[4]. To accept the notion of rights as an unproblematic ignores the political agnosticism of rights discourse, the limitations imposed on the actualisation of rights and the paradoxical effects of the realization of rights (Roach Anleu,1990;208). Furthermore, its fails to take account of the political instability of rights, and the observation that practices of rights are highly localised and contingent. Roach argues that to merely rephrase our conceptual tools in the language of human rights will not change inequality or discrimination based on social characteristics such as ethnicity, race, or gender (Roach Anleu,1990:206)[5]. Roach discussion, therefore, returns attention to the practical efficacy of rights, and the difficulties that surround their realisation.

Conclusion

The already troubled assumptions that support the narrative of patient empowerment are further unsettled by the critique of rights that emerges from the field of governmentality. To view rights as a technology of power unsettles the notion that rights reflects individual patient empowerment and denote a corresponding diminution of medical power. To view rights as a technology of power also unsettles the notion that the relationship between the doctor and patient is the fulcrum of medical development. As Rose points out,

> the problems ….with which medicine will concern itself....do not form naturally in some ancient space of communion between medical personages wishing only to cure and the sufferer wishing only to be cured. The moment of the consultation has a long history, and one that needs to be documented and understood (Rose, 1994:63).

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[4] Anleu cites the work of Turner as an example of a fascination with human rights (Turner,1993)

[5] She also suggests that the universal social need to define ‘outsiders’ has fundamental relevance for a constructive sociological analysis of rights. (Roach Anleu,1990:208).

More importantly, to view rights as a technology of power positions rights as a tool for conceptualising a series of practical, technological and discursive arrangements in such a way that both medical practice and the rationalities that surround and justify that practice are drawn into focus. The emergence of rights discourses in medical contexts, therefore, will mark historical instances where medical problematisations have drawn upon the concept of rights, both the construction of medical problems and in the proffering of medical solutions.

The following account of patient rights has engaged with a historiography that spans the nineteenth and twentieth centuries and takes as its focus the medical concern with the question of the health of population. This engagement is not arbitrary but is dictated by the persistent accompaniment of these issues with the discursive arrangements of rights. To observe the historical presence of rights unsettles the notion that rights are a peculiar invention of the contemporary world. To observe their erratic and inconsistent appearance, unsettles the notion that rights evolved smoothly alongside a progressive evolution in medicine. Also, to observe the divergent manifestations of rights and rights discourse in different western countries underscores the observation that rights are historically contingent. A further effect of posing rights as a ‘diagnostic’ is the revelation that a disproportionate proliferation of rights discourses has coalesced around the medical preoccupation with the health of women. Accordingly, discussion of the medical management of women dominates the account. This might be explained in terms of the medical preoccupation with the dynamic of population and therefore the reproductive capacity of women. Foucault analysis of rights suggests, however, that it in might equally be explained in terms of an amplification of disciplinary procedures invoked to counter the parallel development of women’s suffrage.

I wish to argue that rights, as a technology and practice of government, are far more deeply integrated in the historical constellations of liberalism than is recognised in the progressive narrative of humanitarianism. Rights emerge, recede, and re-emerge in different historical contexts, with different ends and with different forms, while the ‘patient with rights’, framed in the appropriated language of the enlightenment, is honed by the practices of governmental power.

Chapter 2: Poverty, Liberty and Rights

> The community will first learn, and then demand, their right to protection from preventable disease and death. John Simon 1869 Royal Commission on Sanitary Laws (Roach, 1978:201).

Introduction

The transformation in government that fixed itself upon the principle of future security is entwined in the transformations in statistical knowledge that began in the fifteenth century. From that time, evolutions in accounting practices and mathematical discourse resulted in the extraction of statistics from content. This rendered statistical method a technique for obtaining scientific and objective truth (Poovey,). Statistics offered a vision of reality that was supposedly free from subjective or interested evaluations. It was an exemplary tool of government, because it provided a secure knowledge base, an indisputable version of truth, upon which strategic action could be based. Statistics etched the realm of the economic and 'discovered' the cycles of population. The inextricable link that was discerned between the 'natural forces' of population and the 'natural forces' of the economic realm confirmed the notion that the security of the nation rested upon the wealth, wellbeing and tranquillity of the people[1]. By the close of the eighteenth century in Britain the 'natural' forces of the population were increasingly imagined as irrational, unpredictable and ultimately perilous. The management of the natural forces of the population, in terms of the imperatives of the economy and especially in relation to poverty, was imperative.

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[1] Adam Smith published the *Wealth of Nations* in 1776 (Smith, 1776[1976]).

The liberty of the common man

In 1797 Sir Frederick Morton Eden's *Inquiry into the State of the Poor* argued that the traditional system of parish poor relief, a localised system of wage supplementation, was economically unsustainable because it artificially excluded the poor from the 'natural forces' of the economy, and supported a life of 'indolence' and 'improvidence' that resulted in rampant population increase (Roach, 1978:66). The dangers of untempered population expansion were reiterated by Malthus (1776-1834) in his *Essay on the Principle of Population,* published in 1789, and in the extensively revised edition of 1807. Malthus argued that the capacity of the population to increase in geometric ratio would inevitable outstrip the power of the earth to produce subsistence because increases in the earths capacity followed an arithmetic ratio. Critically, he saw that while the population growth in primitive societies was limited by the 'natural' mechanisms of hunger, pestilence and war, in civilised societies excessive population expansion could be curtailed by 'social' mechanisms (Roach, 1978:54).

By 1803, the agriculture downturn in Britain had expanded the cost of poor relief to over four million pounds, fuelling calls for poor law reform. In 1806, Coulqhoun's *A Treatise on Indigence* recommended that 'outdoor' poor relief, or the provision of paid parish work be abolished, and the 'attractiveness' of 'indoor' poor relief in the workhouses be diminished (Rose, 1985:44). Able-bodied workers were to be refused relief and encouraged to relocate to parishes where work was more abundant. This was to be achieved by placing the system of poor relief on a national rather than local basis. A nationalised system of poor relief would prevent manipulation of the local system, diffuse the focus of organised worker movements and encourage people to provide for their own 'relief' in times of unemployment, sickness or injury by joining 'friendly societies' or utilising other insurance or banking systems (Coulquhoun cited in (Roach, 1978:68). The imposition of 'independence' upon 'the common man' would diminish the population of dependent poor, reduce improvident marriage and limit population growth (Roach, 1978:57). At the same time, a nationalised system would enable the ‘criminally indigent’, the million beggars, vagrants, prostitutes and criminals who were not entitled to poor relief and yet received parish assistance, to be identified amongst the ‘genuine poor’ and denied relief (Roach, 1978:67). Widespread civil unrest, frequently directed as the administrators of the parish poor relief and the local gentry, and culminating in the infamous Luddite riots of 1812, eventually prompted the establishment of a formal inquiry. The report by the government appointed Poor Law Commissioners echoed Coulquhoun’s sentiments. These principles were formally reflected in the provisions of the *Poor Law Act* of 1834 (Watson, 1969:5). Principally the *Poor Law Act* abolished ‘outdoor relief’. For those amongst the poor who were unable to work, ‘indoor’ or workhouse relief, was to be reorganised on a national, rather than parish basis, and the ‘favourable’ conditions inside the work houses were to be modified, lest they encourage ‘idleness’, ‘vice’ and ‘sensual indolence’ (Roach, 1978:115)[2]. The able-bodied were accorded the ‘right’ to move to areas where work was available and it was expected that in the absence of parish support, they would leave to seek work elsewhere. The dismantling of the parish system would limit the reproduction of the poor by encouraging a prudent attitude to familial responsibility. Accordingly, the *Act* also removed the entitlement to women with illegitimate children to claim parish support. In its place was granted the ‘right’ to seek financial support from the fathers of their children, in the form of a juridical remedy of breech of promise, to be exercised against the father through a court of law (Acton, 1972 [1857]:274)[3]. It was supposed that the imposition of independence would generate a new moral dignity amongst the poor.

By 1849 Poor Law expenditure had been reduced by 40%. Despite this achievement, public opposition to the new poor laws grew, fuelled by public scandals over the appalling conditions in the workhouses and the recognition that the economic strategy had little effect on population growth. In the century between 1750 and 1850 the population in Britain trebled. By the mid nineteenth century, the problem of the

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[2] Roach argues that these practical measures were aimed at reducing the problem of poverty and its inherent threat to national security and were supported with schemes to provided, elementary education for working children to enhance their moral training, to discouraging crime and to reduce the influence of trade unions and political agitators, and a more uniform and comprehensive system of policing (Roach, 1978:121).

[3] A summons could be brought against a deserting father. If he were found, an ‘order in bastardy’ required him to pay ‘half-a-crown’ weekly for support of the infant. According to Acton theses juridical remedies were unwieldy, expensive and rarely successful (Acton, 1972 1857]:275).

economic condition of the rural poor had been overtaken by problem of the physical and moral condition of the multitudinous urban poor.

The moral and physical condition of the population

While social and political commentary in the early century were preoccupied with the management of poverty, British medical literature began to document the correlation between sickness and disability, and work in the ‘dangerous trades’. For example, Manchester physician, J.P. Kay-Shuttleworth published the second edition of *The Moral and Physical Condition of the Working Classes Employed in the Cotton Manufacture* in 1932, and Leeds physician C. T. Thackrah published *The Effects of Arts, Trades, and Professions on Health and Longevity* (Porter, 1999:410, 401). This focus subtly contrasted with the medical focus in European that directly linked patterns of disease to economic circumstance. In the 1820s the French physician Villermé (1782-1863) subjected data from a massive demographic study of Paris, undertaken by the Hygiene Department of the Royal Academy of Medicine in Paris and completed in 1821, to a rigorous statistical analysis that showed that the in the *arrondissements* of Paris morbidity and mortality rates consistently correlated with income (Porter, 1999:407)[4]. Similarly, Belgian statistician Adolph Quetelet (1796-1872) showed that rates of fertility and death, stature, weight and strength, drunkenness, crime and insanity were linked to economic circumstance (Porter, 1999:406)[5].

In 1838, a non-medical man, Edwin Chadwick conducted a special survey of East London that revealed for the first time the shockingly filthy living conditions of the urban population. In 1939 a similar survey was commenced throughout regional towns. Chadwick’s Report on the *Sanitary Conditions of the Labouring Population* was published in 1842. The report charted the prevalence of disease and poverty through maps and descriptions of streets, dwellings, schools, refuse, ‘privies’, sewers, drainage and odours (Porter, 1999:410). Chadwick’s inquiry produced a shocking image of squalid housing, overcrowding, disease and deprivation in the festering

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[4] In *Recherches statistiques sur la ville de Paris (*Statistical researches on the city of Paris)

localities of the poor[6]. Chadwick recommended complete reform of the drainage and sewer systems, improved housing and the extension of powers of the Poor Law medical officers. In 1843 he also reported on the appalling conditions in the overburdened graveyards (Watson, 1969:48). In 1844 the *Royal Commission into the Health of Towns* acknowledged the need for public management of the environmental conditions of the towns.

> ...it is only when the public health is made a matter of public care by a responsible public agency, that what is understood can be expected to be generally and effectively applied to public protection.' Thomas Southwood Smith (1844) (Roach, 1978:146).

Like the earlier problem of poverty, the problem of health required an orchestrated social intervention in the name of public protection.

The Royal Commission established the first Board of Health and appointed Chadwick its head. Their followed a raft of legislation aimed at securing a sanitary public environment. For example, the *Nuisance Removal Act*, *Common Lodging House Act* and the *Adulteration of Food Act* were passed in 1846 and 1847, followed by the *Public Health Act* in 1848 that established the first, albeit modest, central Board of Health (Roach, 1978:148). Limitations were imposed on the industrial uses of children, child vaccination for smallpox was made compulsory, sanitary facilities were required in factories, and restrictions were made on the sale of poisons.

By the mid century, opposition toward the expanding public health reforms mounted. Conflict was especially heated over a plan to reform the lucrative sewerage and water supply industry that serviced London. The reform proposals were ultimately discredited when the second cholera outbreak in London in 1848 that killed 50,000 people (Porter, 1999:412). The *Metropolitan Water Supply Act* of 1852 left responsibility for water provision to the existing patchwork of supply companies. In

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[5] In *Sur l'homme et le développement de ses facultés, essai d'une phyisque sociale* (On man and the development of his faculties: an essay on social physics)

1854 the abandonment of the Board of Health and Chadwick's enforced retirement coincided with a third bout of cholera (Watson, 1969:92). Ironically, it was during this epidemic that Dr. John Snow famously demonstrated the connection between contaminated water supply and cholera by linking apparently random cases to the use of a water-pump into which raw sewage leaked (Magnusson, 1990:1367).

The opposition to the public health reform of mid-century was voiced in terms of the principles of liberty and freedom of the common man and the essential economic role of independent entrepreneurialism. It was argued, that unlike the interventions in the early century that had sought to expose the population to the forces of economy, the imposition of public health reforms represented a reversion to a style of excessive government protection that impeded the invisible hands of the economy. Disease was regarded, following Malthus, as a 'natural force' of the population. As the achievement of health was yet to be recognised in the economic equation, sanitary reform in the mid-century, unlike poverty reform earlier, failed to engender crucial support.

Sanitary rights

Following the demise of Chadwick's Board of Health Dr. John Simon was appointed Britain's first Chief Medical Officer under a newly created Medical Department of the Privy Council. Simon was a staunch advocate of health reform that followed a clear sanitary logic and his appointment marks the establishment of medical control over the problem of public health. Simon published the results of a series of influential investigations into sanitary health, and successfully introduced legislation that gave local authorities wider powers to tackle various 'nuisances', provide clean water and regulate tenements (Porter, 1999:414) [7]. In accordance with the positions that were honed in the conflict over Chadwick's reform program, however, Simon saw that the absolute propriety of sanitary reform was nevertheless properly limited to the public

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[6] Frederick Engels wrote *The Condition of Working Classes in England* at this time although it was not published in England until 1892 (Engels, 1969[1844]).

[7] This spate of legislation included the *Medical Act* of 1858 which brought control over the qualifications required to practice medicine and surgery under the auspices of the General Medical Council (Willis, 1989[1983]:38).

realm. This stance accorded with the relationship between public and individual liberty expressed in John Stuart Mill's essay *On Liberty* published in 1859. Mills argued that each member of the populace had a responsibility to ensure that a basic level of communal wellbeing was achieved. Society was bound by strict obligations to provide the 'essentials of human well-being' and we were obliged to join together

> …in making safe….. the very groundwork of our existence'
> (Mill cited in (Honderich, 1995:569)

In this framework, public health reform could be considered a social responsibility properly honoured by industrialists and citizens alike. The strict social obligations, however, were tempered.

> The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. …His own good, either physically or morally, is not sufficient warrant. (Honderich, 1995:569).

The philosophical delineation of pubic responsibility and private choice resonated with the emerging philanthropic movement, represented by women's groups who organised visits into the homes of the poor in order to encourage moral reform. Similarly, Simon saw that a great deal could be achieved if the people were positively motivated, rather than forced, to adhere to sanitary requirements.

> The community will first learn, and then demand, their right to protection from preventable disease and death. (John Simon (1869) Royal Commission on Sanitary Laws cited in (Roach, 1978:201).

In terms of sanitary reform, Simon saw that the incitement of a right to health within the population would dissolve the philosophical constraint imposed by Mill's principle of liberty. The constellation of rights that were to pertain in medicine in the late nineteenth century, however, were not drawn from the liberal philosophical pronouncements, but from medical rationales that coalesced around the management of contagious disease.

Moral philanthropy

In the mid-century the recruitment of troops for the Crimean War showed an alarming prevalence of venereal disease. In 1865 the Secretary of State for War and the Board of Admiralty appointed a Committee to report on the best means of protecting the army and navy from 'the ravages occasioned by venereal disease'. The *Contagious Diseases Act* passed through the legislature in 1866 (Acton, 1972 [1857]:v)
The legislation specified ports and garrison towns in which women suspected of prostitution would be compulsorily examined, treated and detained for up to three months. Subsequent acts extended these powers to include regular inspection of all known prostitutes in designated areas (Porter, 1999:421).

Opposition to the legislation was extreme, typically mounted by religiously motivated philanthropic women's groups. It was argued that the legislative regulation of prostitution represented a state sanction of immoral behaviour. Furthermore, it diminished the sense of personal responsibility for moral evil, abrogating the mutual responsibility that existed between all members of society (Roach, 1978:177). Medical voices were equally askance. For example, John Simon opposed the legislative regulation of prostitution on the grounds that venereal disease was not '*prima facie'* a matter for government concern. He thought that regulation would provide the 'civil fornicant' with state protection for his 'commerce with prostitutes'. He argued that

> ….hospitals for prostitutes (are) elements in a machinery proposed to be constituted by law for giving artificial security to promiscuous fornication (per Simon, The 11th Report of the Medical Officer of the Privy Council cited in Acton [1870] 1972:20)

Simon argued that the operation of the *Contagious Diseases Act* in the garrison towns showed that hospital treatment merely provided a sanctuary for prostitutes who were too severely diseased to work. He observed that such women travelled to the designated areas to avail themselves of free assistance, but as soon as the severest symptoms subsided, they returned to their trade. For Simon and the anti-regulation lobby, prostitution was evidence of the profound moral intractability of indigent women. Provision of practical relief, in the form of hospital accommodation and treatment for venereal disease, merely encourage further 'indulgence and fornication' (Acton, [1870] 1972:207). Misguided attempts to control immoral commerce would merely exacerbate and entrench the burgeoning health problem.

In contrast, the London surgeon William Acton, argued that prostitution and venereal disease should be understood as a product of the social (dis)order, not as phenomena outside the social realm. Acton accused the moral philanthropists of characterising the prostitute as a 'fallen' woman who inexorably descended into the vortex of permanent degradation, whereas the statistical evidence proffered an opposite truth. While the police record in 1857, listed nine thousand known prostitutes, the recorded number of illegitimate children suggested that the 'true' number of common prostitutes in England exceeded two hundred thousand. This figure was amplified by the 'inestimable' the number of clandestine prostitutes whose professional activities were hidden or disguised. These numbers indicated that prostitution should not be considered as anomalous, but as part of the normal life of many women. The 'great mass of prostitutes', were 'in the course of time', absorbed into the 'so-called respectable classes' and took their place as mothers and wives.

> . ……in proportion as they are assisted or neglected during their evil days will they assume the character of wives and mothers with a greater or less degree of unsoundness in their bodies and pollution in their minds (Acton, [1870] 1972:xi).

The failure to regulate venereal disease would contribute to an inexorable decline in the health and morality of the population. Acton argued that women resorted to prostitution through economic necessity. He believed the altered laws over seduction and bastardy in the *Poor Law Act* of 1938 had left seduced women with little choice but to earn a living as best they could. Prostitution and venereal disease were not matters of personal moral destiny, but the effect of ill-considered social regulation.

Prostitution and venereal disease, therefore, should be made subject to practical control through an investigation into their ‘true’ nature.

> We must take its measure, probe its depths, and accurately experience and understand its nature. ……. we must discard euphemisms and call it by its true name, we must prescribe the methods of treatment, appoint its limits and subject it to rule.
> (Acton, [1870] 1972:207)

Acton argued that philanthropic insistence upon an assumption of a paramount freedom that was equally accorded to all members of society placed entire sectors of the population as beyond reason and beyond intervention. The philanthropic effort to ‘rescue’ the victims of ‘accidental sin’ only tinkered at the edges of a deep social morass. For Acton, the problem of venereal disease and prostitution, understood as embedded in the social system, should be confronted instead as a social reality. Philanthropists, he argued ….

> Wilfully imagine…that the unfortunates relieved by charity were mere waifs and strays of society (instead of being integral parts of wide-spread system), poor stragglers who have fallen into a ditch, and been bruised and soiled in their fall, whom it is sufficient to extricate if possible, leaving the ditch untouched, in the hope, perhaps, that it will in it may be cleansed by some accidental stream of purity, or choked up… by its own fifth; whereas those saved ones are mere units out of thousands who have fallen into a deep and wide-spreading morass, which claims fresh victims yearly, and yearly encroaches on the honest soil around, who may for a brief space struggle to regain their footing when first made alive to the horror of their position, but who unseen, or unpitied and uncared for by the passers-by, soon cease to struggle, and,

> helpless and hopeless, fall little by little, till they finally sink overwhelmed in the black depths of the treacherous swamp. To what good general end do we rescue a few of those poor sufferers from time to time as chance may favour, leaving multitudes to perish, and, worst and most fatal folly, leaving the morass untouched, to extend as it pleases and engulf all it can. To leave an open stinking ditch unclosed is bad enough- to leave the morass untouched is fatal (Acton, [1870] 1972:221.

Acton's powerful imagery of the social realm as a stinking miasmic morass gave impetus to his criticism of liberal philosophy. To place prostitution outside the realm of social reason was to argue

> not for liberty, but for wanton licence, not freedom, but (for) lawless indulgence (Acton, [1870] 1972:221)

While Acton acknowledged that principle of liberty was the 'core of civilisation', and that English liberty included the 'right to sin', he argued that there were already in existence numerous laws that placed the public good above the principle of liberty. This suggested that the principle of liberty has been accorded a stricter interpretation and allowed that the liberty of any person who commits him or herself to a course of action that represents a danger to the public health could be withdrawn.

> …a person's liberty and personal rights must in all cases be subservient to the public welfare (Acton, [1870] 1972:219) …
>
> .for the common good and for advantages obtainable by this means only, each member of the state must be content to be deprived of the power to do exactly as he pleases-that is, must surrender for the sake of social order a portion of his freedom. (Acton, [1870] 1972:221)

Acton argued that the principle of the common good, coupled with need to implement a raft of multiple and indirect interventions that were simultaneously directed toward the 'regulation', 'amelioration' and 'prevention' of prostitution, sanctioned the legislation regulation of prostitution and venereal disease.

Despite the force of these arguments, the contagious disease legislation was withdraw a decade after its enactment, political victory being claimed by the philanthropists. Nevertheless, Acton's model of rational control and its accompanying recognition that disease is a social condition that is essentially linked to poverty came to dominate medical practice in the last decades of the nineteenth century. In 1872, prior to the repeal of the *Contagious Diseases Acts* the Poor Law and Public Health administrations were amalgamated, collapsing disease and poverty into one administrative category. This was followed by a consolidation and codification of all sanitary legislation, resulting in the passage of the *Public Health Act* of 1875[8]. The amalgamation of the poor law and health administrations resulted in a period of mechanical and ineffectual governance and eventually the resignation of Dr. Simon (Roach, 1978:159). During this period, however, 'poor law' medical officers were granted increasing powers to remove sick persons from their homes and to destroy property in the name of sanitary expediency (Hardy, 1990). Acton's insistence that in matters of health the public good must take precedence over individual liberty held sway. That the for the most part the practical effect of this philosophical shift fell on the poor, no doubt enhanced its political acceptability.

Conclusion

By the close of the nineteenth century, therefore, several crucial developments in the management of population had appeared. While, the insertion of health into the equation of population, economy and national security had forged the gradual acceptance of sanitary reform, the emerging medical claim to an expertise in contagious disease within the population, had shifted the perceived relationship between these three phenomena. Not only was disease inexorably linked to poverty, it

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[8] Cumpston has identified the British *Public Health Act* (1875) as the initiating the first significant legislative reform in public health in Australia (Cumpston, 1958).

was construed as a social phenomena, to be managed by social interventions. The management of disease was crucial because it impinged upon the strength of population, and therefore the strength of the nation, through heredity.

The linking of health and disease with security encouraged the bourgeoning influence of medicine and an acceptance that in matters of health, the liberty of the individual was properly subordinate to ‘the greater good’. As medicine emerged into the twentieth century, therefore, it carried its own internally generated philosophical rationales about the notion of liberty. Coupled with the medical claim to scientific expertise, questions of rights and liberties in relation to health were necessarily construed as matters of medical discretion. At the turn of the century in Britain, and in Australia where British developments were followed closely, any questions that remained about the nature of individual rights in the medical management of the population were effectively dissolved.

Chapter 3:The right to motherhood

> In whatever way the waning birth rate in New South Wales is viewed, whether in its effect on the health, character, or social worth of individuals; on the value of the family as the basis of national life; on the quality and dignity of civic life; on the character of the people; on their social, moral, and economic progress; on their national aims and aspirations; or on their capacity to survive in the rivalry of nations; and whether it is viewed in the light of history or of science, it is seen as a grave disorder sapping the vitals of a new people, dispelling its hopes, blighting its prospects and threatening its continuance. (The Royal Commission into the Decline of the Birth Rate in New South Wales, 1904).

Introduction

In Britain, despite the growing recognition of the importance of poverty, an overriding medical concern with heredity and racial deterioration ushered in the twentieth century (Rose, 1985). For example, the problem of physical deterioration was emphasised in White's *Efficiency and Empire* published in 1901(White, 1901). In 1903, a *Special Report to Parliament* by the Inspector General of Recruiting warned the government that the degraded physical state of the population, observed during recruitment for the Crimean War, was a direct threat to national security (Gilbert, 1977:152). In 1904, the Interdepartmental Committee on Physical Deterioration reported that the widespread physical weakness amongst the working classes was caused by poverty, malnutrition and disease, and was exacerbated by dirt, neglect and ignorance. In these reports the qualities of moral, physical and social degradation were consistently conflated. The inexorable connection between the three was further compounded by the view that deficits, whether moral or physical, could be acquired or inherited, and that acquired characteristics could become hereditary. The central concern with heredity, however, meant that solutions to the problem of racial degeneration were posed in terms of the reproductive capacity of the population, primarily the reproductive capacity of women.

It was observed that adults who came to reproductive age already damaged by environmental squalor or hereditary burden produced inferior children. Sanitary conditions were still important, but the central focus of medical effort shifted to the conditions of reproduction. Providing for the health of children and the health of mothers became a vital concern. In Britain, this shift correlated with a medical acceptance of birth control as a strategic intervention in the dynamics of population and the establishment of the right to ‘procreative information’. In the final decades of the nineteenth century, secular social reformers argued that the conditions of abject poverty amongst the lower classes could be ameliorated by the provision of birth control information. In opposition, philanthropic groups argued that the practice of contraception would merely conceal immoral behaviour. In 1886 Charles Bradlaugh and Annie Bessant were prosecuted for the distribution of an ‘indecent’ publication, the pamphlet *The Fruits of Philosophy*[1]. Their conviction in 1887 was subsequently quashed on appeal, opening the way for wider accessibility in Britain to procreative information (Magnussan, 1990). In medical terms, birth control offered the opportunity to enhance the reproductive capacity of ‘fit’ mothers, while the reproduction of the ‘degenerate’ could be minimised. In Australia, however, parallel concerns with the dynamic of population as the key to national security manifested in a different way because, at the turn of century, the quest for national security was seen as fundamentally dependent upon the numerical strength of the population.

The contraceptive debate in Australia

Toward the close of the nineteenth century, in Australia public lectures were held, and pamphlets distributed, that advised upon the use of contraceptives. Following the British example, however, William Collins was prosecuted in 1888 under the provisions of the *Obscene and Indecent Publications Act (NSW)* for selling Annie Bessant’s pamphlet the *Law of Population*. The Full Court of the Supreme Court of

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[1] *The Fruits of Philosophy* was written in American by Dr. Charles Knowlton in 1832 and was widely distributed by neo-Malthusian groups in Britain.

New South Wales decided that birth control literature should not be regarded as obscene[2]. The comments of the court were so celebrated by supporters of the birth control movement that passages from Justice Windeyer's judgment were published internationally. Following the judgment, demand for contraceptive information remained strong. For example, the Syme Family republished *The Fruits of Philosophy* the three times during the 1890s. As in Britain, secular reformists supported the provision of contraceptive information as a tool for the alleviation of poverty through the restriction of childbearing.

Also prominent was the argument that focussed on the rights of unwanted children. Mrs Bettina Smyth of Melbourne argued in *The Limitation of Offspring* that the provision of contraceptive appliances was necessary to prevent the hundreds of deaths of unwanted infants each year. She claimed these infants were either murdered, or abandoned to a slow death in foundling homes (Seidlecky, 1990:17)[3]. Australian medicine, however, did not embrace contraceptive practice. Instead they exhorted Australian women to attend to their 'duty to society'. For example, in 1897 the president of the New South Wales Branch of the British Medical Association urged women to

> ….recognise that the law of her physical life shaped her destiny and dictated without compromise her physiological duties (quoted in Seidlecky,1990:16).

The concern with the popularity of contraceptive practices was amplified by statistical analysis. In 1900, an essay published by the government statistician of New South Wales, entitled *Childbirth in New South Wales: a study in statistics,* warned that the project of population expansion was failing (Deacon, 1985:34) [4]. Minimal immigration, coupled with a fall in 'natural increase' had resulted in a numerical decline in population that seriously impacted upon the stability and prosperity of the nation. Coghlan attributed the population decline to the general trend amongst women to 'avoid' their biological function, exemplified by the 'common practice' of

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[2] *Ex-parte Colliers*, Law Reports NSW, Vol 1X (1888) per Windeyer J, Stephen J, with Darley J. in dissent.

[3] Smyth openly sold imported contraceptive devices and provided contraceptive advice and information.

taking precautions against the birth of children. While he conceded that these practices were an acceptable feature of social conditions in the ‘old country’, their extension to the ‘new country’, where population was so much desired, was unacceptable (Seidlecky,1990:14). Australian women were endangering the project of national security by deliberately restricting childbearing.

In 1901 the New South Wales Government revised the *Obscene and Indecent Publication Act* in an effort to limit the availability of contraceptive information in that State and in 1902 the New South Wales Supreme Court modified its liberal stance on ‘indecent publications’[5]. Medical criticism of women’s behaviour also became pointed. For example an editorial in the *Australian Medical Gazette* argued that

> …for some reason or reasons, women of today decline the responsibility for maternity and resort largely to artificial preventives against conception, and if conception does occur they resort to abortionists to get rid of their burdens (Editorial, 1903:521).

The intensity of public discussion prompted the government of New South Wales to appoint a Royal Commission to investigate 'the causes of the decline of the birth-rate in New South Wales and the effects of the restriction of child bearing on the well-being of the community’.

The 1904 Royal Commission

The Royal Commission primarily based its findings on statistical evidence and medical opinion. Population statistics in New South Wales showed that there had been a 30% decline in the birth rate over the last 15 years. While this figure was contributed to by factors such as the postponement of marriage, a decline in fecundity,

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[4] Mr. T Coghlan was the government statistician for New South Wales held from 1886 to 1905.

[5] *Patter v Smith* (State Reports NSW Vol. 11 (1902)) failed to attract the public attention accorded to *Ex-parte Collins*

a cessation of fertility at an early age, and a decline of fertility at all ages these were not the primary cause of the decline (Mackellar, 1904:6). Similarly, the age and constitution of the population, the age and constitution of women of conceptive age, the marriage rate, the physiological tendencies toward lessened fertility, birthplace of husbands and wives, and 'all other natural causes' were deemed to have little statistical relevance (Mackellar, 1904 10-12). A statistical comparison between Australia and New Zealand also showed that the falling birth rate in Australia was independent of economic decline. As all 'possibly relevant' had been excluded, the Commission accepted the statistical evidence as proof that fertility was 'a force over which individuals themselves have control' (Mackellar, 1904 #450:14). They identified the 'deliberate prevention of conception' and the 'deliberate destruction of embryonic life' as the 'immediate' causes of fertility decline (Mackellar, 1904:15). As these matters fell within the medical realm, the Commission called forward medical witnesses.

Contemporary medical opinion regarded 'interference with the reproductive capacity' as profoundly debilitating. The female body was thought to be incapable of healthy function in the absence of pregnancy and childbirth, and a delay in procreative function was linked to temporary or permanent disability of the reproductive organs and 'pathological sterility' (Mackellar, 1904:17) [6]. Medical opinion also linked the prevention of conception with insanity in women. Failure to reproduce was thought to have deleterious effects upon the nervous system, leading to mental instability, nervous disease, hysteria, neurasthenia and insanity. The deliberate destruction of embryonic life also carried an extreme legacy. Doctors attributed the marked increase in pathological gynaecological conditions, and the 50% increase in the maternal mortality between 1890-1902 to the 'common' practice of embryonic destruction[7].

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[6] Pathological sterility was thought to result from congestion of the circulation, uterine disease, destruction of the organs of generation, or septic inflammation of the womb and its extension to other organs.

[7] The Royal Commission rejected evidence from one medical witness who suggested that the reproductive capacity of the population was being destroyed by 'meddlesome, bad gynaecology' (at p98). It is significant that the 1904 Royal Commission was conducted towards the end of a period in which the 'midwifery' share of obstetric work, estimated at 'well over half the confinements' in the 1880s, was already well in decline (Willis, 1989[1983]:98). Never the less, at the time of the commission, the death of women in and following childbirth was attributed to the 'deliberate and unnatural' practice of women attempting to obtain relief from 'unwelcome encumbrance' by resorting to a 'degrading crimes' such as induced miscarriage or infanticide. It was assumed that women that women were assisted in these 'crimes' by 'midwives'. An alternate explanation, that medical

In addition to investigating the decline in the birth rate, the Commission was also invited to conduct a general investigation into the 'mortality of infants, whether and to what extent infant mortality was preventable, whether it was increasing, and the nature of its relationship to the prosperity of the state' (Mackellar, 1904:3). The Commission listed the multiple causes of infant mortality as the problems of premature birth, defective care, the ill health of mothers, lack of maternal knowledge, bad food, bad milk, a lack of hospitals, epidemic disease and summer diarrhoea. These problems were most acute in 'defective homes'. The principal problem, however, was the practice of secret adoption, the separation of infants from mothers, and infanticide. The rising infant mortality rate, therefore, was essentially another manifestation of the desire to 'interfere with procreation'.

Not only did interference with procreation effect the individual health and sanity of women, it degraded the mental and moral conditions of the population, and endangered the social fabric. Practices of interference resulted in a loss of self-respect, a loss of respect for one's spouse, a distinct degradation of the character, and a general lowering of the moral standard of the people (Mackellar, 1904:21). Families with insufficient numbers of children produced individuals who were morally, intellectually and physically less well equipped for 'the struggle of life'. Small families diminished the quality of the population by disabling the capacity of the family to forge morally capable citizens (Mackellar, 1904:28). In contrast, the effect of large families was to stimulate a 'conscientious regard for duty and to promote good citizenship'.

Population decline was also a serious threatened national security. With only a small population, Australia was thought vulnerable to invasion from surrounding nations. Russia and Japan were 'seeking outlets, beyond their own borders, for the energies of their ever growing people' (Mackellar, 1904:53). In the face of this danger, the

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attendance at births was responsible for a rise in puerperal infection resulting in both an increase in deaths and in progressive gynaecological complications, was beyond the reach of medical or statistical knowledge at the time of the inquiry. Similarly, the possibility that unrecognised venereal disease was a cause of gynaecological disease in the general community was absent from the medical commentary.

estimated loss of 940,000 people, in New South Wales alone, from 'interference with procreation' made Australia vulnerable to invasion (Mackellar, 1904:53) [8].

The right to motherhood

Having established that interference with procreation was a threat to the health, sanity and life of women and infants, a burden on the social fabric and a peril to the security of the nation, the Commission considered a range of strategic interventions it would stem the practices of contraception, induced miscarriage, and infanticide and child disposal. To limit access to contraception, the Commission recommended that the sale and distribution of all contraceptive devices be banned, and contraceptive information deemed 'immoral and obscene'[9]. The general provision of abortifacient pharmacopoeia was to be restricted by transferring the distribution of these to medical control. This recommendation was aimed at restricting their use by 'druggists and hawkers', thus rendering inert the multiple remedies and treatments for 'nervous disability in women' that were considered veiled advertisement for abortifacient drugs. In order to limit the occurrence of induced miscarriage, 'private' hospitals were to be placed under medical supervision and midwives, as both the assumed practitioners of various techniques for interfering with procreation, and the complicit participants in the practice of infanticide, were to be subject to regulation, training and medical supervision. Midwives would also be required to record the outcomes of their attendance on women in a 'still birth register', as well as the Registry of Birth and Deaths, so that these administrative tools could be utilised in the 'prevention and detection of crime' (Mackellar, 1904:49). To improve maternal health the Commission advocated improvements in the general care of women in childbirth, including increased public hospital accommodation, increased care and accommodation for women with venereal disease, compulsory notification of

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[8]. Similar warnings were voiced in America. 'Among human beings, as among all other living creatures, if the best specimens do not, and the poorer specimens do, propagate, the type [race] will go down. If Americans of the old stock lead lives of celibate selfishness… or if the married are afflicted by that base fear of living which, whether for the sake of themselves or their children, forbids them to have more than one or two children, disaster awaits the nation' (President Roosevelt, 1903).

[9] In relation to information legislative change was thought unnecessary because these items could be listed under the provisions of the *Obscene and Indecent Publications Act (NSW)*, automatically enabling their exclusion under the provisions of the *Customs Act*.

puerperal fever, and improved ‘instruction of mothers’. The purpose of these strategies was to bring pregnant women more firmly within medical supervision.

The medical supervision of women was necessary because of the trend toward ‘maternal indifference’. The Commission found that many Australian women exhibited an inappropriate love of luxury and social pleasures. This was an expression of the ‘decadent state of society’, equally evident in France, England and the United States, that encouraged a ‘perversion of human nature’ that drove women to seek reproductive limitation. Women were increasingly unwilling to ‘submit to the strain and worry of parenthood’, actively eschewed ‘any interference with pleasure and comfort’, and pursued their desire to ‘avoid the physical discomfort of gestation, parturition and lactation’ (Mackellar, 1904:8). Medical witnesses to the Commission reported that at least 50 % of their female patients made open inquiries about availability of contraceptive and abortive products with ‘no sense of shame or wrongdoing’ and that the topic of contraception was a ‘common subject of conversation amongst gatherings of women of all classes’ and ‘freely discussed’ within groups of women of mixed marital status (Mackellar, 1904:8). Women who openly sought medical assistance in these matters exhibited a misplaced attitude toward their social responsibilities. As the Medical Gazette echoed at the time of the Commission’s report.

> Barrenness is a disgrace and a sign of weakness, the glory of motherhood must be emphasized and the woman who enters the married state with the deliberate intention of having no children, who seeks gratification of the sexual passions without the responsibility of motherhood, should be regarded as no better than a mistress or a prostitute. (*Australian Medical Gazette,* Editorial, 1904).

The Commission thought that women’s claim to political suffrage were merely a ruse to disguise their decadent preferences. Instead of pursuing civic participation, the Commission urged women who claimed a place in the political life of the nation to express that ‘precious freedom’ by producing children. This was because

> …the effort of the race towards its increase in numbers is in inverse ratio to the effort of the individual towards personal development (Mackellar, 1904:9)

Motherhood was the only fully moral form of female behaviour, and it was through motherhood that the vitality of the population, and the strength of nation could be secured. Women's civic attention should be refocussed upon the right of honest mothers, struggling to maintain the life health and of their infants, to safe conditions for childbirth and motherhood.

Conclusion

Royal Commission of 1904 affirmed a unique relationship between medicine and government in Australia that would be maintained through the following decades. On matters of population, medical expertise would be consulted and medical views would form the basis of government programs. In the instance of population decline, the link between the prosperity and the security of the nation, and the 'vitality' of the population, through the reproductive capacity of women, dictated that the moral condition of women became the primary object of medical deliberation, and the moral tutelage of mothers an important strategy of practical medical intervention[10]. One effect of this nexus was to bring the practice of midwives further beneath medical supervision, and to further entrench the expansion of medical supervision in obstetrics. The vision of universal medical supervision of women opened the possibility of medical identification and differentiation amongst them. 'Honest' mothers could not only expect the best of medical assistance, but could claim a medically sanctioned right against the community to provide safe conditions for pregnancy and motherhood. 'Demimondes' would also be subject to medical supervision, not as a matter of right, but in the name of the 'common good'. Medicine could nuance its approach at the level of doctor patient interaction in accordance with the moral presentation of women. It is significant that shift toward the imposition of medical supervision over women's reproductive capacity was iterated in terms of the contemporary discourse in rights. In the medical dialogue, the

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[10] This conclusion is consistent with Willis' analysis of medical dominance, but emphasises an explanatory dimension beyond mere medical rapaciousness (see Willis, 1989[1983]).

contemporary quest for women’s suffrage was represented as a distortion of freedom. True freedom, and true participation in the political life of the nation, lay in motherhood. Women’s rights were properly pursued and properly granted, only in the context of (medically supervised) motherhood.

In the first decade of the twentieth century in Australia, questions of individual liberty in the medical encounter were irrelevant to the medical equation. That pronouncement of rights that appeared in the medical discourse was not generated from an instance of individual experience, but reflected the medical engagement with the question of population. In the light of a campaign for women’s suffrage, medicine had adopted the language of rights in order to promote the ‘rightfulness’ of a medico-administrative program that sought, not only to limit reproductive constraint, but also to harness the aspirations of women to the project of national prosperity through population growth.

Chapter 4: The right to liberty

The price of liberty is 'good behaviour'.
(Rosenau, 1935 in Leavitt, 1996:638).

Introduction

While Australian medicine had begun to imagine invocation of a ‘right to motherhood’ as a useful tool in the promotion of population growth, the question of rights in American medicine took a different turn. The contrasting international developments in the early twentieth century reflected a crucial divergence in the medical understanding of the communication of disease. In America, as in Europe, laboratory identification of the possibility of the ‘healthy carrier’ oriented medical research and practice toward the recognition of the carrier phenomena. Research in America that was informed by the carrier principle confirmed that healthy carriers were crucially implicated in the communication of disease. In Britain the phenomenon of the carrier was consistently deemed less relevant to the production of disease than sanitary problems, and in Australia the significance of the carrier was not fully embraced until after the commencement of the First War. The elaboration of rights that accompanied the medical management of the carrier in America in the early twentieth century, however, significantly influenced the way in which questions of rights were subsequently addressed throughout western medicine.

The communication of disease

Since antiquity, explanations for the conundrum of erratic disease communicability have been sought. In the mid-nineteenth century it was understood that disease as carried by 'viscous miasmas' emanating from the stinks and vapours of urban squalor. As the efficacy of sanitary measures consolidated, and the idea of spontaneous generation was challenged by the experience of cholera, objects and insects became implicated in the transport of disease. The common fly was transformed from 'household friend' to

> …winged sponge, speeding hither and thither, to carry out the foul behest of contagion (*The Lancet* 1871, cited in Hardy, 1993:184)[1].

Disease was also thought to impregnate household articles and the structures of squalid homes. This justified in the 1870s the greater use of 'poor laws' to compulsorily remove sick persons to poor law hospitals, in order burn personal possessions, lime wash, 'fumigate' or destroy homes (Hardy, 1993:203).

At the same time as these developments took place, the emerging science of bacteriology offered a different perspective. In 1878, Louise Pasteur (1822-96) argued the case for a 'germ theory of infection' before the French Academy of Medicine (Porter, 1999:433). In 1879, his contemporary in Germany, Robert Koch (1843-1910), presented a paper on aetiology of infectious diseases. Koch's theory, that a specific microorganism could be identified as the cause of each specific disease, was confirmed by the subsequent identification of several major disease causing microorganisms (Porter, 1999:436) [2]. Despite these discoveries, the 'germ theory of disease' was met with incredulity and ridicule[3]. It seemed to provide only further mystification, rather than explication, of the erratic occurrence of disease. The infamous failure of Koch's 'cure' for

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[1] See Rogers (1989) for the American story of the transformation of the fly from household friend to household enemy from 1890-1920.

[2] Koch's pupil George Gaffky isolated the typhoid bacillus in1881 (Gay, 1918:119). (Porter puts this date as 1884. (Porter, 1999:442). The tuberculum bacillus was isolated in 1882 and cholera in 1883(Porter, 1999:437).

[3] Porter reports the incidence of a German hygienist who obtained cholera vibrios from Koch and drank them in order to disprove his theory (Porter, 1999:437).

tuberculosis in 1890 further dampened medical and popular enthusiasm for the ‘miracles’ of science (Porter, 1999:441)[4].

Nevertheless, the early successes of bacteriology spurred the medical effort toward unravelling the conundrum of human resistance and immunity to disease[5]. In 1881 Sternberg demonstrated the presence of microorganisms in his own saliva. This startling observation suggested the presence of ‘germs’ in healthy persons. This seriously challenged the assumption that the non-sick were ‘safe’, and that only the obviously sick were infectious or contagious. Koch formally voiced the possibility of a ‘carrier state’ in 1893 by suggesting that persons recovering from cholera continued to be a source of infection. In 1884 Friedrich Loeffler (1852-1915) recognised the same phenomenon in diphtheria (Leavitt, 1996:264). In 1887, Von Dungern reported that typhoid bacilli had been found to persist in the body of one patient for fourteen and a half years after recovery. The implications of this observation were dire. Far from

> …the patient ceasing to be a danger after his restoration to seeming health, he may carry about in himself the seeds of infection for months or even years (Dungern, 1887 cited in Corfield, 1902:140).

In Britain, where the significance of the carrier was largely rejected, these observations encouraged the medical emphasis away from heredity, and toward the necessity of sanitary control and the alleviation of poverty[6]. In Australia, the new ideas received little attention[7]. In America, the European research gave a specific direction to the medical effort to overcome the persistent problems of diphtheria and typhoid.

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[4] A number of deaths followed Koch’s attempted to inoculate against tuberculosis with the substance tuberculin. Tuberculin subsequently became useful as a diagnostic tool.

[5] Edward Jenner (1749-1823) vaccinated against smallpox, using cowpox, in 1796. Pasteur successfully inoculated cows with anthrax in 1881, and people with rabies in 1885.

[6] cf Rose 1985 on the demise of eugenics in Britain.

[7] The general reluctance to accept new theories in Australian medicine is illustrated by the medical vilification of Dr. John Thompson who pre-empted Koch’s work on the germ theory

Diphtheria in America

During the last decade of the nineteenth century, European bacteriologists had shown that fresh or dried body secretions, together with the clothes and bedding of diphtheria sufferers, were infective[8]. Infective bacillus had also been identified in the throats of apparently healthy persons. This had lead to attempts to differentiate between virulent and non-virulent forms of diphtheria bacillus and other microorganism of the throat that were associated with diphtheria and pseudo-diphtheria illness.[9] Similar investigations were also underway in America. In a significant expansion of laboratory based medical research, the Board of Health in New York City introduced a system of systematic bacteriological examination of diphtheria patients in 1893[10]. The purpose of this program was to enable an accurate diagnostic differentiation between diphtheria and pseudo-diphtheria in order that the health department resources would not be wasted on the unnecessary and expensive hospitalisation, convalescent and disinfection of persons suffering from of non-virulent forms of diphtheria. Prevention of the spread of disease was an important, but secondary, object of the program (Park &Beebe, 1977(1895):2).

Analysis of this data enabled the four significant sources of diphtheria infection to be identified as ‘pseudo-membrane’, the exudate or discharge from diphtheria patients, the secretions of the nose and throat of convalescent cases in which virulent diphtheria is present, and the throats of healthy individuals who acquired the bacilli from being in contact with virulent germs on their

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and failure of doctors at the Royal Melbourne Hospital to recognise Lister’s seminal work on asepsis of 1867, until the first decade of the twentieth century (Pensabene, 1982).

[8] Bacteriological confirmation of the infectivity of personal articles, therefore, provided a moment of reconciliation between the sanitationists and the advocates of ‘germ theory’.

[9] Significant papers were published by Van Hoffmann, Loeffler, Echerich, Beck and Koplick among others (Park & Beebe, 1977(1895))

[10] The Health Department of the City of New York had determined in 1892 to depend solely on bacteriological examination for the diagnosis of Asiatic Cholera (Park & Beebe, 1977(1895):2)

persons or clothing of others (Park & Beebe, 1977(1895):39) [11]. The New York research also confirmed that bacilli sometimes lived in the throats of children for days and weeks before they become sick with disease[12]. Diphtheria was clearly transmitted by 'healthy carriers'.

> We must conclude that virulent diphtheria bacillus are to be found in the throats of a small proportion of healthy persons throughout the city and that they have been derived directly from diphtheria cases or from those who have been in contact with them (Park & Beebe, 1977(1895):42).

It followed, therefore, that the disease was not the automatic sequelae of infection.

> The majority of persons, and even perhaps the majority of children, were not ordinarily susceptible to diphtheria, and that in addition to receiving the germs of the disease into the respiratory passages they must be in a condition favourable for the development of the disease (Park & Beebe, 1977(1895):51).

The understanding that people who were about to become sick were infectious, and the recognition that people who would never become sick might carry dangerously infectious substances within their throats, was disturbing. These observations overturned the traditional reliance on a distinction between the sick and the well. In same cases they completely reversed the prevailing understanding of disease transmission. For example, in American households struck with diphtheria, it was usual for healthy children, particularly babies, to be removed from the sickening household. The New York study suggested that this ostensibly protective practice was in fact responsible for the spread of the disease to the homes that received the healthy children into care[13]. The full

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[11] This included cases 'where bedding or clothing was undoubtedly the source of infection', and cited a European case of a healthy nurse who infected children coming into her care was cited (Park & Beebe, 1977(1895):39,49).

[12] In one hospital epidemic, seven cases were caused by one unaffected child who was found to have virulent bacilli present in the throat (Park & Beebe, 1977(1895):39).

[13] Altered practices in disease containment, such as the imposition of isolation on the family unit, might be construed as an additional factor in the formation of the modern family (see Donzelot 1979).

implications of the phenomenon of the carrier, however, were revealed in the American experience of typhoid fever.

Typhoid fever

The suggestion that typhoid fever might be a 'carried' disease appeared around the turn of the century. In 1888 in America, Hunner reported that

> In one case the (typhoid) bacilli were found in pure culture in the inflamed gall bladder three months, in another eight months and in a third after an interval of seven years (Hunner, 1888 in Corfield, 1902:140).

In Europe, Levi and Kayser reported the presence of bacilli in the gallbladder at the autopsy of a 49-year-old woman whose death was nine years after recovery from typhoid (Park, 1977 (1908):981). It was also observed that a small percentage of persons recovering from typhoid fever continued to pass typhoid bacillus in their urine, even though the attack was several years before (Porter, 1999:487). The immediate impact of these reports was to close a line of speculation that sought to reconcile sanitary logic with germ theory by the suggestion that typhoid outbreaks occurred when unhygienic conditions acted upon normal micro-organisms in the bowel, turning them into typhoid bacilli (Park, 1977 (1908):981). In 1902, the importance of the carrier was confirmed by the publication of noted paper by Koch (Gay, 1918).

In Britain Dr P. Horton-Smith in the Goulstonian Lectures of 1900 drew attention to the significance of the carrier. In the Milroy Lectures of 1902, however, Dr. W.H. Corfield comprehensively rejected the significance accorded to the carrier in the European and American literature. As the significant decline of the disease in England proved, continued sanitary vigilance, especially in relation to the provision of a safe and plentiful water supply, was most essential (Corfield, 1902:155) [14].

In Europe research into the carrier state continued. In 1902, Drigalski and Conradi found that between one and two percent of typhoid convalescents continued to pass typhoid bacilli for long period after recovery. In a study of 400 typhoid patients, six were found to have retained bacilli for three to thirteen months. In 1904-5, Kayser followed the course of an epidemic in Strassburg and found that 13.5% of all the typhoid cases could be traced to six typhoid carriers, all of whom gave histories of typhoid fever from one to twenty seven years before. In 1905, Lentz identified fifty-nine cases of typhoid caused by ten different typhoid carriers in whom manifest typhoid disease had been experienced between three years and forty-two years previously. More astonishing were the results of the bacteriological examination of groups of healthy people. Drigalski and Conradi found typhoid bacilli in the stools of four persons who had never experienced typhoid symptoms, and had no contact with typhoid patients. Klinger examined the stools of 1700 healthy persons who had never knowingly had typhoid and found bacilli in eleven (Park, 1977 (1908):982). In 1905 in America, the first 'healthy' typhoid carrier was identified. The events that followed this discovery published show the profound impact of the new knowledge.

Typhoid Mary[15]

Despite the provision of a clean water supply in the major American cities, 'residual' typhoid remained a problem into the early twentieth century. By 1900, a total of 35,000 deaths across America had been attributed to typhoid fever. The standard response to localised epidemics was for public health

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[14] Different sanitary problems were pertinent to the pollution of shallow wells, deep wells, springs, streams, rivers, and mains water. Pollution in the water supply resulted in infected milk, and infected oysters and shellfish. Instances of typhoid outbreaks related to food consumption were also attributed to water supply problems.

[15] George Soper offered this 'case study' at the Biological Society of Washington in 1907. The famous name 'Typhoid Mary' was coined in the discussion that followed the presentation (Soper, 1977(1907).

officials to investigate the outbreak, identify the cause or causes, and order the rectification of any environmental or sanitary problems (Leavitt, 1996)[16].

In 1906, Dr. George Soper, a senior public health investigator, was asked to re-examine the conditions of a localised outbreak of typhoid because no satisfactory explanation had been supplied by previous assessments (Soper, 1977 [1907]) [17]. After a detailed investigation, Soper concluded that the source of the infection in the Oyster Bay household was the obviously healthy, cook who had been recently employed (Soper, 1977[1907]:20). To attribute a typhoid outbreak to a 'healthy carrier' was unprecedented in America. Soper claimed that his earlier experience with typhoid epidemics and his acquaintance with the current European literature suggested to him the possibility of the role of the healthy carrier in instigating localised typhoid epidemics (Soper, 1977[1919]:14) [18]. Once Soper had formulated the view that the cook was the source of the infection, and had infected household members through the handling of food, he wished to confirm his suspicions by checking the cook's personal account. When Mary Mallon was found, however, she refused to speak to Soper. In the absence of voluntarily provided information, Soper pieced together an account of Mallon's movements over the previous ten years. He found that during her intermittent employment as a cook in a series of respectable homes, an outbreak of typhoid had invariable occurred shortly after her employment. Soper attributed ten outbreaks of typhoid, including fifty-one cases and one death, directly to Mallon (Soper, 1977[1919]:13).

Once Soper had gathered this damning information he approached the New York City Department of Health to request the authorisation of Mallon's arrest.

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[16] This was also standard practice in England and Wales. See for example the Reports to the Local Government Board 1869-1908.

[17] Soper had been employed as an expert by the State of New York in 1903 to handle an epidemic of 1300 cases at Ithica, and by the city of Watertown, New York to fight an epidemic of 600 cases in 1904.

[18] Soper was familiar with Koch's address to the Kaiser Wilhelm's Akademie (November 28, 1902), Koch's account of his investigation of the prevalence of typhoid in Trier (1903) and the work of Conradi and Drigalski (1902). Soper was apparently unaware of the identification of specific carriers by Kayser and Klinger (1903), but familiar with Hunner(1888), and Parks work on the role of the carrier in relation to the spread of diptheria (1895).

He requested that Mallon be detained as ‘a menace to the public health’. Health department rules at the time authorised the detention of persons who were ‘sick with disease’, but not the detention of healthy persons. The phrase ‘a menace to the public health’ usually referred to poor sanitary conditions (Leavitt, 1996:73). It had never previously been construed as a statement that could be made about healthy individuals (Soper, 977(1907):22)[19]. Despite the uncertainty of legislative authority, Soper was authorised to bring Mary into custody in order to perform a series of required bacteriological examinations. At Soper’s next attendance, Mallon refused to speak or to accompany him. At the third, she threatened Soper and a female colleague with a knife and fled. Discovered hiding in a neighbouring house, Mallon was forcibly removed and detained by the health authorities, against her will, for the next four years (Leavitt, 1996:30)[20].

In custody, Mallon was required to provide faeces and urine for regular examination and was forced to accept various dietary and ‘regulatory’ ‘treatments’. These regimes were experimental. The monitoring of Mallon’s condition showed that while the number of bacilli shed from her bowel fluctuated, they never completely disappeared. The data obtained from Mallon’s monitored detention showed that the carrier’s infectivity was an ever present but fluctuating danger (Park, 1977 [1908]:981). Unable to reject dietary modification, Mallon steadfastly refused to submit to the ‘recommended’ surgical removal of her gall bladder. She consistently rejected the medical assessment of her status. Supported by a sector of public opinion that questioned the city’s right to deprive her of her liberty, Mallon issued a writ of *habeas corpus* against the department (Leavitt, 1996:10) [21].

The Court was asked to consider whether the Health Department’s powers to compulsorily detain a person ‘sick with disease’ could validly be interpreted as

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[19] The phrase and was analogous to the concept of ‘nuisance’ in British and Australian public health legislation.
[20] Mary fought like '*..an angry lion..*’(Leavitt, 1996:30).

including persons who were healthy but had the capacity to cause disease. Mallon's lawyers argued that she was being deprived of her liberty without having committed a crime, and without knowingly injuring any person or property (Leavitt, 1996:78). Public health experts were not called on Mallon's behalf, and the bacteriological evidence relied on by the Department was not substantially challenged. The Court held that the Department had acted in the public's 'interest' by detaining Mary, and that the danger she posed was sufficiently great to warrant the deprivation of her liberty (Leavitt, 1996:79).

A principal factor in the court's assessment of Mallon's dangerousness was her refusal to co-operate with the medical authorities before, during and following her arrest (Leavitt, 1996:77). Soper testified that from the outset, Mallon had refused to 'speak reasonably' with him, had deliberately withheld information, had responded to reasonable requests to 'undergo tests' with 'indignant and pre-emptory denials' and had resisted arrest (Soper, 1977[1919]:4), (Soper, 1977[1907]:21). In custody, she had refused treatments, and had complied with testing regimes only grudgingly. Soper believed that Mallon's refusal to cooperate was evidence of a deliberate or reckless disregard for the well being of others, and that her serial employment constituted a flight from disease that she 'must have suspected' were linked with herself. In the eyes of the Court, Mallon's refusal to cooperate was accepted as her most damming and dangerous quality.

Despite court sanction, the policy of compulsory detention for carriers of typhoid did not receive universal medical support. While it was accepted that Mallon's detention was necessary in the circumstances, a more tempered approach was urged (Leavitt, 1996:30). A significant factor that prompted the effort to manage 'the carrier' in a different way was the recognition that as ranks of carriers inevitably increased the carrier effect would mount. Statistical estimates of the number of carriers in given populations began to appear in 1908 (Park, 1977 [1908]:982). European estimates placed the number of

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[21] Her involuntary detention was closely followed in the American press. H*abeas corpus* is a

typhoid sufferers who would become carriers between two and five percent and studies in America confirmed a similar incidence (Leavitt**,** 1996:48) [22]. As it was assumed that carriers were infective for life, the acceptance of even modest estimates represented, in the aggregate, a frightening health problem.

> As the majority of cases occur before the age of 30, the average life of typhoid carriers is fully 25 years. ...we have the ...appalling fact that there are at least half as many recovered typhoid cases who are typhoid carriers, as there are typhoid cases in any year (Park, 1977 (1908) :982).

The necessity to devise workable methods of control beyond incarceration prompted the health authorities to structure Mallon's conditional release. In 1910, she was permitted to leave custody on the condition that she reported periodically to the Department and that she did not cook or otherwise handle food[23]. She was found 'suitable' employment in a laundry, and contact with her gradually ceased. In 1914, the investigation of an outbreak of typhoid at the Sloane Hospital for Women traced the source of infection to the (disappeared) cook. This cook proved to be Mallon working under an assumed name. Further investigation implicated her in two cases of typhoid in a sanatorium in New Jersey in 1914, and in the illness of a friend with whom she was staying (Soper, 1977[1919]:11). Mallon was forcibly re-arrested and detained until her death in 1938.

The public health response

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writ that orders the court to ascertain whether or not a detention is lawful.

[22] In one insane asylum in 1907 the department examined the stools of 52 typhoid sufferers. Two were found to have persistent bacilli eight months after recovery, and of these one continued to shed bacilli on three subsequent tests. In the Long Island Asylum in 1907, of sixteen sufferers two were found to have a constant presence of bacilli sixth months after recovery. In a general study also in1907 a 'large number' of convalescents showed persistent bacillus suggesting a carrier rate of 5%. (Park, 1977 (1908):981).

[23] In 1910 the idea of the criminally motivated carrier provided the basis of a popular crime detection novel entitled *The Silent Bullet* (Leavitt, 1996:146).

Following Mallon's re-arrest, the danger of the carrier was reiterated in terms of Mallon's strangely perverted personality. Although a relatively modest total of 52 typhoid cases and one fatality were directly attributable to Mallon. Soper postulated it likely that

> …the total number of outbreaks for which she is responsible is much larger than this record indicates. It would surprise no one to learn that she produced some extensive epidemics. (Soper, 1977(1919) :13).

Soper perceived Mallon as a strangely flawed creature. He considered her to be an unusually intelligent woman because

> …she writes an excellent hand and the composition of her letters leaves little room for criticism. (Soper, 1977[1919]:12).

But she was 'unwomanly' in 'her walk and her mind', and both had 'a distinctly masculine character' (per Soper in Leavitt, 1996:97). Her obvious intelligence made it clear she was capable of understanding the instruction she had received. Her refusal to adhere to hygienic routines and regimes, therefore, displayed a pointed 'disregard for the life of others', a 'disregard for her own liberty', and a 'deliberate, wilful audacity' (Soper, 1977[1919]:12).

> That she took chances both with the lives of other people and with her own prospect of liberty and that she did this deliberately and in a hospital where the risk of detection and severe punishment were particularly great, argues a mental attitude which is difficult to explain (Soper, 1977[1919]:12).

The true point of danger was not her infective status, but the recklessness of her actions. Mallon was not unwitting.

> She knew that when she cooked she killed people yet she deliberately sought employment as a cook in a hospital. Whatever rights she once possessed as the innocent victim of an infective condition…were now lost (Soper, 1977[1919]:13)

Mallon’s persistent rejection of authority, her ‘obstinate’ failure to comply with the ‘conditions of her parole’, her willingness to ‘deliberately (take) desperate chances with human life’ mean that she was a woman who ‘could not claim innocence’ (Soper, 1977[1919]:13). She was a dangerous character and must be treated accordingly (Soper, 1977[1919]:13).

The emphasis on Mallon’s flawed character was counterpoised with the image of the ‘normal’ or ‘reasonable’ carrier who would be granted liberty provided they demonstrated a responsible attitude.

> A person of intelligence who is a carrier of typhoid bacilli, but who is willing to observe strictly certain essential precautions, may live and mingle with others and still need not be a source of danger to those around him. (New York State Health Authority (1920) in Leavitt, 1996:53-4.)

When informed of their condition, carriers of normal demeanour would accept appropriate limitations. Conscious of the risk they posed to others, the responsible carrier would modify their personal habits, avoid food handling and accept the limitation of home arrest or self-detention (Leavitt, 1996:113).

Carriers could remain in their homes as long as there were ‘adequate facilities’. In effect the department required the provision of a second toilet that could be allocated for the use of the carrier [24]. The privilege of home detention, therefore, tended to unavailable to the poor. Home detention was also considered only suitable in for carriers whose families were ‘intelligent and willing to carry out the rules of the department of health’ (Leavitt, 1996:55).

Whether in home detention, in other accommodation of in detention carriers would be

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[24]. This strategy of home detention was formalised in New York health regulations in 1915 (Leavitt, 1996:54).

> … taught to wash their hands frequently, always after leaving the toilet and always before handling food. They must never handle the food of others and they must try to give up the senseless habit of shaking hands (Soper, 1977[1919]:15).

When in informed of their carrier status, most persons, unlike the strangely perverted Mallon, would 'care for themselves in such a way that will they not be a menace to the public.' (New York State Health Authority (1919) cited in (Leavitt, 1996:54-5). Carriers could be effectively managed in the community provided the sphere of supervision was bounded by strict rules. Typhoid carriers were barred from food handling and for 'extreme cases' the option of compulsory detention continued to be exercised (Park, 1977 (1908):982). Given the formal legal deliberations that accompanied Mallon's detention, educational strategies had a function beyond the mere protection of the public. Carriers who were provided with detailed knowledge about both the danger they posed and how that danger could be minimized, could not claim, as Mallon had done, an exemption from coercive strategies on the basis of 'innocence'. Knowledge invested carriers with a legal responsibility that bound them within the dimensions of a multifaceted public health program and removed their claim to unconditional liberty. Paradoxically, personal knowledge also provided an opportunity for carriers to 'manage' the level of medical scrutiny to which they were subject. The medical gaze could be met, and its intrusive aspects avoided, with evidence of appropriate, responsible and 'intelligent' behaviour. In the figure of the responsible carrier, compliance and resistance merged together. However, as enteric diseases such as typhoid, remained linked to patterns of poverty and disadvantage, some carriers were less able to meet the medical gaze with the appropriate deference. These persons were more likely to breach the conditions of their liberty, and were more likely to be subject to coercive supervision.

The development of public health policy in America at this time, therefore, was built directly in response to the perceived dangers of non-compliance, and inscribed conditions of liberty for the known carrier. The efficacy of this strategy of management, however, was determined by the ability of public health authorities to positively identify ‘carriers’. Only know carriers could be inducted into the proposed program of education and graded restriction, and released into the community on conditions that were specific to the circumstance of each. The second point of emphasis in the emerging public health program was an extended effort to estimate the number of carriers within the population, and the formalisation of strategies by which hidden carriers could be identified.

In accordance with this effort, health departments produced statistical estimations of carrier populations across America. Dr. Milton J. Rosenau, the Director of the National Hygiene Laboratory, estimated that from the total of 350,000 cases of typhoid recorded each year, 9,000 new carriers would be added to the national carrier population annually (Rosenau,1935:137-38). Based on his reading of the European data, Dr. Charles Chapin, the Director of Health of Rhode Island, worked with a carrier rate of three percent to estimate that in 1910 alone, the 200,000 new cases of typhoid nationally, yielded 6,000 carriers. (Chapin, 1910:110). The various State health department statisticians also calculated their carrier populations. In New York in 1908, 3,058 new cases of typhoid fever translated into an estimate of 200 new carriers, with the addition of 100 each year from 1909-1911 (Overlander, 1914). In 1915, an editorial of the *American Journal of Public Health* reported that the addition of 100 carriers annually meant that ‘2,000 typhoid carriers were at large in New York City’ (Editorial, 1915:313). The State of California estimated that between 1913 and 1919, 272 new carriers were added each year to the ‘existing thousands’ (Beck & Hallister, 1962:14). The State of New Jersey agreed with Rosenau’s estimate of 9,000 new carriers nation wide each year (Blanchard, 1924 in Leavitt, 1996:49-50).

The statistical estimations were alarming. The ranks of carriers, already numerous in the population, were swelled by each years additional crop. Even more alarming was the recognition that precious few of these were positively identified. While the health officials in New Jersey estimated the population of carriers at 9,000 nationally, they knew of only twenty-six. (Blanchard,1924). In California, only sixteen of the 'existing thousands' had been traced (Beck & Hallister, 1962:15). In 1910, health officials in Washington DC estimated 1,568 carriers for every 100,000 people. Nine carriers were officially recorded (Leavitt, 1996:251).

The urgent need to devise strategies that would begin to identify the vast pool of hidden carriers prompted a range of approaches. Compulsory laboratory screening of all typhoid convalescents became routine and the examination of the stools and urine of all food handlers was encouraged. The testing of food handlers was widely adopted and its efficacy further confirmed during the First War (Ireland, 1919)[25]. The most effective formal strategy, yielding 75% of registered carriers in New York between 1911 and 1932, and 94% in California between 1910 and 1919, was the shift in investigative from the detection sanitary deficits, to the identification of the typhoid carrier (Leavitt, 1996 :272). Specifically listed for examination were the women of the household, particularly married women who had born children. European studies, confirmed by the American experience of Mary Mallon, suggested this 'type' were possessed of 'peculiarly robust immunity' and were most likely to be carriers (Park, 1977 (1908):982).

> The stools should be examined in all those who prepare food or the family. This included all women over 40; any grandmothers or mothers-in-law whether or not they lived in the house; and all giving a history of typhoid fever (New York State Health Authority cited in Leavitt, 1996:99)

Whether a member of the family or an employee, it was assumed that a woman's inevitable role as personal or family nurse meant that she was more likely to have come in contact with infection. Her parallel role as food preparer meant that she was peculiarly placed to pass infection amongst the family (Leavitt, 1996 :97).

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[25] Testing of food handling was made compulsory in New York in 1923 (Leavitt, 1996:251) Paradoxically, the screening of convalescents identified few cases.

While these strategies immediately improved the official carrier figures, the effort to identify carriers was necessarily limited by the availability of laboratories and practical difficulties of bacteriological science, but also by the availability of resources and personnel (Park,1977 [1908])[26]. It was seen that the effort to detect hidden carriers might be effectively expanded by encouraging members of the community, especially those with a history of typhoid disease, to voluntarily present themselves for examination. To this end, free typhoid blood tests were provided to any who requested them (Leavitt, 1996:266).

There was a further problem. The more effective identification of carriers immediately challenged the assumption that ordinary carriers would automatically comply with health regimes. Between 1910-1919 in California, 50% of the identified carriers did not co-operate with the health authorities. In the 1920s this figure had increased to 58%. With large number s of noncompliant carriers at large, the public needed to be enlisted in their own protection.

The responsible citizen

The constant presence of both unwitting and non-compliant carriers necessitated the development of concerted community vigilance against the invisible threat.

> We know that in every community ...unsuspected typhoid bacilli carriers may always be present (Park, 1977 [1908]:982).

The phenomena of the carrier meant that disease could not be kept way by the traditional strategies of avoiding the ‘sick bed’, avoiding diseased locations or observing social distinctions.

> The dirty man hanging on the car strap may be a typhoid carrier, or it may be that the fashionably dressed woman who used it just before was infected with some loathsome disease (Chapin, 1918:21)

Each citizen could, however, adopt a responsible stance in his or her own sphere (Park, 1977 [1908]: 982). While supplies of food and water should be publicly safeguarded ‘at all times’, personal vigilance was to be exercised over individual consumption.

> We should be careful to avoid eating uncooked food which has come into contact with the hand of person whose history is not known to us and who may have contaminated the food immediately before our getting it (Soper, 1977[1919]: 15).

Personal vigilance could be expressed by seeking medical assistance. Persons were enjoined, not only to seek medical diagnosis and treatment, but also to avail themselves of innovative medical strategies in order to ensure the safety of others.

> If we are carriers, our families should be inoculated against the particular strain of typhoid germ which infects us and special precautions should be exercised against the transmission of bacilli in the household (Soper, 1977[1919]:15).

People who had never experienced typhoid like disease were also encouraged to seek medical diagnosis.

> Probably at least one in every 500 adults who have never knowingly had typhoid fever is a typhoid bacilli carrier. (Park, 1977 [1908]:982).

As it was impossible to exclude the possibility of association with carriers, people were encouraged to avoid disease by ‘turning the face from coughing or load talking’ (Cumming, 1932:60-61). As it was possible that oneself might be

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[26] In 1922 the Rockerfeller Institute for Medical Research was able to attribute 44% of all new cases of typhoid to individual carriers (Barbot, 1922).

carrier, all persons should adopt the habit of 'never putting fingers in the mouth' and of 'washing hands' (Cumming, 1932:60-61).

Middleclass women were doubly charged with the task of policing their own households through personal vigilance, through vigilance over servants, and through vigilance over methods of domestic sanitation (Stokes, 1917). They were particularly exhorted to protect their households from infection by ensuring that servants were hired only after a 'thorough inquiry into the health status and medical history', and only in circumstance where they could be made subject to proper supervision (Soper, 1915:5).

Conclusion

The designation of people, and not places, as 'menaces' to the public health marks a crucial point in the history of medicine. The recognition that healthy people were infective, either as they incubated impending disease, manifested disease, were recovering from disease, or were in a 'carrier' state, encapsulates the shift in emphasis from a filth theory of disease to one of individual causation. In America the control of the environment, including sanitation, the provision of clean water, the cleanliness of the streets, the provision of clean milk supplies, and waste and garbage disposal, was gradually transferred to the Department of Public Works (Leavitt, 1996:26). The medical focus in public health switched to the identification and management of people who 'carried' disease. The new medical concern with people and not places has been interpreted as the true start of medicine's journey toward humanitarianism, and ultimately the enlightened medical recognition of the rights of the patient. In other narratives, Mallon's story is seen as a moment in medical history where the embattled patient, forced to mount a personal and legal challenge to medical authority, extracted the introduction of more liberal medical regimes, and the recognition of patient rights through active resistance. Contemporary concerns about the public health (mis)management of people living with HIV and AIDS have found a poignant resonance in the story of her vilification.

The preceding account of the formation of pubic health strategies in the early twentieth century in America, however, counters both theses analyses. The discovery of Mary Mallon was closely followed by the recognition that carriers were numerous and distributed throughout the population. Incarceration was unwieldy, impractical, expensive and of uncertain legal validity. This dictated that alternate methods of control were urgently needed. The programs that followed were specifically tailored to address the series of legal and practical difficulties that arose in the instance of Mallon's detention, and it was the inadequacies of these that produced the medical campaign to nurture the individual personal vigilance of the responsible citizen.

The public health strategies that were devised at this time were based on specific assumption about the motivations and behaviour of the first carrier, Mary Mallon.

There are, however, a number of alternate explanations for Mallon's refusal to cooperate. It is unlikely that any persons other than members of the medical profession, who were familiar with the latest medical literature from Europe, were able to contemplate the phenomena of a healthy carrier. To Mallon the medical perspective would have been, not only counter intuitive, but absolutely unbelievable (Leavitt, 1996:176). Mallon claimed consistently and vehemently that she had never been sick with typhoid and could not be carrier of disease (Leavitt, 1996:78). As a member of one of the most marginalised groups in the City of New York it may be supposed that Mallon had many reasons to be apprehensive about scrutiny from authority. She was a poor, an Irish immigrant and a single woman (Leavitt, 1996:10). Her existence was frequently precarious. The Health Department was known to wield extensive punitive powers in relation to infectious disease, especially in the poorer areas of the city (Porter, 1999:424). The medical insistence on Mallon's intransigence was also misplaced because, when compared with similar women, Mallon's history reflects a common employment pattern. Her flight from the houses in question could be easily attributed to a desire to avoid the general disruption that inevitably followed an outbreak of typhoid. Alternately, her constant flight may have reflected a desire to avoid infection (Leavitt, 1996:178). Localised outbreaks of typhoid were extremely common. In 1907 4,426 new cases of typhoid were reported in New York City (Leavitt, 1996:50). Far from seeming that typhoid was following her, as suggested by Soper, it must have seemed to Mallon, and everyone in the city, that typhoid was a circling, unpredictable menace.

Nevertheless, the spectre of the carrier that crystallized in the early century rendered every citizen's 'natural' liberty conditional upon an adherence to the new rules of personal hygiene, and a compliance with whatever medical regimes were prescribed. The social basis of the incidence of disease, and the social basis of patient compliance was excluded from the medical vision. The imposition of legalistic, medico-administrative complex around typhoid, removed the carrier's right to claim an exemption, or absolute freedom, from intrusion by the state or its authorities. In the name of the public's protection, individual right was replaced with the 'right' to claim a limited and conditional liberty. At the level of the population a new and specific new kind of civic responsibility, that required a concerted compliance to the pubic health regimes and the adoption of personal vigilance, became the new marker of citizenship.

Chapter 5: The right to medical privacy

It is not a crime to suffer from venereal disease. The patient is a sick man, not a criminal (per Dr. Nash in Fiaschi, 1922:509).

Introduction

In the first decade of the twentieth century, while American public health was forming itself around the problem of the carrier, and British medicine remained fixed on the problem of racial deterioration, Australian medicine continued to be preoccupied with the reproductive capacity of population. The absence of gross urban squalor, the supposed restorative qualities of the Australian climate, and the belief that the degenerative decline of the indigenous people was inevitable and inexorable, maintained the medical focus on the quantum of population. In addition, the outbreaks of plague on the eastern seaboard reiterated the view that contagious disease in Australia was exogenous, and that the carrier phenomena was not relevant to Australian conditions. As the medical control over obstetric practice consolidated, however, it was observed that uncontrolled gynaecological disease, rather than 'interferences with procreation', was wrecking women's reproductive capacity.

The problem of venereal disease

The medical recognition of high levels of venereal disease amongst obstetric patients was mirrored by the discovery of unexpectedly high levels of venereal disease amongst Australian men who were recruited for the Boer Wars. In 1908, the *Australasian Medical Congress,* held in Melbourne, called upon both the State and Federal Governments to join with medicine in a concerted effort against the 'scourge' of venereal disease. The medical lobby urged governments throughout Australia to employ a uniform legislative approach to reduce the level of venereal disease in the community. Following this request, the New South Wales government passed the *Prisoner Detention Act (1909)* permitting the detention of prisoners with venereal disease 'for treatment' after their formal sentence was complete. Victoria commenced a trial of the compulsory notification of all cases of venereal disease in 1910. These meagre efforts reflected the States budgetary concerns and also a lingering disquiet, inherited from the nineteenth century, that government regulation, even in terms of medical prerogative, was acceptable when it was imposed upon criminalized segments of the population, but should never encroach directly on the activities of the free citizen.

At the Federation of Australia in 1901, the new Commonwealth Government had been granted constitutional power over quarantine in order to achieve a nationally coordinated maritime quarantine system. The need for effective quarantine reflecting the dominant opinion that contagious disease in Australia was primarily exogenous, and could be excluded by a vigilant and consistent quarantine practice. The recurrent outbreaks of plague on the eastern seaboard, between 1900 and 1907, pressed the urgency for uniform and coordinated maritime quarantine control (ref). In response to the crisis the Federal Parliament exercised its quarantine power, bringing into effect the *Quarantine Act (1908)* in July 1909. The *Act* created a centralised quarantine administration, headed by a Federal Director of Quarantine. From the outset, the scope of the quarantine power had sparked controversy between the States and the Commonwealth. Legislation that reflected the federal governments interpretation of the power immediately generated further conflict (Cumpston, 1978 (1927-28):20). While the *Quarantine Act* was clearly intended to address the problem of maritime quarantine, the State and Federal conflict was amplified in the light of the suggestion that its provisions might by usefully applied in the management of the national problem of venereal disease[1]. Medical concern about venereal disease was again highlighted during the Australasian Medical Congress held in 1911, at which the second Australian Director of Quarantine, Dr. J.H.L. Cumpston, presented paper entitled *A Special Report on Venereal Disease* (Cumpston, 1919:248). Cumpston argued that as venereal disease had become entrenched within the population and was disseminated throughout the community, the depth and urgency of the problem justified an expansion of the Federal quarantine role. Specifically, he saw the Federal Quarantine Office as being well placed to direct and coordinate, the regulatory activities of the States. In response to the call for a national approach to the management of venereal disease, the Medical Congress developed and formally adopted a list of core principles that should from the essential basis of any legislative attempt to control venereal disease. The principles included the requirement that all diagnosis of venereal disease be made notifiable, the requirement that the treatment all people with venereal disease were made subject to compulsory treatment, the requirement that the treatment of venereal disease be provided by a medical practitioners, the requirement that all public advertisements for the cure and remedy of venereal complaints be banned, and the requirement that all schemes included provided for the compulsory medical examination and treatment of prostitutes. Despite the apparent urgency of the venereal disease problem, only Queensland responded by immediately revising the *Health Act (Qld)* in line with these principles[2].

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[1] The controversy over the quarantine power was considerably heightened by the activities of the second Director of Quarantine, Dr. J.H.L.Cumpston. Cumpston was committed to progressive intellectual ideas of the early twentieth century, including scientific government. He was instrumental in forging a centralised health administration in Australia and saw the 'health of the people' as a fundamental responsibility of government. Cumpston continued as Director of Quarantine until 1945. For accounts of his personal influence and role in the conflict between State and Commonwealth health administrations see Roe, 1976 and Rosen, 1958.

[2] Queensland was the only Australian state that had enacted (and repealed) its own version of the *British Contagious Diseases Acts* in the late nineteenth century.

During this period, branches of the British Society for the Prevention of Venereal Disease had been established in most states, the National Council for Combating Venereal Disease was convened, and many other committees were active. Doctors were well represented in the public sector of the anti-venereal campaign. For example, the Victorian Branch of the British Medical Association nominated one third of the members to the Victorian Council of the Society for Fighting Venereal Disease. In 1914, the Australasian Medical Conference in Auckland again reiterated the need for uniform legislative approach and summoned support from the Australian Federal Government. In 1915, the Prime Minister 'invited' the Premiers of all states to pass legislation that provided for the compulsory notification of venereal disease. In this instance, only West Australia responded with new legislation. The obvious reluctance of the States to address the issue of venereal disease independently prompted the Commonwealth Government to appoint a committee to inquire into the *Causes of Death and Invalidity in Australia*[3]. The investigation found an alarming incidence of venereal disease amongst the community, amplifying the medical apprehension about the impact of the disease upon the health of the nation.

In order to encourage the States toward regulation, the government inquiry recommended that the Commonwealth provide financial assistance to the States in the form of a pound for pound subsidy, provided that acceptable schemes for venereal disease containment were introduced (Cumpston, 1978 [1927-28]:32). In order to be eligible for the innovative subsidy scheme, States were required to make notification of venereal disease compulsory and to establish procedures that could trace the source of infection. They were to provide facilities for microscopic examination and establish clinics that could provide 'modern treatments' free of charge, and they were to implement precautions against the spread of disease. Lectures and practical demonstrations for the diagnosis and treatment of venereal disease were to be provided to medical practitioners, and

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[3] The inquiry was conducted under the auspices of the Department of Trade and Customs because the Commonwealth Government believed itself limited under the scope of the

the medical schools of the University of Sydney and the University of Melbourne were to receive funds for teaching and research into the containment and treatment of venereal disease. The State facilities were also to be made available for inspection and use by Commonwealth Medical Officers. These requirements reflected the recommendations of the Medical Congress except that they did not require the imposition of compulsory treatment of venereal disease. The Federal Government thought the politically difficult issue of the imposition of compulsory treatment should remain a voluntary matter for the States.

Legislation that enabled the Commonwealth scheme to proceed was enacted in West Australia Victoria in December 1916, and in Tasmania and Queensland in February 1917. South Australia and New South Wales followed suit in 1919 (Editorial, 1919s:446). To compliment the State schemes, the Commonwealth Government passed legislation, under the quarantine power, that required medical inspection of all ships crews and immigrants, and imposed compulsory detention and treatment for those with venereal disease[4]. The *Medical Journal of Australia* applauded the legislative innovations.

> Legislation and the man in the street have awakened to the fact that public health is being undermined by widespread venereal infections (Editorial, 1919q:406).

Although there were a number of minor variations, each State adhered to the requirements of the Federal scheme. None imposed compulsory medical treatment upon members of the general population, save of the compulsory medical inspection and treatment of known prostitutes that formed the centrepiece of each State's system of disease control. Despite Cumpston's

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quarantine power.

[4] Under the quarantine power the health of immigrants was federal responsibility. The *Immigration Restriction Act (Cth),* enacted in 1919, deemed an immigrant suffering from venereal disease to be a 'prohibited immigrant'. They were not permitted to land except for medical treatment under the control of the Quarantine Service at quarantine stations in Fremantle, Port Adelaide, Sydney, or Brisbane (Cumpston, 1919c:248).

remonstration that venereal disease was embedded within the general population, the legislative control of venereal disease in Australia was premised on the assumption that venereal disease emanated from the population of feebleminded prostitutes. It was thought that the control of prostitutes would control venereal disease.

The feebleminded prostitute

The dominant medical opinion in Australia in the early century was that prostitutes were 'feebleminded defectives' (Editorial, 1919n:71). They were 'possessed of 'degenerate constitutions' that manifested in various mental and physical anomalies. Prostitutes were women with 'unusually strong' sexual urges, seduced women, or women with defective mentalities or subnormal mental powers. Whereas the former were marked by abnormal sexuality, the intellectual incapacity of the latter left them incapable of moral action. According to the *Medical Journal of Australia...*

> .with the exception of licentious women and betrayed girls, few girls with normal mentality become prostitutes (Editorial, 1919n:71).

The blighted morality or mental incapacity evidenced by prostitution was considered a sign of hereditary deficiency. Dr. Woolston reported from the American Bureau for Social Hygiene in 1917 that

> It was a well-known fact that feeblemindedness was hereditary. Consequently, some of the mental anomalies of prostitutes can be directly traced to weakness in the

> stock from which they come (quoted in (Ehrenreich, 1973 :61) [5]

Medical research into the mental incapacity of prostitutes confirmed this position. The *Medical Journal of Australia* featured an American study that claimed that 68% of women arrested for prostitution had a ‘mental age of ten years’ and were ‘uneducated or incapable of education’. Most had ‘low intellectual function’ and a ‘strongly marked sexuality’ (Editorial, 1919n:71). Male prostitutes were also thought to be predominantly ‘mentally deficient’, as well as violently dangerous (Editorial, 1919:71).

> …youths of low morals, ………perverts and homosexuals.. (are) a danger to each other and to society (Editorial, 1919s:446).

While many prostitutes were visibly marked by physical deformity, the undetected presence of hereditary defects could lie dormant until damaging environmental conditions exposed them. Degenerative processes in the environment such as

> insufficient wages, alcohol and treachery, bad homes, early sorrow, or a faithless love… could create a substratum in a previously normal mind’ (Editorial, 1919n:72).

In unfavourable circumstances, the hereditary defect could ‘turn’ an apparently normal mental and moral constitution. This argument served to exclude an alternate explanation, first offered by Acton in the late nineteenth century and gathering credence in Britain, that prostitution was an economic imperative forced upon destitute, but eminently rational, women (Acton,1857) .

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[5] The American Bureau for Social Hygiene was a private voluntary agency funded by John D Rockefeller.

The medical designation of prostitutes as deficient was critical to the acceptability of the new venereal disease legislations. The perception that ‘defectives’ were incapable of making moral decisions, and were therefore unable to respond to moral philanthropy or find individual salvation, dissolved the hesitation to impose regulation. Provided that the private sphere of the ordinary citizen was shielded from intrusions, restrictive impositions were accepted for the morally deficient sections of the population.

The medical designation of prostitutes as subnormal, feebleminded, morally incapacitated or childlike, excluded the figure of the prostitute from the normal rules of free citizenship. Medical treatment could be imposed upon them by virtue of their criminality, ‘for their own good’, or to protect others. What was needed was

> ….a modern scheme for the detection and permanent
> control of deficient individuals (Editorial, 1919n:72).

Applied through the mechanism of legislation, eugenic solutions to stamp out the degenerative but rampant reproductive force of the feebleminded prostitute were ‘not only desirable’, but ‘essential to the welfare of the race’ (Editorial, 1919n:72)[6]. The legislative control of venereal disease, however, generated a new medical knowledge about prostitution that fundamentally modified the medical perception of the feebleminded prostitute.

The knowing prostitute

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[6] Mary Cawte (1986) has noted that the Australian eugenics movement, while significant, was a paler version of its European counterpart. .

In 1919 the Commonwealth Director of Quarantine, Dr. Cumpston, reported on the progress of the new venereal diseases legislation. Amongst four participating states, 10,500 notifications of venereal disease had been received (Cumpston, 1919c). As this figure was far below expectations a number of explanations were mooted. First, the States were accused of exhibiting a serious 'lack of will' in relation to the control of venereal diseases (Cumpston, 1919c:248). The *Medical Journal of Australia* argued that

> Legislation on venereal disease will not be effective unless those responsible for the administration of the Act make full use of their power and unless governments are prepared to make provision for the full exercise of those powers. Grave doubts have been entertained from the first whether the authorities would be strong enough to apply the punitive clauses with sufficient rigour to compel people to obey the law (Editorial, 1919p:241)

The complete absence of prosecutions, in any State, for the illegal advertising of remedies and cures for venereal disease underscored this accusation. Most telling, however, was the claim by health administrations in each State that they had difficulties in compelling people to undergo treatment. Twelve Tasmanian patients and twenty-one patients in Queensland had failed to continue treatment. In West Australia, 285 patients had absconded. Most seriously, in Victoria 1,500 patients had failed to continue treatment. Of these only 887 had been traced by the health authorities. Similarly, few States had provided 'suitable accommodation' for the enforced detention of prostitutes who were found to have venereal disease (Cumpston, 1919c:248). In Queensland, where accommodation was made available, there had been 54 detentions of infected prostitutes. In Tasmania there had been two, and in Victoria only one (Booth, 1919:123).

While the lackadaisical administration of the legislation was significant, a critical factor in its apparent failure of the legislative measures was the refusal of prostitutes to cooperate. Medical practitioners working with the legislation reported difficulty in the clinical recognition of infection, particularly amongst prostitutes who were subject to compulsory medical inspection. In the light of this failure, doctors surmised that prostitutes were 'cheating' the examination by douching with local disinfectants to mask their symptoms (Cumpston, 1919c:249). This suspicion was confirmed, rather than challenged, by the publication in Australia of a study that identified venereal disease in only one third of prostitutes (Ehrenreich, 1973:61)[7]. The entrenched medical belief that the 'usual wash' would eliminate evidence of infection and enable the infected prostitutes to keep working, undetected and unhindered while she spread venereal disease, persisted in the medical literature (Editorial, 1922j:57). Confronted with the failure of medical surveillance to detect disease, it was assumed that prostitutes with venereal disease either absconded or avoided detection.

The legislative control of venereal disease had fundamentally altered the medical understanding of the character of the prostitute. Medicine now abandoned its image of the feebleminded prostitute and replaced it with a characterisation of the prostitute as a knowing, wily and consummately professional woman. The legislative control of venereal disease had failed because the legislation did not take account of the' true' nature of the prostitute. This new understanding of the prostitute suggested that the inadequacies of legislative control could be overcome by the inclusion of a 'knowing transmission' clause in the legislation. Such a provision would address the problem of deliberate evasion by allowing the lawful detention of prostitutes on the basis of information supplied from persons 'other than medical practitioners' (Cumpston, 1919c:248). Evidence that a prostitute knew she was infected with venereal disease and continued to engage in sexual activity could

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[7] From the American Bureau for Social Hygiene in 1919.

be obtained from the clients, colleagues, or associates. If the knowing transmission clause was supported by the legislative protection of all 'informants', prostitutes with disease would be effectively exposed (Cumpston, 1919c:248). In conjunction, a vigorous effort to prosecute 'quacks and chemists', who provided illegal treatment for venereal complaint, would also 'flush out' hidden disease. (Cumpston, 1919c:249). Once identified, diseased prostitutes could be forced to undergo treatment.

The clandestine girl

Despite the effort to exact an effective medical surveillance of prostitutes through the workings of legislation, the problem venereal disease remained. Having surmised an active deception on the part of known prostitutes, the medical observation that many women were curiously reluctant to seek medical treatment, drew medical opinion toward the conclusion that these women were also deliberately hiding disease. While it was allowed that the failure of women to seek medical treatment might be due to carelessness, the belief that a cure had occurred, a neglect of danger, shyness, inability to pay, or an inability to attend clinics during normal hours, female patients who failed to present for treatment were newly assumed to be women who were 'most likely' intent on disguising their 'clandestine prostitution'. Venereal disease was disseminated throughout the community, not by professional prostitutes, but by the covert activities of casually prostituted ordinary women.

The 'clandestine girl' was typically described as one of the many poorly paid young women who worked in menial, factory or domestic work throughout the cities. As the pay for single women was insufficient to live independently, meagre incomes could be supplemented by prostitution 'on the side' (Cumpston, 1919c:248). The supposition that clandestine prostitution was extremely common was given substance by research published in 1919 that estimated 50% of men in Victoria 'paid for sex' (Cumpston, 1919c:248). In the medical view, this figure indicated that a large segment of the female population were engaged in intermittent prostitution. The clandestine girl, disguised within the community as an ordinary 'working girl', could use her independent status, private lodgings and the guise of moral respectability to indulge in prostitution. As she did so, she spread venereal disease throughout the community[8].

Unlike her knowing professional sister, however, the problem of the clandestine girl was compounded by the fact that she was frequently unaware of her condition. Identification of a venereal condition in these women was often 'missed'.

> It is a well known (medical) fact that gonorrhoea is frequently overlooked in the female and in many cases infected women are unaware of the fact (Cumpston, 1919c :249).

Furthermore, while prostitutes could be forcibly detained

> Attacking the source of infection is more difficult when it resides in a woman who does not solely depend on prostitution for a living (Cumpston, 1919c:248).

The clandestine girl could not be detained, and could not directed to attend medical treatment. She was either ignorant of her condition or avoided medical attention in order to maintain the public image of an acceptable morality.

While clandestine prostitution was initially described as based in economic necessity, commentary from America specifically denied the theory of the economic basis of prostitution and reaffirmed the feeblemindedness of most common prostitutes. This reiteration of this idea operated in Australia to shift

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[8] The phrase 'a working girl' remains current as a euphemism for prostitution.

the emphasis from the clandestine prostitute to the generally promiscuous woman.

> …the prevalence of venereal disease is directly proportionate to sexual promiscuity in the community. The clandestine or amateur prostitute is filling the position previously occupied by her professional sister (Address to the Australian Association for the Advancement of Science in 1922, Morris, 1923:274).

In radical reversal of medical thought professional prostitutes were now allocated only a minor role in the venereal disease epidemic. New estimate suggested that only 25% of prostitutes were infected with venereal disease and that the practices of washing and douching actually protected men from infection, significantly reducing the incidence of infection from contact with ‘professional girls’ (Ellis, 1919:501). Coercive legislative provisions, aimed at prostitutes were no longer relevant to the containment of venereal disease. Instead, the central problem for the medical management of venereal disease was how clandestine prostitutes and promiscuous women could be effectively brought under medical control.

This problem was solved in the light of a new medical appreciation of the full extent of the crisis. Venereal disease not only caused obvious gynaecological disease, but also was wrecking the health and reproductive vitality of the population (Everitt Attkinson, 1922:65). By 1919, 80% of all medical operations for diseases of the uterus were attributed to gonorrhoea (Ellis, 1919:501), 34% of infant deaths at the end of pregnancy and in the two week puerperium were directly attributed to syphilis (Williams, 1923:481) and 20% of all cases of blindness was attributed to congenital gonorrhoea. These figures suggested that venereal disease could not comfortably be attributed to clandestine prostitution or promiscuity. Venereal disease had insinuated itself in the lives of ordinary and unsuspecting women. The medical detection of venereal disease amongst ordinary women could be easily achieved by merely inserting an additional medical vigilance into the existing management of pregnancy, childbirth, infant health and 'women's complaints'. The corollary of the medical recognition of venereal disease in ordinary women was the recognition of venereal disease in ordinary men.

Diseased men

The emphasis that venereal disease primarily impacted upon motherhood, and was the direct legacy of promiscuity, rather than prostitution, gave salience to the argument that men were the source of the disease, and should be the focus of campaigns to eradicate the venereal problem. Sectors of the anti-venereal disease lobby in Australia, argued stridently against the unrestrained immorality of men. Ms. Angela Booth, of the *Association to Combat Social Evil,* argued that it was the 'sexual energy of men', rather than 'the mentally deficient and lascivious girl', that was the greater part of the problem. She argued that men were 'unaccustomed to control and habituated to all kind of artificial stimuli' (Booth, 1919:123). For Ms Booth, the provoking cause of immoral activity, and the spread of venereal disease, was 'demand from the male'. She concluded that full time professional prostitutes should not be castigated because they protected ordinary vulnerable women from seduction and moral ruin by providing an outlet for male passions (Booth, 1919:123).

The focus upon male infectivity also became prominent in medical analyses. For example, Dr. Ellis argued that the most plausible explanation for the high levels of venereal disease and morbidity amongst women was the promiscuous activities of men. Infected men contaminated their unsuspecting wives. According to Ellis,

> 80% of all men in large cities have had gonorrhoea once or more, that 45% of these (men) infect their wives. (Ellis, 1919:501).

Doctors were also fearful that the return of infected servicemen from abroad would extend the circle of martial infection to rural areas.

The recognition that men were an important source of disease once again brought the limitations of the legislative scheme into sharp focus. It prompted the argument that a 'knowing transmission' clause, rendered irrelevant by the shifting interpretations of prostitution, might be usefully evoked to criminalize the irresponsible actions of men. Th*e Medical Journal of Australia* argued that criminalization was necessary because 'endangering ones wife and children is a heinous offence' (Editorial, 1922k:531). Making these men subject to harsh measures and enforced treatment would further reduce the problem because

> …a few prosecutions, strategically published in the press, would have a wholesome, deterrent effect on others (Editorial, 1922k:531).

In opposition to this strategy it was argued that the use of coercive legislative measures would merely exacerbate the problem of venereal disease by encouraging men to conceal their disease (Ellis, 1919:501). Although venereal disease was very difficult to cure, an apparent cure was very easily achieved. Punitive sanctions would encourage the use of 'unscientific' remedies, discourage reliance on medical advice and increase the likelihood that recommended treatments would be ceased too early. Rather than extend and enforce coercive strategies to ever increasing segments of the population, it was seen that the provision of medical facilities, coupled with the removal of all punitive sanctions, would be most effective in encouraging the majority of affected men to seek medical treatment (Ellis, 1919:501). It was argued that the system of medical treatment should offer sanctuary to the diseased man.

Support for the non-coercive management of venereal disease was reinforced by medical accounts of the control of venereal disease amongst Australian troops stationed abroad.

During the First war, venereal disease had accounted for a significant level of disability amongst the troops stationed in Europe and the Mediterranean. In Egypt, 5% of the Australian personnel were sufficiently debilitated with venereal disease to require enforced rest and intensive treatment, usually in the form of regular urethral irrigation. To reduce this burden, British and Australian Army Medical Corps had experimented with mechanical and chemical 'prophylactic' measures. Some medical reports claimed the new 'french letter' provided protection from disease, while other reports suggested that the device was a complete failure (Cumpston, 1919c:250). As the efficacy of the 'french letter' was gradually established, the high incidence of infection was attributed, not to the failure of the device, but to the inexperience and drunkenness of many young soldiers.

> Most of these soldiers were young men still in their teens. Most had no previous contact with venereal disease and had become infected on recreational visits to Cairo. Few of the men had used 'preventive measures' and 50% had been drunk (Swan, 1919:1).

In accordance with the established medical approach, initial attempts to prevent infection amongst solders had been directed at the prostitutes they visited. An Army decree that sought to detain all infected prostitutes in Cairo, did little to curb either the population of prostitutes or the incidence of disease amongst the troops. The Army then imposed penalties of detention and loss of pay upon soldiers who contracted venereal disease. The Medical Corps found, however, that this resulted in men failing to report infection or to seek appropriate treatment. Following this experience, the Army abandoned all punitive and directly coercive measures. In their place, camp lectures on the 'prevention of venereal disease' provided soldiers with information about the dangers of venereal disease and instruction on prophylactic measures. In addition, a range of 'alternate recreational activities' was provided to dissuade men from spending their leave in 'dangerous and immoral pursuits'. (Swan, 1919:1). The medical management of venereal disease for soldiers had alighted upon an innovative and effective strategy. The provision of accurate information and unconditional access to proper treatment combined to both limit the course of the disease and to prevent its spread. The army system of 'voluntary' disease prevention, however, was developed in a context where ultimate authority could be imposed without question. The possibilities and limitations of applying the 'voluntary' principles to the domestic problem, lay beneath the debate that emerged over the question of disease notification.

Compulsory notification

The legislative regulation of venereal disease adopted by the States in Australia enshrined the principle of compulsory notification as an essential adjunct to medical management. This position, however, differed from approaches adopted in other parts of the Commonwealth. For example, in Britain it was recommended that venereal disease clinics should be provided free of charge and should not be linked to an administrative framework of notification, on the basis that a voluntary system would encourage higher levels of attendance at medical clinics (Fiaschi, 1922:509)[9]. New Zealand adopted a similar model to Britain. In Australia, the validity of adopting compulsory notification was confirmed in an inquiry conducted by the Committee of Public Health in West Australia, and was reiterated at the Federal Health Conference of 1922. Evidence that notification was an effective strategy was produced by a statistical comparison between the British and Australian systems. This comparison showed that compulsory systems resulted in the treatment of 'twice as many infected persons' than voluntary systems (Editorial, 1922l:643).

Support for a system of compulsory notification was also forthcoming from doctors in New Zealand who were critical of the adoption of the British model. They cited an inquiry by the New Zealand Branch of the British Medical Association that concluded notification to be an 'essential strategy' for the control of 'all contagious diseases including venereal disease' (per Elliot in Morris, 1923:274). In New Zealand, doctors who worked in the venereal disease clinics argued that although their clinics were free, efficient and provided treatment unquestioningly, the majority of patients, 'especially women', did not proceed with treatment. These doctors favoured notification because they believed it exacted compliance. In their experience, patients were generally unable or unwilling to understand the necessity of proper medical treatment.

> It must be remembered that numbers of these patients were deficient in moral sense and no education nor facilities for treatment would appeal to them, thus rendering notification and following up essential (per Elliot in Morris, 1923:274.

In this view, patients were too inept to avail themselves of proper medical treatment. Coercive measures were necessary to redress the shortfall in good sense.

In contrast, doctors who supported a voluntary approach, and sought the removal of notification requirements in Australia, argued that a system of notification effectively criminalized disease and deterred people from seeking treatment. These doctors stressed that it was

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[9] As recommended in the final report of the *British Royal Commission on Venereal Disease* was published in February 1916.

> …..not a crime to suffer from venereal disease. The patient is a sick man, not a criminal (per Dr. Nash, in Fiaschi, 1922:509).

The advocates of a voluntary system attributed the apparent failure of the venereal disease legislation to the inclusion of the notification clauses arguing that patients avoided the system for fear of retribution.

In attempting to devise a system of venereal disease control that took account of the variable capacities and proclivities of the population, one solution seemed most plausible. If patients were assured of a private relationship with the medical practitioner, the public health imperatives could be accommodated at the same time as the patient's fears and anxieties were quelled. Most importantly, this change in emphasis would lead patients to embrace medical supervision.

> If the best treatment was given free, and no questions asked, the vast majority would proceed with treatment guided by their medical advisers (Morris, 1923:274).

As well as the legislative scheme struggling under the burden of patient non-compliance, it was argued that 'the majority' of medical practitioners were actively disregarding the provisions of the Venereal Disease Acts because they were equally unwilling to expose their patients to possible intrusion or criminal prosecution by government authorities (per Dr Bullock in Fiaschi, 1922:509. This suggested that the failure of the legislative scheme was not due to administrative torpor, but to the active refusal of doctors to accept government intrusion into what they deemed to be the private realm of the doctor-patient relationship. On the one hand, doctors claimed a right to non-interference on the basis of a sacrosanct duty owed to their patients. On the other, they argued it was only through that duty that their role in protecting the health of the population could be fulfilled. This issue was ultimately resolved by administering the requirement of compulsory notification in term of non-identifying information. In acknowledging the sanctity of the doctor-patient relationship, deference was accorded to both the patient's claim to a private realm, and the medical claim to professional independence.

Conclusion

The medical management of venereal disease in Australia shows remarkable parallels with the medical management of the population that arose in America around the phenomenon of the carrier. In the medical imagination, the figure of the feebleminded prostitute (corresponding with the ignorant carrier) was replaced by the knowing prostitute (corresponding with the wilfully dangerous carrier), and then by the image of clandestine girl (corresponding with recognition of the high incidence of hidden carriers). This image was superseded by the medical recognition that venereal disease, like typhoid (although in different ways and for different reasons), was embedded within the population. This recognition prompted the development of a system of medico-administration that worked to provide a comprehensive medical surveillance of the population at the same time as it sought to manage the inevitable resistance to medical intrusion.

In Australia, women who were already subject to medical control through child bearing and motherhood were automatically subject to medical vigilance against venereal disease. The privileging of the doctor patient relationship as a 'private' space was essential to encourage men to the medical encounter. That ultimately a 'voluntary' system of treatment prevailed and the requirement of notification was modified reflects, the construction of a medical strategy that was specifically designed to negate public and professional resistance to the medical supervision of the population, rather than a political recognition of the 'rights' of doctors and their patients. While the American experience had emphasised the need for independent personal vigilance, in Australia, the need for individual medical supervision was emphasised. By privileging the doctor paint relationship within a ‘voluntary system’ there was established, what proved to be, a highly flexible and variable device to be turned to the shifting demands of the enduring medical project of population.

In the nineteenth century in Australia, as in Britain, a pointed debate arose over government regulation of prostitution. Following the British example, the Queensland government had passed controversial contagious diseases legislation that sparked a fierce debate out the appropriate limits of government intrusion into the (im)moral lives of its citizens. As in Britain, the anti-regulation lobby thought that government regulation of prostitution represented an official sanction of immoral behaviour, negated the social benefits of philanthropic enterprise and abrogated the punishments of sin. Conversely, the recognition that prostitution reflected social conditions within an economic realm underpinned the argument for regulation. For example, in Melbourne *The Argus* attributed an obvious expansion in the numbers of common prostitutes from the mid century to the abandonment of respectable wives as husbands fled to the goldfields, and to the seduction of women on the long sea voyage from Britain (Acton, 1972 [1857]:300).

Chapter 6: A child’s right to health

> *Our greatest hope is the child….. Health begins at home, the rights of every child, ……to fresh air, good food, regular open-air exercise, decent recreation and thorough sleep, adequate weather protection, the means for habitual cleanliness and freedom from exposure to infection ……, is gradually filtering into the national consciousness (Sutton, 1923:256).*

Introduction

In parallel with the changed rationales of the medical campaign against venereal disease, the broader effort in Australia to assuage the ravages of the First World War gathered impetus around the medical reconstruction of the population. In an implicit rekindling of the medical concern with heredity and racial degeneration medical commentary decried the loss of ‘millions of men of splendid physique’ and the residual of ‘defectives and maimed men’ (Editorial, 1919f:11). The consequent diminution in the vigour of the population was seen as a direct threat to the economic future security of the nation, primarily because physical deficits were now seen as a problem for individual, rather than military strength.

> The threatening economic position demands that every man and women shall be capable of increased production, and that every child be kept in excellent health so that the next generation may be able to neutralise the damage of war (Editorial, 1919t:533).

The achievement of health was not only seen as necessary for the immediate economic prosperity of the nation, but also of the Commonwealth.

> Human health…. it determines the working efficiency and
> therefore the national wealth of the Commonwealth
> (Cumpston, 1978 (1927-28):42).

Most critically, the recognised nexus between health and poverty meant that economic prosperity would award health to subsequent generations.

Heredity and poverty

In Britain, in the early century the dominant principles of 'heredity' and 'poverty' were conjoined to form a medical focus upon the physical condition of children. British concern about the condition of children had commenced in the early nineteenth century in conjunction with the reform of the poor laws and the growth of industrialisation. In 1833 the Sadler Committee Inquiry documented the perilous conditions characteristic of the employment of children, emphasising the burden of fatigue (Roach, 1978:141). As the century progressed, restrictions were imposed over the hours and condition of the employment of children. The eventual introduction of compulsory 'education' on Sundays, however, was less concerned with the improvement of health, that with the need to nurture children toward the habits of independence and moral constraint and way from the 'habit' of industrial unrest (Roach, 1978:253). The escalating medical emphasis on heredity in the later decades of the nineteenth century brought the medical emphasis in relation to the health and wellbeing of children to the fore, albeit in a new context.

The eugenic logic that saw that saw in the theories of heredity the opportunity to improve the quality of the population through 'selective breeding' was dented as the implications of the statistical work of Francis Galton (1822-1911) gradually disseminated amongst the medical community. In trying to understand the relationship between the incidence of the exceptional and the persistence of the normal, Galton devised a 'theory of regression'[1]. From his multiple observations of inheritance over generations, he noted that that while people with exceptional characteristics, such as high intelligence or exceptional tallness, tended to have offspring with the same characteristics, there was an inevitable reversion toward mediocrity (Hacking, 1990:183). This science suggested not only that the medical belief in the ultimate demise of the degenerative sections of the population was unfounded, but also that an increase in exceptional qualities such as genius or exemplary morality could not be obtained through breeding. The effect of Galton's work was to focus medical attention upon the general condition of the people, rather than the extremes of health. Heredity, however, remained important. If children within the population could reach reproductive age in good health they would in turn, produce unblighted offspring.

In 1903 the *British Medical Journal* was dismayed to note that the 1901 census in England and Wales showed that there remained over two and a half million children, between the ages of ten and fourteen, in the workforce. The *Journal* believed that the poor conditions in which these children worked, lead to thwarted development. They warned that the inevitable production of degenerative adults would result in racial deterioration through damaged reproductive ability (Editorial, 1903:207). The link between poverty and heredity was also relevant for children outside the workforce. These concerns prompted the provision of meals to school children and the eventual passage in Britain of the *Education (Provision of Meals) Act* in 1906. In Britain it was increasingly accepted that the health of the population could be improved through the elaboration of a comprehensive 'welfare' strategy aimed at the alleviation of poverty. The belief that the effects of poverty should be the primary focus of programs brought with it a critical appraisal of the organization of medicine. Along with dissatisfaction about the standard of medical treatment, the rise of specialities and the loss of 'holism', the most

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[1] Galton published *Natural Inheritance* in 1889.

prominent criticism concerned the prohibitive cost of medical services[2]. While some parallels might be drawn between the development of the British and Australian welfare systems, by the inter-war period in Australia, the debate about the organization of medicine had followed its own course.

The nationalisation debate

Historically, one of the first points of conflict between political government and medicine in Australia was the question of control over the public hospitals. In their early form, public hospitals were established as Charity Hospitals where doctors provided services to the poor free of charge, as an honorary adjunct to their private practices. As in Britain, the emerging acceptance in Australia that the amelioration of poverty was central to the reconstruction of health, secured a political stance that sought to ensure that medical services were accessible to the poor. In the immediate post war period, both State and Federal governments suggested that the appointment of salaried medical staff in the charity hospitals would improve the provision of medical services to the poor. In Tasmania the State administration appointed salaried medical officers to staff the Hobart Hospital. Doctors argued stridently that the general provision of free services to the entire public would 'lower the efficiency of hospitals as institutions for the medical care of the poor' (Editorial, 1922f:31). In any case,

> The idea of the provision of free medical attendance for the masses is a bogie and economically unsound (Editorial, 1919l:111).

In 1919, the Australian Federal Committee of the British Medical Association was asked to consider a Federal government proposal for the 'nationalisation' of medicine. The proposal met with deep hostility by the medical profession.

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[2] Critical literature included Benjamin Moore's *The Dawn of the Health Age*, Havelock Ellis' *The Nationalisation of Health*, Beatrice and Sydney Webb's *The State and the Doctor* and Bernard Shaw's *Introduction to The Doctor's Dilemma.* Both Ellis and the Webbs travelled to Australia and made similar comment about conditions in the 'new' country.

> Nationalisation would stifle individual enterprise, substitute intrigue and influence for merit and, in general, hinder medical progress (Editorial, 1919m:270).

It would

> lead to the destruction of the spirit of independence of the medical profession-a spirit upon which progress has been founded in the past and must be founded in the future (Editorial, 1919:533t).

Despite the link that medicine had established between poverty and disease, medicine gave greater credence to the ‘fact’ that the innovative vigour of medical skill was dependent upon professional freedom. The strength of this argument lay in medicine’s claim to a new expertise in ‘preventive medicine’.

Preventive medicine

Preventive medicine was described as medical discipline following the acceptance in Australia of the significance of the carrier. Medical reports that featured explanation and examples of the phenomena of the carrier arrived in Australia during the War, forcing a reappraisal. In 1915, the Australian *Medical Annual* reported that amongst groups of convalescing soldiers in France, up to 12% were carriers of amoebic dysentery. All the men experienced debility, anaemia, wasting, and intermittent symptoms of dysentery and 4% exhibited persistent active dysentery (Rogers, 1915a:102). The journal also reported on research conducted in 1911 at the New York Quarantine station that found 31 carriers of cholera amongst 26, 678 immigrants, four of whom reported having no history of diarrhoea (Rogers, 1915b:196). In 1916, an outbreak of cerebro-spinal fever amongst Allied troops was attributed to healthy carriers. It was advised in this instance that all persons who had been in attendance or in close personal contact with the sick should be regarded as healthy carriers (Anon, 1916:170). In 1918, a military medical report attributed all outbreaks of cholera in the American forces stationed in Mexico to healthy carriers and advised that ‘all carriers should be discharged from the army as dangerous’ (Rogers, 1918:119). In Egypt, 14.8% of healthy natives (sic) in goal, 5.3% of healthy troops and large number of convalescents were identified as carriers of cholera (Rogers, 1918:120). In 1919, testing in one military camp found that 3-6% of soldiers were meningo-coccus carriers, with 1-2 % being chronic healthy carriers (Anon, 1919b:99). Amongst Australian troops returning from France and Flanders, 24% were identified as having amoebic cysts in their bowels (Rogers, 1918:123). This report sheeted home the conclusion that considerable amounts of silent or hidden disease would be ‘carried’ into Australia as troops returned home. In 1916 the identification of cholera vibrios in the gall bladders of completely healthy, recovered patients was also reported in Australia (Rogers, 1916:179). In the spectre of the carrier, medicine found a problem to which the principles that had been honed in the effort to contain venereal disease could be generally applied.

As a new form of disease containment, preventive medicine rested on the fundamental recognition that healthy individuals were directly implicated in the spread disease. In an address to the Public Questions Society on the 4th of August 1919, the Director of Quarantine, Dr. Cumpston, argued that the traditional sanitary approaches to disease prevention were inadequate. While there had been ‘some reduction in disease by the control of environmental factors and sanitation’, the present knowledge was ‘uncultivated’ because it failed to incorporate within its logic the phenomena of the healthy carrier (Cumpston, 1919a). According to Cumpston, the ‘facts of science’ had been ignored in the procedures and administration of public health.

> …bacteriology has shown the importance of the infective carrier in the starting of fresh epidemics of typhoid and diphtheria, and the importance of the open tuberculous contact is recognised, however, there had been no intelligent effort to control the personal infection factor in disease (Cumpston, 1919a:125).

For example,

> few doctors in private practice ascertain whether patients recovering from ..disease, remain infective after a return to health (Cumpston, 1919a:125).

At the heart of preventive medicine was a critical focus on the individual.

For Cumpston the spectre of the carrier meant that preventive medicine should deal with, not only the 'whole man as an individual', but also the whole man 'as a member of a community' (Cumpston, 1919a:125). A new approach could be achieved by the systematic study of the individual in his (sic) environment.

> The individual man as an animal -body, senses, work, resistance- must receive practical attention. The first line of defence to disease is a healthy, well-nourished, resistant human body. Nor is the individual the whole issue. There is a life history, his heredity, his family, his domestic life, his personal habits and customs, his home as well as his workshop (Cumpston, 1919a:128).

In this vision, Cumpston articulated the principles by which the new field would rate elaborate health as the central force in post-war reconstruction. Preventive medicine was to be the science and art of perfecting human capacity.

> How men can learn to live a healthy life at the top of his capacity of body and mind, avoiding or removing external and internal conditions unfavourable to such a standard, able to work to the highest power, able to rest to the fullest, growing in strength and in the joy of living (Cumpston, 1919a:128).

Throughout 1919 nearly every editorial in the *Medical Journal of Australia* carried some reference to the potential of 'preventive medicine'. The *Journal* urged that 'all resources… be put toward the prevention of disease' (Editorial, 1919f:11). Preventive medicine was lauded as 'the most important function of the doctor'. In this task the medical effort was not to be understood as 'consisting only of sanitation, isolation and disinfection' (Cumpston, 1919a:128). In the medical view, the principles of preventive medicine truly promised the eradication of disease.

The intense medical rhetoric that surrounded the concept of preventive medicine heralded its establishment as a specialised branch of medicine. In 1922, the University of Melbourne replaced its medical course on sanitation and public health administration with a course on preventive medicine (Editorial, 1922e:18), branches of the new Public Health Association were formed in each State, and the first National Conference of the Public Health Association was convened (Editorial, 1922d:55). In concrete terms, the practice of preventive medicine was to be conducted by the general practitioner. The doctor in general attendance was seen as the principle 'tiller of the field'. Only in the context of this intimate encounter could the doctor attend to the myriad requirements dictated by phenomenon of the carrier (Cumpston, 1919a:127). The insertion of this essentially benevolent medical authority into the lives of ordinary people would provide an 'important link between the government authority and the public' (Cumpston, 1922a:361). Preventive medicine cast in this style, would enable 'a general collaboration between public health authorities and the general practitioner' (Editorial, 1922c:352). The positioning of the independent doctor as a mediatory between the government and the people, however, contradicted the emerging political aspiration for control of the health of the population through a nationalised health system.

Preventive medicine as a form of nationalisation

In a strategic counter claim to the nationalisation lobby, medical commentary explicitly offered preventive medicine as a form of 'nationalisation' that would satisfy the demands of government, preserve the independence and supremacy of the medical profession and re-establish the mutual relationship between medicine and government that was seen as critical to the implementation of effective preventive medicine and to the progress of the nation. Drawing from the experience of the medical campaign against venereal disease, it was argued that

> …State machinery and legislative action were invariably too cumbersome to address real and pressing problems (Cumpston, 1919a:128).

It was ‘impracticable and doubtfully advantageous to make all doctors public servants’ (Cumpston, 1919a:128). Instead, through the practice of preventive medicine, nationalisation would become ‘part of the knowledge and time of every practicing doctor’. Medicine would be nationalised because the practice of preventive medicine would reach into the lives of all citizens and structure itself according to the needs of the community.

Medicine would be nationalised because the general application of the carrier principle meant that the efforts of government to improve the health of the people would automatically intersect with the medical program.

> All of the major diseases are now understood to be communicated through carrier contact… meningitis, polio-meningitis, polio-encephalitis, diphtheria, tuberculosis, influenza and the plague, are each regarded as the work of human carriers (Butler, 1922:262).

Effective control of disease was now understood as fundamentally dependent upon the identification and treatment of the carrier in terms of the various modes of communication. For example, the control of diphtheria was described as dependent upon the

> …control and treatment of the patient; control and treatment of contacts; correction of infective social habits such as kissing; and diagnosis and treatment of carriers’ (Butler, 1922:261).

The ‘essential feature’ of the campaign for the control of polio- myelitis and encephalitis was the ‘detection and adequate control of unsuspected carriers with active infection or apparently healthy contacts’ (Butler, 1922:261). For influenza ‘the controllable factor’ was the ‘intimate contact with actual patients, patients during the incubation stage, convalescents and carriers’ (Butler, 1922:261).

For typhoid, it was acknowledged that the maintenance of a good sanitary system, control of water supply, control of milk and food supply and anti-fly measures should be continued, but that the 'control of carrier' was the essential addition to these measures. By virtue of its universal application, therefore, preventive medicine would expand

> to its fullest logical extent, those phases of the relationship between doctor and patient which are capable of development to the benefit of the community, as distinguished from, though perhaps concurrent with, the interests of the individual (Cumpston, 1919a:125)

Mirroring the privilege that had attached to the doctor-patient relationship during the campaign against venereal disease, preventive medicine similarly placed that relationship at its heart, thereby translating the rationale of privacy to the broader medical effort. The history of tuberculosis provides an example of the way in which the detailed intersection of different aspects of medical knowledge combined to render the problem of tuberculosis amenable to preventive strategies.

The problem of tuberculosis

Preventive Medicine was to find its most fulminant expression in the problem of tuberculosis. In the early years of colonized Australia, epidemics of 'phthisis' were a persistently prominent cause of death. In the mid-nineteenth century, deaths from all forms of acute pulmonary tuberculosis remained high and were especially common on the goldfields and amongst migrants from Britain seeking 'the cure' in the Antipodes (Proust, 1991:203)[3]. At this time, pulmonary tuberculosis was considered to be a 'dyscrasia', or general disorder, that most likely manifested in persons of degenerative stock and was associated with urbanisation, industrialisation, poor physical development, and lowered moral standards. The isolation of the tubercle bacillus in 1882 by Koch, did little to shift this understanding. In the last decades of the nineteenth century a variety of competing explanations, including hereditary, constitutional, or environmental explanations, remained current. The proposition, generated by research from Koch's European laboratory, that bacilli were harboured in dried human sputum and communicated by breathing in dust borne particles achieved wide acceptance, and served to promote the importance of sanitary measures against tuberculosis (Hardy, 1993). Similarly, infected cattle herds and a contaminated milk supply were recognised as a source of tuberculous disease. This realization lent critical emphasis to the importance of strict sanitary controls over milk and meat supply in order to avoid human infection[4].

In 1898, despite the introduction of controls, tuberculosis was identification as the leading cause of medical death in all the Australian colonies (Proust, 1991:14) [5]. Scientific confirmation of the infectivity of dried secretions and dust, however, emphasized the need to control tuberculous locations. Consistent with this view, the compulsory notification of pulmonary tuberculosis was included in the *Public Health Act* of South Australia in that year, and other States gradually followed suit. Practitioners, however, were rarely reminded of their obligation to report, and the dire consequences of notification made them generally reluctant to notify until cases were obviously advanced (Proust, 1991:204)[6]. In any case, there were few institutions that could provide care, especially to the poor. Standard treatment for tuberculosis consisted of the 'rest cure', preferably away from urban centres, and sometimes in conjunction with tuberculin treatment[7]. At the turn of the century, tuberculosis remained a complaint against which medical men had virtually no armoury.

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[3] The Victorian Year Book of 1877 recorded phthisis as the leading cause of death with 1,088 deaths in that year (Proust, 199:203).

[4] In New South Wales the *Dairies Supervision Act* was introduced in 1886, and the *Diseased Animals and Meat Act* followed in 1892.

[5] Per published a booklet by physician and Member of Parliament in NSW, Dr. Lane Mullins, entitled *Tuberculosis and the Public Health (1898)*

[6] Intense social stigma attached to publicly know cases, often resulting in social ostracism and unemployment.

In 1908, although the statistical accounting of the incidence of disease confirmed a declining trend in the overall incidence of tuberculosis[8], the mortality figures according to age and sex specific population groups showed an alarming rate of disease amongst certain sections of the population[9]. A high level of mortality was identified in both men and women between the ages of 20-29 years, and for men between the ages of 40-49 years (Proust, 1991:15). The statistical evidence was anecdotally confirmed by the alarming rate of rejection, on medical grounds, amongst men volunteering for the Australian armed services. On a positive note, the figures showed a dramatic fall in infant mortality due to tuberculosis between 1885 and 1905. This decline was assumed to be the result of the effective sanitary control of the milk supply, resulting in an effective exclusion of bovine infection in infants. The high mortality and morbidity amongst men and women in the early adult years refocussed government attention squarely on the problem of pulmonary tuberculosis (Proust, 1991:204). The productive, reproductive and defence capacity of the nation was again threatened by tuberculous disease. The medical effort to begin a concerted effort against tuberculosis, however, was overshadowed by the commencement of the First World War (Cumpston, 1978 (1927-28):30).

In the years following the War, anxiety about tuberculosis escalated as news of a resurgence of the disease in Europe reached Australia. Tuberculosis rates in Warsaw were reported to have increased by 300% and in London the increase was calculated at 130% (Editorial, 1922i:539). While Australia was shielded from the worst effects of the war, the pre-war decline in deaths from tuberculosis had been reversed. From 1917 to 1919, deaths due to tuberculosis increased from 2,882 to 3,392. Figures in 1920 showed a fall to 3,078 deaths,

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[7] Deaths form tuberculosis in Australia from 1890-96 has been estimated at approximately 40,500. Death rates in sanitaria were high at over 50% in most sanitaria in NSW (Proust, 1991:148

[8] Data collected by the Commonwealth statistician was first published in Australia in 1908.

[9] This innovative representation of data was provided by the NSW Government Statistician J.B. Trivett

but in 1921 the number reached 3,105 deaths (Editorial, 1922 :539). At the same time, medical belief in the efficacy of the traditional sanitary approach to disease containment was shattered. With advances in bacteriology, laboratory testing had differentiated between human and bovine forms of tuberculosis and confirmed the attachment of each to different disease entities. Pulmonary tuberculosis was revealed as the most common and virulent form of disease, and exclusively of human origin[10]. People, not the environment, were the primary source of pulmonary tuberculosis.

While the control of bovine tuberculosis apparently remained relevant to the control of infant and child tuberculosis in Britain and Scotland (Cowan, 1922 :341), tuberculosis in Australian children was found to be exclusively from human strains of tuberculosis and was far more prevalent in children than had been previously contemplated (Penfold, 1924:261)[11]. Penfold thought it likely that many Australian children harboured unsuspected tuberculous disease. Coupled with the age specific statistics, this suggested that sick parents were infecting their children in the home. The recognition of the domestic environment as the primary site of disease communication underscored the efficacy of a medical approach informed by the principles of preventive medicine. Only through the privileging of the doctor-paint relationship could medicine penetrate the private domestic realm. It was recognised, however, that the success of this strategy was dependent upon the creation of a positive public attitude.

The conquest of public opinion

The first step in that process was to establish the expertise of the new public health practitioner. Traditional methods of disease containment, such as sanitation or quarantine, were useless against the invisible and unidentified carrier. Doctors who claimed expertise in the new knowledge criticised the

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[10] Nevertheless, calls to further improve the sanitary health of the cattle herds and to introduce a system of milk sterilisation in Australia continued (Editorial, 1922a:333)

outmoded and ignorant methods of 'traditional' Public Health Medical Officers. The practices that persisted in Queensland of subjecting the homes of diphtheria sufferers to the 'outmoded practice of drain inspection', and homes where persons had suffered meningitis or typhoid to fumigation as a precaution against disease were openly ridiculed (Butler, 1922:260). Traditional sanitation practices were perhaps comforting, but should be recognised as ultimately ineffectual.

> You cannot prevent disease by plumbing alone. There must be recognition that the prevailing conceptions of infectious disease are a farrago of myths and magic (Butler, 1922:260).

What was required, in the place of sanitation mythology, was acknowledgment that disease was carried by people, and communicated through them to other people. The 'personal factor' in disease communication was critical.

The 'personal factor' was equally important as the basis for disease containment. To medical audiences, the new public health experts further highlighted the inadequacy of the established approach to disease control. They argued that government employed Public Health Medical Officers, hampered by ignorance, misunderstood the urgency of 'carrier situations' and exercised 'excessive discretion'. In failing to intervene in urgent 'carrier situations', their practices actively endangered the public health (Butler, 1922:260). In contrast, medical practitioners equipped with knowledge and understanding of the phenomenon of the carrier, could intervene discretely and privately into the domestic world. In averting the stigma that attached to visits from the Public Health Medical Officers, the practitioner could 'guide' the activities of a carrier. The danger they posed others was most efficiently and effectively minimised when the cooperation of the patient was enlisted. If this could not be achieved, the medical practitioner could call upon the 'coercive powers' of the public health administration that were enforceable by other 'appropriate government authorities' (Butler, 1922:260). Preventive medicine, therefore,

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[11] Penfold's conclusions, based on autopsies conducted at the Children's Hospital in Melbourne, were presented to the Australasian Medical Congress in Melbourne in 1923.

envisaged from the outset a critical interplay of guidance and coercion as a strategy for ensuring the cooperation of the people in the task of disease containment.

The application of this new form of medical supervision to people who had recently experienced an acute episode of disease was considered relatively unproblematic. Supervision of the known convalescent could be automatically extended into the recovery period, and be continued by general practitioners in the community. General practitioners would be able to render identified carriers harmless by ‘supervising their home detention’ (Butler, 1922:262). By providing a ‘minimal amount of general instruction’, doctors would be able to secure the ‘obedience’ of patients, oversee the ‘isolation and quarantine of convalescents and carriers’ and ‘report on the suitability of housing’. Over time, and with appropriate education, the doctor could ‘supervise the loosening of restrictions’ (Butler, 1922:262). This process of supervised liberty and gradually acquired freedom, was sharply contrasted with the gauche, and ultimately ineffective, intrusions of the government employed medical officers (Butler, 1922:262). Preventive medicine, personally administered by the general practitioner with privacy and discretion, protected the interests of the individual patient from the ill-considered intrusions of government.

In order to extend medical supervision in this way, it was recognised that the public would need to be encouraged to bring itself unquestioningly within the purview of medicine. People who had never experienced an acute episode of disease or who were unwittingly incubating disease were unlikely to seek medical advice. In recognition of this problem, medical personnel were encouraged to promote a public ‘belief in prevention’ (Sutton, 1923:251). Just as the (now outmoded) administrative control of the sanitary conditions of the environment had developed ‘a sanitary consciousness in civilised communities’ (Sutton, 1923 :253), a new consciousness could be wrought by the application of ‘health principles to the human being’ (Sutton, 1923:253).

Medicine therefore embarked upon a campaign to awaken ‘the public interest in health matters’ (Editorial, 1922c :352).

> If the imagination and the interest of the people could be stirred, it would be possible to do wonderful things in regard to national health (Editorial, 1922:503g).

The interest of the people was to be nurtured, firstly, by the activities of the individual general practitioner (Editorial, 1922c:352). While they were ‘in attendance on the sick section of the community’ the practitioner could provide general instruction to all members to the household (Editorial, 1919h:174). Secondly, the public’s interest and trust could be ignited by the promotion of ‘early medical diagnosis’ (Butler, 1922:261). If early identification could be achieved through bacteriological testing, timely medical intervention would prevent progression to the ‘infective stage’ (Horne, 1922:53). Laboratories possessed the clairvoyant potential to make hidden disease visible. People were to be encouraged to come forward for medical examination as a matter of routine in order to establish wether or not they were ‘a carrier’. Bacteriological testing was represented as being able to reveal the ‘truth’ of each individual’s infective status, in order to provide reassurance and certainty, and judicious medical intervention[12].

Like the medical management of the problem of typhoid in America, medicine claimed it could manage disease within the population by engaging with the personal predicament of each person within his or her domestic environment. With a preventive stance, medicine could combine the skills of clinical diagnosis, laboratory examination, personal authority and an understanding of domestic and social detail, and with the assistance of an educated and receptive

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[12]. The public lauding of bacteriology stood in contrast to medical disquiet about the inadequacies and difficulties of laboratory diagnosis. Nevertheless, the gradual extension of the network of laboratory facilities outside the major centres was funded at this time. The Federal Department of Health established laboratories in Rabaul (New Guinea) in 1921, in Bendigo (Victoria) and Townsville (Queensland) in 1922, in Toowoomba (Queensland) in 1923, in Rockhampton (Queensland) and Lismore (N.S.W.) and Port Pirrie (SA) in 1924, in Kalgoorlie (WA) in 1925, in Cairns (Queensland) in 1928, in Launceston (Tasmania) in 1929, and in

public, lay claim to a unique capacity to prevent communicable disease. Effective preventive medicine would obviate the need for coercive interventions.

In the instance of tuberculosis, ordinary people were often unable to avail themselves of 'rest cures' or afford the benefits of or private sanitaria. Despite the claim that a preventive approach could limit the need for coercive strategies, medical intervention in the home fundamentally relied upon the judicious removal of dangerously ill people from the household. The certain mortality attached to a diagnosis of tuberculosis added urgency to the medical insistence that the domestic environment be open to medical intervention, and accepting of the compulsory removal of household members. Other fatal contagious conditions sometimes required the removal of ill persons. In the midst of the conflicting trajectories of prevention and intervention, preventive medicine increasingly presented itself as the protector of children's rights.

Children's rights

According to its advocates, preventive medicine was fundamentally grounded in a rekindled 'humanitarian desire' that appeared as 'a natural progression from Victorian humanitarian ideals' and specifically honoured the rights of the child (Sutton, 1923:253). Preventive medicine claimed that it was fundamentally motivated by an 'enthusiasm for humanity' that raised the 'child to a pinnacle of importance previously unknown' (Sutton, 1923:256).

> Our greatest hope is the child….. Health begins at home, the rights of every child, ……to fresh air, good food, regular open-air exercise, decent recreation and thorough sleep, adequate weather protection, the means for habitual cleanliness and freedom from exposure to infection… is gradually filtering into the national consciousness (Sutton, 1923:256).

Broome (West Australia) in 1938. Hobart did not receive a laboratory until 1940 (Cumpston, 1978 (1927-28):48).

The rights of the child were paramount and, above all else, justified the imposition of coercive measures upon the adults around them. In the medical view, the necessity of maintaining the physical health of the child justified the removal of children from a diseased home when the removal of ill parents was impractical. Although the *Medical Journal of Australia* was only willing to publicly sanction this practice 'at least in relation to smaller children', it may be supposed that the removal of children on the basis of 'a right to health' occurred throughout Australia (Editorial, 1922a:333) [13].

The articulation of children's rights in preventive medicine was highly strategic. Reinforced by the humanitarian guise of the new medicine, it produced a sure lever upon voluntary adult behaviour in the domestic sphere, at the same time as it pre-empted opposition to coercive domestic interventions. In construing the rights of the child as denied or fulfilled within the home, the domestic sphere was elevated at the same time as it was opened to medical-administrative intervention. The child's 'rights to health' added a specific burden to both parental responsibility and the responsibility of governments. Specifically, it laid a crucial foundation for the forthcoming elaboration of children's and infant's health services, as well as other professional interventions into the home, such as social work.

Conclusion

The imperatives of preventive medicine juxtaposed strategies of rights and strategies of coercion. This produced a powerful disciplinary force. A public motivated by the injunctions of rights, not for themselves but for their children, would fully embrace medical involvement in the intimate detail of their everyday lives.

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[13] It is pertinent to wonder to what extent the medical construction of a 'child's right to health' influenced the removal of indigenous children from their families.

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Chapter 7:The right to be free from infection

> *Germ theory has generated a fear of the germ that was so great it has become the modern superstition.......* (Parkinson, 1932)[1].

Introduction

Preventive medicine was a medical rationale that addressed the problem of hidden, 'carried', disease within the population. The notion of the carrier upon which preventive strategies were based, however, was one that assumed the carrier phenomena to be confined to a relatively small number of people. The primary problem was identification of these hidden disease foci. That disease was most often communicated to others resided in the intimacy of the domestic environment necessitated the invention of a medical strategy that could penetrate that field. Almost as soon as preventive medicine had established itself as a coherent discipline, these assumptions were challenged by the emergence of new medical knowledge. While the problem of tuberculosis had driven the formation of the preventive rationale, a new appreciation of its incidence within the population fundamentally altered the preventive model. The medical certainty that preventive medicine could succeed in diminishing the toll from tuberculosis through the elaboration of a medico-administrative complex that penetrated the home was shaken by a realisation that tuberculosis permeated throughout the community. The new medical knowledge about the nature of tuberculosis was generated by technical advancement in the areas of autopsy, bacteriology and statistics.

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[1] Presidential address to the Melbourne Branch of the British Union for the Abolition of Vivisection in April 1932

Knowing the tuberculous population

In the interwar period, improved facilities and techniques in autopsy revealed an unexpectedly high level of previously undetected tuberculous disease. Autopsy results showed that clinical diagnoses frequently failed to differentiate between pulmonary tuberculosis, hydatid disease of the lung, and pulmonary syphilis. They also showed that significant levels of simultaneous disease were clinically unnoticed. For example, 25% of adults suffering from pulmonary syphilis were also infected with pulmonary tuberculosis (Anonymous, 1923:316). Overall, at post-mortems conducted on person who had died from causes other than tuberculosis, 25% of males and 22% of females showed definite tuberculous lesions (Penfold, 1924). It was these results that first suggested tuberculosis to be far more prevalent that previously assumed. This was confirmed by new information emerging in bacteriology.

As the phenomena of the carrier clearly applied to a wide range of diseases, and not just to diphtheria and typhoid, bacteriological investigation sought to identify the carrier phenomenon in tuberculosis.

> They had learned, in regard to enteric fever, that an infected individual was not always the same as a diseased individual; that the infected individual was not always the same as an infective individual; and that an infective individual was not always the same as a diseased individual. (Horne, 1922:53).

The certainty that there would be found some level of dissociation between manifest clinical disease and infectivity informed the laboratory research. Applied to tuberculosis, the bacteriological investigation of sputum confirmed that infectivity similarly bore no relationship to the clinical manifestations of the disease. This observation overturned the medical assumption that the quantity and quality of sputum could not be taken as a guide to infectivity (Gillies, 1931:166). Gillies research showed that although some patient’s sputum was scant or absent throughout the course of disease, and in other cases sputum was profuse and purulent, these symptoms were irrelevant to infectivity. The tuberculosis sufferer was only infective when bacilli were present in the sputum.

> Bacilli are present in the sputum only when there is a breaking down of active foci.....(but) there is nothing in the clinical condition of the patient to betray its presence... The sputum of apparently perfectly healthy individuals may be loaded with bacilli...(Gillies, 1931:166).

According to his research, any person with or without respiratory symptoms should be suspected of harbouring pulmonary tuberculosis (Hone, 1931:163). The translation of the post mortem examination and bacteriological findings into statistical estimations indicated that the extent of the 'carrier' problem was unexpectedly pervasive. This conclusion contradicted the assumption that preventive strategies had begun to take effect.

In 1931, a comprehensive review of the incidence and significance of tuberculosis in Australia was published (Cumpston, 1931). In a careful evaluation of the available data, the Director General of Health for the Commonwealth, Dr J. H. L. Cumpston, argued that an apparent decline in mortality from tuberculosis was merely the statistical effect of instability in the age constitution of the population. He argued that a more accurate statistical account of the incidence of disease could be constructed from recent medical research. Cumpston cited research that has subjected a large hospital population to tuberculin testing. In this research, 61% of patients had reacted positively to the test indicating exposure to tuberculosis. Similarly, tuberculin testing of university students between the ages of eighteen and twenty-seven years had yielded positive results in 70% of tests (Cumpston, 1931:137). Accepting the veracity of this data, Cumpston argued it was 'highly likely' that while only one quarter of the population exhibited actual signs of pulmonary tuberculosis, 'three quarters' of the population had been exposed to the disease and therefore harboured bacilli. In an unprecedented estimate of the extent of the carrier problem, Cumpston designated 75% of the Australian population as carriers of tuberculosis (Cumpston, 1931:155)[2].

In preventive medicine the medical effort to penetrate the home had been driven by a concern to effect the removal of obviously sick, and therefore obviously infective, persons from the domestic environment. During the 1930s medicine drew together the disparate strands of new knowledge to create a 'natural history' of tuberculous disease that subtly altered the domestic perspective. Pulmonary tuberculosis was presented as a disease that was predominately contracted in childhood, but exerted its influence throughout life, taking several alternate forms. In some instances immunity was established and there was no further manifestation of disease. In other cases quiescent disease might be activated a period of stress, or dormant disease might reactivate, both resulting in either a florid episode or in persistent mild symptoms (Holmes, 1937:815). Alternately the initial infection might cause recurrent and ongoing disturbances from the outset.

The various trajectories of tuberculous disease were drawn from extrapolations of the most recent mortality statistics for pulmonary tuberculosis. This data showed that, in the early 1930s, mortality for women peaked at 60 deaths per 100,000 in the 20-34 age group, representing a fall in mortality from the 1920s, when 80 in 100,000 women in that age group died from respiratory forms of tuberculosis (Holmes, 1937 :817). In men, the 1930s death rate peaked in males over 55, with a rate of 130 deaths per 100,000. This represented a fall from the 1920s peak of 145 deaths per 100,000 in the 45 to 49 years age group. In other age groups, the male mortality had fallen more sharply than the female[3]. The specific patterns of morbidity were interpreted as showing that the industrial occupations of men, and the hard work and deprivation associated with domestic duties and childbirth for women, precipitated reactivations of childhood disease (Holmes, 1937:818). The assumption followed that the persistence of neonatal and childhood deaths from human tuberculosis was associated with these peaks. A correlation between the patterns of adult mortality and infection in children was observed in other studies. Investigations into the incidence of pulmonary tuberculosis in the mining industry had shown that mining men experienced a rate of tuberculosis mortality three times that of the general population (Cumpston, 1931:156). Pulmonary tuberculosis in the mines was recognised as being closely associated with silicosis and lung damage from dust and poor ventilation in the shafts. The high incidence of tuberculosis in miners, however, also corresponded with elevated levels of tuberculosis amongst children in mining communities. The correlations in the morbidity data, coupled with the recognition of the carrier phenomenon, suggested that people who resided in the home, particularly retired men

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[2] Carrier estimates for the major infectious diseases were usually between 2 and 6% of the population.

and young mothers, were likely to be tuberculosis carriers. These persons unwittingly infected the infants and children in their care (Holmes, 1937:817).

The recognition of circular connection between adult and childhood disease, and the indefinable significance of even the mildest symptoms, fundamentally altered the parameters of preventive medicine. The object of preventive intervention shifted from the effort to limit the effect of the obviously sick, to one of breaking the 'human chain of infection'. The 'crucial point of attack' was now the 'infective individual' (Horne, 1922 :53). Strategies for the prevention of tuberculosis were modified in order to detect tuberculosis, not only in the sick person and their associates, but also in the infective, mildly symptomatic, or symptomless carrier.

Managing infectivity

In the years following the First World War the medical effort against tuberculosis had followed the new preventive model. The 1925 Royal Commission on Health repeated the medical concern that the social and economic burden of tuberculous was dire, and recommended the establishment a Federal Division of Tuberculosis [4]. By 1929, however, the work of the Division had been halted by the budgetary constraints of the depression. The medical construction of tuberculosis as a problem of hidden, but widespread infectivity was critical in re-establishing a public health response to tuberculosis. By the mid 1930s the Federal health authorities once again became actively involved in the medical task of manufacturing an effective approach to the amelioration of tuberculous disease.

The medical recognition that the object of intervention was to 'break the chain of human infection' in the domestic sphere spurred the argument that resources should not be exclusively allocated to the irretrievably ill, but should also be utilised to assist those persons who were only mildly affected with disease. These persons were likely

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[3] On a State-by-State comparison, South Australia exhibited an unexplained and unusually high rate of deaths in young women between the ages of 20 and 29. Other states mimicked the national trend (Holmes, 1937:817).

[4] The unit, with Dr. M.J. Holmes at its head, was created with the object of formulating a national tuberculosis program. The Commission advised that all states appoint a full-time Directors of Tuberculosis. Victoria did so, appointing Dr. J Bell Ferguson.

to be more infective than irretrievably ill. Under the current system, persons were removed and provided with treatment when it was already too late to ameliorate their condition, and after they had infected their respective households. Reports that showed high rates of mortality in sanitaria supported this argument[5]. Instead of removing critically ill people to sanatoria, it was argued that relatively healthy infective people should be the focus of removal strategies. For example, it was suggested that the pension system should be modified to 'encourage the breadwinner to stop work and seek proper treatment in the early stages'. The existing pension arrangements only providing a meagre income after the breadwinner was unfit for work. The entrenched poverty that resulted had dire consequences for family health.

> The family becomes ill nourished, ill clothed and ill housed. The source of infection remains, resistance is minimal and (the family is) exposed constantly to infection (Holmes, 1937:825).

When the sick man was subsequently forced to enter a sanatorium, the compulsory garnishing of the pension by the sanatoria further exacerbated the dangerous conditions for the family.

A more appropriate system, that took account of the scientific data, would emphasise the maintenance of the tuberculosis sufferer in the home under strict medical supervision. Keeping persons in the home would reduce the cost of providing adequate public sanitaria, and reduced the incidence of disease in the family because they would be less compromised by a reduction in circumstance. Furthermore, by maintaining patients could in the home, the 'problems of social ostracism' that were associated with public identification of a tuberculous home, could be avoided (per Dr. Latham cited in Horne, 1922:53). This system, like the home detention of typhoid carriers in America almost two decades earlier, was dependent on the adoption of strict regimes of personal hygiene by tuberculosis carriers.

Infective individuals could be rendered harmless provided they strictly contained and carefully disposed of infected sputum.

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[5] In New South Wales, 109 of the 280 patients admitted to sanatoria in 1930 died within five years.

> They could live for years in the company of others without spreading the infection because of their scrupulous care in their personal hygiene (Hone, 1931:164).

Tuberculous patients were to be taught to cover their mouths when coughing, to spit into a flask or a 'paper handkerchief', and to carry their own sputum flask and pillow when travelling[6]. Domestic supervision demanded of the infective individual an absolute acceptance of the dangerousness of their condition, an ability to sustain complete and constant personal vigilance, and the willingness to co-operate with the medical practitioner. Home maintenance required that the carrier adopt a 'responsible' stance.

As well as shifting the focus toward the home maintenance of the identified, infective carrier, diagnostic efforts should also be directed toward the detection of tuberculosis as the earliest possible moment, in order to avert the onset of infectiveness.

> If the condition is diagnosed early, (the patient) may be prevented from becoming infective, or infectiveness, if present, may be rapidly eliminated (Holmes, 1937:822).

To achieve this goal, medicine was to maintain a 'patient and persistent' vigilance over all the 'contacts' of all known sufferers 'from childhood upwards' (Holmes, 1937:823). There would be a

> …persistent search for the earliest manifestation of disease and so prevent the development of new foci of infection (Holmes, 1937:824).

As this comment shows, in the 1930s medicine maintained the opinion that infectivity must be associated with, at least some level of mild symptom.

The new orientation of tuberculosis prevention required an effort of intense observation over the populace. This was to be achieved by a close co-operation between the general practitioner and the government health authorities. To this end, Australian doctors were urged to adopt a new level of 'social responsibility'.

> The practitioner's immediate consideration is the welfare of the patient, but he should not loose sight of his social responsibilities or fail to realize that the public health authority was dependent on him for data on which to base preventive measures on a large scale (per Dr.Latham in Horne, 1922:53).

Prevention was to be dually sourced in the discrete professional capabilities of the general practitioner and the capacities of a centrally organised pubic health administration. There would be a

> …collaborative and continuous combined effort between general practitioner, sanatorium expert and public health official (Horne, 1922:53).

The 'notification' of disease was posed as the critical point of co-operation between the general practitioner and the health authority. While the compulsory notification of tuberculosis had been enshrined in legislation since the previous decade, the fact of widespread infectivity made the neglected task of practitioner notification crucial. In New South Wales a collaborative system of notification was developed that required the general practitioner to include with notification, an account of the patient's history, and whether or not further action was required. The New South Wales health authorities were to control the subsequent formal notification and admission of patients to institutions (per Dr. Palmer in Horne, 1922:54. The scheme was widely applauded in medical circles for its strict maintenance of practitioner autonomy, independence, and discretion in the matter of formal intervention (per Dr. Palmer in Horne, 1922:54. In the general adoption of this system throughout Australia, doctors were to decide which patients would be removed to sanitaria. By effectively separating notification from coercive intervention, medical support for this system of notification was achieved by maintaining medical discretion as the basis of tuberculosis intervention.

As the key to the planning and allocation of resources, the new perspectives also suggested that a strategic expansion of the system of notification was necessary. In

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[6] Pocket-handkerchiefs were regarded as a source of disease. For example according to Gillies 'the custom of treasuring nasal and bronchial excretion in dainty silk or linen pocket handkerchiefs till disposed of by the unfortunate laundress has little to commend it' (Gillies, 1931:168).

order to provide the most comprehensive surveillance of the infective, it was suggested that doctors be required to notify the health department, not only of verified tuberculosis, but also of

> ….any sickness, the symptoms of which raise a reasonable suspicion that it may be tuberculosis (Holmes cited in (Hone, 1931:164)).

The notification of a ‘reasonable suspicion’ was an entirely new principle in the legislative control of infectious disease. While there was some medical support for this strategy, the medical suspicion that the requirement to report ‘reasonable suspicion’ would undermine the operation of medical discretion, coupled with the very real practical difficulties surrounding the clinical diagnosis of tuberculosis, made this suggestion unworkable. The reality of widespread infectivity, however, required an alternate mechanism of tuberculosis control to be devised.

The responsible citizen

The problem of unrecognisable infectivity was accompanied by the medical concern that these difficulties were compounded by ‘public ignorance’ (Gillies, 1931:168). Like the problem of typhoid it was seen that a motivated and alert population could assist with the medical task. In this instance, however, rather than grooming the population to exercise vigilance against an imperceptible threat, the Australian population was exhorted to adopt hygienic practices in order to reduce the discriminatory burden upon responsible tuberculosis sufferers, and to protect the wider community from their own probable infectivity.

Since the 1920s, books about tuberculosis had been available for use in the ordinary household[7]. Medical opinion had applauded the improvement in public understanding and cooperation that was expected to result from the publication of ‘health’ books.

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[7] For example, Dr. I E Atkinson published *Lessons on Tuberculosis and Consumption for the Household* in 1922 (Atkinson, 1922). The book aspired to improving the layperson’s ability to prevent disease, recognise early symptoms, and ‘win back health’.

It was thought that ‘if the truths made plain’ in them could be grasped by the general public ‘nothing but good would result’ (Editorial, 1923:266). By the 1930s, however, doctors expressed concern that the new level of knowledge was hampering the medical effort. Information about the dangers of tuberculosis was seen as responsible for the fearful public response evidenced by instances of prejudice, ostracism and overt rejection of persons who were known, or presumed to be, tuberculosis suffers.

> Unfortunately, the public has reached a stage of half education in which they see danger in contact with the consumptive. For them the bacilli are ready to spring from the patients skin and to fly in his breath (Gillies, 1931:168).

In particular, doctors were concerned that the stigma associated with tuberculosis would encourage sufferers to conceal their disease by failing to adhere to the necessary hygienic measures, especially in public.

What was required, therefore, was a concerted education campaign that would reinforce the medical emphasis on personal hygiene and public behaviour.

> What must be driven home is the fact that infection is conveyed only in the sputum and only by gross carelessness. The careful consumptive carries no risk to anyone; the use of spitting flasks or paper handkerchiefs is a sign of safety….not a danger signal (Gillies, 1931:168).

In the light of widespread infectivity, medicine saw that beyond an insistence upon the hygienic behaviour of tuberculosis sufferers, the promotion of universal hygienic practices would both limit the infectiveness of known or unknown sufferers and protect the remainder of the public from exposure to disease. What was needed was

> …a deliberate and continuous education of the public in order that intelligent precautionary measures may be taken… (Holmes, 1937:823)

Public education included the promotion of a ban on public spitting, an emphasis on the dangers of the ‘public cup’, and the importance of routine and regular medical examination for all members of the community. In this way the …

> …dread of the disease be replaced by a realisation of the advantages and importance of the examination, investigation and observation of contacts and that early detection is an essential element in successful treatment (Holmes, 1937:823).

With education, members of the public would increasingly recognised themselves as potential carriers of disease. Each citizen would thus become responsible for his or her own infectivity.

Conclusion

The responsibility of the citizen was buttressed by an implicit medical regard for the 'right' of all citizens to be free from tuberculous infection. Promotion of a right that was construed as adhering throughout the community, and not just to children, encouraged the adoption of hygienic practices amongst the whole population and nurtured critical public support for an expanded medical program. Invested with the right to be free from infection, the responsibilised population were ready participants in the programs of universal surveillance that appeared following the Second World War.

Chapter 8: Social medicine

> *In order to get at the root of tuberculosis it is necessary to understand where its springs arise. From some crater in the depths of society, amongst the most wretched poverty and misery, unemployment and imbecility, the fountain of tuberculous infection is thrown up through the community and seizes upon all who are susceptible. Until those social evils can be got under control, we shall never be quite free of tuberculosis. Until then, we shall not deserve to be ….* (Olsen, 1943 in Pagel, 1964)

Introduction

Immediately following the cessation of hostilities in Europe, efforts toward the elimination of tuberculosis were resumed in Australia. While it is possible to imagine the Second World War as merely interrupting the continuity of an evolving medical program, the shifts in rationale that accompanied the developing debate over tuberculosis management were grafted into an entirely new context. In the peculiar atmosphere of the Post War period, the principles of preventive medicine were reinterpreted in the rubric of 'social medicine'. While the term social medicine has come to be understood as interchangeable with public health, in the immediate Post War period in Britain, it was specifically coined to refer to a new form of medical expertise. Despite this specific reference, the concept of social medicine is rooted in the nineteenth century effort to understand the relationship between instances of individual disease and the condition of the population. The connections that were drawn between reproduction, productivity and economy, and the correlations that were understood between disease, heredity, and social degradation, projected the 'social' realm as the interface between individual and aggregate phenomena. In the early twentieth century, the medical focus on 'the social' was wrested away from heredity and strategies that recognised a strong connection between poverty and disease were emphasised. Efforts toward the amelioration of poverty were generally accepted as central to the task of defeating disease. As the century progressed, however, a different relationship between health and the social realm was recognised. In the light of this recognition, 'rights' in medicine in second half of the twentieth century, differed considerably from those that inhabited medicine prior to the Second World War. The advent of social medicine, therefore, represents a hiatus in twentieth century medical thought and practice.

The concept of social medicine

In 1943 the first Professorship in social medicine was established at Oxford University. The appointee, Lord Dawson Penn, hailed the discipline as an entirely new approach to medical care. He described its central precept as the recognition 'that medicine does not stand alone' but 'in relation to the social organism' (BMA 22/9/43). According to Penn, social medicine reintegrated the disparate strands of medical sociology, medical psychology and general medicine to form a coherent whole, and a new medical expertise over the realm of the social. In 1945, Brigadier F. A. E. Crew, the newly appointed Professor of Public Health and Social Medicine at the University of Edinburgh, similarly argued that the strength of social medicine lay in its incorporation of the disciplines of sociology and psychology. He observed that the belated emergence of these complimentary disciplines had caused an uneven development in science that could now be redressed. With the addition of these new perspectives, 'social medicine' emerged as a 'medical science in relation to human groups' (Crew, 1945:37). The crucial innovation of the new science, therefore, was to proffer a unique view of the individual, not as a discrete organism, but as member of a dynamic human group (Crew, 1945:39).

The extent to which the concept of social medicine was embraced in medical thought in the immediate post war period is indicated by the renaming of the official journal of the British Medical Association to *Social Medicine*. The principles of social medicine resonated with the political tasks of post Second World War Britain. They offered a unique skill in the effort relieve the privations of war, rebuild national resilience and security, and return social order. They also resonated in the effort of the international community to set a progressive agenda for the new era. The belief that health was of of profound social significance was reflected in the drafting of *The Universal Declaration of Human Rights.* Article 25 of *The Declaration* recognized a universal right to the circumstances necessary to produce health.

> Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care…(United Nations General Assembly 1948 in Davidson and Spegele, 1991:248)[1]

Like the concept of social medicine itself, this statement reflects an aspiration for an integrated social realm in which the multiple social requirements for health are met, and in which physical health and economic health feature as an indivisible union. In Britain, the utopian vision of an integrated social realm in which health is achieved as a matter of right, fragmented under the political weight of post war reform.

The effect of biostatistics

Since the innovative work of William Farr in the early nineteenth century, British medicine had utilised statistics to compile aggregate data about the health of the population. The British statistical tradition was regarded as the mainstay of its public health programs. In the late nineteenth and early twentieth century the new statistical methods of probability and error-theory were developed by Francis Galton and his successor Karl Pearson (Hacking, 1990). These techniques had little immediate impact on mainstream medical science, were barely accepted by medical scientists and were even less understood by ordinary practitioners (Higgs, :323) In 1911 the General Register Office, as responsible for the collection of mortality and cause of death data gathered via the civil registrar, attempted to improve its statistical apparatus in line with the new mathematical developments. This effort was unsatisfactory and they quickly returned to 'established' statistical methods. (Higgs/Mathews 1995pp115-30). In 1914 the newly created Medical Research

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[1] The practical attainment of these goals was thought to rest with an extension of the work of the International Health Organization, formed by the League of Nations following the 1914-1918 War (Editorial 1945:493).

Council (MRC) established a Statistical Department within the new National Institute for Medical Research (Higgs, :327). The role of the statistical department was to engage in ‘inquiries relating to diet, occupation, habits of life and other matters bearing on the incidence of disease’ as well as to ‘collect and deal with all types of vital statistics including the distribution of disease’. The first report of the MRC included a statistical report of the excessive incidence of phthisis in the boot and shoe industry. The promise of this work, however, was dissipated when the resources of the statistical unit were diverted to the War Office during the First War and eventually subsumed by the Ministry of Pensions (Higgs :328).

In the interwar years, the Statistical Department was re-established and its work expanded. The Departments medical research projects were diverse. For example, in 1931/32 staff in the department were working on whooping cough mortality, anthropological data on pre-school children, the vitamin content of butter, birth rates in Wales and the south-east division of England in the period 1869-1930, the mortality or pulmonary tuberculosis in Wales, the insulin treatment of diabetes, the mathematical analysis of intelligence tests, the relationship between the brain cortex and speech, and how children of different physical types affected the liability of particular diseases, such as asthma and rheumatism (Higgs, 336.) During the 1930’s the Department conducted a comparative study of the mortality figures in the most depressed areas of Britain. This analysis showed that while these areas experienced higher death rates than the country as a whole, they shared in the general decline in morality. The evident decline in mortality was accepted as confirming the contention that the provision of ‘economic relief’ by the government was preventing a mortality crisis in these districts. (Higgs, 337). On the strength of this finding, the Department was invited to consider the effect of unemployment on mortality.

In 1935 the report on unemployment published. The study had relied upon the Pearsonian statistical method of correlation co-efficient analysis. Analysed with this method, the data showed that areas where unemployment was highest, also experienced the highest rates of mortality. No correlation was shown between changes in the rate of unemployment and changes in the rate of mortality. The report concluded that there was ‘no practically important relationship’ between the variables of unemployment and mortality (Lewis Faning:1937:866). These findings were published in the *British Medical Journal* in 1937 in conjunction with an additional study that similarly dismissed the correlation between poverty and mortality. In the latter study, the data was interpreted as supporting the argument that the high rates of mortality in ‘depressed areas’ of England and Wales were probably due to ‘genuine geographical and racial factors’, rather than to poverty induced by unemployment. These conclusions produced a significant challenge to the prevailing medical orthodoxy that poverty caused disease.

In the context of the elaboration of social medicine, the observation that mortality was connected to a range of extraneous factors, rather than poverty, initiated a critical debate about how the international communities requirement that countries provide adequate ‘conditions of health’ could be practically achieved. On one hand, a vehement defence of the relationship between economic circumstance, mortality and morbidity continued to argue that the amelioration of economic conditions would have the most significant impact on the health of the people (for example see Titmus,1943). In terms of the enunciation of human rights, ‘the right to a standard of living adequate for the health and wellbeing of himself and his family’ would be best ensured through appropriate welfare and industrial strategies. On the other hand, the suggestion that the health of the people was crucial to the achievement of an adequate standard of living, meant that ‘the right…. to health care’, rather than ‘the right….to food, clothing, (and) housing,..’ should be emphasised.

Universal vaccination

The argument that the universal delivery of health care, rather than the amelioration of poverty, would achieve health was supported by European example. Instigated by voluntary organizations on the basis that a population devastated by tuberculosis could never achieve economic stability, an orchestrated campaign to vaccinate populations against tuberculosis was commenced across Europe and the Mediterranean region. In 1947 the Danish Red Cross initiated mass BCG vaccination campaigns in Poland, Germany, Hungary and Czechoslovakia. In 1948, the Norwegian Relief for Europe and the Swedish Red Cross added their agencies to the effort. The United Nations International Children’s Emergency Fund (UNICEF) joined the three voluntary organizations in a partnership that marked the creation of the International Tuberculosis Campaign (ITC), known as the Joint Enterprise. Between 1948 and 1951, the ITC assisted 23 countries to conduct mass BCG vaccination programs. The work was continued by the World Health Organization (WHO) and UNICEF, and after 1951 with the support of the WHO Tuberculosis Research Office, established in 1949. Between 1948 and 1951, across twenty-three countries a total of almost 30 million people were tested with tuberculin and close to 14 million people were vaccinated (WHO,1954)[2].

The direction forward continued to be hotly debated in Britain. The apparent utility of providing health care to the population fuelled the suggestion that the introduction of a nationalised health scheme would best achieve the objectives of providing basic health care to every member of the population. Supporters of an economic approach to the alleviation of the burden of health granted that a nationalised medical scheme would provide important medical services to the poor. Those who apposed the imposition of government control over medicine regarded a nationalised health scheme as the beginning of a 'slippery slope' toward socialism. They argued that the realisation of true social medicine would only be achieved by a system of health care delivery that protected the freedom of the people. The European experience of Nazi medicine offered proof that the involvement of the state in medical affairs inevitably resulted in the collapse of individual rights and liberties. Furthermore, the freedom of the people from disease could only be achieved through the defence of medical freedom. This was because the wellspring of medical advance and innovation that characterized British medicine was a direct result of that freedom. Without freedom,

> …medicine is emasculated, stereotyped and devoid of individuality, man works better for himself, and must have freedom from political control (Lord Hunter, 1945:)[3]

Intellectual freedom could not co-exist with political control, and only the intellectual and political independence of medicine would ensure protection of the individual rights of citizens. In social medicine, medical freedom was doubly necessary to

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[2] Czechoslovakia, Poland, Syria, Israel, Malta, Tunisia, Ecuador, Austria, Morocco, Tangier, Greece, Yugoslavia, Egypt, Algeria, Finland, Lebanon, Palestine (Refugees), Italy, Mexico, Hungary Ceylon India, and Pakistan.

[3] Public address by Lord Hunter, Consulting Physician to Saint Bartholomew's Hospital London, first published in *The Lancet*, March 10, 1945)

balance the dual obligation that was imposed by the requirement to treat both the 'individual' and 'society' (Hunter, 1945:). Without independence and freedom from 'political interference' there would be no shield to protect against the 'insidious growth of domestic interference with liberty' (Hunter, 1945:). Any system of medicine that denied the centrality of professional medical freedom and individual practitioner discretion amounted to socialized or totalitarian medicine. A denial of medical freedom, of whatever form, was incontrovertible proof that the individual rights of all citizens would evaporate. Despite these strong arguments, the political assumption that universal health advantage could be assured by some form of universal health program prevailed in Britain. The National Health Scheme (NHS) was introduced in 1948. In 1952, the title of the official journal of the British Medical Association was modified to *Preventive and Social Medicine* and after this time the concept of social medicine, as a specific discipline, faded from view. While a full examination of social medicine as it appeared in Britain in beyond the scope of this paper, the immediate post war years present as a watershed in western medical thought and practice.

Of most importance was the dissolution of a direct link between disease and poverty. This shift was to profoundly alter the trajectories of medical thought in the second half of the twentieth century. Its immediate effect, however, was to dispel efforts to improve health the health of the population through the alleviation of poverty, or through manipulation of the social realm, and to bring the imperative of universal health care to centre stage. From this time onward, debates centred on whether universal health care should be provided through nationalised or independent schemes. Within medical discourse, consideration of the social dimension of health was increasingly marginalised.

The practice of social medicine in Australia

The nationalisation debate in Britain was critical to the type of universal medical strategies adopted in closely aligned nations. While New Zealand followed the British model, the profound impact of the British experience in Australia, produced a configuration of 'social medicine' that eschewed a nationalized health scheme but nevertheless strove for a system of universal delivery. The realisation that the majority of the population, regardless of socio-economic position, had been exposed to tuberculosis confirmed the validity of shifting the emphasis away from poverty as the major cause of disease. While the conditions of poverty remained important, especially for tuberculosis, the view that mortality and morbidity were not directly caused by poor income gathered credence.   For example, in one doctor's opinion

> …if slums produce youth who devote time to pubs, pitches and ponies, they can't be so poor… it is folly to imagine that alteration in the economic system could alter human behaviour (Brown,1945:127).

The debates around the implementation of social medicine in Britain, therefore, served to bring to the fore, in Australia, a medical view that human folly, not economic conditions, was the primary cause of disease. It followed that medical programs should be primarily directed toward the alleviation of medical, rather than economic, conditions.

The tenor of the social medicine debate also attested to the propriety in Australia, of medical men and women adopting a vocal and frankly political stance. The *Medical Journal of Australia* argued that it was important and appropriate for doctors to make open and frank commentary on government social policy. It urged Australian medicine to be involved in the affairs of government, and encouraged individual doctors to contemplate formal entry into the field of politics (Editorial 1945:39). Conversely, the Journal consistently argued that government intrusion into the affairs of medicine would contravene the principle of freedom and interfere with the fundamentals of the medical commitment to national rejuvenation

Similar political tensions to those that erupted in Britain were evident in the Australian effort to interpret the new discipline. In October 1944 Dr. E. P. Dark addressed a meeting of the NSW Branch of British Medical Association With a paper entitled 'Sociological Medicine: its meaning and scope' (Dark, 1945). He argued that social medicine should be properly understood as sociological medicine[4]. He claimed that the unique feature of sociological medicine was its concern with every cause of disease and death in the community, and its incessant searching out, and removal of the primary cause. Dark accused Australian medicine of focussing its preventive efforts on 'bacilli', rather than acknowledging that poverty, physical development, mental development, nutrition, education, and crime should also be regarded as medical problems. He argued that these aspects could be addressed in a medical approach that took as its task treatment of 'the natural life of health' (Dark,1945:31).

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In this argument Dark reflects an effort to draw a valid correlation between social circumstance and health, rather than accepting the medical dismissal of a correlation between poverty and disease. Dark's paper, however, was met with undisguised ridicule. One doctor argued that his implicit rejection of laboratory medicine would lead to 'medical hem stitching and medical doily making for the treatment of elderly female patients'. Another argued that 'society could not be blamed' for some people's 'lack of resources', and another argued that there was scant medical interest in matters sociological. Dark was accused of exhibiting discredited socialist or communist sympathies, of advocating a nationalized health, and of fundamentally misapprehending the restorative task of social medicine (Tiernes, 1945:126) .

While Australian medicine rejected the imposition of a nationalized health scheme, the success of the argument was in part dependent upon its ability to illustrate that social medicine, understood in terms of a modern and progressive effort toward universal health strategies, was already being implemented in Australia. Clearly, the Australian model of social medicine did not disregard the 'right to living standards adequate to the prevention of disease'. On the contrary, Australian social medicine had merely dispensed with the punitive sanctions and 'drain theories' of the 'old' public health. Furthermore, it had refined the 'new public health', as propounded by prominent medical figures in America, by concentrating on an 'anticipatory search for

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[4] Sociology was included in the medical curriculum in Australia in 1945. Some doctors argued that medicine was properly understood as a branch of sociology, rather than the reverse. (Barrett, 1945: 127).

disease causes' (Cilento, 1945:25)[5]. Social medicine in Australia was exemplified by the medical campaign against tuberculosis, and its 'anticipatory search for disease causes' rested on new techniques in statistical epidemiology and the innovative development of x-ray as a 'screening' device.

Universal infectivity

During the interwar years, plans for a campaign against tuberculosis that were formally adopted by the Federal Health Council in the 1920s, foundered in the economic depression of the 1930s. All government spending was severely curtailed during this period including, in 1929, abolition of the Tuberculosis Division of the Federal Department of Health, the Federal Office of the Director of Tuberculosis and all related Federal schemes. State schemes similarly languished beneath economic restrictions. In 1944, the Ministers of Health Conference resurrected the lapsed plan for a national tuberculosis scheme. The *Tuberculosis Act (Cth)* of 1945 allocated financial assistance to the States. It was intended that the States would use these funds to minimize the spread of tuberculosis, to promote better treatment of tuberculosis and to encourage sufferers of tuberculosis to seek treatment and refrain from working. The scheme failed, however, to enlist the cooperation of the States for a variety of practical and political reasons (ref: Boag). This prompted the Federal Government to appoint a committee of inquiry to investigate the urgency of the tuberculosis problem. The committee's examination of current research into tuberculosis revealed a new epidemiological picture.

In the late 1930s 'sample' testing of groups within populations became an accepted method of ascertaining the level of disease within the overall population. Tuberculin testing of the Sydney population between 1938 and 1939 showed that 20% of the population were infected with tuberculosis at age 15. This observation indicated that infection within the home remained an important source of tuberculosis in younger age groups. The new research showed that after the age of 15 years, the rates of tuberculosis infection rose to 80% by the age of 40, indicating that most infections occurred in the early adult years (Boag p24). The enormity of this result prompted a

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[5] Sir Raphael Cilento, Director General of Health and Medical Services

re-examination of mortality statistics. These showed that tuberculosis accounted for 27.6 % of deaths amongst people aged between 20 and 39 years of age, indicating that more young people had died of tuberculosis in Australia between the two Wars than had been killed by enemy action in the two Wars combined.

> Tuberculosis strikes at men and women in their most virile years- their most productive and reproductive years. It causes far more deaths amongst women of child bearing age than are caused by all the risks of pregnancy combined. The incidence of the disease is greatest amongst the young and active with their most useful years in front of them. (Boag, p61-2)

Tuberculosis could no longer be interpreted as an infective process that was confined to the domestic sphere. Tuberculosis was at large, attacking the most productive sectors of the population and impeding post war reconstruction.

In 1946, constitutional amendment broadened Federal power over matters of national health. In 1947, Dr. H. Wunderly was appointed Commonwealth Director of Tuberculosis in a reconstituted Division of Tuberculosis (Proust, 1991:204). Wunderly surveyed tuberculosis programs in the United Kingdom, Europe, Canada and the United States before directing the shape of the forthcoming Australian campaign. With the specific approval of the State Ministers of Health, a joint campaign in which the States controlled policy through the National Tuberculosis Advisory Council was enacted in the form of the *Tuberculosis Act (1948).* This legislation conferred wide ranging power on the Director-General of Health, including power over the conduct of all hospitals, sanatoria, laboratories, diagnostic centres, radiological and other units and clinics for the diagnosis, treatment and control of tuberculosis (Proust, 1991:206). The Federal legislature was confident that the new tuberculosis legislation was launched with ‘the full cooperation of the people’. (Boag, p62). By 1950 all the Australian States had passed complementary legislation that enabled the implementation of the national program (Proust, 1991:207).

The stated objective of the national campaign was to stop the spread of tuberculosis infection by identifying and targeting the ‘open case’, the ‘early case’ and uninfected contacts.

> It must hunt down the open case and convert it to a closed case or prevent, by educative means, it spreading infection. Further, it must seek out the early case in the pre-clinical stage and take such measures as have been found to be effective to protect those who, with a negative tuberculin reaction, are compelled to be in contact with tuberculosis (per Wunderly at Australasian Medical Conference ,1937 in Proust, 1991:220).

While these objectives reflect the familiar language and emphasis of preventive medicine, the 'hunting down' of the open and early case in social medicine was made possible by the development of the mobile x-ray unit.

In Australia, the first primitive X-ray departments had opened at the Sydney Hospital in 1900[6]. At this time, x-rays were used to diagnose limb fractures and it was not until after the First World War that x-rays were applied to examination of the chest. In 1939, Pagel in England reported that mass chest x-ray surveys had been conducted on German Police and Nazi SS troops. Interested in exploring these developments for use in Australia, Wunderly had developed a miniature radiographic unit that took 35mm photofluorography films. This machine was replicated for use by the Australian Army to conduct the first mass chest examination amongst Allied troops (Proust, 1991:139). Cotter Harvey described the expected impact of the new technological capability in the following terms.

> The most important advance in preventive medicine will be the survey of whole groups or even whole communities by mass x-ray photography. A mass survey does not pretend to offer the final diagnosis, its object is to select for a more careful study relatively small numbers of persons from a large population of presumably healthy individuals. (1940 cited by Proust,1991:).

The possibility of identifying the elusive tuberculosis carrier fuelled support for mass population screening. X-rays promised to make the hidden threat of tuberculosis visible. With this device public safety would be ensured because the every infective individual would be plucked from their midst.

With the new tool of mobile x-ray units and the backing of national legislation, the mass diagnostic screening of the population was made possible for the first time. The application of a technological administration of health at the aggregate level was to produce, in its turn, new medical understandings about the population. The immediate impact in Australian of the first universal medical campaign is illustrated in the following account of the Tasmanian campaign against tuberculosis.

Universal medicine

Recognition of the problem of tuberculosis in Tasmania led to the establishment of the Tasmanian Sanatorium in 1905. The work of the Sanatorium was substantially augmented in the mid 1930s with the establishment of two chest clinics and an annex to the Launceston General Hospital that provided accommodation and treatment to tuberculous patients (Goddard, 1947:517). The Tasmanian Division of Tuberculosis was established following the passage of the *Tuberculosis Act (Cth)* of 1948. The opening of the new office marked the beginning of an innovative approach to the containment of tuberculosis as a disease of the population.

The new phase of the Tasmanian campaign commenced with a program of 'propaganda' (sic) that sought to inform the population about the problem of tuberculosis. These efforts included the publication of 'an attractive booklet', couched in 'simple language' entitled *What You Should Know About Tuberculosis*. The division aimed to introduce this booklet into 'every home in Tasmania' (Goddard, 1947:518). The booklet was supported by a series of short press notices of 'educational value' that were published weekly in the three daily newspapers. The co-operation of the commercial broadcasting station was also sought and received. The Government Photographic Department produced three sound films dealing with the work of the sanatorium, the activities of a chest clinic, and the mass X-Ray Unit that was to commence operation. These films were screened in conjunction with free public lectures. Pamphlets were also produced that gave instruction to patients who were awaiting admission to the sanatorium. They showed how to deal with 'germ soiled things' and 'how to kill tuberculosis germs'. Information pamphlets were given to all patients entering sanatoria, and pamphlet information was provided to every nurse who staffed tuberculosis wards (Goddard, 1947:518). Where preventive medicine had been ambivalent about the efficacy and effects of public health

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[6] A second was established at St. Vincent's in Darlinghurst in 1905

information, the tuberculosis campaign tended to embrace public health education. For the first time, the community was saturated with information, not only about prevention and symptomology, but also about innovative medical management of the problem in terms of population screening.

The second thrust of the Department's activities was the re-classification of the past five years of accumulated notifications in order to form a central register of tuberculous cases. The new register recorded how the case was discovered, the predominant symptom, the X-ray report on discovery, the mode of sputum examination, the state of disease at discovery, the family history, the kind of treatment given and the condition of the patient seven years after notification. Continuity between the reclassified register and new notifications was achieved by requiring general practitioners to adhere to standardized diagnostic criteria and management of tuberculosis. The Tuberculosis Division laid out standard diagnostic methods and strict criteria for classification of the disease. The classification criteria also dictated the path of clinical management. For example, a quiescent condition was achieved when all the patients constitutional symptoms had vanished, when a blood haemogram was normal, when the sputum was 'negative' and when the X-ray revealed satisfactory fibrosis[7]. If these criteria remained for two years the condition is considered to have 'arrested.' These patients could be regarded as 'cured under the ordinary conditions of life'. By imposing standardized criteria across a range of technologically generated clinical data, the health status of individuals could be definitively categorized in order to match individuals to the ordered stages of a comprehensive administrative program. In the medical administration of tuberculosis the natural meaning of cure was substituted with specific, scientific criteria in which the subjective experience of the patient, or the attending practitioner, was irrelevant. Symptomology was standardized in order to evaluate the strategy to be employed. While the rhetoric of social medicine had insisted upon the political dimension of practitioner rights and freedoms, the imposition of objective scientific criteria in the course of the tuberculosis campaign fundamentally altered medical practitioners clinical freedom.

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[7] The process of caseation first described by William Thompson in 1882 in Melbourne was widely acknowledged by the interwar period.

The standardization of clinical practice and the effort to heighten public awareness about tuberculosis, however, were merely precursors to the primary activity of the proposed campaign. The central object was to achieve a mass x-ray 'survey' of the entire adult population. A stationary x-ray unit at Hobart, a miniature unit at Launceston Hospital and a mobile unit for touring outside the capital were dedicated to this purpose. The Launceston Unit also routinely examined every patient admitted to that hospital. (Goddard, 1947:520). In Hobart, the Chamber of Commerce, other employer organizations, and trade unions were requested to encourage their members to participate in and support the mass survey. Business houses were contacted directly with the request that their staff be allowed to present for examination in working hours. This approach achieved a response rate of 85%. Between July and October 1945, 6,915 adults were examined by x-ray. Of the 233 people who were requested to return for a repeat X-ray, 63 were recalled for further investigation. This process revealed a total of 20 new 'significant' tuberculosis lesions (Goddard, 1947:522).

The process of orchestrated community organization accompanied the visits of the mobile x-ray unit to centers outside Hobart. These tactics, based on similar processes used in the American campaign against tuberculosis, resulted in an extraordinary level of community penetration.

> Approximately one week prior to the visit of the mobile unit to a town, arrangements were made with the municipal authorities to call a public meeting. All organizations, trade and otherwise, in the district are communicated with and asked to send representatives. An officer of the department attends the meeting and forms a local committee, which usually consists of a good cross section of the community. The organizations usually represented are: the Red Cross Society and the Country Women's Association who supply ladies to assist in the unit; the Labour Party: the Liberal Party; the Parents and Friends' Associations; Mothers Clubs; Trades and Labour Councils; Saint John's Ambulance Brigade; the Waterside Workers Federation. Valuable assistance is always given by members of parliament, school teachers, municipal baths inspectors and other interested people. A section of the town is allotted to each organization who conduct a house to house canvas (Goddard, 1947:521).

In addition to public meetings and door knocking, circulars and booklets were distributed, notices were placed in business premises, pamphlets were distributed through schools, and slides were shown at the local picture theatre. The Tasmanian Campaign aimed to saturate the population not only with information, but with personal exhortations to join the fight against tuberculosis.

In medical terms, the object of these strategies was to subject a maximum number of people to x-ray screening. The returns of the Tasmanian mobile unit showed that 78% of people communicated with presented themselves for examination. This was regarded as an excellent result. From August to December in 1946 11,153 persons were examined. Of these 305 were recalled for re-examination by the larger stationary units. In the recalled group, 41 persons showed healed lesions, 7 cases were already diagnosed, and 93 showed non-tuberculous pulmonary or thoracic conditions. The 55 persons who failed to respond to the recall were subject to 'follow up procedures'. In total, the mobile unit detected 31 new 'significant' lesions, seven of which needed treatment (Goddard, 1947:522).

Despite these apparently small figures, mass screening in Tasmania was regarded as an incontrovertible success because the pool of infective individuals not subject to medical supervision in some way, had been considerably reduced. What emerged from the administration of the universal medical campaign was the critical importance of eliciting participation from the entire population.

The medicalized population

The saturation tactics of the Tasmanian Campaign were imposed upon a population already familiar with the medical exhortation to adopt specific practices of personal hygiene in the name of health. The scope and intention of this campaign, however, both presumed and reified the resposibilised citizen as contributing to the effort against tuberculosis through an unquestioning acceptance of medical surveillance. The population was subject to repeated directions to seek medical examination, whether or not they experienced obvious signs of disease and whether or not they felt well. In tuberculosis, even feeling of wellbeing was construed as a sign of disease. The technique of mass population screening instilled an orientation in the population that recognized the true presence of disease might only be made visible by medical diagnostic technology. The tuberculosis campaign, therefore, was instrumental in steering the population toward the habit of regular medical examination

At the same time as the population was encouraged to surrender themselves to medicine, however, they were bombarded with detailed information about predictive signs and early symptomology. This information was accompanied by repeated exhortations to practice an unprecedented scrutiny toward the possibility of one's own ill health. Dangerous disease was often invisible, and frequently difficulty to discern. Accurate and timely medical diagnosis, therefore, could be augmented by intense personal vigilance. Health information was not offered as an avenue to autonomy, but as the most effective means of achieving general compliance with imposed medical regimes.

Furthermore, the universal nature of the campaign implicitly demanded that every citizen demonstrate their commitment to the community, not merely by maintaining the boundaries of their own infectivity as in preventive medical regimes, but by actively participating in the public eradication of tuberculosis. It was the practical conduct of the campaign, exemplified in the Tasmanian experience, that ensured that the responsible citizen was construed as one who attended screening promptly, encouraged others to submit to medical examination and complied with any medical directives that ensued. Conversely, the irresponsible citizen was one who failed to adhere to the various procedures of the medical program. People sought to participate in the program, not as a matter of individual right, but as a matter of community responsibility.

In preventive medicine the pursuit of the infective individual was sanctioned by the 'right' of the people to be free from infection. In social medicine the similar 'right' to be free from contact with unscreened persons sanctioned universal screening. In this instance, the right to the conditions of health was activated by the assignation of established medical risk to the non-participating (irresponsible) citizen. This right was realised through the active encouragement of voluntary participation, coupled with the demand that those persons who declined the offer were forcibly made subject to medical scrutiny.

The necessity of compulsion

The orchestrated medical program against tuberculosis in Australia spanned the years from 1948 to 1976. In this period, mass x-ray screenings were conducted every three years until 1968. Apart from an initial reluctance from some States to make participation in the campaign compulsory, the bulk of the population maintained their compliance throughout the campaign. While the initial enthusiasm for participation might be attributable to the mood of reconstruction in the years immediately following the Second World War, continued compliance was exacted by the evocation of the risks constituted by non-compliant populations.

The practice of attempting to screen the entire population brought with it an immediate practical problem. In Tasmania the relevant legislation had deemed participation in the Tuberculosis Campaign to be compulsory. The early survey returns, however, suggested a worrisome pattern. Those persons who were most reluctant to attend for further investigation following a ‘suspicious’ initial x-ray were those who were most likely to be subsequently diagnosed with disease. In addition, a full 5% of people who were requested to return for further investigation failed to respond. While the screening program had uncovered what was considered to be a significant amount of disease, there was a growing perception that dangerous disease was harbored within those sectors of the community who were least amenable to medical scrutiny. This association of disease with non-participation threatened the most fundamental rationale of the campaign and reverberated throughout the National Campaign.

Following the 1948 legislation West Australia, South Australia and Tasmania had introduced compulsory schemes. Victoria and Queensland had refused to do so. The observation from the compulsory States that disease resided within sections of the population who failed to participate, however, made the continuation of voluntary schemes increasingly untenable. As tri-annual screens proceeded throughout Australia, the voluntary States consistently returned results for only 50-60% of the population and contributed minimal additions to the annual notifications of disease. In contrast, the States in which participation in mass screening had been made compulsory each contributed between 30-50% of the annual notifications (Boag,1971:74). In the light of these results, the voluntary States were subjected to increasing federal pressure to alter the status of their schemes.

Compulsory surveys were eventually commenced in North Queensland in 1959 and in Victoria in 1962. The belated introduction of compulsion in these States allowed some instructive statistical comparison. For example, a careful examination of both survey populations showed that in Victoria, the discovery rate in the voluntary screenings was 0.29 cases per 1,000 films, whereas the discovery rate in the first compulsory surveys was 0.47 per 1,000 films. Similarly in Queensland, the rate of tuberculosis discovered in 'non-attenders' was found to be 9-10 times higher than in a co-operative groups. The rate of discovery was 0.3 per 1,000 for 'co-operative' subjects, compared with 2.92 per 1000 for 'uncooperative' subjects. In addition, although 'non-attenders' made up 3% of the total population, they produced 15% of all tuberculosis cases. (Abrahams)

The efficacy of compulsion was further confirmed by the overall decline in tuberculosis rates. Between 1950 and 1973, the rate of tuberculosis decline was four times faster than the rate of decline between 1927 and 1950. Overall rates also showed that the accelerated decline experienced throughout Australia was delayed until 1959 in Queensland, and 1963 in Victoria, when compulsory surveys were introduced in those States. Following the introduction of compulsory surveys in Queensland, the discovery rate of tuberculosis declined from 5 in 1958, to 2.5 in 1964 and 0.9 in 1968 and below 0.5 in 1972. However, between 1963 and 1970, only 5,805 active cases of tuberculosis, amounting to 33% of the 17,717 notified pulmonary cases, were discovered in the course of the campaign. This suggests that diagnoses by independent medical practitioners, albeit within the auspices of the anti- tuberculosis quest, were far more significant than the public surveys.

Nevertheless, mass screening was defended on the basis that it continued to achieve the earliest identification of active cases. Intervention when the disease was less advanced amplified the benefits of diagnosis by reducing the spread of infection, improving the chances of cure, and reducing interference with employment. Primarily, however, compulsory mass screenings were continued in order to cast toward disease that was ‘hidden’, less by its insidious nature, than by the irresponsible behaviour of its host. The elision of disease with non-participation was grist for the ongoing machinery of the campaign, and the literal pathologisation of non-attendance repeatedly confirmed the necessity of universal compliance with the campaign.

Conclusion

By its insistence on the importance of the provision of universal health care the practice of social medicine in Australia, in the form of the national campaign against tuberculosis, generated a new medical conceptualisation of the population in terms of compliance. Consideration of social disadvantage, or an epidemiology that was posed around the issue of poverty, were excluded from medical understanding, other than to form narratives of compliance or wilful refusal. Paradoxically, however, the crucial link between disease and the health of the population that was forged by the practice of social medicine, was the psychological bearing of the patient.

Chapter 9: The right to truth

> *To be a person, to have moral being, is to have the capacity for intelligent causal action. It means to be free of physiology! It means to have selfness and self-awareness. This is something that is not found in the body or in any of its organs...but not above the body, more a partner to the body allowing the body to be worked on.* (Fletcher, 1955 :218).

Introduction

The displacement of the lines of connection between poverty and disease that occurred in the mid-twentieth century contributed to the perception that the provision of health services was essential to enhance the productivity of the population and security of the nation. The imperative of universal health care, in turn, emphasised the need for medicine to exact a high level of cooperation from the populace. The education of the public in matters of health had developed as the primary strategy in this task. Following the Second World War, an appreciation that the provision of information could also operate as an exemplary tool of compliance at the level of the individual was brought with the increasing influence of psychology in general medicine. The insertion of psychological rationales and therapies into general medicine, however, rendered problematic the provision of information to the individual patient.

Psychology in general medicine

Psychology presented itself to the realm of general medicine during the First World War. A unique feature of the Great War had been the return of large numbers of service men suffering from chronic, debilitating conditions of unknown aetiology. Management of the ‘chronics’ became one of the most pressing medical problems of the immediate post war period. Traditionally the symptoms that came to be known as ‘shell shock’ had been dismissed by military medicine as ‘malingering’. This term referred to a deliberate affectation of medical symptoms in order to avoid a return to military duty. The usual response to malingerers was to return them to active service or subject them to the formal disciplinary measures of the armed services. The large numbers of men returning from the First World War with apparently genuine and clearly debilitating symptoms, however, forced a reappraisal. As the range of symptoms and disorders experienced by these men was described and classified a re-categorisation of the recognised forms of insanity was formed. Specifically, the ‘psychoneuroses of the war’, with functional nervous disorders, hysteria and reflex nervous disorders listed as sub-categories, were differentiated from the general category of psychosis (Editorial, 1919j:445).

New treatment strategies also emerged. Initially, ‘complete rest, perfect quiet and gentle management’ was recommended that the condition of shell shock (Editorial, 1919c:294). This general approach was soon augmented with specific techniques that were drawn from the emerging discipline of psychotherapy. The new ‘dream technique’ was recommended for hysterics, while the reflex nervous disorders were thought to be best treated by an intimate inquiry into the patient’s personal history. In Australia, the new therapies of personal inquiry were primarily associated with the French psychotherapist Dejeune. Restating this approach for the Australian context, the *Medical Journal of Australia* pressed the point that practitioners

> …must learn the whole of your patients life, all the pleasure that he has been able to gain out of it and all the rancour which may have accumulated in it... to form a coherent

> picture of his mental and moral condition.' (Editorial, 1919:445j).

The care and treatment of shell-shocked servicemen invited an inquiry into the conditions of life of the ordinary patients hitherto unparalleled in Australian medicine. The importance of an intimate inquiry into the 'mental and moral' conditions of the patients' life was emphasised. The therapeutic capacity of this approach supposedly lay in making conscious the reality of a weakened moral constitution. Conscious acknowledgement of moral deficits would allow the patient to be assisted toward the development of a deliberate adherence to habits of mind and body that would improve the underlying moral weaknesses. The focus upon the 'mental and moral' conditions of a patient's life, however, tended to translate existing preconceptions about the inferior moral capacity of marginalised social groups, such as the poor or destitute, into the logic of psychology.

The new condition of shell shock was interleaved with the concept of malingering, to elaborate the gradations of morality that persisted beneath the new diagnostic categories. In 1919, the *Medical Journal of Australia* observed that while 'the majority (of men) did not engage in conscious and wilful malingering', malingering was manifest, in its mildest form, as the behaviour of 'hysterics' who unconsciously exaggerated the physical basis for their symptoms (Editorial, 1919c:294). The ordinary shell-shocked patient, therefore, exhibited a mild form of moral weakness. Deliberate or conscious malingering was assumed amongst soldiers whose behaviour and circumstance marked them as morally degenerate. For example, the appearance of cases of gonorrhoeal ophthalmia amongst prisoners was taken to indicate that the infections had been deliberately produced in order to gain transfer from the military prison to the preferable environment of the hospital. (McClure, 1919:75). It was claimed that

> ….(these) facts throw a very sinister sidelight upon the psychology of demoralised men, whether defective, cowards or criminals (McClure, 1919 :75).

‘Demoralised’ men exhibited the explicit psychological symptom of deliberate manipulation of the benefits provided by the state for legitimate cases. This form of psychological deficit was named ‘sciritrosis’. In 1919, the *Medical Journal of Australia* described sciritrosis as characterised by an ‘imperative desire to obtain material and moral indemnity from the government’ (Editorial, 1919e:77). The typical history of the disorder followed the three stages of ‘shirking under fire, seeking revenge, and then seeking indemnity’ (Editorial, 1919e:77). It was expressed as a grievance against the state in the form of claims for military pensions and was primarily indicated ‘by a lack of desire to get well’ (Editorial, 1919e:77). This, sufferers of sciritrosis were characterised by chronic illness and their propensity to apply for war pensions.

The new techniques of psychotherapy meant that medicine could distinguish between the genuine ‘chronic’ and the man with sciritrosis by discerning the inner motivations of sick men. While the genuine chronic was deserving of pension assistance the psychological condition of sciritrosis would be exacerbated by pension relief. It was imperative, therefore, that doctors employed their new techniques to differentiate genuine from illegitimate claims for military pensions. In this way, doctors would contribute to the war effort by assisting in the task of integrating returned serviceman into normal community life. The *Medical Journal of Australia* thought this is could be achieved by

> …reassuring the sick and wounded, in order to increase their rate of recovery and to calm their sense of grievance (Editorial, 1919e:77).

From this time, the general practitioner, armed with the insights of psychology, was positioned as the ‘gatekeeper’ of government benefits. Doctors were warned to be aware of the impact upon their patients of groups ‘active within the community’ that sought to exaggerate the rights of returned servicemen. There were in the community

> ….well-meaning persons who unconsciously exaggerated the rights of the wounded, while knowing the realisation of these rights is impossible. (Editorial, 1919e:77).

As the ascendant arbiter of these 'rights', medicine rejected the deployment of a rights discourse that sought to understand 'returned servicemen' as a uniformly deserving category. Instead, medicine was preoccupied with the psychological distinctions within the general category of the 'war wounded'. The influence of psychology in general medicine following the First World was further amplified by its apparent versatility and profound utility.

Speaking at a post-graduate lecture at the Melbourne Hospital in 1919, the eminent Dr. Springthorpe claimed that 'the soldier's psychology' had been the outstanding medical feature of the War. He believed the War had shown, 'unexpectedly, the over-powering part often taken by emotion and suggestion' in the course of illness and disease (Springthorpe, 1919:280). Springthorpe was convinced that experience being accumulated within the military mental health hospitals showed that the war neuroses could be treated by a regime of suggestion, re-education, psychoanalysis, physiotherapy, occupation and exercise[1]. Springthorpe hoped that these strategies could be equally well applied to general medicine. He argued it was 'most probable' that a psychological basis underlay many conditions that were currently thought to be organic in origin. If so, they would prove to be amenable to psychological therapy. Springthorpe considered it plausible and 'probably effective' to apply psychological treatment to conditions such as paralysis, contractures, venous stasis, oedema myalgia and gastritis, as well as having obvious relevance in the treatment of traumatic neuroses and lunacy. Springthorpe believed that all branches of medicine

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[1] Separate 'mental institutions' for the care of returned men were first provided in Western Australia where the *Mental Treatment Act (1917)* allowed for the admission of returned servicemen to a separate institution upon a request signed by the responsible military physician (Editorial, 1919j:445). In Victoria, Royal Park Hospital and the facilities at Mont Park had been designated as hospitals for the insane. They were renominated as special Military Mental Health Hospitals specifically for shell-shocked returned servicemen.

> …must rely on the potency and supremacy of the psychological factor. (Springthorpe, 1919:282).

The recognition of the ‘mind factor in disease’ encouraged the introduction of psychology into the medical curriculum in 1919 (Editorial, 1919k:287). From this time onward, the mind factor in disease became melded into the practice of mainstream medicine.

The revolution in general medicine imagined by Springthorpe, however, barely eventuated. While the concept of psychosomatic disease persisted, and recurrently appeared in medical accounts of apparently inexplicable illness, many organic conditions remained stubbornly organic. The most important product of the new psychologising of general medicine, however, was the concept of the ‘therapeutic relationship’. Psychology posed the practitioner not merely as a figure to whom one might turn for moral or hygienic guidance, but as one who could medically engage with the psychologic dimension of illness. The conduct of a scientific inquiry into the conditions of the patient’s life was posed as a diagnostic strategy. Its practice allowed the practitioner to hone a set of psychological remedies that could augment corporeal therapeutic skills. The ‘therapeutic relationship’, therefore, emerged as a crucial factor in individual compliance with medial regimes at the same time, as strategies of general education were commenced in order to encourage compliance at the level of population. This development, evident in various facets of medical practice, can be traced in the changing interpretations of what was regarded as appropriate medical practice in relation to the gravely ill patient.

The therapeutic value of truth

In the aftermath of the First World War, the nature of the relationship between the practitioner and gravely ill patients was challenged. Since before the turn of the century, doctors had routinely withheld unfavourable diagnosis from their patients. This was due in part to the genuine uncertainty brought about by the limitations of medical knowledge and skill, but also because of the persistence of a belief in the therapeutic value of ‘faith’. (Fletcher, 1955:46). Unexpected recovery and unheralded demise were indicators of the mysterious capacities of the ‘life force’, and represented a field in which doctors were unwilling to meddle. The advent of psychology in medicine, however, had invited scientific medical consideration of the motivations of the unconscious patient. Psychology, with its principles of interrogation, challenged the wisdom of maintaining an aloof and deceptive stance in relation to the dying patient. The new movement argued that many patients, like Tolstoy’s *Ivan Illich*[2], were in fact acutely and painfully aware of the deliberate deception practiced by their medical attendants. The insights of psychology suggested that anxieties such as these interfered with the healing process. Deception in this case interfered with, rather than liberated, the life force.

In 1921 in Britain, Dr. Norman Glaister published a paper in the *Lancet* that advocated a new strategy in the management of patients with terminal illnesses. He argued that, rather than imposing a ‘conspiracy of silence’, patients should be offered a truthful account of their prognosis. To do otherwise denied the terminally ill patient ‘companionship on the long road to death’. Glaister thought patients should be told the ‘blunt truth’, with nothing concealed. He argued that once the initial shock had passed, patients who were given the opportunity to talk frankly about their situation would find acceptance and peace.

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[2] Tolstoy published *The Death of Ivan Illich,* in 1886. In this short novel the central character laments the well meant but obstructive behaviour of his doctors, friends and family who consistently maintained in the face of obvious evidence to the contrary, that he was going to recover from his illness. Their insistent resort to cheerfulness and encouragement left the dying man lonely and alone, aware of his own dying, but forced to participate in a charade to maintain the impression of his own deception.

In Australia, Glaister's views were regarded as extreme. The *Medical Journal of Australia* thought that the practice of truth telling should be reserved for a limited the number of heroic individuals. The journal claimed that

> The vast majority are not fitted, and do not expect, to hear the worst. He gains comfort from kindly reassurance. The truth would wound his higher susceptibilities and precipitate an abyss of despair which may kill him (Editorial, 1922h:232).

Hope was, therefore, 'the generous hand maiden of medicine' (Editorial, 1922h: 232). The *Journal*, however, decried instances of lying where hopeless progress had been falsified in order to make claim to the attendant's own skill in producing 'surprising recoveries'. The *Journal* concluded that, as a matter of proper practice, doctors should only tell what is good for the patient to hear and no more. 'Immediate friends' who are 'fit to hear' could be told of an approaching death, but it was thought Dr. Glaister's 'heroic method' should be reserved for the 'visionary future' (Editorial, 1922h:232). Medical practice in Australia continued on the basis that the doctor should impart such information, as he considered appropriate in the circumstances of each case. This entailed the careful nurturing of the patients inner resources or 'hope'. This was no longer to be achieved by blatant deception, however, but by a careful management of the truth. The strongest, most detailed, articulation of this rationale emerged from the United States of America.

In 1936 a prominent America physician, Dr Cabot, publicly declaimed the 'traditional' system of concealment. He admitted that between 1893 to1902 he had adhered to the practice of deliberate and uncompromising deception, but 'bitter experience' had encouraged him to abandon them. (Fletcher, 1955:46). In 1940, Hans Zinsser, an American bacteriologist and immunologist, wrote an evocative account of his own experience with leukaemia. He claimed the medical provision of truth was important to allow the positive change in personal relationships that accompanied approaching death. (Goldner, 1955:43). The salience of Zinsser's apparently modest suggestion reverberated in American medicine following the Second World War.

In 1949, a Conneticut physician Dr. Hooker, attacked the American Medical Association's moral position on truth telling in a book entitled *The Physician and Patient*. In an 'uncompromising denunciation' of lying and deception in medicine, Hooker argued that the task of the physician should be to 'prevent deception'. To this end the only information that should be withheld is that which would confuse or deceive the patients (Faden & Beauchamp, 1986:71). Hooker's text heralded a public consideration of the medical practices around truth[3]. In February 1950 an issue of *McCall's Magazine* carried a dialogue between well-known surgeon Dr. Frank Adair, of Memorial Hospital in New York, and the author of a recently published account of the author's son's death from fatal disease[4]. In this exchange Dr Adair staunchly defended the practice of not telling patients they had cancer. He argued that for most patients, 'truth' was an excessive burden. Also in 1950, published medical research was showed that most patients wished to be dealt with sincerely and honestly at all times. If cancer was discovered, patients expected, and wanted, to be told the truth (Kelly & Frieson, 1950:822). The following year, a front-page newspaper report in New York broke the 'scandal' that that the famous boxer, Babe Ruth, had recently died of cancer, believing that he was suffering from heart disease (Standard & Nathan,1955), The controversy, both within medicine and the public arena prompted a detailed medical deliberation around the question of truth.

According to Dr. Samuel Standard, Associate Professor of Clinical Surgery at New York University College of Medicine, Attending Surgeon at Bellevue University Hospital and Director of Surgery as Sydenham Hospital in New York, the 'primary medical responsibility' was to promote recovery of the individual patient by whatever means were deemed most useful by the

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[3] cf Faden & Beauchamp who claims that Hookers piece had little contemporary impact (1986:72)

[4] *Death be not Proud*

physician. He believed doctors to be ethically bound to make treatment decisions on purely medical grounds. From this point of view, ‘truth telling’ was merely a ‘therapeutic tool’ and should be told only when it promotes recovery and withheld if recovery will be hindered (Standard, 1955:16). Standard specifically dissociated himself from physicians who refused to give any information and from those who actively lied to their patients. He abhorred ‘active lying’ on the grounds that it was ‘sinful’. He also dissociated himself from the ‘brutality’ and ‘misguided heroism’ of those doctors who insist on ‘absolute truth telling’. This kind of truth telling was a brutal act that would ‘destroy peoples will to fight’ (Standard, 1955:23). Standard believed that

> Few (patients) will continue to live bravely and freely under the weight of a poor prognosis (Standard, 1955:22).

As this was the case, he preferred the use of the morally acceptable behaviour of *‘social lying’*. Social lying was both moral and enlightened because it was directed toward supporting and protecting the interests of the individual patient (Standard, 1955 :28). Standard believed that adult patients who were suffering from fatal conditions, ‘sometimes have to be treated like children’ (Standard, 1955:19). Their confidence could be maintained by skimming the truth ‘tangentially’ (Standard, 1955:20). By presenting a positive picture, the doctor could maintain the deception a significant amount of time, especially because friends and family were frequently ignorant of the significance of symptoms that were known to be the forerunners of death. ‘The pretence’, according to Standard, could be dropped once the dying status of a patient becomes obvious, although it was critical that the doctors continued to emphasise to the family that everything was being done to make the patient better (Standard, 1955:23).

One practical example of the application of these strategies of moral deception was the advice Standard offered prior to the surgical removal of breast lumps suspected of being cancerous. He informed all his patients that sometimes the breast is removed even when the tumour is benign ‘just to be sure’ (Standard, 1955:25). By concealing the presence of cancer in this way he hoped to protect the patient from the daily burden of living with the prospect of a possible recurrence.

> Patients accept this (explanation) with gratitude and feel they have escaped having had cancer (Standard, 1955:25).

Should the cancer ‘resurface’, he described this event as a fresh and unrelated cancer. Similarly, Standard declined to inform the post-surgical colostomy patient that the colostomy was permanent. Instead, he told the patient that the result was as yet inconclusive. The truth, that the colostomy was permanent, was revealed only after the patient had learned to accept and manage the prosthesis.

In this view, most patients were deemed to have insufficient internal resources to face the reality of their own demise. Medical manipulation of the truth was therefore necessary to prevent the debilitating effects of a negative psychological response. According to this strand of medical opinion, most patients were wilfully complicit in the maintenance of their own deception. They did ‘not wish to know the truth’ and conspired to avoid the ‘dark subject’ (Casserly, 1955:144; Wolf, 1955:38). For the few who genuinely sought the truth, ‘clues’ could be gleaned from the patient’s demeanour. Truth, however, was a dangerous tool.

> To force any knowledge not demanded or not clearly requested …. ….(would) be unkind and unscientific (Wolff, 1955:35).

Only a few patients who exhibited a desire for the truth, and who were sufficiently psychologically resilient, could shoulder the burden of truth.

The psychological vulnerability of some categories of patients was so extreme that they were automatically excluded from the truth. For example, in obstetrics, the privilege of ‘truth’ was managed according to the particular medical situation in conjunction with the discretion of the husband. For example, where the question of infertility arose the general rule was to give information to the couple. Should the husband prove to be sterile, however, the decision whether or not to inform the wife is left with the husband (Guttmacher, 1955:93). Similarly, where an abnormal foetus was discovered the matter was discussed frankly with the husband, who then decided whether or not to tell his wife (Guttmacher, 1955:95). In the case of foetal death before labour, the husband was the first to be informed. If there was a lethal malformation of the infant, it was recommended that the mother should be prevented from seeing the baby. Doctors were advised to recommend to the father a state autopsy and then 'disposal' (Guttmacher, 1955 :96). If there is a non-lethal malformation it was recommended that the matter was discussed with the father and an appropriate consultant (Guttmacher, 1955:97). If there was an unexpected stillbirth it was recommended that no information be given to the mother for six to eight hours, after which the truth should be 'gradually revealed' while the doctor immediately discussed the possibility of a new pregnancy (Guttmacher, 1955:98). Already deemed to be emotionally and psychologically vulnerable, too much truth could unbalance the parturient woman [5].

As these examples indicate the insertion of psychology into general medicine, tended to support a medical assumption of a universal and debilitating anxiety (Orgel, 1955 :59). As recognition was gradually accorded to the patient's desire for truth, physicians were enjoined to be especially mindful that 'withholding truth may sometimes increase the patient's fear and anguish' (Goldner, 1955:42). To allay this effect, doctors were encouraged to provide 'clear and honest information'.

> Only in this way would the doctor be able to assuage anxiety and offer their patients relief from pain and suffering (Orgel, 1955:63).

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[5] The experiences of mothers whose infants were taken for adoption at this time mirrors this stance.

Simple truths could also be used to ally the fear and anxiety of patients who were reluctant to submit themselves to medical treatment. For example, if the physician stressed the absolute importance of early detection, explained some of the complexity and variability of the disease in question, and emphasised the possibilities inherent in medical advance, they might

> ….encourage the patient towards a positive acceptance of new treatments when a cure seemed unavailable (White, 1955:108).

In this way the doctor could 'assist a reluctant patient's toward surgery or other treatments ' (Standard, 1955:24), and

> …encourage patients toward experimental treatments that might prolong life or reduce pain and suffering (Standard, 1955:27).

In particular, the 'truth' about medical advance could diminish the patient's fear of cancer by disrupting the perceived nexus between diagnosis and death (Snapper, 1955:87). As preventive medicine had shown in relation to contagious disease, early detection also emerged as the key to the successful treatment of cancer. Similarly, encouraging patients toward habits compatible with early detection required the imparting of information, and once a diagnosis was made, patient compliance with medical proposals was essential.

> If we want the patients cooperation, which we must have, of necessity, he must be told. (Wangensteen, 1955:77-78).

With the maxim that 'cancer is curable', doctor's could inform patients about the nature of their illness' without inviting a debilitating crisis of 'confidence' and 'faith' (Wangensteen, 1955:72).

Where diagnoses or prognoses were dire, the practitioner should still provide the patient with adequate information. In the absence of clear and precise statements, some patients might persist in seeking further advice and new or different treatments (Orgel, 1955:61) or they might go ‘from specialist to specialist with the same (unresolvable) problem’ (Guttmacher, 1955:94). Sparing the patient knowledge of ‘the truth’ in such circumstances betrayed ‘misguided sentimentality and false humanitarianism’ (Armiger, 1955:128). Furthermore, the general effect of not telling the truth might be a loss of faith in the healing professions (Armiger, 1955:127).

> …the practice of restraint in the imparting of information, however merciful in motive, may have the unfortunate result of breaking the general faith of the patient with what the doctor says (Casserly, 1955:139).

Not only was truth necessary for individual well being, it was essential to maintain faith in the medical profession.

The efficacy of truth, as a strategy of co-operation, offered new possibilities for the conduct of institutional procedures.

> …every patient (should) know whether he is going to x-ray, to surgery, or to have a hypodermic injection: knowing these simple things allays fear (Lewis, 1955 :115).

The strategy of providing simple truths was also thought to be particularly useful for ensuring the compliance of psychiatric patients. For example, in contrast to the traditional strategies of punishment, reward and the denial of privileges,

> …open communication with the (psychiatric) patients, especially about procedures and rules, is the most useful and effective way of ensuring co-operation. (Weiss, 1955 :66).

Similarly, it was effective to explain to children as ‘simply and clearly as possible’ what was happening or what was going to happen to them (Baer, 1955:102).

The consensus, therefore, was that all patients had 'a right and privilege' to simple truths, provided they were compatible with a freedom from anxiety (Lewis, 1955:115). There was nothing in American law, as in other western jurisdictions, that could be interpreted as a legal 'right to the truth' (Martin, 1955:157). Medical men were obliged to treat their client's affairs with secrecy, except where that obligation must be breached in the 'public interest'. They were also obliged 'to do all that will cure patient as had been established by medical experience' and it was this principle that underpinned the medical responsibility toward truth (Honig, 1955:153). It dictated that if medical experience attested to the dangers of truth telling, then the physician was obliged not to tell. Conversely, the physician might be obliged to communicate the truth if that were necessary to ensure a significant benefit, such as the recognition of a recurrent cancer. (Martin, 1955:158). In the absence of an alternate legal construction the truth debate was elaborated around the issue of therapeutic advantage. This discussion was devoid of reference to patient autonomy or self-determination. Rather in a psychologised field, medicine sought to secure concrete therapeutic outcomes through the vehicle of a patient's (limited) right to know.

The therapeutic calculation

In the debate over truth, the heralds of truth challenged the standard of 'moral lying' on the basis that it was fundamentally detrimental to the therapeutic project. The advocates of deception argued that 'too much' truth telling was also damaging to the patient. Furthermore, in extreme forms it suggested a 'vindictive obsession' on the part of some medical men that represented 'questionable psychological projections' (Meyer, 1955:50). The clash of these competing attitudes found a basis for resolution, not in the subordination of one to the other, but in the articulation of different patient sensibilities and the re-affirmation of practitioner discretion. Whether or not circumstances warranted the ‘truth’ depended on the practitioner’s expert assessment of the psychological capacities of his patient[6].

In order to exercise this judgment, the physician was exhorted to ‘know his patient’. ‘Knowing the patient’ provided appropriate information that was ‘essential to allow each patient to get ready for their (own) truth’ (Wolff, 1955:36). Medical truths were no longer fixed with a permanent or factual core, but varied according to the circumstances of each case and the capacities of each patient. Of most importance, was the practitioner’s ability to maintain a ‘keen interest’ in the ‘welfare and adjustment’ of the patient. The purpose of this interest was to assist the patient in ‘gaining a new purpose and perspective in life’ and ‘adjusting to a new pattern of living’ (Lewis, 1955:119). The physician must be willing to know and accept the patient’s feelings, ‘no matter how different they might be from his own’, including the patients wish to be informed, or to be spared the truth (Wolff, 1955:38). What was absolutely critical was that an ‘..amount of information was given’ that ensured ‘intelligent co-operation from the patient’. This calculation was deemed to be ‘a matter for the physician’ (Goodwine, 1955 :134).

Conclusion

These detailed medical deliberations established the principle that medical ‘practices of truth’ were a matter for individual physician discretion, to be applied in relation to the individual case, and on the basis of what was in the ‘best interests of the patient’. In this formula, articulation of the ‘principle of truth’ was achieved by identifying the myriad paths that the deployment of truth in its various forms, might take within the medical field. Truth was an exemplary tool for exacting patient co-operation. Certain truths could be evoked to contour the therapeutic encounter by dictating the parameters of clinical decision making, partial truths could be a form of encouragement, and

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[6] Rothman (1991) describes the medical ethical practices of the post war era as ‘bedside ethics’. Medical men made ethical decisions on a case-by-case basis, at the bedside, based upon clinical

‘simple truths’ a method of reassurance. In each instance, the psychological demeanour of the patient was recognised as a realm of clinical reality that must be included in the therapeutic calculation.

The right to truth crystallised at a specific historical moment. It was a right that could not have appeared earlier in the century and did not carry itself forward in this same form. It did not reflect a universal medical recognition of humanity, nor did it adhere to a uniform category of the patient. Instead, the right to truth appeared in a highly contingent, strategic response to a particular set of medical problems about the demeanour of the patient that were equally historically specific.

Recognition of these ideas in Australia was carried in the influential work of the Dr. Ainslie Meares (1957). In accordance with their contingent nature, the practices of truth in the medical encounter were subsequently transformed by rapid technological advance in medicine. Different ‘rights’ attached to these different problems of management. Paradoxically, these new historical intersections served to emphasise the psychological importance of ‘autonomy’.

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experience. While this description is accurate, it neglects to highlight the development, at this point, of the specific calculations and rationales that informed those decisions.

Chapter 10:The right to autonomy

> *The fact itself of causing the existence of a human being is one of the most responsible actions in the range of human life. To undertake this responsibility, to bestow life which may either be a curse or a blessing – unless the being on whom it is bestowed will have at least the ordinary chances of desirable existence, is a crime against that being.* (John Stuart Mill, On Liberty (1859) cited in McMichael, 1972:71)

Introduction

At the turn of the century in Australia, the 'right to safe motherhood' had been invoked to justify the medical control of abortion and contraception. Subsequently, the 'right to medical privacy' had sanctioned medical supervision in the home, the rights of the soldier had justified the 'voluntary' management of venereal disease, and the 'right to be free from infection' had justified extensive medical surveillance of the population. Each of these particular rights was coined at specific historical moments in the name of social order, and in terms of the management of the population. Together they represent a strategic allocation of 'social' rights. Although the character of the rights that crystallised in medicine following the Second World War retained this social dimension, their quality had altered. As the emergence of the 'right to truth' illustrates rights in medicine, although still wielded as tool of management, emphasised the importance of the psychological context of health. As the medical effort to manage fertility spanned the century, the medical management of birth control provides an illustration of the transformation of the rights from a political to a psychological register.

The management of fertility

Following the *Inquiry into the Decline of Birth Rate* in 1904 a clear restriction over birth control was imposed throughout Australia. Contraceptive and abortive practices were identified as damaging to the fertility of the nation and contrary to national prosperity and security. The prohibition against 'interference with procreation' was sustained by the imposition of medical supervision over pregnancy and childbirth because these practices fell outside 'proper' medical conduct. Various pieces of legislation directed at achieving prohibition were passed. The *Poisons Ac t(Vic)* of 1905 made 'ergot of rye' available only on prescription, the *Private Hospitals Act* of 1905 required private hospitals to keep a register of births and deaths, and the *Police Offences (Amendment Act)* of 1908 prohibited 'indecent publications' (Seidlecky &. Wyndham, 1990:19). Medical authority over fertility and reproduction was further consolidated by the *Medical Act* of 1906[1], and by the appearance, in 1911, of the first *Code of Medical Ethics* that formally eschewed medical participation in the limitation of reproduction (Petersen, 1993:34). The regulation and subordination of midwifes was also linked to the orchestrated prohibition against 'fertility regulation'. The *Midwives Act* of 1915 required midwifes to demonstrate 'good character' and prohibited them from certifying deaths and stillbirths (Petersen, 1993:41)

Following the First World War, the focus on prevention nurtured a stance within medicine that allowed a reappraisal of the role that contraception might play in improving the health of the family. In conjunction with improved techniques of contraception, the First World War had also produced an improvement in the safety of medical termination of pregnancy. Up until that time, the technique of abortion was formally reserved for situations in which the procedure was necessary in order to save the mother's life. Only this circumstance would satisfy the prohibition expressed in *The Preservation of Infant Life Act(UK)* of 1861[2]. The improved safety of the technique of termination, however, superseded the traditional medical calculation between life and death. Pregnancy and childbirth were now deemed to be more dangerous to the life of the mother, than the procedure of termination of pregnancy.

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[1] The Act restricted registration to practitioners who had at least five years training, effectively excluding overseas trained doctors.

Nevertheless, following the First World War, women continued to be encouraged to 'populate' and formal restrictions remained upon contraceptive and abortive techniques. The *Royal Commission into Health* of 1925 reiterated a central concern about the persistent problem of population decline. High rates of venereal disease, a decreased birth rate and increased maternal and infant mortality were identified as particular problems (Seidlecky & Wyndham,1990:22). Following this inquiry, the task of national advancement formally recognized the need to address the issue of women's reproductive health. The medical recognition of the problem of maternal and infant mortality, however, again drew medical attention toward the practice of criminal abortion[3]. Several articles published in the *Medical Journal of Australia* attested to women's attempts at self-induced abortion by manipulation, drugs or instruments. These practices were described as particularly common amongst working class women. Women in this class also resorted to the services of clandestine abortionists. Medical doctors claimed that they were, not infrequently, called upon to assist with a 'botched job'. The medical recognition of the proliferation of criminal abortion offered a representation of the 'underworld' of 'common life' as critically underpinning the increased level of maternal morbidity and mortality[4].

> For every woman who dies, many others recover, although damaged in health. A later pregnancy exposes this large section to increases risks from septic infection. (Dr. Alan cited Petersen, 1993:54).

Medical attendance at the 'botched job' was justified on the grounds that intervention in life threatening situations had been traditionally sanctioned within medicine.[5] The association of maternal morbidity with the criminal practice of abortion, however, opened the way for an extension of medical practice in to the field of termination of pregnancy. Improvements in the safety and efficacy of the technique of therapeutic

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[2] This legislation was current in Australia and its relevant provisions remain unaltered in the current *Victorian Crimes Act 1958*.

[3] The possibility that high level of infant and maternal mortality might be attributable to inept medical practice and technique in obstetrics was publicly voiced in Australia at this time (per Dame Janet Campbell in Seidlecky & Wyndham,1990:22)

[4] 'Criminal' is used to refer to both medically unqualified and incompetence practice and represents an elision of theses two separate concepts.

[5] For example, A report of a medical conference in London in 1756 stated that there was 'general approval of the view' that the procedure was 'perfectly justified' provided that 'there was a danger to the life or health of the mother' (cited in Petersen, 1993:18)

abortion, in conjunction with recognition of the principles of prevention medicine, shifted the parameters of clinical judgement. As well as being appropriate intervention in life threatening situations, medical terminations of pregnancy could be regarded as valid therapeutic practice, not only when the life and health of the woman was immediately endangered, but also when, in the medical judgment, a future danger might ensue.

The predictability of medical danger was expressed in terms of a threat to health. In the 1920s, medical statements about the presumed legality of medical terminations of pregnancy proliferated. Lord Riddell at a British Medico-Legal Society in 1927 stated that medical abortion performed with 'an honest intention to save life or avoid serious injury to health was lawful' (Petersen, 1993:62). Accordingly, doctors in the 1920s regarded termination of pregnancy as a form of valid therapeutic practice in psychiatric care, as evidenced by the article 'Abortion in the Treatment and Prophylaxis of Mental Disorder' that appeared in the *Journal of Mental Science* in 1927. Other doctors cautioned that 'neurotics' were likely to seek abortion on psychological grounds, when in fact their reasons were personal and economic (per Prof Dawson in Petersen,1993:60). Similarly, the British Medico-Legal Society expressed concern that the increased willingness of doctors to include mental health as grounds for the provision of abortions would 'open the floodgates' (Petersen, 1993:61).

The insertion of the predictability of danger into the clinical equation of the abortion provision, whether due to physical or mental health, was a critical moment in the development of the medical approach to termination of pregnancy. Predictability required scientific elaboration, not only of the statistical incidence of abortion, but of the motivations and behaviour of women, the conditions of pregnancy and the outcomes of the medical and criminal interventions.

Abortion in Britain

In the 1930s, Professor Taussig published a formal analysis of the legal provision of medical termination of pregnancy in the Soviet Union[6]. His study suggested that the legal provision of abortion reduced maternal mortality, although it was noted that morbidity remained high. In 1932 the British Medical Association discussed the issue of criminal abortion at its Centenary meeting. A subcommittee whose task was to review the practice of abortion was convened. Reporting in 1935, the committee found that 16-20% of pregnancies in Britain resulted in an abortion. A high proportion were criminal abortions accompanied by a high maternal death rate (Petersen,1993:53). In 1937 the British Government convened an interdepartmental committee, the Birkett Committee, to inquire into the matter of abortion. The Birkett Report found that 110,000-150,000 abortions occurred in Britain each year, 40% of which were criminal. The Birkett Committee postponed the release of its report until after Justice Mcnaughton had delivered his judgment in the landmark British case of *R v Bourne* in 1939[7].

While medical ethics had moved toward accepting the achievement of health as valid criteria for the performance of a medical termination of pregnancy, the law remained unclear on this point. The relevant provisions in the *Offences Against the Person Act(UK)* of 1861 prohibited the procurement of abortion other than on 'lawful' grounds, although the meaning of 'lawful' in this legislative context remained undefined[8]. Wishing to test the limitations of the law, a respected London obstetrician, Dr Bourne openly performing an abortion upon a 'previously innocent' 15-year-old girl who had been 'brutally' raped by four soldiers. Dr. Bourne attested that he believed his actions were justified because the girl would become a 'mental wreck' if she bore the child (McMicheal,1972:26). His predictions of mental instability were supported by expert psychiatric evidence. In defining his intervention as a necessary preventive strategy, Dr. Bourne argued that he would not have performed the operation on a 'feebleminded girl' or girl of 'prostitute mind'. In these instances, there would be no demonstrable injury to mental health.

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[6] Medical termination of pregnancy was legal in between 1920and 1936. After that time there was re-introduction of strict laws (Peteren,1993:50).

[7] [1938] 3 All E.R. 615.

[8] The law in Victoria is directly based on this legislation.

In directing the jury to treat the preservation of a woman's physical or mental health as a 'lawful' purpose, the trial judge, Justice Macnaghten, drew a close connection between life and health.

> Life depends on health and it may be that health is so gravely impaired that death results (Petersen, 1993:64).

Dr. Bourne was acquitted. In the course of his comments to the jury, Macnaughton J. made three significant remarks. First, he commented that the doctor did not have to wait for the women to be in imminent peril before he performed the procedure. Second, he suggested that if a woman died following a medical refusal to perform the operation, he would be exposed to an action of manslaughter or negligence. Third, he stressed that the case should not be interpreted as condoning 'abortion on request' (Petersen, 1993:64).

Macnaughton's final comments addressed aspects of the abortion debate that had persisted since the 1930s. While his comments may be read as a simply a note of support for medical autonomy, his words halted a line of legal reasoning that sought to pose the legal provision of abortion in term of women's rights. In 1931, Justice McCardie in the Leeds Assizes had called for the law to be clarified and amended. In presiding over the prosecution of two women for the procurement of their own abortions he commented

> I cannot think that a woman should be forced to bear a child against her will… (McCardie cited in Petersen, 1993:63)

Taken in its full context, *R v Bourne* operated as a strategic intervention into the abortion debate. In laying out what should be regarded as the proper formulation of its different aspects, Macnaughten privileged medical autonomy and denied the possibility of accepting women's claims for independent or unsupervised decision-making. The formal introduction of the concept of feeblemindedness into the medical evaluation ensured that a flexible, and highly discretionary criterion for termination of pregnancy was in place. Discretionary principles elevated medical authority, upheld the principle of medical autonomy and ensured that in their practical application, the practitioner was not required to act against their conscience.

Following the decision in *R v Bourne*, the Birkett Committee Report added some general insight into the common behaviour of ordinary women by making a significant connection between economic circumstance and the determination of women to end their pregnancies. The Committee found that most women sought abortions for financial reasons, especially where the women supported a dependent family. Health and personal reasons were also important factors; nevertheless, the decision was usually made 'in the best interests of all the members of the family'. Few women, it was concluded, acted out of 'selfish' motivation (Petersen, 1993:54). The representation of ordinary women as rational and responsible mothers offered the principles of *R v Bourne* a universal resonance. In these terms, the Committee found itself able to support law reform. It noted, and decried, an increased tendency amongst women to see termination as a 'right'. That women might found themselves in dire social or economic circumstance was unfortunate. In general, however, women were not sufficiently informed about the factors that influenced their own health to understand the full implications of an interference with pregnancy. The Committee recommended that while law reform on the issue of abortion should proceed in Britain, such reform should not support the proposition that women be permitted to make autonomous decisions in relation to terminations of pregnancy.

Infant rights in Australia

Following the First World War in Australia, the medical recognition that pregnancy amplified the difficulties of chronic medical problems correlated with an increased willingness to perform abortions on medical grounds. In the 1920s and early 1930s, for instance, learned articles in the *Medical Journal of Australia* enumerated the medical conditions under which it would be clinically valid to provide terminations of pregnancy. Interruption of pregnancy was considered especially appropriate for women who suffered from tuberculosis or heart disease. The problem of tuberculosis, in particular, focussed medical attention on the conundrum of socio-economic circumstance. Rich women with tuberculosis might be able to afford bed rest, sanitaria care, and assistance with the running of a family and household. Poor women, with a similar diagnosis, could afford none of these advantages. Social conditions, therefore, were as much a part of the medical criteria as the clinical diagnosis[9]. The recognition that socio-economic circumstance related to health, considerably expanded the medical grounds upon which terminations of pregnancy could be provided. As the incidence of tuberculosis receded, however, the clinical relationship between health and poverty and its exacerbation during pregnancy and childbirth dissipated. Doctors were warned that while abortion was appropriate where a woman's life was endangered, they should not ignore 'advances in medical science' that could contraindicate termination (Petersen, 1993:59). By the 1930s, the restricted medical criteria for clinically valid terminations of pregnancy coincided with an amplified invocation of women's role as 'mothers of the nation'. The rekindling of a 'right to motherhood' found expression in public forums. For example, the cover of the first issue of the *Women's Weekly* in 1930 carried the banner 'Your right to motherhood'.

Doctors who continued to receive requests for terminations of pregnancy from their patients railed at the clinical and ethical limitations re-established in medical practice while clandestine abortion remained unchecked. In 1933 Dr. Rosenburg, at the Medical Legal Society in Victoria, described his own (proper) practice of refusing women terminations, despite that fact that, he knew that that they would seek, and find, abortions elsewhere.

> Surely these women had some rights? Surely they were entitled to claim the right to exercise some control over their one body and their own progeny?(Petersen,1993:54)

That women might claim a right to abortion and therefore demand that their practitioners provide this service, however, was generally regarded in medicine as antithetical to the principle of medical autonomy and contrary to the social and political responsibilities shouldered by medicine.

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[9] It seems likely that the period of economic depression in the 1930's also increased women's requests for terminations of pregnancy

The *Medical Act (Vic)* of 1933 provided the Victorian Medical Board with the power to deregister any doctor who was found guilty of 'unprofessional conduct'. While the legislation was not ostensibly directed toward the medical provision of termination of pregnancy, it is likely that it influenced medical practice in this area. Supporting the provision of termination of pregnancy in circumstances other than where the operation was medically indicated smacked of 'unprofessional' leanings. In 1935 the *Medical Journal of Australia* commented on the medical role in the provision of therapeutic abortion.

> At no point do principles of medical ethics and the demands of society conflict more bitterly than here. The honest medical practitioner can safeguard his conscience and the welfare of his patient only by considering the matter in a disinterested and strictly professional matter.

The consolidation during the 1930s of a restrictive medical approach to the provision of medical abortion in Australia prompted the National Health and Medical Research to remind its members, in 1936, that abortion was 'evil'[10]. (Seidlecky & Wyndham,1990:23). Nevertheless, the decision in *R v Bourne* supported the view that the provision of therapeutic abortion was legitimate in circumstances where the practitioner honestly believed the procedure would save the woman from serious injury to her physical or mental health. There was considerable medical disagreement, however, about what factors might reasonably be interpreted as constituting 'a serious injury'. Compounding the medical disagreement was the influence of material from the pro-natal lobby that steeped the 'normal' difficulties of pregnancy and childbirth in a popular mythology of heroism, sacrifice and the right to motherhood.

In 1935, the release in Australia of the 'overseas edition' of Dr. Marie Stopes highly influential book, *Radiant Motherhood,* provided a rationale upon which legitimate medical action could proceed. Stopes' book devoted a full chapter to 'Baby's Rights' (Stopes, 1920 [1935]: 143-151). According to Stopes, baby's rights are fundamental. Foremost amongst them is 'the right to be wanted', and the right 'to be loved', 'before as well as after birth' (Stopes, 1920 [1935]:143). The right to be wanted was directly in the national interest, and central to national security, because unwanted babies developed into adults who exhibited ‘the warped and destructive impulse of revolution’ (Stopes, 1920 [1935]:145)[11]. ‘The spirit of strife and malignity’ that occupied the world had its roots in the ‘deep wrong’ of ‘unwantedness’. Unwantedness caused the ‘unnatural’ force of revolution that expressed itself as a jealousy of others’ material goods.

> The revolutionaries- bitter, soured and profoundly unhappy-pit their strength against the normal stream of life and destroy, break down and rob (Stopes, 1920 [1935]:145).

These claims had their roots, not in poverty and injustice, but in ‘a profound longing to be wanted’. While the thousands of readers of Marie Stopes work were not doubt encouraged toward ‘planned parenthood’ as a national defence to insurrection, Australian medicine remained conservative in its approach.

In the 1940s medicine continued to regard the provision of medical terminations of pregnancy as generally outside its legitimate province. In 1944 the National Health and Medical Research Council (NHMRC) conducted another inquiry into worrisome decline in the birth rate. The Council identified ‘deliberate birth control’ as the central problem, surmising that deliberate birth control resulted in high rates of infertility. The proliferation of these practices arose from the ‘decreased dependence of women’ and the increased sense of ‘economic, psychological, social and international insecurity’ that accompanied the war (Editorial, 1945b:151). To ease the problem, the NHMRC supported the establishment of ‘sterility clinics’ and recommended the extension of the existing research effort into infant and maternal morbidity and mortality. At the same time an active ‘abortion network’ existed (Bermann, 1972). In an open lecture on medical ethics in the later 1940’s at Melbourne University, students were advised that should their patients request a medical termination of pregnancy they should ‘open the telephone book and point to some names’. For this referral, nothing should be said and nothing written. (Dr J. R. Love in McMichael, 1972:47). While the provision of abortion continued in this vein

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[10] By 1969 the NHMRC supported the need for Family Planning and by 1975 were participating in teaching programs.

[11] Paradoxically, Stopes right to be wanted appears to have contributed to the philosophical development of the anti-abortion stance of the groups who advocate a ‘right to life’.

in Australia, the issue was of criminal abortion was rekindled in Britain during the 1950s.

The Pocket Book Edition of *Sexual Behaviour in the Human Female* by A. C. Kinsey was published in Britain in 1953. The Kinsey Report showed that class factors influenced a wide range of sexual behaviour. Attitudes to and participation in activities such as nudity, premarital petting, intercourse, masturbation, coital position, and oral sexual contact differed according to class. Similarly class membership dictated whether premarital pregnancies resulted in marriage, illegitimate birth or abortion (per Faust, in McMichael, 1972:28) The Kinsey Report estimated that in Britain, and comparable western countries, one termination was performed for every three live births. This rekindled the British debate about abortion and set in motion the events that resulted in the passage of the *Abortion Act* in 1967.

Reform activity in Britain refuelled medical consideration of the problem of abortion in Australia. Applied to Australia, the Kinsey estimates suggested by the 1960s that 100,000 abortions were performed each year (McMichael,1972:5) with 10,000 to 20,000 abortions performed annually in Victoria. Hospital records show that only a fraction of these were provided by skilled specialists or in public hospitals, while evidence of the activities of abortionists was readily found in wards allocated to the care of ‘septics’. Anecdotal accounts suggest that ‘backyard’ abortions were commonly performed in unhygienic conditions. These accounts also attest that large fees, police bribes, melodramatic procedures and sadistic treatment of women were usual, and that infertility, injury and death were common (McMicheal, 1972:18). According to McMichael

> Like prohibition it was every bodies open secret, kept out of the public gaze. Hundreds of doctors referred their patients to the professional abortion network (McMicheal, 1972:18).

In 1962 the Humanist Society of New South Wales claimed that to deny any person freedom of choice, was ‘repugnant to basic individual rights’. In particular, it argued that the unavailability of abortion denied women freedom of choice. The emergence of a women’s rights lobby in the community, however, did not alter the formal medical position.

In the mid 1960s the Royal College of Gynaecologists (Australian Council) stated that in its view the current law in Australia operated satisfactorily. Should reform be contemplated as in England, however, the College advised that legislation be base on the ruling in *R v Bourne*. They opposed the delineation of specific grounds for abortion, such as rape, incest and socio-economic factors. Most importantly, they opposed the concept of 'abortion on demand' (Pertersen,1993:74). Freedom of choice, in the sense outlined by the Humanist Society, was antithetical to medical principles. Similarly, the AMA defended the existing position on the grounds that it upheld practitioner autonomy and provided women in genuine need with recourse to appropriate medical treatment. The Association assured practitioners that a doctor who provided medical termination of pregnancy would be deemed to be acting lawfully provided a second medical opinion was obtained, and the procedure was performed in a hospital for a reasonable fee (Petersen, 1993:73). Medical discretion must operate within the boundaries of professional conduct.

During 1967 and 1968, Inspector F. Holland, Head of the Victorian Homicide Squad, commenced a series of police raids on illegal abortion clinics in Melbourne, based on the assumption that abortions performed in situations other the medically stipulated criteria were illegal. . During these raids, women on operating tables and in waiting rooms were arrested and forced or blackmailed into giving evidence (Berman, 1972:51). At the height of the police activity the Australian Medical Association (AMA) released a statement that affirmed a doctors right

> …to terminate a pregnancy to preserve the life, physical or mental health of the mother or, if the child is to be born with an incapacitating deformity (McMichael,1992:10).

The AMA, however, refused to make comment about the whether or not the law was sufficient,

> Since the views of our members on the controversial subject no doubt vary as widely as the community in general. The problem is one for the community to decide…(AMA Monthly Supplement, Paper no.64, April 1968 in Petersen, 1993:74).

In 1968, a survey of AMA members conducted revealed considerable division amongst individual doctors, particularly about the proposition that abortion might be legally provided for socio-economic reasons. There was little medical support for ‘abortion on request’[12]. In contrast, a survey conducted the same year by the Australian and New Zealand College of Psychiatrists showed that 91% of their members condoned the legal provision medical termination of pregnancy where there was a risk to the life of the woman, and 98% where there was a risk to the mental health of woman, 70% thought termination of pregnancy should be available on family grounds and 78% where the ‘foreseeable environment’ was unfavourable (McMichael, 1972:41).

The police raids in Victoria resulted in the prosecution of Dr. Davidson. He was tried on a charge of ‘unlawful’ provision of abortion. The case was heard in 1969 in the Supreme Court of Victoria with Justice Menhennit presiding[13]. In his judgment, Justice Menhennit provided a statement of the law that followed the principles of *R v Bourne*, and therefore closely mirrored the prevailing medical opinion. While it has been hailed as the foundation for legal provision of abortion Victoria, and therefore cognisant of women’s rights, the judgement, did little to alter the conditions under which terminations of pregnancy were provided to Victorian women. Doctors remained extremely reluctant to accept medical terminations of pregnancy as legitimate practice. Their hesitation was reinforced by the ongoing police action against ‘abortionists’, the absence of statutory legislation, and the historical association of abortion with crime, corruption and extortion and immorality (per Prof. Woods in McMichael, 1972:30).

More importantly the statement of the law appeared to be inapplicable to the majority of cases. In the 1960’s most terminations of pregnancy were sought for a variety of social and economic reasons. At least half were performed on married women wishing to space or limit their families (McMichael,1972:10). In the absence of dire economic conditions or debilitating chronic disease such as tuberculosis, few such

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[12] At the time of the raids, opinion polls also began to ascertain the level of public support for abortion. Surveys conducted in 1967 and 1968 showed overwhelming public support for legislative reform. (per Dr P. Wilson in McMichael, 1972:35).

[13] *R v Davidson* (1969) VR 667. The similar case of *R v Wald* (1971) 3 NSW DCR 25 was heard in New South Wales.

terminations could be plausibly be justified under the grounds of ‘serious risk to physical health’. The medical understanding that a ‘serious risk to mental health’ was as a reference to suicide also removed the applicability of this condition. Following the Mennenhit judgment, therefore, women who were unable, or unwilling, to demonstrate ‘serious’ psychiatric incapacity, continued to take their chances with the illegal ‘abortion network’. The fact that unqualified abortionists continued to operate dangerous backyard operations under corrupt police protection, prompted medical providers of abortion to action. Famously, Bertram Wainer sought to challenge the limitation of *R v Davidson* by openly declaring that he performed abortions solely for socio-economic reasons. He also sought to expose the police corruption and protection of the non-medically trained ‘backyarders’. Under the weight of intense pubic pressure, the Victorian Government eventually appointed William Kaye QC, in 1970, to inquire into police corruption (McMichael,1972:20). Two senior members of the Victorian Police Force and a former member of the Victorian Homicide Squad were subsequently convicted and imprisoned (Petersen, 1993:73).

The rights of reform

The Kaye Inquiry sparked a clamorous public appeal for legislative reform and strident opposite to the possibility of a liberalized abortion law. In this debate the central arguments were posed in term of rights. The obvious vigour of the ‘right to life’ movement has encouraged the assumption that the crux of the controversy lies in an unresolved opposition between ‘a women’s right to choose’ and the right of the foetus ‘to life’ (McMichael,1972:5; Minson 1985). The unfolding of the legal and medical debate around abortion reform, however, reveals instead, a paradoxical concinnity between the position of the abortion law reform lobby and the central principles of the medical position. Both the reform lobbyists and the doctors couched their arguments in terms of a woman’s right to optimal motherhood. Both these positions relied on the strategic expansion of the role of psychiatry in the legal provision of abortion.

In the light of the history of abortion debate, supporters of abortion law reform were careful to pose their arguments in terms of a detriment to the maternal role, and not in terms of an absolute claim to 'abortion on demand'. Inaccessible abortion subjected not only pregnant women to 'desperate misery and hardship', but also infringed the rights of pre-existing family members and contravened the right of any child to be born wanted, healthy and properly provided for. Furthermore, it contravened the right of society to the contribution of fully adequate members.

> Most unwanted pregnancies result in unwanted children. Such children are subjected to physical and emotional derivation and …are significantly more likely to experience a miserable and inadequate adulthood (McMichael, 1972:5).

In large part these arguments drew from the emerging understanding in psychiatry that pregnancy, childbirth and motherhood were associated with a range of serious mental health problems beyond the risk of suicide.

At the time of the decision in *R v Davidson*, psychiatry had already begun to elaborate the numerous factors, circumstance and recognised sequale that might be included in an expanded medical category of 'serious risk'. The impact of pregnancy, childbirth and motherhood upon the mental health of women was rapidly becoming delineated as an important clinical field. Beyond the extreme circumstance of a becoming a 'mental wreck', as had been envisaged in the scenario of *R v Bourne*, motherhood was accompanied by a range of psychiatric problems. It had been observed, for instance, that mothers were much more likely to experience severe depression. The sequelae of depression had dire consequences, not only for the wellbeing of the mother, but also for the family in her care. The elaboration within psychiatry of the mental health problems associated with 'normal' pregnancy and motherhood provided a legitimate medical basis upon the judgment in *R v Davidson* could include mental health grounds, in the absence of direct evidence, as in *R v Bourne* that the women in question would become a 'mental wreck'.

The medical observation of psychiatric sequale associated with pregnancy and childbirth drew additional legitimacy from the findings of the Henderson Inquiry into Poverty. In 1971 Henderson reported that in Australia of the 43,000 large families, 22% lived below the poverty line. The connections that could be drawn between the mental health dangers of pregnancy, childbirth and motherhood and unfavourable social circumstance had a general applicability. Rather than seeing pregnancy and childbirth as being of little consequence to the feebleminded or prostituted girl, as in the 1930's, doctors were exhorted to recognise

> ...the mental burden of illegitimate birth, hastened marriage and the birth and rearing of an unwanted child (per Prof. Woods in McMichael,1972:12).

In the light of the psychiatric difficulties that might arise throughout a woman's reproductive life and in a range of social circumstances, medical intervention in the 'regulation of fertility' could be solidly justified in terms of the avoidance of 'serious risk' to the mental health of the woman.

While the insertion of expanded psychiatric criteria broadened the application of the test enunciated in *R v Davidson*, calls for legislative reform continued unabated. Despite the more liberal position that could now be read in to the decision of *R v Davidson,* palpable change was slow, despite an expansion of the law in NSW[14]. The AMA was accused of obfuscating the legal position in a statement issued in 1971 that listed 'rape, eugenics and viral infection of the foetus' as insufficient to warrant the provision of a therapeutic termination of pregnancy[15]. The statement added, however, that these circumstances

> ...may be factors influencing the mental health of the woman to a degree that would be considered sufficient to warrant termination (McMichael,1972:4).

While the abortion law reform lobby had initially avoided a confrontation on the matter of rights, the legal proceedings of the early 1970s amplified the discourse in rights that had already adhered around the issue of abortion. The invocation of rights was seen as a strategy that would encourage doctors, and patients, to make good use of the existing law. It was claimed that women were 'being denied their legal right

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[14] Justice Levine in *R v Wald* included 'any economic, social or medial ground' as a valid basis for medical termination of pregnancy

because they don't know the scope of the ruling' (McMichael,1972:18). Similarly, doctors 'needed to be educated about their rights under the law', because

> …the danger is very great that doctors may yet be bluffed out of their right to exercise their clinical judgement by over cautious interpretations of the law …(McMichael,1972:22).

According to Germaine Greer speaking on ABC Radio in 1972, 'liberation and relaxation of the abortion law was simply not enough' (McMichael,1972: 160.) The introduction of an overt rights strategy, and the rekindling of the principle of a women's 'right to choose' in the public domain, however, correlated with a further development in the application of psychiatric medicine to the issue abortion.

Quality of life

The continuing disagreement in medicine about whether or not social grounds should be included as valid criteria for medical abortion was resolved by privileging the 'doctor-patient relationship'[16]. Since abortion and reproductive management had entered the province of medicine following the First World War, medicine had consistently supported the principle of medical autonomy. Where the trajectories of general medicine and preventive medicine had clashed, consistency was sought by either enumerating valid criteria for medical abortion or by imposing principles of 'professional' conduct. The persistent problem of medical disagreement about the issue of abortion found a resolution in a new medical engagement with the aspirations of their patients. In the context of abortion, the concept of 'quality of life' allowed the dispute over medical recognition of social criteria to be resolved.

> To prescribe criteria of 'lawfulness' is to discriminate against some women automatically, and to create an artificial division between 'medical' and 'social' criteria that is at odds with our current comprehensive approach to 'quality of life'. The woman, in conjunction with her doctor, can only assure quality of life, both for the woman and for her prospective children, if abortion is available

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[15] *Supplement Statement* to their *Monthly Paper (April 1971)*

[16] The Balint Institute was established in London 1972 for the purpose of research into the doctor-patient relationship.

> on request, such that it becomes a matter for private decision. (McMichael, 1972:21).

Quality of life evaluations could only be made in the intimacy of a full and private exchange between the doctor and their patient. In this way, medical autonomy, independence and professionalism were upheld while reasonable requests for termination of pregnancy were honoured. Furthermore, the emerging information about the social impact of 'unwanted' children in jurisdictions where abortion had been legalised, meant that a medical approach that centred on establishing 'quality of life' was consistent with the role medicine had adopted as 'guardian of the health of the nation'. This was seen in a Swedish study showed that unwanted children were more likely to have a psychiatric problem, anti-social and criminal behaviour and drunken misconduct. (McMichael, 1972:61) According to the Family Planning Association (Victoria) these and similar studies showed that 'any child not planned and not wanted is a potential misfit' (McMichael,1972:54) . In the view of advocates of abortion reform,

> …the optimal chance for an individual to achieve emotional and physical good health only occurs where conception is planned and the child is wanted. This principle would seem basic to the development of a productive and healthy population. (Prof. Woods in McMichael:11).

The medical introduction of the concept of 'quality of life', therefore, was not aimed at establishing the happiness or wellbeing of the mother, except in her capacity for effective motherhood. As the medical disagreement had foreshadowed, a capacity for motherhood was no longer assumed to be merely a function of socio-economic factors or culinary skill. Instead, the elaboration of a psychology of motherhood understood a capacity for motherhood as being a matter of emotional and psychological competence.

> It is the role of the psychiatrist to evaluate the woman's potential and capacity (for motherhood) against her true feelings and wishes and help her to an understanding and reconciliation between the two (per Dr. S. Gold in McMichael:44).

Medical expertise, especially psychiatric expertise, was necessary to make an evaluation of the cumulative mental health burdens of the different physical, social and mental elements in each patient's circumstance. Psychiatric risk had become the pivotal assessment for the legal termination of pregnancy. Accordingly, it was advised that if the pregnancy was in its early stages, the patient was a protestant or agnostic, had demonstrated good emotional health, and social factors were present that would contribute to the formation of depression or anxiety, a termination would be likely to satisfy the criteria of serious risk. On the other hand, if the pregnancy was beyond twelve weeks, the emotional health was poor, or the girl was Catholic, a serious risk to metal health would more likely if the procedure was performed (Prof. Woods in McMichael,1972:9).

The concept of quality of life allowed a medical calculation that invested psychiatric risk with weight of the women's current social circumstance but in terms of the expected health and social outcomes for her child [17]. The correlation between healthy outcomes and 'wantedness', allowed a further elaboration of the psychological capacities of prospective mother's. In Britain, surveys of women to whom legal abortions had been provided found that 65% were 'pretty happy'. These studies showed that favourable maternal outcomes were not linked to family or economic circumstance but to the attitudes that surrounded them. Psychiatric disturbances were most likely when women had experienced punitive responses to the decision to terminate their pregnancy. In contrast, extremely low levels of mental disturbance were found amongst women who had been supported in their decision (Prof Walter in McMichael,1972:59). Once again, the psychological well-being of the mother was critically linked to the production the psychologically healthy child. According to a prominent American commentator

> The right to abortion, along with all birth control measures, must establish the Century of Wanted Child (Lawrence Lader in McMichael, 1972:21).

The 1974 Royal Commission on Human Relationships chaired by Justice Elizabeth Evatt considered the matter abortion law reform. In its submission to the Commission the Australian and New Zealand College of Psychiatrists submitted that

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[17] The legal configuration that had developed in Victoria, however, had excluded physical risk to the potential child as a legitimate ground for abortion

> ...it is the opinion of this College that the problem of unwanted pregnancies should be a matter betweens a doctor and patient. This should be part of his expertise, as a reflection of his training and education to recognise social, economic and psychological pressures acting on his patient, and to take into account the women's state of general emotional health, maturity and general fitness for motherhood at the time in question (cited in Petersen,1993:76).

Similarly the Royal College of Obstetricians and Gynaecologists (Australian Council) submitted that terminations should be performed only when the continuation of pregnancy would cause more harm (physical or mental) than carrying the pregnancy to full term or when foetal abnormality was expected. As the medical knowledge upon which this critical calculation was based was incomplete, more research into the effect of abortion was called for and a conservative approach advocated. The College argued that 'abortion on demand' must be resisted because it was contrary to a patient's right to safety and the doctors right of medical freedom (Petersen,1993:75). The submission before the Commission showed that medicine has held fast to the historical view that women should be denied abortion on demand. By the 1970's, however, this was couched in terms of patient rights. Patients had a fundamental right to the provision of safe medical care. That right, and the correlative obligation upon practitioners to provide safe care, could not be abrogated by request, or demand.

Conclusion

While the Royal Commission on Human Relationships recommended abortion law reform no legislation was forthcoming. Nevertheless, the medical discourse that was drawn around the issue of legislative reform, especially in terms of the psychology and psychiatry of motherhood, served to augment the principles in *R v Davidson* is a way that allowed a more liberal practice of abortion. Medical terminations of pregnancy became more readily available in Melbourne from this time, both within the public hospitals and in freestanding specialist clinics[18]. The conduct of the abortion debate in terms of rights, the prominence of rights claims in the public domain, and the liberalization of abortion practice have contributed to the assumption

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[18] Access to termination of pregnancy in rural areas has remained problematic throughout this period.

that ultimately, medical opinion gave sway to popular social change. In this view, a victorious patients rights movement quelled a demur medical power. The analysis of the intersections of rights discourse within the abortion debate, however, suggests an alternate interpretation. Despite various periods of altered practice, the medical position on abortion throughout the twentieth century is primarily characterised by a high level of consistency around the central principle of medical autonomy, albeit within the limitations imposed by its harnessing to the project of national prosperity to health of the population. While it is possible to discern in this history some medical recognition of 'women's rights', these have only been countenanced in terms of women's rights to 'healthy' motherhood. The elaboration of a psychology of motherhood provided the means by which the political stance of women's rights was transmuted, in medicine, to a question of psychological health. Optimal fitness for motherhood could only be achieved when pregnancy was desired. Respect for women's autonomy was an essential precondition for the optimal psychological health of the mother, the psychological and physical health of the child, and ultimately of the nation. In one sense, the language of rights in the history of the abortion debate has served to obfuscate the practice of abrogating women's rights claims. In another, rights can be seen to have operated as a strategic intellectual technology. Rights principles delivered women accessible abortion, but only in terms that were understood as contributing to the health of the nation. From the 1970s that contribution was primarily understood in terms of psychiatric, rather than physical, health.

Chapter 11:The right to 'rights'

'..human subjects had to become their own protectors'
(Rothman,1991)

Introduction

The medical construction of autonomy as central to psychological health gradually permeated medical thought in the later decades of twentieth century. While the development of a 'right to truth' shows this construction to be principally a product of the deployment of psychological rationales into general medicine, the deployment of education as a strategy of population compliance is equally implicated in the construction of autonomy. From the mid-century, the behaviour of the responsible citizen was increasingly designated as practices of self-determination. The nurturing of a population as responsible for the protection of their own health inevitably confronted medicine with the 'problem' of patient knowledge.

The right to be informed

In 1957, a new drug, Thalidomide, was launched in Germany amidst an aggressive marketing campaign that claimed the drug to be 'completely non-poisonous', 'astonishingly safe', and 'non-toxic'. In the 1950s it was not universally known or acknowledged that certain substances could pass through the placenta and affect the foetus in the womb and few drugs were tested on this basis. By the late 1950s, a Professor of Paediatrics in Germany had become suspicious that there might be a link between the new drug and the appearance of deformities in children. By 1961 Germany had launched an official investigation. Thalidomide was released in Australia in 1958 as 'Distaval', and was similarly advertised as 'completely' safe. At the time of the German investigation, Grunenthal distributed information in Australia that affirmed Distaval as ‘completely safe for pregnant women and nursing mothers’ (Punch,1996 :159). In 1962, the connection between the drug and deformities in children observed by the Australia Dr. McBride was published in *The Lancet*. That year English laboratory research demonstrated the production of gross deformities in rabbits that were given thalidomide and the drug was removed from the British market (Punch 1966:159) [1]. While the thalidomide scandal is often studied as an example of corporate misconduct, its revelation fundamentally altered the medical field.

In the United States of America, for example, although the number of children affected by thalidomide was relatively small, the scandal prompted a radical reassessment of medical research practice[2]. In 1965, Dr Beecher gave a paper at a medical conference that claimed research abuses and unethical practice characterised American medical research. He cited 22 examples of projects in the postwar period, in a range of contexts, that he believed clearly flouted ‘recognized’ ethical principles. He also claimed that many physicians routinely administered drugs to the patients without their ‘informed consent’. While conferences in medical ethics had gradually emerged in America in the previous decade, such concepts were relatively new in general medicine. Beecher’s paper was publicly discredited by colleagues, and was refused publication by the *Journal of the American Medical Association (JAMA)* (Rothman, 1991:79*)* [3]. The American National Institute of Health subsequently initiated an inquiry into the ‘moral and ethical aspects of clinical investigation’ (Rothman,1919:98). By confirming a widespread lack of ethical conduct, there followed the imposition of an unprecedented degree of formal regulation and supervision over the laboratory in America. For research conducted at the level of the general practitioner, however, regulation was to take the form of activating a ‘responsible’ public attitude. It was recognised that ‘human subjects had to become their own protectors’ (Rothman, 1991:98). Drawing on the language and principles of the civil rights movement, the ethical principles of ‘patient consent’ were to be adopted by American medicine.

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[1] 8,000 children across fifty countries were born with deformities as a result of their mother using thalidomide in pregnancy.

[2] The drug was distributed ‘for trial’ to about 20,000 patients, but did not receive clearance from the American Food and Dug Administration and was never released onto the American market.

[3] A highly truncated version was eventually published in the *New England Journal of Medicine.*

In Australia, the Thalidomide scandal made prominent a public disquiet about the safety of medical technological advance. This disquiet found expression in concern over the medical use of radiation. In 1972, the Federal Division of Tuberculosis recommended that another compulsory mass survey be undertaken to ensure that tuberculosis remained effectively contained. Doctors expressed particular concern that an explosion of tuberculosis in the national capital might accompany the rapid population expansion that was a result of an influx of migrants (Patel,1990:141). Public health officials who administered the Canberra survey in 1972, however, found a profoundly changed community attitude. Whereas previous surveys had been characterised by unquestioned compliance, the 1972 'call up' notice in Canberra prompted 'hundreds' of phone calls seeking information about the proposed program, its efficacy and the safety of medical exposure to radiation.

Concern about the global effects of nuclear testing had reached a crescendo in Australia following France's proposal to commence nuclear testing in the South Pacific (Porter & Boag, 1991:72). The perceived dangers of radiation from nuclear fission fuelled doubts about the safety of exposure to artificial radiation sources. A call by the American College of Radiology, the American College of Chest Physicians and the American Food and Drug Administration, in 1972, to cease the operation of mobile miniature x-ray units was publicized in Australia. These agencies claimed that the radiation exposure from mobile units, at three times the radiation emitted by large static units, was unacceptably high. The use of mobile units was outdated because of the consistently low case yields from mass x-ray screening, and the increased availability of other diagnostic methods. This meant that the danger posed by the mobile units could no longer be recognised as offset by diagnostic advantage. Visiting Australia in 1973, Nobel laureate Dr Linus Pauling, argued that x-ray damage, from whatever source, accumulated with each exposure. In light of this, the Australian Society for Responsibility in Science reported the American calls for limiting radiation use. This idea was challenged in the public arena by the argument that exposure to natural radiation was apparently benign, and the incremental exposure to small amounts of artificial radiation was unlikely to be harmful (Porter & Boag, 1991:75).

The ‘tuberculosis team’ administering the 1972 survey in this charged environment, sought to calm the palpable public anxiety about radiation through the provision of information and a modification of the program. In recognition of the unresolved scientific position in relation to radiation, the categories for exemption were expanded. Pregnant women, housebound invalids, people whose work already exposed them to radiation, and people who had been x-rayed in the last twelve months were offered exemptions. In addition, alternative arrangements in the form of tuberculin testing were provided (but not publicized) for persons who had ‘an unreasonable, but apparently genuine fear of radiation’ (Patel, 1990:142). Of the 32, 900 who received a ‘chest notice’ in Canberra, only 210 people ultimately refused x-ray. One quarter of these were deemed to be eligible for exemption, and another quarter agreed to accept compulsory x-ray if a tuberculin test proved to be positive. In all, only 96 persons, or 0.3% of the target population, proved to be ‘hard core’ (*sic*) refusals. In preventive medicine, information was not a matter of right, but a strategic tool of population management.

The right to complain

In the early 1970s the strategy of providing information in order to secure the voluntary participation of members of the population within preventive health strategies was not universally mirrored in the practices of general medicine or psychiatry. In the intimacy of the doctor patient relationship it remained usual for the interaction to be guided by the authority of the medical figure. In the public realm, doctors continued to claim the clinical importance independent practice and the unfettered exercise of medical discretion.

In March 1974 a *Four Corners* program raised suspicions about the standard of psychiatric practice at Chelmsford Private Hospital. The program alleged that several of Dr. Harry Bailey’s patients, treated with the discredited ‘deep sleep therapy’, had died or suffered injury (Bromberg & Fife-Yeomans, 1991:91) [4]. A ‘Psychosurgery

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[4] As a successful young psychiatrist, Dr. Bailey had been invited to view the most up to date psychiatric facilities abroad in order to establish an Australian centre at the forefront of practice. He

and Society Conference' followed the screening. Psychiatrist who attended the conference expressly supported the notion of 'deep sleep' therapy on the grounds that mental disturbances were known to improve with 'a good rest' (Bromberg & Fife-Yeomans, 1991:99). In 1978 the Citizen's Committee on Human Rights (CCHR) made public allegation against Bailey[5]. They supported their case with information gleaned from copies of patient files. These had been secretly photographed by a casual member of staff who had been appalled by conditions at the hospital. Inquiries were commenced by the Health Department, and later the Attorney Generals Department. In 1982, an inquest into the death of one Bailey's patients was held. Bailey's bed rights at Chelmsford hospital were eventually withdrawn and in 1986 the Chelmsford Victims Action Group held its first meeting[6].

The gradual unfolding of events at Chelmsford Private Hospital coincided with a medical campaign in New South Wales that vigorously opposed a proposed amendment to *Health Insurance Act (1983)*[7]. Specialists had joined in formal strikes in 1983 and 1985, claiming that the amendment would fundamentally damage their ability to practice medicine (Blecher,1998). The Chelmsford affair seriously undermined the medical position by drawing a direct correlation between independent medical practice and patient abuse. Furthermore, it illustrated the limitations of a collegial system of securing ethical practice. This observation was supported by the fact that the accounts of Chelmsford patients who had attempted to alert their referring doctors to the conditions at Chelmsford, had been dismissed as delusional (Bromberg & Fife-Yeomans, 1991:53). Despite medical protest that Chelmsford should be understood as an extraordinary aberration, the affair galvanised government, medical and public support for a more closely regulated medicine.

A politically acceptable solution to the problem of medical regulation was found in the strategy of 'patient compliant'. Formal systems to receive patient complaints

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headed the Cerebral Surgery Research Unit in 1957.The work of the centre included inducing schizophrenia with the 'wonder drug' LSD (Bromberg & Fife-Yeomans, 1991:18).

[5] The CCHR was closely associated with the Church of Scientology.

[6] Bailey committed suicide in 1985. (P154)

[7] Referred to as 'section 17' the amendment south to 'safeguard the balance between the private and public sectors within public hospitals to restrain the rates of growth of domestic diagnostic services and to protect the interests of patients by ensuring the appropriateness of fees charged where publicly funded facilities were used to provide the services' (Sax 1990:75 cited in Belcher 1998:221)

about inappropriate medical conduct were established in the years following the Chelmsford scandal. It was expected that these systems would operate simultaneously as systems of redress and systems of accountability. In New South Wales power to oversee medical practice was removed from the AMA and vested with Parliamentary Council, and an independent complaints process was established (Walton, 1998:58). In Victoria, where existing complaints mechanisms were fragmented and unworkable, the *Health Services (Conciliation and Review) Act 1987* was passed amid strident opposition from the AMA. The Office of the Health Services Commissioner commenced operation in 1988.

Interpreted in this purely administrative form, ‘patient rights’ were necessarily restricted by the processes and capacities of the agencies to which they were attached. While the work of Health Service Commission in Victoria is exemplary, its scope is crucially limited. Patients who make inquiry to the service are encouraged, in the first instance, to complain directly to the services in question. Although this may be satisfactory, it is likely that some serious matters are overlooked. At the other end of the process, where allegations against doctors are sufficiently serious to warrant examination by the Medical Broad, the substance of the complainant’s case is often overshadowed by the adoption of aggressive legal defence. The imbalance between the unrepresented complainant and the medical representation of Queens Counsel and Junior has recently been modified by the appointment of a ‘council to assist the board’, whose function is to ensure the legal propriety of the hearings. Despite this change, doctors continue to fully avail themselves of the procedural advantage allocated to then in the process of complaint. Relatively few accusations result in disciplinary action or deregistration of the medical practitioner. This is particularly true if the accusation being bought against the doctor is one of sexual misconduct. Between 1988 and 1992 the Medical Board in New South received 92 complaints of sexual misconduct, while the Victorian Board Reported receiving only 9 (Walton, 1996:58). This suggests that Victorian patients who complain of sexual misconduct are not bringing their complaints through the Office. While these complaints may be progressing through the alternate forum of the Medical Division in the County Court, the difficulties faced by a complainant in cases of a sexual nature are well documented. This suggests that the Victorian administration of patient complaints, while relatively effective in some areas, is limited in its ability to handle the most serious matters. Any administrative complaints system that is under resourced, or must contend with unjust administrative processes, is only capable of a limited realisation of 'patient rights'. The translation of patient rights into an administrative forum, especially where that forum is compromised, is likely to represent a strategic abrogation of patient rights.

The right to consent

A Royal Commission investigating events as Chelmsford found that deep sleep therapy had been the cause of twenty-four patient deaths in twenty-four years and that the suicide rate of Bailey's patients was twice that of patients who did not receive the treatment (Bromberg & Fife-Yeomans, 1991:162). In June 1988 the publications of the findings of an investigation into cervical cancer research at the National Women's Hospital in New Zealand revealed that, as subjects of research aimed to investigate the efficacy of cancer treatments, women with carcinomas *in situ* had been left without treatment. Unfettered medical autonomy was exposing patients to unacceptable danger. The report recommended new legislative control over medicine, a system of patient advocacy and the implementation of a system of hospital ethics committees (Coney, 1988). In the same year in Australia, an independent enquiry into laboratory research conducted by Foundation 41 found that research at the Foundation was not conducted in accordance with proper scientific standards and that research results were falsified and reported dishonestly (Walton, 1998:94) [8]. These public scandals forced a further re-evaluation of the systems of medical overview and supervision. Following the New Zealand example, ethics committees were established within medical institutions to oversee the conduct of medical research, especially in relation to human subjects. While the efficacy of this system of control has been questioned in terms of the effective independence of committee decisions, it remains one of the primary mechanisms of research supervision (Walton, 1998:64).

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[8] Foundation 41 was a private research organization headed by Dr William McBride (of thalidomide fame) who was seeking to establish the teratogenic effects of the drug Debendox.

The development of ethics strategies at the level of the institution, and the establishment of complaints processes at the level of government form two points of regulatory triangle. The third is the legal obligation upon the practitioner to provide appropriate information to their clients. In 1983, Mrs. Whitaker bought an action of negligence against her surgeon. She claimed that he had failed to warn her of a possible outcome of the proposed surgery, and that had she been so informed, she would not have consented to the procedure. The action was brought following the judicial acknowledgement in two States that the 'Bolum test' no longer represented the common law in Australia[9]. In 1989 the Law Reform Commission of Victoria, the Australian Law Reform Commission and the New South Wales Law Reform Commission jointly published a report that supported the retention of a common law standard of reasonable care and recommend that the relevant *Medical Practitioner Acts* specifically provide that the definition of medical misconduct include the failure to provide adequate information to a patient concerning proposed treatment and medical procedure. Prompted by the report, the Nation Health and Medical Research Council established a working party to formulate 'general guidelines for medical practitioners on providing information to patients'[10]. The High Court decision of *Rogers v Whitaker,* handed down in 1992, created a new test to determine whether a patient had been provided sufficient information to form a valid consent[11]. Henceforth, doctors were to provide patients with information about the common side of effects of the proposed treatment, any grave side effects and any information that might be relevant to that particular patient (Cordner et al, 1994: 109). Many doctors publicly greeted the decision with disapproval, claiming that the new law would prove expensive, were difficult to comply with, and would expose doctors to an unpredictable threat of litigation. Doctors were encouraged to understand that in the context of 'a trusting doctor patient relationship' the doctor would benefit from the provision of information to the patient. Patients who were given appropriate information were more likely to comply with medical advice, and were more likely to accept the occurrence of an 'adverse outcome'. If this were true, the provision of information would also contain costs and reduce the level of general antagonism

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[9] The Bolum test provided that a doctor was 'not guilty of negligence if he act in accordance with the practice accepted as proper by a responsible body of medical men… *Bolum v Friern Hospital Management Committee* [1957] 2 All ER 118, 121 per Mc Nair J. (Cordner, 1994:108)

[10] The *Guidelines* were eventually published in 1993, following the High Court decision in *Rogers v Whitaker.*

[11] (1992) 109 ALR 625, (1992) 175 CLR 479

toward medicine (Skene& Smallwood,1993) Considered in this way, ‘patient rights’ did not undermine medical privilege, but secured the sanctity of the doctor/patient relationship.

Despite its gradual accommodation within medical practice, the High Court decision fuelled a residual medical anxiety about the scope of the rule. Two subsequent High Court decisions have affirmed the general principle of *Rogers v Whitaker*, but have implied a more specific test[12]. It is now regarded as clearly stated that the crucial information must be ‘material’ in the sense that it must be directly relevant to the patient’s decision whether or not to continue with the proposed treatment (Hartley, 2001). The reassurance provided by the analysis of case law that affirms a limited interpretation of the common law, is welcomed by medicine because it is seen as providing a more exact standard upon which legitimate practice can be based. Almost a decade after *Rogers v Whitaker,* it is clear that medicine will not be swamped with negligence actions based on the question of consent. While anecdotal accounts of the medical encounter suggest that much has changed at the level of doctor/patient interaction, the right to autonomy, as represented in the practical outcomes of the law of consent as well in its statement of principle, is relatively muted.

The responsibility of rights

This analysis suggests that while the effects of the social events dubbed the ‘patient right’s movements’ are palpable, the medical claim that patient rights have created a crisis in contemporary medicine, and the opposite claim, that medicine has been transformed by the empowerment of patients, are unsustainable. More plausible is the observation that the proliferation of a patient rights discourse in Australia has emmersed the patient in range of limited responsibilities that have come to denote the ‘autonomous’ patient. As different argument and ideas about the regulation of medicine were cast in term of rights, the discursive elaboration of rights produced a particular arrangement of rights ‘truths’. The privileging of certain rights, allowed these to be formally represented by administrative, quasi-legal or legal mechanisms.

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[12] *Chappel v Hart* (1998) 195 CLR 232, and *Rosenberg v Percival* [2001] HCA 18

In turn, the elaboration of rights discourses around these discrete arenas reinforced the restriction and further containment of each.

As doctors seek to practice in accordance with the law, the strategic limitation of substantive rights impacts upon the clinical encounter in contradictory ways. Despite the apparent reification of 'autonomy', the exercise of autonomy by the patient in the clinical encounter is construed as a matter for medical evaluation, to be assessed, measured, and incorporated in the clinical equation. Autonomy may be appropriately recognized and upheld in the clinical encounter, only if is judged to be the exercise of a 'responsible autonomy'. The criteria for assessing 'responsibility' are drawn from prevailing medical ethical precepts. For example, a person living with HIV and AIDS, who seeks access to 'experimental' technology and treatments might be granted access to these on the basis that such measures are potentially life saving. Conversely, the same patient might be denied a request for medically assisted death. Contemporary medicine, as suggested by these to examples, is increasingly characterised by a range of ethical questions around which no firm medical consensus has been established. 'Patient autonomy', therefore, provides medicine with a strategic and flexible orientation with which it can traverse the ethical complexities of the contemporary medical field.

Conclusion: The power of rights

> *We need to think in terms of a crisis of the subject, or rather a crisis in subjectivity-that is, in terms of a difficulty in the manner in which the individual could form himself as the ethical subject of his actions, and efforts to find in devotion of the self that which could enable him to submit to rules and give a purpose to his existence* (Foucualt,1984b:95).

Introduction

The preceding inquiry into the nature of patient rights is inspired by the historical and contemporary questionings of the transformative capacity of rights in modern political systems, and the resonance of those queries with the argument that modern forms of power seek to 'govern through freedom'. In attempting to understand the phenomena of patient rights, the assumption that the present carries of a burden from the past has necessarily drawn the study toward a historiography of medicine in the 19th and 20th century that places patient rights within a 'history of the present'. This perspective reveals the triad of population, economy and health as central to the generation of rights strategies in medicine, and shows patient rights to be crucially implicated in the devolution of medical strategies that are designed to achieve successful medical management of the population. This observation unsettles the notion that rights in medicine originate directly from the demands of resistant and oppositional interests or are a consequence of active resistance from patients themselves. Instead, the analysis suggests that rights are themselves a consequence of medical interventions that have taken the health of the population as its principle object. From this view, patient rights appear as an effect of the exercise of medical power.

To pose rights as an effect of power neither denigrates rights based activism, nor diminishes the historical significance of rights movements. Instead is suggests that rights based politics might be better informed by an analysis of the past. The identification of the historical resonances in contemporary rights discourse offers a way to dissect the plethora of rights based language, images, strategies and laws that dominate the present. In Marxist terms, this project would seek to differentiate between the reification of an idealised ‘patient with rights’ and the identity of a patient who is fixed by the realities of social and political circumstance. In Benthamite terms, ‘real rights’ might be discerned from ‘rights on stilts’. These theoretical distinctions can usefully inform an analysis of patient rights that proceeds from the perspective of governmentality by paying attention to the nuances of rights language and context.

The nature of rights

In the nineteenth century the questions of population, and the relationship of population to the realm of the economy, were constructed in terms of a medical problems and medical solutions. The addition of health into the equation of population and economy, dictated the different ways in which medical power came into operation. The critical link that was drawn between economy (or ‘security’), population and health also dictated that medical interventions were simultaneously cast at the level of the individual and at the level of population. The dual imperatives of the individual and of the population became characteristic of medical thought and practice throughout the twentieth century. The joining of government and economy, through the prism of medicine, therefore, posited the medical realm as a field of ‘bio-politics’[1]. Bio-politics construed questions of population, such as the birth-rate and contraception, contagion, venereal disease and prostitution, and ultimately of medical regulation itself, as problems of government that are properly managed distally, and through the logic of medicine. While politics construed the question of population as medical, however, medicine also construed its own task as ‘political’ in the sense that

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[1] In *History of Sexuality*, Foucault argues that sovereign power, thought of as ‘the ancient right to *take* life or *let* live was replaced by a power to *foster* life or *disallow* it to he point of death’ and that the power of life evolved into the two forms of *anatomo-politics,* or the disciplining of the economically useful human body and the and *bio-politics* that focussed on the species body as imbued with the mechanism of life (Foucault:1978:138-139). In the field of ‘governmentality’, the term bio-politics has tended to denote the practices of government that apply to the medical realm. This interpretation eschews the distinction offered by Foucault. In the current context, the term bio-politics refers to the rationalities of government (social, medical and political) that adhere around the ‘problem of population’.

its projects were fundamentally linked to the prosperity of the nation. The medical techniques and rationalities that developed in late nineteenth century and throughout the twentieth century, therefore, were imbued with a sense of governance. In this orientation, the language and concepts of 'rights' are appropriated from civil political government to centre amongst the medical iconography of the twentieth century. Medical governance proceeded with 'rights' as a crucial adjunct to the medical management of the population.

Historically, the problem of population set the health of groups and individuals within the population as both the tool of medical achievement and the consequence of its success. As medical knowledge defined its task and established reflexive methods of intervention at the level of the individual, rights language began to appear in the 'spaces' created by the paradoxical trajectories of this complex medical project. While the problem of population remained the central to medical practice throughout the twentieth century, a series of shifts in medical focus emphasised its different facets. The question of the vitality of the population became understood in terms of women's reproductive capacities, the question of the health of the population was linked to the identification of the hidden carrier, and the question of universal infectivity dictated the expansion of medical surveillance. Each of these discrete but related problematisations spored disparate rights dialogues and a range of rights practices. In each instance, the simultaneous evocation and practice of rights also established the validity of proposed medical interventions. In this way rights also operate as a practice of 'truth'.

Until the mid twentieth century the problem of population had been driven by the core principle that there existed a relationship between poverty and health. The competing fields of medical knowledge that proliferated in the late nineteenth and early twentieth century, in part reflect the medical quest to elucidate the detail of the perceived interaction between individual health and social or environmental conditions. In the mid century, the application of coefficient statistical method to this central question displaced the notion that economic conditions dictated the production of health. Instead, in a reversal of the causative analysis, health was assumed to dictate economic conditions. It followed, therefore, that national prosperity could be best enhanced by the provision of health care. Accordingly, the ‘right to health care’ was privileged over the ‘right to the conditions of health’.

The privileging of a right to health care had profound implications for the subsequent development of medical thought and practice. Not only did the universal provision of health care become important, the problems of patient compliance and cooperation were brought to the fore. These considerations opened the way for a psychological, rather than social, elaboration of the patient. Within this axis, rights dialogues formed and coalesced around a series of new problems. In order to maintain the psychologically motivated patient within the purview of a medical program that continued to be informed by the prerogative of population, the problems of ‘truth’ and ‘autonomy’ became the object of medical management. The medical elaboration of the psychologically inscribed patient amplified the utility of rights language and strategy in the medical field. From these dialogues emerged ‘the patient’ as responsible for their own care. The corresponding enunciation of rights in this instance took the guise of the technical administration of rights.

The transformations in rights that traverse the twentieth century, therefore, show ‘rights’ to be inherently chameleon. They also reveal rights to be attached to the shifting medical notions of the patient, rather than to some ontological constant that has been liberated by the intumescent humanity of modern medicine. They illustrate that while rights dialogue and practices are generated at the intersection of different medical knowledges, their amplification and accumulative weight is generated by the intersecting trajectories of different modes of power.

The triumvirate of governmental power

Within the field of ‘studies in governmentality’, Foucault’s insistence that governmental power represents a triumvirate in which sovereign and disciplinary forms of power persist but are overshadowed by the dominance of governmental power is rarely explored, beyond the recognition that the exercise of different forms of power can be clearly observed in the contemporary field (see O’Malley, 1991). Conceptualising governmental power as tripartite, however, provides the analysis of patient rights with a broader dimension. The examination of the highly specific instances of patient rights in medicine, suggests that they not only correspond to the exercise of different but co-existent modes of power, but that the simultaneous exercise of different powers establishes a dynamic interaction between them. In this view, the persistence of sovereign and disciplinary modes of power within governmentality provides a strategic opposition or interplay within which a 'government through freedom' can operate.

This may be seen in the medical intervention into the 'problem of population'. Intervention rested on the articulation of a series of discrete problematisations wrought by different medical, social, psychological and statistical knowledges, the constitutive characteristics of the population came into medical view. In this way, delineated groups became the object of medical deliberation, and the salient characteristics of prostitutes, 'clandestine prostitutes', 'sick children', 'infected soldiers', or 'honest mothers' were construed according to the current canons of medical knowledge. Each of these categories congealed amid a range of social, behavioural and psychological criteria that attached to the disease entities in question. These criteria dictated the thrust of medical interventions, and therefore the character of the rights dialogues that accompanied them. In the twentieth century the complexity of medical knowledge meant that a range of medical interventions, and therefore a range of rights strategies, were simultaneously brought to bear upon the medical event.

In the instance of the 'typhoid carrier' in America, a refusal to comply with medical expectations frequently resulted in the imposition of coercive intervention or detention, especially for women. Such action was accompanied by a discursive consideration of rights that sought to bring forward an understanding of 'individual rights' as forfeit to the 'rights' of the wider community. In concert with coercive strategies, the carrier was enjoined through the discursive arrangement of rights, to adopt specific standards of behaviour. Known carriers were encouraged to avoid a withdrawal of their 'rights' by complying with restrictions such as hand washing and declining employment as cooks. At the same time, rights appeared as a powerful injunction upon the rest of the community to avail themselves of their 'right to be free from infection', by voluntarily governing their own behaviour. In this instance, rights were construed around the problem of the management of the carrier in the population.

The historical event of the typhoid carrier has particular relevance in the contemporary era of HIV and AIDS. The compulsory detention in 1994 in Australia of a person known to be HIV positive, and suspected of working as a prostitute, prompted the reiteration of the rights arguments that were posed in terms of the forfeiture of individual rights, and the priority of community rights. These events occurred in the context of an ongoing public health campaign against HIV/AIDS in which the entire community was being urged to adopt safe sex practice in order to exercise their ‘right to be free from infection’, and the ‘gay community’ were being urged to base their ‘right’ to public acceptance upon the demonstration of a kind of ‘civic’ responsibility. Here, too, rights are multifariously deployed around a problem that requires management. This suggests that far from being an external imposition, patient rights are a product of medical deliberations around the problem of managing health within the context of population.

In both the historical example of typhoid and in the contemporary example of HIV/AIDS the voices of groups or individuals who assert oppositional rights claims in order to resit the oppressive actions of a dominant group, can be heard amid the dialogue that proliferates around these problems. These claims are not so much thwarted, as incorporated in to the problematisation as part of the ‘truth’ that must be taken into account. As ‘practices of truth’, rights claims are incorporated into techniques of management in particular ways, in support certain strategies and in concert with other rationales. This process cannot be adequately described as a denial of rights, or as a cynical deployment of rights against the claimant. It is best represented as an instance strategic government, or a government of freedom.

The examples of typhoid and HIV/AIDS, also illustrate the significance of the interaction of different modes of power. While different rights arguments arise in relation to different aspects of the medical problem, their connection, each with the other, is crucial to their aggregate effect. In these instances, the contemporaneous intersection of the different modes of power (sovereign, discipline and governmental) achieves coordination and articulation through the tool of ‘patient rights’. In this process patient rights are taken up and amplified, appearing ultimately as the dominant feature of the medical field and the figure of the patient with rights is spun by the interleaving of different rights between the different modes of power. The phenomenon of patient rights can be understood, as not merely the effect of a relatively static governmental power, but as the effect of the dynamic interaction of the triumvirate of governmental power.

Similarly, the psychological elaboration of the patient in the second half of the twentieth century was accompanied by an expression of rights that was amplified by the interaction of different modes of power. The inscription of ‘autonomy’ as a feature of psychological wellbeing of women seeking medical terminations of pregnancy, was simultaneously cast in terms of a right to a medically determined psychological wellbeing, and the denial of a right to self-determined independent choice. At the same time, these rights were juxtaposed with the rights of the child. While the exercise of sovereign or coercive intervention is less applicable in this example, a strategic interaction between disciplinary and governmental rights dialogues accorded a crucial validity to some rights questions and undermined others. In accordance with the ‘truths’ generated by this discursive arrangement of rights, technically possible medical interventions were either validated or excluded from legitimate medical practice.

The medical inscription of ‘autonomy’ also dictated that the clinical encounter was restructured to include patient participation in treatment decisions. This shift was encouraged by the statistical accounting of the problem of patient dissatisfaction, that showed persons who were invited to actively participate in their own medical decisions proved to be far less likely to complain or sue in the advent of an ‘adverse event’. In this instance, the patient is enjoined to exercise their (supervised) right to self-determination. This right is extended to encourage the responsibly autonomous patient to assist in the medical task of medical self-regulation by alerting the medical fraternity to the incidental anomalies, risks or hazards that inevitable arise in the practice of modern medicine. The patient who makes a complaint, however, is subject to disciplinary measures imposed through the administration of rights. Paradoxically, the patient who arms themselves with procedural rights is ultimately seen by medicine as vexatiously litigious, and by implication, flawed in the psychological attribute of ‘normal’ autonomy. The medical construction of normal autonomy at the close of the twentieth century marks the close of a period in which the imperatives of medical knowledge invented, inscribed and then sought to manage what became the problem of patient rights. Contrary to the progressive narratives that purport a medical valorisation of the patient, rights have been consistently deployed as a strategic adjunct in the medical management of the population. It follows that rights cannot be viewed as attached to the ‘liberated’ patient, nor should rights be understood as a tool that might deliver ‘true’ freedom or liberation. Instead, these observations suggest that rights are crucial to the practices of a government through freedom. As a form of government through freedom, however, rights have historically assisted in the differentiation of the population according to criteria of compliance and cooperation. As Roach Anleu suggests, if rights can be understood as crucial to the social definition of ‘other’, patient rights are deeply imbricated in the medical construction of marginalised and dispossessed social groupings (Roach Anleu, 1999:200). These observations encourage us to ponder the implications of consistently configuring the aspirations of ordinary patients in the chimera of rights.

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