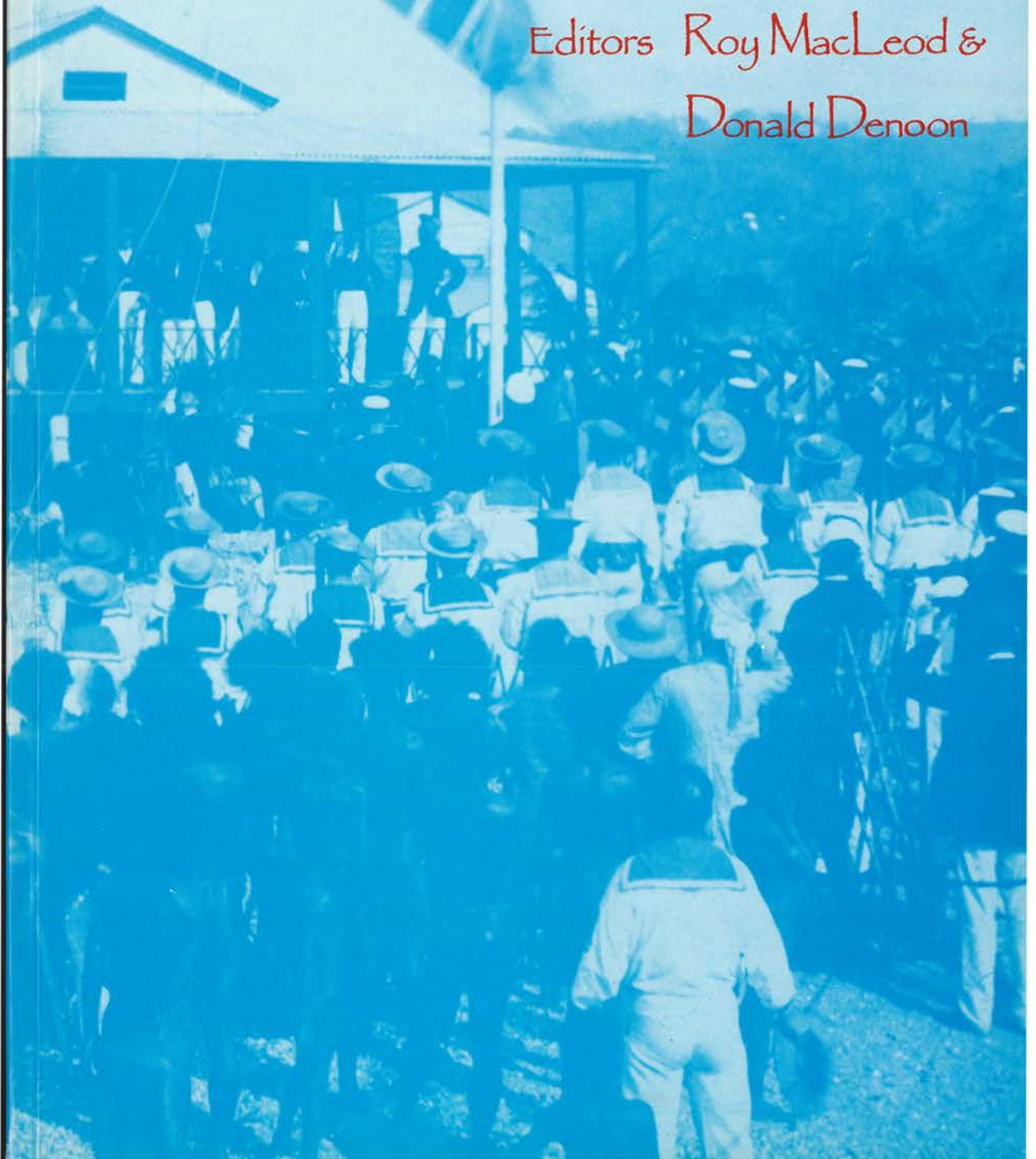


# HEALTH & HEALING IN TROPICAL AUSTRALIA AND PAPUA NEW GUINEA

Editors Roy MacLeod &  
Donald Denoon



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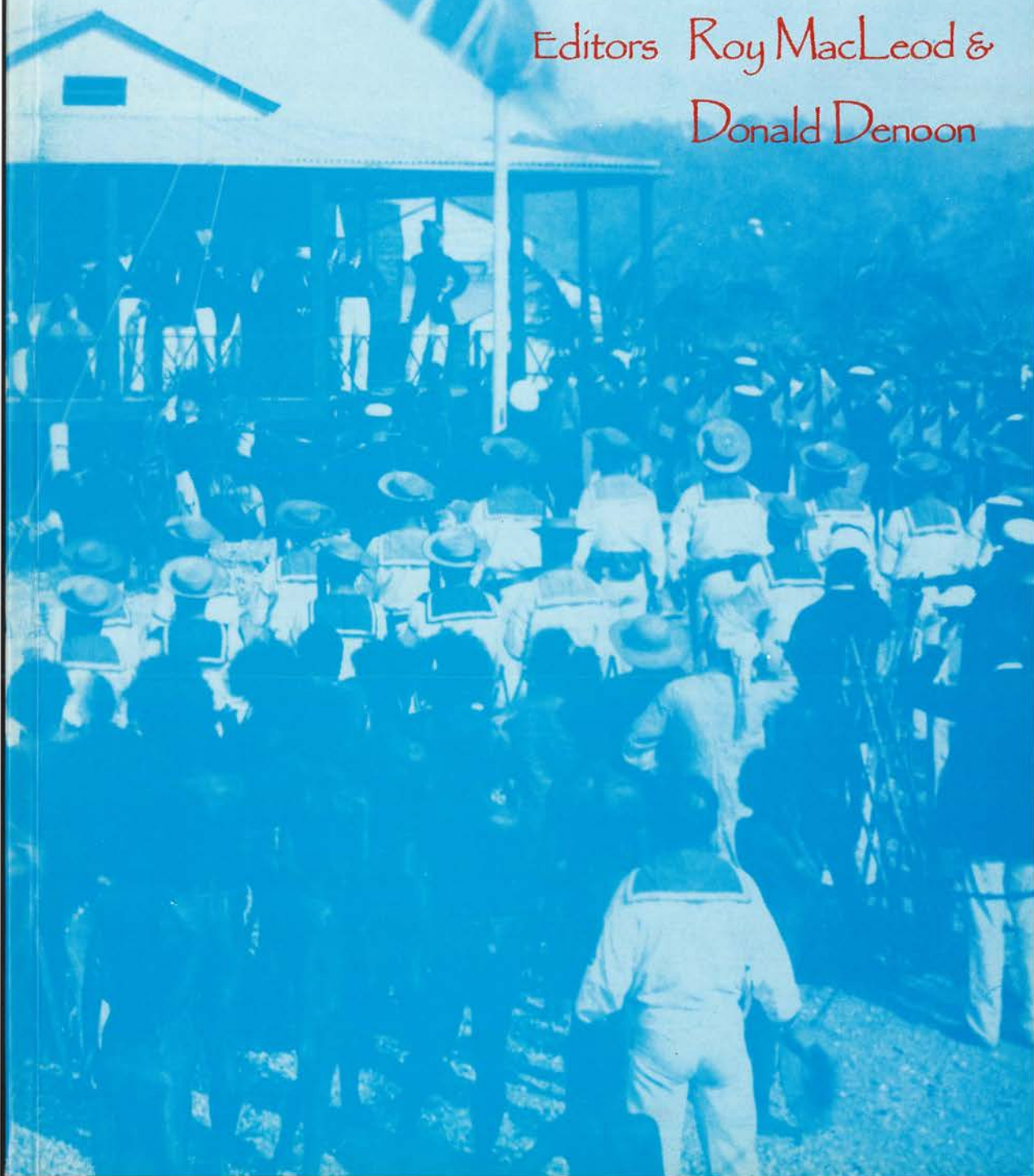
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# HEALTH & HEALING IN TROPICAL AUSTRALIA AND PAPUA NEW GUINEA

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## **HEALTH AND HEALING**

Published under the joint sponsorship of the Department of History and Politics, and the Centre for Melanesian Studies.

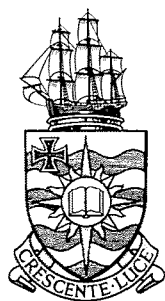
*The cover, designed by Mr. J. Ngai, shows the British flag being raised at Port Moresby on 6 November 1884. The house from whose verandah annexation was proclaimed, belonged to the Rev. W.G. Lawes, missionary.*

# **HEALTH AND HEALING**

## **in Tropical Australia and Papua New Guinea**

**Edited by**

**Roy MacLeod and Donald Denoon**



**Townsville**  
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## PREFACE

In August 1987, scholars gathered in Townsville to attend the first Australasian conference devoted to the history of medicine in the tropics. Held under the auspices of an Australia and New Zealand Association for the Advancement of Science (ANZAAS) Congress on "Science in the Tropics", this section had a particularly innovative quality. Over fifty historians, medical administrators, anthropologists and practitioners of medicine with experience of practice in tropical areas confirmed their interest in an historical agenda few historians had hitherto recognised. This volume represents the early fruits of this rewarding collaboration.

Traditionally, medical history in the tropics comprehends both the history of tropical medicine - as medical speciality and as "tool of empire" - and the history of medical practice in tropical regions. As such, it deals with questions of central importance to the creation of new disciplines, the relationship between medical ideas and political institutions, and the history of colonial dependencies, both medical and administrative. To these questions, historians in Australasia have begun to give increasing attention. Given the leading role played by British, and later Australian medical administrators and medical scientists in the "expansion of Europe" into tropical regions, this new interest is not surprising, if long overdue. At its zenith the British Empire covered one quarter of the world's land surface, and a third of the Empire fell within the tropics. The history of the tropical Empire in the last century is interwoven with the exploits of pioneers in bacteriology, preventive medicine and sanitary engineering.

But where once the history of tropical medicine in the Empire would have focussed principally upon these disciplines, and upon the "imperial experience" of tropical life, with its immediate consequences for occupation and settlement, in Australasia today we grasp a wider reality. This new historical present now reaches across the strait that divides Australia from Papua New Guinea and unites the Melanesian and European cultures, across a time of colony and mandate, into our own era of states and nation states. It reaches deeply into the lives and times of white settlers eking out a living on the sugar plantations and gold fields of Queensland and on the cattle stations of the Northern Territory. More significant still, this new perspective opens upon the lives of pioneer European women, whose voices have as yet scarcely been heard, and upon the sufferings of Aboriginal men and women whose experiences for too long have escaped the history textbooks of our schools and universities.

In virtually all respects, this subject forms a new dimension in the corpus of medical history, in contact with distant lands half won. It is perhaps too soon to expect this new domain to be accepted as received wisdom, either in Europe or in Australasia. We are in many ways bound by our eurocentric perspectives; in our historical geometry, an area half the size of Europe still subtends a small angle of

arc when viewed from London. But there are reasons why our perspective may change. In tropical Australia, no less than in the northern hemisphere, the study of disease and dying, of health and healing, lies at a crossroads between the formal history of medicine and public health, and the history of political and economic thought. In either direction, one encounters two abiding principles: first, that tropical knowledge is, and has been, inseparable from the social and economic conditions of its production; and second, that European medical wisdom, like the rules of colonial medical administration, has been mediated by individuals, often in very small number, whose particular ontological preferences have determined the direction and outcomes of research and policy. In the "tropical north", where Europeans brought with them preconceived ways of seeing and ways of doing, such factors have been of enormous consequence in shaping contemporary attitudes towards health, the environment and community well-being.

The papers in this volume represent a selection of those delivered in Townsville, and together address the experience of health, life and healing among Europeans and Aborigines in Northern Australia and Papua New Guinea. In this realm, historians of James Cook University have already made substantial contributions, and it is a pleasure to recognise their prominence among our authors. We would thank those North Queenslanders, in particular, who patiently endured the questions and suggestions of southern editors. All those knowledgeable in this area will in particular give thanks to Professor Brian Dalton, Head of the History Department at James Cook University, who acted as local organiser of the section, and whose generous cooperation ensured its success. We would also express our appreciation to Professor A.T. Yarwood, who has contributed an important essay not originally given at Townsville. The courtesy of ANZAAS, as fruitful in its facility for innovative scholarship now as it was a century ago, is gratefully recorded, as is our thanks to the organisers of the 57th Congress.

It is said that the peripheral location of Australia sometimes provides a clearer vantage point from which to review the assumptions of European societies, made more visible in their contact with settler colonies and traditional cultures. Historically, Northern Australia and Papua New Guinea have been on the periphery of this "periphery", and their experience has been the preserve of local specialists. That their message now, however, speaks to scholars internationally, this collection will, we believe, amply demonstrate.

Roy MacLeod, Sydney  
Donald Denoon, Canberra

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## INTRODUCTION

The history of European medicine in the tropical world is a protean concept. Until recently, it has been the province of European practitioners, medical professionals and administrators, who in different ways helped shape the architecture of empire. For a century and more, their attitudes and the assumptions of temperate medicine were translated ambivalently, as they met unfamiliar environments and peoples. Throughout the western experience of colonial occupation, medicine and its administration - or health and healing in the widest sense - became central to political stability and economic progress. At the same time, the idealism of European medicine searched for ways to enhance the lives of "primitive" societies and to place white men in settlement, sometimes learning from these new contexts lessons which the rest of the world has long ignored.

In understanding the importance of medicine in the "expansion of Empire", the history of European tropical settlement has become too insistent to be left as a specialty of medical history alone. This is not to say that the resourcefulness, scientific acumen, heroism and self-sacrifice of Europeans devoted to the conquest of disease are to be disregarded by a generation impatient of the slow degrees of progress by which health improvement in tropical regions is measured - or frightened by newly-discovered viruses, whose ravages seem certain now to plague the world for at least the rest of our lives. On the contrary. Medical history has taught us that societies and civil institutions, possibly more than drugs and therapeutics, have everywhere influenced conditions of health and the practice of healing. In turn, the history of medicine has come to reflect the history of societies, their religion and demography, their social behaviour and their expectations of life.

In certain ways, this transformation of medical history is illuminated by the experience of human health in tropical regions. Unquestionably, some of the most dramatic changes in the world's health, and in medical ideas and practices, have occurred in tropical societies during the past fifty years. These developments have taken medical historians into ever more difficult scholarly terrain. At the height of imperial self-confidence, Dr Albert Schweitzer exemplified all that was benevolent and effective in the civilising mission of Europe, and his charismatic image dominated the metropolitan view of colonial medicine. Since the 1960s decolonisation and the defenestration of the Schweitzer model have framed a new agenda for medical historians. It has become relevant to ask how can we best understand the role of colonial governments, as the providers and orchestrators of "modern" medical services, and how best to assess the consequences of colonial rule - in institutional models, as in academic observances - on the lives of colonised peoples. Moreover, it has become important to enquire into the nature and extent of "internal colonialism", as Europeans colonised tropical areas with white settlers,

drawing them into a world "European" by extension, but with practices often lagging behind European expectations. To put it another way, the medical historian of the tropics must deal with imperialism and anthropology, demography and medical professionalism, and also with the political economy of medicine in regions which were once thought unsuitable, and which today remain inhospitable for white habitation.

Within this realm of historical enquiry, there is now a thinly populated province which we may call "imperialism and medicine", whose denizens share certain assumptions - that colonial medical policy has always been more complex than the simple altruistic Schweitzer model - or its technical analogue, the "biomedical" model - has implied; that the motives and expectations of medicine can be understood only in relation to over-arching imperial interests; and that the health of colonised populations, whether European or indigenous, has traditionally owed more to general standards of living than to medical intervention. If these assumptions confer to some extent a shared outlook, scholars of "Europe in the tropics" are nevertheless divided by the influence of the disciplinary tools they bring to the task. Since few actually enjoy mastery of all the relevant disciplines - demography, geography, anthropology and even political sociology, together with bacteriology, urban planning and sanitary engineering - few scholars of "imperialism and medicine" actually approach the same questions in quite the same way.

To take advantage of the varied skills which are required in making sense of health in tropical regions, it is useful to address one general question: why are some people less healthy than others? One popular approach to this question relates health status to the physical environment; so that, for example, tropical peoples are expected to suffer more frequent morbidity and earlier mortality than temperate peoples, even more than temperate peoples suffer in tropical regions. Others may consider that health care - itself essentially a product of the history of temperate countries - has not yet come to grips with avoidable suffering in tropical conditions. A third point of view stresses the colonial experience, the almost invariable lot of tropical societies in the recent past, and seeks in "imperialism" the macro-historical explanation which environmental determinists seek in "tropicalism". Possibly a further, and more promising line of enquiry, lies in considering the social and institutional behaviour of particular peoples, with the object of explaining why different communities have responded so variably to much the same physical environments and natural hazards.

At this early stage in our enquiry, we cannot afford to neglect any of these approaches; yet to entertain all of them is to mystify the general reader. The parameters of scholarship must be carefully drawn. If one writer "proves" that polio in Peru is a consequence of political causes, and another shows that high child mortality rates in Pakistan could be averted by better vaccination programmes, what have we learned about the human medical condition? The problem is that most of

the literature consists of single case studies, whether in the colonial dependencies or in the metropolitan centres of research and professional organisation; and single case studies can never quite carry the weight of conclusions we would like. In fact, nothing short of a *world-history* of health and healing could settle many of the intriguing questions on the agenda of "medicine and empire". Until some medical Wallerstein tackles health and healing on a world scale, perhaps our best prospects still lie in regional accounts. It is, in any event, this belief that inspired the Townsville conference on "Medical History in the Tropics", and has conspired to produce the present volume.

## -II-

The papers in this collection deal with tropical northern Australia and the neighbouring arc of Melanesian islands across Torres Strait. For our purposes, the regional organisation of case studies has decided advantages. Over the past hundred years, fundamentally the same medical authorities (and for considerable periods, the same individuals) have been in charge, since medical officers were all appointed by the Australian states or (in New Guinea and Papua) by the Australian federal government. At its peak, one-third of the British Empire lay within the tropics; and the emergence of "tropical medicine" as a distinct discipline from the 1890s facilitated the mobility of specialist doctors among British overseas territories, and their frequent interaction at public health conferences "overseas" and at "home". From Australian Federation in 1901 onwards, the same traditions continued, under the newer conditions of "colonial imperialism". Australian doctors reported in much the same terms, on the very different phenomena which they had to confront, although now to a different metropolis. The colonial states were governed by much the same social assumptions as before Federation, and by almost the same operating procedures.

However, beneath the veneer of shared political and medical institutions, Australia's "far north" and neighbouring Papua New Guinea exhibit an excellent diversity of tropical environments and social organisation. If the region gained coherence through the expansion of settlement from the temperate South through geographically different environments - the distance from Melbourne to Rabaul is about the same as that from London to Timbuctu - it is, after all, somewhat more varied. Apart from the wetlands of coastal Queensland and the "top end" of the Northern Territory, tropical Australia comprises varying degrees of aridity shading into desert, permitting hunting and collecting on one hand, and very extensive pastoralism on the other, but in either case very low population densities and seasonal nomadism. Across Torres Strait, there lies more typically "tropical" country, as mountainous as Australia is flat, and covered for the most part by thick tropical forest. Melanesia permitted the development of fairly dense populations,

especially in the cool highlands, relying on varying combinations of hunting, collecting, and swidden agriculture.

To this variety of physical environment, we must add variations in colonial experience. Australian settlers flourished in the temperate grasslands of the South, and tackled the tropical North only in the second half of the nineteenth century, drawn thither by gold, plantation crops and grazing animals. Following the precedent so firmly established in the South, settlers ignored Aboriginal title to land, dispersing populations and sometimes concentrating them in reserves. Only in a few remote regions did some measure of social autonomy persist. In pockets of east coastal country, especially where sugar would grow, labourers were imported from the Pacific islands to work at first on plantations, and then farms managed and owned by settlers from the South. In possession of the land, white settlers developed sugar along the tropical Queensland coast, bringing in Melanesian labourers in the process; and in the arid interior they ran cattle and then sheep, employing Aborigines as outdoor and domestic workers.

The more densely populated Melanesia was also settled first by gold prospectors and missionaries in the 1870s. When gold rushes erupted, whites were attracted in ill-planned and unsupervised settlements of short duration. The Melanesians defied dispossession, and their village social structures endured as partial protection against direct control. Plantation development was attempted, mainly on small islands and good anchorages; but most of the indigenous population continued to control their own lives under a thin administrative umbrella. Settlers prospered only in the highlands from the 1950s onwards, which was much too late (and the location much too remote) for large-scale alienation. Such a small settler population had no hope of dominating the emerging political system, and in due course Papua New Guinea became an independent state under overwhelming indigenous control, in a manner which was inconceivable south of Torres Strait. There, Aborigines played no formal role in the politics of the self-governing colonies. In all these circumstances settlers were confronted by acute difficulties in ensuring the basic necessities of adequate diet, potable water, and safe sewage disposal. And governments were hard-pressed to cope, where communications were slow, erratic and unreliable.

Forms of government in the tropical north varied with space and time. Northern Australia was governed as an integral part of the southern city-state system until well into this century. North Queensland was politically a mere extension of self-governing Queensland, although Townsville was 1,000 kilometres from Brisbane, and Cape York another 1,000 kilometres beyond Townsville. The Northern Territory was - even more awkwardly - an extension of South Australia, whose capital was Adelaide. After Federation, South Australia surrendered the Territory to the Commonwealth Government, which was scarcely more successful in establishing there a productive economy and dense settlement. The geography of

Torres Strait marked also a crucial constitutional divide. When Queensland attempted to annex Papua in 1883, it was spurned by Downing Street, but a generation of British Protectorate administration intervened from 1884, before the Commonwealth Government reluctantly assumed responsibility for Papua in 1906. When the Great War began, Australian forces landed in Rabaul and captured German New Guinea, which was held by Australia under a League of Nations mandate from 1921 onwards.

That constitutional divide was profoundly important in shaping Australia's own neo-colonial assumptions and programmes. On mainland Australia, indigenous land rights were ignored, Aborigines were not full citizens, and the federal government's "White Australia policy" made Pacific islanders and Chinese ambivalent and anomalous minorities. White Australian laws governed individual relations and property rights, and white Australian priorities inspired public policies and programmes. In Papua and New Guinea, by contrast, for practical purposes, indigenous land rights, social structures, and some freedom of movement prevailed, except in plantation and mining enclaves. Although Papua New Guinea's destiny as an independent country was not accepted officially by Australians until the 1960s, there were clear differences, and limitations, upon the style and content of colonial politics and government.

In Australia, settlers took rather different views of the role and potentiality of the indigenes. Aborigines were expected to disappear entirely, and settlers debated the subsidiary question: how long would their demise require? In the early years of this century, there was a widespread settler fear that Melanesians might also die out; but as they were perceived to be the chief economic asset of the territories, the prospect of their disappearance generated more alarm than satisfaction. Social policies reflected this dichotomy clearly. Reynolds describes the impact of white Australians, unmitigated by the assimilationist and protectionist policies advocated by A.P. Elkin and Baldwin Spencer, as revolutionary for Aboriginal society; but the thrust of policy in New Guinea and Papua was, instead, conservative and conservationist, seeking to preserve Melanesian village societies as little changed as possible.

Just as the nature, environment and government of indigenous societies shaped the kind of colonial experience they would endure, it is not surprising that the quality of health among indigenes varied widely. Australian Aboriginal communities - too small and scattered to sustain the crowd infections - were well able to extract nutrition from a seemingly unpromising landscape. Aboriginal therapies were more than sufficient to sustain good health, and severe population control measures prevented the exhaustion of nutritional and therapeutic resources. Much less is known about the general health of "pre-contact" Melanesia, which was in any event uneven, with the worst to be found in the highlands fringe areas. These were remote from sources of shellfish and fish, yet not sufficiently elevated to enjoy the crisp

climate of the highlands themselves. Recently, indigenous therapies have been surveyed, and it is thought that Melanesian well-being owed more to the isolation of small communities from each other, and to adequate levels of nutrition, than to therapeutic interventions. In any case, well-being depended partly on isolation and uninterrupted exploitation of the landscape: and in each case that well-being was inevitably threatened by European settlement. With the rupture of isolation came new social organisations, which allowed new infections to enter and old infections to circulate more freely.

If indigenous health and healing practices could cope with the ordinary wear and tear of pre-colonial life, then the facts of settlement and colonialism must be considered as the central threat to well-being. Not only did settlement and colonisation expose indigenous societies to quite new stresses: settlers and colonists themselves were exposed to hazards unfamiliar to the settled and temperate South. It was these dangers - brought forcibly to the attention of the state - that provoked the intervention of medical practitioners and colonial planners.

The settlement of northern Australia began in earnest in the 1860s, and of coastal Melanesia from the 1870s, almost coinciding with the emergence of western medicine as a science, and with the rise of the medical profession to influence in public policy. Professional men exercised a great deal of power as they sought to impose patterns of behaviour on settlers at least, with the full authority of Science and the State. These authorities perceived medical problems, quite naturally, in terms of their own interests and responsibilities. From that perspective, it was irritating that European settlement was so vastly dispersed. Gold prospectors and pastoral lease-holders (in northern Australia), and prospectors and planters (in Melanesia), were sprinkled lightly over an immense region. If miners sometimes concentrated themselves in settlements and boom towns, these townships were short-lived, and prospectors were apt to move on as soon as they thought the easy deposits had been worked out. The State and Science were then obliged to spend immense sums on relieving the sufferings of small numbers of careless but impatient settlers, who showed little care for their personal hygiene or public sanitation. Even if responsibility could sometimes be imposed on local government in northern Australia, or on the feckless colonists themselves, such measures were likely to be casual, and of indifferent success. Problems of providing health care over distances were resolved in Australia only with the 1920s, when the Flying Doctor service came into operation; problems of financing health improvements, particularly on a broad environmental scale, would wait until the Second World War.

Compounding the problems of settlement and distance in northern Australia, was the evident risk of cross-infection from Aborigines, Melanesians and Chinese, all suspected of being reservoirs of loathsome infections, both in Australia and across Torres Strait. There was no money for the effective treatment of whole populations,

and in any event tropical medicine encouraged the assumption that certain races were predisposed to harbour certain human infections disproportionately. By this view, the obvious strategy for medical planners was international quarantine and local segregation by race.

Until the miracle drugs of the 1940s armed the medical profession against hitherto lethal infections, much state medicine aimed to isolate actual and potential carriers of disease, and to immobilise the population. That strategy generated continuing tension, since most of the people concerned highly valued their mobility. In northern Australia, large numbers of Aborigines were immobilised on reserves, or expelled beyond the pastoral frontier; but the settlers, including Chinese prospectors and Melanesian indentured labourers, were not so easily controlled. Prospectors were inclined to push themselves beyond the limits of endurance, and to eat whatever was cheap and available. Pastoralists and Melanesians made greater efforts to feed themselves on fresh vegetables, but it required the genius of the Chinese to produce fruit and vegetables for the remote markets. Across Torres Strait, prospectors were equally reckless in matters of diet, and in pursuit of the one lucky strike which would set them up for life (or more frequently death). Although Melanesian horticulture generated ample food for villagers, indentured labourers were at the mercy of poor or parsimonious employers. Effective health measures implied a degree of control which the circumstances of distance and broken terrain denied. There was a gulf - at least until the 1920s - between accepted medical ideas about tropical life, and measures which isolated groups took in order to sustain themselves. In many ways, the consequences of this separation tyrannize us yet today.

### -III-

The studies in this volume collectively traverse the narrow and increasingly untenable boundaries that separate scholarly disciplines dealing with health administration, the social history of northern Australia and Melanesia, and the historical relations of race and class. In each of these areas, long neglect is now being compensated, but much of the most important scholarship is yet to appear in print. To place the subject in context, the general reader is unusually reliant upon tangential, and frequently secondary, sources.

On mainland Australia, the history of health administration is vastly better understood in the temperate South than in the tropical North. Even so, one measures our knowledge in scruples. T.S. Pensabene<sup>1</sup> and Diana Dyason (for Victoria), Brian

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<sup>1</sup> T.S. Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University Press, 1980).

Gandevia and Evan Willis,<sup>2</sup> Roy MacLeod and Milton Lewis (for New South Wales),<sup>3</sup> have charted the rise of the medical profession and their influence upon health policy, but little is known of colonial medicine in South Australia, Tasmania, Western Australia and southern Queensland.<sup>4</sup> Fortunately, the key figure of J.H.L. Cumpston - first Director-General of Health for the Commonwealth from 1920 - has now found a biographer in his daughter Margaret Spencer,<sup>5</sup> and Milton Lewis is currently preparing Cumpston's magisterial *Health and Disease in Australia* for publication;<sup>6</sup> both will complete many parts of a tapestry half-spun. Raphael West Cilento, the influential health administrator, has been the subject of a dissertation by F.G. Fisher,<sup>7</sup> and is further considered by A.T. Yarwood in this volume. James Gillespie's work on the evolution of national health policies in post-Federation Australia is eagerly awaited, and partly foreshadowed by his chapter in this collection. For Papua New Guinea, Donald Denoon's *Public Health in Papua New Guinea* is a useful introduction.<sup>8</sup> That heavy burden of health care carried by mission organisations, has recently been discussed in studies edited by Margaret Jolly and Martha Macintyre.<sup>9</sup>

On the northern frontiers, Australian life is now the subject of an impressive array of energetic scholarship, mainly at James Cook University of North Queensland. Meanwhile, the standard works on the subject are Geoffrey Bolton's *A Thousand Miles Away*, and *Far Country*, Alan Powell's study of public policy

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<sup>2</sup> Evan Willis, *Medical Dominance: the Division of Labour in Australian Health Care* (Sydney: George Allen and Unwin, 1983).

<sup>3</sup> Roy MacLeod and Milton Lewis, "A Workingman's Paradise? Reflections on Urban Mortality in Colonial Australia, 1860-1900", *Medical History*, 31 (1987), 387-402; "Medical Politics and the Professionalisation of Medicine in New South Wales, 1850-1901", *Journal of Australian Studies*, 23 (1988).

<sup>4</sup> See, however, the essays in Roy MacLeod and Milton Lewis (eds.), *Disease, Medicine and Empire* (London: Tavistock, 1988).

<sup>5</sup> Margaret Spencer, *John Howard Lidgett Cumpston 1880-1954* (Tenterfield, N.S.W.: privately published, 1987).

<sup>6</sup> J.H.L. Cumpston, *Health and Disease in Australia: A History* (edited and introduced by Milton Lewis) (Canberra: AGPS, forthcoming).

<sup>7</sup> F.G. Fisher, Raphael West Cilento: Medical Administrator, Legislator, and Visionary, 1893-1945 (unpublished MA thesis, University of Queensland, 1984).

<sup>8</sup> Donald Denoon, *Public Health in Papua New Guinea, 1884-1984* (Cambridge: Cambridge University Press, 1989); B.G. Burton-Bradley, *The History of Medicine in Papua New Guinea* (Kingsgrove, N.S.W.: Australian Medical Publishing, 1990).

<sup>9</sup> Margaret Jolly and Martha Macintyre (eds.), *Family and Gender in the Pacific: Domestic Contradictions and the Colonial Impact* (Cambridge: Cambridge University Press, 1989).

in the Northern Territory.<sup>10</sup> Across Torres Strait, James Griffin, Hank Nelson and Stewart Firth's *Papua New Guinea: a Short Political History* is useful, although dealing (like Bolton and Powell) more with administration and policy than with medical history *per se*.<sup>11</sup>

The field of race relations in Australia generally, and in northern Australia in particular, is dominated by Henry Reynolds' *Frontier* and his *The Other Side of the Frontier*,<sup>12</sup> which have rescued the subject from a hand-wringing mode with little analytical precision, and have placed it squarely at the centre of Australian historical writing. In a sense all literature on Papua New Guinea is about race relations, but E.P. Wolfers' *Race Relations* gives the most systematic coverage, and C.D. Rowley's *New Guinea Villager*, the most sensitive and perceptive.<sup>13</sup>

#### -IV-

Against this general background, our explorations have much ground to cover. Our contributors have addressed the agenda set by European settlement and colonisation, in analysing the measures attempted in the century before, and the half-century since, modern drugs, rapid transport, expanded finances, and altered ideas about race have narrowed the gap between temperate and tropical societies in the region. The structure of the book takes advantage of the opportunities this presents for comparative investigation, in what amounts to almost-laboratory conditions. As responsibility for public health rested with much the same officers, who shifted smoothly between Commonwealth and Queensland governments as members of a small elite of tropical medicine specialists, we can gauge the impact of policies and programmes, attitudes and assumptions, on public health in different parts of the region. Equally important, this volume presents much new evidence on the actual health status of different communities, and allows us to compare societies which struggled against a variety of harsh circumstances and social disabilities.

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<sup>10</sup> Geoffrey Bolton, *A Thousand Miles Away: a History of North Queensland* (Canberra: Australian National University Press, 1963); Alan Powell, *Far Country: a Short History of the Northern Territory* (Melbourne: Melbourne University press, 1988).

<sup>11</sup> James Griffin, Hank Nelson and Stewart Firth, *Papua New Guinea: a Short Political History* (Melbourne: Melbourne University Press, 1979).

<sup>12</sup> Henry Reynolds, *The Other Side of the Frontier: Aboriginal Resistance to the European Invasion* (Ringwood: Penguin, 1982); *Frontier: Aborigines, Settlers and Land* (Sydney: Allen and Unwin, 1987); and *The Law of the Land* (Melbourne: Penguin, 1982).

<sup>13</sup> E.P. Wolfers, *Race Relations and Colonial Rule in Papua New Guinea* (Sydney: Australia and New Zealand Book Co., 1975); C.D. Rowley, *New Guinea Villager* (Melbourne: Melbourne University Press, 1958).

In Part I, authors address key individuals and attitudes in health administration generally. Donald Denoon considers the impact of contemporary ideas on the outlook of doctors responsible for health in New Guinea and Papua until the 1940s. In Australia, some authorities doubted the conventional wisdom that Aborigines would die out, and began to ask how that outcome could be averted. R. McGregor traces these esoteric debates among amateur and professional scholars, and links them to their consequences in public policy. Lori Harloe traces the uneven development of the Australian Institute of Tropical Medicine in Townsville, where international ideas about tropical health were "domesticated" to Australian and Melanesian circumstances. Prominent in all these manoeuvres was the pioneer medical administrator and planner Raphael Cilento, whose career took him to the Australian Institute of Tropical Medicine, then to New Guinea, and to the new federal Department in Canberra, before he moved to Brisbane. A.T. Yarwood's account of his career illuminates the interaction of personal and corporate ambition in the accomplishment of public health policies, whose sources and limitations otherwise lie somewhere between international ideas and parochial politics. James Gillespie's account of the Rockefeller Hookworm Campaign measures the influence of international organisations on the evolution of an effectively coordinated public health programme for Australia. He elegantly demonstrates the manner in which Rockefeller's initial interest in hookworm became the lever for promoting efficient public health institutions. As hookworm was more common in tropical than in temperate environments, progressive doctors who joined the campaign for a federal Department of Health (to coordinate and even supercede the state departments) saw Australia's tropical dependencies as a fortuitous short-cut towards achieving increased federal responsibilities for health generally. J.T. Griffin's essay on Papua New Guinea's first post-war Director of Health - Dr John Gunther - describes the conceptual and programmatic advances which occurred from the 1940s onwards, when new drugs, new resources, rapid transport and more ambitious medical policies broadened the scope and reach of public health. Taken together, these chapters demonstrate the working of international ideas, local political pressures, and shifting perceptions of health risks, towards the outcome of a genuine public health bureaucracy.

In Part II, we consider conditions of health and survival in northern Australia, distinguishing between the different communities which made up the tapestry of tropical life. Clive Moore describes the pattern of Melanesian living in Queensland's sugar country, by investigating the records concerning alcohol consumption and its social outcomes. Dawn May explains why Aborigines working on cattle stations contrived better diets and much better health than their kin on reservations or in urban fringe-settlements. The implication emerging quite clearly is that notions of race and destiny confounded the problems of ensuring the health of communities, which often enjoyed knowledge and resources that could enable

them to live satisfactory lives in seemingly unpromising circumstances. The social and medical notions which animated State and Science in the region had occasionally benevolent, but more often dire consequences for those who were captured by the institutions of governmental and professional paternalism. John Maguire's account of the Fantome Island leprosarium leads us into an underworld dominated by some science and much superstition. The institution he describes was a product of debates about isolation as a public health technique, and racial segregation as a social strategy, set against changing treatments for victims of Hansen's disease. Lyn Riddett describes how Northern Territory settlers made shift to sustain nutrition and health, and to heal themselves on the frequent occasions when needed medical assistance was unavailable. Peter Bell reconstructs the appalling conditions in which white gold miners subsisted, and contrasts those conditions with the more successful and sensible strategies of the Chinese, who were largely responsible for balancing their own diets and those of their European customers. Janice Wegner investigates two different styles of local government in North Queensland, revealing the heavy burdens imposed by a remote and disinterested state government, and describes the problems posed by dry and wet environments and casual sanitary practices. Where resources were slim, demands insistent, and frustration endemic, each community dug into its own (sometimes irrelevant) experience and perceptions to devise strategies for survival, hindered as much as assisted by the regulations laid down outside the region itself.

Taken together, this collection of papers can claim to demonstrate the importance of considering as inseparable the history of medical ideas, the evolution of social ideas about race, the changes wrought by constitutional status and folk traditions of nutrition and healing, as well as more obvious circumstances of institutional arrangements, natural resources, and climate. The health status of a given community is the outcome of all these interacting conditions. That the outcome of given policies and beliefs can vary enormously from one community to another, inhabiting much the same physical environment, sustains the argument that more such case studies are needed, as the work of interpretation and evaluation proceeds. It is, above all, a view that these essays underscore: disease "never stays at home". Only by paying closer attention to the tropical regions of our world, may we obtain a better understanding of the human medical condition, how it emerges, and how it can be improved.

## THE IDEA OF TROPICAL MEDICINE and its Influence on Papua New Guinea

Donald Denoon

European and Australian perceptions of Melanesia were coloured by fear of an environment which struck them down swiftly and mysteriously. No European attempted to settle on the New Guinea mainland until 1871, when the Russian scientist Miklouho-Maclay was conveyed to the north coast with two man-servants. He concluded that

it is not the Papuans or the tropical heat or the impassable forests that guard the coasts of New Guinea. Their mighty ally protecting them from foreign invaders is the pale, cold, first shivering and then burning fever.<sup>1</sup>

His own health was undermined, his Polynesian servant died, and the surviving Swede fell chronically ill. Within months, Polynesian pastors and teachers (established in the Papuan Gulf by the London Missionary Society) were dying like flies from malaria.<sup>2</sup> Gold prospectors fared no better: not only malaria but dysentery (a consequence of casual sanitation) struck them down.<sup>3</sup> The German New Guinea Company was better organised, but in July 1887 every European in Constantinhafen was shaking with fever. Four years later, when 13 of the 45 European residents had died of malaria, the survivors fled and the German doctor Schellong concluded that "malaria has conquered".<sup>4</sup> An early British doctor in Papua summarised the colonial experience before he departed:

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<sup>1</sup> Nikolai Miklouho-Maclay, *Travels to New Guinea: Diaries, Letters, Documents*, ed. D. Tumarkin (Moscow: Progress Publishers, 1982), 13.

<sup>2</sup> S. Latukefu, "Oral History and Pacific Island Missionaries", in D. Denoon and R. Lacey (eds.), *Oral Tradition in Melanesia* (Port Moresby: Institute of Papua New Guinea Studies, 1981), 175-87.

<sup>3</sup> Hank Nelson, *Black, White and Gold: Goldmining in Papua New Guinea, 1878-1930* (Canberra: Australian National University, 1976).

<sup>4</sup> W.H. Ewers, "Malaria in the Early Years of German New Guinea", *Journal of the Papua New Guinea Society*, vi (1) (1973), 3-30.

Throughout Australasia the climate of New Guinea is regarded with terror, and the country has much the same reputation, in the antipodes, as the West Coast of Africa formerly enjoyed among ourselves...<sup>5</sup>

Questions of public health assumed an urgency quite different from the laissez-faire attitudes of Australians. If the new colonial dependencies were to be administered and exploited, the colonial states would have to adopt more drastic public health measures than were common in temperate regions. Since New Guinea and Papua were (from 1884) colonial dependencies, the general public would not be privy to health policy debates. Who would determine strategy?

The colonial state itself was suffering. A Governor of German New Guinea was retired from the service, broken by fever; the first Commissioner of British New Guinea (i.e. Papua) died before he could pen his first annual report. Most officials veered between feverish depression and alcoholic elation.<sup>6</sup> Help was at hand, however. The great German scientist Robert Koch himself visited German New Guinea, bringing the good news about anopheles mosquitoes, and quinine as an effective suppressant of malaria.<sup>7</sup> And fortuitously the first Administrator of Papua, from 1888 to 1898, was a Scotch doctor, Sir William MacGregor. His careful survey suggested to him that the chief priority must be to prevent dysentery, the leading killer of Melanesians and gold miners. His prescription was public works, to ensure pure water and effective sewage disposal.<sup>8</sup> Koch and MacGregor were proposing the simple extension to the colonies of those hygienic measures which had dramatically transformed the quality and length of life in western Europe. If that humane strategy had been implemented, the ensuing fifty years would have witnessed a health revolution in Melanesia - but there were many other interests at stake which would divert health policy and practice to less beneficent purposes. What follows is an account of those malign interests and their consequences.

Schools of Tropical Medicine opened at the end of the nineteenth century in London and other metropolitan centres. They followed the important discoveries of Ronald Ross and Patrick Manson, who incriminated mosquitoes in the malaria cycle and in filariasis.<sup>9</sup> Equally important for the new discipline was political patronage.

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<sup>5</sup> R. Fleming Jones, "Tropical Diseases in British New Guinea", *Transactions of the Royal Society for Tropical Medical Hygiene*, vi (1910/1911), 93-105.

<sup>6</sup> Ewers, *op. cit.*; Nelson, *op. cit.*

<sup>7</sup> Stewart Firth, *New Guinea under the Germans* (Melbourne: Melbourne University Press, 1983).

<sup>8</sup> W. MacGregor, "Some Problems of Tropical Medicine", *Lancet* (13 October 1900), 1055-61.

<sup>9</sup> Michael Worboys, "The Emergence of Tropical Medicine: a Study in the Establishment of a Scientific Specialty", in G. Lemaire, R. MacLeod *et al.*, *Perspectives on the Emergence of Scientific Disciplines* (The Hague: Mouton, 1976).

The orchestrator of British imperialism, Joseph Chamberlain the Secretary of State for Colonies, funded the discipline in the hope of preserving the lives of administrators and entrepreneurs in the new tropical estates. Directed by Patrick Manson, the London School developed as a laboratory-based institution promoting research into the curing of specific diseases, and comparing and contrasting the response of different races to specific infections. Those measures of public health which had actually improved living conditions in the temperate world (clean water, pure food and safe sewage-disposal) were neglected in favour of research into diseases deemed (wrongly, as it happens) to be tropical in provenance. Similarly, research was more interested in hereditary factors than in social circumstances.

The first medical research centre in Australia reflected and exaggerated the bias inherent in the metropolitan discipline. The Australian Institute of Tropical Medicine was founded in Townsville in 1911 by private capital, popular sentiment and government subsidy.<sup>10</sup> In northern Australia (but nowhere else in the world) it was an urgent question whether a predominantly white population could establish itself in a tropical environment.<sup>11</sup> It was this question which Dr Anton Breinl and his colleagues addressed in the Institute, and which dominated the curriculum for the quarantine officers and tropical doctors who attended courses. Breinl himself was curious about everything, and the Institute's program of research was diffuse. As a recently-naturalised alien, however, he was harassed during the Great War and removed from the Institute. His successors were more narrowly obsessed by threats to white survival. In 1922 the Institute's purpose was advertised in these terms:

From the earliest days of colonisation European diseases were introduced in quantity among the early settlers; various tropical diseases were introduced by the Kanakas from the islands of the Pacific; and by the hordes of Chinese and other Asiatics that poured in before the days of Federation...Three sets of disease conditions consequently present themselves for control:

- (1)those introduced from European countries;
- (2)those introduced from neighbouring tropical lands;
- (3)those indigenous to the country.<sup>12</sup>

Sir Raphael Cilento, who wrote the advertisement, stated the matter more plainly in retrospect. The successful settlement of North Queensland by people of European descent was attributed to:

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<sup>10</sup> R.A. Douglas, "Dr Anton Breinl and the Australian Institute of Tropical Medicine", *Medical Journal of Australia*, (1977) (i), 713-6, 748-51, 784-90.

<sup>11</sup> e.g. A. Grenfell Price, "The White Man in the Tropics", *Medical Journal of Australia*, (1933) (i), 106-110.

<sup>12</sup> R.W. Cilento, Circular Letter 30 November 1922, School of Public Health & Tropical Medicine series, SP106/1, General Correspondence 1908-55, file 65: Australian Archives (AA) (Sydney).

the absence of any teeming native coloured population, riddled by endemic disease [combined with effective quarantine, improved standards of living, and an increase in the Queensland-born population]...it was with the arrival of swarms of coloured labourers that the situation became critical.<sup>13</sup>

These perceptions tied tropical disease to tropical people, ignoring the physical circumstances in which people lived, and stressing hereditary pre-disposition. In the Townsville environment, tropical medicine became more explicitly racist in its focus than in London: nothing remains of MacGregor's enthusiasm for public works to raise the living standards of the whole population; and it was the Townsville version of tropical medicine which influenced medical policy in New Guinea and Papua through the training of doctors to serve in the dependencies, and through research collaboration.<sup>14</sup>

MacGregor's observations could be unclouded in the 1890s, when very few Europeans lived in Papua and there were no resources for a health program. The arrival of settlers placed new and intransigent demands on the administration, backed by the implicit threat that if settlers could not survive, there would be no cash economy to administer. By 1914 there were three tiny hospitals in Papua, each with an average occupancy rate of one or two patients, segregated from neighbouring Native Hospitals, and engorging a large proportion of public health budgets.<sup>15</sup> The situation was not very different in German New Guinea.<sup>16</sup> The settlers not only demanded hospital facilities: they also wanted resources deployed towards their labour lines. With Breinl's encouragement, therefore, one of Papua's three doctors before the Great War devoted himself to the study of bowel parasites in plantation labourers, seeking some means for improving the efficiency of their hosts.<sup>17</sup> In an establishment of three doctors and three or four white nurses, the actual division of responsibility precluded any effective public health program, let alone health extension work. White women nurses were confined to white hospitals; doctors doubled as quarantine officers. In effect they were all tied to the care of individual patients of whom the great bulk were indentured workers and government employees, who were medically inspected at the beginning and end of

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<sup>13</sup> Cilento, in R.W. Cilento and C. Lack, *Triumph in the Tropics: an Historical Sketch of Queensland* (Brisbane: Smith & Paterson 1959), 426.

<sup>14</sup> The links are traced in my *Public Health in Papua New Guinea 1884-1984* (Cambridge: Cambridge University Press, 1989).

<sup>15</sup> Facilities and costs are laid out in *Papuan Annual Reports*.

<sup>16</sup> See *German New Guinea Annual Reports*, and the *Annual Report to the League of Nations* from the Mandated Territory of New Guinea.

<sup>17</sup> *Papuan Annual Reports*, 1912-1914.

their terms of employment.<sup>18</sup> Only Bellamy, a lapsed medical student and gold prospector working as a Resident Magistrate and Medical Officer in the Trobriand Islands, found a research project which would benefit the population, when he took over the administration of a lock hospital for venereal victims.<sup>19</sup>

The paralysis of medical policy was largely a consequence of grossly inadequate funding. For that complaint, Dr Lambert turned up a remedy.<sup>20</sup> Sociable, breezy, infectiousy enthusiastic, he was an admirable agent of the Rockefeller Foundation (described by Gillespie in chapter 5). He panned the medical service of Papua immediately after the war:

The whole medical service was pared down to an excellent Chief Medical Officer [Walter Mersh Strong] with nothing to work with, a Judgment Day prophet in charge of the [Port Moresby European] hospital, and one physician for each of three far-flung districts. These five, with a couple of nurses and two European dispensers, were supposed to service the 90,000 odd square miles. The officer at Samarai was efficiently modern: the other three were elderly hacks. This was typical of the general situation over the South Pacific.<sup>21</sup>

In both New Guinea and Papua, the Foundation offered substantial aid for campaigns to eradicate hookworm. Planters believed that the campaign might strengthen the labour line; colonial officials were willing to believe that a healthier population would result. There was little resistance to therapists bringing gifts. In the long run it proved that Melanesia was unsuitable terrain for Rockefeller technology. The significance for medical practice in New Guinea and Papua was not therapeutic, but in weaning medical services onto specific disease campaigns.

Probably the most crippling defect was the absence of nurses. To be employed by the administration, a nurse had to be female, British, unmarried, and not beyond middle age (lest she have independent ideas beyond her station).<sup>22</sup> She was then allowed only to nurse in the white hospitals, while a cadre of European Medical Assistants (partially trained doctors, male and unmarried) patrolled the countryside. Melanesian health was largely the province of mission societies, which would

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<sup>18</sup> Ian Maddocks, "Medicine and Colonialism", *Australian and New Zealand Journal of Sociology*, xi (3) (1975) 27-33; S.M. Lambert, *Australian Hookworm Campaign, Survey Report on Papua* (New York: Rockefeller Foundation, 1920).

<sup>19</sup> R.H. Black, "Dr Bellamy of Papua", *Medical Journal of Australia* (1957) (x) 713-6, 748-51, 784-90.

<sup>20</sup> I am grateful for Dr Jim Gillespie's guidance on the Rockefeller Foundation's work in the Pacific. An interesting general introduction is Victor Heiser, *A Doctor's Odyssey: Adventures in Forty Five Countries* (London: Jonathan Cape, 1936).

<sup>21</sup> S.M. Lambert, *Doctor in Paradise* (London: J.M. Dent & Sons, 1942).

<sup>22</sup> Correspondence on recruiting nurses, A1928, 710/20: AA (Canberra).

employ female nurses but could attract and retain very few of them.<sup>23</sup> Only one mission society (the Kwato Extension Association in Milne Bay) trained indigenous nurses, who were then encouraged to marry evangelists and conduct clinics on mission plantations.<sup>24</sup> This combination of circumstances ensured that nothing was done for women, until the 1930s. Colonial taboos about race and gender therefore inhibited the adoption of a genuine public health program.

In this general sense, Australian public opinion shaped the nature and extent of medical services in the dependencies. For most purposes, however, the medical profession enjoyed absolute discretion in allocating the slender resources at their disposal. During the Great War, German New Guinea passed into Australian control, first as occupied territory (from 1914) and then (from 1921) as a League of Nations Mandate. German property was expropriated, and held by the Expropriation Board for some years until it could be passed to ex-servicemen. While the Board held the plantations, its Secretary - the redoubtable Walter Lucas, manager of Burns Philp and a close friend of Prime Minister Hughes - made a grant of £10,000 for medical services, and hoped that it would be invested in preventive measures to improve the quality and quantity of indigenous labour. The Chief Medical Officer of New Guinea, Colonel Honman, was a political nobody - "hard crusted, soft-hearted, not afraid of alcohol or anything else" in Lambert's opinion.<sup>25</sup> Yet Honman was able to lift the £10,000 and spend it on hospitals and medical equipment.<sup>26</sup> If so feeble a force as Honman could ignore so powerful a politician as Lucas, then the medical profession was immune to ordinary political pressures.

Doctors had their own agenda to pursue. They were particularly vexed that there was no federal Department of Health to supercede (or coordinate) the work of the several states and territories.<sup>27</sup> The next best thing in the first generation after federation was a Quarantine section in the Commonwealth Department of Customs; and it was there that Doctors Cumpston and Elkington planned the drive towards a full Federal Department. One of few Commonwealth responsibilities was for external territories, so that an emphasis on Tropical Health was the lever to push the Commonwealth into a more active role in health policy. Cumpston and

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<sup>23</sup> Ellen Kettle, *That They Might Live* (Sydney: F.P. Leonard, 1979).

<sup>24</sup> Interviews Sir Cecil Abel and Nedulia, Medical History Research Tapes 9, 10, 1980: New Guinea Collection, University of Papua New Guinea Library.

<sup>25</sup> Lambert, *op. cit.*

<sup>26</sup> Lucas to PM's Secretary, 21 July 1922, A518, R832/1/3: AA (Canberra). *New Guinea Annual Reports* record the actual expenditure.

<sup>27</sup> Research in progress by Dr Milton Lewis and Dr Jim Gillespie, to whom I am indebted for information.

Elkington discovered and cultivated a young South Australian doctor who had become interested in the new discipline; and Dr Raphael West Cilento became their spearhead in the capture of AIM in Townsville and the medical service of the Australian Mandated Territory of New Guinea.<sup>28</sup> The Rockefeller Foundation was also important in persuading Prime Minister Billy Hughes to create a Department.<sup>29</sup> Throughout the 1920s, therefore, New Guinea was the focus of a coalition of powerful forces in the world of health politics: the Foundation, the medical profession, the Townsville Institute and the discipline of Tropical Medicine, and (since New Guinea was a conquered territory reserved to ex-servicemen as administrators and planters) the Returned Soldiers' League.

This curious political context enables us to understand the few strengths and many weaknesses of medical policies and programs in New Guinea and Papua between the wars. First, who delivered programs? Apart from a handful of female hospital nurses, health programs were carried out by male doctors and male Medical Assistants many of whom had picked up some medicine as ward orderlies in armies, and all of whom were persuaded of the merits of Tropical Medicine. During the 1930s, three batches of Papuan primary school leavers were trained in Sydney to supplement the work of their European counterparts. A proposal to send New Guineans to train as Native Medical Practitioners in Suva was vetoed by Cilento, who assured the cabinet that New Guineans were socially and intellectually incapable of education and responsibility.<sup>30</sup> By contrast, the mission medical establishments were much more feminine in composition, and much less committed to the health of the white population.

The leading strategy of the public health officers was quarantine and segregation. Cilento's priorities included the creation of a tight quarantine chain from the Dutch East Indies through the Pacific islands, and the segregation of the racially mixed capital of New Guinea, Rabaul.<sup>31</sup> Strong in Papua advised Europeans to live a quarter of a mile from Papuans if they valued their health.<sup>32</sup> Segregation was a signal of defeat, acknowledging that disease could not be prevented or cured, and must therefore be contained, if necessary on a racial basis.

It was a very unusual patient who escaped Epsom salts: purging varied from gentle to severe, from palatable to a gut-wrenching brew prescribed for the

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<sup>28</sup> *Ibid.*; and F.G. Fisher, Raphael West Cilento, Medical Administrator, Legislator and Visionary (Unpublished MA thesis, University of Queensland, 1984).

<sup>29</sup> *Ibid.*

<sup>30</sup> Correspondence between Lambert, Brennan, Griffith, Cumpston and Cilento, late 1932, A 518, U 832/1/3: AA (Canberra).

<sup>31</sup> Fisher, *op. cit.*

<sup>32</sup> In Staniforth Smith (ed.), *Handbook of the Territory of Papua* (Melbourne, 1912, Canberra, 1927).

widespread colonial disease, Malingering.<sup>33</sup> Even dysentery was treated by purging. This limited pharmacopoeia meant that patients could neither be drugged nor nursed back to health: nor could illness be prevented in the absence of the proven health measures of temperate climates. In the circumstances, segregation and quarantine may not have been as stupid as they seem half a century later. The authorities recognised the significance of diet, since the discovery of vitamins; but diets could be prescribed only for indentured labourers; and even on plantations (and indeed in government gaols) there were occasional outbreaks of beriberi.<sup>34</sup>

Apart from patrolling the international and inter-racial boundaries, what did medical authorities actually do? Not very much. Strong in Papua explained that:

You can take a horse to water, but you cannot make him drink...the Government pays me to look after [Papuan's] health and I am quite willing to help them all I can, but if they will not come for treatment it is their own concern, and as far as I am concerned it merely saves trouble.<sup>35</sup>

A certain amount of advice was made available, notably in the *Handbook on the Treatment and Prevention of Disease in Papua when Medical Advice is Unobtainable* (Port Moresby, 1917), and in leaflets describing useful dietary and sanitation hints.<sup>36</sup> The few literate Papuans may have been impressed by the recommendation that

The people must not fight with spears and arrows any more; they must not pretend to kill one another with bad magic; they must not bury the dead inside the village. These are bad fashions.<sup>37</sup>

But in practice most medical impact was achieved by medical patrols. Since a medical patrol was visible and audible a long way from its village destination, even attendance at village centres was in effect voluntary.

One of the attractions of the medical patrols came into production after the Great War. Yaws - a non-venereal form of treponemal infection - had previously been treated by arsenical compounds, in a single injection which often cleared up yaws as if by magic. During 1922 Dr Harse treated all the children of Poreporena village (near Port Moresby), with spectacular success. 360 cases were treated, and the resident missionary reported that every child responded well. The populace responded even better; mothers mobbed the hospital, clamouring for their children

<sup>33</sup> Hera Ganiga (who was one of Strong's Papuan Medical Assistants) interviewed by Leo Wearden, Port Moresby 1980.

<sup>34</sup> R.W. Cilento, "Food deficiencies in New Guinea", *Medical Journal of Australia* (1926) 309.

<sup>35</sup> W.M. Strong, "The Medical Education of Papuan Natives", *Ibid.* (1935) 305-9, cited and discussed in Maddocks, *op. cit.*

<sup>36</sup> e.g. W.M. Strong, *Bacillary Dysentery* (Port Moresby: Government Printer, 1938), and his *The Feeding of Native Labourers in Papua* (Port Moresby: Government Printer, 1926).

<sup>37</sup> *Papuan Villager*, 1, (1), (15 February 1929).

to be injected; and people flooded in from the whole coastal region.<sup>38</sup> Since little skill was required in administering the injection, delivery was often delegated to missionaries. Then in the mid-1920s the new compound M&B 914 became available: it was cheaper than the arsenicals and almost as effective.<sup>39</sup> As news of these injections spread, medical patrols were guaranteed an enthusiastic reception, even in villages which resented every other manifestation of colonialism.<sup>40</sup>

The technical simplicity of the hookworm campaigns and the yaws treatments, the cheapness of the materia medica, and the overwhelming popularity of yaws treatments, swung the population from distrust to tolerance and even enthusiasm. The same qualities confirmed the medical authorities in a disease-based, campaigning mode of behaviour. It is this which explains the curiously slanted record of treatment. The records for 1925-26 in Papua, for instance, reveal the following:

49,518 hookworm treatments  
12,643 yaws treatments  
186 cases of venereal disease  
51 cases of everything else.<sup>41</sup>

New Guinea presented similar symptoms, although on a larger scale, since the population and the medical establishment were both substantially larger than in Papua.<sup>42</sup> Since the hookworm treatment was often ineffective, and yaws was more often inconvenient than lethal, the extension work achieved little except impressive statistics.

None of this would matter, if it did not also involve neglect of conditions which were not "tropical" but which were certainly manageable. One of these was tuberculosis, from which New Guinea and Papua were substantially free before colonial intervention. The pattern of infection precisely maps the extent of colonial influence, so that the highlands remained free of the disease until the 1930s, and the chief victims were the plantation labourers and mission converts who came into the most intimate contact with foreigners.<sup>43</sup> In New Guinea, researchers recorded the increasing incidence of TB with regret. In Papua, Constance Fairhall of the London

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<sup>38</sup> J.B. Clark to Administrator Staniforth Smith, 20 February 1922, CS 1061, box 16, file 408: AA (Sydney).

<sup>39</sup> Strong's memorandum of 30 June 1926, CS 1061, box 17, file 449: *Ibid.*

<sup>40</sup> Interviews with Sir John Gunther, Melbourne 1982, and Stan Christian, Canberra, 1982.

<sup>41</sup> *Papuan Annual Report*, 1925/26.

<sup>42</sup> See *New Guinea Annual Reports*.

<sup>43</sup> Stan Wigley, "Tuberculosis and New Guinea: Historical Perspectives with special reference to the years from 1871 to 1972", in B.G. Burton-Bradley, (ed.) *The History of Medicine in Papua New Guinea* (Sydney, forthcoming).

Missionary Society directed Gemo Island isolation hospital in the late 1930s, but deferred to Papuan sentiment and failed effectively to isolate victims from their families.<sup>44</sup> Pneumonia and dysentery, too, broke out wherever large concentrations of workers were brought together.

Throughout the first fifty years of colonial administration, planners were fearful that depopulation would undermine economic prospects. We might suppose, therefore, that much attention would be given to maternal and infant mortality, the proximate causes of massive population loss. Strong had in fact considered maternal and child health from an ethnographic point of view as early as 1904. A quarter of a century passed before he considered them from a medical perspective. One approach was to pay a "baby bonus" to the fathers of large families.<sup>45</sup> Another was to appoint one or two nurses at appropriate mission stations, where they would teach Papuan girls to teach mothers to feed their children better.<sup>46</sup> On the New Guinea side, matters were tackled more brusquely: birth control became a criminal offence, and the state delegated to the missions any medical intervention in child-birth or child-rearing.<sup>47</sup> This is precisely the period when - in Australia and in much of the West - parturition and nurturing were being professionalised and rates of maternal, infant and child mortality were declining sharply. Through this neglect, New Guineans and Papuans were shielded from all those public health measures which could have improved the quality and stretched the length of their lives.

How is it that such criminal neglect persisted for fifty years? The medical profession was unchallenged in designing policy and practice: only very briefly did the plantation industry in New Guinea attempt to divert medical resources towards preventive measures. What reconciled the medical profession to the delivery of grossly inadequate services, stressing exotic disease rather than actual living conditions? Undoubtedly policy was influenced by the masculine composition of the colonial state generally, and of the expatriate population; and taboos regulating racial and gender relations coloured the lens through which living conditions were perceived. Yet that had been true in the late nineteenth century as well as the twentieth, and in any event it was possible (in Fiji, and in New Zealand) for genuinely therapeutic measures to penetrate the obfuscating gloom of racial stereotyping. It is hard to escape the judgment that it was the evolution of Tropical

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<sup>44</sup> "Papua - establishment at Gemo of Hospital for treatment of leprosy and tuberculosis": Gemo Island Hospital Report by Constance Fairhall, November 1938, A 1929, 775/12: AA (Canberra).

<sup>45</sup> *Papuan Annual Report*, 1921-22.

<sup>46</sup> Strong memo, 16 July 1930, enclosed in Murray to Minister, 6 September 1930, A 518, Item N 840/1/5: AA (Canberra).

<sup>47</sup> Denoon, *op. cit.*

Medicine, and its transmission through Townsville and the new Commonwealth Department of Health, which was chiefly responsible. Tropical Medicine was not only fixated on exotic conditions: it was necessarily disease-based rather than health-based, and the diseases which it could treat in New Guinea and Papua happened to be either cosmetic or trivial. The discipline guided doctors into channels which were intellectually stimulating but therapeutically marginal, and thereby reconciled them to programs of doubtful utility, which occupied so much of their attention that they turned their backs on conditions which would have yielded to more mundane approaches.

## **THE IDEA OF RACIAL DEGENERATION**

### **Baldwin Spencer and the Aborigines of the Northern Territory**

**R. McGregor**

In the late 19th and early 20th centuries, considerations by white Australians of Aboriginal health and welfare issues took place in the shadow of the "doomed race" concept. A hundred years of observations of declining Aboriginal health and numbers, combined with the powerful explanatory device of evolutionary theory, led white Australians to the conclusion that nothing could be done to save the race from extinction. If Aborigines were suffering the impact of disease, alcohol and drugs, if their mortality rate was high and their birth rate low, that was merely symptomatic of their ultimate demise. Moreover, regrettable as it might be, their demise was merely in accordance with the immutable laws of nature. Such ideas, supported as they were by scientific certainties, found ready acceptance in a society founded upon the dispossession of the indigenous inhabitants and loudly proclaiming its commitment to a White Australia. But, powerful as the "doomed race" concept was, its ambiguities must also be recognised; ambiguities which allowed at least some scope for human intervention on behalf of a "dying race". This chapter examines one official report by a noted Australian anthropologist - Baldwin Spencer's Preliminary Report on the Aborigines of the Northern Territory of 1913 - in the light of the prevailing "doomed race" idea, pointing out that Spencer's report was constrained by this pervasive idea, yet simultaneously transcended the inherent fatalism of the concept.

The "doomed race" idea in Australia predated Darwinian evolutionism; but it was evolutionary theory that elevated the concept to the status of a scientific certainty. According to the evolutionists, Australian Aborigines were amongst the most primitive of peoples; in all their attributes - social, cultural, physical, intellectual - they were thought to represent the "type" of primeval humanity. It was this assumption that lent the Aborigines their unique scientific value. The ethnologist Dr. Ramsay Smith explained to the 1913 meeting of the Australasian Association for the Advancement of Science (AAAS) that:

Centuries ago, nature "side-tracked" a race in Australia. At the present time, despite some drawbacks or interference from outside, that race remains, to a large extent in

primitive conditions. It is capable of casting light on the evolution of human races in a way, and to an extent, that probably no other can equal.<sup>1</sup>

The "primitivity" of the Aborigines was not merely an incidental assumption; it was fundamental to the whole enterprise of evolutionary anthropology.<sup>2</sup> Given the extent of scientific commitment to the idea of Aboriginal primitivity, their extinction was a foregone conclusion; for a race which had stagnated in an evolutionary backwater, a living fossil in the modern age, could not hope to survive in competition with the highest product of the evolutionary process, any more that the dinosaur could survive into the age of mammals. James Barnard epitomised the scientific certainty in his statement to the second meeting of the AAAS in 1888:

It has become an axiom that, following the law of evolution and survival of the fittest, the inferior races of mankind must give place to the highest type of man, and that this law is adequate to account for the gradual decline in numbers of the aboriginal inhabitants of a country before the march of civilisation.<sup>3</sup>

As an axiom, the "doomed race" concept was seldom accompanied by evidence or explanation; the doctrine of survival of the fittest rendered any further explication redundant. Some anthropologists, however, did attempt to explain not merely why, but also how, the Aborigines would become extinct. Charles Darwin attempted to explain the extinction of "primitive" races in terms of introduced diseases and alcohol, an inability of "savages" to change their habits and their lack of motivation; but he was forced to conclude that racial extinction remained an "obscure problem".<sup>4</sup> Amongst Australian anthropologists the favoured causes of the Aboriginal demise were disease and the "vices of civilisation", including alcohol, opium and prostitution, sometimes combined with an hereditary weakness in the

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<sup>1</sup> W.R. Smith, "Australian Conditions and Problems from the Standpoint of Present Anthropological Knowledge", *Australasian Association for the Advancement of Science* (hereafter AAAS), 14 (1913), 374.

<sup>2</sup> For a more detailed assessment of the importance of the idea of "primitivity" to late 19th and early 20th century Australian anthropologists see: D.J. Mulvaney, "The Australian Aborigines 1606-1929: Opinion and Fieldwork: Part II: 1859-1929", *Historical Studies*, 8, 306-312; D.J. Mulvaney, "The Ascent of Aboriginal Man: Howitt as Anthropologist" in M.H. Walker, *Come Wind, Come Weather* (Melbourne: Melbourne University Press, 1971), 285-312; I. Langham, *The Building of British Social Anthropology* (Dordrecht: D. Reidel Publishing Co., 1981), 20-49; G. Cowlishaw, "Aborigines and Anthropologists", *Australian Aboriginal Studies*, (1986), No. 1, 2-12; A.K. Chase and J.R. von Sturmer, "Mental Man and Social Evolutionary Theory", in G.E. Kearney, P.R. de Lacey and G.R. Davidson (eds.), *The Psychology of Aboriginal Australians* (Sydney: John Wiley and Sons, 1973), 3-15.

<sup>3</sup> J. Barnard, "Aborigines of Tasmania", AAAS, 2 (1890), 597.

<sup>4</sup> C. Darwin, *The Descent of Man* (Princeton: Princeton University Press, 1981), 236-240.

Aboriginal constitution; some acknowledged also that blacks were deliberately killed. A.W. Howitt made a more ambitious attempt than most to explain the mechanisms of Aboriginal extinction. He noted that at first the frontier was "marked by a line of blood". Following the initial violence of the frontier, Aborigines fell victim to "the fatal enticements of intoxication" and to "newly-acquired evil diseases", the impact of which was all the more severe for the simultaneous disintegration of their social constraints. To complete the picture, and to add the necessary element of inevitability, Howitt claimed that there were "hereditary physical and mental peculiarities" of the race which prevented it from adapting to the circumstances of civilisation.<sup>5</sup> Howitt's was quite an orthodox explanation. The real strength of the idea of inevitable extinction, however, lay not in the empirical evidence but in the theoretical constructs of evolution.

In tropical Australia, as in the temperate zone, the Natural Law of survival of the fittest sentenced Aborigines to extinction. Carl Lumholtz was saddened to think that the Aborigines he had lived with on the Herbert River, North Queensland, in the 1880s were destined to share "the same fate as that which overtook their brothers in Tasmania".<sup>6</sup> In 1907, Daisy Bates declared that:

The Northern natives are disappearing more slowly [than those in the south] but none the less surely...their ultimate extinction also is but too certain...To save and civilise the race we are supplanting is an impossibility, for they are physically uncivilisable and are inevitably doomed to perish.<sup>7</sup>

There was, however, one distinctive feature of the tropics: by the early 20th century it was only there that significant numbers of Aborigines still lived in a manner relatively uncontaminated by the contagion of civilisation. Outside the coastal fringe of North Queensland, white settlement in the tropics was sparse and in most places recent; relations between Aborigines and Europeans were often tenuous. Indeed, at this time there still existed, especially in the Northern Territory, substantial numbers of Aborigines who maintained no permanent contact with Europeans at all. Was there then no hope for these people?

The "doomed race" concept notwithstanding, around the beginning of the second decade of the 20th century when the Commonwealth was about to assume control of the Northern Territory and thus of significant numbers of Aborigines, a note of restrained optimism regarding the future of the Aborigines was sounded in scientific

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<sup>5</sup> L. Fison and A.W. Howitt, *Kamilaroi and Kurnai* (Melbourne: George Robertson, 1880), 181-185.

<sup>6</sup> C. Lumholtz, *Among Cannibals* (London: John Murray, 1889; Facsimile edn.: Caliban Books, 1979), 376.

<sup>7</sup> Text of a Lecture delivered to the Governor-General and Lady Northcote at the Karrakatta Club, Perth, 1907, Daisy Mary Bates Papers, MS365, Series 88, item 119: National Library of Australia (NLA).

circles. In 1910, Dr. Ramsay Smith - an anthropologist who in other contexts wholeheartedly endorsed the idea of inevitable extinction - concluded his article on the Aborigines in the *Official Year Book* with the sentence:

The problem of what to do with the race, the most interesting at present on earth and the least deserving to be exterminated by us, and the most wronged at our hands, is not a difficult one to solve, were a solution really desired.<sup>8</sup>

Although Ramsay Smith gave no reason to assume that a solution really was desired, his remark did make extinction a matter of human choice rather than natural law. More pertinently, in 1910 a group, which was to become the Association for the Protection of Native Races, was founded under the leadership of Archdeacon C.E.C. Lefroy, to advocate a coherent program for the future welfare of Aborigines. Lefroy presented a paper to the 1911 meeting of the AAAS, in which he argued for the preservation and "uplifting" of the Aborigines by "making the whole of the remnant a national responsibility under national control".<sup>9</sup> Lefroy's ambitious proposals received a sympathetic hearing from the assembled scientists, and a committee was set up to draft an "organised scheme for the future of the Australian aborigines".<sup>10</sup> While it certainly could not be claimed that these tentative ideas shook the scientific foundations of the "doomed race" concept, they did engender a less fatalistic attitude toward Aboriginal welfare in general, and toward the future of those in the Northern Territory in particular.

### Baldwin Spencer and the 1913 Report

Baldwin Spencer was, when the Commonwealth government appointed him Special Commissioner and Chief Protector of Aborigines for the Northern Territory in late 1911, Australia's most eminent anthropologist, as well as Professor of Biology at Melbourne University and a prominent publicist of scientific matters. His commitment to evolutionary theory is amply attested in the first paragraph of the preface to his book *The Arunta*:

Australia is the present home and refuge of creatures, often crude and quaint that have elsewhere passed away and given place to higher forms. This applies equally to the aboriginal as to the platypus and kangaroo. Just as the platypus, laying its eggs and feebly suckling its young, reveals a mammal in the making, so does the aboriginal show us, at least in broad outline, what early man must have been like before he learned to read and write, domesticate animals, cultivate crops and use a

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<sup>8</sup> W.R. Smith, "The Aborigines of Australia" in *Official Year Book of the Commonwealth of Australia*, No. 3 (1910), 175.

<sup>9</sup> C.E.C. Lefroy, "The Future of the Australian Aborigines", *AAAS*, 13 (1911), 453-454.

<sup>10</sup> Resolutions Passed by the General Council, *Ibid.* LVIII.

metal tool. It has been possible to study in Australia human beings that still remain on the culture level of men of the Stone Age.<sup>11</sup>

On the "doomed race" idea, Spencer expressed himself unequivocally in an early (1896) anthropological account: "In contact with the white race the aborigine is doomed to disappear".<sup>12</sup> Late in life he told a reporter that the Aborigines "were doomed, and nothing could be done to save them from extinction".<sup>13</sup> Some of his statements, however, were more cautious. In his 1921 Presidential Address to the Australasian Association for the Advancement of Science, he remarked that "it can only be a matter of comparatively few years before they [the Aborigines] are extinct..." but added the rider "...or the surviving remnants of the tribe have lost all knowledge of their original habits and customs".<sup>14</sup> Although Spencer's remarks were sometimes ambiguous, he maintained throughout his career a strong commitment to Social Darwinist notions, and to the idea that in inter-racial encounters the extinction of one was likely.<sup>15</sup>

Yet in Spencer's "Preliminary Report on the Aborigines of the Northern Territory" in 1913, the "doomed race" concept does not appear. Certainly, he emphasized the fact that the Aborigines were suffering a heavy mortality: "One thing is certain, and that is that in all parts where they are in contact with outsiders, especially with Asiatics, they are dying out with great rapidity".<sup>16</sup> But the tenor of Spencer's report was that this "dying out" could be arrested if appropriate measures were taken. His report gave no definite assurance that the Aborigines could be saved from extinction; the "doomed race" concept was too firmly

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<sup>11</sup> W.B. Spencer and F.J. Gillen, *The Arunta: A Study of a Stone Age People* (London: Macmillan, 1927), vii.

<sup>12</sup> W.B. Spencer, *Report on the Work of the Horn Scientific Expedition to Central Australia* (London: Dulau and Co., 1896), 1, 111.

<sup>13</sup> *Argus*, 23 August 1926, 12, quoted in D.J. Mulvaney and J.H. Calaby, "So Much That Is New": *Baldwin Spencer, 1860-1929* (Melbourne: Melbourne University Press, 1985), 384.

<sup>14</sup> W.B. Spencer, "Presidential Address to the Australasian Association for the Advancement of Science", *AAAS*, 15 (1921), 89.

<sup>15</sup> See especially W.B. Spencer, "The Aborigines of Australia" in Federal Handbook prepared in conjunction with the eighty-fourth meeting of the British Association for the Advancement of Science, held in Australia, August, 1914, 35-36. Spencer's commitment to Social Darwinist ideas and the "doomed race" theory is well documented in the detailed biography by Mulvaney and Calaby. However, unlike the interpretation advanced in this paper, Mulvaney implies that Spencer never wavered in his conviction that Aborigines were inevitably and irretrievably doomed to extinction.

<sup>16</sup> W.B. Spencer, "Preliminary Report on the Aborigines of the Northern Territory", *Commonwealth Parliamentary Papers (CPP)*, 3 (1913), 41. Although this report was entitled "preliminary", a sequel was never published.

entrenched for that. But Spencer's report did embody positive and far-reaching plans for Aboriginal health, welfare, education and for their partial entry into European society, as if their long-term survival was a real possibility.

It is possible that Spencer's positive policies were merely an exercise in "smoothing the pillow of a dying race". That humanitarian activity, which dovetailed perfectly with a belief in inevitable Aboriginal extinction, was prevalent. Daisy Bates, probably the most vociferous exponent of both concepts lamented:

All that can be done is to render their passing easier and for this reason if for no other, no effort should be spared on their behalf as long as they remain with us.<sup>17</sup>

Mrs Bates devoted her life to "rendering their passing easier", fully convinced that none of her efforts - or the efforts of anyone else - could alter the fact of their ultimate demise.<sup>18</sup> Spencer's close colleague, Frank Gillen, advised the South Australian Select Committee on the Aborigines Bill of 1899 that: "You cannot do any more than make their path to extinction as pleasant as possible".<sup>19</sup> Spencer himself made a similar remark in his first major anthropological publication in 1899; he noted that after contact between Aborigines and Europeans, with its attendant disease, "all that can be done is to gather the few remnants of the tribe into some mission station where the path to final extinction may be made as pleasant as possible".<sup>20</sup> But this does not seem to be the thinking behind the 1913 report. Rather, the report bears the imprint of the ideas of the Aboriginal welfare group from the 1911 AAAS meeting. Throughout his report Spencer referred to the "preservation" of the Aborigines, their "uplifting", and the need to acknowledge the "national responsibility" for their future. Spencer, it seems, shared the mood of restrained optimism.

The upgrading of medical facilities constituted a part of Spencer's scheme for the preservation of a dying race. He reorganised the duties of the two medical officers, Burston and Holmes, in the interests of greater efficiency. He advocated that all government officials and station managers in contact with Aborigines should undergo courses in first-aid and be equipped with medicine chests together with instructions in the use of selected drugs.<sup>21</sup> All future medical appointments to the Northern Territory, he advised, should undergo training at the Australian Institute

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<sup>17</sup> Bates, Lecture 1907, as above.

<sup>18</sup> See D. Bates, *The Passing of the Aborigines* (London: John Murray, 1944).

<sup>19</sup> South Australia. *Legislative Council Select Committee on the Aborigines Bill, 1899: Minutes of Evidence and Appendices* (Adelaide: Government Printer, 1899), 96.

<sup>20</sup> W.B. Spencer and F.J. Gillen, *The Native Tribes of Central Australia* (New York: Dover, 1968; first published London: Macmillan, 1899) 17-18.

<sup>21</sup> Spencer, *op. cit.*, 45.

of Tropical Medicine in Townsville, and it may have been due in part to Spencer's advice that Anton Breinl was sent to the Northern Territory in 1915 to investigate, amongst other things, the diseases prevalent amongst the Aborigines.<sup>22</sup> Spencer believed that hospitals should cater for Aborigines, and although he argued that "in each hospital there should be special provision made for treating aboriginals apart from white patients", this appears to have been motivated by more than mere racial antipathy. He explained that the wards should take "the form of tents or bush shelters", staffed by "half-castes", the "conditions in fact approximating as nearly as possible to their own native camp and open air life only under hygienic conditions".<sup>23</sup> Spencer's concern was at least partly to induce Aborigines to remain in hospitals by making them as familiar and as non-threatening as possible.

On the issue of serious contagious diseases, especially venereal, Spencer was not so considerate of Aboriginal feelings. The prevalence of venereal diseases in Aboriginal communities had long been associated with the idea of the "doomed race"; for venereal diseases were both fatal and a cause of sterility.<sup>24</sup> Venereal diseases, being linked to "sexual immorality" and "promiscuity", also stamped its sufferers with the stigmata of degeneracy. For the control of venereal diseases, Spencer claimed that:

there will be no other course open but to follow the example of Western Australia and establish lock-hospitals for men and women to which, if necessary, they can be forcibly removed and where they can be detained until cured.<sup>25</sup>

In Western Australia, lock-hospitals operated more to prevent white men from coming into contact with the contagion than to cure Aborigines.<sup>26</sup> No doubt the protection of the health of the white community of the Territory loomed large in Spencer's thinking too. It is notable also that he made no suggestion that venereally diseased whites should be sent to lock-hospitals, an omission probably deriving partly from his racial assumptions, partly from administrative practicalities. Aboriginal civil rights could be denied with impunity; they had never, in any case, been acknowledged. The rigid racial and class stratification of Territory society was accepted as given throughout Spencer's report.

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<sup>22</sup> Mulvaney and Calaby, *op. cit.*, 288.

<sup>23</sup> Spencer, *op. cit.*, 45.

<sup>24</sup> See, for example: E.M. Curr, *The Australian Race* (Melbourne: Government Printer, 1886), Vol. 1, 209; W.R. Smith, *Report on Hygiene in the Northern Territory of South Australia* (Adelaide: Government Printer, 1906), 5-8.

<sup>25</sup> Spencer, *op. cit.*, 45.

<sup>26</sup> See M.A. Jebb, "The Lock Hospitals Experiment: Europeans, Aborigines and Venereal Disease", *Studies in Western Australian History*, 7 (1984), 68-87.

Preservation of a dying race involved more than attention merely to medical matters. One of the most pervasive motifs of the "doomed race" theory was the Aborigines' "fatal attraction" to introduced "vices". A.W. Howitt asserted that:

in all parts of Australia the native race is doomed to extinction sooner or later; contact with the white race is fatal; the aborigines lose the original savage virtue and acquire instead our vices which destroy them.<sup>27</sup>

In northern Australia the "vices" given greatest prominence as causes of the Aboriginal decline were not those of the white race but of the Asian; in particular, the use of opium. Howitt himself stated that the "rapid extinction" of the blacks in Queensland was due in large measure to opium abuse.<sup>28</sup> A visiting German anthropologist, Hermann Klaatsch, remarked on the "state of decay" of the Aborigines of North Queensland "owing to the introduction of opium by the Chinese".<sup>29</sup> Carl Lumholtz illustrated his remark about the "degeneration and demoralisation of the natives," with a vivid description of Aboriginal opium addicts from the Rockhampton district.<sup>30</sup> Even where the vice was not opium, an "Asiatic" source was often attributed. Walter Roth, conducting investigations in the north-west on behalf of the Western Australian government in 1904 found that:

Along the whole coastline...drunkenness and prostitution, the former being a prelude to the latter, with consequent loathsome disease, is rife amongst the aborigines. This conditions of affairs is mainly due to Asiatic aliens.<sup>31</sup>

Frank Gillen in 1899 made the remarkable statement that "syphilis alone is responsible for the decay of the Australian aborigines"; he added that syphilis had been introduced into northern Australia by "Malay traders".<sup>32</sup>

Spencer's assessments of Asians and "Asiatic vices" were fully in accord with those of other anthropologists. Shortly after arriving in Darwin he wrote that: "The Chinese are a great curse here. They get hold of the natives and give them opium

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<sup>27</sup> A.W. Howitt, "Anthropology in Australia", *Proceedings of the Royal Society of Victoria*, 3 (1891), 22.

<sup>28</sup> A.W. Howitt, *The Native Tribes of South East Australia* (London: Macmillan, 1904), xiii.

<sup>29</sup> H. Klaatsch, "Some Notes on Scientific Travel amongst the Black Population of Tropical Australia in 1904, 1905, 1906", *AAAS*, 11 (1907), 578; see also H. Klaatsch, "Australian Aborigines", *Proceedings of the Royal Society of Tasmania* (1906-1907), xxvi.

<sup>30</sup> Lumholtz, *op. cit.*, 363-364.

<sup>31</sup> Western Australia, *Report of the Royal Commission on the Condition of the Natives* (Perth: Government Printer, 1905), 11.

<sup>32</sup> South Australia, *Legislative Council Select Committee on the Aborigines Bill, 1899: Minutes of Evidence and Appendices* (Adelaide: Government Printer, 1899), 99.

and sundry vile concoctions that they call whiskey".<sup>33</sup> These vices, he claimed, led to the "wholesale prostitution of native women" and were "common and constant practices amongst the great body of Asiatics".<sup>34</sup> Spencer's assessment was summed up in his statement that: "Nothing is more patent than the rapid degeneration of the native in contact with Chinese".<sup>35</sup> No doubt Asians did bear responsibility for some of the social and health problems of the Aborigines in the Northern Territory. Equally, there is no doubt that Spencer's remarks were partly inspired by the anti-Chinese feeling prevalent in early 20th century Australia. His almost obsessive focus on the "wholly evil" influence of the Chinese contrasts with his far more restrained accounts of white misdeeds. Nowhere is the depth of his prejudice better illustrated than in the contradictory remark he made after witnessing the Chinese New Year celebrations at Pine Creek:

Picturesque as they look I would like to deport the whole lot of them because with their opium and spirits they ruin the blacks and are doing no good to the country. If only the white men here were half as industrious as the Chinese this would be a great country.<sup>36</sup>

Yet it was more than prejudice. Spencer's firm conviction, supported by other anthropological opinion, that "Asiatic vices" were the most potent degenerative influence on the northern Aborigines allowed him, to some extent, to skirt around the "doomed race" idea. If Asians were responsible for so much of the Aboriginal decline, then prohibiting contact between the two races could only help to preserve the latter. Such a prohibition was exactly what Spencer intended. On February 9th 1912 he proclaimed Darwin's Chinatown a "prohibited area" for Aborigines. Despite a deputation from the "better class" of Chinese merchants, Spencer refused to relax his ban.<sup>37</sup> Complaints came later from the upper strata of Darwin's white society, for the Chinese merchants were economically vital to the town and the leading European citizens all had Aboriginal servants to run errands to Chinatown. Under this pressure, Spencer retreated slightly, instituting a system whereby designated Aboriginal servants, wearing numbered brass identity discs, were permitted access to Chinatown on their employers' business.<sup>38</sup> In all other circumstances, Aborigines were totally prohibited from the Chinese district: "The

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<sup>33</sup> Journal, 30 January 1912, W.B. Spencer Papers, MS71, Box 1, item 5 (photocopy of original in Pitt-Rivers Museum, Oxford): Australian Institute of Aboriginal Studies (AIAS).

<sup>34</sup> Spencer, *op. cit.*, 42.

<sup>35</sup> *Ibid.*, 43.

<sup>36</sup> Spencer, Journal, 18 February 1912.

<sup>37</sup> *Ibid.*, 9 February 1912.

<sup>38</sup> *Ibid.*, 15 February 1912.

general policy in regard to Asiatics is, and always must be, that of preventing them, as far as possible, from coming into contact with the aboriginals".<sup>39</sup>

With the European community of the Northern Territory - the other major source of degenerative influences on the Aborigines - Spencer suggested no such ambitious scheme. Severe curtailment of European rights would have been totally unacceptable. Besides, the Commonwealth's administration of the Northern Territory, and Spencer's role in it, were premised on the idea of developing the north for the white man; and Spencer acknowledged that in this process Aborigines had a vital role to fulfil as a labour force.<sup>40</sup> He did, however, insist on a much closer regulation of relations between Aborigines and Europeans than that to which Territorians had been accustomed. The number of Official Protectors should be increased, and the powers of *ex officio* police protectors reduced; according to Spencer's plan, all government officials working with Aborigines should have their powers and responsibilities clearly defined.<sup>41</sup> Employment of Aborigines by Europeans was to be controlled by a regularly and strictly policed permit system.<sup>42</sup> (Employment by Asians was prohibited.) Spencer was determined to put an end to laissez-faire attitudes.

For those Aborigines "living more or less in their wild state" Spencer declared that:

in view of the settlement of the country for which provision is now being made, there is no other practicable policy but that of the establishment of large reserves, if the aboriginals are to be preserved, and if any serious effort is to be made for their betterment.<sup>43</sup>

Despite his commitment to the development of the north by white agriculturalists and pastoralists, he argued for a minimum reserved area of 7,000 square miles, comprising seven reserves, each of which "must be of such a nature as to provide sufficient water and abundant native food supplies and be suitable for agricultural or pastoral work".<sup>44</sup> On these reserves Spencer envisaged Aborigines being trained in agricultural or pastoral pursuits under the paternal guidance of white superintendents, although it appears that he also expected at least a partial and temporary continuation of the traditional economy. He evidently intended reserves to act as a buffer-zone, in which Aborigines could be assisted toward the "high

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<sup>39</sup> Spencer, Preliminary Report, 42.

<sup>40</sup> *Ibid.*, 40-41.

<sup>41</sup> *Ibid.*, 43-44.

<sup>42</sup> *Ibid.*, 44.

<sup>43</sup> *Ibid.*, 48-49.

<sup>44</sup> *Ibid.*, 49.

evolutionary stage" of land-cultivation and animal-husbandry; they were not to be simply labour pools for adjacent settlers. The white superintendents were to be granted enormous powers over Aboriginal reserve dwellers; entry and egress were to be strictly controlled; but it was only, Spencer believed, through such control over inter-racial contact that its fatal effects could be mitigated.

While Spencer's proposals imposed some restraints on the white community, and more severe restrictions on the Asian, it was on the Aborigines themselves that the hand of authority fell heaviest. Spencer's authoritarian paternalism followed logically from his assessment of Aboriginal character:

The aboriginal is, indeed, a very curious mixture; mentally, about the level of a child who has little control over his feelings...He has no sense of responsibility and, except in rare cases, no initiative.<sup>45</sup>

In addition, he noted that Aborigines possessed a "wonderful" memory and an extraordinary "fondness for fun" and "sense of humour".<sup>46</sup> Patronising though it may have been, such an assessment was in complete accord with contemporary scientific opinion, and a good deal less vindictive than the majority of popular opinion. Like his anthropological colleagues, Spencer was convinced that Aborigines were incapable of making an autonomous adjustment to changing circumstances; instead, they had been "degraded by contact with a civilisation that they do not understand and from which they need protection."<sup>47</sup> "Protection", for Spencer, included stringent control over Aboriginal marriages (and sexual activities), separation of children from their parents, compulsory education and training for "civilisation". But the authoritarian severity of his proposals must be viewed against the background, not merely of contemporary racial stereotypes, but also of past experience, in which laissez-faire seemed to lead only toward Aboriginal extinction.

Baldwin Spencer was Special Commissioner and Chief Protector of Aborigines for only one year, 1912, not nearly long enough to implement his ambitious proposals. Apart from a few specific items, his recommendations were never acted upon, not because they were adjudged illiberal or authoritarian, but because they were considered too idealistic; besides, governments regarded Aboriginal welfare as not worth the expense.<sup>48</sup> Spencer's priorities lay with saving Aborigines from drink and drugs, disease and dissolution which were believed to spell the doom of the entire race. His proposals were essentially straight-forward: racial degeneration

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<sup>45</sup> *Ibid.*, 41.

<sup>46</sup> *Ibid.*

<sup>47</sup> *Ibid.*, 39.

<sup>48</sup> See Mulvaney and Calaby, *op. cit.*, 306-309.

leading to ultimate extinction was seen to result from the contact of Aborigines with other races; the solution, then, was to prohibit racial contact or, where prohibition was impractical, to regulate and delimit racial contacts. The authoritarian paternalism of his recommendations derived from contemporary racial assumptions; the severity of his authoritarianism is indicative of the perceived magnitude of the problem. For Spencer was attempting to arrest a decline in the physical and mental health of the Aboriginal population which he thought would probably - or even inevitably - end with the death of the entire indigenous population.

## ANTON BREINL AND THE AUSTRALIAN INSTITUTE OF TROPICAL MEDICINE

Lorraine Harloe

Between 1890 and 1914, Australia witnessed a period of nationalistic fervour in which the aspirations of the new nation became inextricably linked with policies that bred racism and discrimination. Nowhere is this more clearly seen than in the history of tropical medicine and public health.

In 1910, nine years after Federation, the Commonwealth government established the Australian Institute of Tropical Medicine. Sited at Townsville, its formal function was to gain knowledge of diseases "peculiar to the Australian tropics" and, at the same time, grant the antipodean medical profession an opportunity to redress deficiencies in research and teaching. However, the Institute was established not only for humanitarian and medical reasons. On the contrary, its purposes were construed as a consequence of, and a vehicle for, the extension of European culture into the tropical north.<sup>1</sup>

### "The Unhealthy Tropics"

When the Barton government passed the Immigration Restriction Act (No. 17, 1901) an absurd situation arose. The legislation forbade entry of non-European immigrants and provided for the expulsion of those already in the country; by 1906 all Pacific indentured labourers were to be expelled. Because the indigenous people were confidently expected to "die out" the land would free for "white civilization". The only drawback was the belief commonly held that a "working white race" could not successfully colonize tropical regions. For this reason the idea of an Institute became an issue of political importance.<sup>2</sup> Thus, its foundation "at the psychological moment" to "keep Australia white" determined much of its character as well as its political and scientific justification.<sup>3</sup> Apart from some studies in the Philippines (which were later discredited), no definitive scientific investigations had been

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<sup>1</sup> M. Roe, *Nine Australian Progressives: Vitalism in Bourgeois Thought 1890-1960*, (Brisbane: University of Queensland Press, 1983), 1-21.

<sup>2</sup> "The Australian Institute of Tropical Medicine", *Australasian Medical Gazette* 34 (1) (5 July 1913), 16.

<sup>3</sup> "Proceedings of the British Medical Association, Queensland Branch", *Ibid.*, 30 (2) (20 February 1911), 87-89.

carried out into European labourers residing permanently in the tropics as a "working white race". For north Australia and its inhabitants the Institute's work was significant in dispelling misconceptions about white people in the tropics; but there was a cost to the Institute and its Director, Anton Breinl. His career was sequestered from the mainstream of medical research in which it had begun with great promise. The Institute was barred from extending its activities from north Australia, which was largely free from tropical health problems, to Papua where they were very serious.

At the time of North Queensland's great pastoral rush in the early 1860s and 1870s health was regarded as an issue of small consequence. As a nineteenth century traveller commented: "no great value is set upon human life in the new colony. Every man is supposed to take care of himself and the weakest go to the wall".<sup>4</sup> This indifference became more pronounced once gold was discovered. During a particularly unhealthy wet season, Biddulph Henning, a central Queensland grazier, considered building a hospital for "sick travellers" on their way to the gold-fields,<sup>5</sup> but nothing came of it, probably because Henning, like Alex Rattray who wrote about Somerset at the tip of Cape York Peninsula, accepted that disease was invariably associated with climate and that the tropics were unhealthy.<sup>6</sup>

The stigmatization of the tropics was due to a combination of confused notions about race, place, and the causes of disease. The "geography of disease" was advanced to explain the prevalence and intensity of diseases which conformed to a spatial and a seasonal pattern. It had been traditional practice for Europeans residing in India, Java, the African West Coast and the Philippines to return to temperate climates to recover from the enervating effects of the tropics.<sup>7</sup> In humid regions the list of diseases was always longer than elsewhere.<sup>8</sup> Certain diseases were as much part of the economic and social environment as they were of the locality.

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<sup>4</sup> [G. Carrington,] *Colonial Adventures and Experiences by a University Man* (London: published by the author, 1871), cited in A. Allingham, "Pioneer Squatting in the Kennedy District", *Lectures on North Queensland History*, Second Series (Townsville: James Cook University, 1975), 87.

<sup>5</sup> D. Adams (ed.), *The Letters of Rachael Henning* (Ringwood: Penguin Books, 1979), 162.

<sup>6</sup> A. Rattray, "Notes on the Physical Geography, Climate and Capabilities of Somerset and the Cape York Peninsula, Australia", *Journal of the Royal Historical Society*, 38 (XIII) (22 June 1868), 370-411.

<sup>7</sup> J. Bondwick, *Climate and Health in Australasia* (London: Street & Co., 1886), 37-38. See also P. Courtenay, "The White Man and the Australian Tropics - A Review of Some Opinions and Prejudices of the Pre-War Years", *Lectures on North Queensland History*, Second Series, 57-65.

<sup>8</sup> A. Grenfell Price, *White Settlers in the Tropics* (New York: American Geographical Society, 1939), 34 & 37.

European experience in other tropical areas contributed to the idea that northern Australia was unhealthy. Those who had unhappy experiences due to ill health or an inability to adapt as expatriates returned to temperate regions believing that the climate was to blame. As this group propagated their discontent popular misconceptions flourished. One writer to the *Melbourne Argus* claimed after forty years residence in the tropics that white men could not "personally work the land".<sup>9</sup> Representative of those who believed climate made little difference were gold miners. In the tradition of the impoverished in search of riches, they disregarded even the most basic health requirements to engage in their hazardous occupation wherever a gold strike was announced. Robert Gray, an early western Queensland cattleman, typifies the prosperous settler: he coped by taking regular leaves in cooler climates.<sup>10</sup>

Belief in the "unhealthiness" of northern Australia was fairly common among the medical profession. Tom Nisbet, who had practised medicine in Townsville since the late 1880s, said to colleagues that permanent white settlement in northern Australia was impossible because "our race...[will dwindle] away to a few highly neurotic, anaemic people, incapable of reproducing their species, unless fed with a constant stream of European immigration."<sup>11</sup> However, by the turn of the century, momentous advances in tropical medicine had been recorded overseas and a simple geographic explanation for the occurrence of disease was modified by the response of scientific medicine and sanitation to tropical problems.

Motivated by commercial advantage as much as by the desire for consolidation of its imperial authority, the British government initiated investigations into the causation and treatment of tropical diseases. In 1899, two schools were opened in Britain. Patrick Manson, medical advisor to the Colonial Office, was the driving force behind the London School. Ronald Ross, consultant to various commercial interests and local colonial governors, was responsible for the Liverpool School. However as Michael Worboys has written:

The different approaches and priorities of Manson and Ross had direct effect on policy...Both accepted the "theory of science for development" which postulated that disease was the main factor holding back tropical development. The difference came over whether it was to be "scientific research" for development, or "public health" for development.<sup>12</sup>

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<sup>9</sup> Courtenay, *op. cit.*, 60.

<sup>10</sup> R. Gray, *Reminiscences of India and North Queensland* (London: Constable & Co., 1913).

<sup>11</sup> *Transactions of the Australasian Medical Congress* 9th Session Sydney 1911 (Melbourne: Government Printer, 1912), 1, 533.

<sup>12</sup> M. Worboys, "The Emergence of Tropical Medicine: a Study in the Establishment of a Scientific Speciality", in G. Lemaire, R. MacLeod et al. (eds.) *Perspectives on the Emergence of Scientific Disciplines* (The Hague: Mouton, 1976), 90.

As it eventuated the British authorities tended to adopt Manson's method and tropical medicine developed less effectively than it could have done under Ross's practical and preventative approach.<sup>13</sup> Following the British lead, all the European colonial powers established similar Institutes. All sponsored research parties to survey and discover cures for "new" diseases. Just as British capitalists who controlled most Amazon rubber plantations were concerned about the high death rate from yellow fever among their indentured Spanish and Portuguese labourers, the German planters in New Guinea faced a threat of loss of indentured labour due to malaria, dysentery, and other medical problems.<sup>14</sup> Aware that depopulation was imminent, Governor Hahl repeatedly requested financial and medical aid but was obstructed by settlers and plantation companies, while the German government preferred to direct money from New Guinea to the Army.<sup>15</sup> The final analysis reveals that rarely did indigenous people benefit from western advances in tropical medicine: the European schools served to advance imperial control of their colonies.

### **Australian Debate Regarding a Tropical Diseases Institute**

The medical profession in Australia soon followed suit. At the Hobart Intercolonial Medical Congress of Australia in 1902, John Goldsmith, a medical practitioner, proposed that a Tropical Board or School of Tropical Medicine be established by the Commonwealth Government to educate the Australian medical profession and to conduct research into diseases peculiar to Australia's north. So little was known about tropical diseases that Australian authorities sought advice from Asia regarding causation, prevention and treatment.<sup>16</sup> Daily shipping communication with India, China, and the Pacific Islands represented a threat to Australia, and gave rise to fears that the continent was vulnerable to exotic diseases. The medical profession experienced a new primacy. Practitioners were asked to monitor not only quarantine matters but also the settlement of northern Australia. Their role addressed, in particular, the popular prejudice that the tropical climate was hazardous for Europeans. Many believed the main reason for a research facility

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<sup>13</sup> *Ibid.*

<sup>14</sup> It is outside the scope of this paper to provide international comparisons: Worboys says "the emergence of tropical medicine in Britain was foremost and typical." German scientific involvement in New Guinea had the benefit of Robert Koch who prescribed quinine to malaria patients.

<sup>15</sup> Griffin, Nelson & Firth, *Papua New Guinea*, 41; See also S. Firth, *New Guinea Under the Germans* (Melbourne: University Press, 1982).

<sup>16</sup> J. Goldsmith, "The Necessity for the Study of Tropical Medicine in Australia", *Transactions of the 6th Intercolonial Medical Congress of Australia Hobart 1902*, (Melbourne: Government Printer, 1903), 178-179.

was to demonstrate those factors involved in the survival of a "working white race" in tropical Australia.<sup>17</sup>

Not all medical men concurred. When the Royal Society of Tasmania met on 21 November 1905, John S.C. Elkington, Tasmanian Medical Officer, delivered a paper entitled "Tropical Australia: Is It Suitable For A Working White Race?". He argued that the area was by "no means an earthly paradise" but neither was it "a fever smitten jungle" as many believed.<sup>18</sup> Others argued that whilst the investigation of tropical diseases was urgently needed, a separate institute in Australia was not warranted when the British schools were so active. Acting on the resolutions, the Commonwealth government allocated an annual grant of £200 for a period of five years to the Imperial authorities in Britain.<sup>19</sup>

The matter did not rest there, however. Dr George Frodsham, Anglican Bishop of North Queensland, well acquainted with the effects of disease in his diocese, publicly protested and advocated the establishment of a local institute to study Australian tropical diseases in Australia.<sup>20</sup> A meeting in Cairns with Richard O'Brien, one of the first in North Queensland to substantiate reports on malaria with microscopic evidence of parasites in blood films, had convinced the Bishop of the urgent need for research and treatment.<sup>21</sup> Frodsham gained local support, and in January 1907 Gordon Ross, Medical Superintendent of the Townsville Hospital, recommended that an expert pathologist be employed in the north to research and treat a number of diseases which could be best studied in "their localities, for, in these places only can the exact causation be arrived at and the best methods of dealing with outbreaks be discovered."<sup>22</sup> Further support was

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<sup>17</sup> "Tropical Disease Institute Townsville, 1909-1911." Governor General's office, CP78/5 item 2: AA (Canberra).

<sup>18</sup> J.S.C. Elkington, *Tropical Australia: Is It Suitable for a Working White Race?* (Melbourne: Government Printer, 1905), 1-8; M. Roe, *op. cit.*, 90-117; R. Cilento, "The Versatility of the Medical Pioneer", The Elkington Oration 12 August 1959. Elkington, the architect of the Australian Quarantine system, was a medical progressive who planned that the Australian Institute of Tropical Medicine would develop an Australian consciousness of the tropics. Like Elkington, Richard Arthur, physician philanthropist and parliamentarian believed in the primacy of Anglo-Saxondom. However, from 1901, Arthur made repeated calls for population of northern Australia to be increased. He suggested that regular immigration from cold countries was the solution.

<sup>19</sup> CP78/5 item 2: AA; T.B. Millar, *Australia in Peace and War*, (Canberra: Australian National University, 1978) argues that Australia, until 1941, identified almost totally with Britain.

<sup>20</sup> *Ibid.*; E.C. Rowland, *The Tropics for Christ* (Sydney: Halstead Press, 1960), 141.

<sup>21</sup> R.A. Douglas, "Dr Anton Breinl and the Australian Institute of Tropical Medicine", *Medical Journal of Australia*, 1 (19) (7 May 1977), 714.

<sup>22</sup> "Submission to Governor-General by T.G. Ross, January 1907", CP78/5 item 2:AA (Canberra).

forthcoming in March 1907. Ramsay Smith, chairman of the Central Board of Health of Adelaide, confirmed that "Frodsham's Scheme" was sound because it was "free from any suspicion of place seeking".<sup>23</sup>

Although a similar scheme for the establishment of an institute of tropical medicine was promoted by the southern universities, the Deans of Medicine of the universities in Melbourne, Sydney and Adelaide acknowledged that the north Queensland plan was well advanced and had the backing of many influential individuals.<sup>24</sup> The Bishop's proposal was adopted in 1908, with the approval of the universities, although doubts about having educational facilities sited so far away from the southern centres of learning were later to surface.<sup>25</sup> In the meantime, the Deans nurtured the hope that an Australian-qualified superintendent would be appointed. But the selection committee chose as the inaugural director the Austrian Dr Anton Breinl, one of the most promising tropical medical scientists then working in Britain.<sup>26</sup>

### Anton Breinl

Anton Breinl's arrival in Townsville, on 1 January 1910, was a significant step in dispelling popular misconceptions about the Australian tropics and its diseases. The same year Breinl was awarded the Mary Kingsley Medal for distinguished contributions in the field of tropical medicine and kindred subjects.<sup>27</sup> This honour had been previously bestowed upon Patrick Manson, David Bruce, Alphonse Laveran and Robert Koch. Breinl was at the apogee of his career. In 1904 he was working in the Liverpool School of Tropical Medicine as the John Garrett Fellow in Bacteriology. His main contribution to science was the discovery, in collaboration with H. Wolferstan Thomas, of a cure for sleeping sickness,<sup>28</sup> using an organic arsenical, "atoxyl". This was to become a corner-stone of the incipient discipline of chemotherapy.<sup>29</sup> Paul Ehrlich, a pioneer in merging descriptive cellular pathology into experimental intercellular chemistry, quickly realised its

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<sup>23</sup> *Townsville Daily Bulletin*, 6 March 1907.

<sup>24</sup> S.J. Way to G. Frodsham, 10 May 1907, CP78/5 item 2: AA (Canberra).

<sup>25</sup> Madsen to Frodsham, 23 May 1907, *Ibid.*

<sup>26</sup> Charles J. Martin to Anton Breinl, 6 August 1909, Breinl Papers.

<sup>27</sup> R.A. Douglas, *op. cit.*, 749.

<sup>28</sup> See H. Wolferstan Thomas & A. Breinl, "Trypanosomes, trypanosomiasis and Sleeping Sickness", *Liverpool School of Tropical Medicine Memoir XVI* (1905).

<sup>29</sup> H.H. Scott, *A History of Tropical Medicine* (London: Edward Arnold, 1939), 525; H.H. Dale, "Advances in Medicinal Therapeutics", *British Medical Journal* 1 4644 (7 January 1950), 1-7; "Atoxyl", a by-product of the German dye industry, had been available since 1900, and had been prescribed with minimal success in the treatment of some skin diseases and anaemia.

importance. Meeting Breinl in 1905, Ehrlich returned to Berlin and discovered that in protozoan diseases, which could not be treated with antitoxins, the patient's blood could be sterilized of parasites without injuring the body tissue. The result of the work by Ehrlich and his Japanese assistant, Hata, was the production of salvarsan or "606" - the first cure for syphilis.<sup>30</sup>

On leaving England, Breinl left the comfortable surroundings of Crofton Lodge, the Liverpool School's Research Laboratory at Runcom, where he had been Director since 1907. He also left the security of European intellectual stimulation, to determine physiological changes in white workers in isolated northern Australia. As a protozoologist Breinl was excited by the prospect of surveying this tropical region for new protozoan diseases and searching for new cures. With the Commonwealth's assumption of control of Papua in 1906 and the Northern Territory in 1911, public and commercial interest in tropical lands and the associated problems acquired a new intensity. All aspects of health and disease of the white population and the indigenous people were to be examined. Breinl who had studied under and worked with Ross in Liverpool shared his holistic, practical and preventative approach to tropical medicine. However, Breinl too was to be thwarted by the authorities. His early enthusiasm was soon to be subjugated by the Institute's main brief to investigate the effects of climate on "a working white race".<sup>31</sup>

### The Australian Institute of Tropical Medicine - Townsville

Until 1912, Breinl and Fielding, his laboratory assistant, were the only members of the scientific unit, housed in a three-roomed building which had been wardsmen's quarters in the grounds of the Townsville Hospital.<sup>32</sup> Arrangements were made for the construction of a galvanised-iron animal house at the rear. Each week-end, Breinl and Fielding took to the bush on horseback in search of native animals, birds and insects which they later examined in the laboratory. They also gathered data from medical practitioners, examined patients with tropical fevers, and collected blood and tissue samples.<sup>33</sup> When the Committee of Management met

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<sup>30</sup> F.H. Garrison, *An Introduction to the History of Medicine* (Philadelphia: W.B. Saunders & Co., 1919), 709-710.

<sup>31</sup> "Institute of Tropical Medicine, Story of its Establishment 1932- 1934", Department of Health: Correspondence Files, Multiple Number System (first series), CRS A1928, item 575/28;AA; Breinl, "The Object and Scope of Tropical Medicine in Australia" in *Transactions of the Australasian Medical Congress 9th Session*, 1; 1911, 524-535.

<sup>32</sup> J. Fielding, *A History of the Australian Institute of Tropical Medicine: 1909-1954*, unpublished manuscript, 6-7: Breinl Papers.

<sup>33</sup> A. Breinl, 'The Australian Institute of Tropical Medicine, Townsville', Half Yearly Report from 1 July 1915 to 31 December 1915, *CPP* 1916, 1108-1109.

in Sydney in 1911, they gauged the Institute's work justified more staff. A Commonwealth subsidy was forthcoming, a new building was constructed, and during 1912 the staff was increased to six. John Nicol, Henry Priestley, William Young and Frank Taylor were engaged as parasitologist, bacteriologist, biochemist and entomologist, respectively.<sup>34</sup> With these material changes came more responsibility to comply with the philosophy of the "White Australia" policy.

On survey trips throughout northern Australia and Papua, Breinl recorded benign and malignant forms of malaria, dengue fever, filariasis, typhoid, hookworm, many fevers of unknown aetiology, amoebic dysentery, tropical sprue, leprosy, yaws and gangosa. Perhaps the most threatening was the protozoal infection, amoebic dysentery. This had been common in Japan, the Philippines and Indonesia, and by the turn of the century had produced high mortality figures in New Guinea.<sup>35</sup> Breinl recommended that a branch laboratory of the Australian Institute of Tropical Medicine be established in Papua to study the pathology of "the greatest scourge of the country".<sup>36</sup> However, his proposal failed, partly because of insufficient finance but also because of the rationale for the Institute's establishment in Townsville: to investigate the problems of white settlement of northern Australia.

The outbreak of the First World War seriously affected the work of the Institute. Breinl was recalled from Port Douglas where he had been investigating Mossman Fever.<sup>37</sup> Immediately he volunteered for military service, but was refused because his skills were needed at the Institute and at the Townsville Hospital, where he assumed the duties of Medical Superintendent. Month after month Breinl worked at his dual tasks, until early January 1916, when he became embroiled in bitter personal controversy. Although he had been treating Australian soldiers suffering from malaria, and was performing investigations in the national interest, a campaign was instigated against him. His Sudeten ancestry was reason enough for union officials and a few local doctors, under the guise of patriotism, to harass the Director in the local and southern newspapers.<sup>38</sup> The attacks began with the issue of quarantine. Tom Nisbet, the Townsville-based Quarantine Officer since 1909,

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<sup>34</sup> J. Fielding, *op. cit.*, 15-16. When appointed Nicol, Priestley and Young had been engaged in research at the Lester Institute of Preventative Medicine in London.

<sup>35</sup> *Proceedings of the Queensland Legislative Assembly*, 1501.

<sup>36</sup> A. Breinl to Attlee Hunt, 6 October 1912: Breinl Papers.

<sup>37</sup> Fielding, *op. cit.*, 29; Breinl, *op. cit.*

<sup>38</sup> Studies of North Queensland history have demonstrated that prejudice against "the foreigner" was widespread. See M. Douman, Townsville 1914 to 1919, Unpublished B.A. Hons. thesis, 1969; E.M. Holt, A Study of the Reactions of Rockhampton's Newspapers to Questions Relating to the War 1914- 1915, Unpublished B.A. Hons. thesis, 1984; R. Rexa, Reactions to Germans in Northern and Central Queensland, Unpublished B.A. Hons. thesis, 1984, all James Cook University.

resigned because he had been compelled during urgent absence to transfer duties to Breinl.<sup>39</sup> Daily, for at least a month, letters were published in the press. Calls were made "for the blood of Breinl";<sup>40</sup> it was argued that his presence was "detrimental to recruiting";<sup>41</sup> that he was "searching for the microbe of Kultur which may be located in North Queensland";<sup>42</sup> Ahearne wrote:

The Hun Breinl has been working with a microscope only, for years, but when he was placed in this position of Surgeon to the Hospital could have no practical knowledge of work to fill that place, more than a Clerk from a Merchant's office.<sup>43</sup>

Breinl's "disportation behind barbed wire" appealed to some correspondents to the *Townsville Daily Bulletin*.<sup>44</sup> Threats of "trouble" from the unionists and the resignation of Nisbet culminated in the cancellation of Breinl's appointment as Quarantine Officer in Townsville on 26 January 1916.<sup>45</sup> Breinl was not without supporters; prominent defenders included Dr F.S. Thomas of Ayr and Mervyn Holmes, the chief Health Officer of the Northern Territory.<sup>46</sup> Moreover, Breinl had always been popular with his patients, and they too supported him against the malicious newspaper campaign.<sup>47</sup> To settle the question and vindicate its position, the Hospital Committee held a referendum among the patients and staff. The result was unanimous support for Breinl. Nevertheless he remained deeply wounded by the attacks on his integrity.<sup>48</sup> His scientific work also suffered. Plans for discussion

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<sup>39</sup> T. Nisbet to T. Ryan, 19 January 1916; 5070/1919-1923 No. 17/10189:QSA. Resentment that an Australian had not been appointed manifested itself throughout Breinl's career with the Australian Institute of Tropical Medicine. From the start Bishop Frodsham recommended "co-operation" be the Institute's motto. However, once World War I broke out hostility to Breinl was legitimized because of his origins. The Australian medical profession wanted an Australian Institute not a "inere branch of any British school".

<sup>40</sup> "Paying the Foreigner for his 'Investigations' ", *The Bulletin* (Sydney), 27 January 1916, 7.

<sup>41</sup> A. Ogden to Editor, *Townsville Daily Bulletin*, 16 February 1916.

<sup>42</sup> W. Chapman to Editor, *Ibid.*, 15 February 1916.

<sup>43</sup> J. Ahearne to Home Secretary, 11 June 1916, 5070 (1919-1923) No. 17/10189: QSA.

<sup>44</sup> "Australian" to Editor, *Townsville Daily Bulletin*, 17 February 1916.

<sup>45</sup> T. Nisbet to T. Ryan 19 January 1916; J. Christie to T. Ryan 17 January 1916; T. Ryan to G.F. Pearce 2 February 1916, 5070 (1919-1923) No. 17/10189: QSA.

<sup>46</sup> Holmes to External Affairs Department, 29 February 1916, *Ibid.*; F.S. Thomas to Editor, *Townsville Daily Bulletin*, 17 February 1916.

<sup>47</sup> A Unionist to Editor, *Townsville Daily Bulletin*, 16 February 1916. Ogden was advised "to keep away from the Hospital, as the patients are looking out for him".

<sup>48</sup> CRS A2 item 1919/590:AA. For comparison see J.H. Voigt, "A Man of Two Nations: Dr Eugen Herschfeld (1966-1946)", in J.H. Voigt (ed.), *New Beginnings: The Germans in New South Wales and Queensland*, Studies in International Cultural Relations, Institute of Foreign Cultural Relations (Stuttgart Germany: 1983), 130-138.

of the "Tropical Question", to be held at the Medical Congress of 1914 in Brisbane, were postponed until 1920 when Breinl presented the Institute's three major findings: first, the tropical region of Australia differed little from other zones in its suitability for a "working white race"; second, there were specific medical conditions such as leptospirosis, and many unidentified fevers, which required investigation; third, staff shortages, the lack of experimental animals, insufficient coal gas for laboratory procedures and inadequate equipment had curtailed some programmes and forced modifications on others.<sup>49</sup> What the report failed to mention was that the Institute had become the birthplace of biochemistry in Australia. Through its work, both William Young, biochemist, and Henry Priestley, bacteriologist, were introduced to distinguished careers as professors of biochemistry at the universities of Melbourne and Sydney.<sup>50</sup>

At the end of the war, the Institute staff was reduced; by 1920 Anton Breinl was the only medical member. As it was no longer possible to leave the Institute or the tropical wards to follow up medical problems outside Townsville, his research into the aetiology of fevers of unknown origin was severely hampered. The administration of the Institute declined. At first, functioning under a co-operative agreement among the three universities of Melbourne, Sydney and Adelaide, it had been virtually autonomous, determining its own research priorities within very broad guidelines. However, in 1911, with assumption of financial responsibility by the Commonwealth came increasingly tight control from above, culminating in 1921 when the Institute was subsumed into the newly founded Commonwealth Department of Health.<sup>51</sup>

By 1920, Breinl's position had become intolerable. He had no security of tenure; no scientific paper could be published unless approved by the Department; and the Department exercised complete control over all appointments. Possibly Breinl also clashed with the intensely authoritarian Director-General of the new Department, Dr John Cumpston.<sup>52</sup> In October 1921 he resigned.

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<sup>49</sup> W.J. Young, "The Australian Institute of Tropical Medicine", Report of the Biochemical Laboratory for the half year July - December 1917, *Commonwealth Parliamentary Papers* (1917-18), 1220-1223.

<sup>50</sup> V. Trikojus, "Biochemistry comes to Australia", *Trends in Biochemical Sciences* (3 August 1978), 3 (8), 174-178. B.C. Slater, "Townsville - Home of Australian Biochemistry", *Trends in Biochemical Sciences* (February 1979), 4 (2), 30.

<sup>51</sup> Cumpston to Harvey Sutton 18 November 1932, CRSA 1928 item 575/28:AA.

<sup>52</sup> Cumpston was a graduate of the Melbourne University and the London School of Tropical Medicine. At the age of twenty-seven he returned to Australia determined to become involved in public health. This he did for the remainder of his life in the states of Western Australia, Victoria, and Queensland, and finally, as Director of Quarantine and Director-General of Health. Ironically a major impetus to creation of the Commonwealth Health Department had been Breinl's

In the last 20 years of his life, Breinl worked in private practice in Townsville, greatly respected, active - though increasingly frail - until a few months before his death in 1944. But 1921 marked the end of his career as a researcher. After Breinl's resignation, there was a succession of Directors in charge of the Institute until the appointment in 1923 of Raphael Cilento, who remained Director until 1928. In 1930, The Australian Institute of Tropical Medicine was moved to Sydney and incorporated in the School of Public Health at The University of Sydney.

### Conclusion

Tropical medicine in Australia was based squarely on the British model. Since the turn of the century, progress in this medical speciality science had shown the benefits available to its recipients. However, together with the amazing advances, the worst aspects of the discipline - racialism and imperialism - were readily adopted by the Australian authorities. As the dominant political themes of nationalism and racial homogeneity went hand in hand, it is not surprising that tropical medical science was used to strengthen the white man's hold on the northern third of the continent. Although an attempt was made to find any "new" diseases which might harm the infant nation, the main thrust of the research was directed to physiological investigations of white settlers. Tropical medicine had been used in the colonies by the European powers to stabilize their dominion socially, politically and above all economically. Generally benefits flowed on to the indigenous people only if the means of production were endangered, or their diseases were likely to infect the colonizer. In Australia the lack of attention to Aboriginal health reflected this attitude. As a "doomed race" there was little need to expend time or money on their well being. Their numbers did not pose a threat to health of white Australians. In Papua New Guinea introduced diseases and tropical conditions were devastating the indigenous population. Tropical medical science failed to address their suffering. The resentment of the Australian medical fraternity that Breinl, a Sudeten, was appointed rather than an Australian as Director of the Australian Institute of Tropical Medicine effectively quashed any real influence the position of Director may have held regarding the formulation of policy. Breinl was powerless to convince the authorities of the pressing need to extend the Institute to Papua. In this respect it is unfortunate that nationalism and patriotic selfishness tended to blind otherwise rational men to the outstanding perception of Breinl. By taking that course the Australian medical profession was guilty of ignoring the plight of a large number of Papuan New Guineans under Australian rule.

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recommendation that a national hookworm eradication programme be started with funding from the Rockefeller Foundation.

The Institute made a brilliant start, demonstrating that scientific research of international standing could be sustained by a small group isolated in an Australian tropical backwater. It launched on distinguished careers a number of young scientists; by 1920 it had given a clear answer to the first question put to it: a white race could live permanently in the tropics without suffering irreversible degeneration. That answer was to become a new orthodoxy in the course of the next generation. This justified, to the Commonwealth Health Department, the disbanding of the Australian Institute of Tropical Medicine. In 1930, the School of Public Health at The University of Sydney assumed the roles of research and teaching of tropical medicine.

It could be argued that failure to accept Breinl's contributions and proposals deferred recognition of the real problems of tropical medicine on Australia's doorstep. It is, however, some consolation to note that in 1986 a new Centre for Tropical Medicine and Health was established within James Cook University named in honour of Anton Breinl which may well pursue some of the unresolved questions posed by Breinl and his colleagues more than fifty years ago.

## SIR RAPHAEL CILENTO AND THE WHITE MAN IN THE TROPICS

A.T. Yarwood

R. W. Cilento's influential book, *The White Man in the Tropics*, bears the dateline Rabaul, Territory of New Guinea, 1 June 1925. Cilento was then Director of the Australian Institute of Tropical Medicine, although he had recently been seconded to the position of Director of Public Health in the Mandated Territory. The book expressed his belief as an Australian nationalist and public health administrator, that the "white race" had the capacity and indeed the duty to populate and develop the Australian tropics.

This chapter traces Cilento's route to that position, showing the decisive influence of Dr J.S.C. Elkington, the guide and mentor whom he addressed affectionately by the Malay term "tuan", or master. Cilento's concern for the white Australian's tropical role is considered in relation to his broad views about race and politics, to his preoccupations as a medical hygienist, and to his career in the health services of the Commonwealth and the state of Queensland. Born at Jamestown, South Australia, in 1893, he was a fairly typical product of the society into which he was born, notably in his attachment to a "White Australia", which was given legislative expression eight years after his birth by the first two substantive acts of the new Commonwealth parliament. What was unusual in Cilento was the reinforcement of white supremacist assumptions by a powerful elitism that made him hostile to many of the forms and usages of Australian democracy. Although he lived, worked and travelled extensively in New Guinea, Malaya, and the South Pacific, and observed those cultures with something like an anthropologist's eye, he remained profoundly apprehensive of the dangers that their people might bring to an unwary Australia.

Raphael West Cilento was the eldest son of a young station-master whose Neapolitan father arrived in Adelaide in 1855 after involvement in a Garibaldian uprising. Our man had the ability, courage, and tenacity to win a place at the Adelaide Medical School in 1914, and graduated with first class honours and equal first place. As Fedora Fisher argues in her thesis on his career, Cilento gave himself an "inner shield" against the disdain of his fellow-students by constructing an

illustrious ancestry which stemmed from Marcus Cilenius, an ancient Etruscan.<sup>1</sup> Consistent with this view was Cilento's lifelong performance of the *noblesse oblige*, notably in relation to Aborigines and New Guineans. This was very much in the tradition described in Kipling's "The White Man's Burden".

When, in his latter years, Cilento attempted an autobiography, he drew on his diary entry for 17 December 1917, which describes one of the key experiences of his medical training. This shaped decisively his view of the needs and capacities of Aborigines, and of his own duties towards them. The encounter is important to an understanding of the man.

My Aboriginal patient was in a meanly built cottage...As the car drove down it was greeted by scores of mongrel dogs...Their furious barking brought natives old, young and middle-aged, black, yellow and almost white to every door and window...The home of the sick woman was floored with mud and stamped hard with bits of wood and an old door to help flatness. The living room was crowded with waiting gins who, like children, seemed terrified to see a stranger. The bedroom was smaller, dirtier and similarly floored and roofed with bags that bulged with many a hint of vermin and dirt.

The woman was a half-blood, about twenty-five, married to a portly, scowling buck of about sixty and had aborted at about six months from violence. I had been called because the afterbirth would not come away...a dreaded complication among ill-fed and anaemic women...I had little difficulty in removing the afterbirth successfully, watched by half a dozen Aboriginal women who refused to leave but lay or sat on the floor and watched my every movement...A few questions - no answers but a desperate shyness. I left the room, running the gauntlet of staring eyes and so to the car and home.<sup>2</sup>

Recalling the incident fifty years later, Cilento wrote "That one experience set me on the road to a life-long interest in their complex situation in relation to our after-coming race that had dispossessed them." Evident in this passage are many elements of the lives of fringe-dwelling Aborigines that concerned and disgusted the writer. Above all there is awareness of unhealthy living conditions and diet, representing inescapable misery for the Aborigines themselves and a persistent menace to white society. We see, too, compassion and the practical concerns of a white man who accepted part of the collective responsibility for what had happened to the Aborigines. Yet there is more than a hint of revulsion in the image of the "portly, scowling buck". Such images recur throughout Cilento's diary-letters,

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<sup>1</sup> F.G. Fisher, Raphael West Cilento: Medical Administrator, Legislator, and Visionary, 1893-1945, unpublished MA thesis, University of Queensland, 1984, 6.

<sup>2</sup> *Ibid.*, 11.

written to his wife Phyllis in Brisbane from field trips among Aboriginal communities during more than twenty years' service as a health administrator.

In the closing days of the first world war, Cilento volunteered for active service, and was posted to German New Guinea. Commissioned as a captain in the Australian Army Medical Corps, he was sent to Rabaul to join the Occupation Force. His fellow-student and fiancée, Phyllis McGlew, saw him off from Sydney on 18 December 1918, on his first, decisive, encounter with the tropics. From March to October 1919 he was stationed at Kavieng in medical charge of a district extending from New Hanover to the northern Solomon Islands. Keen to explore, he visited outlying villages and island settlements, urged on by a professional need to study the health and living conditions of the indigenes, and by a strong anthropological impulse which took him into areas where head-hunting and cannibalism had been practiced until recent times.

This experience convinced him that diet and nutrition were the keys to effective health policies in the tropics. At Namatanai he had been impressed by the initiative shown by the medical assistant, who used convalescent labourers to grow profuse crops of fruit, vegetables and nuts to supplement the inadequate diet of polished rice and tinned meat or fish that was provided by the government. Returning to Kavieng, he tried to emulate the Namatanai experiment, cultivating similar crops for hospital inmates, but was dismayed when the produce was commandeered by the district officer on the grounds that it was grown on government land by native labour. When he returned to New Guinea in 1925 as Director of Health he introduced what he later described as "one of the first dietaries for native labourers in the world." At much the same time, Dr Boyd-Orr reached similar conclusions in East Africa: both men were knighted on 20 February 1935, largely for their pioneering work on tropical health.<sup>3</sup>

After his first year in New Guinea, Cilento spent a short time in private practice in Adelaide while Phyllis completed her studies of maternal and child health in London. At the same time, using data collected in New Guinea, he submitted a thesis entitled *A Study of Nutrition of Native Populations*, for which he was awarded an M.D. by Adelaide University. Now married to Phyllis, he found little joy in private practice, and he responded to an advertisement in the *British Medical Journal* on behalf of the Sultan of Perak in the Federated Malay States, seeking six medical graduates. The Cilentos presented themselves for interview at Kuala Kangsar and were appointed to Teluk Anson for twelve months from November 1920.

Their bungalow in the grounds of Teluk Anson hospital lay in the native quarter of the town, which proved not only convenient professionally but also of immense

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<sup>3</sup> Fisher, *op. cit.*, 17.

interest to Cilento as a linguist and anthropologist. As his wife later recalled, he spent much of his leisure sitting cross-legged on the concrete floor below the bungalow, talking for hours with the pengulus, discussing Malay history and traditions. In his final month in Malaya, he dressed as a Malay doctor and travelled extensively with his clerk, Mohamed Ali, absorbing the lore of bazaar and village.<sup>4</sup> Professionally, the experience was important for what Cilento learned of the treatment of tropical diseases, and the accommodation of his methods to the conservatism of his patients. The success of his framboesia clinic was so spectacular that he was soon averaging eighty or ninety injections in a morning. Not only did the single injection of an arsenical compound effect a cure within a fortnight: it often cleared up related chronic disabilities as well.

Life in the large, airy, two-storied bungalow constructed in the "better class native style" (though modified by Colonial Office planners in the light of two centuries of tropical experience) gave Cilento a taste of the architectural adaptation that could transform the prospects for Europeans in hot, humid climates. Not all the detail could be translated to Australia, but five years later, when he drew up his blueprints for a healthy life in tropical Queensland, he could call on vivid recent memories.

One of his tasks was to act as quarantine officer, with a special brief to watch for the arrival of people with communicable diseases, brought by ships which had called at some of the most dangerous ports in the world. Twenty years later, in a radio broadcast, he recalled an occasion when smallpox had been detected among pilgrims returning from Mecca. Three suspects had broken away from quarantine and set out by boat for their home village. Desperately concerned to isolate them, Cilento rode off on horseback with a Sikh policeman and arrived just in time to prevent contact, drawing his service revolver and firing warning shots in the air. These experiences added special point to his perception of the racially exclusive immigration policy adopted by Australia at the beginning of its federal history.

At Teluk Anson Cilento was visited by Dr J.S.C. Elkington, Director of Quarantine in the Commonwealth Department of Health, which had been formed only a few months earlier in March 1921, largely as the result of manoeuvres by Dr J.H.L. Cumpston, who became the first Director-General (see chapter five). Elkington had been deputed by Cumpston to offer Cilento a post in the tropical section of the new department.<sup>5</sup> A letter followed from Cumpston, confirming the offer of the position of "Medical Officer for Tropical Hygiene", based at A.I.T.M. in Townsville, with duties in New Guinea and the tropical portions of Australia.

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<sup>4</sup> R.W. Cilento, *The World my Oyster*, unpublished and incomplete autobiography, held at Fryer Library, University of Queensland; and interview with Lady Cilento, 18 May 1983.

<sup>5</sup> Fisher, *op. cit.*, 22.

Cumpston outlined an agreeable programme to begin in August 1921 with a Congress of the Far Eastern Association of Tropical Medicine in Batavia (now Jakarta). He was to detach himself from the Malayan post in December and proceed to London for a course of laboratory work at the London School of Tropical Medicine, and sit the examinations for the Diploma of Tropical Medicine and Hygiene. (Against a field of 54 postgraduate students he won both the Duncan and the Lalcaca medals.) As he later told the story, in taking his leave from one of his examiners, Dr Philip Manson-Bahr, he was asked:

"And what would you say is the vital problem on which you will spend the life you are now beginning?"

"Populating tropical Australia" I said at once, to which, with a chuckle, he replied:

"Not alone, I hope." and waved his hand in farewell.<sup>6</sup>

On his way to London, Cilento had visited the quarantine stations at Ceylon and Port Said. At the latter occurred an incident which reinforced the lesson he had learned in the jungles of New Guinea and Malaya: that below the gorgeous surface of tropical life lurked a terrifying range of diseases and disabilities which boded no good for his own country. As he recalled years later, he had looked in on the post mortem of a girl of 13 years who had been killed in a street accident that morning:

She was beautiful and looked healthy and I said how sad it was to see her life ended just as it was beginning, which drew the reply from the dour professor that

"Appearances are deceptive. I'd be prepared to wager she has at least seven or eight parasitic worm or other diseases," and so it proved.<sup>7</sup>

Cilento was director of the A.I.T.M. at Townsville from his return to Australia in October 1922 until March 1930 when it was absorbed into the new School of Public Health and Tropical Medicine at Sydney University. In Townsville he replaced the distinguished Dr Anton Breinl (see chapter three). From the outset, the Institute reflected the urgency of the new Commonwealth's attachment to the "White Australia Policy". Put simply, a great deal of the new nation's energy was to be directed towards making white occupation of Australia effective, most of all by solving the problems of settlement in the tropical north.

The impulses that shaped the creation of the A.I.T.M. were far from spent in the 1920s.<sup>8</sup> At the B.M.A. meeting held in Brisbane to welcome him as Director, Breinl had been told of the diseases which merited attention, the risk of exotic infection from Asia and the Pacific islands, and the need to keep northern Australia

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<sup>6</sup> Cilento, *op. cit.*, chapter 8, 26.

<sup>7</sup> *Ibid.*, 23.

<sup>8</sup> R.A. Douglas, "Dr Anton Breinl and the Australian Institute of Tropical Medicine", *Medical Journal of Australia*, 7 May 1977, 714-5.

predominantly white.<sup>9</sup> In reply, Breinl described the results of his initial surveys, noting the danger of yellow fever being introduced, since the vector was present all along the Queensland coast. But he made the point which was emphasised by all enthusiasts for white settlement in the tropics, that Queensland was unusual "in that there was no large reservoir of disease in a numerous native population". To Breinl, as to Cilento, tropical medicine was concerned less with treatment than with prevention. The research of the Institute, he said, would address the White Australia question by finding out: "Is the white race capable of propagating and living in the tropics? Is the offspring as healthy and fit as in a temperate region?"

When the Institute's new buildings were opened in June 1913, Sir William MacGregor, Governor of Queensland, suggested in the light of the Panama experience that "tropical diseases, although important, occupy only a second place, and the main problem is whether conditions of heat and light will permit the establishment of a working white race."<sup>10</sup> He went on to stress the problems of living conditions and especially accommodation, and its bearing on the health and contentment of tropical residents. Typically for the period, his brief mention of Aborigines is dismissive:

With the disappearance of the Aboriginal race, with a prohibition on other domestic servants of colour, and the practical impossibility of obtaining white servants, it should not be expected that the mother of young children can live in the north in a house, the walls and roof of which are of galvanized iron, where she has to do the cooking, the washing, the mending and the ironing of clothes, and to tend to the ceaseless round of domestic duties...It is therefore, absolutely essential that everything that is possible be done to lessen the labour of the white woman in the north and make her life more comfortable.

As will be seen, this question of living conditions provoked perhaps Cilento's most durable contribution to tropical hygiene.

At Townsville, Cilento was responsible to Elkington, who was stationed in Brisbane as Director of Quarantine for Tropical Australia, and second in charge of the Commonwealth Department of Health. Travelling north as cabin companions in the ship from Melbourne to Brisbane after Cilento was briefed by Cumpston, the two men discovered an immediate accord that went beyond personalities to their deeper professional commitments. It would be satisfying indeed to be able to document the steps by which Elkington's enthusiasm for promoting white settlement in the tropics was transmitted to the younger man. Though we cannot do that, we can show the remarkable correspondence of their views, which may well have been established in the fortnight they spent touring the main centres of north Queensland after Cilento was installed at Townsville.

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<sup>9</sup> *Idem*, 14 May 1977, 750.

<sup>10</sup> *Ibid.*, 751.

Elkington's first major statement of his tropical creed was made in a paper which he prepared as Chief Health Officer for Tasmania and read at the Royal Society meeting at Hobart on 21 November 1905. Entitled "Tropical Australia: is it suitable for a working white race?"<sup>11</sup> the paper was immediately seen as urgently relevant to the question being played out on the sugar plantations and farms of Queensland.

The prime consequence of federation for the northern colony had been the loss of Pacific Island labour, on which sugar growing had been largely based for forty years. At an economic level it was possible to compensate growers by offering a nation-wide market free from internal tariff barriers, coupled with protection against imported sugar and rewards for farmers who employed only white labour. The added cost to the consumer was seen as a small price to pay for the boon of racial homogeneity. Yet there remained real doubts as to the ability of white men to survive as field workers in the tropics, and the *Pastoralists' Review* was one influential paper that advocated the use of coloured labour north of the Tropic of Capricorn.<sup>12</sup> Small wonder, then, that Elkington's Royal Society paper was immediately noticed by the Commonwealth Parliament and ordered to be printed by the Senate.

Elkington began his paper, as Cilento was to begin his book *The White Man in the Tropics* twenty years later, by stressing the geographic and climatic variety of the 1,145,000 square miles of Australia that lies within the tropical zone. It includes not only the steamy coastal plain where most of the sugar cane is grown, but also the elevated tablelands just to the west, which "afford for many months of the year as "bracing" an atmosphere as can be found anywhere in the world." He went on to notice the existing industries and stressed the almost untapped potential for growth.

"It already supports," he wrote, "a fairly considerable white population, who do not appear to be degenerating, despite the recklessnesses and ignorance so often displayed in relation to personal health and habits." The health statistics for tropical Queensland compared "excellently well" with non-tropical areas and though special diseases existed, such as malaria, dysentery, and ankylostomiasis, their incidence was mainly local, and the means of prevention well known. And he concluded on this point: "Their limitation and eventual extinction is mainly a question of money".

Elkington argued from historical examples and personal observation that the health of Europeans in low latitudes hinged upon domestic and personal

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<sup>11</sup> J.S.C. Elkington, "Tropical Australia: Is It Suitable for a Working White Race?" 21 November 1905, Miscellaneous Health Reports, vol 2: Ford Collection, Royal Australian College of Physicians Library.

<sup>12</sup> A.T. Yarwood, *Asian Migration to Australia* (Melbourne University Press, 1964), 33-35.

environments and habits. He quoted the finding of the Indian Sanitary Commission in 1863, that the causes of high mortality amongst white soldiers lay in a few readily preventable diseases and above all in bad habits, including alcoholic abuse and unsuitable clothing. In a rare error, in which he was conspicuously followed by Cilento, he discounted a recent attempt by Major Woodruff of the U.S. Army to ascribe a "powerfully hostile effect to the actual rays of tropical sunlight as affecting white peoples, quite apart from questions of temperature". He was unconvinced by the arguments, which lacked as yet the support of any definite experimental investigation.

Cilento's thoughts on this matter are best pursued in the weekly articles he wrote for the *Courier Mail* for ten years from 3 August 1929 under the *nom de plume* of Hygeia.<sup>13</sup> Reflecting his young family's enjoyment of sun, sand and surf at their beach cottage on the Sunshine Coast were the pieces he wrote on the eve of the Christmas holidays, urging his readers to adapt to and take advantage of their natural environment. He rejected the idea that enjoyment of sunshine carried a high risk of skin cancer, and argued that for an Anglo-Saxon population to establish itself in Australia it must develop "natural defences against the climate." His message on 9 December 1933 was that "Adaptation is the only safeguard worth considering." It was a matter of gradually acclimatising the body to heat, beginning in infancy, and wearing light, loose clothes that permitted the body to operate its own cooling system.

This question of sun and skin became an extension of Cilento's belief in the white man's capacity to live in the tropics and an affirmation of the bright future that awaited Australians, and especially Queenslanders, if they had the courage to take advantage of their "magnificent heritage". In defending the Queensland climate against its detractors, Cilento crossed swords with southern critics like Griffith Taylor and Grenfell Price, who declaimed against efforts to develop the north because of its alleged unsuitability for white settlement. Broadcasting from Brisbane as the newly appointed Director General of Health and Medical Services for Queensland on 28 April 1935, he urged his listeners to rid themselves of the "inferiority complex about our tropics that has been a drag on the wheels of our progress for six generations."<sup>14</sup>

Though we must recognise the magnitude of Sir Raphael's positive contributions to the reform of dress and housing in Queensland, we must admit that in the issue of skin cancer he was a conspicuous failure. Almost aggressively hatless, he suffered in his old age from the skin cancers which he had so long underestimated. And, as his student and successor, Professor Doug Gordon remarked in 1959, long

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<sup>13</sup> Volume of Cilento Press Cuttings as "Hygeia": Fryer Library, University of Queensland.

<sup>14</sup> Radio Broadcasts, Cilento Collection, Fryer Library.

term residence in north Queensland doubled the chances of developing skin cancer, when compared with residence in the south.<sup>15</sup>

Elkington's 1905 paper to the Royal Society is one of the earliest statements of the advantage enjoyed by white Australians as tropical dwellers in being free from the necessity of coexisting with, as he put it, "a considerable native population undergoing the natural penalties of their insanitary methods of living", which not only spread the "so-called tropical diseases" but also those introduced by Europeans.

Another Elkington initiative followed by Cilento was in relation to miscegenation. Whereas the older man wrote temperately (in the context of 1905) that "On the whole, the evidence is against the half-caste, and the experience of other countries goes to show that it is advisable to keep the white stock pure," Cilento was still adamant and uncompromising in his defence of the "White Australia Policy" when he gave the Elkington oration in 1959, at a time when it was coming under ever stronger criticism from within Australia and abroad.

It is in the manuscript copy of this oration that we can best discern the nature and extent of Cilento's legacy from Elkington. In paying tribute to his predecessor's versatility, he wrote of the "core of conviction" round which his many-sided activities revolved. For Elkington *"it was an absolute belief in the capacity of the white race to colonise the tropics - at a time when the idea was held universally to be absurd - and an all-consuming urge to force it into recognition."*<sup>16</sup> Elkington's chief task as Commissioner of Public Health for Queensland and later as Director of Tropical Hygiene was to deal with the epidemic diseases which became established in the colony in the 1870s and 1880s with, as Cilento described it, "the arrival of swarms of colored laborers". Even after the Pacific Islanders were repatriated, he went on, "a few seedbeds of dysentery, malaria and leprosy still persist. Hookworm was so prevalent in the wetter coastal strip that it was known as 'hookworm alley', and it is still grossly infected."

In telling the story of the medical, economic and racial dangers that were brought to Australia by non-Europeans in this period Cilento saw the crucial outcome as the adoption, "almost as an article of faith, [of] the 'White Australia' policy - a sine que non for white survival." The argument of this chapter is that Cilento followed his mentor in a passionate attachment to the policy of white settlement in the tropics, which carried an equal concern to maintain the purity of

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<sup>15</sup> D. Gordon, *Mad Dogs and Englishmen go out in the Queensland Sun. Health Aspects of the Settlement of Tropical Queensland*, unpublished Bancroft Oration, 1969, Royal Australian College of Physicians Library.

<sup>16</sup> R.W. Cilento, *The Versatility of the Medical Pioneer*, Elkington Oration, ms copy in Fryer Library. Cilento's italics.

the white stock and exclude coloured migrants who might reintroduce the diseases which constituted the main obstacle to success.

When Cilento completed the manuscript of *The White Man in the Tropics* he had just begun his second tour of duty in New Guinea, as Director of Health, so that when he wrote the introduction at Rabaul in June 1925, he had been freshly reminded of the great differences between the situations of white residents in Queensland and those in similar climatic regions. He attributed the "more happy experience of Queensland" not only to the relative absence of tropical disease and of a "resident native race", but also to the fact that the white man in Queensland carried out "every occupation, from the work of the labourer to the highest intellectual pursuits."<sup>17</sup> At the end of his section on Effects of Residence in the Tropics, he offered several conclusions:

1. to live in the tropics, physical exercise - work - is absolutely essential;
2. preventive medicine must be foremost in every aspect of life and industry;
3. If one more point may be allowed definition, it is undoubtedly the repeated emphasis history places upon the importance of race purity. The nation that admits native labor abandons its birthright.

A good deal of the argument in Cilento's book is drawn, with generous acknowledgment, from the work of his predecessor at the A.I.T.M., Anton Breinl, and his colleagues. The studies of blood pressure by Breinl and Priestley showed that climate, as such, had no marked effect on blood pressure in school children. Dr. Sundstroem found at Townsville that the average blood sugar of long term tropical residents was lower than that of immigrants, and his outstanding work in this area indicated that there was a definite deficiency in the organic and lipoid fractions of the phosphorous content of the blood. As well, he found an alkalitic blood condition which was associated with the easy fatigue and depression of the tropics, but which tended to be neutralized by muscular effort. Sundstroem, again, found that the energy output in tropical Australia corresponded almost exactly with standards from temperate climates, and as a result of a year's experiments with 100 growing girls, found that there was no retardation of growth at the time when heat and humidity in Townsville were greatest.

Perhaps the most remarkable, and for Cilento the most significant, experiments, "demonstrated that those people who most nearly approach what is considered the standard for temperate climates were people engaged in the arduous duties of wharf lumping." By contrast, "The least satisfactory of all the tests was that taken from a girl who followed the sedentary occupation of stenographer, and who avoided every form of exercise."

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<sup>17</sup> R.W. Cilento, *The White Man in the Tropics* (Commonwealth Department of Health Service Publication, 7, Melbourne, 1925), 5.

One of the most persuasive parts of Cilento's book was taken from the report of Breinl and Young on the feasibility of white settlement in the tropics. In their summary, Queensland health statistics compared more than favourably with those of the Commonwealth as a whole in every important respect: overall death rates, infant mortality rates, and life expectancy.

Cilento then looked at the discussions of the Australasian Medical Congress of 1920, held at Brisbane, which reviewed the work of the previous decade on the subject of white settlement. The overwhelming view of medical practitioners present was in favour of north Queensland's suitability as a home for a "working white race". Medical examinations for Citizen Forces and Cadets showed a substantially smaller proportion of rejections from tropical Queensland compared with non-tropical. But perhaps the most persuasive testimony of all came from C. A. Elliott, the Chief Actuary of the Australian Mutual Provident Society, who found from an examination of nearly 5,000 policies issued to adults from the Cairns and Townsville offices from 1910 to 1919 that the number of deaths was much below the expectations based on 54 years of A.M.P. experience. So he concluded:

I have no hesitation in saying that, so far as we know at present, there is no need for life assurance offices to treat proponents who live in North Queensland differently from proponents who live in other parts of Australia.

The 1920 Medical Congress, although concluding optimistically as to the prospects of a healthy indigenous white race in the tropics, uttered a word of warning that was to have a bearing on Cilento's future at the A.I.T.M. Though agreeing that the successful occupation of tropical Australia was "fundamentally a question of applied public health," with a solution greatly eased by the "absence of a semi-civilized coloured people," the Congress emphasized

that any considerable extension of population and settlement under the existing loose conditions of sanitary administration and sanitary practice...[in tropical Australia]...cannot hope for lasting success, and cannot fail to result in ultimate disaster.<sup>18</sup>

On 27 September 1919, little more than a year before he resigned from the A.I.T.M., Breinl wrote to the Secretary of the Department of Home and Territories asking for senior staff to replace departures. He justified this by referring to the conclusion of a recent paper published with Dr. Young, that, in spite of the Americans' work in the Philippines, "the whole question of the physiology of the white men in the tropics is still far from being solved."<sup>19</sup>

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<sup>18</sup> *Ibid.*, 56.

<sup>19</sup> School of Public Health and Tropical Medicine, S.P. 1061/1, General Correspondence files, 1908-55, file 350, 2, 8: AA.

Breinl suggested not only a highly qualified physiologist, but also a new departure that clearly anticipated Cilento's *White Man in the Tropics*. He and Young "had often been impressed," he wrote, "by the influence which general social conditions, environment, etc. exert upon the mental attitude and consequently upon the working capacity of the individual, "and they repeatedly spoke of the need for an economic inquiry. The investigation could be in two parts, one primarily a personal inquiry by a sociologist, the other a statistical inquiry into conditions which influence life in tropical Australia compared to the south, including the cost of living and other general statistics, and the incidence of lunacy according to district. Dr. Elkington, he mentioned, had already suggested such an inquiry in relation to Croydon, in his capacity as Queensland Health Commissioner.

It seems clear from this that the sociological survey conducted by Nurse A.M. Gorman under Cilento's direction before he went to Rabaul, which formed the original part of *White Man in the Tropics*, resulted from initiatives taken first by Elkington and Breinl. As to its importance, Professor Doug Gordon wrote in 1969 in his lively and perceptive Bancroft Oration:

One might predict that, of all the papers written on the subject of North Queensland settlement, a future social historian will place the highest value on the account provided by this sociological investigation. It gives a good picture of how the "ordinary" people lived and by modern standards this was rather meagrely.<sup>20</sup>

Nurse Ada Gorman was introduced to the editor of the *Cairns Post* by the acting director of the A.I.T.M. as "a trained nurse with high qualifications both in general nursing and maternity work", who had already completed an investigation at Townsville into the physique of children of the first, second and third generations (of white people).<sup>21</sup> Miss Gorman's qualifications draw attention to the stress placed by Cilento on desperately poor standards of accommodation used by virtually all north Queensland residents, with working conditions for housewives so badly planned as to create real health hazards. At their best the ill-ventilated boxes of galvanized iron acted as ovens at the height of summer; at their worst they formed, with their primitive privies and uncovered water tanks, the foci for hookworm infestation, and breeding grounds for mosquitoes.

This is not the place in which to attempt an assessment of the sociological investigation that was published as pages 75 to 92 of *The White Man*. Clearly, it was carried out by Cilento under great financial pressure, as was true of all the work of the A.I.T.M., with Nurse Gorman the only fresh member of staff. Cilento

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<sup>20</sup> Gordon, *op. cit.*, 38.

<sup>21</sup> School of Public Health and Tropical Medicine, S.P. 1063/1, General Correspondence files, 1930-65, file 786: AA.

began by explaining in a memorandum dated 16 January 1924 the main purposes of the Sociological Unit.

- I. To inquire into conditions of which women in the inaccessible parts of Tropical Australia complain.
- II. To observe and file at all times and whenever suitable, particulars concerning the following points:
  1. Is the kitchen a room or a mere penthouse?
  2. Is the kitchen stove set in a properly constructed recess?
  3. Is water laid on into the kitchen?

He went on to suggest questions about draught, ventilation, ceilings, cooking facilities, cooling and refrigeration, food storage, security of water storage, privies, gutterings, the range of foods used in families.

Nurse Gorman was to visit and report on a total of 740 families drawn by lot from the coastal cities of Cairns and Townsville, from the plateau country of Atherton, Chillagoe and Charters Towers, and from the "hot dry interior" as represented by Julia Creek and Cloncurry.<sup>22</sup> As her third task, she was to be prepared to advise mothers on:

1. Housing and house management.
2. Work economies and the essential nature of mental and physical recreation [always a major element in health programmes suggested by both Sir Raphael and Lady Cilento].
3. The principles of good feeding and infant welfare.
4. Sanitation.
5. Practical medical hints.

This paragon was also to lecture on any of the above subjects, and to become "thoroughly acquainted with the importance and significance of the tropical diseases affecting the North, such as malaria, filaria, and hookworm, sprue, infantile diarrhoea, and the importance of mosquitos and flies and soil pollution in the transmission of these diseases.

A further task was to collect full information on the question of residence in the tropics, noting especially the second and third generation children born in Tropical Australia on both sides of the family, and the incidence of any physical feebleness or degeneration. As Cilento added, he was particularly interested to know how adult tropical dwellers performed "when the larger responsibilities of family life make their demands upon a possibly exhausted system. The usual figures, drawn as they are from children not yet at the age of puberty, are (although we do not say so) largely inconclusive." He added that the last feature would be the outstanding part

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<sup>22</sup> Cilento to Gorman, *Ibid.*; *White Man*, 75.

of her work, from which the department was looking for the "most permanent publishable data."

Not only is Gordon right in drawing attention to the value of what followed as a resource of information for the social historian. It is also fascinating as a reminder of the gap between the investigative methods of 1924 and those of latter years, fed by grants, scholarships and research assistantships.

No more than an impression can be given here of the results of the survey by Nurse Gorman. An astonishingly low 3% of Townsville households had electric light, more than half of the kitchens were on the hot side of the house, and only 15% were ceiled. In 33% of houses no water was laid on in the kitchen, and 30% had no ice chests, refrigerators being then almost unknown: this in a city of 27,000 people! On the subject of sanitation, which had been given a good deal of publicity in the hookworm campaign in which the A.I.T.M. was financed by the Rockefeller Institute, Nurse Gorman reported that only 25% of housewives showed a good knowledge in all matters pertaining to hygiene and personal cleanliness, while 27% remained who had "absolutely no knowledge of sanitation." She observed widely the pollution of soil with urine, closet pans with the contents exposed to flies, stale kitchen and bath water lying in pools and uncovered drains and scraps of garbage in yards and drains.<sup>23</sup>

Cilento's *Sunday Mail* article on 5 March 1931, "Riches Lying Fallow in the North", expressed some of the writer's accumulated anger and frustration at the tendency of north Queenslanders to see themselves as temporary sojourners, carrying out the policy "get rich and get south". Even in the largest town in the north, most of the homes were completely unserviceable. He therefore used 38 pages in his book to describe, illustrate and explain the types of houses, and especially bungalows, which had been developed in many parts of the world, not least in India and in Britain's African and southeast Asian dependencies. He concluded that there were two fundamental principles to be observed: the attainment of the greatest amount of ventilation and air circulation, and the exclusion of the greatest amount of heat. The means to this were provided either by the bungalow pattern, distinguished by wide verandahs, big window spaces and easy circulation on elevated piles, or by a Spanish type, verandahless, thick-walled, with narrow shuttered windows to exclude heat and light.

One of the keys to Cilento's tropical creed was his insistence on the need for adaptation, putting aside the usages of temperate climates in housing, dress, food and clothing, and the adoption of a sensible total living style that would satisfy not only the more obvious needs for appropriate food, raiment and shelter, but also the creative urges and emotional requirements. As he had perceptively remarked, the

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<sup>23</sup> *Ibid.*, Gorman Report on House to House Visitation; *White Man.*, 77-81.

desire to create, whether this is effected by actual procreation or by the consummation of some work that holds the dominant interest of its agent, or by both, alone can satisfy the universal and imperative demand for self-fulfilment.<sup>24</sup>

The "white man in the tropics", can now be related clearly to Cilento's perceptions and beliefs. He was a complicated person, not to be explained simply as an old-fashioned racist or white supremacist, with a disdain for "the lesser breeds without the law". Neither was he an old-fashioned would-be exploiter of black labour, for part of his attachment to the "White Australia Policy" was his belief in the necessity for all men performing the entire range of daily tasks, physical and mental. Not for nothing was his first article as "Hygeia" entitled "Patriotic Muscularity. Health as a duty".<sup>25</sup>

As Milton Lewis remarks astutely about Dr. J.H.L. Cumpston, the long-time Director-General of Health saw the pre-requisite of health progress in Australia as the development of a "more positive government, guided and promoted by an elite group of experts." He quoted the view of William Holman, the labour leader, on the need for a bureaucracy, because of the absence in Australia of a leisured and cultured middle class on the British model.<sup>26</sup> Cilento, in a letter of 30 August 1935, described Queensland as "the premier State of Australia", with problems "essentially different from those of the rest of the continent, and those who are pioneering their scientific control must be guided by the power of their own personalities not by precedent."<sup>27</sup>

Cilento's elitism comes through at many points in the diary letters held now in the Fryer Library, which he wrote to his wife in Brisbane from scores of towns in tropical Australia. Consider this letter from Queen's Hotel Townsville of 1 October 1931 complaining of the O'Neills "genius for vulgarity." He went on:

Really I sometimes wonder at the detestable atmosphere of these dirty little towns with their ill bred squabbling brood of nincompoops and crawlers. Autocracy had much to condemn it but nothing half as foul as democracy has.<sup>28</sup>

Cilento's sharp and omnipresent race consciousness is shown by scores of candid diary letters. This was not simply a matter of colour or race prejudice, though this was an important element. It is more broadly an elitism which tends to see all lesser people, however defined, in patronising or disparaging terms. His anti-American

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<sup>24</sup> *White Man*, 106-7.

<sup>25</sup> *Brisbane Courier*, 3 August 1929.

<sup>26</sup> M.J. Lewis, introduction to J.H.L. Cumpston, *Health and Disease in Australia: A History* (ms in preparation for publication), 13-4.

<sup>27</sup> Cilento to Hon. F.W. Bulcock, M.L.A., 30 August 1935, Cilento Collection, 44/11: Fryer Library.

<sup>28</sup> *Ibid.*, 44/21

feeling, which is shown in a letter of 26 June 1929, was probably a mixture of resentment at the racial impurity and at the brashness and confidence of American people. By the time of his residence in New York in the late 1940s, that feeling was profoundly elevated by his long term anti-Semitism and the more recent but powerful anti-Zionism, stimulated by his work as a U.N.O. official for the Arab cause.<sup>29</sup> This anti-Semitism appears briefly in a letter of 14 July 1929 from the Grand Hotel on Thursday Island. After mentioning how pleasant it was to meet Malay-speaking Chinese servants, he described the "usual uninteresting crowd - several pawky nouveaux riches, a Polish or Russian Jew called Zomeroff (a pearl-buyer & probably stealer)". The racial barbs and general elitism go on throughout the letter. Cilento has just met a professional companion, Dr. R. "He is a tall young dark rather handsome fellow... He looks Irish & has the impulsive vivacious temperament, the lack of judgment, entire self-confidence and lack of a sense of responsibility of that race."<sup>30</sup>

Writing of the island itself, he says "The place reeks with all kinds of coloured and discoloured natives, half-caste mixtures - 'liquorice allsorts'...the north is seen as a sweltering tropical waste peopled by the riff-raff of the world & only suited to gins and goats. But what we could do if we had statesmen in politics". Going on to describe the high level of yaws and gonorrhea on the island, he concluded with a cry from his medical and racial heart, "and yet we have a damn silly lot of cranks who talk about the desirability of native servants, & introducing natives into Australia to corrupt our stock, pollute our children and debase our social order."

Other examples of Cilento's anti-Semitism, which usually makes the Jew a figure of ridicule from the moment of his appearance in a narrative, occur in his letters of 29 July 1933, describing the seductive efforts and failure of Rosa, a Jewish fellow passenger, and of 25 January 1940, on the subject of Jewish refugee doctors.<sup>31</sup> In the latter he wrote "The Britisher is an individualist...The Jew has two thousand years of servility behind him." If refugee doctors were permitted to go on taking jobs along the Queensland coast, they would create the same situation "that caused them to be thrown out of Germany and Austria."

Equally coarse were Cilento's diary references to Aborigines towards whom he stood in a special professional role for 25 years, ending only in 1945 with his retirement from the position of Director General of Health in Queensland to take up a U.N.O. position. While one may concede the skill and persistence of Cilento's work in promoting Aboriginal health in relation to venereal disease, hookworm, leprosy, and malaria, the terms in which he described them ("coons", "niggers",

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<sup>29</sup> *Ibid.*, 26 June 1929.

<sup>30</sup> *Ibid.*, 44/21

<sup>31</sup> *Ibid.*

"nigs", "darkies", "gins"), and the images he employed, remain offensive to modern ears.

On 14 November 1933 he wrote from the Strand Hotel at Cairns a passionate letter to his wife, describing how she inspired him "to do something for Australia - something especially that will teach our own people that work & discipline, not piracy & mendicancy are the only things that make a nation great." At his table that morning he had met a Sydney businessman who "ranted...on the delights (to the bosses) of a 'Black Australia'...what would it matter to Sydney residents if niggers raped the daughters of white settlers in North Queensland?"<sup>32</sup> From the Aboriginal settlement at Palm Island he wrote on 23 October 1932 describing his efforts to follow up leper contacts. Nurse G. he thought a "curse to discipline...Her disability is that she is utterly sloppy with the nigs - calls them all 'dear', mugs & hugs the snotty-nosed & rheumy-eyed kids, fools about with the men...and is producing an atmosphere very dangerous among the bucks (saucy enough at any time) to herself & the other white women".<sup>33</sup> Summing up his impressions at Innisfail on 28 October 1932, after inspecting the V.D. depot at Fantome Island, he concluded:

The whole abo population should be worked through Fantome & then regraded into new cases, incurable aged, incurable young & part cured & thence drafted when clean back into Palm from which they can be sent out to the mainland to be (1) assimilated if white enough; (2) employed under supervision & protection; or (3) kept on Palm as minor officials or peasant proprietors working personal strips around a collective farm.<sup>34</sup>

It is perhaps unfortunate to conclude an account of one of Australia's most important health administrators by dwelling on his extreme racial intolerance. Cilento was remarkable for his ability to see the big issues in public health in a broad international perspective. His work in New Guinea and Queensland was innovative and forward looking, notably in its stress on diet and the vital commonplace aspects of life that tended to be neglected by microscopic medicine. Yet any assessment of Cilento's views and policies on the question of white settlement in the Australian tropics unavoidably encounters the negative aspect of his creed. For Cilento, the consequence of his attachment to the peopling of north Queensland with sturdy white settlers was an unrelenting racism that showed itself in the defence of the migrant and quarantine frontiers of white Australia, and in a rigid, paternalistic control of the Aborigines.

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<sup>32</sup> *Ibid.*

<sup>33</sup> *Ibid.*, 44/22.

<sup>34</sup> *Ibid.*

## **THE ROCKEFELLER FOUNDATION, THE HOOKWORM CAMPAIGN AND A NATIONAL HEALTH POLICY IN AUSTRALIA, 1911-1930**

**James Gillespie**

Between 1916 and 1924 the International Health Board (IHB) of the Rockefeller Foundation, in co-operation with Commonwealth and State governments, spent well over £100,000 on a survey and eradication campaign against hookworm mainly in North Queensland and Northern New South Wales. With the exception of sewerage schemes, this probably represented the greatest expenditure on an Australian public health campaign directed against a single disease. It was also the first major post-war involvement of the Commonwealth Government in public health activities outside the Quarantine Service and played a crucial part in the establishment of the Commonwealth Department of Health in 1921. Paradoxically, given the importance of the hookworm campaign in Australian public health history, it is difficult to find much interest in the problem of hookworm disease either before or after the campaign. Why was the Rockefeller Foundation involved in Australia and what were the circumstances in which Australian public health officials forgot their earlier reluctance to join in enthusiastic public support for a program towards which they were skeptical in private? The major theme of this paper is the manner in which a health program not regarded as intrinsically important by most of its professional participants was developed to further other, quite distinct ends.

### **The Rockefeller Foundation and the Hookworm Campaign**

Recent studies of the Rockefeller Foundation in public health policy have moved beyond the older framework of admiring philanthropy. The older official histories of the Rockefeller Foundation dwelled on J.D. Rockefeller I's Baptist upbringing and linked this to a new sense of the responsibility of wealth. More daring versions suggested that the threat of income tax and other confiscatory state policies coupled with the anti-trust campaigns pushed the Rockefellers in the direction of philanthropy out of self defence.<sup>1</sup>

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<sup>1</sup> R.B.Fosdick, *The Story of the Rockefeller Foundation* (New York: Harper Brothers, 1952) gives the older version.

A more radical view has emerged since the Rockefeller Archives were opened in the 1970s. Greater stress has been laid on the political and labour market objectives of the great foundations (in particular the Rockefeller and Carnegie Foundations) which have been seen as fulfilling the functions marxists have traditionally assigned to the state as the organizer of class rule in a capitalist society. E. Richard Brown and Howard Berliner have analysed the Carnegie Foundation's sponsorship of Abraham Flexner's report on American medical education and the subsequent campaign by the Rockefeller Foundation using the lure of endowments to impose a particular model of medical education. "Fringe" therapies, such as homeopathy, were squeezed out of medical curricula as the Foundation required its beneficiaries to establish a closer relationship between clinical and theoretical instruction, with full-time teaching staff, modelled on the Johns Hopkins Medical School. The public health work sponsored by the Rockefeller Foundation was a more directly political extension of these concerns, involving both labour market considerations - ensuring healthy labour forces within the United States and in those areas of the European colonial empires where American capital desired to expand - and an expression of the same urge to moral uplift that animated American missionaries. In short, it was the application to public health of the same mixture of high-minded altruism and the ruthless pursuit of commercial and cultural domination which animated the "open door" and other aspects of early twentieth century American imperialism.<sup>2</sup>

The selection of hookworm disease for the first project stemmed from this mixture of medical and political considerations. By the early twentieth century the etiology and cure of hookworm infestation was well understood. Hookworm disease, known medically as *uncinariasis*, or more frequently, *ancylostomiasis*, is caused by either of two species of parasitic nematode worm, *Ancylostoma duodenale* or *Necator americanus*. Their life cycles are similar. The larvae live in the soil, thriving in hot and humid conditions. The wet tropics or coal mines in more temperate areas provide the classic locations. The worms enter the human bloodstream through the skin, making infection more frequent in areas where it is common to go barefoot. Once in the lymphatic system the young worms proceed to the heart whence they are pumped to the lungs and coughed up through the windpipe. After being swallowed by the victim the worm eventually lodges itself in the small intestine using the sharp "hooks" on its mouth and drawing on the bloodstream for sustenance. Its eggs are passed out with faeces, starting the whole cycle again. Mild cases of infestation bring few symptoms, although such carriers

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<sup>2</sup> E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979); H. Berliner, *A System of Scientific Medicine* (London: Tavistock, 1986); B.D.Karl and S.N.Katz, "Foundations and Ruling Class Elites", *Daedalus*, CXVI (1) (1987), 1-40.

can spread infection. Severe attacks can lead to anaemia, weakening the victim and opening the way to other diseases. This was the condition known as "hookworm disease". Sufferers display an unhealthy pallor and other symptoms such as earth eating, stunted growth and a general lassitude.<sup>3</sup> By the late nineteenth century hookworm had been found to be swiftly curable with courses of treatment of the drugs thymol and oil of chenopodium. While these drugs were efficacious, both presented some medical problems.<sup>4</sup>

In the context of the medical knowledge and therapeutics of the early twentieth century, then, hookworm disease offered several advantages for a public health campaign. It was relatively straightforward to diagnose - hookworms could be seen under an ordinary microscope, providing a dramatic illustration of the germ theory of disease in semi-literate rural communities. Treatment was equally simple and dramatic. More importantly, although doses of thymol and oil of chenopodium purged the worms, without a revolution in sanitary behaviour - the acceptance of a "a new concept of dirt" emphasizing personal hygiene - reinfection was almost inevitable. Hence, the diagnosis and treatment of disease must be accompanied by mass education in basic public health and reinforced by administrative reform, or creation, of permanent local public health agencies.<sup>5</sup>

In the American South these concerns came together as Charles Stiles and other medical advocates of a regional campaign used the hookworm as the cause of the economic and social malaise of the post-bellum South. Stiles' term "the germ of laziness" not only reinforced Northern prejudices that Southern economic backwardness was a result of personal failings but offered an apparently cheap and rapid solution. Hence from the outset the campaign had a strong political element. The medicalization of the problems of Southern labour markets led to the targeting of communities of poor whites and helped to persuade the Rockefeller Foundation of the necessity for the project.

From its inception, public health was a major area of activity by the Foundation. John D. Rockefeller was looking for a suitably dramatic project. His advisers, in particular Frederick Gates, were advocates of the model of public health encouraged

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<sup>3</sup> These paragraphs are based on M.Boccaccio, "Ground Itch and Dew Poison: The Rockefeller Sanitary Commission 1909-14", *Journal of the History of Medicine and Allied Sciences*, XXVII (1) (1972), 30-53; E.R.Brown, "Public Health and Imperialism: Early Rockefeller Programs at Home and Abroad", *American Journal of Public Health*, LXVI (9) (1976), 897-903; J.Ettling, *The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge, Mass: Harvard University Press, 1981).

<sup>4</sup> V.G. Heiser, "The Administration of Chenopodium", *The Military Surgeon*, XLI (1917), 1-5.

<sup>5</sup> On changing concepts of "dirt" and public health see P.Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 189-90.

by the late nineteenth century revolution in bacteriology, the search for single causes of public health problems. Following the research and public health campaigns associated with the United States Army in Puerto Rico under Bailey Ashford, the Foundation appeared to have a suitable object for its work. The Rockefeller Sanitary Commission for the Eradication of Hookworm Disease was established in 1909 and began an active campaign in the South the following year. Its work embodied the view of Wickcliffe Rose, a southern educationalist without scientific training who was the moving spirit behind the early public health work of the Foundation, that medical knowledge had outstripped its practical applications. Rose aimed to develop a public health campaign around a disease that was readily identifiable and curable. The campaign was to be primarily an exercise in the application of established medical knowledge. Hookworm was seen as an important scourge in the South, but the Foundation's interest in it was primarily as a springboard for work on other diseases, and as a means of imposing a particular sanitary model on the world.

This mixture of medical and political considerations dominated the thinking of the Rockefeller Foundation's International Health Board when it launched an international campaign. As the Annual Report noted, hookworm was chosen :

...not primarily because of its relative importance as a disabling disease, great as that is, but rather because it lends itself readily to purposes of demonstration in disease control. It serves at once as an end in itself and as a convenient means to a larger end. The work, while bringing immediate relief to hundreds of thousands of suffering people, is at the same time serving the more useful purpose of creating a popular sentiment in support of permanent agencies for the promotion of public health.<sup>6</sup>

### **The International Hookworm Campaign**

In 1911 the Rockefeller Sanitary Commission made the first move to extend the hookworm campaign to the rest of the world. Requests were sent to public health departments in most countries, including Australia, asking for information on the prevalence and severity of hookworm infestation. The Commission's motives were complex. As with the American campaign, there was not so much a conviction of the importance of hookworm, as that it provided a convenient focus for a demonstration of the effects of linking field-work, the pathology laboratory, mass treatment and health education. Hookworm was taken as the target which through application of American sanitary and educational methods could become the first disease to be eradicated world-wide. A further attraction was the chance to develop a world wide co-ordinated research effort, taking a single disease as the focus. This aim of establishing an international clearing house of information about a disease (so that experiments with treatment in Jamaica, for example, could be correlated

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<sup>6</sup> Rockefeller Foundation, International Health Board, *Annual Report, 1921* (New York, 1921), 121.

with work in Fiji) provided one of the major attractions for many of the younger doctors drawn to the program. Hence the international campaign started from a limited and inflexible model of public health administration and a vision that this should be extended throughout the world.<sup>7</sup>

Although the campaign was always seen as the first stage towards application of its methods on a wider scale, many local public health officials initially found this priority bizarre. This resistance was most pronounced in Asia and the Pacific. During negotiations in Papua, Malaya and the Straits Settlements the colonial medical officers denied the importance of hookworm and requested that the funds be used for more pressing purposes. In the face of intransigence from the IHB most succumbed and adjusted their views to meet the demands of the Board.<sup>8</sup>

At the very beginning, Dr Victor Heiser, the IHB's far eastern director and former Director of Health for the US colonial administration in the Philippines, responded sympathetically to this skepticism and attempted to redirect the Foundation's approach. In June, 1914 Heiser proposed that the IHB's Commission for the Study of Uncinariasis in the Orient start with an independent assessment of the need for such a campaign in the region.<sup>9</sup> He was swiftly overruled by the Commission, already showing the bureaucratic impetus that was to mark the international campaign. Field officers and the local health officials were required to work within a rigid framework imposed from the centre. The particular model of public health dominant in the IHB stressed the close links between bacteriology and parasitology, sanitary engineering and public health administration. At the same time the program was marked with a strong individualism, public health problems seen as a question of popular attitudes, hence a stress on local government and education. The campaign was to be conducted according to strict guidelines. The IHB was insistent that the American presence should be as discreet as possible, field workers were to avoid open association with United States diplomatic personnel and to keep the public profile of the Foundation at a low level. The Board was to approach governments and work through them, only initiating a project if local participation was freely granted, and insisting on the formation of

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<sup>7</sup> W.A.Sawyer, *Advantages of Nationwide and International Organization for Disease Control With Special Reference to Hookworm and Beri-Beri* (Singapore: J.E. Tyler, Government Printer, 1923), 1-11. Dr Wilbur Sawyer was the International Health Board's Australian representative from 1919 to 1924.

<sup>8</sup> V. Heiser, Diary, 4 August 1917, RF RG5/ 1.2/53/784: Rockefeller Archives Center (RAC).

<sup>9</sup> V. Heiser, "Memorandum with Regard to a Commission for the Study of Uncinariasis in the Orient", Manila, 17 June 1914, RF RG5/2/54/342: RAC.

permanent administrative structures. As in the US the attraction of hookworm was not so much its virulence as its utility as an exemplar.<sup>10</sup>

### The Hookworm Campaign in Australia

The international campaign began with work in the British Empire and in Central and South America. Access to British territories was seen as a particular priority. As Fisher has noted, "this 'Empire' theme runs through all the Foundation's activities in medicine and public health".<sup>11</sup> Consequently, after Victor Heiser was appointed Far Eastern Director of the IHB in 1914 he began approaches to the British and Dutch colonial authorities. In 1916 Dr Samuel T. Darling, of the IHB, commenced surveys of Malaya and Java, making an initial concession to local interests by examining the relationship between malaria and hookworm infestation. Later that year the work was extended to Fiji, which would serve as a valuable non-malarial control for field work elsewhere. In 1917 IHB officers carried out a survey of Papua, New Guinea and the coastal areas of North Queensland.<sup>12</sup>

Although a medical literature noting the presence of hookworm in Australia extends from the 1880s, these observations were more in the nature of medical curiosities than the identification of a national scourge. Before 1911 these clinical notes of isolated cases generally followed in the wake of attention in the British medical journals. After the identification of hookworm amongst tunnel construction workers at St Galle in Switzerland in 1880 Australian cases received more attention. Again, there was a considerable gap in any published interest until the *British Medical Journal* published an extended report of the anti-hookworm campaign carried out by the US Army medical corps in Puerto Rico in 1906 under the direction of Bailey Ashford.<sup>13</sup>

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<sup>10</sup> Sawyer, *op. cit.*

<sup>11</sup> D.Fisher, "Rockefeller Philanthropy and the British Empire: the Creation of the London School of Hygiene and Tropical Medicine", *History of Education*, VII (2) (1978), 129.

<sup>12</sup> Rockefeller Foundation, *Annual Reports, 1916 and 1917* (New York, 1917, 1918).

<sup>13</sup> J.B. Hogg, "A Case of Death from Anaemia due to *Ankylostomum Duodenale*", *Australasian Medical Gazette*, VIII (1889), 133-4; J.L. Gibson and A.J. Turner, "Notes on the Occurrence of *Anchylostomum Duodenale* in Queensland", *Transactions, Intercolonial Medical Congress, Third Session* (Sydney, 1892), 134-7; A.J.Turner, "The Prevention of Parasitic Anaemia"; and A.S.Salter, "Ankylostomiasis amongst Queensland Children", *Australasian Medical Gazette*, XXVIII (1909), 350-6. Hookworm was also mentioned in the original plans for the work of the Australian Institute for Tropical Medicine, "Tropical Diseases: Report by Dr Breinl, Director of the Australian Institute of Tropical Medicine, Townsville, on the Results of His Journey to the Northern Parts of Queensland, July 1910", *Commonwealth Parliamentary Papers (CPP)* (1910), III, 141-2, A. Breinl, "The Object and Scope of Tropical Medicine in Australia", *Transactions, Australasian Medical Congress, Ninth Session* (Sydney, 1911), I, 536-41.

A major interest only appeared in Australia after this date and was linked to the formation of a Commonwealth interest in tropical health, the medicalization of the problems of settlement of the Australian north and the encouragement of the Rockefeller Foundation. In the wake of the expulsion of Melanesian labour from the canefields of north Queensland and the White Australia policy of the early Commonwealth, white settlement in the north became a pressing problem. The debate was increasingly dominated by medical considerations. The Australian Institute of Tropical Medicine had the investigation of the physiology and pathology of Europeans in the tropics at the centre of its program. Given the absence of evidence of serious endemic diseases in northern Australia, this medical interest at first seems unusual, especially as it played a prominent part in the early years of the Commonwealth Department of Health in the 1920s. The prestige of tropical medicine as a speciality linked to the advance of European imperialism in Asia and Africa attracted the more ambitious advocates of a more activist public health policy. At the same time, quarantine concerns played a major part in the new interest in tropical disease as improved communications with Asia increased the chances of the accidental introduction of tropical diseases.<sup>14</sup>

Hence, from the beginning of the twentieth century there was an increasing tendency to explain the problems and backwardness of northern Australia in medical terms. The American literature which justified the Rockefeller Sanitary Commission's campaign quickly found some Australian imitators. In 1907 Dr Thomas McDonald informed a conference of British tropical helminthologists that the children of north Queensland infested with hookworms acquired "deeper and deeper immoral qualities growing and strengthening with the progress of the disease...definite symptoms of positive nerve poisoning as anaemia was of blood destruction. Later stages of degeneration were of the sexual order...a rational explanation of child immorality". Other observers were somewhat more sanguine. Dr J.S.C. Elkington, Queensland's Commissioner for Public Health, reported in 1910 that hookworm was present in north Queensland, but added that it was not accompanied by the severe symptoms reported in the American South. The first involvement of the Rockefeller Foundation in Australia occurred in 1911 when the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease launched its survey of foreign countries. The Commission mapped a broad band of

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<sup>14</sup> On the model of tropical medicine see M.Worboys, "The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific Specialty" in G.Lemaine, R.MacLeod et al (eds.), *Perspectives on the Emergence of Scientific Disciplines* (The Hague: Mouton, 1976), 75-98; Report of the Royal Commission on the Sugar Industry, *CPP* 1912, III, 1048-9; J.S.C.Elkington, "Tropical Australia: is it Suitable for a Working White Race?", *CPP* 1905, II, 1389-96; "The White Man in the North", *Medical Journal of Australia* (16 April 1919), I, 315.

hookworm covering the tropical areas of the globe. All of Queensland was included as an affected area; the survey quoted McDonald that in the Johnstone River district infection was so severe that it "is sucking the heart's blood of the whole community".<sup>15</sup>

The first direct contacts with Australia were made in early 1914. During a visit to London to persuade the Colonial Office to assist the work of the International Sanitary Commission to the British Empire, Wickcliffe Rose met the Queensland Premier and won some interest, although no action was taken before the outbreak of war. When Heiser was appointed Far Eastern Director contact with Australia was placed in his hands. He was already acquainted with Dr J.H.L. Cumpston, the Commonwealth Director of Quarantine, and Dr Elkington. Both men had visited the Philippines during his tenure as Director of Public Health. One of his first moves was to consult with Elkington who was to become his principal adviser during the negotiations. In late 1915, in a private communication, Elkington urged that the Board should avoid the states and go directly to the Commonwealth, despite its lack of constitutional power or direct involvement in health services outside quarantine. He argued that co-operation with Cumpston, "a very keen and progressive man", would provide the best means to avoid interstate rivalries by strengthening public health work at the national level.<sup>16</sup>

In 1916 Heiser followed up this informal contact with a visit to Australia, Papua and Fiji. He visited health officials in Brisbane, Sydney and Melbourne, and prepared a survey of administration of all aspects of public health. His first visit to Cumpston at the Commonwealth Quarantine Service in Melbourne was inauspicious:

The whole question of our being serviceable in Australia is filled with difficulty. Jealousy between the individual states and between the states and the Federal power, and the Federal government's jealousy of the states, is one of the big stumbling blocks. The general hatred of large corporations on the part of the public and of the officials is another important factor. There is also a lurking suspicion that our work is a scheme to put Americans in charge of operations in foreign countries. Dr Cumpston does not see how anything can be accomplished by us in Australia. I suspect that he is planning in his mind a federal health department.<sup>17</sup>

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<sup>15</sup> "Report on a Tour of Inspection in Tropical Queensland by the Commissioner of Public Health", 22 October 1910. A/31738: QSA; Rockefeller Foundation Sanitary Commission for the Eradication of Hookworm Disease in Foreign Countries, *Hookworm Infection in Foreign Countries* (Washington, D.C.: Rockefeller Sanitary Commission, 1911); T.E. Macdonald, "Ankylostoma in Australia", *Lancet* (11 January 1908), I, 102.

<sup>16</sup> Michael Roe, *Nine Australian Progressives* (St Lucia: University of Queensland Press, 1984), 110; Elkington to Heiser, 11 October 1915, RF RG5/1.2/10/151: RAC.

<sup>17</sup> V. Heiser, Diary, 11 April 1916, RF RG12.1: RAC.

In advocating the co-operation of Australian governments in a hookworm eradication campaign Heiser did not dwell on the intrinsic threat of the disease, a position with which he felt uncomfortable, but on the by-products of an eradication campaign - public health education and the establishment of administrative machinery. By the end of his stay in Melbourne he had come to a close understanding with Cumpston, making the formation of a federal health department the main pre-condition of funding. There was a complex interweaving of local politics and the rigidities of a program drawn up in New York. The approach of health officials such as Cumpston was based on intelligent opportunism. They attached themselves to the new crusade not from any interest in hookworm but as the financial bait to lure the Commonwealth and states into extending their public health activities.<sup>18</sup>

Following these informal discussions, the Board made its offer of co-operation to the Australian Government in April 1916, offering experienced medical officers to survey the incidence of hookworm in Papua, German New Guinea and northern Australia, covering all the areas with a reported or potential hookworm problem.<sup>19</sup> It is apparent from Heiser's correspondence with his head office that the matter was left in his control. The offer was drafted with no reference back for approval until after it had been put to the Government. Heiser's motives were a mixture of hopes that an Australian campaign would ease the Board's access to other British areas of the Pacific and Asia as well as offering assistance to old colleagues such as Elkington, giving them the lever to increase the Commonwealth's activities in public health administration. For Heiser and the Board the Australian operations were a sideshow to the real work in India, Ceylon and Malaya, providing a safe training ground for survey teams and helping to improve access to other British possessions. When the first estimates of the cost of the Australian operations came through in late 1918, Heiser warned his field officers that:

The ultimate goal is the hope that a five years program would result in the creation and actual functioning of a central health department, after which we would withdraw altogether. Whether the hookworm route is the best to achieve this end is a matter upon which we should very much like to have your judgment...we believe that the proposition would scarcely be worthwhile unless there could be assurance of effective and continued co-operation between the states and the federal government. We are also wondering whether there is sufficient hookworm infection in Australia to warrant the large expenditure.<sup>20</sup>

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<sup>18</sup> *Ibid.*, 12 and 13 April 1916.

<sup>19</sup> Heiser to G.Pearce (Acting Prime Minister), 29 April 1916, RF RG1.2/31/482: RAC.

<sup>20</sup> Heiser to Waite, 19 November 1918, RF RG5/1.2/66/949A: RAC.

While the Australian officials showed a similar skepticism, they were eager to exploit the political opportunity to commit the Commonwealth government to a substantial responsibility for the nation's health. Elkington, who had entered the Commonwealth's Quarantine Service after despairing of progress under state administration, saw the only hope for the future of public health administration in a greater Commonwealth influence. He warned IHB officials that the Queensland government "would let the people rot before they would lift a hand to improve the health". As Cumpston argued in a letter to Heiser in mid-1919:

I feel a strong hunch that this is the opportunity that will only occur once in my career at least for putting public health where it should be in this country, and I mean to try all I can to get full value out of this chance. We here in Australia have been drivelling along on old-fashioned and effete lines and doing nothing real.

I want to take the stand that this is a chance to shew that public health means health, and that it is practicable for earnest and trained men to attack and control a disease. The major part will be solid education of the public...It will not do to work modestly even if efficiently, and the advertising and publicity must be such as will appeal to the Australian mind - which is as specialized a form of mentality as is seen in any other country in respect of publicity. More than even this publicity is the necessity for education of the governments and departmental officers...this next May there will be Federal elections, and there is going to be a real struggle. This time it will be between the two main forces - the workers who eat, and the capitalists who charge them extortionately for what they eat. This rude distinction will convey readily enough to you what the struggle will be. It is impossible for me to form any notion of what will develop in the way of general developments in health matters - but I am intending not to let the opportunity pass without an attempt to get either or both parties committed to a clear constructive policy of real public health. I just missed it over the influenza [epidemic] - unfortunately it fizzled out just one week too soon, but there is a strong feeling amongst the whole community of dissatisfaction with the way things are played at present, and the one side which comes out with a policy will secure public sympathy on at least that point. I am going to try in my own way to try to get both sides committed to a policy of some sort, and hope to secure a big scoop with my favourite ambition - to see every medical practitioner saddled with a definite responsibility for many functions in public health, and an orderly scheme of devolutionized [sic] local administration with paternal central supervision.<sup>21</sup>

The work of the Board in Australia commenced in 1917 with a survey of Papua by Dr J.H. Waite. Waite, joined by Dr Sylvester M. Lambert (formerly a medical officer with the United Fruit Company in Central America) then moved to north Queensland where they directed a survey from 1918. This was nominally under the

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<sup>21</sup> Elkington, quoted in J.H.Waite to Wickcliffe Rose, 7 October 1917, RF RG5/1.2/53/785: RAC; J.H.L. Cumpston to V. Heiser, 27 June 1919, RF RG5/1.2/81/1147: RAC.

direction of the Australian Institute of Tropical Medicine in Townsville. Dr Anton Breinl, its director, had carried out his own surveys before the war and shared the medical profession's skepticism about the severity of the problem. No medical politician, he appears to have reacted with some irritation. Waite complained bitterly that Breinl showed little or no interest in hookworm work.<sup>22</sup>

This helped to confirm the American dominance of the administration of the campaign. When a full-scale campaign was launched in late 1919, Dr Wilbur Sawyer, the IHB's new representative, was appointed Director. The Australian Hookworm Campaign was officially under the control of a committee based in Melbourne, with executive committees in each of the participating states to approve appointments, the staffing of medical units and financial transfers. In practice, all day-to-day operations were left in the hands of Sawyer at the campaign headquarters in Brisbane. At first all field medical survey units were also controlled by IHB doctors, but difficulties in obtaining suitable Americans led to the recruitment of three Australian doctors, recently demobilized from the armed forces.<sup>23</sup>

Given the administrative reform which the IHB demanded as a *quid pro quo* for its assistance, from the start there were conflicts over the IHB's preferred model of public health work. Borrowing from American experience, the IHB stressed the strengthening of local government health authorities. Cumpston and Elkington, with long and unhappy experiences of the failings of local administration, stressed a more centralized model. These differences were underscored by major disagreements in the philosophy of public health. In its early years the IHB was still heavily influenced by the ideas of the American public health reformer William Sedgwick, a member of the IHB until his death in 1922. Sedgwick stressed the interdependence of the more medical and engineering aspects of public health. In contrast to the narrowly laboratory and curative emphasis of much public health thinking since the acceptance of the germ-theory of disease, Sedgwick saw the engineer as the central figure of public health work. When the IHB insisted that the Commonwealth Department of Health must develop a Division of Sanitary Engineering, and nominated F.F. Longley, a former student of Sedgwick, as director

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<sup>22</sup> S.M.Lambert, *A Doctor in Paradise* (Melbourne: George Jaboor, 1942), 11-12; Australian Institute for Tropical Medicine, "Half Yearly Report to 31 December 1914", CPP (1914-17), V, 1091; Waite to Heiser, 1 June 1918, RF RG5/1.2/65/949: RAC.

<sup>23</sup> Australian Hookworm Campaign, Queensland Executive Committee, Minutes, 4 December 1919, Sawyer to Heiser, 3 November 1919, RF RG5/1.2/82/1153: RAC.

until an Australian could be trained in the United States, Cumpston did all in his power to prevaricate.<sup>24</sup>

The survey methods of the hookworm campaign were directly copied from IHB practices in other countries. Methods developed by Dr Hector Howard in British Guiana, in 1914 became the basis of the IHB campaign elsewhere. A strong emphasis was placed on health education, "Virtually every difficulty, however, may be rightly attributed to one cause: lack of proper co-operation on the part of the people who are to be most benefited". Howard's "intensive method" involved the selection of a limited geographical area in which an attempt was made to locate, map and treat all affected individuals. The IHB was to provide fieldwork teams and finance to carry out this work. The development of effective methods to prevent reinfection, through improved sanitary administration and public education was to be the proper role for the participating government. These two stages corresponded to diagnosis and cure, the destruction of the worms, followed by improved sanitation to prevent the ova reaching the soil and reinfesting the population.<sup>25</sup>

There were several major problems associated with the intensive method, all of which followed from a misunderstanding of the epidemiology of hookworm. First, the early epidemiology used the percentage of the population infested as the measure of the seriousness of the problem, instead of the average number of worms. This helped to exaggerate the dimensions of the clinical problem by including those with very low worm counts and few symptoms (although potential carriers). This compounded a failure to recognize the existence of an equilibrium of community infestation, determined by factors such as climate, soil, rainfall, vegetation and race. Even where the presence of hookworms had been demonstrated, very specific environmental conditions were required before this could develop into a major health problem. Similarly, if all sources of infection were not eliminated, the elimination of worms in a population, by disturbing this equilibrium, was often followed by an immediate increase in the rate of infestation until it returned to the former equilibrium point. The more thorough the clinical treatment, the more rapid the return to the original rate of infestation. This approach led to a characteristic over-estimation of the physical and social ill-effects of relatively minor levels of

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<sup>24</sup> E.O.Jordan, G.C.Whipple and C-E.A.Winslow, *A Pioneer of Public Health: William Thompson Sedgwick* (New Haven: Yale University Press, 1924); Sawyer to Heiser, 30 December 1919, RF RG5/1.2/82/1153: RAC. Dr Cumpston's reluctance was an aspect of his general caution about intruding into areas of state responsibility. Such jurisdictional conflicts had the potential to disrupt the entire programme of the new department.

<sup>25</sup> H.H. Howard, *The Control of Hookworm Disease by the Intensive Method* (New York: International Health Board, 1919); L.Hackett, "Notes on the History of the International Health Board", chapter 5, 47, RF RG3/908/5/32: RAC.

infestation, followed by frustration at the inability to achieve the over-optimistic goal of eradication.<sup>26</sup>

Although the main work of the Campaign was in Queensland, it was clear from the start that it was primarily a joint Commonwealth/IHB exercise. Cumpston was able to steer it to strengthen his view of the future department - the development of a Commonwealth Department of Health with responsibility for public health administration at a national level. The execution of policy would remain in the hands of the states and local government. A condition of the IHB grant embodied this program. A satisfactory Federal Department must be established with divisions covering areas approved by the IHB and initially headed by officers seconded from the Rockefeller Foundation while Australians were trained in the US on Rockefeller Foundation fellowships.<sup>27</sup>

These objectives involved a radical shift in the structure of public health administration. Hitherto the Commonwealth had possessed minimal powers, merely a quarantine power which was contested by the states until the debacle of the 1919 influenza epidemic led to a strengthened Quarantine Act which enabled the Commonwealth to override all conflicting powers. At a state level departments of public health had considerable achievements in the control of infectious disease, particularly typhoid in the capital cities, but remained understaffed, short of funds and suffering from the low esteem in which public health work was held by the medical profession. In most states, including Queensland, the day-to-day work (see chapter 12) was in the reluctant hands of local government. Only the largest cities employed full-time medical officers of health; the practical work in sanitary inspection was carried out by ill-trained inspectors. In north Queensland public health administration was vestigial. The state department had no regional office north of Brisbane and relied on local authorities. Shortly before his resignation from the state's service, Elkington warned his political superiors that "I must now request to be absolved from responsibility for the effective control of any considerable epidemic occurring there until a northern staff is established".<sup>28</sup>

This gave the hookworm campaign one initial advantage. Despite its political suspicions of the Rockefeller name, the Queensland government was only too glad to shed some of the financial burden of public health, so initially gave the

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<sup>26</sup> L.Hackett, "Notes", vol.1, 137-40, RF RG3/908/3/19: RAC.

<sup>27</sup> This national outlook included surveys for hookworm in all states - including Victoria and Tasmania where there had been no suggestions of a problem. Australian Hookworm Campaign, *Reports of Surveys, Victoria, 23 September to 8 December 1920* (Brisbane: AHC, 1920); *Tasmania, 20 December to 28 February 1921* (Brisbane: AHC, 1921).

<sup>28</sup> "Establishment of a Northern Sub-Office and Staff at Townsville", 7 August 1911, A/31738: QSA.

Commonwealth a relatively free hand. However, intergovernmental jealousies persisted not least because the Queensland Labor government of T.J. Ryan was in open conflict with Hughes' renegade Labor-Nationalists. States rights arguments received a blow from the incompetence and parochialism of the state response to the influenza epidemic in 1918, but continued to play a large part in suspicion of the Commonwealth's ultimate intentions. For otherwise sympathetic Queensland civil servants, such as the Under-Secretary for Home Affairs, Charles Chuter, the Commonwealth had a limited but legitimate role in quarantine and research - which was how he defined the hookworm campaign. Beyond that, all authority must remain in state and local government hands, "any other control would be a return to bureaucracy".<sup>29</sup> Consequently, the centralizing ambitions of the Commonwealth met suspicion from the start. When Waite began work in Queensland in October 1917 he found the doors of the Premier's Office closed to him and was only granted a four minute audience with the Home Secretary as he walked from his office to Parliament House. In the political instability of Queensland politics in late 1917 Waite gained some leverage with the Cabinet by threatening to take his story to the press, but at the cost of a severe reprimand from New York for interfering in local politics.<sup>30</sup>

Elsewhere in the state bureaucracy there was a more receptive reaction. The Department of Public Instruction, anxious to expand its school health inspection service and led by an energetic medical officer, Dr St Vincent Welch, offered school nurses for survey work. Working with Waite, Irene Neilson, a DPI nurse, organized a study of Queensland school children in the Cairns, Innisfail and Ingham areas. At the same time the Queensland branch of the British Medical Association gave strong support.<sup>31</sup> After the completion of the initial survey work, the campaign proper commenced in October 1919 with a budget of £100,000, drawn equally from the IHB, the Commonwealth and the States (in effect Queensland and, to a lesser extent, New South Wales). The program was to run for five years after which the states and the Commonwealth would take over the full cost and administration.

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<sup>29</sup> C.E.Chuter, "Local Authority and Health" [1921?], A/27281: QSA.

<sup>30</sup> Waite to Heiser, 17 October 1917, Heiser to Waite, 22 November 1917, RF RG5/1.2/53/785: RAC; compare the extraordinary account of the hookworm campaign by a recent Queensland Director-General of Health who describes the Hookworm Campaign as an initiative of the Queensland government, and manages to leave out the role of the Commonwealth altogether: R.Patrick, *A History of Health and Medicine in Queensland 1824-1960* (St Lucia: University of Queensland Press, 1987) 250-1.

<sup>31</sup> J.H. Waite and I.L. Neilson, "A Study of the Effects of Hookworm Infection upon the Mental Development of North Queensland Schoolchildren", *Medical Journal of Australia* (4 January 1919), I, 1-8; "A Health Problem and its Solution", *Ibid.*, (16 November 1918), II, 411-2.

Much of the early work of the campaign can only be described as propaganda, to raise public awareness (and fear) of the effects of hookworm. The early public statements and reports slid over two features of hookworm in North Queensland which had been noted by earlier researchers and were confirmed when the main survey work was underway. Dr Philip Maplestone, who resigned as acting director of the AITM in 1919, doubted the usefulness of the medical approach, declaring that the Australian tropics had little or no serious disease, "let the advocates of medical research...cease for a time at any rate from trying to make poor tropical Australia appear a hotbed of dread diseases for the purpose of trying to stimulate into ineffectual life a moribund institution".<sup>32</sup>

This skepticism stemmed from several of the features of epidemiology of hookworm in Queensland, aspects which were recognized but not publicized until the political support for the Commonwealth Department of Health was assured. Infection in North Queensland was localized to areas with a rainfall greater than 40 inches a year, sandy soils and warm climate. The disease was practically non-existent in other areas. Rather than a scourge crippling the entire population of the north, it was confined, in its more severe occurrences to narrow coastal pockets. In the drier zones, such as Townsville, there was little sign of infection outside institutions such as mental asylums and orphanages. The source was usually traced to a recent arrival from an affected area. This localized incidence was noted from a very early stage. Waite's first survey of 10,000 people along the coast from Cooktown to Townsville, carried out during the dry season of 1918, noted this unevenness, with heavy infestation confined to very small areas.<sup>33</sup>

The second major feature of hookworm was that even within affected areas, cases were limited to a few, admittedly significant, sections of the community. In the white population hookworm disease was primarily a disease of childhood, mainly because of the habit of going barefoot. In the adult population it was an occupational disease affecting workers such as cane cutters who were likely to work in susceptible climates and suffer cuts and grazes allowing entry of the worms to the bloodstream. Rates of infestation amongst miners, particularly in the coalfields

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<sup>32</sup> Most of this early propaganda appeared in newspapers and pamphlets published in affected areas, see *Hookworm Disease or "Bloodsuckers" or Earth-eating Disease* (Cairns: Cairns Post Print, 1919); *Medical Journal of Australia* (29 April 1922), I, 477.

<sup>33</sup> W.A.Sawyer and W.C.Sweet, Australian Hookworm Campaign, Survey Report 30, *The Investigation and Control of Hookworm at the Hospital for the Insane at Sandy Gallop, Queensland, 16 August to 31 December 1922* (Brisbane, AHC: 1923); Sawyer, Sweet and A.Eland Shaw, "Institutional Hookworm Disease in a Non-Endemic Region", *Journal of Hygiene*, XXII (1) (1923), 77-88; J.H.Waite, *Relief and Control of Hookworm Disease in Queensland, Australia from April 17 to August 28 1918* (New York: IHB, October 1918).

at Ipswich and Burrum, were quite severe, an incidence which was closely linked to the absence of sanitary facilities. The final peculiarity of hookworm in Australia was that, of those affected, almost all were at a very mild level, not enough for external symptoms to show. The detailed surveys revealed nothing resembling the mass physical degeneracy pictured by the early researchers. In 1923, N.B. Charlton, the parasitologist at the AITM, echoed Breinl's earlier skepticism, noting the "average low number of worms harboured is in conformity with the infrequency of obvious clinical signs and symptoms". The instances of heavy infection were mainly found within Aboriginal settlements, in northern New South Wales as well as Queensland. These were closely linked to the restriction of traditional migratory patterns, coupled with total failure to provide sanitation.<sup>34</sup> Early statements from the Campaign aimed more to stir up public and political support than to reflect the limits of the problem in Australia. The survey of school children carried out by Waite and Neilson included a lurid warning that:

The direct outcome of the results of such a blighting disease, which is preying upon 40% of the total school population from Cooktown to Townsville, and which is stamping serious mental, physical and sexual degeneracy upon 25% of the total school population, can be nothing other than the weakening of the social fabric and the unfitting of the coming generation for the struggle for existence. Indeed, the tendency of the disease, if not controlled, is toward the obliteration of the race through the unsexing of its victims and reducing individual resistance toward acute infections, such as pneumonia and tuberculosis. To the economic loss from social inefficiency must be added the wasted educational effort of 4,000 teachers with an expensive plant, trying to carry along 40% of relative mental deficient and mental laggards in their classes. Fortunately, the disease, with all its effects, can be prevented through applied sanitation, and the infected children can be cured with resulting physical and mental recuperation, provided the disease has not through prolonged duration indelibly stamped its degeneracy upon the bodies of its victims.<sup>35</sup>

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<sup>34</sup> W.A. Sawyer, "Hookworm Disease as Related to Industry in Australia", *American Journal of Tropical Medicine*, III (1923), 159-76; N.B. Charlton, "Bowel Parasites of Australia and Her Dependencies. Their Relation to Disease and Their Frequency of Occurrence", *Transactions, Australasian Medical Congress, First Session* (Sydney, 1924), 325; W.A. Sawyer and A. Ping, Australian Hookworm Campaign, Survey Report 17, *An Investigation of Hookworm Disease at the Barambah Aboriginal Settlement and in Murgon Shire, Queensland, 18 May 1920 to 28 June 1921* (Brisbane: AHC, 1921); G.A. Murray and A.J. Metcalfe, Australian Hookworm Campaign, Survey Report No. 29, *The Incidence of Hookworm Disease in the Thursday Island District of North Queensland, 4 May 1920 to 5 August 1922* (Brisbane: AHC, 1922).

<sup>35</sup> Waite and Neilson, *op. cit.*, 4-5.

Waite's successor as IHB director in Australia, the ebullient Sylvester Lambert, made even more colourful predictions of disaster, arguing that along the North Queensland coast 23 per cent of the population were seriously affected, "if it is left to run for a few more generations [this] will mean a race of comparative imbeciles and physical degenerates instead of a dominant white race in the north". This rhetoric was toned down when the Queensland government threatened to withdraw its support from the campaign on the grounds that it was scaring away potential migrants.<sup>36</sup> Press campaigns, however, continued to play a major part in the campaign. As Raphael Cilento, Sawyer's successor as Director of the Hookworm Campaign, noted of a particularly lurid article in *Smith's Weekly* in 1923 with the title "Earth Eaters of Queensland", "while the facts are, strictly speaking, inaccurate, they are set out in a sensational manner and may be useful".<sup>37</sup>

The procedure followed by the campaign again following the preferred model set out by the IHB, was to introduce the issue with an intensive press campaign on the horrors of hookworm and the ease of eradication, in the hope of winning complete local co-operation. This would be followed by survey work. A team of microscopists would move into the area and attempt to survey all families, while a DPI nurse would organize a school survey. This would be followed by the treatment of infected cases, with a follow-up after two weeks to ensure the treatment had been effective. Finally, to ensure that the disease did not return, all unsanitary premises would be reported to the local councils which would order repair and improve its night soil collection system.<sup>38</sup>

Despite periodic deputations of aggrieved citizens complaining about the smear on the good name of their towns, there was remarkably little public resistance. Opposition tended to come from areas with low or negligible infection rates and where the labour movement was strong and objected to the attempt to put both the blame and the cost onto individuals. For example, commenting on the active public resistance to the Hookworm Campaign in Townsville (a low infection area), Dr Henry Hastings Willis, one of the Australians heading a campaign medical unit, noted that:

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<sup>36</sup> *The Argus*, 15 April 1919, *The (Melbourne) Herald*, 26 April 1919; T.J.Ryan to W.M.Hughes, 4 September 1919, Hughes to Ryan, 11 October 1919, CRS A458/D368/4: AA (Canberra).

<sup>37</sup> The article had suggested that those affected with hookworm "dropped to the level of little more than a feeding, breathing and breeding animal", H.C.McKay, "Earth Eaters of Queensland", *Smith's Weekly*, 16 June 1923; R.W. Cilento to Elkington, 25 June 1923, CRS SP1061/1/195: AA (Sydney).

<sup>38</sup> W.A.Sawyer, "Teamwork in Sanitation", *Medical Journal of Australia* (9 April 1921), I, 286; Australian Hookworm Campaign Memo No.3, *Memorandum on Methods of Working and Reporting* (Brisbane: AHC, 1919).

The advocacy of sanitary improvement did not help the work and perhaps some passive opposition experienced in certain quarters was due to this cause. The difficulty of making ends meet in a family whose breadwinner must perforce be unemployed for long periods - especially in the summer months - as the result of industrial strife, caused mothers to be irritated by a request to supply specimens from their family for examination.<sup>39</sup>

In some inland rural areas, by contrast, there was a major grievance that their community health was not given the same attention as the high risk coastal areas. Waite complained that after completing his survey of Cairns in mid-1918 there were loud protests from the bush settlements of the hinterland that they were being neglected, a public uproar that could only be quieted by performing a hasty survey. He noted with asperity:

It is difficult to describe the mental attitude of the Australian bushman but above all things he is gifted in a very narrow viewpoint, restricted to the small locality in which he lives...Consequently, he claims the right to receive the benefit of any and all state undertakings just as the more favored seaport towns.<sup>40</sup>

### Results of the Campaign in North Queensland

In 1924, after five years of intensive work, the IHB withdrew as planned and Australian officials assessed the results and future. As early as 1919 the hopes of eliminating the disease had fallen. The word "eradication" was quietly dropped from the title and replaced with "control". The central weakness of the campaign, identified from the beginning in internal evaluations, was the absence of political machinery to achieve a lasting solution. Given that the formation of permanent administrative structures had always been a central objective of the IHB, this was a serious failing. In the areas of higher infection, follow-up visits found little or no improvement, the small progress which had been achieved in Cardwell had been "obtained by educational and persuasive methods, and it will be noted how little improvement is to be expected from the employment of these methods alone in an Australian community".<sup>41</sup> Similarly, a re-examination in Proserpine which, with an annual rainfall of 75 inches, had been one of the worst affected areas, found that the "splendid public co-operation" experienced when the team visited in 1920 had

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<sup>39</sup> H. Hastings Willis, Completed Area Report No.6, *The Control of Hookworm Disease in the Townsville District, Queensland, April 16 1920 to 30 June 1921* (Brisbane: AHC, 1921).

<sup>40</sup> J.H. Waite, "Preliminary Report of the Completed Cairns Survey", Memo to Dr Heiser, 1 June 1918, RF RG5/2/39/231: RAC.

<sup>41</sup> Sawyer to Heiser, 30 December 1919, RF RG5/1.2/82/1153: RAC; Australian Hookworm Campaign, Report No.8, *Cardwell, 25 August, 1920 to 31 October, 1920* (Brisbane: AHC, 1920) 62.

not been sufficient to win lasting results. "Although the enthusiasm might wax strong while the campaign was in the district, when we moved on to another district the work almost ceased until we returned".<sup>42</sup>

Sawyer remained critical of the failure of Commonwealth, state and local governments to force improvements in sanitation, leaving the campaign to deal with the symptoms rather than the cause of infestation. In the immediate wake of the appearance of the campaign in their area some Shire Councils appointed full-time sanitary inspectors. Nambour, north of Brisbane, was typical of the half-heartedness of local authorities, reluctantly appointing a full-time inspector after pressure from the state Public Health Department, but abolishing his position as an economy measure after only six months. The normal procedure adopted by the campaign was to report all sanitary problems to the state authorities who then ordered the errant local authority to remedy the problems. Here the campaign struck its main obstacles. The common response by councillors, who were often the main offenders, was to "draw down abuse and offensive comment" on the head of the medical unit of the campaign. Even where resistance was covert, administrative obstacles could be insuperable, "the Health Officer (MOH) has his own practice, is not particularly interested in hookworm and with rare exceptions all health work is left to the Health Inspector who is already overworked".<sup>43</sup>

These problems were reflected in disappointing results when areas were re-surveyed. When the campaign first surveyed Ingham in 1920 it found an infestation rate of 13.6 per cent: three years later this had returned to 13 per cent. The doctor in charge of the campaign's medical unit complained:

...it is useless for us to continue to work here, if conditions like this prevail. They are such a stupid, scared crowd of jelly spines that they do not realise that they are cutting off their noses to spite their faces.<sup>44</sup>

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<sup>42</sup> S.M. Lambert, Australian Hookworm Campaign, Completed Area Report No.1, *The Control of Hookworm Disease in the Bowen District, Queensland: Report of Intensive Campaign October 27 1919 to April 17, 1920* (Brisbane: AHC, 1920), 19.

<sup>43</sup> Sawyer to Cumpston, 5 February 1923, RF RG5/12/166/2146: RAC; W.A. Sawyer, "Hookworm Disease in Relation to the Medical Profession and the Individuals", *Health*, 1(1923), 11-12; "Summary of Hookworm Campaign Work, 1 October 1924-31 May 1926", CRS SP1061/350: AA (Sydney); Elkington to Cumpston, 14 August, 19 January 1925, CRS A1928/495/13: AA (Canberra); F.F. Longley, "Some Defects in Country Health Administration and a Practical Remedy", *Transactions, Australasian Medical Congress, First Session* (Sydney, 1924), 327-32.

<sup>44</sup> R.E. Richards (medical officer in charge, unit 4 of Hookworm Campaign) to Cilento, 19 April 1923, SP1061/1/222: AA (Sydney).

By 1925, with the end of the direct involvement of the IHB, Elkington suggested that its achievements had been "at best, vague". Few lasting improvements of sanitation had been accomplished and the survey of malaria and filaria had become a "mere pretence". "The whole system, in fact, was at the time of transfer getting very near to becoming fixed in a groove of routine".<sup>45</sup> A further assessment in 1927 placed the blame on the uncritical adoption of the American model and a failure to generalize from Australian epidemiological data. Unlike the American South, in Queensland hookworm was not a problem of the whole community but of narrow groups, hence the mass survey method had led to "an unjustifiable diversion of public money". A major survey of tropical diseases in northern Australia by Cilento and other Commonwealth officers, while pointing to hookworm as the only serious helminthic disease of the Australian tropics, noted that it was common but rarely as a "disease", more usually as an "infection", and that it was "exceedingly rare" in areas with less than 50 inches of rainfall. Furthermore, "as a rule, the number of worms harbored is exceedingly small...few serious cases come under the observation of the general practitioner as a rule".<sup>46</sup>

Given this skepticism the attempts by Raphael Cilento to revive the program in 1928 call for some comment. After taking over as director of the Commonwealth Department's Tropical Hygiene Division from a disillusioned Elkington, Cilento, like his predecessor, appears to have seen the joint project as the best means for asserting a Commonwealth role in health policy. The Queensland government took a similar attitude, seeing the campaign as a renewed attempt to annex its responsibilities. James Stopford, the Home Secretary, opposed continuation as he did not trust Dr Cumpston and...he considered the scheme to be nothing more than an attempt on the part of Dr Cumpston to carry into effect what he had for a long while intended, namely, the control of the health services of Queensland...He continued to insist that the whole question was one of control, and not related to the treatment of the disease.<sup>47</sup>

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<sup>45</sup> Elkington to A.Baldwin, 10 May 1927, CRS SP1061/1/62/1: AA (Sydney); Elkington to Cumpston, 14 August 1925, CRS A1928/495/11: AA (Canberra).

<sup>46</sup> R.W.Cilento, R.D.McIntosh and N.B.Charlton, "The Diagnosis of Bowel Diseases in Northern Australia", in *Commonwealth Department of Health Service Publications (Tropical Division), No.5* (1924), 14-17. Later surveys continued this line of argument. In 1928 Baldwin found that hookworm in the Australian tropics was "prevalent, but seldom actually in the form of a disease", see A.H.Baldwin, "Life in the Queensland Tropics: Suitability for Whites", *Queensland Geographical Journal*, XLIV (1928), 10; A.Chandler, *Hookworm Disease, its Distribution, Biology, Epidemiology, Pathology, Diagnosis, Treatment and Control* (London: Macmillan, 1929), 53-4.

<sup>47</sup> Cilento to Cumpston, 24 July 1928, CRS A1928 495/26/sect. 2: AA (Canberra).

The dispute centred on the Commonwealth Department of Health's preference that responsibility for the enforcement of public health measures should be centralized at state level. This would require a greatly strengthened (and more expensive) public health department to administer a general policy laid down by the Commonwealth. The only alternative appeared to be persistence with the discredited policy of reliance on local government. As with the original administrative arrangements of 1919, the medical issues of hookworm control became lost in the clash of political ambitions. The Commonwealth Department (in the persons of both Cumpston and Cilento, now its Queensland director) took the place of the Rockefeller Foundation, withholding its subsidy until administrative arrangements were altered to its satisfaction. Queensland public health officials co-operated with Cilento to set conditions on the Commonwealth's offer of funding, to impose their own plans on their reluctant Minister.<sup>48</sup>

This conflict was compounded by the hostility of Queensland Labor governments to the medical profession. Only with the election of the conservative Moore government in mid-1929 was the impasse broken. The new Commonwealth scheme embodied Cumpston's more general objectives for Commonwealth health administration, "the aim has been to arrive at local programmes as nearly as possible identical, but all including, as a postulate, that ultimate control of policy by the Commonwealth which is essential for success". The onset of the Great Depression and the near abolition of the Commonwealth department in 1932 meant that by the mid-1930s the last vestiges of the campaign had been wound up. Although Cilento, as Director-General of Health in Queensland from 1934, stimulated some activities, these were never on the scale of the Rockefeller campaign. Instead the small incidence of hookworm in the white population continued to decline with improved sanitation.<sup>49</sup>

### Hookworm Disease as an Aboriginal Disease

The political and racial determinants of the hookworm campaign were nowhere more apparent than in its work with Aboriginal populations. Although the early surveys examined infestation amongst Aborigines, they remained within the general framework of tropical medicine. Aboriginal hookworm disease was viewed as a

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<sup>48</sup> Again, the Department of Public Instruction's medical officers were more open to Commonwealth involvement. Dr St Vincent Welch wrote to Cumpston to thank him for his pressure on the state government. See CRS A1928/495/26/52, 28 August 1928: AA (ACT).

<sup>49</sup> Cilento to Cumpston, 29 August 1929: CRS A1928/495/26/pt3: AA (ACT); Patrick, *op. cit.*, 250-1; the conflict between local government and central control, represented respectively by Chuter and Cilento, continued through the 1930s, Cilento to E.M.Hanlon, 21 July; C.E.Chuter to Hanlon, 7 August 1936: A/31717, QSA.

reservoir of infection threatening the white population, not as a problem in its own right.<sup>50</sup>

If the surveys had revealed generally low levels of infection for the white population, for Aborigines the proportions were reversed. At the Aboriginal settlement at Yarrabah in 1918 Waite found a 100 per cent infection rate. A 1921 survey of the Aboriginal settlement of Palm Island found over 75 per cent infected. More importantly, worm counts were high. The few genuine Australian examples of hookworm disease were in Aboriginal populations. Nor was it merely a problem of the frontier of north Queensland. A survey of the Northern Rivers district of northern NSW found almost 60 per cent infection rates, most of these Aborigines living in settlements such as Purfleet near Taree, where all children of school age suffered. These surveys treated infestation amongst Aborigines as the source of white infection, although one which was difficult to remedy as they were almost impossible to treat. The IHB teams sent back frequent complaints of the reluctance of Aborigines to have contact with whites. In the Cardwell area they were "hunted by the police who seek to remove them to Palm Island". Their receptiveness to treatment was not increased as the Campaign used annual blanket days, organized by local police, to administer mass treatment.<sup>51</sup>

These problems were posed even more clearly in the Northern Territory. When the first survey of the Territory was completed in 1922 little infestation was found amongst whites: the only serious problems existed in the Aboriginal population around Darwin. A rudimentary attempt was made to treat the sufferers, performed rather reluctantly by Commonwealth quarantine officers under instructions from Elkington in Brisbane. Three years later a follow-up survey found no progress had been made "by reason of the objection of natives to take the necessary medicine".<sup>52</sup>

During this brief flurry of interest several administrative solutions were canvassed. Complete segregation of the Aboriginal population was quickly rejected because of objections from their white employers. Proposals for more drastic measures of compulsory treatment were rejected by the Administrator as he "was

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<sup>50</sup> Lambert to Heiser, 22 February 1919, RF RG5/1.2/8/1150: RAC.

<sup>51</sup> Waite to Heiser, 28 September 1919, RF RG5/1.2/66/949A: RAC; H. Hastings Willis, Supplement to Completed Area Report no.7: Ingham, *An Investigation into the Incidence of Hookworm Infestation at the Aboriginal Settlement at Palm Island, December 1921* (Brisbane: AHC, 1922); Australian Hookworm Campaign, Report No.8, *Cardwell, August 25 1920 to October 31 1920* (Brisbane: AHC, 1920); Lambert to Heiser, 21 March 1919, 18 April 1919, RF RG5/1.2/81/1150: RAC.

<sup>52</sup> A. Baldwin and L.E. Cooling, *An Investigation into Hookworm Disease, Malaria and Filariasis in the Northern Territory, 21 March to 6 July 1922* (Brisbane: AHC, 1922); Elkington to Cumpston 12 August 1922, 20 March 1923, CRS A1928/495/21: AA (Canberra).

afraid that aboriginals would ignore the regulations and he suggested that before compulsion was attempted which might demonstrate to the aboriginal the weakness of the whiteman" an incentive payment of one shilling per treatment should be offered. The cost of this would be reasonable when compared with the alternative of a "wired in segregation camp" which would have the additional disadvantage of keeping Aboriginals "in idleness for a month at a time". Instead, the Treasury in Melbourne approved the cheaper, more dangerous and probably ineffective method of "mass treatment" at various coastal points every six months. No attempt was made to evaluate this treatment and in 1927 an attempt by Cecil Cook, the Darwin quarantine officer, to interest the Commonwealth Department of Health in a follow-up campaign drew the reply from Elkington:

Hookworm is not apparently a definite menace to white people in the Northern Territory, and the problem presented by it in New South Wales and Queensland will require all available funds and staff for a considerable time.<sup>53</sup>

As in Queensland, there was a major change when Cilento replaced Elkington as Director of the Division of Tropical Hygiene in 1927. The Aboriginal hookworm problem became another stake in his moves to increase the administrative importance of his Department and he treated the revival of the joint Commonwealth/state hookworm campaign, under his own direction, as a major priority. To justify this policy, Cilento returned to the analysis of endemic hookworm infestation which was associated with tropical medicine. The persistence of the disease was explained as the result of the survival of reservoirs of infection in the Aboriginal population, and the reinfection of treated areas by wandering Aborigines. (The Campaign's own survey found that the problem was worst on the compulsory settlements.) Pointing to the problems state authorities faced in regulating Aboriginal wanderings across state borders, in particular that of Queensland and New South Wales, the Commonwealth Department of Health should assume responsibility for Aboriginal health with a revived hookworm campaign. Although the campaign was temporarily revived under Cilento's direction, it was never given the resources of the IHB campaign and, again, it relied heavily on the use of local police in survey and treatment work. The remnants of the campaign were transferred to the Queensland government in 1932.<sup>54</sup>

This did not end Cilento's interest in the issue. In 1933, on secondment from the Commonwealth, he completed a major survey of Aboriginal health for the

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<sup>53</sup> Cumpston to Elkington, 20 March 1923, Elkington to Cumpston, 16 May 1923; Cook to Elkington, 6 July 1927, Elkington to Cook, 18 August 1927, CRS A1928/495/21: AA (Canberra).

<sup>54</sup> Cilento, Memo, 23 August 1929, CRS A1928/495/26/Pt3: AA (Canberra); Constable J.V.Dowd, Cairns District, Cardwell Station, Report, 29 October 1932, POL/J50/1516M: QSA.

Queensland Government. This unpublished report provides one of the most forceful expressions of the tropical medicine approach applied to Australian Aborigines. After outlining the prevalence of leprosy, yaws and hookworm infestation, he concluded that Queensland Aboriginal populations, particularly those able to wander freely, provided a major threat to public health and called for confinement in closely supervised settlements such as Palm Island.<sup>55</sup>

### Conclusion

The hookworm campaign in Australia was dominated by political considerations from the start. Few saw it as a major priority until the offer of funding provided Australian health officials with a lever to achieve other, essentially unrelated goals. In 1932 Cumpston summed up the achievements with the bland judgement that it: ...presents a very excellent example of a major public health problem, threatening at the outset to become a serious economic burden, being successfully and efficiently attacked by joint effort on the part of the Governments concerned and their officers and being transformed from a somewhat indefinite and menacing problem to a matter of routine entirely subject to control if measures already proved efficacious are maintained in their entirety.<sup>56</sup>

While this exaggerated both the extent of the initial problem and the success of the campaign it pointed to its most lasting influence on Australian public health administration. Even allowing for its lack of constitutional powers, the Commonwealth Department remained remarkably unadventurous in questions of the finance and control of health services. During the interwar years the two attempts by Commonwealth governments to establish national health insurance were ignored or quietly opposed by Cumpston and the Commonwealth Department. This account has stressed the manner in which the IHB's definition of public health priorities and methods were redefined in the Australian context to advance quite distinct political and administrative projects. These, however, shared the model of public health advanced by the IHB; a model which saw the development of public health not as a question of social welfare, but as an administrative problem, the development of efficient administrative hierarchies to translate the results of scientific research into practical action.

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<sup>55</sup> "Report to the Queensland Home Secretary", April 1933, CRS A1928/4/5: AA (Canberra).

<sup>56</sup> "The Reorganization of the Department", 20 May 1932, CRS J367/55/1/24: AA (Brisbane).

## JOHN GUNTHER AND MEDICINE IN PAPUA NEW GUINEA

James Griffin

A trivial but well-publicised incident on 18 April 1944 symbolically separates pre-war from post-war colonialism in Papua New Guinea. An army work-boat carrying Australian officials grounded in shallow waters 100 metres from the beach at Papa village, west of Port Moresby. Village men came out and linked hands so that Major-General Morris could sit on them and not wet his dungarees. A civilian in a lounge suit, no tie and a jaunty solar topee was then approached - a rugged six-footer with round glasses and a nose dented from boxing. When villagers bent to hoist him over the water, he shouted "No! No!", pulled off his shoes and socks, rolled up his trousers and waded ashore. The Royal Papuan Constabulary guard snapped to attention and villagers, hibiscus in their hair, gazed in puzzlement as the Hon. "Eddie" Ward, Minister for External Territories and Transport, and most pugnacious member of the Labor Government's socialist wing, squatted in the sand to put his footwear on. A press photograph of Ward bare-shinned, with arms akimbo, grinning at the sights, caused a furore among the "B4s" (i.e. pre-war colonial residents of PNG) and their spokesmen. *The Pacific Islands Monthly* was aghast: "A minister who arrives like a sandboy pursuing worms must not be unhappy if he is regarded by scornful fuzzy-wuzzies as 'something-nothing'".

Stories were deliberately circulated that local people now called the Minister "kanaka bilong Sydney" and "mista nambawan pissim pants". Ward replied that Australians did not need such colonial practices: "the chap who thinks it necessary probably thinks we ought to use a stockwhip to display our superiority".<sup>1</sup>

Soon afterwards, Ward proclaimed that Australians owed Papua New Guineans a "debt of gratitude" for their cooperation in defeating the Japanese. This would involve giving them a greater share in their country's wealth, abolishing the indentured labour system, establishing better health and education services and, eventually, allowing them some say in their own government. When the war ended wages were increased, existing labour contracts cancelled, hours of work reduced and an enlightened Administrator, Colonel J.K. Murray, appointed, who insisted that "the interests of the native people are paramount" (and was dubbed "Kanaka Jack"

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<sup>1</sup> E. Spratt, *Eddie Ward: Firebrand of East Sydney* (Adelaide: Rigby, 1965), 142-45; *Pacific Islands Monthly*, xiv (May 1944), 5-7.

for entertaining "natives" at Government House). Pre-war, the Mandated Territory of New Guinea had supported itself (through gold-mining) and Papua had a subvention of £42,500; after the war the Australian grant to the combined administration rose to three million by 1948-49, and each year of the provisional administration (1945-49) a small surplus was recorded.<sup>2</sup> There was no budget control and departmental heads were able to spend money as they chose.<sup>3</sup> Ward was utterly absorbed by his other portfolio, Transport, and his ambition to become Prime Minister or, at least, deputy. He provided no plan for reconstruction and development in PNG; the changes that did occur were conceived and promoted by the Australian Army think-tank, the Directorate of Research and Civil Affairs.<sup>4</sup> Ward did little to activate his inert department, and he failed to give the Territory administration the power to set its own priorities and implement them. He held office until 1949, but did not visit the colony again.

Not until (Sir) Paul Hasluck became Minister in May 1951 did an Australian minister assume a responsible supervisory role over the administration of PNG. Hasluck, who relished the description "non-conformist...Inspector-General" aptly pinned on him by Couve de Murville,<sup>5</sup> was appalled by what he found six years after the war. Port Moresby was ramshackle, Rabaul still a shambles, and Lae hardly a town at all. He thought Colonel Murray dispirited, the Administration slack and indecisive, the European settlers racist and demanding.<sup>6</sup> In the crucial department of Education, the director had neither formulated a coherent policy nor taken ad hoc measures to put pupils in desks. Hasluck had to listen to the director's "enthusiasms about visual aids...Oxford readers prepared for African countries...seminars and wall charts and UNESCO pamphlets". He wanted instead a "carefully prepared scheme for more schools and many teachers" and "a bigger bid for education in the estimates".<sup>7</sup>

There was, however, one luminous area in the Administration: the Department of Health. Hasluck had been forewarned in Canberra that its Director was "difficult

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<sup>2</sup> J. Griffin, H. Nelson and S. Firth, *Papua New Guinea: a Political History* (Melbourne: Melbourne University Press, 1979), 102.

<sup>3</sup> Ian Downs, *The Australian Trusteeship: Papua New Guinea* (Canberra: Australian National University Press, 1980), 37-38; interviews with Sir John Gunther by Hank Nelson (1971) and Donald Denoon (1981).

<sup>4</sup> Brian Jinks, *Policy, Planning and Administration in Papua New Guinea with special reference to the role of Colonel J.K. Murray* (unpublished PhD dissertation, University of Sydney, 1975).

<sup>5</sup> Paul Hasluck, *A Time for Building. Australian Administration in Papua New Guinea, 1951-1963* (Melbourne: Melbourne University Press, 1976), 407.

<sup>6</sup> *Ibid.*, 13-22.

<sup>7</sup> *Ibid.*, 86.

to handle and wanted everything his own way". Instead Hasluck found that Dr (later Sir) John Gunther "had the sort of mind and character" he liked. The director immediately told his minister bluntly all that was wrong in his department and "all the things he had not done and how inadequate all the present health services were". Most of the other public servants either gave rosy pictures or told tales of personal hardship in the course of duty. Hasluck found Gunther "not too bad at all":

When I discussed tentatively some of my own impressions about the problems of hygiene, sanitation, nutrition, maternal and infant welfare and routine medical examination, it was plain that he had thought about these matters and had developed ideas on how they should be tackled. When I asked about the major diseases and their treatment or control or eradication, he revealed that he saw the problems in their full depth and breadth. On questions of staff, medical stores and equipment and hospital building he was well furnished with facts and ready to make plans and he was also clearly aware of the practical problems and the political problems of obtaining approvals for forward programmes and of obtaining money.<sup>8</sup>

In Gunther he had found "someone who needed no pushing...If there had been six other senior officers of the Administration as good as Gunther in 1951", he wrote, the story of post-war PNG would have been "vastly different". Gunther had not waited for major policy decisions or the provision of munificent funds and "was easily the strongest single driving force in the Administration as well as being one of the very few senior men with a trained intelligence and a practical political sense".<sup>9</sup>

One could go further. However stultifying the Ward-Spender period may have been for timid officials, it was almost ideal for Gunther's improvising talents. His flair contradicted the usual pejorative connotations of "bureaucrat", which term he cheerfully embraced. He disliked long-term planning and, although given to short cuts and unabashed at using compulsion to get things done, he preferred to promote autonomy in his staff and clients. A mobiliser, and a scrounger of resources, he also knew how to spend them effectively in order to justify asking for more. He was opportunistic in recruiting personnel and he could energise them to work at his set campaigns. He was not shy of confrontation if necessary, but his solution to the incompetence of a subordinate might be a lateral shift, or even promotion, if he could not give the sack. He was a pragmatist with vision, foreseeing in 1946 that Papua New Guineans would manage their own health services in a generation and a half. Gunther was also politically apt, seeking progressive rather than radical solutions to problems where the latter were not practicable. At heart a social democrat, Gunther accepted colonialism as a fact of life, and took the idea of "sacred trust" seriously while seeing the interests of both Australia and PNG as

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<sup>8</sup> *Ibid.*, 103.

<sup>9</sup> *Ibid.*

being inseparable, at least in the foreseeable future.<sup>10</sup> He dismissed the idea of "noble Melanesian traditions" and believed that Papua New Guineans shared his enthusiasm for their acculturation to Australian ways.<sup>11</sup>

Gunther was born in Sydney in 1910, the son of Cyril Maynard Gunther, a well-connected sugar-mill manager on the Tweed River who had done a stint in Fiji. His paternal grandfather had been Archdeacon William James Gunther (1839-1918), Rector of St John's, Parramatta. His Swiss-German-born great-grandfather, Archdeacon James Gunther of Mudgee, New South Wales, had joined the Anglican Church as a missionary and arrived in Australia in 1837.<sup>12</sup> Gunther's mother, née Jean Thomson, was one of the first women graduates in medicine from Sydney. Gunther was third generation at The King's School, Sydney, and his parents were staunch supporters of Stanley Melbourne Bruce and his Nationalist Party. His father, although chairman of the Tariff Committee of the Chamber of Commerce and of the diocesan Church Property Trust, was "not an efficient businessman" and left the family in straitened circumstances when he died prematurely in the early 1930s before Gunther graduated in medicine. He finished his course without distinction, but in minimum time. Failing to get preferment and lacking the money (and probably the inclination) to buy into general practice, he accepted a position with Lever's Pacific Plantations in the Solomon Islands in 1935, at a handsome salary of £600 a year. He was to supervise the health and conditions of five thousand labourers and provide services to the general community.

Although it lasted only two years before torrid rivalry for white female companionship drove him out, the Solomons experience determined Gunther's future. He virtually made himself a specialist overnight, he said, by reading Castellani's *Tropical Diseases*, the *Transactions of the Royal Society of Tropical Medicine* and "the equivalent of four tropical disease journals a month". When war came to the region in 1942 he was one of a handful of "experts" on tropical diseases, particularly malaria. However, in the interval before war broke out he gained a further three years' experience as chairman of the Medical Board, Mount Isa, Queensland, reporting to the State Government Insurance Commissioner.<sup>13</sup> If he did not know it already, his work in the RAAF (which he joined in 1941) would

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<sup>10</sup> Gunther interviews, 1971, 1981.

<sup>11</sup> John Gunther, "The People", in J. Wilkes (ed.), *Australia and New Guinea* (Sydney: Angus & Robertson, 1957), 44-56.

<sup>12</sup> Obituaries are in the *Sydney Morning Herald*, 17 November 1932; *Church Standard*, 21 June 1918; and *Town and Country Journal*, 3 January 1880.

<sup>13</sup> James Griffin, "'Someone who needed no pushing': the making of Sir John Gunther", in S. Latukefu (ed.), *Papua New Guinea: a Century of Colonial Impact* (Port Moresby: University of Papua New Guinea Press, 1988), 214-34.

have persuaded him that, in epidemiology, discipline and control could be as important as drugs. As Deputy Principal Medical Officer in charge of units in Papua in 1942-43, and later as Senior Medical Officer in Milne Bay,<sup>14</sup> where malaria was catastrophic, he had to mobilise staff and resources, extemporise and even discipline superior officers, much to their chagrin.<sup>15</sup> In 1943 he became chief malariologist and in 1944-45 commanding officer of the Tropical Field Research Unit. His travels stimulated his interest in the conquest of malaria and the general health problems of the Papua New Guinean people.

Uncertain what to do after demobilisation, Gunther applied for the post of Director of Public Health in PNG in 1945. He was not the first choice, and was surprised to be offered the position in early 1946. It was suggested that he fly to Port Moresby, look around and write the estimates for 1946-47 before deciding. In his own words, he arrived "unheralded, unsung and unwanted". He was obviously resented as an interloper likely to disturb the inertia of the "B4s". No one met him at the airport. His departmental headquarters had walls which were half iron plus bird-wire, a roof of black tin, and a mud floor. In PNG, he was told, there were five doctors, five trained Australian nurses and 23 European Medical Assistants (EMAs).

But there were telephones. Gunther rang the Government Secretary and was advised to call in about three days' time. He rang Government House and received the same treatment from the Administrator's Secretary. So he rang the Government Secretary again and "virtually told him he could get stuffed and that I didn't have to take this job". He threatened to catch the next plane to Australia and tell the Minister he had been prevented from doing his job but, naturally, did not mention that he had not yet met Minister Ward. Almost immediately he received a phone call from Government House inviting him to dinner. He had been delivered, he said, "a studied insult", but in his resilient way he later became "very good friends" with both men - "and liked them!" Two things stood out for him: the overall challenge (perhaps sharpened by his initial reception) and the prospect of achievement if Ward could deliver the funds. By mid-year he was back in Port Moresby setting a strategy. What was the disease pattern? What was needed to control it? What resources were there of manpower, buildings, materials, drugs and vehicles? An indefatigable traveller as well as an assiduous desk-worker, by October 1946 he was able to say what he thought he needed.<sup>16</sup>

At opposite ends of the spectrum of health were villages like Hanuabada (Port Moresby) with seventy years of European contact, and the newly contacted Central

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<sup>14</sup> A.S. Walker, *Medical Services of the R.A.N. and the R.A.A.F., Australia in the War of 1939-1945* series v, vol. iv (Canberra: Australian War Memorial, 1956), 277-78 and 286.

<sup>15</sup> A.S. Walker, *Clinical Problems of War*, *ibid.*, series v, vol. i, 108.

<sup>16</sup> Gunther interviews, 1971, 1981.

Highlands. Gunther recalled his first walk through Hanuabada whose people had just returned from war-time exile:

The children had sores of all kinds; enlarged spleens (from malaria) were visible.

Among young children there were occasional scrofulous abscesses discharging tubercle bacillus; asthenic individuals looked as if they had tuberculosis

- and in fact 18 per cent probably did, while another 12 per cent were shedding the bacillus. There were cases of florid yaws and tropical ulcers. A cursory walk showed Gunther that at least a hundred should have been in hospital, but Hanuabadans did not believe in hospital care. The London Missionary Society provided out-patient treatment and used their own houses for in-patients. The ugliness and the suffering, said Gunther, were all too obvious.<sup>17</sup>

Mortality rates were unacceptably high and had increased during the war. Dr Roy Scragg's research showed actual depopulation in New Ireland while, in Lemankoa village on Buka Island (North Solomons Province today) the death rate was 4.07 per cent, the pre-war life expectancy had been about 23, and only six of every ten children lived beyond their fifth birthday. (By 1960 this death rate was cut by half, life expectancy nearly doubled, and eight children of every ten survived past five years.<sup>18</sup>) The Highlands gave Gunther particular concern because here were perhaps half a million people who might not be immune to decimating diseases. Five thousand had died during a war-time epidemic of bacillary dysentery. Obviously TB would be a problem while, in spite of altitude, malaria would be brought in with population movement, land development and ecological change.<sup>19</sup>

Even if medical personnel had been available, Gunther would have seen the need to involve Papua New Guineans in safeguarding their own health. This required community education as well as trained health and medical officers in a country where secondary education hardly existed and would not really begin until the late 1950s. Choices had to be made as to which diseases to target. For example hookworm was endemic and a significant cause of anaemia. However, campaigns against hookworm were frustrated by the lack of public hygiene which fostered continual re-infestation. A solution to hookworm would therefore have to wait on long-term community acceptance of the need for salubrious latrines. Meanwhile resources could more profitably be targeted on those major diseases where a clear impact could be made.<sup>20</sup>

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<sup>17</sup> *Ibid.*

<sup>18</sup> Roy Scragg, Lemankoa 1920-1980: a study of the effects of health care interventions on the people of a pre-industrial village in North Solomons Province, Papua New Guinea (unpublished MA thesis, University of Sydney, 1983).

<sup>19</sup> Gunther interviews, 1971, 1981.

<sup>20</sup> *Ibid.*

Malaria control was one such area, and one could call it Gunther's obsession - so much so that in 1947 he toyed with the idea of resigning his post to devote his full time to it. Malaria, Gunther continually stressed, destroyed red blood cells; which led to loss of haemoglobin; which led to anaemia; which produced lassitude, apathy and indolence; which led to his notorious "80 per cent man".<sup>21</sup> He used to repeat the argument with a percentile certitude which might have been queried:

- \* Control malaria and double the expectation of life.
- \* Control malaria and halve the infant mortality rate.
- \* Control malaria and double the population in fifteen to twenty years.
- \* Control malaria and improve the aptitude of pupils or students by up to 25 per cent.

(For those more interested in profits, he added)

- \* Control malaria and add 15 per cent to the efficiency of the individual labourer - in the village and outside it.
- \* Control malaria and reduce the potential need for labour by 25 per cent.
- \* Control malaria and save hundreds of thousands of pounds.<sup>22</sup>

Malaria control, said Gunther, was a social problem; but villagers and expatriates believed it was something you had to live with in the tropics. It was to a large extent man-made, he argued, and could be controlled by disciplined measures. All field officers in district administration, agriculture and engineering needed to be educated if anopheles breeding sites were to be attacked. For example, in Madang, most malarious of towns, breeding was difficult to control by oiling the swamps, because of heavy grass verges. The swamps were turned into ornamental lakes with easy access. A massive campaign against malaria was bound to be expensive as it involved public education, supplies of suppressive drugs, and engineering. If cooperation were not forthcoming, then compulsion was needed. Pre-war employers generally believed that suppressives destroyed natural immunity and only Gunther's personal prestige (and friendships in some cases) prevailed on them. When the Highlands Labour Scheme came into operation in 1949, control had to be enforced. One evening Gunther accepted an old-time plantation manager's hospitality only to find on inspection the next morning that he had a very sick labour line. The manager was dismissed and Gunther learned never to accept hospitality before inspection.<sup>23</sup> The ethos in which he worked is captured in the *Pacific Islands Monthly's* criticism of April 1954:

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<sup>21</sup> John Gunther, "80 per cent Man" (University of Papua New Guinea History Department typescript, 1980).

<sup>22</sup> John Gunther, "Epidemiology of Malaria in Papua New Guinea", *Papua New Guinea Medical Journal*, I (1) (1955), 1.

<sup>23</sup> Gunther interviews, 1971, 1981.

Drastic measures seem to have been taken by the PNG Department of Health when it ordered the removal from a plantation in the Rabaul area of "Highland labour" alleging the planter had taken insufficient steps to suppress malaria among the labourers. I hate to think of the costs the planter has had to bear,...It does not appear that such regimentation is conducive to...Agricultural development...although the P H D will get a pat on the back from UNO. Once again New Guinea planters pay the U N price.

Gunther was particularly concerned that TB should not spread to the Highlands, where most people were still outside government control. While the world was making up its mind whether everyone should be vaccinated, he decided that any foreseeable risks were worth taking in the Highlands. The Australian authorities, however, would not release BCG vaccine unless they controlled the way it was used. This would double the cost and the time which Gunther had budgeted. "We just wanted to go through the place like a bush fire", he said, "vaccinating everybody". At a dinner party in Canberra Gunther stamped away from a dinner table telling the Director of Tuberculosis in Australia, Sir Harry Wunderly, that he would do things his own way and, if necessary, get Pasteur vaccine from the French instead of Australian BCG. A compromise was worked out. As Gunther said, Wunderly "never had any rough bloke telling him to go to hell before".<sup>24</sup>

Gunther enjoyed extraordinary advantages over pre-war directors, as he readily acknowledged. Sulpha drugs and penicillin changed medical practice, making quarantine less necessary and enabling a majority of patients to be cured. If greater mobility brought greater risks of infection, rapid transport made it easier to attack potential epidemics and give prompt attention to individuals. Techniques of physical and social engineering made it possible to undertake campaigns against specific diseases. War-time discipline was retained to some degree in the approach of ex-military medical personnel and in the supineness of colonised communities, especially as it was a criminal offence to disobey medical instructions. The esteem in which doctors were held had risen, so that there were fewer problems in persuading politicians, bureaucrats and planters that the medical profession knew best.<sup>25</sup> Australia had only one colony, empiricism and innovation could prevail as there were no binding precedents and no routines required for the sake of uniformity.

The off-hand way in which funds might be solicited and granted is illustrated in Gunther's conversation with Ward in late 1949. There was, Gunther told Ward, "an absolute crisis in hospital building". "What do you need?" asked Ward, no

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<sup>24</sup> *Ibid.*

<sup>25</sup> Donald Denoon, *Public Health in Papua New Guinea: technical possibility and social constraint* (Cambridge: Cambridge University Press, 1989), part II, chapter 1.

doubt hoping that money would obviate his need to become specifically interested. "Seven million pounds", said Gunther (i.e. more than twice the previous year's total Territory grant). Ward replied, "God! I can't give you seven million pounds worth of buildings. What would the whole administration want?" "Probably thirty million pounds worth", said Gunther. Ward protested:

Don't be silly, sonny, we're about to fight an election. You couldn't possibly fight one on thirty million pounds worth of buildings for PNG when we're in a mess in Australia. But I'll promise you something: that immediately after we get back into power, Chifley will make an announcement that will give you seven million pounds worth of buildings.

Ward had not seen the Prime Minister, but Gunther believed that Ward was confident he would pull it off with Chifley, and took it as a promise. Labor was not returned, but the Liberal-Country Party coalition did not renege on the general commitment to welfare, especially once Hasluck became Minister and could "cut the Gordian knot so well tied by the Commonwealth Department of Works".<sup>26</sup>

Gunther's opportunism is evident in the way he recruited medical personnel even from the pre-literate population. Six schools were opened to train "native medical assistants" (later called aid-post orderlies) for one thousand villages, to replace the pre-war medical tultuls. The village was asked to select the person to be trained and to build him a house. He would be self-employed and paid on a part-time basis and have time to maintain his own garden, or else villagers would do that for him. He was taught to recognise common skin diseases and infections with a high mortality rate such as pneumonia, malaria, dysentery, meningitis and TB. Appropriate measured doses would be administered from bottles with coloured and pictorial labels. Patients who did not respond, or who did not fit into common categories, would be referred elsewhere. Inevitably there were errors - and tragic errors. At Faita, Madang District, a well-intentioned hygiene assistant during a yaws campaign used fresh coconut milk instead of sterile water for injections. This was a practice he had observed in war-time. Unfortunately at Faita he opened a coconut, covered it with clean gauze and used the milk after it had been exposed for some time. Seventeen men, women and children, the bulk of the hamlet, died painfully that day. Gunther offered his resignation. It was no immediate consolation to relatives of the dead that the NMAs had saved thousands of people elsewhere from death and misery. The NMA training (one to two years) was "the quickest way available of getting people into the field to treat killer diseases".<sup>27</sup>

As early as 1947 the first six students were sent to the Central Medical School, Suva, to train as Assistant Medical Practitioners. Initially they were handicapped by

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<sup>26</sup> Gunther interviews, 1971, 1981.

<sup>27</sup> *Ibid.*; and Hasluck, *op. cit.*, 105-106.

poor educational background but the first returned in 1952 and three more followed in 1953. By 1955 there were 26 in training. The Papuan Medical College opened in Port Moresby in 1959. European Medical Assistants (EMAs) had to be the backbone of the system until sufficient doctors were recruited or trained. Technically, said Gunther, they were "a nebulous group". Generally they had been army medical orderlies, though some had pre-war experience on plantations. Most had no more training than a male nurse: some only that of a first-aid orderly; but some built up extraordinary competence. Gunther encouraged them to improve their qualifications. The best of them did degree courses and ultimately left the department. By 1949 their numbers had grown to 93. "The good EMA", said Gunther, "was given the same responsibilities as a doctor".<sup>28</sup> In 1946-47 it was decided to allow the officer-in-charge of a hospital - usually an EMA - to train his own ward help, and to determine how much time he could spare for this. By and large the EMAs responded to that trust.

By 1949 there were still only 32 doctors in the country, 18 of whom were official and the others in Missions and other organisations. There were 131 trained nurses, of whom 40 were official. Recruitment was complicated by the red tape of advertising and selection procedures. One capable officer was almost lost through insisting that he was a citizen of Ireland, and a precedent had to be found for admitting him. The daughter of an American diplomat refused to take the oath of loyalty to the Queen: a sympathetic public service commissioner got around that for Gunther but when she came up for re-appointment Gunther was away, the appointments officer was unsympathetic, and she returned to the USA with her republican principles intact.<sup>29</sup>

Gunther was fond of saying that "good medicine can be conducted under a tree, or in a bush materials shelter". He had seen "first-rate emergency surgery...done behind the battle lines...under a tent with the surgeon wearing gumboots because of the mud floor". But he did not flaunt improvisation for its own sake:

No argument can be made for deliberately working under adverse conditions...There are those who see merit in pioneering, in the Spartan life - and the zealot will be successful. But most people would prefer equable conditions, where they can do their best without too many side issues - their results will speak for themselves...We had to provide better shelters. In 1946 I knew only one name for such a place. It was hospital.<sup>30</sup>

Of those who suggested that priority should be given to preventive medicine rather than expensive hospitals, Gunther bluntly said that "usually they don't know what

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<sup>28</sup> Gunther interviews, 1971, 1981.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*

they are talking about", and that in PNG there was no alternative for those needing routine treatment.

Taking Ward's promise seriously, Gunther set up makeshift structures until proper hospitals could be built. Local building materials were used and dilapidated wartime sheds and huts were renovated. Hasluck recalls

earth floors, rows on rows of beds made of planks supported on forked posts, hundreds of patients being nursed, hundreds of relatives camped outside or even alongside and under their rough beds, operating theatres of crude simplicity. The Health Department had not waited...for someone to give them both instructions and money, but had done with energy and directness whatever tasks of healing immediately awaited them.<sup>31</sup>

To get patients to hospital could mean overcoming distance, but also conquering fears of white strangers, sorcery, and travel through hostile territory. Confidence and some understanding of the need for routine treatment had also to be instilled into sufferers who would pine for their village and kin.<sup>32</sup>

Gunther's political realism led him into careful accommodation with the Christian Missions and with the white community, without compromising more than necessary the obligation of the Administration to the people. In October 1946 at an Administration-Missions conference he offered aid for building and staffing certain hospitals. Assuming that Ward would provide the finance, Gunther drew the Missions into an entirely unprepared programme. He saw the Missions as "better attuned psychologically and better organised to look after the long-term patient" than his department, so he made an immediate offer. While Missions would use their own resources, PHD would pay the salaries of staff at public service rates providing that their work did not encroach on areas where PHD was already effective. PHD would retain some oversight and provide drugs and equipment. Missions were encouraged "to establish a welfare policy to a standard policy with full assistance - finance and supply - under the supervision and inspection" of PHD. While he rejected the strict "spheres of influence" demarcation of territory,

it must be accepted that certain missions in certain areas have an influence that reaches up to 100% of the population. It is in these areas that the missions can be encouraged to undertake the work on behalf of the Administration. In those areas where the sects and creeds...meet and clash, the Administration should withhold subsidy and supply and establish the service themselves, though working in the closest contact with each mission ...<sup>33</sup>

The Missions eventually overcame their suspicions and cooperated.

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<sup>31</sup> Hasluck, *op. cit.*, 105.

<sup>32</sup> Gunther interviews, 1971, 1981.

<sup>33</sup> *Ibid.*

The Missions were also better suited to infant and maternal welfare than was the male-dominated Provisional Administration. In January 1949 Gunther judged that there was "possibly a greater need" for infant and maternal care than for any other aspect of public health. Infant mortality could rise to "appalling figures". Population increase - devoutly to be wished - was entirely dependent upon the "rapid-as-possible correction of this rate [up to 500 per thousand infants dying before their first birthday]...The economic destiny of the country demands an increased population".<sup>34</sup> A small start was made through the initiative of a Catholic nun in Port Moresby who also wanted to establish a maternity hospital. "Naturally we were delighted", said Gunther. Fortunately, Dr Joan Refshauge accompanied her husband to PNG in 1947. With a science degree, a diploma in education and experience in a women's hospital, she was placed in charge of women's and children's welfare. Sister Annette's hospital was turned into a training institution under the professional supervision of Dr Refshauge, and from this small beginning emerged similar institutions elsewhere.<sup>35</sup>

Gunther's plans for general betterment, however, attempted to be holistic. He envisaged the Department of District Services and Native Affairs providing logistics, erecting clinics, encouraging people and "tactfully" eliminating unwise practices; the Department of Education providing hygiene instructions and deploying teachers to assist in keeping a Register and dispensing artificial foods; and the Department of Agriculture, Stock and Fisheries helping to improve local food production and consumption.<sup>36</sup>

Whites were inevitably demanding, and used resources inequitably. They expected, said Gunther, a medical service "equivalent to what they would get in an Australian country town". They also demanded hospital treatment separate from "natives". The President of the Returned Soldiers' League threatened to horsewhip Gunther if he tried to integrate white and Chinese or "native" wards. It was not lack of physical courage which caused him to let integration emerge gradually. Once satisfactory fee-paying wards were set up, the issue resolved itself.<sup>37</sup>

Gunther's interviews say little about the creation of an *esprit de corps* in a department which began, he said, "without traditions". There is ample testimony, however, that he energised his department by his visitations, his concern, well-conceived policies, personal decisiveness and authority. He provided library facilities for his staff, distributed the *Lancet*, and set up the *Papua New Guinea Medical Journal*. Among other facets of his departmental work, he established two

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<sup>34</sup> "Public Health Department Circulars", A 518 Item K852/6/3 part 1: AA (Canberra).

<sup>35</sup> Gunther interviews, 1971, 1981.

<sup>36</sup> "Public Health Department Circulars", as above.

<sup>37</sup> Gunther interviews, 1971, 1981.

workshops: one for the maintenance of hospital equipment, the other for making artificial limbs. The latter was hard to justify when neither mental health services nor health education had been launched; but makeshift resources were available and so was a craftsman, and Gunther, when he met his customers, felt that they were very satisfied with their artificial limbs.

In 1956 Gunther had a serious operation for emphysema which partly incapacitated him but did not prevent him from accepting the post of Assistant Administrator early in 1957. One of the last problems to cross his Public Health desk was the discovery of a localised epidemic of "kuru" (sensationally reported as "laughing death") in the Eastern Highlands. It was typical of his discernment that he agreed immediately with his informant, Dr Vincent Zigas, that here was a disease whose aetiology might have a profound effect on the history of medicine.<sup>38</sup> It proved to be the first slow virus known to exist in humans. Patriotically, even chauvinistically, Gunther envisaged the researchers as Sir Macfarlane Burnet's team at the Walter and Eliza Hall Institute, Melbourne. For once he was outmanoeuvred by Dr Carleton Gajdusek, an American prodigy<sup>39</sup> and prodigious egotist, who crashed through Gunther's surveillance and ultimately shared a Nobel Prize for his research. It was an accolade Gunther wanted for an Australian. In retirement, however, he wrote a remarkable paper in which he acknowledged that Australia had not had the necessary resources - particularly, colonies of chimpanzees - to research the problem expeditiously. This paper reveals a capacity for deferred objectivity and a generous willingness to admit misjudgements.<sup>40</sup>

As Assistant Administrator (1957-66) Gunther was the most dynamic figure in the Administration, attending not only to effective public service but also to dismantling discriminatory legislation and developing those institutions which would prepare Papua New Guineans for Independence. He was also a member of the three-man Currie Commission which prepared the ground for university education. Hasluck seems to have intended that Gunther should succeed Lambert as Secretary to the Department of Territories, and eventually take over from Administrator Sir Donald Cleland when he retired in 1967. The plan was undone when Sir Robert Menzies called an election in late 1963 and any appointment had to be deferred until a new cabinet was formed.<sup>41</sup> When Hasluck was promoted to Defence, the Territories portfolio was allotted to a Country Party minister, Charles Barnes, who

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<sup>38</sup> J. Farquhar and D.C. Gajdusek (eds.), *Kuru: Early Letters and Fieldnotes from the Collection of D. Carleton Gajdusek* (New York: Raven Press, 1981), 1-2.

<sup>39</sup> D.C. Gajdusek, "Autobiographical Sketch" in *Les Prix Nobel en 1976* (Stockholm: Nobel Prize Institute, 1977), 161-62.

<sup>40</sup> John Gunther, *Kuru and a Nobel Prize! a Participant's View* (unpublished, undated ms).

<sup>41</sup> Hasluck, *op. cit.*, 418-19.

intended to delay self-government and who found Gunther antipathetic. Gunther became the popular choice for Vice-Chancellor of the new University.<sup>42</sup> In that capacity he relished winning a battle with Barnes to establish a medical faculty within the University, capping his long-conceived plan for full localisation of medical practice.<sup>43</sup>

Denoon has pointed to the prominence of "suffering" in Gunther's vocabulary,<sup>44</sup> and it may appear incongruous that such a rugged and sometimes ruthless man should have been so determined to combat it. His vision, however, went beyond individual suffering to nation-building. PNG needed, he believed, a greater population (1.5 million in 1950) as well as a healthier one. In 1956 he wrote:

Public health means the advancement of the welfare, physical and mental, of all the people. It can possibly be measured by a change in the "expectation of life"...We hope rapidly to increase the population [so] that...[the Territory] can [also] safeguard itself against covetous eyes, and that it may be economically developed for the future of its inhabitants.<sup>45</sup>

Not everyone agreed. Perhaps humanitarian aims of a different sort moved Prince Philip, Duke of Edinburgh, to ask Gunther in 1956:

- Gunther, what do you see to be your main task as Director of Health?
- In a few words, Your Royal Highness, to give the people a greater expectation of life and to increase the population.
- But why increase the population when you can't teach them even English?
- Well, Your Royal Highness, I don't think that's my responsibility. That's a problem for the Director of Education.
- But I've heard that the population is also underfed. Why increase it if there's not enough food?
- Well, Your Royal Highness, that seems to me to be a problem for the Department of Agriculture.

The Prince looked down at Gunther and snapped: "Are you a Catholic, Gunther?", swung on his heels and strode off.<sup>46</sup>

Gunther was certainly not a Catholic and was not opposed to population control and responsible parenthood and, in spite of what he told Prince Philip, he took (in Ian Downs's words) "initiatives which linked education, agriculture and manpower

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<sup>42</sup> Ian Howie-Willis, *A Thousand Graduates: Conflict in University Development in Papua New Guinea, 1961-1976* (Canberra: Australian National University Press, 1980), 66-67.

<sup>43</sup> James Griffin, "The Instant University", in E.B. Thomas (ed.), *Papua New Guinea Education* (Melbourne: Melbourne University Press, 1973).

<sup>44</sup> Denoon, *op. cit.*

<sup>45</sup> John Gunther, "Editorial: Our Duties", *Papua New Guinea Medical Journal*, I (1) (1955), 33.

<sup>46</sup> Gunther interviews, 1971, 1981.

to his responsibility for public health".<sup>47</sup> Nor did he see himself as a self-sacrificing missionary. In old age he was prepared to suppose that he had been an "imperialist" but not in the sense that the British were<sup>48</sup> - whatever he meant by that. When he found himself in conflict with Australian authorities, he assumed that they did not know Australia's best interests which in his view coincided with PNG's. A biographer of John Gunther should be fascinated by his ethnocentricity, and moved to ask how relevant ideology was to efficacy, and even to marvel at how irrelevant it is to those leaders of an independent PNG who esteem Gunther as the greatest of Australia's post-war colonial public servants.

- \* The author wishes to acknowledge his debt to Dr H.N. Nelson and Dr Donald Denoon for access to their interviews with Sir John Gunther, and to Dr Denoon for access to his research notes. To simplify nomenclature, the author uses only "PNG" and "Papua New Guinea", although "The Territory of Papua-New Guinea" and "The Territory of Papua and New Guinea" would have been correct at different periods of post-war history.

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<sup>47</sup> Downs, *op. cit.*

<sup>48</sup> Gunther interviews, 1971, 1981.

## "ME BLIND DRUNK":<sup>1</sup> ALCOHOL AND MELANESIANS IN THE MACKAY DISTRICT, QUEENSLAND, 1867-1907

Clive Moore

Memeendi came before the Mackay Magistrate's Court in December 1900, charged with being drunk and stealing half a bottle of beer. He was let off the drunkenness charge but was jailed for seven days for theft. His lack of comprehension as to what was going on around him in the Court room, and of what he had done while drunk, was typical of thousands of Melanesians who got drunk in Queensland over the four decades during which Pacific Islanders were recruited to work in the Queensland sugar industry in the nineteenth and early twentieth centuries.

This chapter begins with an outline of Melanesian mortality in Queensland and questions the effect of alcohol on Melanesian health. It then outlines government attempts at prohibition, Melanesian sources of supply, the extent of alcohol consumption and drunkenness, and mission temperance campaigns. The second half examines the effect of alcohol on Melanesian health and society, their reaction to racism and European hegemony, and the connection between drunkenness and crime. I conclude that alcohol played a part in both easing and inflaming community tensions, and also helped bridge the cultural gap, but that its effect on health cannot be measured accurately .

### Melanesian Health and Mortality

On average, each year that the labour trade operated (1863-1907), fifty Melanesians in every thousand died in Queensland. At its worst, in 1884, the Melanesian death rate in the colony was 147 per thousand. The labourers were mainly young men, aged between fifteen and thirty-five. The death rate among European males, of equivalent age, was nine or ten per thousand. Historians have sought explanations for the high mortality rate, stressing poor working and living conditions on the labour trade vessels and on the plantations and farms, citing malnutrition and over work as prominent causes. In fact the deaths were principally the result of exposure to virus diseases, to which new recruits in the circular labour

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<sup>1</sup> "Not guilty; no savee; might me take 'em; me blind drunk." Memeendi, quoted in the *Mackay Mercury*, 23 December 1900.

migration brought little or no acquired immunity.<sup>2</sup> Historians of the Pacific labour trade have made only passing references to alcohol consumption, indicating that it exacerbated violence, but little more. Alcohol consumption, though substantial, cannot have been a major factor in the death rate: consumption increased steadily over the years but there is no similar increase in the mortality statistics. Nor is there evidence of alcoholism. The Islanders drank in binges, the timing of which were related to their pay periods, and never had constant access to alcohol. Yet there is no doubt that alcohol affected their health, exacerbated violence and heightened the degree of injury and death among them.

### Government Attempts to Prohibit Alcohol Consumption

Before contact with the world beyond the Pacific, the peoples of Oceania did not manufacture alcoholic beverages, but many availed themselves of other drugs. The most common were kava and betel nut.<sup>3</sup> Alcohol was introduced to Oceania by Europeans, first in Polynesia and Micronesia, and only relatively recently in Melanesia. Prohibition of alcohol consumption by indigenes was introduced into most Pacific island colonies in the nineteenth century, the restriction remaining until the 1960s.<sup>4</sup>

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<sup>2</sup> C.R. Moore, *Kanaka: a History of Melanesian Mackay* (Port Moresby: The Institute of Papua New Guinea Studies and the University of Papua New Guinea Press, 1985), chapter Seven, particularly 244-73.

<sup>3</sup> Kava is an infusion made from the pounded root of the *Piper methysticum* shrub. Betel nuts are the seeds of the *Areca Catechu* palm, usually chewed with fresh leaves of *Piper betel* or other similar plants, in a quid with powdered lime to intensify the effect. M. Marshall, "A History of Prohibition and Liquor Legislation in Papua New Guinea, 1884-1963", (Port Moresby: Institute of Applied Social and Economic Research, 1980), Discussion Paper No. 33, 5, fn 2; and, "The Distribution and Use of Kava and Betel in Papua New Guinea: a Preliminary Survey", paper presented to the Tenth Annual Meeting of the Association for Social Anthropology in Oceania, 25 February - 1 March 1981, San Diego, California; J. Bonnemaïson, "Territorial Control and Mobility within niVanuatu Societies", in M. Chapman and R.M. Prothero (eds.), *Circulation in Population Movement: Substance and Concepts from the Melanesian Case* (London: Routledge & Kegan Paul, 1985), 59.

<sup>4</sup> The most significant studies of the effect of the introduction of alcohol are by Mac Marshall and his colleagues. Cf. M. Marshall and L.B. Marshall, "Opening Pandora's Bottle: Reconstructing Micronesians' Early Contacts with Alcoholic Beverages", *Journal of the Polynesian Society*, 84 (4) (December 1975), 441-65; and, "Holy and Unholy Spirits: the Effects of Missionization on Alcohol Use in Eastern Micronesia", *Ibid.*, 16 (3) (1976), 135-66; C. Miller, "A Temperate Note on 'Holy and Unholy Spirits'", *Journal of Pacific History*, 14 (4) (1979), 230-2; M. Marshall and L.B. Marshall, "Some Sober Reflections on Miller's Temperate Note on 'Holy and Unholy spirits'", *Ibid.*, 15 (4) (1980), 232-4; M. Marshall, *Weekend Warriors: Alcohol in a Micronesian Culture* (Palo Alto, Calif.: Mayfield Publishing Co., 1979); M. Marshall (ed.), *Through a Glass Darkly: Beer and Modernization in Papua New Guinea* (Port Moresby: Institute of Applied Social

Queensland labour trade vessels were allowed to carry a quantity of fermented or spirituous liquors not exceeding one-eighth of a pint a day for each member of the ship's company. Government Agents sailed on all recruiting ships from 1871. It was their duty to ensure that no alcohol was given to any Islander on shore, from any of the ships' boats, or on board ship, except for medical purposes and under their supervision.<sup>5</sup> These rules were occasionally flouted, but by-and-large recruits had no access to alcohol until they reached Queensland.

It is possible that some of the earliest Melanesian labourers in Queensland in the 1860s were already familiar with alcohol, as most of the first recruits came from French Melanesia where there was no prohibition. For a year, until the *Polynesian Labourers Act*<sup>6</sup> was passed in March 1868, they could have been supplied with alcohol quite legally. But the terms of the 1868 Act and all later *Pacific Island Labourers Acts*, which governed the lives of Pacific Islanders in Queensland, made it illegal to supply them with alcoholic spirits. The 1868 Act was replaced by the 1880 *Pacific Island Labourers Act*, Section 42 of which states:

Any person who sells, supplies, or gives to a labourer or islander any fermented or spirituous liquor, or any liquor, or any liquor part whereof is fermented or spirituous, shall be liable to a penalty not exceeding five pounds.<sup>7</sup>

For a second or subsequent offence a person could be fined between five and twenty pounds.

These specifications remained standard. It was never an offence for Melanesians to drink alcohol in Queensland; the emphasis was on preventing them from being supplied. If they became drunk they could be charged with drunkenness or disorderly conduct in the same way as any similar offender, regardless of race. The laws in Queensland and the regulations about alcohol in force on labour trade vessels were concerned, not with the health of Islanders, but with law and order. Despite the intention of the laws and regulations Melanesians in Queensland always had easy access to alcohol, and often drank to excess. A substantial number of charges brought against Melanesians in the Mackay district directly related to alcohol consumption. In a sample of 1,598 charges between 1871 and 1907, 391 were for drunkenness. And over the same period there were more than one hundred charges against individuals for supplying alcohol to Melanesians. Alcohol was

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and Economic Research, 1982), Monograph No. 18.

<sup>5</sup> *Queensland Government Gazette*, XXXIV (66) (18 April 1884), 1152; *Regulations Under "The Pacific Island Labourers Acts, 1880-1892"* (Brisbane: Queensland Government Printer, 189

<sup>6</sup> The term "Polynesian" was often used to mean "Melanesian" in the nineteenth and early twentieth centuries. There were some Polynesian labour recruits, but only a handful.

<sup>7</sup> Queensland, 44 Victoriae No.17.

probably also a contributing factor to the next three most numerous offences: disobedience, absenteeism, and assault.<sup>8</sup>

### Alcohol: Sources of Supply

Mackay in the nineteenth century was a drunken, brawling frontier town. Alcohol consumption was one of the major forms of recreation for all races. The town had its own brewery from 1883 until 1897.<sup>9</sup> Five of the plantation mills had their own distilleries, but by 1894 low prices for rum, government excise taxes and stricter regulations had forced them all to close. They varied in size, producing anything up to 40,000 gallons of rum each year.<sup>10</sup> Until 1884 Melanesians were employed in the mills and distilleries, and probably also in the brewery. (In that year an amendment to the 1880 Act limited Melanesians to work in agriculture, effectively confining them to field work.) There is evidence that Melanesians did steal from the mills, so it would not have been difficult for them also to steal from the distilleries, though there is no proof of this. It seems that most of the alcohol which they consumed was purchased directly from hotels, shops and illicit stills in rural areas.

The major money supply available to the Islanders was always their wages, which varied considerably, depending on experience, length of contract, and negotiating skills. Most served out their three year contracts and returned to their islands. These were called first-indenture labourers. But other categories of Melanesian labour also existed, considerably varying the picture. Not all labourers were enlisting for the first time. Re-enlistments occurred in the islands from the 1860s, and by the 1890s about one-quarter of all newly enlisting Melanesians had already worked in Queensland, Samoa or Fiji. Melanesian labourers were called time-expired when they had completed a three year agreement but opted to remain in Queensland, entering into a new agreement. The proportion of time-expired labourers increased steadily from the 1860s, but no register of their contracts was

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<sup>8</sup> Moore, *op. cit.*, Appendix Four, Table One, 361-2.

<sup>9</sup> *Mackay Mercury*, 23 July 1884, 5 January 1889; *Mackay Chronicle*, 7 July 1897; *Pughs Almanac* (1885), 456; (1886), 458. I am indebted to Mr John Kerr for help in researching these references.

<sup>10</sup> Alexandria Plantation: *Mackay Mercury*, 23 September 1868, 13 July 1872; *Queenslander*, 26 May 1877; C.R. Moore, *Kanaka Maratta: a history of Melanesian Mackay* (unpublished PhD thesis, James Cook University of North Queensland, 1981), 198-202; Pleystowe Plantation: *Mackay Mercury*, 5 February 1870; *Queenslander*, 16 June 1877; Lorne Plantation: *Queenslander*, 26 May 1877; J. Kerr, "Sugar Mills: a Brief Account of the History of Each of the Sugar Mills in the Mackay District", (first published in the *North Queensland Register*, November 1975 to July 1978), 7. (Bound into one volume, in the James Cook University of North Queensland Delamothé Collection); Balmoral Plantation: *Mackay Mercury*, 4 July 1874; Te Kowai Plantation: *Mackay Mercury*, 17 July 1878; *Queenslander*, 19 May, 8 September 1877.

kept until 1884. In 1883 there were 1,476 time-expired Melanesians in Queensland, about one-quarter of the total number.<sup>11</sup> At Mackay between 1888 and 1904, eighty-four per cent of the total number of agreements, varying between a few months and three years, were made by time-expired labourers. Already trained, less likely to fall ill, preferring shorter contracts, and mobile within districts and between districts, they worked primarily on small cane farms not on plantations. The final category of Melanesian labour was an elite but constantly diminishing group known as ticket-holders. In 1884 the Queensland government placed occupational restrictions on all Melanesians in the colony, except for 835 who had been resident since before September 1879. Expressed as a proportion of the overall Melanesian population of Queensland, from 1885 to 1906, in any one year ticket-holders constituted between seven and eleven per cent of the Melanesian population. They were farmers, seldom indentured labourers, and occupied a variety of occupations from boarding house keeper to market gardener. The time-expired and ticket-holding Islanders were a considerable proportion of the Melanesian population. They were not subservient in the way first-indenture labourers often were; they negotiated over wages and conditions and were generally considered obstreperous by Europeans in Queensland.<sup>12</sup>

The wages of Melanesians on three year contracts were paid annually from 1868, and bi-annually from 1876. Time-expired labourers on short contracts were paid more frequently, usually once a month. First-indenture labourers on their first contracts were paid £6 per year, but labourers with previous plantation experience, enlisting in the islands, bargained with recruiters for £8 or £9, or as high as £12 in the final years of the trade. Recruiters always left trade goods, worth anything from 10/- to £2, with the relatives of recruits; but some re-enlisting men asked for the amount to be paid directly to them when they embarked. These recruits had a pound or two in their possession right from the beginning of their contracts. The wages of time-expired labourers varied: between 1884 and 1903, on average, they each earned from £13 to £23 a year. Ticket-holders were usually self-employed. They certainly earned more than time-expired labourers, and were quite likely to be earning as much as poorer Europeans.<sup>13</sup> Theoretically new recruits would have no money whatever in their first twelve months of service before 1876, and in their

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<sup>11</sup> *Votes and Proceedings of the Queensland Legislative Assembly (QVP)*, 2 (1883-4), 1445.

<sup>12</sup> Moore, *op. cit.*, 123-69; R. Shlomowitz, "Markets for Indentured and Time-expired Melanesian Labour in Queensland, 1863-1906: an Economic Analysis", *Journal of Pacific History*, 16, (2) (1981), 70-91; and, "Time-expired Melanesian Labour in Queensland; the Measurement of Job Turnover, 1886-1906", *Ibid.*, 20 (1) (1985), 55-56.

<sup>13</sup> Shlomowitz, "Markets" *ibid.*, 78-79; Moore, *op. cit.*, 170-73. In the same period European labourers received an annual wage of between £30 and £50, plus board and lodgings.

first six months thereafter. But even the most penniless could expect to share in alcohol, obtained by relatives or men from the same language area, or by friends met on board ship, who were of longer service and therefore in possession of money.

There must have been many months each year when the majority of the labourers had no direct access to money. A standard size bottle of rum, gin, brandy or whisky cost between 6/- and 9/-, though publicans and shop keepers also decanted spirits into soft drink bottles, for 3/- a bottle, and sold beer by the billy-can or bottle. Alcohol produced in illicit stills was much cheaper, and Melanesians were also constant customers at these stills.<sup>14</sup> To purchase a bottle labourers clubbed together with others from the same island or language group, or with their mates living close by. Some chose to do washing or other odd jobs for Europeans working on the plantations. Another method of gathering cash was to steal property from an employer and sell it, to steal from other Melanesians, or even to try burglary. "Old hands" fleeced gullible "new chums" in gambling games.<sup>15</sup> "New chums" often did not fully comprehend the relative values of coins of the realm and it was not unknown for them to prefer a penny or a half-crown to a gold sovereign, because the lesser value coins were bigger.<sup>16</sup> "Old hands" were quick to take advantage of them. There were also less obvious ways of making money, by accepting rewards for performing sorcery and murders. And, if the craving was too strong, and the money available too little, there was always one way of getting drunk for free. Field workers were known to fake the symptoms of snake bite, to get drunk on part of the cure: a hefty swig of spirits.<sup>17</sup>

On weekends the Islanders were free to roam around, visit friends on neighbouring plantations and farms, go fishing or hunting, go to the missions, or head for any of the small towns in the valley, or to Mackay. On any weekend night in the 1880s between 500 and 800 Islanders converged on Mackay. Most headed straight to Chinatown, the cosmopolitan shanty suburb on the edge of the European

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<sup>14</sup> R.W. Goodall to Inspector of Distilleries, Brisbane, June 1880, CPS 10B/G1: QSA. Goodall noted that the still was operating in a rural area on the north side of the Pioneer river and that Melanesians were going there almost daily to buy alcohol; *Mackay Mercury*, 28 June 1892.

<sup>15</sup> *Mackay Mercury*, 17 February 1886, 28 January, 3 March, 6 December 1900; Mackay Planters Association Minute Book, 1 January 1883; Delamothe Collection, James Cook University (JCU). Also refer to Moore, *op. cit.*, Appendix Four, Table One, Items 25 to 28: Burglary, Larceny, False Pretences, Illegally on the Premises, 361-2.

<sup>16</sup> *Sugar Journal and Tropical Cultivator*, 2 (1894), 316; *Mackay Mercury*, 28 January 1902, quoting *The Leader*, 4 January 1902. Oral testimony from Melanesians in Queensland is recorded in the Black Oral History Collection (BOHC) of the History Department, JCU. BOHC Tape 4B (Winnie Miller and Noel Fatnowna); 7B (Norman Fatnowna); 37B (Sam and Flo Bobongie).

<sup>17</sup> *Mackay Mercury*, 17 February, 1876.

business centre, inhabited by Asians, Melanesians, Aborigines, and Europeans of dubious reputation. Here they could shop for goods to fill their trade boxes, try their luck in a Chinese gambling parlour, or visit a brothel. There were no hotels in Chinatown though several bordered it; but there were plenty of boarding houses and shops which sold sly-grog. Others wandered over to the streets of the European business centre, where several of the stores specialized in goods favoured by Melanesians, or waited quietly in the shadows while some European or Asian fronted the bar to buy them a bottle of alcohol, for a substantial commission.<sup>18</sup>

Mackay and district had dozens of hotels. Most of them featured in the Courts at some stage, their publicans fined for supplying alcohol to Melanesians. Indeed, some publicans featured so regularly that one is left to wonder how much money they were actually making from Melanesians, given that they did not seem perturbed by fines ranging from £5 to £20. The earliest case known of a publican being charged is November 1876. The police happened upon half-a-dozen Islanders sitting in the bar of J. Cook's hotel.<sup>19</sup> From then on, each year for the next thirty years anything between two and a dozen publicans were charged with supplying Melanesians. In 1879 Mackay's Magistrate wrote to the Queensland Colonial Secretary that "nearly every publican in this town could have been convicted, many of them more than once, on evidence of kanakas whom they have supplied."<sup>20</sup> The Islanders' favourite hotels seem to have been those on the edge of Mackay, or those in the neighbouring small towns in the centre of the sugar fields.<sup>21</sup>

Publicans almost always pleaded not guilty, forcing the police to prove their case. In at least one-third of the cases known the publicans managed to have the case thrown out of Court because of insufficient evidence. On several occasions when the Melanesian concerned was from French Melanesia, or of mixed race, publicans argued, unsuccessfully, that the person was not covered by the provisions of the *Pacific Island Labourers Acts*. Because many of the Islanders were still pagan, and even the Christians among them were only semi-literate, speaking pidgin English, not standard English, their evidence was often disregarded. Several cases were dismissed because the police witness could not identify the particular bottle

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<sup>18</sup> Goodall to Colonial Secretary, 8 January 1884, In-letter 495 of 1884, COL/A375: QSA; Moore, *op. cit.*, 181; *Mackay Mercury*, 21 August 1890.

<sup>19</sup> *Mackay Mercury*, 4 November 1876.

<sup>20</sup> Goodall to Colonial Secretary, 10 July 1879, CPS 10B/G1: QSA.

<sup>21</sup> *Mackay Mercury*, 3 April 1886, 26 January 1889, 30 December 1890, 3, 10 December 1892, 26, 31 January 1893, 18, 20, 22 April 1893, 30 April, 7 May 1895, 9, 14 January 1896, 10 November 1896, 2 January 1897, 21 April 1904, 14, 16, 23 September 1905; Residents of Hill End to T. Judge, Inspector of Police, Mackay, 31 December 1885; and Inspector of Police at Mackay to Commissioner of Police, Brisbane, 31 December 1885, COL/A452: QSA; *Mackay Mercury*, 21 August 1890, 20, 22 April 1893.

tendered as evidence.<sup>22</sup> For the police to gain enough evidence for a conviction they either needed good luck in catching Melanesians on licensed premises, or had to pay Melanesian agent provocateurs. A classic case involved Rambai and Sampson, who, in January 1893, were given money by the police to go and purchase alcohol from Evan Davies, licensee of the Commercial hotel. When the police arrived there were thirteen Islanders drinking in the hotel. Evans was fined £6 on two offences. The Magistrate noted during the trial that he had driven past the hotel on Christmas Day and seen fifteen "blacks" at the kitchen door, adding that "They are not there for prayers or cold water."<sup>23</sup>

The police always asked where Melanesian drunks obtained their alcohol, but they usually refused to divulge their source.<sup>24</sup> If either the buyer or the seller wanted to be less straight-forward the transaction could be made in secret, or by a third party. In July 1890 Robert Kippen kept a general store at Conningsby, just north of Mackay. An Islander approached Kippen with money. Kippen refused to supply the man directly, but he was quite willing to accept the money and hide a bottle of alcohol outside at a pre-arranged spot. Unfortunately for Kippen the thirsty Melanesian was a police agent provocateur.<sup>25</sup> Until the 1890s, 95% of the individuals caught for supplying alcohol to Melanesians were publicans, but after 1890 the names are more various, including more Cingalese, Chinese, and European store keepers, labourers and vagrants.<sup>26</sup>

The police, Magistrates and Inspectors of Pacific Islanders were worried by the amount of alcohol that Melanesians were consuming, but felt powerless to stop their supply.<sup>27</sup> In 1888 a Mackay publican was charged with selling alcohol to a Melanesian crew member of the *Fearless*, a labour trade vessel. James Sura went to a door at the back of William Lobie's hotel, bought a bottle of gin, then went to a hut in the backyard to drink it. Lobie had a long record of similar offences. Magistrate Goodall told Lobie that if it was within his power he would have taken

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<sup>22</sup> *Mackay Mercury*, 14 September 1891, 14 August 1897; 1, 6 January 1891; 28 November 1 1899.

<sup>23</sup> *Ibid.*, 21, 26 January 1893.

<sup>24</sup> *Ibid.*, 30 March 1895.

<sup>25</sup> *Ibid.*, 26 July 1890.

<sup>26</sup> Cingalese: *Ibid.*, 15 May, 31 October 1896; Court case, 27 February 1896, DCT 10/N6: QSA; Chinese: *Ibid.*, 14 March 1895, 3 November 1896; European store keepers: *Ibid.*, 26 July 1890, 3 November 1896, 9 March 1901; European labourers: *Ibid.*, 16 February 1895, 17 December 1904, 31 October 1905; European vagrants: *Ibid.*, 4 April 1901, 28 January, 21 February, 14 September 1905, 19 February 1906.

<sup>27</sup> It was so difficult to catch sly-grog sellers that the Inspector of Pacific Islanders based at Cairns went as far as disguising himself as an Islander and hiding among a group going to buy alcohol. Questions were asked in Parliament about his actions, and the *Mackay Standard* of 1 January 1900 criticized him for "excess of zeal".

away his publican's license.<sup>28</sup> W.R.O. Hill, magistrate at the turn of the century, also tried his hardest to stop the illegal traffic in alcohol:

The police under Sub-Inspector Martin did their level best to stop this detestable drink traffic, but were heavily handicapped in this direction by the small kanaka store keepers, who, for the sake of their miserable gains, would resort to any mean device to thwart the efforts of the police...<sup>29</sup>

When store keeper Charles Froggatt was fined £20 for the offence in March 1901 Magistrate Hill warned the community that the next person brought before him on a similar charge would be sent to jail without option of a fine. Down-and-out Europeans, particularly drunks, found that supplying alcohol to Melanesians was an easy way to make a shilling or two. True to his word, in April, Hill sentenced a European vagrant to six months jail in Stuart prison, Townsville, for supplying alcohol to an Islander. Hill dealt severely with everyone brought before him and widened the net of charges to include Melanesians supplying alcohol to other Melanesians, and to Aborigines.<sup>30</sup>

From the late 1870s until the late 1890s, each year there were more than 2,000 Melanesians working in the district. From about the middle of the 1870s there was an escalation in the amount of alcohol consumed by Melanesians. This was partly due to the increase in the number of Melanesian migrants, but it was also related to two government directives. From 1877 restrictions were placed on the ownership and use of guns, ammunition and explosives. Until then a gun and ammunition was usually among the earliest items purchased by any first-indenture labourer. It was not unusual for one man to own several guns.<sup>31</sup> At weekends groups of ten to fifty men roamed around rural areas, all armed. By the mid 1870s Europeans in Queensland were beginning to think about what would happen if there was a major uprising. In the sugar districts along the coast Melanesian males, all in their prime of life, usually considerably outnumbered the able bodied European males. In any uprising, they posed a considerable threat.

In 1877 Mackay district employers held a meeting to discuss the legality and practicalities of disarming their Melanesian servants. There were then about 1,400

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<sup>28</sup> *Mackay Mercury*, 1 October 1879, 14 July, 30 August 1888.

<sup>29</sup> W.R.O. Hill, *Forty-five Years' Experience in North Queensland, 1861 to 1905. With a few incidents in England 1844 to 1861* (Brisbane: Pole and Co., 1907), 122-23.

<sup>30</sup> *Mackay Mercury*, 30 April, 7 May 1895, 25 December 1897, 5 April, 4 October 1900, 9 March, 4 April 1901.

<sup>31</sup> *Queenslander*, 2 December 1876; *Mackay Mercury*, 7 July 1880; J. Cromar, *Jock of the Islands: Early Days in the South Seas. The Adventures of John Cromar, Sometime Recruiter and Lately Trader at Marovo, British Solomon Islands Protectorate* (London: Faber & Faber, 1935), 29, 111-15.

Islanders in the district, about 1,000 of them with firearms. They were disarmed over two days in May by W.R. Goodall the Magistrate and Inspector for Pacific Islanders, with the aid of the district's five police officers, and backup support from the Native Police. The event went smoothly and thousands of pounds worth of guns and ammunition were confiscated without recompense.<sup>32</sup> The effectiveness of the ban did not last long and by 1880 the prohibition was no longer fully observed.<sup>33</sup> Between 1877 and 1907 official policy varied. At different times a variety of rules were enforced, or more often ignored. It is clear that Melanesians continued to possess guns for the entire span of time they were involved in circular-migration to Queensland, though at times access was limited. When restrictions on the ownership of firearms and ammunition were stringently enforced the Islanders had plenty of money spare, and often spent it on alcohol.

The other initiative which also inadvertently increased the rate of alcohol consumption was the change in the system for paying wages. Until 1876 wages were paid annually. After 1876 wages were paid bi-annually, doubling the number of occasions when the labourers had enough money to get drunk with their friends.

### Melanesian Drunks

By the 1880s drunkenness amongst Melanesians was a problem of serious proportions. Drunken bands of Islanders roamed the rural areas, or played at being bushrangers on the roads, some armed; and all of them were ready for skylarking, fighting and giving cheek to passers-by.<sup>34</sup> Many a pious Christian on the way to church on a Sunday morning was accosted by drunken or hung-over Melanesians. "North Side Resident" in a letter to the editor of the *Mackay Mercury* in 1887 said that

The crossroads at the Mandarana Church is a favourite spot for these savages, and their yells and jabbering can be heard a goodly distance when camped there, while their presence makes the road quite impassable for the time being. It is also a quite common occurrence to meet them on the Bowen Road between "Hill End" and "The

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<sup>32</sup> Goodall to Freudanthal, Fort Cooper (Nebo), 8 May 1877, Goodall to Colonial Secretary, 18 May 1877, CPS 10B/G1: QSA; *Mackay Mercury*, 12, 19, 26 May 1877; *Queenslander*, 19 May 1877; James Martin Diary, 19 May 1877, B1322-1: Mitchell Library.

<sup>33</sup> Moore, *op. cit.*, 231-32; O.W. Parnaby, *Britain and the Labour Trade in the Southwest Pacific* (Durham, N.C.: Duke University Press, 1964), 174; *Mackay Mercury*, 6 January, 23 March, 6 April 1878; *Queenslander*, 2 February 1878; *Mackay Mercury*, 7 July 1880; Mackay Planters' Association Minute Book, 1 February 1881: JCU; *Mackay Mercury*, 30 April 1884, 11 December 1894.

<sup>34</sup> *Mackay Mercury*, 7 October 1885, 1 March 1887, 14 February, 25 August 1888, 9 July, 3 September, 7 November 1889.

Leap", in mobs of half a dozen or more, all well supplied with guns, powder and shot, carried quite openly.<sup>35</sup>

A few years earlier, December 1885, residents of Hill End (now Glenella) wrote to the Mackay Police Inspector, complaining that Melanesians frequented their little town to buy alcohol. The Inspector reported to his superiors in Brisbane that

Hill End is a favourite resort of the islanders employed on the north side of the Pioneer River and from the number who visit the place especially on Sunday nights and get drunk shows pretty clearly that the supplying of liquor to the Islanders is carried on to a great extent. The publican sells the liquor to Cingalese or Chinamen who carry it away and sell it to the Islanders at a high price...Planters have complained to me more than once about the danger that attends them and others on the plantations when those kanakas return intoxicated.<sup>36</sup>

The majority of the drunkenness charges occurred after the mid 1880s and there was a distinct increase in the 1890s, carrying through to the deportation years, 1906-07. Magistrates and Justices of the Peace varied the sentences and fines they imposed, for all races, depending on the number of offences an individual had previously committed, the severity of the offence, and any mitigating circumstances, though when relative incomes are taken into account Melanesians were being penalized more severely. A first offender was often let off with a night in the lock-up and a warning. Those before the Bench for a second or third time were fined between 2/6 or twenty-four hours in the lockup, and £2 or seven days, depending on exactly what they had done, and any associated charges.<sup>37</sup> From the 1880s onwards a new type of case found its way into the Court: Islanders who were habitually drunk, going on alcoholic binges for days at a time. The Bench dealt compassionately with habitual drunkards of all races: they were usually admonished once again and discharged.<sup>38</sup>

### The Missions and Temperance

The establishment of the Anglican and Presbyterian missions in the Mackay district during the 1880s had a controlling influence on the growing alcohol

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<sup>35</sup> *Ibid.*, 1 February 1887, 10, 14, 17 April 1886.

<sup>36</sup> T. Judge, Inspector of Police, Mackay to Commissioner of Police, Brisbane, 31 December 1885. Also refer to Residents of Hill End to T. Judge, Inspector of Police, Mackay, 31 December 1885, COL/A452: QSA.

<sup>37</sup> Some sample cases can be found in *Mackay Mercury*, 3 April, 26 June 1875, 10, 17 October 1877, 3 December 1879, 6 January 1890, 23 May 1891, 4 June 1892, 12 January 1893, 4 February 1907.

<sup>38</sup> *Mackay Standard*, 6 April 1886; *Mackay Mercury*, 7 April 1886, 8 March 1887.

problem amongst Melanesians. Before the missions began work there were a few Christian Melanesians at Mackay, but the white churches did not include them in their congregations. The missions' headquarters and branches were scattered through the central plantation land, within easy walking distance for most of the Melanesians; and there were also mission-sponsored night classes and Sunday schools on some plantations and farms. Both had similar aims: to teach fundamentalist Christianity; to teach literacy in Sunday schools and night schools; to encourage Melanesians to be law abiding; and to stop them from drinking alcohol.<sup>39</sup>

Reverend McIntyre, the Presbyterian missionary, was able to claim in 1893 that two-thirds of the Melanesians in the district had pledged themselves to abstain from alcohol. Two years later he gave an exact number: 2,158 Melanesian men and women had taken the pledge since the mission began.<sup>40</sup> McIntyre was well satisfied with the progress that his mission had made:

...there are plantations in this district where, a few years ago, on Sundays it was a veritable pandemonium, where hell seemed to have been let loose, and where drunkenness and fighting endangered the lives of blacks and white alike. On these same plantations the Sabbath is now one of peace and tranquility. In the place of the shrieks of the drunkard, the hymns of praise to Almighty God rise peacefully from the boy's quarters.<sup>41</sup>

Less is known of the temperance activities of the Anglican Selwyn mission, but it also held crusades and encouraged its members to sign the pledge.<sup>42</sup> The numbers of pledgers and McIntyre's claims are impressive, but so are the number of charges of drunkenness over the same period. Perhaps the key to the significance of the pledges is George, an Islander working on Te Kowai plantation in 1890. He regularly attended the Selwyn mission, and also occasionally drank at the Victoria hotel.<sup>43</sup> Taking the pledge was more often done for entertainment or from a desire to please the missionaries, than out of conviction. Mission activities did keep occupied many Melanesians who prior to the 1880s spent their spare time getting drunk, when they had the money. But neither Court fines nor threats of damnation made a great deal of difference.

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<sup>39</sup> Moore, *op. cit.*, 306-20.

<sup>40</sup> *Mackay Mercury*, 13 May 1893; H. M. Nelson, Chief Secretary, to Governor Norman, 1 August 1895, with extract from the *Brisbane Courier*, 9 May 1895, In-letter 8184 of 1895, COL/A807: QSA; Report on Missions to Kanakas to the Presbyterian General Assembly, Brisbane, May 1895.

<sup>41</sup> *Mackay Mercury*, 4 August 1892.

<sup>42</sup> *Ibid.*, 16 April 1893.

<sup>43</sup> *Ibid.*, 25 December 1890.

### The Effect of Alcohol on Melanesian Health and Society at Mackay

There is no evidence of betel nut chewing or kava drinking by Melanesians in Queensland. The genus including the *Areca Catechu* palm which produces betel nuts is native to northern Australia, but there is no evidence that Melanesians cultivated the palm nor any of the related species which are sometimes used as substitutes. There are records of Melanesian crews of recruiting vessels purchasing large quantities of betel nuts, lime and the accompanying pepper vines or tree barks in the islands. But these supplies soon ran out and it would have been rare for the nuts, leaves or bark to have survived uneaten until the vessels reached Queensland. One Government Agent noted his surprise at how easily the Melanesians coped without betel nuts when the shipboard supplies ran out.<sup>44</sup> And while recruits may have had betel nuts with them on board recruiting ships, nuts for chewing are selected at a different stage of ripeness to nuts for planting. *Areca* (betel nut) palms take a decade to bear fruit, but the average recruit only stayed in Queensland for three to six years. Of the Melanesians who came to Queensland the use of kava is only significant amongst those who came from southern Melanesia, and although the shrubs from which it is manufactured grow more quickly than *areca* palms, there is no evidence that it was brought to Queensland by recruits. Commercially produced alcohol, and tobacco (bought and home-grown), seem to have been adopted as substitutes.<sup>45</sup>

The recruits were almost all young men in their prime of life, bereft of female company, spending their working and private lives with groups of men. Consumption of alcohol seems to have been an exclusive male preserve. Women never comprised more than six per cent of the recruits; and all women either arrived with a husband, gained one on the voyage out, or married soon after they arrived in the colony.<sup>46</sup> They were not free agents, and as is the pattern with alcohol consumption in contemporary Melanesia, women did not participate. Certainly, there is no evidence of Melanesian women drunks ending up in front of the Bench at Mackay.

The worst drinkers were time-expired labourers, Melanesians working as crew on labour trade vessels, and presumably the ticket-holders. These men had the

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<sup>44</sup> D. Rannie, *My Adventures among South Sea Cannibals. An Account of the Experiences and Adventures of a Government Official Among the Natives of Oceania* (London: Seeley, Service, 1912), 57; Mills Diary, 24 March 1884, CRS/151: QSA. I am indebted to Ms Caroline Edmonson for locating these references.

<sup>45</sup> Another conjectured source of drugs, both alcohol and narcotics, is the many patent drugs on the market which were based on narcotic ingredients. S. Eldred-Grigg, *Pleasures of the Flesh: Sex and Drugs in Colonial New Zealand 1840-1915* (Wellington: Reedf, 1984), 112-13.

<sup>46</sup> Kay Saunders, "Melanesian women in Queensland 1863-1907: some methodological problems involving the relationship between racism and sexism", *Pacific Studies* IV (1) (Fall, 1980), 26-44.

easiest access to money, and were the most knowledgeable in the ways of life in the colony. Europeans considered time-expired men the most obstreperous, often complained about their behaviour and advocated restrictions on them. The worst offences by drunken Islanders occurred when time-expired men were milling about Port Mackay at the end of contracts, waiting for a vessel to take them home. Publicans did well selling alcohol to them. Once they had filled their boxes with trade goods and, if they could, obtained a gun and ammunition, the rest of their cash was superfluous. European currency was not of much use back on their islands, so like tourists in foreign countries trying to use up all of their local currency, they frittered away any cash they had left, often on alcohol.<sup>47</sup> The very worst Melanesian drunks seem to have been those who worked on labour trade vessels. Islander members of crews were often still drinking in Mackay hotels when their ships departed from the tidal river to anchor outside, and had to hitch rides out on other craft, then jump overboard and start swimming to their ships. The harbour pilot at Mackay recorded rescuing many of them from the water, and noted that they were invariably drunk and usually had one or more bottles of rum stuffed into their shirts.<sup>48</sup>

Thousands of pounds changed hands when the Inspector of Pacific Islanders paid labourers. Bouts of drinking occurred in the week or so after pay days, in the same pattern as was common among European and Aboriginal seasonal workers. On these occasions alcohol was purchased by the case, and whole plantation labour lines got drunk. Islanders quarrelled in the main streets of Mackay and in the lesser towns. It was wise for non-Melanesians to keep out of the way as the Islanders were usually aggressive and obnoxious, and often violent. Three examples from 1889 will suffice to indicate the extent of their behaviour. On a Saturday night in July a mob of sixty to seventy Islanders were all over the road between River plantation and the Mackay cemetery, fighting, cursing, and intercepting passers-by, grabbing at the reins of horses. In September, the *Mackay Mercury* noted that any time between Saturday night and Monday morning it was usual to meet mobs of drunken Islanders almost anywhere. And in November three Europeans were stuck-up in Cemetery road by three Melanesian drunks, Bombassie, Arrass and Gabo, demanding alcohol. They treated to "kill the white b...", and hit one of their victims.<sup>49</sup>

Given the fragmentary nature of the evidence, it is difficult to distinguish between alcohol abuse and alcoholism. There was probably very little alcoholism. Several Islanders died from excessive consumption of alcohol, usually from

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<sup>47</sup> *Mackay Mercury*, 20 August 1884; 5, 12, January 1889.

<sup>48</sup> *Mackay Mercury*, Jubilee Edition 1912, p.24; and 15 July 1886, 30 August 1888.

<sup>49</sup> *Ibid.*, 9 July, 3 September, 7 November 1889.

swigging a whole bottle of rum or brandy. But it seems most likely that these isolated instances (four cases)<sup>50</sup> were due to inexperience not over-experience. Most Melanesians never had enough money to sustain alcohol addiction. The worst drunks went on alcoholic binges lasting for days, but these bouts would have been followed by long money-less periods of sobriety until the next cash wind fall. Though, as shop keepers allowed Melanesians to obtain expensive items, such as guns, on credit, publicans and sly-grog sellers were probably also willing to advance credit for the purchase of alcohol.

### **Racism and European Hegemony**

Melanesian labourers must have felt anxiety, aggression and a sense of alienation and powerlessness in colonial society. They were bonded workers in a master-servant relationship, governed by legal penalties imposed to keep them subservient, if not docile. Men and women fresh from the islands had never worked such long, regular, boring hours and days, chipping weeds, and planting, stripping and cutting cane. They faced restrictions on the type of work they were allowed to perform, the areas of the colony in which they could live and, in the 1890s, restrictions on their movement from one district to another.<sup>51</sup> Racism was part of the ethos of colonialism in Queensland. From the moment Melanesians stepped aboard recruiting boats they encountered racism in every aspect of their dealings. Melanesians are a proud race with a warrior tradition. But in Queensland they were "niggers", shunned by Europeans, but too useful to do without. They can only have resented this treatment.<sup>52</sup>

The Queensland sugar industry was maintained and expanded through European entrepreneurs, both plantation owners and small farm cultivators, who sought to maintain their dominance by controlling access to the means of production. Melanesian labourers were closely supervised in day-to-day work, and controlled by a variety of government regulations not applied to other racial groups. They were fitted into already existing European ethnic and class structures, at least to the satisfaction of the Europeans. The whole body of practices employed by, and the

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<sup>50</sup> JUS/N46 1875/318: QSA; *Mackay Mercury*, 21 August 1875, 11 July, 4 November 1889. In one case Davey from River plantation died from drinking a bottle of carbolic oil, which he mistook for alcohol.

<sup>51</sup> Moore, *op. cit.*, 140-47.

<sup>52</sup> Melanesians were either called "Kanakas" (a Polynesian word for man), or "niggers". Several elderly European residents of Mackay, interviewed in the 1970s when they were in their 80s and 90s, referred to the Melanesians as "niggers". Kay Saunders' section in R. Evans, K. Saunders and C. Cronin, *Exclusion, Exploitation and Extermination: Race Relations in Colonial Queensland* (Sydney: Australia and New Zealand Book Co., 1975), 147-234, is the best account of racial responses towards Melanesians in colonial Queensland.

expectations of, Europeans in Queensland, were intended to intimidate and force Melanesians into a subordinate role. Even the best-educated Europeans thought of Melanesians as some kind of race intermediate between Europeans and their animal ancestors. Melanesian labourers in Queensland had to put up with the bullying and racism of Europeans whose whole body language and *modus operandi* could be an aggravation and an insult. It is not at all surprising that some individuals in such surroundings availed themselves of alcohol as an escape.

Melanesians in Queensland lived in an almost totally male environment. The male-female imbalance disrupted the men's previous social roles within their island societies. The loss of women could not be made up for by comrades at work, close friends, even lovers amongst the other males. They must have been frustrated by the lack of women but they were powerless to do anything about the sexual imbalance. Alcohol, mixed with fighting over the few women available, frequently exacerbated violence.

But alcohol was more than an escape: it was also a bridge used by Melanesians to join the other colonists, to show that they were familiar with one important activity within European society, which through their enjoyment of it joined them to the rest of the community. B. Burton-Bradley and Eugene Ogan, writing on attitudes towards alcohol in Papua New Guinea, both comment that young adult males in particular related their right to consume alcohol to identification with Europeans. Drunken fantasies allowed them to narrow the social and economic gulf.<sup>53</sup> This was probably also true in nineteenth century Mackay.

Europeans and Melanesians did occasionally drink together, but we know very little of specific relationships. European and Melanesian labourers on the same plantations could become friendly. Take, for example, Ole Matsen from Denmark and Billy Seekis from Lifu island. Matsen arrived in Mackay in 1872, and got his first job on Pioneer plantation. Seekis was also working there, having arrived the year before. Matsen used to help Seekis and his friends by re-writing their letters home into a nice firm hand and was on good terms with them. Fifty years later they were both elderly and still living in the district. Matsen now retired from life as a successful farmer, and Seekis, one of that rare breed, the ticket-holders, had his own carting business. They often met each other when they were in town and chatted over old times.<sup>54</sup> Friendships did form, regardless of racial differences. One

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<sup>53</sup> B. Burton-Bradley, "Alcohol Dependency in Papua New Guinea", *Papua New Guinea Medical Journal*, 19 (1976), 30-35; E. Ogan, "Drinking Behaviour and Race Relations", *American Anthropologist*, 68 (1964), 181-87; and "'Taim Bilong Sipak': Nasioi Alcohol Use, 1962-1978", *Ethnology* 25(1) (1986), 21-33. Also refer to J. Conroy, "Problems of Alcohol: an Idiosyncratic Survey", in his *Essays on the Development Experience in Papua New Guinea* (Boroko: Institute of Applied Social and Economic Research, 1982), Monograph No. 17, 103-32.

<sup>54</sup> Ole Matsen, Diaries One and Two; *Mackay Mercury*, 3 May 1957.

alcohol-inspired instant friendship developed in Mackay one night in September 1881. A drunken Islander fell off one of the wharves along the Pioneer river, and was rescued by a European man. After the rescue they both went off to the nearest hotel. Or consider the case of Mamawai, Castel, Tom and Jimmy, who were caught drinking in John Thomas's house in 1907. Mamawai had paid for the alcohol, though unfortunately for Thomas he had to pay the fine. But sometimes promising relationships obviously did not work out. In January 1906 Alick was visiting the house of a man named McCann. McCann and Alick got drunk on whisky, then for reasons unknown Alick grabbed an axe and chased McCann to the next house, threatening to kill him.<sup>55</sup> How often, and how close relationships were, is difficult to reconstruct. Even the best intentioned Europeans would have been paternalistic in their attitudes towards the Melanesians. Alcohol was both an aggravation and a levelling factor allowing Melanesians to feel drunkenly equal to Europeans, and one would hope, aiding a few Europeans in understanding that Melanesians were, after all, human.

### **Drunkenness and Crime**

Several authorities on alcohol consumption in the Third World have suggested that fighting and violence associated with alcohol can become a substitute for traditional warfare. Mac Marshall in his *Weekend Warriors*, a study of the effects of alcohol on the people of Truk in Micronesia, supports this contention as do authors in the major study on alcohol consumption in Papua New Guinea.<sup>56</sup> Linked with this is the fact that in Oceania drunkenness is often regarded as a legitimate expression of aggression, an altered state of consciousness when individuals cannot be held entirely responsible for their words and deeds. Marshall's description of this as a "culturally sanctioned mask of temporary insanity"<sup>57</sup> is particularly apt. Other writers have described what is generally called the "wild man" state, the term applied to drunks in modern day Papua New Guinea when men run amok, but are regarded socially as belonging to the same category as people possessed by supernatural spirits, and are not considered fully accountable for their actions.<sup>58</sup>

In 1891 the *Mackay Mercury* claimed that thirty per cent of the crimes reported in the first six months of the year were the result of Melanesians being drunk or

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<sup>55</sup> *Mackay Mercury*, 7 September 1881, 4, 5 April 1907, 14 January 1896.

<sup>56</sup> Marshall, *op. cit.*

<sup>57</sup> Marshall, *Weekend Warriors*, 53.

<sup>58</sup> *Ibid.*, 112; M. Strathern, *No Money on Our Skins: Hagen migrants in Port Moresby* (Port Moresby and Canberra: New Guinea Research Unit, Australian National University, 1975), New Guinea Research Bulletin No. 661, 238-9.

arose in some way from their use of alcohol. If absconding from hired service, disobedience or assault in the fields were included, about fifty per cent of all recorded local crime was connected to Melanesians.<sup>59</sup> Alcohol consumption was the root cause of a great number of the violent acts committed by Melanesians at Mackay. Racial tensions bubbled just below the surface of colonial society. On several occasions between the 1870s and the turn of the century Europeans in the district were expecting uprisings by the Islanders. Fortunately the flashes of inter-racial violence that occurred were all reasonably small and brief. In 1877, at the time when all of the Melanesians' guns and ammunition were rounded up and confiscated, there were about 1,800 Melanesians in the district, but only about 500 able bodied European males. The European settlers were worried about the consequences for them if the Melanesians resisted. Fears of uprisings are a constantly iterated theme in the newspapers. In 1895, after a series of vicious murders of Europeans by Melanesians, particularly by Malaitans, a public meeting was held in Mackay to discuss once again disarming the Islanders. The meeting suggested that all firearms be confiscated, that they also be prohibited from owning other lethal objects, such as customary weapons and knives, and that a system of passes be introduced to control their movements when they left the plantations and farms on which they were employed.<sup>60</sup>

There are many reports of Melanesians blocking roads and accosting passers-by. Drunken brawls regularly developed in the streets of Mackay and the police often had to cope with difficult situations.<sup>61</sup> There were similar disturbances in all of the Queensland sugar towns during the nineteenth century, and armed skirmishes were not unusual. Kay Saunders has catalogued a number of these incidents. Forty Melanesians and 100 Europeans were involved in a riot at Bundaberg in 1883, and from the same town in 1901 comes a report of 1,000 riotous Melanesians "inspired by whiskey, gin and opium". The journal which carried the report luridly added

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<sup>59</sup> *Mackay Mercury*, 18 August 1891. An interesting comparison can be drawn with crime statistics in contemporary Papua New Guinea. In 1977 Deputy Chief Justice Sir William Prentice, was quoted as saying that as many as 80% of offences such as murder, rape, stealing, and housebreaking were committed while the persons concerned were under the influence of alcohol. More recently an authoritative study on law and order in Papua New Guinea has suggested that in some areas no less than 70% of all serious crime was alcohol related. Ogan, "Taim Bilong Sipak" *op. cit.* note 52, 23; W. Clifford, L. Morauta and B. Stuart, *Law and Order in Papua New Guinea*, Volume 1: Report and Recommendations, (Port Moresby: Institute of National Affairs, 1984), 89.

<sup>60</sup> *Mackay Mercury*, 13 August 1895; In letter 10053 of 1895, COL/A792: QSA.

<sup>61</sup> *Mackay Mercury*, 30 March 1878, 31 December 1879, 14 April 1891, 4 April 1896; see also 3 March 1898.

that: "Some of these days, some of the Kanaka towns of Queensland will be laid in ruins by the drunken orgies of their semi-cannibal population".<sup>62</sup>

The most serious racial disturbance occurred at Mackay in 1883, caused by excessive consumption of alcohol by all concerned. The incident, known as the Racecourse riot, occurred on Boxing Day at the big race meeting of the year. A Mackay publican operating a liquor booth at the race track refused to supply alcohol to a New Hebridean, Boslem, who had already been drinking with his friends. As a result a quarrel began amongst some of the Islanders, which turned into a bottle-throwing skirmish, ill-directed bottles hitting Europeans. None too sober themselves, the Europeans retaliated and the small incident turned into a full-scale riot. Melanesians forgot their differences and grouped together against the Europeans, the two sides backing and advancing for some time before European reinforcements arrived from the nearby Caledonian hotel. Fifty to sixty European horsemen took to the field wielding stirrup irons and riding crops. By the time the police and cooler-headed spectators gained control many of the rioters had received serious injuries. At least three Melanesians died as a result of the riot, but legend suggests a larger number. Europeans at Mackay were understandably disturbed and petitioned the government to impose restrictions on all Melanesians, but particularly on the time-expired men.<sup>63</sup>

Not all of their aggressions were loosed on non-Melanesians, and in fact Melanesians were far more violent in their dealings with fellow Melanesians. At a bare minimum Melanesians murdered 100 people in the district between 1867 and 1907, the majority of the victims being other Melanesians. An unknown number of Melanesians died from sorcery or received mutilating wounds. Some attacks were by individuals on individuals, but there are also many cases of inter-tribal and inter-island group fights. Melanesians were adept at using spears, clubs, bows and arrows, and lately had learnt the killing and maiming potential of metal knives and firearms. How much alcohol was involved is difficult to estimate, but alcohol certainly featured as a cause of many attacks. Rather than replacing traditional fighting, alcohol may well have exacerbated fighting on the plantations. Melanesians in Queensland came from more than seventy different islands, and many more language and dialect groups. They were gathered together in groups that inadvertently included enemies from other islands or language areas. Suspicions, competition, tensions, linguistic misunderstandings, battles between rival sorcerers

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<sup>62</sup> Evans, *et al.*, *op. cit.*, 220.

<sup>63</sup> C. R. Moore, "The Mackay Racecourse Riot of 1883", in B.J. Dalton (ed.), *Lectures on North Queensland History: Third Series* (Townsville: James Cook University of North Queensland, 1979), 181-96.

and political leaders, and between antagonistic tribal and language groups, were commonplace and were constantly inflamed by the influence of alcohol.

### **Conclusion.**

New patterns of Melanesian social stratification were created by colonial regulations, the work regime and the missions. Amongst the Melanesians were first-indenture and time-expired labourers, ticket-holders, Christians, the literate, lay preachers and Sunday school teachers: all of these categories were additions to customary Melanesian divisions between men and women, and between different types and levels of leadership. At Mackay, leaders of various island or language groups and sorcerers co-existed with lay preachers and ticket-holders. Melanesians who had lived in the district for thirty years co-existed with "new chums" just out from the islands. Fragments of traditional political structures fell together into a mosaic of pan-Melanesian culture. While always vibrant and exciting, this culture was also violent and not predictable. Alcohol played a prominent part in both easing and inflaming community tensions, but also helped to bridge the cultural gap. Drugs of addiction were not new to Melanesians, but alcohol certainly was. Ironically, they were saved from alcoholism only by poverty.

When Memeendi told the Mackay Magistrate in 1900 that he was not guilty, did not understand, and was not at all certain whether he had stolen the beer, because he had been blind drunk at the time, he was expressing bewilderment over a complex phenomenon of human social behaviour. Alcohol dramatically altered the state of consciousness and the normal rules of personal comportment of Melanesians already in a peculiar transitory state between their ordered island world and life as wage labourers in an Australian colony. Its effect can never be measured in any accurate way, but the social history of the Queensland sugar industry is too firmly bound to alcohol consumption for it to be ignored.

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## THE HEALTH OF ABORIGINES ON NORTH QUEENSLAND CATTLE STATIONS

Dawn May

It is widely recognised today that Aborigines are less healthy than white Australians. They have a shorter life expectancy, their infant mortality rate is higher and among their communities malnutrition is widespread. Diseases associated with third world countries are found disproportionately among Aboriginal groups. Although the divergent health profiles of blacks and whites are widely accepted, there has been little historical analysis of the different environments in which Aborigines have lived. It will be argued in this paper that the health of Aborigines was largely determined by their position in the European economy. For instance those living on cattle stations who made such a valuable contribution to the industry had better health, both physical and mental, than their counterparts eking out an existence in fringe camps. This situation began to change from the 1920s when there was increasing interaction between townships and stations.

### Decimation of the Aboriginal Population

Before the arrival of Europeans it appears that Aborigines were relatively healthy, with trachoma and yaws the main endemic infections. From his reconstruction of the early contact situation, Professor Max Kamien concluded that collectively the health of the late eighteenth century Aborigines was "almost certainly better than that of the English, whose occupation of Australia led to the Aborigines' rapid decline."<sup>1</sup> So quickly did the Aboriginal population dwindle it

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<sup>1</sup> Cited in S. McIlraith, J. Reid and M. Franklin, *Aboriginal Health and Life Style* (Canberra: Australian Medical Association, 1982), 5. Abbie argues that trachoma was endemic in the Aboriginal population before the arrival of Europeans. (A.A. Abbie, "The Health of Australian Aborigines", *Organorama*, 3, (3) (1966), 13). Ronald Wood on the other hand believes that there was no evidence of trachoma amongst the Aboriginal population before 1780. (R. Wood, "Ophthalmia in nineteenth century Australia" in J. Pearn and C. O'Carrigan (eds.) *Australia's Quest for Colonial Health*, (Brisbane: Royal Children's Hospital, 1983). This proposition is also supported by Mann who argues that trachoma was introduced by European and Chinese settlers. (I. Mann, "Probable Origins of Trachoma in Australia", *Bulletin World Health Organisation*, 16, (1957), 1166). There has also been a long running debate between Judy Campbell and N.G. Butlin concerning the origins of smallpox amongst Australian Aborigines. Campbell strongly supports a Macassan origin of early epidemics but Butlin believes that the disease was introduced by Europeans at Port Jackson. (J. Campbell, "Smallpox in Aboriginal Australia, 1829-31", *Historical*

was widely believed by the end of the nineteenth century that the demise of the race was inevitable. The only uncertainty was how long the process would take. The editor of the *North Queensland Herald* noted for instance in 1902 that:

year by year the blacks have continued to wither away under the influence of civilisation, until today it seems only a question of a generation or so, judging by the present spread of settlement throughout the continent, when their total extinction shall have been recorded.<sup>2</sup>

Governor William McGregor, after visiting camps around the outback Queensland towns of Normanton and Boulia, concluded that "dirt, rags, venereal disease, hunger and exposure are hurrying the native race to extinction, and, so far, it would not appear that there is to be any survival of the fittest in this race". He was convinced that if the situation continued, Aborigines would have disappeared from Queensland within 50 years.<sup>3</sup> The editor of the *North Queensland Register* thought the process could take twice that time, adding that it "has always been a peculiarity of the Briton that when he has colonised a country, the native races go down".<sup>4</sup>

These observations about Aborigines were largely based on the experience of those living on the periphery of European settlement. In 1897 the Commissioner of Police reported that the 100 Aborigines in Normanton "were the most miserable disease stricken wretches [he] had ever seen but was assured that these were the 'kings and queens' compared with those to the south-west and further along the coast west of and around Burketown".<sup>5</sup> At Camooweal nearly all the 35 individuals

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*Studies*, 20, (81) (1983), 536-556; N.G. Butlin, *Our Original Aggression: Aboriginal Populations of Southeastern Australia 1788-1850*, (Sydney: Allen & Unwin, 1983; J. Campbell, "Whence Came the Pox?" *The Age Monthly Review*, 3, (10), (1984), 19-20; N.G. Butlin, "Macassans and Aboriginal Smallpox: The '1789' and '1829' Epidemics", *Historical Studies*, 21, (84) (1985), 315-335; J. Campbell, "Smallpox in Aboriginal Australia, the early 1830's", *Ibid.*, 336-358). See also D.J. Mulvaney and J.P. White (eds.), *Australians to 1788* (Sydney: Fairfax, Syme and Weldon, 1987), 115-117.

<sup>2</sup> *North Queensland Herald (NQH)* 6 December 1902, 25.

<sup>3</sup> R.B. Joyce, *Sir William MacGregor* (Melbourne: Oxford University Press, 1971), 357.

<sup>4</sup> *North Queensland Register (NQR)*, 13 June 1904, 32.

<sup>5</sup> "Report on North Queensland Aborigines and Native Police", 2, (30). Aborigines who lived in squalid fringe camps were extremely prone to infectious diseases. At the end of 1899 five deaths occurred at Cloncurry during "an epidemic of a disease resembling measles" while at Urandangie just a couple of months later, 13 deaths were attributed to influenza and dysentery. (Annual Report, Northern Protector of Aborigines (AR. NPA), (1899), *QVP* 1900, 5, 590). These camps were viewed with some concern because of the possibility that Europeans would be contaminated. In one instance this led to the Mt. Carbine police officer being authorised to shift the local Aboriginal camp to some suitable place at a convenient distance in order "to safeguard the health

in the local camp were suffering "more or less from venereal", at Cloncurry "the few remaining blacks [were] nearly all diseased and at Mount Garnet it was reported that the natives were 'reeking with syphilis, etc.'"<sup>6</sup> However reports of bush blacks tended to portray a different picture; these people appeared to be healthier than those Aborigines living on the fringes of towns. Northern Protector of Aborigines, Walter Roth noted in 1900 that "the more serious diseases phthisis and syphilis appear to be fairly common in the townships becoming comparatively rarer as the more unsettled districts are reached".<sup>7</sup> Even as late as the 1930s, there were parts of Cape York Peninsula where Aborigines were less affected by European diseases than were those living around towns. It was noted that among the group which ultimately formed the nucleus of the Edward River Mission in 1938, there was a minimal incidence of syphilis, and gonorrhoea was unknown.<sup>8</sup> Similarly, a survey conducted in 1950 revealed that mission Aborigines had a higher incidence of tuberculosis than bush blacks.<sup>9</sup> Between this situation of disease-ridden residents in fringe camps and relatively healthy Aborigines living away from the influence of western culture, were those Aborigines on cattle stations. This chapter addresses their health.

### Experiences on Cattle Stations

Given the isolated nature of stations and poor working conditions, employers have always had trouble attracting white workers into the northern cattle industry. From the 1870s they relied increasingly on Aboriginal stockmen and domestics. Apart from being on the spot, blacks were much cheaper, most receiving only a fraction of the white wage. As it was customary for larger stations to have their own Aboriginal camps for which they assumed some responsibility, employers vehemently rejected the notion that Aboriginal labour was cheap. Nevertheless there were sound economic reasons why these camps were located on properties; it was well understood that black stockmen were less inclined to go "walkabout" and worked better if their extended families were nearby. It is impossible to say with

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of the community", A.P. Herberton to Police officer Mt. Carbine, 18 September 1912, Protector of Aborigines Herberton Letterbook 12 December 1908-24 February 1914, A38082: QSA.

<sup>6</sup> AR. NPA, 1900, *QVP* 1901, 3, 1335.

<sup>7</sup> *QVP*, 1900, 5, 591.

<sup>8</sup> J. Taylor, "A Pre-contact Aboriginal Medical System on Cape York Peninsula", *Journal of Human Evolution*, 6 (1977), 430.

<sup>9</sup> F.W. Macken, Aboriginal Survey - Interim Report 19 October 1950, A/47301: QSA.

any certainty just how many Aborigines were employed in the cattle industry<sup>10</sup> but there is little doubt that before World War 1 the bulk of stockmen and domestics on remote stations were black - probably in the vicinity of five to every European.

The condition of Aborigines living on cattle stations has never been subjected to a systematic medical survey.<sup>11</sup> It is therefore necessary to rely on accounts from people who visited stations. Police Sgt. Green who patrolled the Cloncurry district around the turn of the century was of the opinion that the health of the 76 Aborigines employed on local cattle stations was "good" and in marked contrast to the 108 other blacks in the vicinity. He described the physical condition of 40 of these as bad; some were old and feeble, some were sick, one crippled and three blind.<sup>12</sup> Clearly, Aborigines in such poor health would have been of little use to station owners. It was in their own interest not to allow the well-being of those living on stations to deteriorate to such an extent that they were unable to work. Moreover, the social relations between station blacks and the manager required the "boss" to look after the camp and ensure a steady supply of goods. In return, Aborigines accepted the right of the manager to direct and control their working lives. Station blacks with contagious diseases were often removed to missions and settlements and this acted as a check to the spread of infection on properties. Besides, station Aborigines, particularly those living on their own land, were

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<sup>10</sup> See D. May, *From Bush to Station: Aboriginal Labour in the North Queensland Pastoral Industry, 1861-1897* (Townsville: History Dept., James Cook University 1983), 159-161, and *Aboriginal Labour in the North Queensland Cattle Industry, 1897-1968*, (unpublished PhD thesis, JCU, 1986), 407-411, for detailed discussion of this aspect.

<sup>11</sup> Until recently there have been few studies of Aboriginal health in Queensland. Between 1910 and 1914 Anton Breinl, on his survey trips of northern Australia, documented aspects of Aboriginal health. At the end of the 1920s the Australian Board of Missions commissioned Dr Erben to investigate venereal disease on the Mitchell River (*QPP* 1930, 1, 905). In 1933/4 a medical survey of the islands of Torres Strait and the Aboriginal missions on the east coast of the peninsula was carried out by the Government Medical Officer from Thursday Island. A further medical survey of Aboriginal health conditions in the north was undertaken by Dr. R. W. Cilento on the eastern peninsula as far south as Yarrabah. (*QPP* 1934, 1, 883). At the end of the 1930s an extended medical survey of all the mainland settlements and missions and some of the Torres Strait islands was carried out by Dr. Croll on behalf of the National Health and Medical Research Council. Its primary focus was on the incidence of leprosy and tuberculosis and resulted in the establishment of a leper lazaret on Fantome Island (*QPP* 1940, 1, 1078). Some North Queensland station Aborigines were included in this survey as Dr. Croll examined Aborigines at Dunbar station when he visited the AIM nursing home there. K. Payne to Hughes, 25 July 1939, Folder 1, Box 79, AIM Records 5574: Australian National Library (ANL). In 1950 Dr. Macken, state T.B. officer, personally examined Aborigines living on northern missions and TSI. (See Special Batch on TB. 1947-51, A/47301, QSA). In 1971 the Queensland Institute of Medical Research began a study of the health problems in Aboriginal children on Queensland missions and settlements.

<sup>12</sup> M. Green to Inspector Lamond, Normanton, 8 June 1899, POL/14B/15 58/1899: QSA.

emotionally more settled; many had cash reserves which could be used to pay for medical treatment. In any event, they were less likely to be suffering from malnutrition. All these factors affected health generally, but infant mortality rates specifically.

While observers often noted the paucity of children in town camps,<sup>13</sup> they appeared to be more numerous on northern cattle stations. Photographs taken of Aboriginal groups on stations usually included a number of children. The operators of one such property actually had a reputation for "breeding their own stockmen" and indeed on that station in 1929, there were 11 children.<sup>14</sup> Protector Roles who toured Gulf stations in 1935 expressed "surprise" at the number of young children on the various stations - at least 25 on the 12 properties he visited.<sup>15</sup> In the absence of statistics, it can only be suggested that the infant mortality rate was lower on stations than in fringe camps. In part this can be attributed to a more abundant food supply.

In 1934, Dr. Raphael Cilento found that many North Queensland Aborigines were suffering from "food deficiencies or lack of dietetic balance" which he considered to be the major reason for their diminishing numbers.<sup>16</sup> Protector Roles was of the opinion that the Aborigines on the stations he visited around the same time were well fed, adding that on most stations "there are large gardens, and as beef is cheap, the only expense in maintaining the gins and children is the price paid for flour, viz 4d per lb." He estimated that the cost to stations in maintaining an Aborigine would not exceed 2/- per week.<sup>17</sup> He considered the garden on Dunbar station was "about the largest that he had seen in the District."<sup>18</sup> On nearby Van Rook station it was recalled by others that the residents lived "very well so far as food was concerned; vegetables are grown on the station in season and snake beans particularly thrive up here". Gulf pawpaws, bananas, pineapples, limes, lemons and oranges were also plentiful.<sup>19</sup> Even on remote Delta Downs, gardeners produced an array of delicacies including watermelons, mangoes, custard apples,

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<sup>13</sup> The Governor of Queensland made this observation about the Normanton camp in 1912 noting that there were only three or four children compared with some 60 adults. He wondered how cattle stations would be worked in the future. (Joyce, *op. cit.*, 356). Of the 123 Aborigines around Townsville in 1902, only six were under the age of 10 years. (NQH, 6 December 1902, 25).

<sup>14</sup> Station Manager to Protector of Aborigines (1 April 1929), Lorraine station letterbook held in History Department, JCU.

<sup>15</sup> Report of Normanton Protector of Aborigines, 15 July 1935, 335/14054, A/3811: QSA.

<sup>16</sup> QPP, 1934, 883.

<sup>17</sup> A/3811: QSA.

<sup>18</sup> *Ibid.*

<sup>19</sup> D. Head, "Life in the Gulf Country" *Dawn*, 8, (11) (November 1959), 7.

pawpaws, with potatoes and tomatoes being grown all year round.<sup>20</sup> With an ample supply of fresh fruit and vegetables, the diet of station personnel by the end of the century was a vast improvement on the monotonous salt beef and damper endured by the pioneers. A traveller in 1903 noted that:

On most of the mustering camps, I have seen this year, there have always been vegetables. Pumpkins, carrots, cabbage, eschallots, turnips, and potatoes have been the usual thing to see in a camp while watermelons are to be obtained on many places now, and many of the banks of the creeks and rivers have large patches of these growing wild, and they are very acceptable on a hot day.<sup>21</sup>

One stockman working in the "fearful north" went so far as to argue that conditions on outside stations were superior to those in the more settled areas.<sup>22</sup>

While it is unlikely that Aborigines on these stations ate as well as Europeans, there was nevertheless plenty of beef with fruit and vegetables in season. That station Aborigines were better fed than those living in fringe camps, is not to say that they were well fed. There has not been a survey of the dietary intake of Aborigines on Queensland cattle stations but Winifred Wilson conducted such a study in the Northern Territory. She found there that the food consumption and nutrient intake of stock camp workers was in general more satisfactory than for those working and living around the station. While food in stock camps was usually prepared by a cook, it was common for Aborigines at the headstation to be issued with uncooked rations which were then prepared back in the camp where storage facilities and cooking equipment and hygiene were extremely primitive.<sup>23</sup> Similar rationing arrangements were made on Queensland properties.

Apart from a more abundant food supply, station Aborigines were able to supplement their European diet with food from traditional sources obtained while mustering cattle. An early twentieth century observer has left an interesting account:

Should a snake, iguana, or lizard be observed, it is quickly despatched and attached to their saddles, the tails of the two latter being especially esteemed as great

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<sup>20</sup> *North Australian Monthly*, 15 February 1955, 43. The gardens on many northern stations had been originally established by Chinese who had previously worked on the goldfields. It was also common to see Aboriginal women and older men no longer capable of the strenuous work in mustering camps, engaged in gardening activities.

<sup>21</sup> *NQR*, 23 November 1903, 47.

<sup>22</sup> He wrote that: "There is not to my knowledge one station of any note in the Gulf that has not got a tip-top garden; consequently the men have an ample supply of vegetables and this is more than can be said of most of the stations within the pale of civilisation." (Reprinted from *Croydon Mining Record*, in *NQR* supplement, 2 November 1903). With the removal of Chinese and fewer Aborigines on stations, homestead gardens are largely a thing of the past, fruit and vegetables now being purchased through regular retail outlets.

<sup>23</sup> Winifred Wilson's *Dietary Survey of Aborigines in the Northern Territory*, 42/14/2, Victoria River Downs Records, 42/14: Archives of Business & Labour (ANU).

delicacies...If in camp early, when their horses are hobbled out, firewood procured, fires lit, billies and waterbag filled they turn their attention to whatever amusement or diversion the immediate surrounds will provide. Trees are examined for 'possums, wild bees (or sugar bag, as they call them); the surface of the lagoon or waterhole, as the case may be, will be eagerly scanned for duck or other water fowl; if in the mood they will throw hooks in for whatever fish it may contain to further vary their diet.<sup>24</sup>

Aborigines resident on cattle stations, particularly if they were living on their traditional land, were emotionally more settled than their dispossessed counterparts. Station blacks were able to preserve their traditional lifestyle by incorporating into it aspects of the station routine. It took them little time to realise that if they engaged in stockwork, they could live legitimately on their own land without fear of being hunted, quite apart from having access to traditional food. There were also similarities between techniques involved in mustering cattle and hunting native game. Mustering was done by groups of people under the leadership of a European head stockman. This arrangement suited Aborigines, as they had the company of fellow clan members as in tribal life. Mustering cattle required a high degree of co-operation between members of the group, as in hunting game. It was commonly observed that Aborigines were incapable of working without white supervision. Employers knew that when blacks worked in their own environment they could slip back into their old system if Europeans were not present. One manager actually preferred black to white stockmen but believed it was expedient to employ both: "blacks needed a European to steady and boss them or else a horse or cattle muster would probably turn into a wallaby hunt or a fish spearing expedition".<sup>25</sup> When they worked in their own environment, Aborigines were still able to visit sacred sites many of which were centred around waterholes. Bush blacks were usually kept away from these valuable resources but stockmen could openly attend to their religious requirements. Even the gathering of tribes found a counterpart in the picnic races, which became an important part of outback life for blacks and whites alike. Finally, Aborigines living and working on cattle stations had access to traditional bush remedies.

Station Aborigines were healthier than those living in town camps also because of the Queensland state government's guidelines for station operators.<sup>26</sup> From

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<sup>24</sup> *Dalgety Review*, October 1902.

<sup>25</sup> Cited in May, *Aboriginal Labour*, 152.

<sup>26</sup> The Minister for Health and Home Affairs in 1934 argued that "One thing that we in this state, indeed all civilised people, cannot afford to neglect is the health of the community. We cannot afford to allow people to lose their health; we cannot afford to let people die". (Cited in H. MacPhail, "Women Aborigines and Health in Queensland, 1939-80: Some Preliminary Thoughts

1904, along with a small cash wage, employers were required to provide "suitable shelter, blankets, rations (including tobacco) clothing and maintenance during sickness."<sup>27</sup> In 1914, employed Aborigines became eligible for the benefits of the Workers Compensation Act, the Chief Protector of Aborigines arguing that it would make employers "more careful in their treatment of servants and cause them to protect themselves by insurance in accident corporations".<sup>28</sup> The editor of the *North Queensland Register* was skeptical, pointing out that few employers were aware of their obligations in this regard, but conceded that "the principle is amiable if only to demonstrate that aborigines are not mere goods and chattels - that they have rights and that the employer who recognises the fact will be wise to protect himself by insurance against casualties".<sup>29</sup> Aborigines were excluded from the Station Hands Award in 1918, but a more comprehensive employment regulation was drawn up in 1919. No deductions were to be made from Aboriginal wages for time lost due to sickness or accident contracted or "occurring ordinarily in the course of duty". In addition, the employer was required to

provide every reasonable facility in the event of the illness of an employee or any accidents occurring to an employee for such employee to obtain medical attention or medicine and no charge shall be made against any wages due to the said employee for such attention or medicine without the approval of the local protector". The employer was to be responsible for the cost of medical attention of employees under the age of 18 years. In all cases, employers were required to report the illness or death of an employee to the local protector.<sup>30</sup>

In practice, these requirements were seldom permitted to interfere with the smooth operations of the station. Besides, numerous Aborigines were not legally employed so station managers and owners were able to evade some of their responsibilities. However, strict control of the wages of those Aborigines legally

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in Australia 1939-1988", *Bicentennial History Bulletin*, No. 2, December 1980.) However one of the primary concerns of administrators in relation to Aborigines was to ensure that they cost the state as little as possible. The regulations were designed to see that while they were employed, Aborigines would not be a charge on the state. Strict control of wages and savings accounts also meant that Aborigines had large reserves to tide them over times of sickness and unemployment thus relieving the state of this responsibility at a later date.

<sup>27</sup> *Queensland Government Gazette*, 26 March 1904, 1187-1189.

<sup>28</sup> AR. CPA, 1914, *QPP* (1915-6), 3, 1680.

<sup>29</sup> *NQR*, 6 December 1915, 48. The following year a memo was sent to all protectors advising them that the State Insurance Commission had ruled that it was obligatory for all employers of Aborigines under agreement to insure their employees. (Deputy CPA to All Protectors, 19 July 1916, CPS 12J/W8: QSA).

<sup>30</sup> *Queensland Government Gazette*, 6 June 1919.

employed meant that many had quite substantial bank accounts which could be used to cover the costs of medical treatment.

Despite government regulations, and the fact that station Aborigines were better fed and less traumatised than those living on the periphery of outback towns, infectious diseases were still prevalent. Housing on stations was far from adequate; washing and cooking facilities compared poorly with those supplied to white workers. Lack of adequate amenities facilitated the spread of diseases and in one incident five Aborigines died on Barclay Downs station from "a sickness like typhoid".<sup>31</sup> However, because stations were relatively isolated, there was some check to the spread of infectious diseases. For instance, some North Queensland stations were free of hookworm until the 1950s despite prevalence of the disease on missions and government settlements.<sup>32</sup>

### Changing Circumstances

The transfer of diseases between town camps and stations increased significantly from the 1920s as employers began discharging stockmen at the end of the mustering season rather than keeping them on stations all year round.<sup>33</sup> Those Aborigines forced off stations gravitated to the towns where their bank accounts were held. This gave them access to funds to tide them over the non-working season. During this period, station Aborigines took up residence in town camps, sometimes stretching facilities there to the limit. It was recalled that in the 1940s there were hundreds of people camped on the outskirts of Burketown under makeshift shelter. In Croydon the population of the camp rose from 2 men, 2 women and a few children to 35 men, 14 women and 30 children when station

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<sup>31</sup> *NQR*, 13 May 1918, 73.

<sup>32</sup> AR. CPA, 1918, *QPP* (1919-20), 2, 540. Hookworm was first detected on Forest Home Station in 1955 when a group of new stockmen and their families arrived from a town camp. Mrs. O'Conner noticed that one child in particular had trouble breathing. "With every breath she took she gave a strange grunt as though the inhaling and exhaling of air was an effort to her. Her stomach was distended and her skin the colour of cold ashes." E. O'Conner, *Second Helping* (Sydney: Angus and Robertson, 1969), 130.

<sup>33</sup> The 1919 Aboriginal Regulation required adult Aboriginal stockmen to be paid at two-thirds the weekly rate of Europeans. This represented a substantial pay increase and was followed soon after by a severe downturn in beef prices during the 1920s and into the 1930s. Around the same time, some of the larger stations were subjected to resumptions making them less able to support large camps of relatively unproductive dependants. One way of cutting costs was to send surplus Aborigines to missions and government settlements. Palm Island had coincidentally been set up in 1918. Another means of economising was to discharge Aborigines at the end of the mustering season. This relieved the station operators of the costs of paying Aborigines during the less productive months. This aspect is more fully covered in May, *Aboriginal Labour*.

Aborigines arrived in town.<sup>34</sup> Jean Devanny, a popular novelist, recalled visiting the Normanton camp in the early 1950s:

To reach it we walked across a low-lying salt pan on the edge of the ridge and climbed a gentle slope to the high river bank. There, upon a stark red, flinty belt, stood a collection of horrible corrugate iron and bag structures scarcely to be dignified by the name of huts...Not a tree for shelter, and the iron roofing so low, that the heat in summer would be scorching.<sup>35</sup>

These camps were typically located on the outskirts of outback towns - well beyond the limits of water and sanitary services. Conditions were perfect for the spread of infectious diseases.

The nature of medical treatment changed as station Aborigines came into contact with fringe camps and contagious diseases. From the 1950s, it became common for station Aborigines to be brought into town for hookworm testing and polio vaccinations. Local protectors, who usually made these arrangements, would on occasions also advise employers not to allow their Aboriginal staff into town if there was an outbreak of an infectious disease such as measles or influenza.

Other aspects of preventative medicine were brought to stations as more European women took up residence there. Because of the large number of Aboriginal domestics on cattle stations, managers' wives usually had little to do in the way of housework. Their main responsibilities were associated with the welfare of the station blacks. Elizabeth O'Conner remembered that when there were numerous Aborigines employed on Forest Home she was kept busy "issuing milk to the piccaninnies, dabbing sores with mercurochrome, bandaging and exhorting and endeavouring to keep peace among the women".<sup>36</sup> She recalled that:

In my ignorance I tried to introduce clinic methods to the mothers. "The water for the babies," I said "should be boiled and kept covered in a cool place. And their noses must be kept clean. A piece of cotton wool and some oil is best for that "...I issued them each with a small jar of my precious olive oil. Martha, who had a taste for such things, drank hers with a little salt added. Mary Anne put hers in her hair. Aggie spilt her issue all over Lucy's new dress, and Lucy did not speak to her for a week...During these little lectures on hygiene and care of the young, Aggie and Mary Anne would regard me with serious brown eyes. Martha would squat on the

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<sup>34</sup> Croydon Aboriginal Protector to Under Secretary Dept. Health and Home Affairs, 23 February 1950, A/33326: QSA.

<sup>35</sup> J. Devanny, *Travels in North Queensland* (London: Jarrolds, 1951), 187. Elizabeth O'Conner, a local station manager's wife, visited the camp a couple of years later and left a similarly depressing description. See E. O'Conner, *op. cit.*, 209-10.

<sup>36</sup> O'Conner, *op. cit.*, 129.

ground suckling her infant and smoking a foul-smelling pipe. Every now and again she would remove the pipe and spit. She couldn't care less.<sup>37</sup>

Similarly Dulcie Head, the only white woman on Van Rook station in the 1950s, recalled that she soon made herself useful "in the capacity of nurse - attending to casualties which occur from time to time on or about the station".<sup>38</sup> CPA Bleakley was of the opinion that European women substantially contributed to the smooth running of cattle stations; "the presence of a decent motherly white woman is more protection for the camp women than all the laws, and also a valuable help in the discovery and treatment of sickness".<sup>39</sup>

### Aboriginal Responses to White Medicine

Administering European medical treatment was not always an easy task for these women because of conflicting traditional practices. Rebecca Bode, wife of pioneer squatter F.R. Bode, was left somewhat shaken after attempting to treat a sick child. An Aboriginal stockman had persuaded the mother to let Mrs. Bode look at it. Her granddaughter recalled that:

Finding the child was taking convulsions, Grandmother, put it into a hot bath. All the watching blacks became terribly angry and threatening. Budakey gave the baby back to them and told Grandmother that she had broken a tribal custom by putting the baby into water, so she shut herself and family inside the house and had a frightening night as they roamed around the place shouting and yelling.<sup>40</sup>

The dominance of cultural factors was just as pronounced in parts of North Queensland almost a century later. In the 1950s, for instance, an Aboriginal domestic on Forest Home refused to go to Normanton for hookworm treatment, not because she was afraid of the medication but because an old Aboriginal resident of that town had "threatened to put a bad magic" on her, and she would rather risk hookworm than the evil sorcery of Granny Batfoot.<sup>41</sup>

Knowledgeable Europeans were aware that Aborigines held differing conceptions of the causes of ill health. Chief Protector of Aborigines Bleakley made reference to this in his 1915 annual report pointing out that "the natives" superstitions, fears and want of perseverance often made successful treatment difficult, if not

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<sup>37</sup> E. O'Conner, *Steak for Breakfast* (Sydney: Angus and Robertson, 1958), 22.

<sup>38</sup> Head, *op. cit.*, 6.

<sup>39</sup> J.W. Bleakley, "Can Our Aborigines Be Preserved?", *Australian Quarterly*, 2, (1930), 69.

<sup>40</sup> E. Kerr, F.R. Bode of Bromby Park, typescript of paper read to Queensland Women's Historical Society, 7.

<sup>41</sup> O'Conner, *op. cit.*, 206.

impossible.<sup>42</sup> As far as Aborigines were concerned sickness was usually the result of the malignant magic of distant tribes;<sup>43</sup> accordingly, they placed greater faith in traditional remedies than in European cures. This fact was appreciated by some employers. Mrs. Duncan-Kemp recalled that her father who operated Mooraberri station at the turn of the century always maintained "that as far as the aborigines were concerned sickness and its treatment, no matter how serious, was better left to the ministrations of the medicine man. The Aborigines had great faith in him, whereas they had little trust in the white man or his methods."<sup>44</sup>

This conviction was not without benefits to European employers. By utilising the Aboriginal faith in traditional medicine they could minimise station expenses. During the influenza epidemic which swept Australia in 1919, for instance, many employers sent their station blacks to the bush to recover. At Wrothom Park there were more than 30 Aborigines affected by the disease. Evelyn Maunsell recalled that during the day:

we kept them out in the sun, sitting up if they could, otherwise lying on home-made stretchers...Once they were cured of the flu and strong enough to walk we sent them away on walkabout to recuperate. They had remedies of their own in the bush that would help build up their strength, and we always made it a practice not to interfere with their customs any more than we had to for their own good.<sup>45</sup>

There are many recordings of the reluctance of station Aborigines to seek help from Europeans. The manager of Lorraine station, when reporting the death of a woman advised that she had been "in declining health for some time but the seriousness of her condition was not reported to me until it was too late to render assistance effectively."<sup>46</sup> When pressed by the protector to diagnose the cause of death, the manager pointed out that:

As Minnie refused to go to the hospital where her condition might have been better understood, it is not an easy matter to say decidedly what was actually the cause of death. All that my enquiry has elicited is as follows: A. Somewhat prematurely confined resulting in prolonged debility and ultimately a disorder of the bladder - about two months. B. Nature of attention she received - chiefly from Paddy (her husband) and daughter who received from the station store anything specially required in the shape of food and medicine. C. Death not due to neglect. D.

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<sup>42</sup> AR. CPA, 1915, *QPP* (1916-7), 3, 1734.

<sup>43</sup> H. Reynolds, *The Other Side of the Frontier* (Ringwood: Penguin, 1982), 57; A. Hamilton, "The Traditionally Oriented Community", in *Better Health for Aborigines?* (St. Lucia: University of Queensland, 1974), 19.

<sup>44</sup> A.M. Duncan-Kemp, *Where Strange Gods Call* (Brisbane: Smith and Paterson, 1968), 35.

<sup>45</sup> H. Holthouse, *S'Pose I Die* (Sydney: Angus and Robertson, 1973), 199.

<sup>46</sup> Manager to Aboriginal Protector, Cloncurry, 6 December 1928, Lorraine station letterbook.

Necessaries of life were provided during her illness. E. Body was properly interred.<sup>47</sup>

When another employee from the station had died a few years earlier the manager was equally uninformed about the details of death. "Our boys say he died of heart disease because he died sitting up so we learn something everyday. Another boy says he had rheumatism. No doubt natural causes carried him off."<sup>48</sup>

Even when Aborigines were persuaded to go to hospitals, medical staff encountered resistance as late as the 1950s. The nursing sisters at the AIM hospital situated on Dunbar station frequently had to contend with fears and superstitions of black patients as well as the ailment itself. Recounting one such incident involving an old Aboriginal stockman, visitor Margaret Ford wrote that:

Both Sisters stayed up all night watching Brassey, and the next day because the Flying Doctor was unable to get out, the Aerial Ambulance took him to Cairns. The decision facing Sister Wilson had not been easy to make for it had become established in the minds of the aboriginal folk that once one of their number was taken away in the medical plane he would never return. This was because so often patients were not brought into our hospital until they were very seriously ill, by which time little could be done for them. On the one hand there was little doubt in the minds of the Sisters that Brassey, who was an old man, would die, so by sending him away the hoodoo would be confirmed; on the other hand, as nurses their duty was clear, and they had to appear deaf to the impassioned pleading of his friends and relatives that he be allowed to stay with them.

There was a moving scene at the airstrip when Jessie clung fiercely on to Brassey and prevented anyone putting him into the plane. All the others, now deathly silent, stood around and watched, looking at each one of us with the painful pleading eyes of an animal that knows something is being done to it but cannot understand why. Eventually Mrs. Macrae solved the impasse by persuading Jessie to go too, so she, plus swag which was rushed down from the quarters, plus tobacco pouch, set off as well. The Ambulance bearer was very understanding and assured us they would put her in the hands of the Protector of Aborigines once she arrived in Cairns.

For a few days the hospital sent favourable reports back about Brassey's condition and we hastily conveyed the news to the still strongly distrustful natives. It was quite pathetic observing the way these strangely simple people all shared in the experience. Just as they had all taken the sorrow onto their own shoulders prior to his leaving for Cairns, so now they naively rejoiced in the good news.

Then came the telegram saying he had died. Another of their flock had come to this place, had been sent away by those Sisters, and would never come back again. It

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<sup>47</sup> *Ibid.*, 31 December 1928.

<sup>48</sup> Manager to Sergeant of Police, Burketown, 3 April 1924, *Ibid.*

would be a long, long time before they would have faith in what the A.I.M. was trying to do for them.<sup>49</sup>

On other occasions Aborigines would tolerate European cures but the treatment dispensed by bush doctors was more highly valued. In one instance on Mt. Mulgrave station when an Aboriginal domestic was obviously very sick, the manager's wife prepared the food she considered suitable for the invalid - beef tea, poultry, custard and so forth without success. Mrs. Maunsell remembered that Maggie ate it:

...to please me, but showed no sign of improving and by the time the musterers including her husband, Dick returned was no better. Dick apparently summed up the situation and he asked the boss if he could go walkabout and take Maggie and Robin with them. They all set off and we did not see a sign of them again for about a month...Then one day Maggie appeared in the kitchen...I have never seen a black gin look so dreadful. She pulled aside the dress to show me big weals on her body and on her arms where the skin had been cut with something sharp and ashes rubbed into the fresh wounds. Her head was all bandaged up in bark so I could not see what had been done to it...In spite of her starved appearance and terrible wounds, Maggie pronounced herself cured "me bin all right now, Missus. Me work all right. Him bin let em bad blood out. No more sick now". Dick had apparently taken her to their original tribe in the bush somewhere and the witch-doctor had gone to work on her.<sup>50</sup>

A similar situation occurred on Koolatah station in the mid 1930s. An Aboriginal domestic was badly burnt when a petrol iron exploded. The manager contacted the Cloncurry doctor by wireless and was advised to "give the gin any amount of oil and clean rags". Although this was done, the woman's husband insisted on taking her to a "bush doctor".<sup>51</sup> In another incident at the Dunbar Australian Inland Mission hospital, nursing staff experienced a "very worrying time" when handling a group of Aborigines with extremely high temperatures. Sister Shaw reported that "we spent a good deal of last night chasing them down the paddock and watching in case they went into the lagoon".<sup>52</sup> Immersion in water or the application of wet mud packs was in fact the standard Aboriginal remedy for feverish patients.<sup>53</sup>

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<sup>49</sup> M. Ford, *End of a Beginning* (Melbourne: Hodder and Stoughton, 1963), 36-7.

<sup>50</sup> Holthouse, *op. cit.*

<sup>51</sup> Report of Normanton Protector of Aborigines, A/3811: QSA.

<sup>52</sup> Shaw to Hughes, 10 April 1944, Folder 3, Box 79, AIM records, 5574: ANL.

<sup>53</sup> Taylor, "Pre-Contact Aboriginal Medicine", 426.

Some employers were reluctant to use any non-Aboriginal techniques for treating medical cases because of possible repercussions to station routine. When a young Aboriginal boy was bitten by a snake, the first reaction of the Europeans on the spot was to produce Condyl's crystals and a tourniquet. Just in time they remembered the importance of not usurping the authority of the bush doctor who was treating the child with a paste of ground roots and leaves from a special shrub. These particular Europeans understood the implications of humiliating the medicine man in front of his fellow clan members. Not only would he lose his prestige and standing in the community, "but in the final reckoning might incite open rebellion against the authority of the European. Time has proved that a powerful medicine man is also a diplomat and a powerful ally, and usually his word is law, not only among his own people, but among the neighbouring tribes as well".<sup>54</sup> In another incident involving Inkerman station Aborigines in 1935, the local Protector was highly critical of the station manager who seemingly moved a group of Aborigines off the property to avoid the inconvenience when one of them died. According to the protector, "Big Jimmy in times past has given good and faithful service to the Curr family and he should have received more attention in his hour of need, but he was turned out like a beast that has served its purpose."<sup>55</sup> While this may well have been the case it is also possible that Curr, having a long association with the local blacks, had a good understanding of their different cultural requirements.

### Discriminatory Treatment

Aboriginals' experience with European medicine had done little to generate faith in it. There were, of course, outstanding incidents such as that in which a doctor was brought from Sydney to Herberton by the owners of Valley of Lagoons station to save the life of an Aboriginal stockman,<sup>56</sup> but normally there was less urgency in seeking medical help for Aborigines. It cannot be denied that the Flying Doctor was called to treat Aborigines and ambulances were summoned where it was thought necessary, but employers generally reacted more slowly than they would have done if the patients had been white.

In 1925 the editor of the *Worker* complained to the Minister for Health about the death of an Aboriginal woman on a station near Charters Towers. It was alleged that she was lying on the ground in a hut for three days in childbirth before an

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<sup>54</sup> Duncan-Kemp, *op. cit.*

<sup>55</sup> Report of Normanton Protector of Aborigines, A/3811: QSA.

<sup>56</sup> P. Sutton, *Gugu-Badhum and Its Neighbours*, unpublished M.A. thesis, Macquarie University, 1973, 21.

ambulance arrived.<sup>57</sup> In another incident a young Aboriginal lad broke his arm in a riding accident. Although this was splinted and bandaged by an employee, gangrene set in and it became evident that amputation was the only solution. The bookkeeper contacted the Cloncurry doctor by wire to ascertain the correct procedure. Before this could be implemented a large amount of flesh from the upper arm fell away exposing the bone. This made the operation considerably easier: a sharp knife was used to sever the socket strings at the shoulder and the arm simply dropped off. Throughout the ordeal the boy's strength was sustained by beef tea, tonics and brandy and "anything the station store could supply". It was reported that "at last accounts the shoulder was healing splendidly and the boy [was] learning to make this one hand and arm do double duty".<sup>58</sup> It is difficult to imagine such a cavalier approach being adopted if the patient had been European. Some doctors also adopted a casual approach to Aboriginal patients. For instance when a black stockman from Wrotham Park station told the bookkeeper that he had rheumatism, he was taken to the doctor in Chillagoe for treatment. Sambo recalled that "Dr. Woodhead said I was only shamming and what I wanted was a big stick around me" and with that he was sent back to work.<sup>59</sup>

Just as there were differences in attitudes to black and white patients, Aboriginal women were accorded different treatment from men. Because their contribution to station routine was considered less important, Aboriginal women received less attention than the men. Sensing the seriousness of his wife's condition, an Aboriginal stockman on Strathmore station pleaded with the manager to send the woman to hospital. Nothing was done, however, until it was too late and she was dying.<sup>60</sup> In another instance it was reported that an Aboriginal woman on Lorraine station had been sick for two weeks and complained of pains in her legs which the manager concluded was rheumatism. When she eventually became so weak she could no longer stand up, her husband was instructed to take her to Burketown hospital for treatment. The pair got only 20 miles along the road before the woman died.<sup>61</sup> A few months later however an Aboriginal stockman from the same station was sent for treatment for a wound which would not heal. The manager advised the

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<sup>57</sup> The subsequent inquiry revealed that the woman had received all the assistance possible, the problem being the time taken for the ambulance to arrive. Editor of *Worker* to Home Secretary, Bundle HOM/J564: QSA.

<sup>58</sup> *NQR*, 21 April 1902, 39; the same story was reported in *Science of Man*, 26 April 1902, 44-5.

<sup>59</sup> Wrotham Park Inquiry, A/31709: QSA.

<sup>60</sup> Georgetown Aboriginal Protector to Home Secretary, HOM/J454, 23/834: QSA.

<sup>61</sup> J. Kirkaldy to Protector of Aborigines, Burketown, 7 January 1913, Lorraine station letterbook.

protector to arrange the necessary hospital treatment "for which the station will pay unless you utilise the amount to his credit in your books for that purpose".<sup>62</sup>

To some extent, managers' reluctance to send employees to local hospitals was justified. In 1901, Protector Roth noted that "there was a tendency for certain hospital committees to repudiate or rather, to put obstacles in the way of admission of black patients".<sup>63</sup> Nowhere was this more apparent than at Burketown where no provision was made for Aborigines "directly or indirectly".<sup>64</sup> The situation remained unchanged for many years. In 1913, the manager of Lorraine station was angered by the poor treatment one of his employees received. "It is to be conjectured", he wrote to the hospital secretary:

that the Committee considers the treatment of a case by a wardsman is equal to, and worth as much as that by a medical practitioner, also that the charge for an Aborigine camping in the morgue (or as Tiger expresses it, in the deadhouse) or on the woodheap, without expense, to the institution for bedding, should be charged for at the same rate as attendance on a white man enjoying the comfort of a more or less well appointed ward.<sup>65</sup>

In fact it transpired that, between 1905 and 1913, none of the Aboriginal employees from Lorraine station who were sent to Burketown hospital received adequate attention.<sup>66</sup> Under such circumstances, Aborigines' experiences would have reaffirmed their commitment to traditional remedies.

Not all medical staff lacked interest in their Aboriginal patients. Matron Hulbert, for instance, was most dissatisfied with the way they were housed at Normanton hospital in 1939. She advised the Minister for Health that the building had no verandah other than a lean-to at the front. She argued that "in fact its nearest description is a shed with a board floor".

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<sup>62</sup> *Ibid.*, 6 June 1913.

<sup>63</sup> AR. NPA, 1900, *QVP*, 1901, 4, 1335.

<sup>64</sup> The results of a circular sent to 24 northern hospitals in 1901 showed that unemployed blacks were treated free at Charters Towers, Richmond, Winton, Ravenswood, Thursday Island, Bowen, Herberton, Hughenden, Chillagoe, Cairns and Mareeba. Other hospitals made a weekly charge as follows: Normanton 10/-, Cloncurry 12/6, Mackay 14/-, Montalban 15/-, Geraldton 15/- to 18/-, Cooktown 20/- and Croydon 25/- (but in Croydon the patient was not allowed a bed in the ward, only on the verandah). The regulations of Burketown hospital "do not provide for the treatment of aborigines directly or indirectly". (Cited in AR. NPA, 1901, *QPP*, 1902, 1, 1140).

<sup>65</sup> J. Kirkaldy to Sec. Burketown Hospital, 27 November 1913, Lorraine station letterbook. The manager had earlier indicated that the station would be responsible for hospital fees.

<sup>66</sup> Conditions were so bad that protectors sometimes took the unusual step of complaining personally to the minister. In 1923, the Georgetown protector complained of the poor treatment meted out to a dying Aboriginal woman at the local hospital. HOM/J454, 23/834: QSA.)

Into this front room were herded men, women and children with no screens or partitions to separate them, or to put round them when dressings were done, toilets performed or at death beds!! I leave to your imagination the fears and feelings of superstitious aboriginals under such conditions and our difficulty in getting them to come here to be treated.<sup>67</sup>

On occasions she was forced to put two Aboriginal patients into each bed in the special ward set aside for them some 100 yards from the main hospital.<sup>68</sup> Although the hospital committee had approached the Minister for more adequate facilities for Aboriginal patients a couple of years earlier,<sup>69</sup> it was unwilling to have Aborigines relocated in a much more suitable and unused building set aside for infectious cases.

Racial discrimination was evident in another motion passed by the same committee, which "could not see its way clear to allow aboriginals and non-whites to be operated on in the theatre nor to receive any surgical after treatment in the annexe to the main building".<sup>70</sup> As a result of this decision the local doctor was forced to send an Aboriginal woman to Cloncurry for surgery.<sup>71</sup> Several other country hospitals were reluctant to treat Aborigines suffering from venereal disease and sent them either to missions<sup>72</sup> or to the lock hospital on Fantome Island. In other instances Aborigines suffering from gonorrhoea and granuloma were treated as outpatients if suitable isolation could be arranged. The local jail was commonly used for this purpose.<sup>73</sup> Although these hospitals treated Aboriginal patients as second class citizens, the black community was still expected to do its share of fund raising. Even here segregation was a key feature. In one instance, two hams were purchased; one to be raffled to whites, the other to Aborigines.<sup>74</sup>

## Conclusion

A number of reasons have been suggested why Aborigines on cattle stations were healthier than others. They were less alienated from their traditional lifestyle,

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<sup>67</sup> J.R. Hulbert to Minister for Health, 18 May 1939, Special Batch, A/29546: QSA.

<sup>68</sup> *Ibid.* Burketown hospital also had two patients to a bed and even erected tents in which to house Aborigines. Burketown hospital to H.S. office, 11 July 1934, Special Batch, A/290545: QSA.

<sup>69</sup> Sec. of Normanton hospital to Dept. Health and Home Affairs, 8 June 1937, Special Batch, A/29546: QSA.

<sup>70</sup> Cited in CPA to Dept. HHA 10 August 1937, Special Batch, A/29546: QSA.

<sup>71</sup> *Ibid.*

<sup>72</sup> K. Payne to Mr. Hughes, 18 October 1938, Australian Inland Mission Records, Folder 3 Box 78, MS5574: ANL.

<sup>73</sup> CPA to Department of Health and Home Affairs, 26 May 1938, A/4035, see correspondence 39/347: QSA.

<sup>74</sup> Normanton Hospital Minute Book, 12 November 1934, HOS14 C/D1: QSA.

and as a result their physical and mental health was better than those dispossessed from their land. In addition, they were less likely to be suffering from malnutrition given the availability of beef and the prevalence of gardens tended by Chinese. Thirdly, station Aborigines had cash reserves which could be used to pay for medical treatment.

However, from the 1920s, with the increasing practice of discharging blacks at the end of the mustering season, their physical isolation was reduced, bringing them into more contact with diseases rampant in fringe camps. This development coincided with the removal of Chinese gardeners, resulting in the reduction of fresh vegetables on stations. To some degree these factors were offset by the movement on to stations of more white women, who commonly took some interest in the welfare of black women and children. There was also some improvement in medical services with the arrival of the Australian Inland Mission and Flying Doctor; neither was designed for Aborigines, but they benefitted to some degree nevertheless. Notwithstanding these improvements, many Aborigines fiercely resisted non-Aboriginal medical practices. Removal to hospital must have seemed like a sentence of death, a belief underlined for some by the discriminatory treatment they received. This analysis focusing on the historical dimensions of one section of the Aboriginal community does help to explain why Aboriginal people today are turning away from conventional medicine in favour of a health system more in tune with their culture.

## THE FANTOME ISLAND LEPROSARIUM

John Maguire

We find the moral condition of our poor people in a deplorable state. The building accommodation is temporarily inadequate. The sexes are intermixed. There is much to be desired in the way of cleanliness and so on...Tomorrow we hope to set some of the people on the way to make their own bread, which will provide occupation and may overcome the present problem of their diet. Until that is in order the medical treatment peculiar to leprosy would be of little use.<sup>1</sup>

This was the first description recorded of the Aboriginal leprosarium established on Fantome Island off the coast of Townsville in 1940. It sums up the general attitude of Government to the problem of leprosy in Australia during the preceding decades; great promises and good resolutions, but too often insufficient practical organisation. As long as leprosy was primarily an Aboriginal disease it seemed difficult for European administrators to summon the will to effective action. Only for a time in the 1920s and 1930s, when leprosy seemed to threaten the white population, did the health authorities treat the search for the source of infection and the means of containment as matters of priority. At that time Australia was among the world leaders in this research.

There is no evidence that leprosy was known among Aborigines in any part of the continent before white settlement. Dr Cecil Cook reached this conclusion after exhaustive investigation between 1923 and 1925.<sup>2</sup> As Wandsworth Research Scholar for the London School of Tropical Medicine, he studied all available records of leprosy cases throughout Australia. He also examined the theories concerning the source from which leprosy was first introduced into this country. After careful discussion he rejected the first European settlers, British soldiers who had seen service in India, and Macassars (traders from Sulawesi who had long been visiting the northern coastline) as likely sources. Eventually he pinpointed the arrival of Chinese to work on the gold-fields and later on railway construction.<sup>3</sup> Dr Cook's reasoning is long and complex. Because of the extraordinary disproportion

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<sup>1</sup> Sister M. Peter to Bishop H. Ryan, 6 March 1940: Archives of the Sacred Heart Cathedral Townsville (ASHCT).

<sup>2</sup> Cecil Cook, *The Epidemiology of Leprosy in Australia* (Canberra: Government Printer, 1927).

<sup>3</sup> The first recorded case in Queensland was Chinese. Oun Tsar appears in the Brisbane Hospital records with anaesthetic leprosy in 1855. *Ibid.*, 74.

between males and females on the goldfields and in the outback<sup>4</sup> the infection seems to have been transmitted first to Aboriginal women, then to the European community via contacts with white men. Cook found little recorded evidence of direct infection from Chinese immigrants to Europeans, an index of the gulf between the two groups. Later, he points to the arrival of Melanesians to explain further infection. In Queensland "practically all the early cases were coloured aliens: Chinese migrants or Melanesian plantation workers"<sup>5</sup> Later again in the 1920s Cook argued that there was some evidence in the Cairns region of leprosy coming via southern Europeans.<sup>6</sup>

How far the medical evidence fuelled existing racial tensions and established White Australia as a national ideal, is difficult to assess. Cook had no doubt about its influence in creating a national climate of prejudice.<sup>7</sup> That question cannot be answered through medical records, and the historian must refer to anecdotal evidence of novels and autobiographies.<sup>8</sup> Leprosy at this time was a disease only of the poorer classes in European society. Cooks, farm labourers, canefield workers, domestic servants, unattached male stationhands or railway workers figure in Cook's statistical tables.

Although Hansen had isolated the *Mycobacterium leprae* in 1872, many questions still remained unanswered in the 1920s concerning types of leprosy and the factors affecting their spread. There were debates about hereditary predisposition, the effects of hot, dry or moist climates, the influence of possible vectors such as bed-bugs, mosquitoes, lice, the rat flea, general uncleanness, its incubation period, the course of the disease, its periods of apparent remission, and the extent to which the disease was becoming "domesticated". Today two distinct types of leprosy are identified: tuberculoid and lepromatous, the former being the more benign in that it is often self-healing. There is also a group of "indeterminate" or "dimorphous" cases where lesions resembling both types are seen in the same patient.<sup>9</sup> During the 1920s, the differentiation was more often made in terms of symptoms: "nodular" where areas of the skin whiten or ultimately form massive nodules, and "neural" where local swelling of nerves may occur, large areas of the

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<sup>4</sup> In 1891 there were 3613 Chinese in the Northern Territory, 15 of whom were women; in 1921 722, of whom 113 were women. *Ibid.*, 35.

<sup>5</sup> *Ibid.*, 118.

<sup>6</sup> *Ibid.*, 115.

<sup>7</sup> *Ibid.*, 17. He saw the desire to blame Macassars as a sign of the same racial attitudes. *Ibid.*, 34.

<sup>8</sup> Jean Devanny, *Cindie* (1949, London; Virago, 1986) and *Point of Departure: the Autobiography of Jean Devanny* (ed. Carble Ferrier, St Lucia: University of Queensland, 1986).

<sup>9</sup> W.A.R. Thompson, *Black's Medical Dictionary* (London: Adam and Charles Black, 33rd edn., 1981), 530ff.

skin become anaesthetised, finally involving large scale deformities such as foot-drop, wrist-drop, claw-foot, or ulceration of the extremities.

In the 1920s Australia was considered unique for the possibilities it offered for the study of leprosy: its compulsory segregation of cases, its sparse population, and its possession of the facilities of a highly organised government. Its sanitary legislation was regarded advanced compared with that of other countries where leprosy was a concern. At the same time, Norway with a much inferior prophylactic system had reduced its leper population from 960 to 160, whereas Queensland, after thirty years of compulsory notification and strict isolation, had failed to eradicate the disease. Rather the contrary: in Queensland in 1923 there were 106 European lepers, only 10% having had contact with known lepers.<sup>10</sup> The disease seemed to be gaining ground, whereas in New South Wales it was under control. Yet both states had apparently identical prophylactic systems.

### Attempts to Contain the Disease in Queensland

In 1892 the Queensland parliament passed the Leprosy Act, empowering the Minister for Home Affairs to order the examination and detention of persons suspected or ascertained to be suffering from leprosy. In 1889 a leprosarium had been established on Dayman Island for the reception of lepers, principally Chinese. This was closed soon after the 1892 Act, and replaced by a lazaret at Dunwich on Stradbroke Island in Moreton Bay (for European lepers) and one at Friday Island in the Torres Strait (for "coloured" races). Both were closed in 1910, when a lazaret was established at Peel Island in Moreton Bay to which all lepers detected in Queensland were sent.

Though many State records prior to 1910 were destroyed, it is possible to determine that there had been a marked decline in the number of coloured persons isolated following the cessation of *kanaka* indenture (see chapter 7), reaching a minimum in 1919. The infection rate among Europeans reached a minimum in 1917: thereafter it increased annually, doubling between 1920 and 1925 from 23 to 44.<sup>11</sup> Cook's report was published in 1927. That same year the inaugural meeting of the Federal Health Council requested the Commonwealth Department of Health to investigate the position in regard to leprosy. Nothing more happened until 1931 when the fifth session of the same Council resolved that there should be a common form of clinical record, and a common scheme of epidemiological records for all

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<sup>10</sup> Cook, *op. cit.*, 10.

<sup>11</sup> *Ibid.*, 74ff.

States, to be collated by the (federal) Director of the Division of Tropical Hygiene. By 1937 no State had provided any of the information requested.<sup>12</sup>

By this time the need for the rapid colonisation of northern Australia added urgency to the search for medical and social means to contain the diseases inhibiting white adaptation to the tropics. Although "coloureds", especially Aborigines, were the larger number of affected people, the prime concern was the effect on the European community.

The successful colonization of tropical Australia, the great problem before this generation - the problem, indeed, which may make our "place in the sun", or may, perhaps, mean no son of ours in that place - is essentially a problem of applied public health

wrote Dr Raphael Cilento in 1932.<sup>13</sup> He noted that leprosy "continues its insidious course to an extent unsuspected. The slow but continual discovery of new cases...represents, perhaps, the most pressing problem of the moment, although one that offers the readiest hope for control".<sup>14</sup>

Two years later, the seventh session of the Federal Health Council again tried to get the States to collect complete records and forward them to the Commonwealth Department for analysis. Again nothing eventuated.<sup>15</sup> In the same year Cilento (now Director-General of Health and Medical Services in Queensland) raised the possibility of setting aside

an area as a leprosarium and village community for aboriginals, where not only bacteriologically positive cases may be segregated and treated, but where suspects also may be kept in confinement and dealt with more satisfactorily.<sup>16</sup>

He was responding to the difficulties of maintaining sufficient medical supervision over suspect cases among Aborigines, in light of the migratory way of life, their fear of separation from their families, and their dread of white men's medicines and hospitals. (Cook had already vividly described what it meant for suspects to be separated.)<sup>17</sup> However, in 1934 the Federal Health Council rejected the idea that such a station be located on an island, "the disadvantages of such a location [being] far greater than the advantages". The same Council also

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<sup>12</sup> R.W. Cilento, "Leprosy in Australia as a Problem of Preventive Medicine", *National Health and Medical Research Council (NH&MRC) Report*, 2nd session (1937), 6-8.

<sup>13</sup> R.W. Cilento, "Australia's Problems in the Tropics", *Australia & New Zealand Association for the Advancement of Science* (Sydney, 1932), 216-33.

<sup>14</sup> *Ibid.*, 228.

<sup>15</sup> Cilento, "Leprosy in Australia", 7.

<sup>16</sup> R.W. Cilento, "Leprosy in Australia and its Dependencies", *International Journal of Leprosy*, 5 (1933), 50.

<sup>17</sup> Cook, *op. cit.*, 12.

recommended that the Commonwealth appoint a specialist in leprosy "and other diseases especially affecting aborigines".<sup>18</sup> However, nothing happened. In 1937/38 the National Health and Medical Research Council (NH&MRC) urged the Commonwealth to fund investigation of the infection among Aborigines. Later, it was further recommended that this work be done "at a selected spot in the Palm Island group".<sup>19</sup> Again, in 1939, the NH&MRC recommended that methods be devised to coordinate interstate efforts especially in relation to leprosy, and Cook was asked to take the responsibility. Interstate cooperation remained difficult to achieve.

### The Lazaret at Fantome Island

Meanwhile Cilento was moving ahead to establish a special lazaret for Aborigines in the Palm Island group. As soon as rumours began to be heard, opposition was swiftly expressed. In April 1936 the Townsville Chamber of Commerce wrote to the Director of Health and Home Affairs requesting that the rumour be denied.<sup>20</sup> Plans proceeded nonetheless. In 1939 Dr Croll surveyed all mainland Aboriginal settlements and missions, and some Torres Strait islands, on behalf of the NH&MRC: his primary focus was leprosy. One result was approval for the establishment of a lazaret on Fantome Island, on 10 May 1939.<sup>21</sup> A month later, £516 was approved for a laboratory on the island.<sup>22</sup> The lazaret was opened finally on 10 January 1940, with Aborigines brought by special train from Peel Island. By 1 July 1940, 74 Aboriginal lepers were housed there, 41 men and 33 women.<sup>23</sup>

To staff the hospital, the State government approached the Sisters of Our Lady Help of Christians, a Catholic congregation already working on Palm Island. To prepare them for their work, Mother Peter, Sisters Catherine, Bernadette and Agnes had gone first to St Margaret's Hospital in Sydney to study obstetrics, then to the University of Sydney to study tropical diseases, and three months at Peel Island where Cilento trained them in the treatment of leprosy. As the Bishop of Townsville put it in his welcome on 25 February 1940, the Sisters approached their work in light of Christ's words: "I was hungry and you fed me, ill and you cared for me".<sup>24</sup> Some may have felt it appropriate that missionary sisters should care for

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<sup>18</sup> *Ibid.*, 52.

<sup>19</sup> *NH&MRC Report*, 1st Session (1937), 9; 2nd Session (1937), 4; 3rd Session (1938), 11.

<sup>20</sup> Health & Home Affairs, Institutional Register, 24 April 1926, A/4751: QSA.

<sup>21</sup> *QPP* 1940, 1, 1078.

<sup>22</sup> Health & Home Affairs, Institutional Register, 1939, A/4065 (4954), A/4069 (5707): QSA.

<sup>23</sup> *Annual Report of the Director-General of Health and Home Affairs*, 1940, 3.

<sup>24</sup> *Townsville Catholic News*, March 1940.

lepers at this remote island: mainland missions had been blamed in the past for raising the incidence and dispersing leprosy among Aborigines.<sup>25</sup>

The Sisters needed all their spiritual fortitude. Their only contact with others of their congregation involved crossing to Palm by open boat, often drenching their voluminous habits. During the war, petrol rationing made these visits rare. Once Japan entered the war, fear of invasion was persistent. One of the priests had a nervous break-down, as did one of the Sisters. Mass was infrequent. Buildings were inadequate. The first Bishop of Townsville, Terry McGuire, gave money to build a small chapel for the Sisters. The Americans released enough fibro and timber - as part of Lend Lease - to allow a church and a presbytery to be built. Father Tom Dixon pointed out that the Americans "in a few weeks did what the Government was thinking of for decades".<sup>26</sup> The number of Aboriginal Catholics increased from three or four at the beginning, to eleven by early 1942. This in turn created another problem: sectarian tensions with the local Anglican Church<sup>27</sup> and accusations that the Sisters were forcing patients to attend religious services twice a day. Towards the end of the war, internal religious politics led to the replacement of the Australian Sisters of Our Lady Help of Christians by an international order, the Franciscan Missionaries of Mary.

Though the Sisters did all they could for the welfare of their charges, patients felt deeply their separation from their families, and some tried to escape from the island.<sup>28</sup> However, as the material environment improved, it became a refuge of beauty and peace. On the medical side the Director General of Health reported in 1945 that "recent work in America indicates that some hope of a specific may be expected from among the sulphonamides".<sup>29</sup> Three years later, in 1948, Sulphone treatment was introduced at Fantome Island.

By the 1950s, given the growing use of Sulphones, there were moves to relax the severe prophylactic measures which prevailed; but the NH&MRC resisted.<sup>30</sup> By 1956, however, the Director General of Health was able to report that the response to Sulphone therapy by patients on Fantome Island had been as successful as that of white patients elsewhere in the State. The number of inmates at Fantome

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<sup>25</sup> Cecil Cook, "Dr Cook Recalls Australia's Fight With Tropical Diseases", *Health: Journal of the Commonwealth Department of Health*, 12 (1962), 117ff.

<sup>26</sup> T.S. Dixon, *The Wizard of Alice: Father Dixon and the Stuart Case* (Morwell, Vic: Alella Books, 1987), 2.

<sup>27</sup> Sister M. Peter to Bishop Ryan, 6 March 1940: ASHCT.

<sup>28</sup> *Health and Home Affairs, Institutional Register*, 1941, B/573, 7128: QSA.

<sup>29</sup> *Annual Report of the Director General of Health, 1944-45*, 8.

<sup>30</sup> C. Cook, "Leprosy and its Management", *Health*, 8 (1958), 21.

Island had dropped to 26 (21 men and five women).<sup>31</sup> From then on the numbers gradually declined to 24 in July 1957, 17 in 1960, 11 in 1962. Though the numbers increased slightly in 1963-64, by 1966 there were only six patients at Fantome. In Western Australia and the Northern Territory however, the picture was still not good: 26 new cases were reported in the Northern Territory in 1966, and 12 in Western Australia.<sup>32</sup> In 1963 an ad hoc committee of the NH&MRC stated hopefully that leprosy might be eliminated within this century. The same report praised the Queensland legislation as "an admirable basis for uniform leprosy legislation within Australia". But the hopes for cooperation had yet to be fulfilled.

By 1966 the Franciscan Missionaries of Mary felt it was time to withdraw from Fantome Island. During their time, about 100 people had been buried on the island. Now, however, with so few needing special isolation, the Sisters thought their time might be better spent elsewhere. (Eventually they established a hostel for Aboriginal girls in Townsville.<sup>33</sup>) It was not until 1973 that the last patients were transferred to a special section of the government hospital on Palm Island. All buildings at the former leprosarium were then razed. Sister Mary Paul Duford FMM, a French Canadian Sister who had come to Fantome in 1946, even in her retirement refused to be moved too far from the island and the people she loved. With the closure of the leprosarium, she made the convent on Palm Island her home. She remains there a living guardian of the leprosarium memories.

Fantome Island may no longer exist as a lazaret. Leprosy, however, has not been wiped out in Australia.

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<sup>31</sup> *Annual Report of the Director General of Health, 1956-57*, 17.

<sup>32</sup> *NH&MRC Report, 65th session (1967)*, 132.

<sup>33</sup> *Townsville Catholic News*, January 1967.

## **SISTERS WIVES AND MOTHERS**

### **Women as Healers and Preservers of Health in the Northern Territory during the 1930s<sup>1</sup>**

**Lyn Riddett**

The lives of women in the 1930s in the settler society of the Northern Territory is best viewed from the two complementary aspects of history: time and place. Their story is unique from both perspectives. The conditions of the North, a "Dry-Wet" tropical region, were harsh. Long months of hot and humid weather broken only by the heavy rains of the monsoon were scarcely relieved by four months or so of cooler weather during the "Dry". Every aspect of human activity was affected by these conditions. Europeans, not particularly conditioned by world view, or even by a hundred and fifty years of settlement in Australia, to adapt to the climate, found the way tough. Climate contributed to the special health problems they faced: malaria and dengue fever were endemic, and by the 1930s only malaria was being held in check. Necessary supplies of fresh food were hard to produce locally, and very few Europeans learnt from Aborigines how to exploit the local resources.

Distance was a compounding factor. The Northern Territory itself was not easily accessible, travel to the region from other parts of Australia was difficult and lengthy, and within the Territory the situation was no better. Many months of the year, during the Monsoon, townships and settlements were cut off from each other and from the rest of Australia. Families on cattle stations, in mining communities, i.e. people in the back country, were even worse off: not easily able to travel to townships during the "Dry" because of appalling roads, they were constrained to spend months during the Wet unable to travel at all.

Settlement of the Northern Territory by Europeans came late in the overall settlement of Australia and the timing of the process caused additional problems. There was a shortage of capital for investment in infrastructure; consequently transport and communication systems in the Northern Territory lagged behind the rest of Australia. In addition at a time when families in southern cities were beginning to have a range of community facilities, particularly in the areas of infant and child health and welfare, settlers in the Northern Territory were still having to

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<sup>1</sup> This chapter was previously published in *Hecate: A Women's Interdisciplinary Journal* 15(2), 1989, and is reprinted with the permission of the editor of that journal.

cope with very basic problems like finding adequate fresh food. Women who had grown up in areas of closer settlement in the south had to make dramatic adjustments to their life-styles and life-expectations. Significantly those adjustments were made without the support of a close circle of other women and far from the wisdom of older women in the family.

This chapter looks at the lives of European women in the remote frontier society of the Northern Territory in the 1930s. Their lives were hard and their response courageous. Many conventional wisdoms had to be left behind in the process; new wisdoms took their place. These women naturally saw their lives as an individual and personal experience, but for politicians and planners they had an added dimension: the presence, or absence, of European women was seen as a major issue in the development of the North. The women were, of themselves, a crucial political and economic factor in the process. And politicians and planners were agreed that the single most important factor affecting their presence, or absence, was provision of adequate health services. If development and settlement in the Northern Territory can be seen as successful in any way then the sisters, wives and mothers command our respect.

### **The Pastoral Frontier**

Two incidents from the 1920s provide a focus for the discussion. In each story a European woman dealt with that most primary of women's experiences - childbirth. One woman survived and passed on her story to her daughters and granddaughter. The other died; her story has been told, sixty years later, by one of her sons. Both women were living in the Victoria River District at the time; both were married to white men employed as manager on stations owned by the British company, Vestey's; each had an Aboriginal woman close at hand at the time of her confinement.

The first story concerns the Fogarty family who have become one of the better known families in the pastoral industry. Originally from Queensland they came into the Territory in the early 1920s. Sometime in mid 1923 Ted Fogarty, the grandfather of the family's chronicler Pearl Ogden, was given the management of Delamere, a Vestey's station in the north-east Victoria River District. He travelled from Katherine in horse and buggy with his pregnant wife Sarah, and their three children Ann, Dave and Mardie.<sup>2</sup>

Sarah's first three children had been born in town: Ann and Dave at Cloncurry in September 1917 and April 1919, and Mardie in Darwin hospital in June 1922. The fourth Fogarty child was born at Delamere not long after the family arrived.

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<sup>2</sup> P. Ogden, *Leg's More Sweeter than Tail* (Professional Services Branch, Northern Territory Department of Education, 1983), 8-9.

Unfortunately Sarah's granddaughter has not explained why Sarah and her children did not stay behind in Katherine until after her confinement.<sup>3</sup> Her journey to Delamere, pregnant and with a small child still in arms, cannot have been comfortable, but Sarah seems to have become used to the rough life of a settler's wife. Delamere Station was a rough posting for the young family and health problems set in almost immediately. It was frequently without a manager, and although trusted Aboriginal families were left in charge they were expected to do no more than caretake the property. Consequently some of the features of more settled cattle stations were lacking; there was for example no vegetable or fruit garden. "There was very little hope of getting anything delivered to the station" wrote Pearl Ogden. The only local fresh nutriment was beef, and milk from the station's herd of goats. "The whole family broke out in boils...and soon they all had fever".<sup>4</sup>

Malaria was common in the area. A severe outbreak two years earlier had caused a number of deaths. Sarah must have feared her family were suffering malaria and she dosed them with quinine hoping the fever would pass; unfortunately she overdosed herself and went into labour a month early. Ted and Sarah had made an arrangement with Sister King, the Australian Inland Mission Sister stationed at Wimmera Home on Victoria River Downs Station, to come to Delamere a week before Sarah was due to be confined and assist at the birth. The quinine overdose of course upset those plans, and Ted had to make a hurried trip to fetch Sister King. He set off in the buggy to make the 90 km journey to VRD Station. Sarah's story, as told by Pearl, continues:

Meantime Ted junior arrived. Sarah sent the aboriginal who delivered the mail to find Ted and Sister King and advise them that the baby had arrived. After she had delivered the child, Sarah called the aboriginal servant to bring some water to wash him...

Harry Huddleston...Ted's head stockman on the station...knowing his boss had left...told the cook to go in and ask Mrs Fogarty if she would like a drink or something to eat. Harry knew that all the Aboriginal women were frightened and were on the verge of running away. He realised that he and the cook would have to help the Missus, as she was about to give birth without any assistance. The cook then became upset, because he felt the head stockman was giving him orders. Ted and the Sister arrived to find trouble in the homestead - and that the baby had arrived twenty four hours earlier.<sup>5</sup>

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<sup>3</sup> *Ibid.*, 9.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*, 9-10.

With our recent understanding of Aboriginal medicine and health practices we can now look back at Sarah's predicament and sympathise with her for having no Aboriginal companion. Aboriginal women are very expert in these matters and station women might have done much to ease Sarah's mind and body. The conditions however which governed social and race relations in the 1920s were so strong that Sarah would have found little support from within her own community had she formed a friendship with an Aboriginal woman. She was therefore left without any female support at a time when she needed it most.

Two and a half years later on Waterloo Station, many miles further to the west of Delamere, another European woman, May Cockburn-Campbell, was due to give birth to her fourth child. May had had a difficult pregnancy but despite her husband's remonstrations she refused to leave the station and go to Wyndham, the closest town, for her confinement. During the hot and humid months of December, January and February she became ill and, increasingly weak, she was forced to spend most of her time in bed. Unlike Sarah Fogarty, May Cockburn-Campbell was fortunate in having with her all through this difficult period an Aboriginal companion, Alice, who had been her friend from the time of their childhood on Springvale Station, near Katherine.<sup>6</sup>

Her oldest son, Thomas, now an old man, has written an account of those days in early 1926.

One afternoon I was allowed into mother's room...She was panting and Alice was fanning her, and putting wet sponges on. I thought it unusual. Mother was never like this. Besides, she had two bung eyes from the flies...<sup>7</sup>

The next day the distraught husband sent Alice, on horseback, to Wyndham to fetch the doctor - a round trip of 700 kms at a time of most extreme weather conditions, the north-west monsoon. Alice and the doctor rode back into the station two weeks later. Young Thomas understood that by sending Alice on this errand his father had perhaps acted out of fear and distress, but not very wisely: "Lily was to fill in for Alice. She was sympathetic and did the best she could but she lacked the enthusiasm of Alice. It just wasn't the same."<sup>8</sup>

May Cockburn-Campbell probably would not have survived her ordeal even if Alice had stayed, and by the time the doctor arrived it was too late to save her life. The young Thomas listened through the closed door:

"Bloody hell, you must do something."

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<sup>6</sup> T. Cockburn-Campbell, *Lands of Lots of Time* (Fremantle Arts Press, W.A., 1985), 51.

<sup>7</sup> *Ibid.*, 74.

<sup>8</sup> *Ibid.*

"I'm sorry Sir Alex, there's nothing I can do. I wanted her to come down earlier but she said it would be all right."

"Well, it's not all right. Do Something."

"Sorry, I can't. She won't last more than two days at the most."

"For God's sake, man, can't you take it away from her."

"No, she is past that. Had it been earlier with care and attention, maybe yes."

"You can't let her go like that, you have to do something. There must be some way."

"I'm sorry, but I assure you there is nothing I can do."

"For God's sake, nothing at all?"

"No, Sir Alex, nothing at all."<sup>9</sup>

She died on the 12 February 1926, aged thirty-four years.

Earlier in the 1920s, largely in response to events similar to these, the Australian Inland Mission (AIM) had established a hospital, Wimmera Home, on Victoria River Downs Station. As we have seen, the sister who was stationed there in 1923 arrived too late to assist Sarah Fogarty and would have been too far away to help May Cockburn-Campbell. The sisters were able to assist many others, however, and their presence in the district was seen by the Government, and by large pastoral companies like Vesteys, as an essential factor in the permanent settlement of the district by whites. It was believed, perhaps on good foundation, that white men would not marry and bring their wives, European women, until there was adequate medical support.

Vesteys, in particular, were strong supporters of the AIM work in the Northern Territory: members of the Company's Board of Management served on the AIM Board; and they provided moral and financial support to the nursing sisters serving their two year postings at the bush hospitals. In their view, however, nursing sisters alone were not enough, and while not gainsaying the nurses' excellent work Vesteys' men lobbied for a fully-staffed medical service, complete with flying doctors. At a conference in Canberra in mid 1929 attended by members of the Northern Territory Pastoral Lessees Association and representatives of the Commonwealth Government, two Vesteys' managers, Alex Moray and C.W.D. Conacher raised the matter. Mr Moray was most likely referring to May Cockburn-Campbell when he said:

we had a manager's wife out in the Territory 150 miles from Wyndham. She developed sickness. It was during the wet season when it was almost impossible to go to Wyndham. Had medical aid been available her life might have been saved.<sup>10</sup>

Later Moray averred: "The outstanding fact is that we need more doctors in the Territory".<sup>11</sup> He then addressed the social evils of a society which lacked the

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<sup>9</sup> *Ibid.*, 75-75.

<sup>10</sup> Northern Territory Development Conference (Canberra, 30 July 1929), 59, CRS A1 29/210: AA.

<sup>11</sup> *Ibid.*, 61.

civilising presence of white women, due to the failure of the government to provide families with adequate medical facilities:

The men out there are men with red blood in their veins. Their manners may be rough and their morals loose, but they are very good for developmental work. I think the attendant evils that lead to grave social problems would be largely overcome by the provision of doctors.<sup>12</sup>

### **Sisters - The AIM hospital on Victoria River Downs Station**

The nursing sisters at Wimmera Home were sent to the Victoria River District, two years at a time, to care for the sick, to introduce social programs which would create a good environment for single men on the stations, to monitor the general physical and mental health of the people of the district, and to administer the affairs of the hospital. They had to acquire additional skills: transmission of telegrams by Morse Code; dentistry, at least in the area of teeth pulling; and basic diagnostic skills so they could discriminate between cases and decide which needed referral to a doctor. Having to decide which cases needed a doctor's care created problems for the sisters as some cases were not obviously critical at the time a patient first came for treatment. In 1937 one of the nursing sisters incurred the wrath of Dr Clyde Fenton, the Air Medical Service physician based in Katherine, and the case caused enough controversy to require conciliation from John McEwan, the Minister for the Interior. In effect the sister was exonerated but not before months of quite bitter wrangling had caused her and her colleague considerable distress.<sup>13</sup>

Mrs Dorothy Hall (née Allen), forty years after she had left the AIM Service, recalled another skill which she and her colleague had to acquire:

Now with regard to medicines, we had to do our own dispensing. We had prescriptions which we made up for treatment of malaria and various other things. We didn't know too much about dispensing although we'd had a lesson before we left Melbourne, but we did the best we could. We had our little scales that we measured everything up, but we were rather nervous about dispensing to begin with, and my friend and I always saw to it that we took a dose of our own medicine because we felt that if we poisoned anyone we'd rather be dead than face the consequences.<sup>14</sup>

During the 1930s, the AIM sisters maintained a regular correspondence with their Headquarters in Sydney. From this correspondence, and a diary kept by one of the Sisters, a clear and fascinating picture of their life and work emerges. They

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<sup>12</sup> *Ibid.*

<sup>13</sup> AIM correspondence, various 1937, Ms557: NLA.

<sup>14</sup> Interview with Noel and Dorothy Hall 28 August 1978, NTRS226 TS230: Northern Territory Archives (NTA).

were a professional group specifically trained to be observant and to respond to requests for aid; they knew not to intervene unless asked. These attributes stood them in good stead in the cross-cultural world of the cattle station. Practical and down-to-earth for the most part, they were well equipped to deal with emergencies, hardship and sheer hard work.

They obviously enjoyed what they did. The only unhappy note in the correspondence creeps in towards the end of the 1930s. By the mid 30s malaria had been largely controlled; the government aerial medical service had been properly established; and single men were no longer in the district in the numbers they had been during the 1920s and the early 1930s. Many were enlisting to fight the War, and others, discouraged by management from camping on the drovers' commons near the stations, were taking their "spell" in the towns. The sisters' work, medical and social, was not needed as much as it had been, and amid some unpleasant local political cross-fire the hospital was closed. Not all the sisters left the District however. Some married local men, mostly drovers, and settled down themselves to raising families in the bush. At any one time the AIM sisters were only two nurses in a very large district where near neighbours might be a hundred miles away and where weather conditions could isolate a family for months at a time. Mothers of families on these remote cattle properties had to learn many basic nursing skills as well as acquire an understanding of sound preventative health practices. At a time when families probably relied more on home cures and folk remedies than we are inclined to do, the cattle station women had to extend that basic knowledge to cover strange ailments and often serious injuries. European and Aboriginal women alike were preservers and maintainers of health and healers of at least minor ailments. In both societies it was men who dealt with the more serious cases, something the two societies had in common when so much else separated them.

### **Infant Welfare Practices**

By the 1930s, the AIM sisters were not usually needed to assist at the confinements of European women, who went as a rule into town for their confinements. Their role was more to care for the post-natal needs and general well-being of the mother and her new-born, a difficult enough task in an area where eye infections were common, and where it was often impossible to obtain fresh fruit and vegetables. If the mother had difficulty in establishing lactation she could not always count on fresh cow's milk and Sister Dorothy Allen could not remember seeing milk in powdered form much before the late 1930s. Often goats milk was available, but, because of the animal's indiscriminate grazing habit the milk was often bitter and children fed the milk became ill.

Sarah Feeney remembered goats being kept on Victoria River Downs when she was there with her first husband and their family in the early 1920s. In an interview recorded only a few years ago she recalled:

They had goats, but they were over the other side of the river and used to eat Leichhardt pine - Leichhardt pine is bitter and you couldn't even drink the goat's milk.<sup>15</sup>

In May 1936, Sister Jessie Langham wrote to AIM Head Office about the case of the hospital's youngest ever in-patient, six months old John William. Baby John had been brought into the hospital from Wave Hill, a hundred miles away, by his mother because he had been "vomiting badly and losing weight rapidly".<sup>16</sup> According to Sister Langham the baby had been fed on goat's milk "and goats eat anything this time of the year so causing the milk to be bitter and upset the baby".<sup>17</sup> The sister started feeding John William on fresh cow's milk from the hospital cow, but achieved only one day's success because "next day it rained and the cows went bush, result no milk - however there was a plentiful supply of Nestles in the store. We commenced with it and baby went straight ahead".<sup>18</sup>

Later in the same year Sister Langham and her colleague Sister Stewart kept a watchful professional eye on young James Francis West Reynolds who was soon to appear regularly in reports to HO as he grew into a healthy little boy. "Westie", as he became known, had a hard start in life. Born to a young English woman who lived much of the time alone at Gordon Creek outstation, the young West was known to be a "difficult feeder". His mother, Audrey Reynolds, had not much experience with babies and often wrote to the sisters for advice. On one occasion the sisters sent her out "a box of tricks" and rode out the 10 miles to check on things the next day. Sister Langham wrote to Head Office. "Found advice etc effective and baby doing nicely - except I am afraid the prickly heat is going to vex him a good bit".<sup>19</sup>

Audrey Reynolds formed a close friendship with these two nursing sisters and their successors, Sisters Dorothy Allen and Joyce Falconbridge. A young woman, she preferred the sisters' company to the older women on Victoria River Downs Station, the manager's wife Mrs Martin and the book-keeper's wife Mrs Roden, and often stayed at Wimmera Home when she came in from the outstation. Photographs of Audrey taken by Joyce Falconbridge at lazy afternoon picnics on the river bank show her a pleasant, attractive woman with a flair for stylish clothes. She and young West were good company for the sisters who made an effort to help with the baby's development. Dorothy Allen noted in one of her letters:

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<sup>15</sup> Interview with Sarah Feeney, 23 September 1980, 27, NTRS226 TS202-1: NTA.

<sup>16</sup> Sister Langham to Head Office May 1936, AIM correspondence, MS5574: NLA.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*

<sup>19</sup> *Ibid.*

Baby Reynolds...[then nine months old] had not been well earlier in the week but is better again now. We took Baby a gift which I hope he appreciated, it was a bunch of nice fresh carrots. He may have preferred orange juice but when they are scarce carrots are just as good but I always find them rather difficult to extract the juice from.<sup>20</sup>

Joyce Falconbridge wrote in her letter to Head Office in May 1938 that West Reynolds was "a lovely child, and is now running everywhere and a real little boy for trouble".<sup>21</sup> By then another of the young European women Eileen Thompson had given birth to a boy. The baby, Brian, was quite ill for a few days in May and Sister Falconbridge wrote that they had some very worrying days and nights with him, and that this was a "very anxious time" for Mrs Thompson.<sup>22</sup> Later Mrs Thompson herself was an in-patient at the hospital for five days "with a very septic throat" which Sister Falconbridge described as "such nasty painful things".<sup>23</sup>

### Aboriginal Women

Out of respect for traditional custom the sisters did not intervene in the births of Aboriginal children. They did however keep in touch with the Aboriginal mothers and babies and tended to the general health needs of the Aboriginal community. On one occasion when Sisters Langham and Stewart were visiting the Reynolds family an Aboriginal woman brought her baby "for the white missus to see".<sup>24</sup> Sister Langham described the little girl as "a sturdy intelligent looking 'pic' but fat".<sup>25</sup> The baby was lying in a coolamon which sister inspected. The coolamon was made of stiff bark lined with paper bark and the little girl when lifted out was discovered to have firm and straight back and muscles. She added "I think there is a lot to be said for the absence (sic) of pillows and soft mattresses".<sup>26</sup>

It was Sister Langham who was called out in the only recorded case where it was felt a "lubra" needed help during labour. In January 1937, the sisters were asked by "Roley" Bowrey who ran Humbert River Station with Charlie Schultz, to give some assistance to an Aboriginal woman. "She was to have her first picaninny

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<sup>20</sup> Sister D. Allen to Head Office, 12 July 1937, AIM correspondence, MS5574: NLA.

<sup>21</sup> Sister J. Falconbridge to Head Office 25 May 1938, *Ibid.*

<sup>22</sup> *Ibid.*

<sup>23</sup> Sister J. Langham to Head Office, 27 November 1936, *Ibid.*

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

<sup>26</sup> *Ibid.*

and was in great pain and difficulties", a most unusual situation.<sup>27</sup> As Sister Langham was on duty as "District nurse" at the time she felt that as it was a confinement it was more appropriate for her to go to the woman than to simply advise Mr Bowrey on what to do. Sister Langham and Mr Bowrey set off, on horseback, to the station 30 miles away. Their journey took them nearly two days because of heavy monsoonal rains, rising creeks and very boggy ground. They were forced to spend the first night out from Victoria River Downs Station with the Reynolds family at Gordon Creek Outstation and the second night in the open on the banks of Riley Creek 8 miles out from Humbert River Station. The Humbert itself was "high and running swiftly", Sister Langham continued her account:

The boys thought it was a bit far for me to swim my horse so I was brought across in a "Birkmyre" boat. A camp stretcher was placed upside down in the centre of the Birkmyre (same is a material similar to duck used for tents, blinds etc). The ends and sides were turned over and I sat in the centre - one black boy in front - two pushed behind, one swam each side, also one of the Humbert lads - so reached the other side safely high and dry amidst much shouting and "yabbering" of the blacks. However, the picaninny arrived before I did - It was a breach birth - supposed to be most unusual for a native - found mother and "pic" both well. The lubras were very reticent on the subject of the birth and would not give any information away.<sup>28</sup>

From other sources it is possible to put together a picture of at least some of the methods the Aboriginal midwives would have used. Aboriginal healers understood the relief that heat, properly applied, could bring to a person in severe pain. It was customary for them to heat stones in a fire and have the patient sit crouched over the hot stones. The midwives would have supported the young mother while she crouched and massaged her back and abdomen. If the mother had suffered fever they would have sat her on large bunches of eucalypt leaves which had been heated over a fire, or which had boiling water poured over them to bring out the aromatic oils. While she sat they would enclose her in a small "tent" of a station-issued blanket. In the Victoria River District the women customarily smeared the forehead, chest and back of a newborn infant with crushed ant bed mixed to a paste with water. This practice was designed to "keep out the cold" from the baby's head and lungs. They were then, as they are still, expert in concocting herbal teas made from plants which, when drunk (sometimes hot, other times cold), could cure dysentery, fever or pain.<sup>29</sup>

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<sup>27</sup> *Ibid.*, 24 January 1937.

<sup>28</sup> *Ibid.*

<sup>29</sup> Material and comment in this paragraph are based on field work observations made by the writer at Daguragu, 1970-1973 in the Northern Territory.

Sister Langham's account admirably illustrates the commitment the nursing sisters felt for the community of the District, and highlights the compassion the two white men felt for their Aboriginal staff. At the time of the incident such care and concern were not universal in this part of the Territory. For the most part the relationship between settlers and Aborigines were strained and difficult. There were still sporadic incidents when white men were speared by Aborigines apparently in retribution for abuses of Aboriginal law, which usually related to problems concerning Aboriginal women. Sometimes Aborigines fought back when being chased by police, and this appears to have been the situation in an unusual case later in 1937.

Sister Joyce Falconbridge noted in her diary:

Saturday 14 August 1937

About 8pm down came George and Frank Spencer to say they were going out to Gordon Creek to bring in a black boy who had been badly speared through the back by wild blacks. Got everything in readiness and the car came back at 10.45pm plus Mr Fitzgerald. It was one of his black police boys, and had saved Mr F's life by running in front and getting the spear. Put in 12 sutures and finally got to bed 1 a.m. No letters.<sup>30</sup>

By the Tuesday following the sisters became quite concerned that the man, George, was still bleeding from the wound. On Wednesday they sent a wire from the station to Dr Fenton in Katherine asking him to come to the man's aid. Sister Falconbridge's diary continues:

Wednesday Aug 18th

Decided...[i.e., Dr Fenton] to open up George's back and tie off some vessels that appeared to be bleeding. The boy was wonderful and declined an anaesthetic. Dr Fenton and I scrubbed up and after two hours fight could not manage to tie off the bleeders as the tissues were so rotten where they had been injured by the spear. So just plugged him tightly and decided to take him to Katherine in the morning...Thursday Aug 19th

Up early and got George washed and dressed and gave him some breakfast. Mr F came for him in the truck about 6 a.m. and took him to Dr Fenton's plane...<sup>31</sup>

In her letter to Head Office later in the month Joyce Falconbridge added that the day Dr Fenton had worked to fix George's back had been

frightfully hot...and by the time Dr Fenton had finished we were all just grease spots. During it all George had lain perfectly still and not murmured (sic)...after Dr Fenton had finished George amazed us all, by sitting up and saying "Thank you Dr."<sup>32</sup>

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<sup>30</sup> Joyce Falconbridge, Personal Diary, 14 August 1937.

<sup>31</sup> *Ibid.*, 18, 19 August 1937.

<sup>32</sup> Sister J. Falconbridge to Head Office, August 1937, AIM correspondence, MS5574; NLA.

August had been a very busy time at Wimmera Home and while Dr Fenton was there he saw some of the hospital's other patients. Mr Winters, who had been brought in from Pigeon Hole Outstation on 15 July after his horse had thrown him and then rolled on him - ("he looked rather ghastly after his 30 mile jolting in the truck")<sup>33</sup> - and Mr Wye, who was an outpatient receiving treatment four times daily for an injury to his eye. Dr Fenton told the sisters that "Mr Winters had had a touch of Pleurisy which was not uncommon with broken ribs".<sup>34</sup>

The sisters had also had the station blacksmith in for treatment for rheumatics; he was an inpatient for 2 weeks. An old man, well read and articulate, he was good company for the sisters. An Aboriginal man who had been shot through the foot was referred by the sisters to Dr Fenton and taken into Katherine by the Manager. In Joyce Falconbridge's words the man's wound was a "nasty looking mess, but decided it was useless looking for the bullet".<sup>35</sup>

During this period Sister Dorothy Allen had bad boils on her hands, and Joyce Falconbridge had to fill in for both cooking and nursing duties as Dorothy could not scrub up. Boils were common during the dry months that year, and a number of station workers received treatment - the sisters applied foment, then lanced the offending eruptions when they came to a head.<sup>36</sup>

Because the two sisters carried the total responsibility for running the hospital they usually rostered domestic and nursing duties for each other on alternate weeks. If one of the sisters became ill, or one had to go away to assist someone at another station, then the full burden fell on the other. They felt this keenly and worried about doubling the work for their colleague. Sometimes unavoidable situations came up: as for instance the time Sister Langham went to help the Aboriginal women on Humbert River. Another incident, from earlier in the 1930s, brings into focus the strength of the nurses' dedication to their work and their loyalty to their nurse mates. Sister McKenzie wrote on 2 May 1934 to Miss Brodie at Head Office:

We still continue to be very busy, had had 4 and 5 patients for the past month...We had a couple of very sick ones...I have not been well myself just when we were at our busiest, I had to go down with fever, I really kept up as long as I could thought I would fight it out, but it got the best in the finish, I am getting around again now, but seem slow in my progress, however I can help a little, as will soon be back to my old form again.<sup>37</sup>

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<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.*

<sup>35</sup> J. Falconbridge, Personal Diary, 13 August 1937.

<sup>36</sup> *Ibid.*

<sup>37</sup> Sister McKenzie to Head Office, 2 May 1934, AIM correspondence, MS5574: NLA.

### **Wives and Mothers - Keeping Families Alive**

The memories of the European wives and others who cared for their families have been revived and recorded over the last few years. The accounts help provide a historical counterpoint to the contemporary accounts and records of the nursing sisters. So we can add to the stories of Sarah Fogarty and May Cockburn-Campbell, and to the accounts of the sisters, remembrances of the Johnston family who lived on the Barkly Tableland in the 1930s.

At Alexandria Station on the Barkly Tablelands, Ellen Johnston was left very much to fend for herself and her family and their employees. As manager's wife she had to oversee the general health of people on Alexandria, and she was expected to provide care to the sick and infirm. Ellen accepted the responsibility and made her way as best she could using very basic medical supplies: "Aspro", "Condeys Crystals", Senna tea, and that most basic of all bush remedies, common sense.

In an interview recorded in 1981, Mrs Johnston made it plain that she had never been frightened of illness because she realized that if she did become afraid she would not have been able to cope. "But", she conceded, "I did feel much better when we got the flying doctor".<sup>38</sup> In particular she found it a relief to have the flying doctor service when she was pregnant.

Before that I was isolated...I had no tests like the women have now - go to the doctor every fortnight or every three weeks or anything because I was too far away. So I just had to use my own judgement and look after my own health to the best of my ability, and I suppose because I was young and healthy I had no complications. I had a complication - I had my appendix out - I had to be taken by flying doctor to Mt Isa and have the appendix out a month before Tony was born, and that was the only fright that I got...Fortunately, Tony wasn't born...<sup>39</sup>

Indeed the whole family was fortunate in that they were healthy and free from illness apart from one very serious accident suffered by their daughter, Pat, when she was still a toddler. Pat had been left for a short while in the care of "a lady help" and while the baby-sitter was not watching the little girl went down the back steps and managed to tip up a tin of caustic soda and drink its contents. Both the lady help and the poor station butcher must have felt very bad about this accident. He had put the tin down while he tended to some other part of the soap making process and hadn't noticed Pat pick it up. Mrs Johnston herself had to care for the little girl during the rushed car trip into Camooweal hospital. She was frightened for her daughter. Remembering the incident later, she said: "That was nearly her

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<sup>38</sup> Interview with Mr Cay and Mrs Ellen Johnston, 29 May 1981, 101, NTRS226 TS250: NTA.

<sup>39</sup> *Ibid.*, 101-102.

death because she took sick in the car going in and she stiffened in my arms and I thought oh, she'll die now - she's dead now, but she came around".<sup>40</sup>

On another occasion Ellen Johnston's calm practical treatment of a man close to death from dehydration saved his life. He was one of the many who took to the road during the Depression and walked from Queensland looking for work, and was one of the many who found nothing. Aborigines working on Alexandria discovered the man lying face down in the mud of the river close to the station. He was very ill and Ellen had to do what she could for him without any medical advice. In her own words:

...I just used my own sense and we washed him and bathed him and let him absorb water through his pores then I fed him with a desertspoon full of water every hour, until such time as I could make him understand...I had him, say, all day and all night, and all the next day and then the Alexandria car took him into Camooweal. There was a doctor in Camooweal - it was one hundred and forty miles...<sup>41</sup>

Calling on that same good sense Ellen treated a stockman suffering from a snake bite with raw "Condy's Crystals" applied to the wound. She stayed all night with the man, walking him around so he would not go to sleep and pass into unconsciousness, and then next morning arranged for him to be taken into Camooweal. And during the Depression she coped with cases of beri beri suffered by men working on a contract to sink Government bores. The men were not being fed properly and "they were smothered in sores, all over their hands and everywhere". Again her common sense triumphed:

And the way we used to treat berri-berri (sic) was we used to give Vinegar drink and we used to put dried peas on a plate, on a towel, and put a wet towel over the top of them and let the shoots come off the dried peas, and we used to give them that to eat.<sup>42</sup>

### **Finding Fresh Food**

Station women appreciated the importance of fresh fruit and vegetables and understood the basic principles of diet: that it must be balanced, palatable and contain a good variety of foods. Whenever they could they started kitchen gardens on the stations, close to the station house, and often a women would remember a station her family had worked on by the quality of the garden produce. Sarah Fogarty's children remember that while the family was on Hodgson Downs Station in the 1930s the conditions there were quite reasonable and that Sarah was able to

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<sup>40</sup> *Ibid.*, 90.

<sup>41</sup> *Ibid.*

<sup>42</sup> *Ibid.*, 94.

have a good vegetable patch. She was able to send "a supply of these things to the convent in Darwin, where her daughter was at school".<sup>43</sup>

On Alexandria Station, the Johnstons employed a gardener "who grew good vegetables" and they always had a good supply of potatoes and onions and pumpkins. These were the staples and appear in all the records of cattle stations right into the 1970s as the most available fresh food items along with fresh beef. Some stations planted fruit trees - mango, orange, sometimes paw paw and bananas - but the ravages of termites and grass-hoppers and the difficulty of keeping up a good supply of water during the dry, more often than not defeated their purpose.

Sister Allan wrote to the Head Office staff in August 1938 describing the difficulties they had had in keeping a garden:

Our garden had not been too good this season. We planted five dozen little trees - such a smart shrubbery we intended to have, but the white ants finished our hopes for us and we just had to go round and fill in the holes. We had such hopes for our little trees, there were - mangoes, five corners, guavas, ceylon oaks, tamerands (sic), acacias, polyantheas, ixoras and diva-divas.<sup>44</sup>

Of this list of trees, mangoes, five corners and guavas, would have produced edible fruits had they survived. Each year the Sisters planted out seedlings, vegetables and flowers, and each year their letters back to Sydney record the loss of their plants. It is easy then to understand why the gift of some fresh grapes from a family in Wyndham, and a few weeks later some apples from the same people, pleased Sisters Langham and Stewart so much that they wrote of it in a letter sent south.<sup>45</sup> The importance of fresh food was understood so well by the bush people that they shared readily what fresh produce they had, even as in the case of the grapes and apples, with friends more than 200 miles away!

Knowledge and understanding of basic preventative health measures and first aid were not enough to see them through when accidents, difficult confinements or serious illnesses occurred. Then, as the health givers in the community, professional and lay women were called on to make critical decisions about whether to evacuate a patient, and when and how. They had to assess whether a limb had been broken in a fall from a horse, if severe stomach pain was a symptom of appendicitis, and diagnose leprosy cases which had to be sent immediately to Darwin for treatment at the isolated leprosarium on Channel Island. To make the situation even harder the women were often forced to make these decisions about members of their own family.

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<sup>43</sup> Ogden, *op. cit.*, 32.

<sup>44</sup> Sister D. Allen to Head Office, 11 August 1938, AIM correspondence, MS5574: NLA.

<sup>45</sup> Sisters Langham and Stewart to Head Office, 5 May 1936, *Ibid.*

### **Saving a Son's Life**

Sarah Fogarty faced such a crisis when her son Dave was seriously injured in a motor vehicle accident at an isolated spot on a station road between Katherine and Wyndham. Dave himself described his damaged legs which had needed 26 stitches in one and eighteen in the other:

I was very lucky that the bone wasn't broken. The flesh was torn, so the leg was bandaged and dressed continually. Had the leg been broken, I'd have lost the leg for sure.<sup>46</sup>

After two weeks of treatment at Wyndham hospital "the damaged flesh turned black...and the doctors wanted to remove the leg". The family then faced the prospect of raising a male child who would not have been able to do bush work. Sarah, alone with her children in Wyndham, refused to give permission for the amputation. She looked for help from many sources, and was advised by a Chinese doctor from a foreign ship in Wyndham port that daily baths in salt water would help, but he insisted that the child really needed to be taken away from the tropics. Finally Sarah accepted the inevitability of this last piece of advice and arranged for her other children to be cared for in Wyndham while she took Dave on a long journey to Derby by road and then by ship to Brisbane. Pearl Ogden writes:

Surely the most difficult thing Sarah had to cope with was an accident her eldest son had. It must have taken great courage for Sarah to sit with Dave while he begged her not to let the doctors remove his leg. Mardie said they could hear him crying in the hospital at Wyndham when his mother was visiting him.<sup>47</sup>

### **Birth Control - A Woman's Problem**

Sarah is now remembered as a tough woman, a battler with a biting tongue and an uncomfortable habit of telling home truths. Her earlier experiences in the bush no doubt helped to create this side of her character. Sarah faced up to many difficult decisions without the comfort and support of other women; understandably those decisions would sometimes affect her life and her family's ever after. Another aspect of her life which her grand daughter has touched on, lifted a screen as it were and dropped it again quickly, was her decision, after the difficulty of Ted's birth, to have no more children. At the time Sarah was a young woman, her husband a young man and as there were no more children apparently they came to some arrangement regarding contraception. Unfortunately there is no indication as to what method they used and no detail about the specific effect such an important decision had on their lives: a decision made more significant by the fact that the Fogarty's were practising Catholics.

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<sup>46</sup> Ogden, *op. cit.*, 16.

<sup>47</sup> *Ibid.*, 46.

The women in this discussion have been largely ignored in the past because of a myth of frontier society: it's a man's world. Nevertheless, as the evidence shows, women were part of frontier history. European women were never present in large numbers, and so it has been possible to act as if they were irrelevant to the development of settler communities. Aboriginal women were, of course, present in numbers that exceeded the total population of Europeans. Social historians have ignored them because until recently frontier histories emphasised European endeavour.

An examination of the available documents for the 1930s reveals that the women were in fact important contributors to settlement of the north. Their contribution was perhaps more subtle and less exciting than the men's, but essential all the same. They filled their roles as sisters, wives and mothers with dedication and fortitude. Responding to danger and crisis when these arose women spent most of their time carrying out their tasks with quiet dignity and commitment. They were also intelligent, skilled and inventive. They gave life and saved lives. The presence of women, particularly as healers and preservers of health, was an essential part of the Northern Territory's settlement and development.

## HEALTH, DIET AND MORTALITY Among Nineteenth Century Alluvial Miners in Tropical Queensland

Peter Bell

Mining communities seem well covered in historical literature. From the lead miners of the Pennines to the silver miners of Nevada, the settlements created by underground mining in the past two centuries have attracted much attention, as historians have diligently pursued the documentary records they generated. However, silence hangs over the parallel activity of alluvial mining. Throughout the second half of the nineteenth century, there were always thousands, and often hundreds of thousands of miners engaged in extracting alluvial gold: that is, gold in secondary deposits on or close to the earth's surface. Their settlements were short-lived and often squalid, and while they have left their mark in folklore, they have contributed surprisingly little to the historical record.

The reasons for this are easily explained, as they arise from the transient way of life of the goldseekers. One must forget the image of underground miners trudging homeward from the pit to families housed in row cottages in Ebbw Vale, Camborne or Rothbury. Miners of these societies can be scrutinized for their health, income, diet, education and morality in reams of records kept by the company, the parish, the municipality, the school, the government, the storekeeper and the police. Instead, the basic unit of the North Queensland alluvial miners' society was a man and a horse, equipped with a shovel, a pan, perhaps a tent, and extraordinary optimism. In the course of a year, not one word was likely to be written about such a miner in any document.

The subject of this paper is the health and related aspects of the lives of North Queensland miners on alluvial fields in the period when they were most numerous, from the 1860s to the early twentieth century. Alluvial mining has few counterparts among other industries in the large and ephemeral settlements it creates. In 1876, when Townsville, now the region's largest city, had a population of 2,174 there were 9,215 people on the Palmer goldfield, which is now virtually uninhabited.<sup>1</sup> But no alluvial field in Queensland remained in significant production for more than five years. Sometimes their lifespan was measured in months or weeks. Even to say that the richer fields, like the Palmer, remained in robust production for five years

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<sup>1</sup> Fifth Census of Queensland, 1876, *QVP* 1877, 2, 50 & 54.

is misleading, for this period saw a succession of migrations from gully to gully over an area of thousands of square kilometres. An individual who stayed on the Palmer for its entire heyday from 1873 to 1878 could well have shifted camp twenty times.

### The Alluvial Settlements

The population of these settlements was predominantly male.<sup>2</sup> These men constituted a society with an artificial economy in which earnings were low and costs were high. The majority of alluvial rushes took place in unsettled country, with little or no economic infrastructure. There was no agriculture or commerce, and little pastoral industry. Labour was scarce and costly, and virtually all goods had to be imported and distributed by a makeshift and inefficient transport system. In these circumstances nearly all goods and services were very expensive.

But the miners themselves could not benefit from this inflated economy, for they contributed no goods or services to it; if they were persistent or lucky, they produced gold, whose price was fixed.<sup>3</sup> Their average income can be calculated from goldfield wardens' reports. Dividing the reported gold yield by the number of alluvial miners producing it, we find on the Palmer that in 1874 when the field was in its infancy, average weekly earnings were a highly respectable £4/6/8. But by 1877, at the field's peak population, the average income had declined to 18/9d per week.<sup>4</sup> This was less than a third of an urban worker's wage, and inadequate to meet the Palmer's inflated costs. In 1875, the "bare necessities" for a man and horse cost £2/2/- per week.<sup>5</sup>

### Health Administration

In this strange society, there was little concern or provision for public health. Matters of public administration were in the hands of the Warden (or Commissioner, until 1874), who was usually also the Police Magistrate and Mineral Lands Commissioner, among other positions. Presiding over a small and mobile body of assistant wardens, clerks, European police and Aboriginal troopers and trackers, the Warden exercised a scope of authority rarely granted to an Australian

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<sup>2</sup> The Palmer was 98.7% male at the May 1876 census (9,096 men, 119 women), *Ibid.*, 50. For a fuller account of alluvial miners see chapter 2 of P. Bell, *Timber and Iron: Houses in North Queensland Mining Settlements, 1861-1920* (St Lucia: University of Queensland Press, 1984).

<sup>3</sup> Fine gold was valued at £4/2/6 per troy ounce. To allow for impurities and a profit margin, alluvial gold was usually valued at £3/10/0 to £3/15/0 in circulation on the gold fields.

<sup>4</sup> Based on figures in the Annual Report of the Undersecretary for Mines (AR) 1878, *QVP* 1879, 2, 399, assuming a gold value of £3/15/0 oz.

<sup>5</sup> P.F. Sellheim to Secretary for Works and Mines, 10 January 1875, CPS 13B/G1: QSA.

public servant in peacetime. This authority derived from the Gold Fields Act 1874, which was preoccupied with maintaining order on a potentially unruly frontier, and said not a word about health. The larger alluvial fields also had a Government Medical Officer, who was responsible only for the health of Crown employees and prisoners in custody, not that of the public, although some took it upon themselves to intervene more widely in such matters as sanitation.<sup>6</sup>

Where the stability of a settlement warranted it, a hospital could be established on local initiative, paid for by public subscription and administered by a local committee, much as were schools, churches and libraries. More systematic attention to preventive public health measures came only with the establishment of local government by the Divisional Boards Act of 1878.<sup>7</sup> The circumstances favouring this development meant almost axiomatically that alluvial mining had already ceased to be the district's main economic activity before a council was formed. Thus the Palmer gained a ten bed hospital by public subscription in 1876, and a Divisional Board was set up in 1880. By that year, population and annual gold production had both fallen to about a quarter of their earlier peaks, and were still falling.<sup>8</sup> Public health measures as a rule appeared on mining fields only when the most pressing need had passed.

### Mortality

The need for public health measures is difficult to quantify, as no source allows even a guess at the incidence of morbidity among alluvial miners. In the rudimentary state of record-keeping by a busy administration, health problems were usually committed to paper only when they proved fatal, so it is to the mortality figures that we must turn in order to gain an insight into the miners' state of health. The principal source of data on mortality among the alluvial mining population is the Register of Deaths.<sup>9</sup> This source is of questionable completeness, for it can be shown from other sources that not all deaths were registered.<sup>10</sup> Nonetheless, it is the most trustworthy record in existence, provided all conclusions drawn from it are regarded as conservative. The first 200 deaths were registered on the Palmer

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<sup>6</sup> Diary of Government Medical and Health Officer, Thornborough Police district, 1888-89: John Oxley Library, Brisbane (JOL).

<sup>7</sup> Janice Wegner, chapter 12 in this volume.

<sup>8</sup> N.S. Kirkman, *The Palmer Gold Field 1873-1883* (unpublished BA Hons thesis, James Cook University, 1984), 55, 70, 94, 155.

<sup>9</sup> Register of Births, deaths and Marriages for the Palmer District: Cooktown Courthouse.

<sup>10</sup> Chinese deaths seem to be seriously under-represented in the death registers. Kirkman shows that only 29% of recorded deaths from 1873 to 1883 were Chinese, although the Palmer population was 73% Chinese in 1876: *op. cit.*, 318.

between October 1873 and July 1875, a death rate of 114 per year, while the mean population during that period was 3,300.<sup>11</sup> This gives a mean death rate on the Palmer of 34.5 per 1,000. The mean death rate in Queensland as a whole for the decade 1867-1876 was 17.58 per 1,000.<sup>12</sup> Thus it is an easy conclusion that something was killing the population of the Palmer goldfield at twice the rate applicable to the colony as a whole. That conclusion is sure to be conservative.

When we turn to the causes of death recorded in the Register, the culprits are not difficult to identify. Some 61% of the deaths on the Palmer between 1873 and 1875 were attributed either to "dysentery" (37%) or "fever" (24%).<sup>13</sup> The proportion of deaths from these causes in the colony as a whole was usually about 15%.<sup>14</sup> Therefore the additional mortality attributable to these two causes is nearly sufficient to account for the district's elevated death rate.

### Disease

What were dysentery and fever? In the 1870s both were generic terms, implying respectively any disease involving inflammation of the lower bowel, and any disease characterised by a raised temperature. In many conditions they could be used interchangeably, and neither word sheds much light on the specific morbid conditions, especially as many of the diagnoses recorded in the Register of Deaths are of dubious provenance, and must reflect the lay opinions of both informants and registrars.

Nonetheless, there is abundant contemporary evidence that a condition or conditions known collectively as "fever" was common in nineteenth century North Queensland. It was an obstacle to early pastoral settlement, more often debilitating than fatal:

My own health seems completely broken, and it is with the utmost difficulty some days that I am able to wash and dress the two babies. Every day I have this weary fever...Quinine, Opium, laudanum and Turpentine, and Brandy are almost in daily request...The deaths have not been so many as one would imagine where so much sickness existed, but it seems to utterly prostrate every faculty of mind and body.... It is a miserable way to live, neither dead or alive.<sup>15</sup>

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<sup>11</sup> Register of Births, Deaths and Marriages for the Palmer District, as above; Kirkman, *op. cit.*, 55.

<sup>12</sup> Vital Statistics, 1876: *QVP* 1877, 2, 655.

<sup>13</sup> For the decade 1873-83, Kirkman, gives 54% of deaths as due to these two causes: dysentery 23%, fever 31%, *op. cit.*, 318.

<sup>14</sup> Dysentery 8.6%, fever 6%, Vital Statistics 1876: *QVP*, 2, 713.

<sup>15</sup> Mrs James of Nulla Nulla Station, 1865, quoted in G.C. Bolton, *A Thousand Miles Away* (Canberra, ANU Press, 1963), 34.

It is tempting to speculate on the identity of this condition. Malaria, Dengue fever and Ross River fever, all insect-borne, have all been endemic in parts of North Queensland in the twentieth century. Any one, or a combination of them, could account for what seems to have been endemic in the nineteenth. Fever was high on the list of hazards for which the region was notorious, as one early settler recorded wryly:

...before we left Brisbane we were told that we should most likely be killed and eaten by the Blacks, or else by the Crocodiles, and if not we should die of the fever ...<sup>16</sup>

There are numerous anecdotal references to the condition, some of them almost casual. Marian Rowan, visiting the silver mining town of Muldiva in the 1890s, listed her activities for the day, including: "then I went back to the hotel...where I sat and fanned a child dying of fever..."<sup>17</sup>

This rudimentary amelioration of fever symptoms seems to have been the full extent of the treatment available. One diary describing the Hodgkinson rush of 1876 mentions several fever cases with the same weary prognosis:

...there is a very bad case of feaver just along side of us, one poor fellow as got it very bad and as be up here about 12 or 14 days he as no mate no money and cannot walk as far as the place were he makes his fier to make a drop of tea we have looked after him since we came here pretty well but I dont know what he will do when we are gone I suppose he must die like many a poor fellow a done before him that is all the comfort there is up here for one with the feaver...<sup>18</sup>

More comprehensive cures were available for the gullible. One E. Myers, MD, published the following dubious advice in 1875:

INTERMITTENT FEVER - A handful of gum leaves in a quart of water: drink a panikinfull, hot or cold, three or four times a-day. It may be sweetened with sugar, if so preferred. Is very effective, and in constant use at the fever hospital in Berlin.  
DYSENTERY - A moderate-size piece of the inner-bark of the gum-tree, bruised and boiled in a quart of water, adding the juice scraped off the wood from whence the bark was taken. It should be drank cold, three or four times a-day. Equally effective as last.<sup>19</sup>

Whereas the diagnosis and treatment of fever were baffling, there was a clearer understanding of the causes of dysentery, which by the 1870s were known to be

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<sup>16</sup> Arthur Neame, unpublished typescript diary, 1871, 20: Hinchbrook Shite Council.

<sup>17</sup> M.E. Rowan, *A Flower Hunter in Queensland and New Zealand* (Sydney, Angus & Robertson, 1898), 57.

<sup>18</sup> Peter (surname unknown), unpublished diary, 1876: JOL.

<sup>19</sup> *Cooktown Courier*, 27 November 1875, quoted in Kirkman, *op. cit.*, 154.

associated with contaminated water supplies. The goldfield wardens occasionally alluded to miners' insanitary living arrangements, although they had no power to alter them. Likewise the Government Medical Officer on the Hodgkinson kept copious records of the proximity of lavatories to wells and streams, but this was no more than an academic study.<sup>20</sup> There were no regulations governing sanitation and water supply during the great alluvial rushes of the 1870s, when they were most needed.

In a later era, when local government had adopted responsibility for the mitigation of infectious diseases, there was a distinctly different reaction to the decline in living standards brought about by an alluvial rush. The Oaks rush of 1908 occurred in the Etheridge Shire, which was equipped with regulatory powers and inspectors to deal with public health. Immediately the Shire imposed regulations on the new town of Kidston, prohibiting buildings within five chains of the river, and controlling pollution of the watercourse and the disposal of human waste.

When in early 1910 an epidemic of "fever" broke out at the Oaks there was a hospital capable of handling seventy patients. One case of typhoid was diagnosed, but the remainder were malaria and blackwater fever, and the health inspector responded by treating stagnant waterholes with kerosene, for the role of mosquitoes as a vector had become known in the late 1890s. The Oaks epidemic caused three deaths, and was contained within weeks.<sup>21</sup> By this time, at the last of the alluvial rushes, the combined effects of improved medical knowledge and local government health administration had controlled the nemesis of infectious disease that prevailed a generation earlier.

## Diet

One aspect of the miners' health on which there is considerable information is their diet. Ephemeral settlement and expensive supply lines encouraged a cheap and simple diet that was nutritionally poor for the majority of Europeans, although probably Chinese tended to eat a healthier diet. The staples of the European diet were fresh meat and flour. Meat, of course, was regarded as the single most important foodstuff, and there was widespread faith in its nutritional value.<sup>22</sup> Paradoxically, in an economy where the costs of virtually all commodities were inflated, fresh beef and mutton were usually plentiful and cheap on the mining fields. An impoverished miner could afford to eat steak at every meal, although even flour was sometimes beyond his budget.

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<sup>20</sup> Diary G.M. & H.O. Thornborough, 1888-89: JOL.

<sup>21</sup> Etheridge Shire Council Minutes 1908-1910, (notes kindly provided by Janice Wegner).

<sup>22</sup> F.W. Clements, *A History of Human Nutrition in Australia* (Melbourne, Longman Cheshire, 1986), 34-38.

Pastoralism was established in North Queensland in the 1860s, and beef cattle were available close to most alluvial rushes. The pastoralists welcomed, and indeed actively encouraged, the discovery of minerals and the market they brought, for until a local market existed, most beef cattle could not be sold as beef. Unable to compete by overlanding to metropolitan markets, and awaiting the eventual success of several decades of experimentation in canning and freezing, the cattlemen's only local outlets before the gold rushes were the boiling-down works.<sup>23</sup> In these, possibly the most wasteful and noisome industrial plants ever devised, cattle carcasses were reduced to hides, tallow, bones, and a brown substance which was consumed without enthusiasm as "extract of beef". Thus the alternative market provided by the alluvial rushes was welcome to all concerned. Reminiscing about the Palmer rush, one writer said: "Beef was our cheapest commodity; fat cattle were very cheap. Any cut of beef was often sold at threepence per lb without the bone."<sup>24</sup> Beef consumption per head was high, and so predictable that goldfield wardens used the butchers' sales figures to estimate the population.

This estimate is based upon repeated personal examination of the various camps, consultation with the leading Chinese storekeepers, and the quantity of beef consumed. I have invariably found the latter test the most reliable in application. The average consumption of bullocks weekly is 78, which, at 500 lbs of saleable meat each, gives a total of 39,000 lbs. Four hundred and thirty-four Europeans, including women and children, will consume 10 lbs each weekly, leaving 34,660 lbs, which, at 8 lbs per adult, represents 4,332 aliens, or, in all, a total population of 4,766.<sup>25</sup>

The anecdotal evidence of this staple diet is strong and consistent. One account of the Palmer recalls, "there were no luxuries in the way of fruit and vegetables and no bread or cakes - only damper. Tinned fruit was a real luxury and seldom obtainable in any town."<sup>26</sup> This is borne out by the daily journals and diaries of the time, when food is mentioned. From the Hodgkinson rush: "made my way back...to have a good meal on jonny cake and stake griddled on the ashers..." This same writer provides other valuable insights into the mechanics of the beef price and the preservation of the product:

there is two butchers and one is trying to run the other off so the beef is down to three pence a pound and you can see beef at every tent tied on string and hung out in the sun to dry that is the way it is cured not salted as salt is a shilling a pound.

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<sup>23</sup> K.T.H. Farrer, *A Settlement Amply Supplied: Food Technology in Nineteenth Century Australia* (Melbourne University Press, 1980), 48-129.

<sup>24</sup> J.H. Binnie, *My Life on a Tropical Goldfield* (Melbourne, Bread and Cheese Club, 1944), 28.

<sup>25</sup> AR 1881: QVP 1882, 2, 760.

<sup>26</sup> Binnie, *op.cit.*, 12.

He also recorded the bravado which made miners take perverse pride in their poor diet:

we have a grate old northerner in the camp to night, and can tell some grate old yarns if there is any truth in them he is a rum stick, he as a billy can and flour and tea no sugar dont use it now can do without it, flour and water bread nothing else wanting only a bit of meat now and then none tonight a half a blanket and the same size of calico that is all his bundle contains, and he laughs at us for carring so much, he turms us fat-southerners...<sup>27</sup>

One of the most informative documents in the study of miners' diet and health is the diary of E. G. Chapman, kept during four years of itinerant life on the North Queensland alluvial fields. Chapman was hardly one of the great diarists; terse and lugubrious, he was quite capable of a daily entry which read: "Put handle in shovel. Rained nearly all night."<sup>28</sup> But his diary is remarkable for three things. First, it contains what seems to be a scrupulously thorough record of every purchase he made during that period, and its price. Second, Chapman was a hypochondriac, describing his bouts of poor health in more detail than any other topic. And third, during his periods at home on the outskirts of Charters Towers, he was a vegetable grower, and clearly understood the value of fresh vegetables to his diet.

Yet, when he was on the road or in an alluvial camp, Chapman lived, like everyone else, on a diet of fresh meat and damper, enlivened by whatever condiments he could purchase. (His complete list of foodstuffs is given in the appendix.) His accounts show that he bought an average of eight pounds of beef each week, for which he paid an average of just over threepence per pound. When he described individual meals, he referred to them as "meat and bread and sugar" or "bread and beef". He caught fish when camped by the Lynd River, and occasionally travelled well out of his way to buy sweet potatoes and pumpkins.<sup>29</sup>

Chapman records one episode in which he sought to treat symptoms of ill-health by seeking a specific remedy (sarsaparilla) and an improved diet:

Sat 11-Sun 12

Worked till today then I got too ill to work, bad all Sunday cannot eat salt meat and bread, my ankles are swelled with scurvy.

Mon 13

Started for Charleston to get some Sarsaparilla, when I got to the township I was very weak after I had some supper with vegetables I felt better, bought a bottle of

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<sup>27</sup> Peter, *op.cit.*

<sup>28</sup> E.G. Chapman unpublished diary, 1895-99, entry for 20 January 1885. Original held by Mr V. Butcher, Charters Towers.

<sup>29</sup> *Ibid.*, 28 March, 3 April, 7 April, 14 June 1896.

Sarsaparilla from Candlish's shop at Finnigan's out of 5½ weights of gold got from Reilly it did me good as soon as I started taking it...<sup>30</sup>

We learn from this that Chapman recognised the symptoms of scurvy, and had some idea of what would prevent it, and yet he habitually ate a diet which was likely to encourage it. There is little knowledge of the general incidence of scurvy among alluvial miners, as there is no documentary source which could be expected to record it. "Scurvy" appears only once in the Palmer death register, and then not as the primary cause of death. However, from what is known of their diet, it is reasonable to infer that diseases related to malnutrition were probably quite common among Europeans on alluvial fields.

### The Chinese

There is considerable evidence that Chinese tended to eat a more balanced diet, with less meat, and more grains and fresh vegetables. The Chinese were highly regarded for their competence at growing vegetables and their willingness to do so. Several accounts suggest that the Chinese arrived on alluvial mining fields in organised groups with a carefully-timed plan for establishing themselves, and that the first arrival was likely to be a gardener to cultivate a vegetable plot.

Within weeks of the initial rush to the Palmer, the Chinese were present, not mining at that stage, but gardening. The Commissioner arrived on the new field to discover that a Chinese gardener had planted vegetables on the riverbank a fortnight earlier.<sup>31</sup> Marian Rowan observing the early days of Muldiva twenty years later commented, "John Chinaman goes by with his pack-horse, for already he is pioneering with his garden stuff; where his garden is I do not know: everything seems baked and parched up..."<sup>32</sup> When the township of Byerstown was only three months old a visitor observed: "...a constant supply of fresh vegetables of all kinds are always on hand, from the Irish spud to a Yankee water melon, and sold at a very reasonable price..."<sup>33</sup> Once established, the Chinese had a virtual monopoly on the vegetable market. A description of Charters Towers in 1878 noted: "Gardens there are none, save those cultivated by the Chinese."<sup>34</sup> And these gardens were not simply producing a few veggies for domestic consumption; they were a major industry. On the Hodgkinson goldfield in the 1880s, Warden Towner, one of the few

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<sup>30</sup> *Ibid.*, 11-13 December 1896. A fortnight later Chapman recorded "Since I began living chiefly on oatmeal and tinned milk my health has greatly improved the swelling in my ankles has gone down I have a better appetite and can work better..."

<sup>31</sup> *Queenslander*, 13 December 1873.

<sup>32</sup> Rowan, *op.cit.*, 56.

<sup>33</sup> *Cooktown Herald*, 17 June 1876.

<sup>34</sup> *Queenslander*, 8 November 1878.

officials to take an interest in these matters recorded the Chinese garden output each year, mentioning figures such as 273 tons of maize, 80 tons of sweet potatoes, 38 tons of English potatoes and 4,000 dozen bananas.<sup>35</sup>

It might seem that there were two distinct economies on many alluvial mining fields: one in which Europeans suffered from scurvy for the want of fresh vegetables, while alongside them the Chinese were producing those vegetables by the ton. The Chinese were self-sufficient to a much greater degree than Europeans, and significantly were said to be able to live on eight shillings a week as a result, less than a fifth of what was expended by their European counterparts.<sup>36</sup>

But of course the two economies did overlap, and at least a few Europeans relied on the Chinese for their food. In the early rush to Ravenswood, it was observed:

Nearly all the people boarded in two boarding-houses kept by Chinamen, one on each side of the street. I think there must have been two or three hundred boarders in each. They were both alike, two large bark-houses, no floor, only two immense tables with forms on each side...The charge was one pound per week, payment beforehand, and those of their customers who wanted sleeping accommodation might, without extra charge, fix themselves up as they liked in some sheds behind.<sup>37</sup>

There was apparently a high degree of consumer satisfaction with these arrangements, for one first-hand account from Cooktown in 1876 records:

We make it a rule to have our dinner at a Chinnies boarding house and the other two meals we have in camp you may depend we pay proper attention to the dinner meal I must say the Chinaman keeps a very good table and you may bet we dont want much tea after we have had our eighteen pence worth from him...<sup>38</sup>

Unfortunately, there is no evidence of what fare these Chinese eating establishments offered, whether traditional Chinese cuisine, or the bread and beef diet to which their European clients were accustomed. However, their economic significance can be calculated easily. If the meal provided by a Chinese boarding house was indeed tasty, filling and cheap, as this account implies, we might suppose that it could account for roughly half of a miner's food intake for a day. At eighteen pence for this daily meal, or 10/6 per week, the thrifty miner could then feed himself at roughly half the cost calculated by the Warden for essentials on the Palmer.

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<sup>35</sup> AR 1882-1886: *QVP* 1883-84, 1, 1558; 1885, 3, 45; 1886, 3, 28; 1887, 3, 884.

<sup>36</sup> AR 1881: *Ibid.*, 1882, 2, 760.

<sup>37</sup> T.P.L. Weitmeyer, *Missing Friends, Being the Adventures of a Danish Emigrant in Queensland, 1871-1880* (London, Unwin, 1892) 219.

<sup>38</sup> Peter, *op.cit.*

## Conclusion

To sum up what is known about nutrition and health among North Queensland's alluvial miners is to make a synthesis of a small amount of hard information about mortality, and a broader range of inferences drawn from scattered descriptions of individual miners' lifestyles. It can be shown that mortality rates were high, and that the differences between death rates on alluvial fields and those of the population at large can be accounted for by a very high death rate from infectious diseases. There is some reason to believe that these diseases fell into two categories, those transmitted by insects, and those transmitted by polluted water. The former means of communication was not understood in the 1870s and 1880s, but the latter was. Even where a probable cause of infection was recognized, however, there was no effective mechanism for its control during the alluvial mining period.

Nutritional standards among European miners were poor, and at least some of them were aware of this, and its implications for their health. The Chinese in some circumstances ate a healthier diet and, on occasions, Europeans utilised Chinese eating institutions. The extent to which this occurred is unknown. However, it was quite consistent with the general behaviour of Europeans in nineteenth century Queensland, while seeking to exclude Chinese from economically competitive occupations such as goldmining, to tolerate and even encourage their contribution to service industries which benefited the European population<sup>39</sup>.

But there is little evidence of European miners actively seeking a healthier diet. Even Chapman treated his diet as a therapeutic rather than a preventive measure, going in search of specific foodstuffs to alleviate symptoms of ill-health whenever he thought it necessary. Peter, the new-chum miner who recorded two terminal fever cases near him in the space of a week, gave no indication that his attitudes to his chosen occupation or its hazardous way of life were in any way altered by the experience. This was perhaps in part bravado, but may have stemmed too from the ephemeral nature of alluvial mining, and the expectation that one's stay in any area or indeed in the industry would be brief. The likelihood of death from fever or dysentery was a calculated risk, which, like the heat and the flies, could be tolerated for a limited time in anticipation of the reward which came to a few.

But the over-riding characteristic of the alluvial miners' way of life is that, contrary to much that has been written about the nineteenth century goldrushes, the majority of them were poor and deprived. Their patterns of diet, disease and death may perhaps be simplest to explain in these terms. It would be instructive to compare their health, diet and mortality with those of other contemporary groups of people living in poverty far from home in primitive circumstances.

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<sup>39</sup> See C.R. May, *Topsawyers: the Chinese in Cairns 1870-1920* (Townsville, James Cook University, 1984).

**Appendix. Items mentioned in accounts of E.G. Chapman, 1 January  
1895-30 July 1899.**

| Mentioned regularly                                                                                                                                                                                                                                                                   | Mentioned once or rarely                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Meat</b><br><br>fresh beef                  mutton<br>salt beef                  roast                                                                                                                                                                                             | <b>Meat</b><br><br>steak                      suet<br>Chops                      Corned beef<br>Bacon                      Pork                                                                                                                                                                                                                                                                                          |
| <b>Other Food</b><br><br>Flour                      Oatmeal<br>Sugar                      Jam<br>Tea                          Rice<br>Syrup                      Curry Powder<br>Baking Soda              Extract of Beef<br>Pickles                      Sardines<br>Cream of Tartar | <b>Other Food</b><br><br>Vinegar                    Bread<br>Currants                   Potatoes<br>Pepper                    Tinned Salmon<br>Plums                      Sauce<br>Spice                      Apricots<br>Ginger                    Mustard<br>Coffee                    Milk<br>Sago                       Apples<br>Salt                                                                               |
| <b>Medicinal</b><br><br>Painkiller<br>Epsom Salts<br>Castor Oil                                                                                                                                                                                                                       | <b>Medicinal</b><br><br>Lime Juice<br>Sulphur<br>Sarsaparilla                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other</b><br><br>Corn<br>Chaff<br>Bran<br>Tobacco<br>Soap<br>Kerosene Soap<br>Washing Soda<br>Matches<br>Kerosene                                                                                                                                                                  | <b>Other</b><br><br>Tent                      Reel Cotton<br>Blanket                   Clothes Line<br>Mug                      Blue<br>Plate                      Candles<br>Knife                      Pipe<br>Fork                      Dog Chain<br>Shirt                      Nails<br>Flannel                   Tacks<br>Saddle Straps              Fuze<br>Axe Handle                  Acid (for assaying)<br>Saw |

**NIGHTCARTS AND NUISANCES**  
**Rural Local Government and Public Health**  
**in North Queensland, 1879-1945**

**Janice Wegner**

Local government has carried much responsibility for public health in Queensland. This would appear to be dictated by geography; the state capital of Brisbane, situated in the south-east corner, is remote from much of its population. However, for over a century, geography was less important than finance in decentralising public health. In a developing economy such as Queensland's, demand for public works was high and the Colonial (and State) Governments did all they could to divest themselves of expensive obligations. For public health, governments in Brisbane could also argue that the prevailing theory of disease transmission in the nineteenth century - the "miasma" theory - looked to local conditions for the causes of disease.

However, local communities in North Queensland did not welcome the duties thrust upon them. They were more concerned with establishing the infrastructure, such as roads and bridges, necessary for settlement. Health had a lower priority. Consequently, health measures were often imposed by the central Government upon reluctant or even hostile communities. Even after 1900, when the State assumed more control over public health because of increasingly accurate knowledge about the transmission of disease, it did not necessarily accept responsibility for financing health measures. Instead, additional obligations were loaded on to local government without the finance or even the powers required to implement them effectively. The Government often displayed little understanding of local conditions, and areas of responsibility were not well delineated. However, the administrative structure set up by the discarded miasma theory continued to determine the basic health concerns of local government: sanitation, pollution, water supplies, and infectious diseases. These issues are well illustrated in the experiences of two rural local authorities during the period 1879-1945: Etheridge, a dry inland Shire with a marked monsoonal climate; and Hinchinbrook, a coastal area in the wet tropics. These Shires represent the major climatic types in tropical North Queensland; most North Queensland rural local governments would fit one or the other model.<sup>1</sup>

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<sup>1</sup> The exceptions are on the cool wet tablelands east of the Great Dividing Range, such as Atherton and Eungella. These are numerically insignificant.

### Environment and Public Health: Two Shires

In geography, climate and type of settlement, Hinchinbrook and Etheridge are quite different. Hinchinbrook is small in area, so that health matters could be easily supervised; primarily agricultural, it has a high population density and population growth has been continuous since first settlement in 1870. From 2683 people in 1901, it grew to 5503 in 1921, and doubled again to 12900 in 1939.<sup>2</sup> Its major industry, sugar, had large labour requirements usually drawn directly from overseas. Pacific Islanders and Asians, notably Chinese, Javanese and Japanese came in the early period, and increasing numbers of Italians after 1893.<sup>3</sup> They brought their health problems with them: hookworm, leprosy, filariasis, malignant tertian malaria.

Even before this, Hinchinbrook had unclassified fevers which affected early settlers, and which may have included scrub typhus, malaria and leptospirosis. Dengue fever and typhoid became endemic quite early. Indeed a health inspector in 1912 said of Ingham, Hinchinbrook's largest town, that it was the most "interesting" place in Queensland for its range of tropical diseases. Fortunately it did not have the highest incidence of any.<sup>4</sup> As a coastal Shire, it had a port, Lucinda, which allowed the periodic entry of bubonic plague and exposed it to the risk of cholera. Its warm wet climate created perfect conditions for disease-carrying pests. Ticks and flies thrived and sugar cane and dense vegetation provided breeding grounds for rats. The swampy flood plain of the Herbert River encouraged mosquitoes and presented major drainage problems.

The Etheridge Shire, by contrast, was large and difficult to administer. Its sparse population relied on mining and pastoralism, and could fluctuate dramatically as mineral discoveries were rushed and abandoned. Conditions in mining settlements were primitive and sanitation poor. Cesspits were the most advanced method of sanitation, and miners often resorted to more casual arrangements. The dry climate and settlement patterns combined to cause a perennial shortage of water, with supplies often of dubious quality. Wells were contaminated by nearby cesspits, dams and waterholes by cattle and ore treatment plants.<sup>5</sup>

The scarcity of water towards the end of the dry season in September- October, coupled with hotter weather, resulted in regular epidemics of "fevers", including

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<sup>2</sup> The population declined after that year because of evacuations and internments during the war.

<sup>3</sup> Italian immigration peaked in the early 1920s. Lyn Henderson, *Italians in the Hinchinbrook Shire, 1921-1939* (Unpublished B.A. Hons.thesis, James Cook University, 1978), 24,27.

<sup>4</sup> Report of the Commissioner for Public Health for 1912-1913, *Queensland Parliamentary Papers* (QPP) (1913), 2, 21.

<sup>5</sup> Reports of the Sanitary Inspectors, Georgetown, 17 August 1907 and 3 November 1909, and Kidston, 28 September 1910; J.J.O'Rourke, Kidston to Etheridge Shire Council, 20 April 1910; John Williams, Cumberland to Etheridge Shire Chairman, 19 August 1905. Etheridge Shire Council Offices (ESC).

benign tertian malaria and typhoid. During the wet season from November to March, other factors prolonged sickness until the return of dry weather in April-May. Epidemics spread by insect pests could break out at any time. As rushes drew in population from all over Australia, new diseases came with them. Unlike Hinchinbrook, however, new arrivals rarely came directly from overseas, so diseases then labelled "tropical" were not a major problem.<sup>6</sup> But poor communications with the coast limited the diet of the population, and probably lowered its resistance to disease. The high incidence of sickness in the late dry season and during the wet could be related to the fact that transport almost stopped during these periods.<sup>7</sup> Local agriculture was insignificant, and fresh fruit and vegetables were never plentiful or cheap.<sup>8</sup> Only meat was available in large quantities; the staple diet was meat, flour, tea and sugar, often supplemented by liberal quantities of alcohol. Before the turn of the century, beer was less popular than spirits: whisky, rum, gin, sometimes poisonously adulterated. Indeed, alcohol and heat alone could account for some deaths. For the Etheridge, health was most affected by poor living conditions, particularly inadequate diet and primitive sanitation.

Local medical services could have had some impact on public health. Both Shires had hospitals relatively early: Hinchinbrook at Ingham in 1884, and Etheridge at Georgetown in 1873. The Ingham hospital was always sufficient for Hinchinbrook's smaller area, but other hospitals were established in the Etheridge as the population of other towns rose: Forsayth in 1911, and Einasleigh in 1914. However, medical services were not abundant and could be of dubious quality. Doctors in the first few decades of settlement ranged from the drunken and incompetent to the merely unqualified. The situation improved quickly in Hinchinbrook because of its larger and more stable settlement, but medical services in the Etheridge were always scarce and likely to disappear as the population of a town declined. The problem was not solved until the 1920s when regular Flying Doctor clinics were instituted for the townships, backed by the Cairns Aerial Ambulance for medical emergencies.<sup>9</sup> There were close connections between hospitals and the local government bodies, the Shire Councils; the superintendent was often the Shire's medical officer and advised local governments, while Councils

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<sup>6</sup> One notable exception was the Kidston malaria epidemic of 1910, which was introduced by miners returning from gold rushes in New Guinea. Report of the Commissioner for Public Health for 1909-1910, *QPP* (1910), 2, 858.

<sup>7</sup> Lack of water and grass for the teams stopped transport in the late dry season, and the country was too boggy for travel during the wet.

<sup>8</sup> See, e.g., Report of the Warden for the Etheridge Goldfield, *Annual Report (AR) of the Queensland Department of Mines for 1889*, 289, and 1893, 65.

<sup>9</sup> T.W.C. Briggs, *Precis of the Cairns Aerial Ambulance Service* (Cairns: Cairns Q.A.T.B., 1956).

contributed financially to hospitals in limited ways. However, the influence of the medical establishment on local government health measures seems to have been largely indirect, and then principally through the Queensland Government.

Local conditions thus resulted in different public health problems for each Shire. For Hinchinbrook, the major factors were its high population density, which put pressure on sanitation, water supply and drainage; natural conditions favouring tropical and other diseases; and the poor drainage of a coastal flood plain. Etheridge suffered from the consequences of a sparse, restless population scattered over a large area, careless of proper sanitation and weakened by poor diet and hard living conditions. Despite these differences, however, the Councils' public health policies were similar, because they were determined by central Government.

### **The "Miasma Theory" and Local Government**

The most obvious and influential of these policies followed from widespread belief in the "miasma" theory of disease transmission, which persisted in Queensland well into the twentieth century.<sup>10</sup> "Miasma" was rather like an evil and invisible mist arising from "nuisances" such as swamps, open drains and sewers, garbage, rotting carcasses, excreta, and anything else which stank. A stink, in fact, indicated the presence of miasma.<sup>11</sup> Public health policy revolved around preventing or disposing of these nuisances. Because this theory was prevalent at the time rural local government was formed in 1879, it determined the role assigned to local authorities in public health. They were to prevent or suppress nuisances. Even after the miasma theory had been discarded, the "miasmatic" approach persisted in local government and limited its responses to public health problems. Throughout the same period, for example, the medical profession knew that poverty was linked with disease. Social welfare became one strand of public health policy, particularly after World War One in Australia.<sup>12</sup> However local government has rarely

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<sup>10</sup> The Commissioner for Public Health was still appealing for an end to this theory as public policy as late as 1912; *QPP* (1913), 3, 19. I am grateful to Lori Harloe for bringing this to my attention.

<sup>11</sup> Margaret Pelling has cautioned against too simplistic an interpretation of the "miasma" theory, which sprang from the work of Benthamite reformers on the London Board of Health. She prefers to call it "sanitary explanations of fever" and points to its great advantages over previous "contagion" theories of disease transmission. Popularization of the theory caused distortion and oversimplification of the sanitary reformers' philosophy. However, it was this popular view that prevailed in Queensland, even at the highest level of government. Margaret Pelling, *Cholera, Fever and English Medicine 1825-1865* (Oxford University Press, 1978), 1-75 *et passim*.

<sup>12</sup> See Michael Roe, "The Establishment of the Australian Department of Health", *Historical Studies*, 17 (67) (1976), 184.

involved itself in welfare, leaving it to the State and Commonwealth Governments.<sup>13</sup>

The miasma theory might be erroneous, but for public health options in new settler societies it is both practical and effective. Nuisances can cause disease. Swamps and open drains breed mosquitoes; garbage, fecal matter and dead animals encourage rats and flies; unsanitary living conditions are responsible for many diseases, from hookworm to hepatitis. If a Council cleaned up nuisances and provided a clean plentiful supply of water, it could do a great deal to prevent the spread of those diseases which most troubled early settlements: typhoid, "dysentery", and mosquito-borne "fevers": malaria and dengue.

It was, of course, ineffective against other diseases, including the great killers of children in the same period: measles, diphtheria, and scarlet fever. However, the miasma theory brought infectious diseases under the umbrella of local government responsibility. They remained there even when it became clear that their causes could not be controlled locally, so that when immunization campaigns became State policy in the 1920s, they became a local government function.<sup>14</sup> Similarly the central Government forced local authorities to quarantine infectious disease cases, disinfect their houses - sometimes by burning them down - and provide isolation wards during epidemics.<sup>15</sup> They even had to pay for the treatment of infectious disease patients in hospitals. Doubtless local authorities were the only regional organisations with the necessary resources, but this policy was really intended to penalise local governments which allowed nuisances to exist. In effect, the prevention and cure of all infectious diseases remained their responsibility as a consequence of the miasma theory, long after the justification for this had vanished.

### Nuisances and Nightcarts

Local government began in Queensland with powers to correct and prevent pollution, site slaughterhouses, remove and dispose of dead animals and garbage, control straying animals, provide sanitary services or sewerage schemes, and

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<sup>13</sup> Local authorities did supervise relief works during the 1930s Depression and took an interest in relief arrangements. However, they considered this part of their traditional role in public works rather than breaking new ground in social welfare.

<sup>14</sup> *Health Act of 1884*; Report of the Commissioner for Public Health for 1920-1921, *QPP* (1921), 2, 45. The Commissioner made this quite clear when he said that the greatest incentive for local government immunization campaigns would be the prevention of infectious diseases.

<sup>15</sup> These were usually *ad hoc* arrangements in response to emergencies. The Etheridge Shire Council commandeered the Kidston school for the malaria epidemic of 1910, and Hinchinbrook nervously awaited the 1900 Bubonic Plague with a tent hospital. Report of the Commissioner for Public Health for 1909-1910, *QPP* (1910), 2, 858; Hinchinbrook Shire Chairman to Home Secretary, No. 06731, 3 May 1900, and No. 08132, 23 May 1900, COL/035: QSA.

provide water for the public.<sup>16</sup> However, attempts to use these powers met with limited success. Etheridge had no trouble keeping slaughterhouses out of its towns, but the first attempt by the Hinchinbrook Divisional Board (later Shire Council)<sup>17</sup> to enforce this in Ingham led to an uproar from butchers.<sup>18</sup> Local resistance in the Etheridge also nullified attempts to control straying goats. These animals roamed the mining towns, camping under buildings and causing unsanitary conditions and offensive smells. However, goats were the source of fresh milk on the goldfields, particularly for the working classes, and so were tolerated. Hinchinbrook faced a similar problem with the milk cows which wandered through Ingham, fouling footpaths and shop verandahs. After the cattle tick plague of the early 1890s, shopkeepers could even find their premises invaded by hordes of ticks.<sup>19</sup> However, cows were again essential for supplying families with milk and the Council, though concerned, gave the problem such a low priority that a pound was not built until 1916.

Water supplies were considered of greater importance, and some effort was made to provide water and prevent pollution. Both Councils dug and maintained public wells; the Etheridge Shire Council also took responsibility for the upkeep of mining dams used by the public. In 1935, Ingham in Hinchinbrook acquired a reticulated water supply, taken from beneath the sandbanks of the Herbert River, which provided natural filtration and clean water of good quality. This was credited with stopping the annual outbreaks of sickness at the end of each dry season.<sup>20</sup> Pollution was a local government concern, and though Hinchinbrook had fewer problems, it monitored water quality and forced owners of rainwater tanks to screen them against contamination. Its worst pollution problem followed close upon the construction of Ingham's water supply. In 1944, the Herbert River became polluted with slimes from tin dredges working upstream in the Mt. Garnet area. The clay might not have been inherently harmful but it made the brown liquid issuing from Ingham's taps unsuitable for human consumption. Much energy was expended by the Council over the next thirty years, trying to stop this pollution at its source.<sup>21</sup>

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<sup>16</sup> *Divisional Board Act of 1879*, s. 156, 168-171, 187 (10, 13, 14, 22, 23, 25, 26).

<sup>17</sup> The first rural local governments were called Divisions and their governing bodies, Divisional Boards. This was changed to Shires and Shire Councils by the 1902 Local Authorities Act. The Etheridge Shire was called Einasleigh until 1919, but "Etheridge" has been retained for the entire period to avoid confusion.

<sup>18</sup> J. Hull to Minister for Works, No. 6684, 29 May 1884, WOR N/11: QSA.

<sup>19</sup> *North Queensland Register (NQR)*, 23 March 1914, 42.

<sup>20</sup> *Herbert River Express (HRE)*, 10 June 1944, 21 December 1944.

<sup>21</sup> J.V. Way, "Report on Pollution to the Hinchinbrook Shire Council", 1971; "Submission to the Senate Select Committee on Water Pollution", 1969, 11-12: HSC.

In Etheridge, because of the primitive and unsanitary nature of its settlements, scarce water supplies were liable to pollution by sewage. Ore treatment plants also discharged waste into water-courses; the Council was often called in on disputes between ore mill owners and other water users. Other situations were more difficult to control. In 1908, for example, the Council tried to remove all camps of miners and Aborigines from near dams and rivers, and reserved protective esplanades around water supply sources.<sup>22</sup> However, these regulations were hard to police. Reticulated water supplies were the only satisfactory solution to the pollution problem and, except in Ingham, these were provided by both Shires only after World War Two.

Garbage was a perennial nuisance. Even if the Councils could prevent house yards being littered with rubbish, as so often happened in the Etheridge mining towns, illegal dumping occurred. Hinchinbrook's greater population and smaller area put more pressure on the Council to supply tips despite the high cost of supervising and covering them when they were closed. It tried to recoup the cost by using rubbish as fill, at the risk of temporarily creating breeding places for flies and mosquitoes in urban areas.<sup>23</sup> It eventually solved its illegal dumping problem by simply providing legal tips where dumping persisted. The use of earthmoving equipment after World War Two made garbage disposal easier.

Drainage was rarely a problem in a hot dry area like Etheridge, but the swampy country and high rainfall in Hinchinbrook put great strains on urban drainage, particularly as settlement increased and wastewater and industrial effluent grew in volume.<sup>24</sup> A few saltwater swamps around Lucinda were drained but the complex drainage system of the Herbert River flood plain required careful management; two drainage proposals for Ingham in the 1930s would have worsened drainage in nearby farms or increased erosion on the Herbert River.<sup>25</sup> Despite piecemeal efforts, effective drainage had to await the flood management plan and sewerage scheme for Ingham developed after World War Two.

The most necessary and troublesome public health service was that of sewage disposal. Cesspits could be replaced by a closet pan system, requiring people to dispose of their own nightsoil in a sanitary reserve. But there was no guarantee that the reserves would be so used; nocturnal dumpers in the Etheridge used nearby

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<sup>22</sup> ESC Minutes, 14 July 1908.

<sup>23</sup> HSC Minutes, 6 January 1920, 17 April 1928, 4 September 1934, 10 December 1935, 17 May 1937; *NQR*, 25 April 1936, 59.

<sup>24</sup> HSC Minutes, 11 May 1926, 10 August 1926, 13 December 1927, 10 April 1934.

<sup>25</sup> *NQR*, 15 February 1936, 69; Minutes, 22 January 1940, Works Committee 13 February 1941, Works Committee 13 March 1941, 21 June 1945: HSC.

gullies or trusted their Aboriginal servants to dispose of wastes.<sup>26</sup> Under these circumstances, sanitary contracts were infinitely preferable. These were provided for the larger townships only, paid for by sanitary rates levied on the town. Most consisted of the double pan system whereby the pan would be removed and replaced with one cleaned at the sanitary depot, though the cheaper single pan system was also in use. The vehicles which removed nightsoil were known as "nightcarts".

There were many jokes about runaway nightcarts, but sanitary services were no laughing matter. Closets were rarely built to the required standard, which indeed in some places would have made them more costly than the houses.<sup>27</sup> Slipshod construction annoyed the contractors, who had an endless stream of complaints about their customers. One nightcart operator at Kidston capped a list of sorrows about low pay, customers using butter or kerosene tins instead of pans, and obstructions to the cart in the form of logs and stumps, with having to go to the front of ill-built closets to get the pan, "and then a bag door will fall over your ears and you can't see what you are doing".<sup>28</sup> As most operated at night, their distress was understandable. Customers reciprocated with complaints about the sanitary services. Even the decision to provide a service was fraught with difficulties. In the Etheridge, towns in need of sanitary services might refuse them because of the cost, or the population might decline to the point where a service was no longer economical though still required.<sup>29</sup> No wonder Council minutes indicate an obsession with sanitary matters. The most effective sewage disposal measure is a sewerage scheme, which also assists drainage. These, however, were not instituted until after World War Two and then only in Hinchinbrook. The Etheridge Shire Council eventually converted its towns to septic systems, again after World War Two.<sup>30</sup>

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<sup>26</sup> Sanitary Inspector, Kidston to Etheridge Shire Clerk, 27 October 1910; Etheridge Shire Clerk's Reports, Works and Sanitation, for February 1913; Correspondence Out Book, 1913-1915, Etheridge Shire Clerk to Secretary, Health Department, 4 July 1913: ESC.

<sup>27</sup> Business Papers 1915-22, Etheridge Shire Clerk's Annual Report on Health for 1918, 5 March 1919: ESC.

<sup>28</sup> Sanitary Contractor, Kidston to Etheridge Shire Clerk, 14 August 1910: ESC. "Bag doors" were curtain doors made from hessian bags.

<sup>29</sup> E.g. Minutes, 2 August 1911, 7 August 1913, 6 October 1930: HSC. It was desirable, in the interests of efficient administration, that a local authority control local services. But the State seemed more interested in offloading its more burdensome responsibilities than in increasing efficiency.

<sup>30</sup> The last nightcart service in Hinchinbrook was abolished in 1979, the centenary of the establishment of local government. Minutes, Health Committee 16 November 1978: HSC.

### The Problem of Finance

It is obvious that many of the Council's worst "nuisances" could have been abolished much earlier by reticulated water supplies and by sewerage schemes which incorporated effective drainage. The technology was available even before local government was established in 1879. However, several factors prevented its use. Good public health is expensive. As local government was originally established to relieve the Queensland government of demands for public works, there was little hope of assistance from that source. In fact, automatic subsidies of local government rate revenues were stopped after 1904. This meant that the greater burden of financing the expansion of settlement was thrown on to local authorities. Unlike other colonies, Queensland imposed a comprehensive system of local government over all of its rural areas in 1879. Local communities were supposed to provide for most local needs, and as a result the three major local government acts - those of 1879, 1902 and 1936 - were very broad in scope. This had the advantage of allowing "local democracy", so that communities could determine their own priorities. However, these lay with roads and bridges, as they were necessary for economic survival, rather than with public health. Another drawback was the creation of a large number of sparsely-populated rural local authorities with insufficient revenue for major works. As a result, rural Shires were simply too poor to afford extensive borrowings for non-essentials like sewerage. Only municipalities could afford such luxuries.<sup>31</sup> It is not surprising that public health measures were usually makeshift.

Certain policies of the Queensland government worsened this situation by imposing more responsibilities on local governments without making provision to finance them. During the Depression, for example, which severely cut local government income from rates, local authorities were required to finance public hospitals.<sup>32</sup> Worse still, they were not free to raise funds at will. Local government revenue has always been firmly regulated by the State. Its rating powers have been limited, its borrowing restricted, and its more lucrative taxes and enterprises appropriated.<sup>33</sup> The State itself, in a developing settler society, was always in desperate need of funds for its own projects, and naturally tried to reduce competition from local authorities for loan capital. Major public health works therefore had to wait until subsidised loans became available during the Depression, when the Commonwealth government entered the field of local government finance.

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<sup>31</sup> R. Wettenhall and J. Halligan (eds.), *Local Government Systems of Australia* (Canberra: AGPS, 1981), 380-387.

<sup>32</sup> *HRE*, 9 November 1926, 6 July 1943, 19 April 1945.

<sup>33</sup> Vehicle tax, for example, was taken away after increasing numbers of motor cars made it financially attractive and electricity supply likewise when it became profitable.

Lack of government assistance delayed or prevented many public health measures, but financial restrictions could also be found at a local level. Because it was customary to pay for public health works by charging a special rate over the town to be benefited, ratepayers could object and prevent them proceeding. Ingham's water supply could have been built in 1929 but was stopped by a poll of ratepayers.<sup>34</sup> Etheridge was even worse off because much of its land, held under mining acts, could not be rated as high as freehold. The mobility of its population also made rates difficult to collect, and long-term planning for loan repayments was impossible. Local governments often refused to provide expensive services until the permanence of a town was assured.<sup>35</sup> The Etheridge Shire Council refused requests from Einasleigh and Forsayth for reticulated water supplies because it knew it could never recover the costs.<sup>36</sup>

Local governments have been accused of neglecting necessary social and health reforms if these meant raising the rates. As Councils were usually dominated by farmers, graziers and businessmen, there was probably some truth to this. It would appear to be borne out in the case of Hinchinbrook in 1936, when a Labour council was elected for the first time. Soon after, the rates were increased, Ingham's water supply was built and the Shire's townships blossomed with so many improvements that the local newspapers' correspondents carried on a paper war between "town" and "country".

However, closer examination proves this picture to be false. The planning for Ingham's water supply had been done by previous Councils, which were dominated by graziers and farmers. The Labour council itself had a high percentage of farmers, graziers and small businessmen. It appears that the real reason for the spate of public works was the injection of financial expertise into the Council by its new Chairman, J.L. Kelly, an accountant. He changed the major source of funding for public works from revenue to loans, on the now well-accepted principle that payment for projects should be spread over the life of those works. In any case, legislation had been established to protect pastoralists and farmers by ensuring that loans for public works should be paid off by the area affected. Higher rates could be charged over these "benefited areas" or over subdivisions of the Shire which were receiving more improvements than others. Self-interest and corruption certainly occurred in local governments, but it is likely that financial conservatism

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<sup>34</sup> Minutes, 14 June 1932, 13 September 1932, 25 October 1932: HSC.

<sup>35</sup> The State government did the same with services such as education.

<sup>36</sup> Minutes, 3 June 1908, 2 September 1908, 3 March 1909, 6 September 1911: Etheridge Shire Clerk to Forsayth Progress Association, 7 September 1911: ESC: Petition, residents of Forsayth to Home Secretary, 30 January 1912, COL/027: QSA.

and lack of expertise were more important causes of local delays in health reform.<sup>37</sup>

### The "Germ Theory" and Centralisation

Centralised control of public health in Queensland was certainly necessary, partly to force negligent Councils into action, but also to accommodate the gradual realisation that local government could not be held responsible for all health problems. Centralisation had been occurring before the turn of the century but it took the 1900 Bubonic Plague outbreak before real power was given to a central health authority, the State Commissioner for Public Health. Bubonic plague could hardly be blamed on local government; it was well known that it was carried from visiting ships by rats. This centralising tendency was reinforced as the "germ theory" of diseases was absorbed by the Queensland Government. After 1912 the Queensland Health Department began to take a close interest in North Queensland and appointed Inspectors to supervise the local authorities, probably inspired by the emphasis being placed on white settlement in the tropics as part of the White Australia policy.<sup>38</sup> The Commissioner was able to force Councils to carry out work considered necessary by the Department's Inspectors and also made them appoint qualified Health Inspectors which many could hardly afford.<sup>39</sup> However, there were other drawbacks to centralisation. Often there was little real understanding of local conditions. This is well illustrated in the Weil's Disease epidemic in Hinchinbrook in 1933-34.

Sugar cane and rank tropical vegetation provided ideal rat harbourage in Hinchinbrook. The Council had long been aware of the problem. After an outbreak of bubonic plague among the rats in the Macknade sugar mill in 1921, it expressed relief that the plague had not spread to the huge population of field-rats and become

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<sup>37</sup> A.A. Morrison, *Local Government in Queensland* (Brisbane: W.B. Smith and Paterson, 1950), 43.

<sup>38</sup> These inspectors, after all, were "to systematically supervise sanitary matters in the art of healthy tropical life". *HRE*, 1912, clipping in CSR 142/3413: Archives of Business and Labour (ABL), Australian National University,

<sup>39</sup> Report of the Commissioner for Public Health for 1906-1907 and 1919-1920, *QPP* (1907), 2, 91-93; (1920), Session 1, 634. Both Etheridge and Hinchinbrook had Inspectors of Nuisances after 1890 and 1900, respectively, but these bore roughly the same relationship to Health Inspectors as road overseers did to qualified engineers. As well, they could be used more economically by performing additional duties, such as controlling traffic and registering dogs. Shires which could not afford engineers were not likely to voluntarily employ Health Inspectors. Eventually the same solution was used as for engineers: groups of contiguous Shires would share the services of a qualified Inspector.

impossible to eradicate.<sup>40</sup> However, with the appearance of rat-borne leptospirosis or Weil's Disease in the cane cutters it was forced to attempt just that. The Council would have preferred an extensive baiting campaign but the State government insisted that all rat harbourage around canefields, along creeks and in swamps be cleared by cutting and burning.<sup>41</sup> Considering the luxuriance of the tropical vegetation and its high moisture levels, it is not surprising that this proved difficult, expensive and time-consuming.

The clearing campaign cost £9000 of which the Council was expected to pay a third, an enormous sum in the mid-Depression.<sup>42</sup> The Council objected because vegetation grew back so quickly in the wet season, and surrounding hills and unsettled areas provided reservoirs of infected rats.<sup>43</sup> Clearing was at best a temporary solution which would have to be repeated every year, and conflicted with the Council's policy on erosion. For over twenty years the Council had been trying to educate farmers to leave a dense cover of vegetation along their watercourses. And when the Council tried to cut clearing costs by leasing unused roads and reserves to farmers for growing cane, an outcry arose from the sugar industry, at that time trying to control overproduction.<sup>44</sup>

None of these problems evoked a sympathetic reaction from the Public Health Commissioner, who in fact publicly derided the Council's attempts to control the epidemic.<sup>45</sup> It is probably impossible to evaluate the effectiveness of the Department's clearing campaign; its effect on the number of leptospirosis cases was hard to judge because of diagnostic confusion over the disease. Farmers saw a reduction in rat-damaged cane by 1936, but this could have been caused by the phosphorus bait campaign.<sup>46</sup> The Council did note that rats preferred swampier fields and began to encourage agricultural drainage schemes.<sup>47</sup> After 1936 drainage and baiting were used rather than clearing, and by World War Two the Council considered the disease under control.<sup>48</sup>

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<sup>40</sup> *HRE*, 8 December 1921, in CSR 142/3490: ABL. Minutes, 9 November 1921, 14 March 1922, 8 August 1922, 10 July 1923: HSC.

<sup>41</sup> Minutes, 20 March 1934, 11 December 1934: HSC.

<sup>42</sup> Report of the Director-General of Public Health for 1935-36, *QPP* (1936), 1, 56-69.

<sup>43</sup> Minutes, 4 September 1934: HSC. *NQR*, 8 September 1934.

<sup>44</sup> *NQR*, 24 October 1936, 23; 22 October 1938, 98; *HRE*, 22 May 1941, 30 December 1944.

<sup>45</sup> Minutes, 9 April 1935: HSC.

<sup>46</sup> Report of the Director-General of Public Health for 1936-37, *QPP* (1937) 2, 1063.

<sup>47</sup> Minutes, 13 November 1934, 10 March 1936: HSC.

<sup>48</sup> *NQR*, 9 May 1936, 69; 25 July 1936, 61; Reports of the Department of Health and Medical Services for 1939-40, 1943-44, 1945-46, *QPP* (1940), 1, 1055; (1944-45), 1, 926; (1946), 2, 924. The problem had already been solved in one sense by the Director-General of Public Health,

Another drawback to centralisation lay in the division of responsibilities between the Council and various State departments. In some cases, Councils were called upon to take action which exceeded their legal authority. After the 1900 bubonic plague epidemic, for example, Hinchinbrook was expected to rat-proof buildings though it had no control over building regulations until 1902.<sup>49</sup> Health Department inspectors frequently criticised the poor drainage in Ingham, which had been built on a distributary of the Herbert River. However, proper drainage and sewerage schemes needed town planning powers not given to local government until 1922.<sup>50</sup> Sometimes the effectiveness of local government action was limited by this shared authority. The Rockefeller and State government hookworm campaigns in Hinchinbrook during the 1920s depended on adequate sanitation to prevent re-infection, particularly as immigration from affected areas in Southern Europe peaked at this time. However, cane cutters' barracks, which housed a large proportion of the new arrivals, were taken out of the Council's control during this period by the Workers' Accommodation Regulations so that it was unable to supervise their sanitary arrangements.<sup>51</sup>

The most distressing case of limited authority for Hinchinbrook came with the mining pollution of the Herbert River after 1944. This contaminated water supplies for Ingham and many farmers along the river. Because the pollution originated outside the Shire, it was beyond the Council's control. As the State government had abrogated the common-law rights of river users by previous legislation,<sup>52</sup> it was naturally appealed to for help. However the Government proved strangely slow to take action. During World War Two the dredge's tin output was needed for the war effort but the Council was probably unaware that the dredging company also had Government-guaranteed overdrafts totalling £160,000.<sup>53</sup> Even after the war, the Government was reluctant to harm the dredges economically by insisting on effective anti-pollution measures, particularly as the Council was never able to

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Cilento, who was reported to have limited the use of the term "Weil's Disease" to a variety of leptospirosis which had never been found in cane cutters. The reason for this became obvious when three cutters from Hinchinbrook immediately lost their claims for workers' compensation, which covered Weil's Disease. *NQR*, 5 March 1938, 97.

<sup>49</sup> *Local Authorities Act of 1902*, s. 8 (2).

<sup>50</sup> C.P. Harris, *Local Government and Regionalism in Queensland, 1859-1977* (Canberra: Centre for Research on Federal Financial Relations, A.N.U., 1978), 81.

<sup>51</sup> Minutes, 7 May 1918, 12 March 1929: HSC. Report of the Director-General of Public Health, *QPP* (1935-1936), 1, 56; W.C. Sweet (Director), *Final Report of the Australian Hookworm Campaign, 1919-1924* (Brisbane: Australian Hookworm Campaign, 1924).

<sup>52</sup> L.G. Mack, Opinion *ex parte* the Council of the Shire of Hinchinbrook, 3 April 1945: HSC.

<sup>53</sup> *AR of the Department of Mines for 1943*, 4; 1944, 6; *HRE*, 28 July 1945; Report of the Bureau of Industry for 1945-46, *QPP* (1946), 844.

prove that drinking clay in suspension was harmful to health. Of course, the inhabitants of Ingham, who had to drink the water, considered the matter more serious. Despite a great deal of political pressure, however, the pollution continued to recur sporadically until quite recently.<sup>54</sup> Very often local government seemed to have more responsibility than power.

The drawbacks of centralisation and divided authority might be troublesome, but they hindered rather than paralysed local government action in most cases. Current medical knowledge, had limited impact. The state of public medical beliefs in 1879 was certainly responsible for delineating local government responsibilities for health, but these were little changed by subsequent advances in medicine. Advances and fashions in medicine might affect the State health departments but they rarely appear in the pragmatic minutes of Shire Councils. Geography and a tropical climate can create favourable conditions for disease, but the worst can be prevented by good sanitation and water supply. The major problem was finance. Councillors usually knew the sanitary short-comings of their Shires and how to rectify them; they were simply unable or unwilling to obtain the large sums required. It is only since the Depression that money has been available in quantity, as State or Commonwealth subsidised loans. In fact since the war, Hinchinbrook's spending on public health has been greater than for any other area of local government responsibility. This access to finance and the greater maturity of the economy have meant that local governments are under less pressure for "roads and bridges" spending, and can devote more attention to the quality of life of their citizens. It is even tempting them to break out of the straightjacket imposed on their public health policies by the miasma theory, more than a century ago.

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<sup>54</sup> For more detail see J. Wegner, *Hinchinbrook: the Hinchinbrook Shire Council, 1879-1979* (Unpublished M.A. thesis, James Cook University, 1984), Chapter 9.

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