



West of Subiaco

A History of the Shenton Park Campus

Philippa Martyr

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Table of Contents

Preface to First Edition	i
Preface to Second Edition	iv
Abbreviations.....	vi
Chapter One: A Fever Hospital in a Suitable Position	1
Chapter Two: Six Shillings a Day	19
Chapter Three: A Piecemeal Accumulation.....	43
Chapter Four: The Metropolitan Infectious Diseases Hospital	65
Chapter Five: Intermezzo	99
Chapter Six: Back On Their Feet.....	112
Chapter Seven: The Royal Perth (Rehabilitation) Hospital)	127
Chapter Eight: Things Old and New	144
Epilogue	170
Appendix 1 - Senior Staff at the Infectious Diseases Hospital.....	172
Appendix 2 – Copies of Masseur Certification.....	175
Appendix 3 – Daily Rates Charged Per Patient, IDH.....	177
Appendix 4 - Comprehensive Hospital Rehabilitation Facilities, 1975.....	178
Bibliography	179
Index	187

Preface to First Edition

This book took on the challenge of trying to provide a history of a hospital - or rather, a succession of hospitals - which had never before been examined in any detail in Western Australian historical writing. This involved the location and analysis of a vast amount of previously untouched archival material. I am very grateful to Chris Stronach for lifting some of the burden off me with his research assistance.

This book has proved (quite accidentally) to be, for me, the genesis of a happy and intellectually productive career in writing and researching histories of medicine and health care in Australia. In early 1991, Sir George Bedbrook inquired of the University of Western Australia's History Department, via the Head of Department, Professor Norman Etherington, as to whether there would be any chance of starting a recent Honours graduate on the project of the Royal Perth (Rehabilitation) Hospital's history, from the 1893 smallpox epidemic, as part of a higher degree. I was just such an honours graduate, and one with no other major direction in mind, apart from a vague interest in the history of medicine which I had never previously indulged. As I began my research into the project, it became obvious that the history of the RP(R)H could not be understood unless its foundations as an Infectious Diseases Hospital were explored thoroughly. Sir George, some months before his death, told me that as the project progressed, he was finding himself more and more curious about those first sixty years of infectious care, and so we decided to incorporate the entire history of the Hospital site into the work.

Sir George, his medical colleagues including Ellis Griffiths, and his diligent and extremely helpful office staff threw themselves into finding money for the project, which was eventually raised and supported me through one year of research. Those companies and individuals who contributed must be thanked: National Australia Bank, BankWest (formerly R & I), Commonwealth Bank, Health Services Credit Union, Roche Products, Surgical Orthopaedic Services, Medical Sales and Services, Stubber Medical, 3M Australia, Morris Surgical, Stryker Australia (WA), Rosanel Traders, Orthotic Prosthetic Services, the Australian Physiotherapy Association (WA), the Occupational Therapy Association of WA, the Arthritis and Rheumatism Foundation of WA, Smith and Nephew Australia, the Hon G M Evans MLC, Drs P & P Goatcher, Mr E R Griffiths, Dr P Kailis, Dr W Pannell, R & P Sarich, Mr P Hardcastle, Mr T Keenan, and Mr Richard Vaughan. Mr Ellis Griffiths also deserves an award for bravery for reading through early drafts of the manuscript and offering much-needed encouragement.

At the end of 1991, I applied for and gained an Australian Postgraduate Research Award to complete the doctorate which had grown out of the Hospital history, entitled "The professional development of rehabilitation in Australia, 1893-1981". By this stage, the thesis supervised by Professor Etherington - providing a thorough analysis of the development of physical rehabilitation in Australia over a hundred-year period - had outstripped the hospital history, and it was not until the end of 1992 that I turned my full

attention back to RP(R)H. When the doctorate was submitted in July 1994, I was able to dedicate more time to writing, and to using the material gathered in interstate libraries and archival collections accessed earlier in 1992.

The research I had already completed placed the Hospital in a truly national context, and now the local element had to be established. For this, I needed archival material, and plenty of it. The secondary writing on the history of medicine in Western Australia has in the past been rather thin, so I went beyond those sources into wider social history. Chris and I ransacked the Royal Perth Hospital Library archives, and searched the Battye Library's oral history collection for any glimmerings of anecdotal information. The staff of all these institutions, and the Reid and Medical Libraries, University of Western Australia, bore with us in tolerance and good humour, and were of great assistance. The Metropolitan Cemeteries Board also provided valuable information on what became of the graves of the original smallpox victims.

I collected some oral history, the tapes of which were very kindly transcribed by Ms Judy Carr of Royal Perth (Rehabilitation) Hospital. I also had many untaped phone and personal conversations with the following people, all of whom are thanked wholeheartedly: Mrs Betty Bell, Mrs Pat De Castilla, Mrs Margery Copley, Miss Rosalind Denny, Mrs Kath Garden, Dr Phyllis Goatcher, Mr Brian Gower, Miss Freda Jacob, Mr John Johnson, Dr Rex Joyner, Mrs Clare Lamb, Mrs Lucy Lockett, Mrs June Rankine-Wilson, Dr Mercy Sadka, Mrs Grace Sedgley, Mr Eric Stovell, Mrs Pat Thorburn, and Mr F Woodbridge. Many of these people also offered photographs for the text, which were gratefully received. The late Brian Gower very kindly gave me access to the Royal Perth Hospital Annual Reports, which filled in many of the gaps. My work with the Western Australian Arthritis and Rheumatism Foundation (now the Arthritis Foundation of Australia (WA)), although unable to be completed, was also a valuable source of information about some of the agencies and other providers of services located around the Hospital, and led to other fascinating and productive taped interviews.

A major break came in mid-1993, when Gower's successor, Garry England, allowed us access to Royal Perth Hospital's Board of Management Minutes, and when we unearthed the Public Health Department's enormous collection of previously restricted files in the State Archives. We thank the Department for its prompt clearance of relevant files for our purposes. These files were a goldmine of information on the Infectious Diseases Hospital, and have proved crucial to the descriptions of the early Hospital.

Finally, there are the people who put up with me: my parents, whose love of me has always been essential to my achieving anything at all, and in my mother's case it took the form of proof-reading a draft of the manuscript; my friends, especially Helen Vella Bonavita, who had already borne with me through my doctoral thesis and had vowed 'never again'; the staff at the University of Western Australia's History Department, most of whom have taught me at some stage, especially Dr Philippa Maddern, who let me loose as a tutor in her own history course in 1994. And finally, I must thank the late Dr Derek Dawes, who patiently endured all demands for office support and

liasion with the current RP(R)H administration, and to Colin Xanthus, who succeeded him in this task.

It saddens me that Sir George was unable to see the completion of this book which he so longed to see written, and I hope that it is a worthy testament to his own committed and groundbreaking work at the Hospital. But this book is also a testament to the thousands of nursing staff, medical officers and patients who endured what were often trying and appalling conditions at the Infectious Diseases Hospital, and to those who have been given a second chance at life through the pioneering rehabilitation work done at the Hospital since the early 1950s.

Philippa Martyr
25 April 1998
(the Hospital's 105th birthday)

Preface to Second Edition

In early May 2009, I received a phone call from Beth Allen at RPH's Shenton Park Campus library, delighted to have tracked me down at last. When *West of Subiaco* was available free of charge online, she had printed out and bound some hard copies for the library. They proved to be so popular that they had now gone missing, and no electronic version remained from which to make new ones. In desperation, the library purchased a copy of my PhD thesis on rehabilitation from UWA. No-one has yet stolen this, for reasons which will become obvious to anyone who tries to read it.

It has been my lifelong ambition to have my books stolen from libraries – an irrefutable hallmark of true popularity. With this in mind, I am very happy to offer this updated version of *West of Subiaco*, with photos integrated into the chapters at the appropriate places, and what the first edition lacked so conspicuously – an index. Although strongly tempted at times, I have not altered the style of the earlier manuscript, apart from weeding out a few grammatical errors. E H Carr is fond of reminding us that historians have histories of their own, and it is a historical document in its own right: a snapshot of how I was writing in 1991-1996.

Also intact are the original references listed for various documents and photographs. For example, the State Archives of Western Australia is now known as the State Records Office; the collection of photographs at Royal Perth (Rehabilitation) Hospital may now be at the Shenton Park Campus, or may have moved to the main hospital. Experience has shown that it is best to leave these references untouched, as paradoxically it can make it easier to track the originals, rather than harder.

I cut my historical teeth on *West of Subiaco* – my first monograph, and my introduction to the demanding discipline of archival research and oral history collection. Things have come full circle in ten years, and I am now working at the Centre for Clinical Research in Neuropsychiatry at Graylands Hospital, just down the road from the Shenton Park Campus. When I drive around the area and see Bedbrook Place and Ellis Griffiths Avenue, and it always stirs up happy memories of my time working on the Hospital's history. As I carry out my own present-day research into the history of Claremont Hospital for the Insane (later Swanbourne-Graylands, and then finally Graylands Hospital) I find many parallels in the life-stories of these two institutions.

Since I wrote the last words of my preface in 1996, I have had some adventures. I left Perth to work at the University of Tasmania's Launceston campus, and after six years there (during which I wrote a history of the then-Australian and New Zealand College of Mental Health Nurses, Inc), I moved to the UK and did postdoctoral work at Oxford Brookes University and the Wellcome Unit for the History of Medicine at UEA, Norwich. In 2002 I published my book *Paradise of Quacks: an alternative history of medicine in Australia* (Macleay Press), and took a 'gap year' that turned into five and a half years before I returned to Australia once more.

The Shenton Park Campus too has had some adventures since we last met, and some of these are recounted in the epilogue. I hope that if you are reading this book for the first time, you will find what you are looking for, and that even if you don't, you will find a great many other things along the way that perhaps you didn't expect.

Philippa Martyr
6 May 2009

Abbreviations

AUS - Assistant Under Secretary
 Battye OH (+ number) - Battye Library, Perth, Western Australia, Oral History Collection + accession number.
 BMA - British Medical Association
 CBH - Central Board of Health
 CH - Children's Hospital
 CRMO - Chief Resident Medical Officer
 CS - Colonial Secretary
 CSD - Colonial Secretary's Department
 CSO - Colonial Secretary's Office
 Dist MO - District Medical Officer
 IDB - Infectious Diseases Branch
 IDH - Infectious Diseases Hospital
 LBH - Local Board of Health
 LGA - Local Government Association
 Med Dept - Medical Department, Public Health Department
 MIDH - Metropolitan Infectious Diseases Hospital
 Min - Minutes
 PCC - Perth City Council
 PH - Perth Hospital
 PHD - Public Health Department
 PMH - Princess Margaret Hospital for Children (formerly Children's Hospital)
 PMO - Principal Medical Officer
 PPH - Perth Public Hospital
 PWD - Public Works Department
 RBA - Road Board Association
 RPH - Royal Perth Hospital
 RPH AR - Royal Perth Hospital Annual Report (includes minutes of Perth Public Hospital and Perth Hospital)
 RPH BM Min - Royal Perth Hospital Board of Management Minutes (includes minutes of Perth Public Hospital and Perth Hospital)
 RP(R)H - Royal Perth (Rehabilitation) Hospital
 Sec - Secretary
 SPA - Shenton Park Annexe
 US - UnderSecretary
 VH - Victoria Hospital
 VIDH - Victoria Infectious Diseases Hospital
 WA - *West Australian* [newspaper]
 WAPD - *Western Australia. Parliamentary Debates*

Chapter One: A Fever Hospital in a Suitable Position

The Royal Perth Rehabilitation Hospital would probably not exist at all today were it not for a smallpox epidemic in 1893 in Western Australia. This epidemic was, by Australian and overseas standards, minor. Its consequences, in hindsight, were considerable. Practically overnight, a tiny quarantine hospital was thrown up on the site of the current Rehabilitation Hospital complex, at that time deserted commonage land. To understand the state of panic in which the hospital was brought into being, and many aspects of the future maintenance of the site, one must understand a little of Perth in 1893, and of contemporary ideas about infectious diseases and public health.

Western Australia was entering into its second major gold rush at this time - the Coolgardie claims had been pegged in 1892, and Perth was well on its way to becoming a boom town. A substantial influx of immigrants from overseas and hopeful prospectors from the goldfields of the Eastern States was flooding into the metropolitan area. The State's population rose from forty-eight thousand in 1890 to about sixty-five thousand in 1893, the year of the Kalgoorlie gold discoveries, which in themselves brought yet more people to the State, making a total population of over one hundred thousand by 1895.¹ A population rise of such substantial numbers left Perth and Fremantle barely able to catch their breath. Rental prices soared, and accommodation was desperately short.

The Colonial Hospital in 1890s Perth was a far cry from the reputable establishment that it gradually became in the following century. Situated at the top of Murray St, overlooking Perth and commanding a beautiful view of the bushlands and river, it had few nurses and very little in the way of facilities for infectious diseases cases.² Country areas usually cared for their own infectious cases, and had 'fever wards' (usually little more than tents) attached to the hospitals - examples were abundant in the Eastern Goldfields.³ Infectious cases were less likely to be moved over long distances because of the risks both to their health and those that came in contact with them, on trains and on long, dusty journeys in horse-drawn carts.

¹ K Spillman, *Identity Prized: a history of Subiaco*, Perth: UWA Press, 1985, p 72.

² G Bolton, P Joske, *History of Royal Perth Hospital*, Perth: UWA Press, 1982, pp 36-7.

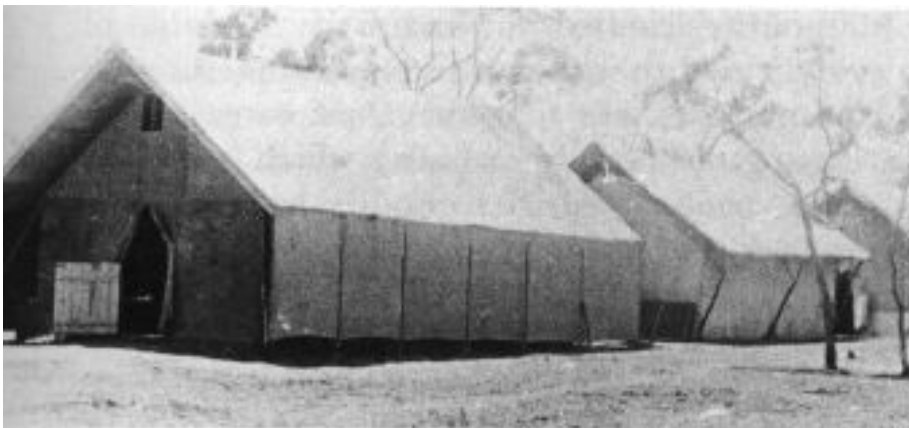
³ D Snow, *The Progress of Public Health in Western Australia*, Perth: UWA Press, 1981, p 81; see also V Whittington, *Gold and Typhoid: two fevers*, Perth; UWA Press, 1988.



Perth Colonial Hospital

Bolton and Joske, *History of Royal Perth Hospital*, Perth: UWA Press, 1983

Orthodox medical opinion at the time was still uncertain as to what caused many infectious diseases. Germ theory was gaining in popularity, but there was still some popular persistence of the miasmatic theory; that 'bad air' would bring on infectious disease.⁴ Many of Perth's inhabitants were of English origin, and some would even have remembered the cholera epidemics in London earlier in the century, which attacked inner-city populations until its link with polluted water sources was discovered. Other common infectious diseases were diphtheria, a respiratory disease; influenza, scarlet fever and measles, all now preventable but in the 1890s potential killers of young and old alike. Typhoid had been present in the colony under various names and varieties since white occupancy - in May of 1892, there were 106 typhoid patients at three hospitals in Western Australia.⁵ It was believed that smallpox could even be spread through the wind blowing the germs for up to a mile.⁶ An ugly, visible and scarring disease, smallpox had Asian connections which increased its capacity for causing panic in White Australia.⁷



A typical fever hospital, WA Goldfields.

Snow, *The Progress of Public Health in Western Australia*, Perth: UWA Press, 1981.

⁴E Willis, *Medical Dominance: the division of labour in Australian health care*, 1983, p. 57.

⁵ Snow, *op cit*, p 61.

⁶WA 7.4.1893, p 3, report by Dr Scott.

⁷Bolton, Joske claim that there were strong Asian connotations in smallpox, p 29. During the epidemic, one wag pasted the yellow quarantine notice on the windows of Sam Lee's Chinese laundry in St George's Terrace.

Vaccination against diseases such as smallpox was still a relatively new technique, and regarded with dark suspicion by many. Dr Alfred Waylen, the Colonial Surgeon since 1872, could remember his experiences in the smallpox epidemic in Geraldton in the 1860s, and was a keen promoter of compulsory vaccination against the disease, especially for young children, who were most vulnerable to infectious diseases. Although the Vaccination Act was passed in 1878, many West Australians chose to neglect this duty for various reasons. Despite Waylen's enthusiasm for vaccination, he was undermined by individuals like Perth City Councillor William Traylen, who publicly advocated the use of cream of tartar as a smallpox medicine - it seems to have been widely believed that this substance, dissolved in water and drunk, would cure the disease.⁸

The Colonial Hospital had a small infectious diseases ward in its grounds, built in 1885 as a response to the measles epidemic of the early 1880s, and which accommodated up to ten patients.⁹ A new Central Board of Health had been created by the passing of the Health Act of 1886, which also empowered local boards of health to control infectious diseases. The Health Act was itself a result of an investigation in 1884 into the sanitary state of Perth and Fremantle. Little had been done, however, to adapt the Colonial Hospital to the changing demographics of the city. Waylen had done much to improve general standards of cleanliness in the municipal area, but he did not extend these public health concerns to the running of the Colonial Hospital.¹⁰ While money was allotted and plans made for the improvement of the Hospital in 1892, it was clear that the facilities would be unable to cope with any emergency.



Dr Alfred Waylen

Snow, The Progress of Public Health in Western Australia, Perth: UWA Press, 1981.

⁸WA 7.4.93, p 6; also 25.4.93, p 2.

⁹ Bolton, Joske, *op cit*.

¹⁰ *ibid*.

The summer months of early 1893 were hot ones - early March was still recording temperatures of 90 degrees Fahrenheit. In late February, the SS *Saladin*, a steam clipper that regularly made the trip from Singapore to Fremantle with coastal stops en route, sailed into Fremantle Harbour. The ship had on board a Malaysian sailor named Ibrahim,¹¹ who spoke a little English and perhaps had hopes of making his fortune in the goldfields. He left the ship and made his way into Perth, where he found work as a servant in Miss Keough's boarding house on the north side of Adelaide Terrace, a few doors down from the Lord St corner. He began to feel ill, and on March 16 1893 made his way up to the Colonial Hospital near the top of Murray St. Agnes Seymour, who was nursing at the Hospital at the time, wrote later that the doctors were "puzzled" by Ibrahim's rash.¹² Dr William Elgee, the resident medical officer of the hospital, diagnosed the case as smallpox. Upon reporting this to Dr Waylen, the Colonial Surgeon expressed grave doubts as to the accuracy of Elgee's diagnosis. He believed that it was instead a case of 'German measles', or rubella.¹³ Several other medical officers examined the man, and Waylen was forced to concur - Ibrahim was suffering from smallpox.

The matter was reported to Perth's Health Officer, Dr Edward Scott, the sailor's clothes were destroyed and he was isolated, but the quarantine precautions were minimal: on Wednesday 29 March 1893, a local cricket match was played, and on the two teams were, among others, Dr William Elgee, Dr Harvey Kelsall and Dr Michael O'Connor, at least one of whom had been in contact with the patient.¹⁴ A small item appeared in the *West Australian* on that Wednesday, reporting that the patient was doing well and there was no cause for alarm.¹⁵ But two days later, on Good Friday of 1893, Agnes Seymour - who had been nursing Ibrahim - was showing the first signs of smallpox.¹⁶ Two weeks later, at least eight people had come down with the deadly disease, and an epidemic had begun which was to last for three months and kill nine of the fifty-two who contracted the disease.

A widespread outbreak of smallpox does not seem to have been considered a real possibility, despite the presence of the case at the Colonial Hospital. The main hospital in Murray St would not be able to cope with any sort of epidemic; Dr Edward Scott, a vigorous inquirer into the weaknesses of the Hospital and its administrators, knew this and was to act upon his findings. Dr Scott's influence in the eventual construction of the infectious diseases hospital came about

¹¹ The man's name was usually recorded as Bryan or Brien, probably due to misunderstanding of Ibrahim. The captain of the *Saladin* later mentioned that a man had left the ship at Fremantle in late February, and that his name was Ibrahim. The two men are almost certainly one and the same. WA 25.4.93, p 2.

¹²Elizabeth Agnes Seymour [Sadlier], 'Reminiscences of Nursing', doc 5.24, P Joske, 'Health', in M Aveling (ed), *Westralian Voices: documents in Western Australian social history*, Perth: UWA Press, 1979, p 248.

¹³Bolton, Joske, p. 50.

¹⁴WA 31.3.93, p 2.

¹⁵WA 29.3.93, p 4.

¹⁶Seymour, op cit, p 248.

through an unusual set of circumstances. Normally in such an emergency, the Central Board would have assumed control of quarantine matters, but four of its members, Waylen included, were sick at the time and unable to attend meetings. Perth's own Board of Health then stepped in to administer the situation, and Scott was their health officer and therefore a key player.

Scott ordered the quarantine of the Colonial Hospital on 6 April 1893. But this caused problems as well as providing solutions. The Resident Medical Officer, Dr Elgee, was now forbidden to leave the building, and Waylen, having recovered, was unable to enter it. Elgee had to be excused from attending a court case because of his quarantine,¹⁷ and as he was the only doctor with a first-hand knowledge of the state and condition of the sick Malaysian, his quarantine would have paradoxically held back further information on the possible dangers of an epidemic. Quarantining Miss Keough's itself was seen as pointless, as Ibrahim had been gone from there three days before Waylen was informed that the man was suffering from smallpox.

The Perth Local Board of Health held their usual meeting on the night of 6 April 1893 at the Town Hall, with Mayor Alexander Forrest and Councillors Quinlan, Traylen, McKernan, Williams, Chipper, Molloy, Dromey and James. Dr Scott was also in attendance, and spoke vigorously for the construction of "a special building for the accommodation of patients suffering from infectious diseases".¹⁸ If another case occurred, the local health authorities would have nowhere to isolate those suffering from smallpox, without a thorough disinfection of the Colonial Hospital and more inconvenience and risk to all. The complaints about the Colonial Hospital's 'cottage' were numerous. A wall topped with broken glass such as that which could be found at the rear of the Hospital could not keep in germs that could, according to popular belief, be blown about in the wind. The disinfection of the Hospital itself meant that other patients had to be moved and kept in tents, a further health risk.

Dr Scott had plans for a proper building, along the English model of galvanised iron lined with matchboard, rather than the tents suggested by some of the city's medical practitioners.¹⁹ Such a proper building already existed in the Woodman's Point quarantine station, but Dr Scott claimed that it would be courting disaster to move the cases all the way to the south of Fremantle when they could be isolated closer to home. And he therefore suggested that Mount Eliza would be the ideal location - the bush reserve close to Perth that was to become Kings Park.

Scott had other bad news for the councillors - five cases of typhoid fever had occurred in the city, all of which were being lodged in tents on Government Reserve land. The tents had been put up by some of the blow-ins who had arrived in Perth to make their way to the goldfields, and who could not afford

¹⁷ WA 8.4.93, p 2.

¹⁸ WA 7.4.93, p 3.

¹⁹ WA 7.4.93, p 3.

house rents or find lodging house accommodation. Faced with a serious health risk that looked like turning into not one but two epidemics, the Board of Health had no other option. An isolation ward had to be created, and quickly. The question of where would be “a matter of detail”,²⁰ and the real difficulty was perceived in finding a medical officer willing to attend the site for a reasonable retainer.

The editorial of the *West Australian* discussed the meeting with some criticism of the Colonial Hospital's lack of facilities:

there can be no doubt that a fever hospital in a suitable position is a form of insurance against the spread of infectious disease which should have been long since provided in a very different manner than by setting apart a cottage almost part and parcel of the general hospital and situated in a populous quarter of the city.²¹

Proposals for the type of building included Dr Scott's iron and matchboard construction; a ward of iron inside and out, which “is said to afford a perfectly habitable abode even in the hottest weather”, and even one including a primitive form of flywire.²² A site between Perth and Fremantle would have the advantage of serving both communities, and Mount Eliza was firmly rejected because “it will, in time to come, be much frequented by the public”.²³ Two choices



Dr James Hope

Snow, The Progress of Public Health in Western Australia, Perth: UWA Press, 1981.

emerged: the commonage land across the new railway to the west of the little settlement of Subiaco, or the large cemetery reserve near Claremont, Karrakatta. The editorial pointed out that either site could even have a little wayside station off the railway to make it more accessible. The fever hospital could be supplied with nurses and equipment from the Colonial Hospital, which would make it cheaper to maintain.

But reading the *West Australian's* opinion of the subject was probably not the first priority of the Board of Health the following day, for on 8 April another case was reported - Miss Amelia Bogue, who lived on the corner of Pier and Wellington Sts, a stone's throw from the Colonial Hospital. While the *West Australian* was quick to point out that quarantine regulations were being strictly enforced at the Hospital, this fresh case must have caused consternation to all who lived close to its Murray St site. Miss Bogue's residence was quarantined, thus turning the Murray St hill area into a virtual no-go zone.²⁴

²⁰ *ibid.*

²¹ *ibid.*, p 4.

²² *ibid.*

²³ *ibid.*

²⁴ WA 8.4.93, p 2.

It would seem that even quarantine was too good for the house. At the meeting following the discovery of this fresh source of infection, Timothy Quinlan, a prominent councillor (and founding member of the future Perth Public Hospital's Board of Management) cried "Burn the house, burn it! It is only a wooden one!"²⁵

At the subsequent Board meeting, Dr Scott maintained that the proposed fever ward had to be 'attractive' to the public, so that the more well-off Perth citizens would be persuaded to have their sick isolated properly. The Board itself had no real power to force people into quarantine away from their homes, although as the epidemic continued, the local constabulary was most helpful in assisting the more recalcitrant cases.

Scott produced diagrams for the proposed hospital, Forrest allotted them £500 for the building, and the Board got down to the serious business of appointing an attending medical officer. The obvious first choice was Dr James Hope, the future Commissioner for Public Health and Fremantle's Principal Medical Officer. But Hope had already quite enough to do - he was in attendance at Woodman's Point on suspected cases of various infectious diseases. Fremantle, as well as Perth, had been on the receiving end of the early gold rush population boom in the 1890s, and the port city had infectious diseases worries of its own.

Until the proper buildings could be erected on the as-yet-undecided site, the patients were to be kept in tents. There were reservations expressed about the wisdom of this move as well, as Perth in April could be hot and sultry one day and pouring with rain the next. Finally, Scott made a decision: he would select a site and have tents put up, so that the few patients could be moved on the forthcoming Sunday.²⁶ But by the time Sunday came, another case had been recorded.



Woodman's Point quarantine station

Garrick and Jeffrey, *Fremantle Hospital: a social history to 1987*, Perth: UWA Press, 1988.

²⁵ *ibid.*

²⁶ *ibid.*

Ellen Montague was about twenty-eight years old, and had been married to her labourer husband for about a year. She had only recently recovered from a bout of typhoid fever, with which she had suffered while pregnant. On Sunday 9 April, she was diagnosed as having smallpox, having delivered her still-born child that day. She and her husband lived in Goderich St, which ran east from its starting point, Victoria Square - the site of the Colonial Hospital. Ellen Montague herself told Dr Haynes that she had been doing laundry for her mother, who lived opposite the Hospital, and had been there all day a fortnight before she showed symptoms of the disease.²⁷

Dr Scott had by this time located a tent site on Mount Eliza, "within safe though convenient distance of the Waterworks".²⁸ Military stores tents were to be used, housing six persons - the three patients, two nurses and a male orderly for Ibrahim. Patients suffering from other infectious diseases were also to be kept in tents, and the Colonial Hospital was to be disinfected upon their removal. The proposed fever ward was costed at some £700 *in toto*, and was to accommodate no more than a dozen or so patients. It was to have double galvanised iron walls, and a jarrah floor, which could "without much delay or expense be taken up, destroyed, and replaced with fresh boards".²⁹ The main building was planned to consist of two wards, male and female, seventy-two feet long and twenty feet wide, with a porch but no architectural adornments. The entire structure was to be built on piles to keep it dry, and so that it could be easily dismantled. The site for the wards, however, was still not chosen - it was to be somewhere on the Perth commonage, about two miles from Subiaco, and preliminary building was to start that Monday, 10 April 1893. Dr Scott was to inspect the area that day also, in the company of Mr Castilla, the City Surveyor.

The *West Australian* made its position clear in Monday's edition, attacking the present state of smallpox provisions at the main hospital, and praising the proposed isolation ward, to be built "on the latest and most approved designs, with all the improvements suggested by recent experience".³⁰ Infectious disease, it would seem, was on everyone's mind in Perth that April - the *West Australian* was able to posit in May 1893 that "what with financial troubles on the one hand, and smallpox on the other, most people can spare very little thought for any less absorbing topics."³¹ The quarantine enforcements led to some panic and confusion in various quarters of the city. Miss Montague, the sister-in-law of the afflicted Ellen Montague, was suspected by some of also having the disease, and the police tried to quarantine Ellen Montague's mother-in-law as well, having her confused with the other two members of the Montague family, who all lived on Goderich St.

²⁷E Haynes, 'Smallpox in Perth (Western Australia) with some observations on vaccination', *Australasian Medical Gazette*, July 1893, p 212.

²⁸ WA 10.4.93, p 2.

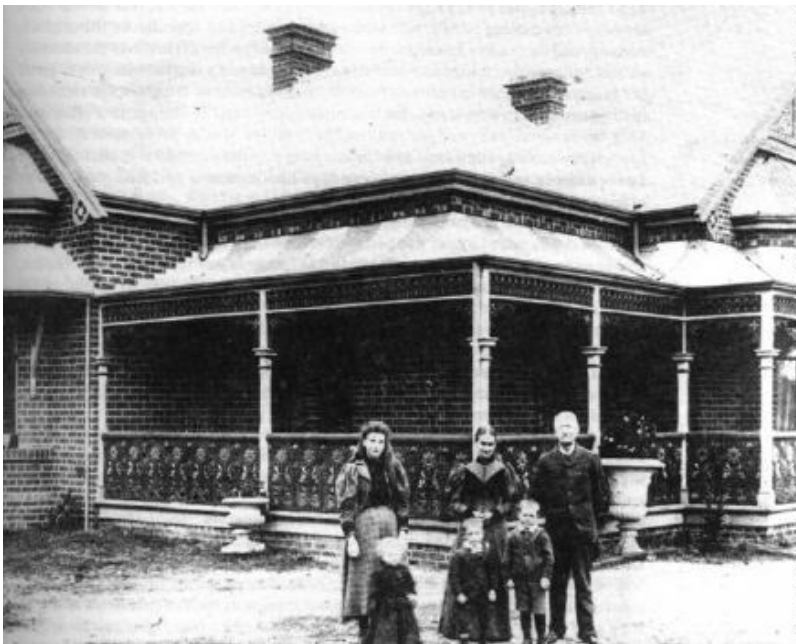
²⁹ *ibid.*

³⁰ *ibid.*

³¹ WA 3.5.93, p 4.

As soon as the plans for the tent encampment on Mount Eliza became known, there was a vigorous protest from the residents of the area, in particular those living in Malcolm St. The patients could not be moved directly to the Subiaco encampment, as there was some difficulty in getting water for the site, as John Rowland Jones of Mueller Road was quick to point out in a letter to the *West Australian*. Jones, himself one time a temporary editor of the newspaper, was the builder of Subiaco's first private residence in 1886, 'Jones' Folly'. He had anticipated finding water at eighteen feet, and had sunk a well to sixty feet before finding any.³² The well alone had taken Jones some nine months to complete, and if the Subiaco fever ward had similar problems, the proposed carting of water by train and horse-drawn vehicle over such an extended period may have increased the risk of infection of the general community, and worsened the condition of the patients.

Mr Edward Courthope, of 'Pinehurst', Mount Eliza, was the most vocal of the protesters. His letter, in the same edition, stated in no uncertain terms that it was "inhumanity" to keep the smallpox patients in tents. Presumably Mr Courthope had no such objection if the tents were to be at Subiaco and not in the vicinity of his own home.



The Jones family outside Jones' Folly, Subiaco

Spillman, *Identity Prized: a history of Subiaco*, Perth: UWA Press, 1985.

The Board of Health was faced with their own crises. Dr Scott, working a full day in practice and then attending nightly meetings of the Board, had fallen ill, although not with smallpox. Dr Henry Kelsall, an ophthalmologist and an honorary at the Colonial Hospital, relieved him.³³ Dr Michael O'Connor had

³² Spillman, *op cit*, pp 66-7; WA 11.4.93, p 3.

³³The honorary system was the chief means in Australia of staffing public hospitals with doctors,

been selected as his assistant. Dr O'Connor, a dashing young native-born West Australian, who was brother-in-law to Timothy Quinlan, was in fact eventually selected to take Scott's place as the physician in charge of the epidemic.³⁴ He quickly demonstrated his authority by stating that he wanted the cases kept away from Mount Eliza and placed outside the municipal limits, at Subiaco, as soon as possible. He encouraged vaccination, and disinfection with Condy's fluid, burnt sulphur and eucalyptus.

O'Connor's rise to power was not unimpeded. Dr E J A Haynes, a doctor who experienced several personality clashes with the Perth medical fraternity, had offered his services as medical officer to the epidemic, citing his considerable experience in England with similar epidemics. The medical officer was to be offered a salary of £200 for his pains, and Haynes was more than a little displeased when the Board voted for O'Connor. Haynes did not let the matter rest there, and eventually went to the extent of setting up his own infectious diseases encampment at Subiaco, separate from that organised by the Board of Health.³⁵

At the Board of Health's meeting, at which Dr O'Connor was voted in as the new health officer, further plans were made for the Subiaco site. It had been chosen as 150 yards from the railway gates and approximately one mile from Subiaco itself. The following day, there was another definite case of smallpox diagnosed, this time a Mr Stacey, and two other young men were suspected to be carrying the disease. The local residents had impeded the attempted erection of tents on the Mount Eliza site - one of them pulled up a tent peg and challenged the workmen to take him to court over the issue.³⁶ The next day, the two suspected cases - John McAllen and Samuel Proctor - had been diagnosed as smallpox victims, and a three year old child, William Sullivan, had also contracted the disease. A tender for building the hospital had been submitted, by Mr D A Gray for £500, to be completed by no later than 23 April, with an incentive of an extra £5 for every day within that deadline. The Board of Health yielded to public pressure, and moved the tent encampment to some distance from the planned hospital site west of Subiaco. The patients at the Colonial Hospital were moved on the afternoon of 14 April, and two nurses were made available for their care at the site. Three nuns also offered their nursing abilities, a gesture much appreciated by the beleaguered Board.³⁷

until the early 1970s. An 'honorary' physician or surgeon would earn his living in private practice, but would give a certain portion of his time per week free of charge to the hospital. While demanding and often unrewarding, it was an excellent means of widening skills and encountering a variety of different sorts of medical and surgical conditions. Honorary service was obtained by elections held by the honorary staff of a hospital, and fitted in well with the professional ideal of service to the public. It also provided the poor and indigent with what was often first-class medical care, which they would never have otherwise been able to afford.

³⁴ Bolton, Joske, op cit, p 48; W Kimberly, *History of Western Australia: a narrative of her past together with biographies of her leading men*, Perth: 1897, p 176.

³⁵ WA 15.4.93, p 2.

³⁶ WA 13.4.93, p 2. This would appear to be the origin of Bolton and Joske's story of the pulling-down of the tents, p. 51.

³⁷ WA 14.4.93, p 2.

Agnes Seymour, who had been in attendance when Ibrahim was first brought to the hospital, had no official qualifications but was recognised as a professional nurse, joining the Colonial Hospital staff in 1892.³⁸ She had been delegated to care for the Malay seaman, and even her inadequate vaccination proved not totally wasted, as her subsequent contraction of the disease left her capable - but only just - to care for the other patients as they came to the encampment while she convalesced. Father Prendergast, a Roman Catholic priest, and Reverend Wallace, an Anglican minister, had voluntarily gone into isolation with the patients.³⁹ Seymour spent her off-duty hours playing draughts with Fr Prendergast, "whose genial personality", she recollected, "endeared him to all those quarantined, whether Protestant or Roman Catholic."⁴⁰

Not all the patients were bedridden: a report came from the site as follows –

The three worst cases were all unvaccinated. All the mild cases were vaccinated. These cases are chopping wood, putting up tents and making themselves useful generally.⁴¹

And still the list of cases grew. Reuben Adams, again of Goderich St near the Perth Hospital, had worked as a timber foreman at Messrs Gill & Co's yard before contracting the disease. John Morris and Miss Dore also had smallpox, and by this stage several cases had appeared in Fremantle, quickly transported to Woodman's Point under the care of James Hope.

Most of the cases had so far come from working-class families, or were single men living in cheap boarding-houses. But smallpox was not concerned with social status, and one case in particular illustrates this. Herbert Crook had come to Australia in 1872 from his home in Clifton, England, at age seventeen. Having become a successful bank clerk in Melbourne, he transferred to Western Australia in 1889. Crook had joined the Victorian Militia in December 1886, where he was commissioned in the rank of captain.⁴² He was also a competent amateur musician, and Western Australia's oldest surviving theatrical poster shows that he performed in the colony's first staging of Gilbert and Sullivan's *The Sorcerer*, in 1890.⁴³ Crook fell victim to a virulent strain of smallpox, which caused ulceration of the mucous membranes and severe delirium. He, too, lived near the Colonial Hospital.⁴⁴

³⁸Seymour, op cit, pp 248-51; V Hobbs, *But Westward Look: nursing in Western Australia, 1829-1979*, Perth: UWA Press, 1980, pp 8-9.

³⁹Seymour, op cit, p 250.

⁴⁰ibid, pp 250-1.

⁴¹ Snow, op cit, p 64.

⁴²WA 29.4.93, p 2.

⁴³The poster is now in the possession of His Majesty's Theatre Museum, Perth, WA.

⁴⁴ This phenomenon has been commented on by Cumpston, cited in Snow, op cit, p 140.

The 'new' ambulance
used in the epidemic,
c. 1909

Bolton and Joske, *History of
Royal Perth Hospital*, Perth:
UWA Press, 1983



In his interview with the *West Australian* on 17 April, Dr O'Connor said that there were now fourteen patients at the Subiaco site in fifteen or sixteen tents. A wardsman from the Perth hospital, Mr Martin, was in charge of the site, and O'Connor reiterated his need of a proper ambulance to transport patients to the site, as the old police van that was being used at the time was "not all I could desire".⁴⁵ Basically a horse-drawn cart, it was given an improvised cover of sacking over a skeleton frame for shelter. A team of three horses drew it, accompanied by Mr Smith, the Health Inspector, and a police officer. An eyewitness account of the removal of a patient appeared in the *West Australian*, again of Monday 17 April.

The vehicle devoted to small-pox removals, drove up to the infected house in Moore-street, and in a short space of time the inhabitants of the surrounding houses were on the *qui vive*. The boarders of the Occidental Hotel, passing pedestrians, and residents, soon congregated at the railway crossing to watch operations ... The man was huddled into the trap, and those in charge endeavoured to arrange the interior so as to make it as comfortable as possible. Dr Connor [sic] then rode upon the scene, gave a casual glance around, and rode away. In the meantime a mounted trooper appeared, and submissively watched the proceedings, occasionally warning the spectators to keep at a respectful distance ... Inspector Smith then mounted his steed and lead the way into Wellington street, when he urged his animal into a gallop, and the small-pox van proceeded on the even tenor of its way up Murray street to the encampment. As the *cortege* drove away a huge bonfire was begun in the garden of one of the quarantined houses.

This vivid picture of the nearby residents gathering to gape at the removal (a *fin-de-siècle* version of a traffic accident), leaning over the balconies of the Occidental Hotel, always keeping out of range of the 'germs' in the air, is a perfect image of morbid curiosity.

⁴⁵ WA 17.4.93, p 2.

A Mr Targress had fallen ill at the same time as Mrs Montague. Still the cases continued to develop, some of which were reported by Dr Haynes. John Parsons of Brown St, aged about 18, had been living in a "canvas house"⁴⁶ with his mother and four brothers and sisters, all of whom were unvaccinated. Robert Healey, a labourer, had been working on a building site on the Hay St hill, and had the added misfortune to live in a lane off Wellington St, less than fifty yards from Miss Bogue's quarantined house, and directly opposite Stacey's. When he came down with smallpox, the boarding house in which he lived was also home to several small children, all at risk. A case out of the immediate vicinity of the city was that of Mrs Neeson, who lived with her husband on the Mount's Bay-road, and who was in a particularly dangerous condition - like Mrs Montague, she had been expecting a child. Dr Haynes was called in to attend the Neesons, but upon his arrival, the police prevented him from entering the building. Dr O'Connor had received word of the case before him, and had ordered quarantine. Haynes was left to stand out in the road and shout directions to Mr Neeson, and sent them some medicines afterwards.⁴⁷ This incident would not have improved relations between the fiery Haynes and the assured O'Connor.

The old police van was busy for the next few days, transporting case after case along the route out of Perth to Broome St⁴⁸ where the tarmac road ended and a dirt track began, leading eventually to the tent hospital. So continuous were these trips that before long, Edward Courthope wrote again to the *West Australian*. He and eight other signatories from the Malcolm St area protested against the smallpox "ambulance" using the Broome St route. The "melancholy cavalcades" were not just a source of aesthetic displeasure to the residents of Mount Eliza, but they also allegedly constituted a health risk. The letter suggested instead a route along Douro St and Mueller Road,⁴⁹ both of which were dirt tracks, to take the cases to Subiaco. Another letter, from Alred Miller, protested at the authorities' irregular and inconsistent approach to the epidemic, claiming that the patients had been cruelly neglected in their physical and mental comforts. He was one of the few who appeared to care - most of Perth's residents were only too glad to have the city cleared of the smallpox cases, although the arbitrary nature of the quarantine procedures worried some. One woman, "An Eye-Witness", claimed that her heavily-pregnant neighbour had developed a rash and was hustled off to Subiaco without proper examination.⁵⁰

By Wednesday of that week, a horse-drawn omnibus had been provided for the transportation of the patients in a better manner than the old police cart. And the smallpox epidemic had had its first death - the unfortunate, worn-out Ellen Montague, who died of the complications ensuing from her typhoid fever and tragic confinement. She was to have been moved to Subiaco on the morning of 18 April, but instead her final journey was to the tiny burial ground at Jolimont, newly created in pragmatic preparation for the infectious cases. There she was buried at midnight in a coffin tarred inside and out, and with quicklime coating it

⁴⁶ *ibid.*

⁴⁷ *ibid.*, p 2.

⁴⁸ Now Hay Street West.

⁴⁹ Now Roberts Road.

⁵⁰ WA 18.4.93, p 2.

as a further protection against the spread of disease. Mr D Chipper presided, accompanied by a policeman. Mrs Montague was a Roman Catholic, and had in preparation for her death received the last sacraments some ten days previously, so a priest had asked to be allowed to attend at the funeral.⁵¹ This was disallowed on the grounds that his future pastoral duties may have led to further spreading of the disease.

Vaccination had understandably become a popular and urgent matter in Perth. On 19 April, free vaccinations at the Town Hall were besieged - three hundred people presented themselves during the day, and then there was a second rush in the evening. Eventually those wanting to be vaccinated had to attend one of two sessions - women and children in the morning, and men after work in the evening. Dr Haynes did much of the vaccination, assisted by Waylen and Elgee. It was eventually decided by the *West Australian* that "many of the most apprehensive are those who have been most guilty in breaking the law as to vaccination ... It is one happy circumstance of the present outbreak that it will leave us in all probability with a perfectly vaccinated population."⁵² Waylen arranged for the publication of a thirty-two page pamphlet on smallpox, vaccination and other health information for the public consumption, at a cost of sixpence.⁵³

The doctors were taking control of the situation once more - Drs Kenny, McWilliams, Kelsall, Harvey and Elgee had attended a meeting the previous night at O'Connor's house. As Dr Haynes was conspicuous by his absence, perhaps it is not surprising that together they passed a rousing vote of confidence in the abilities of Dr O'Connor.⁵⁴ The Haynes-O'Connor row was further fuelled by the appearance of a letter in the *West Australian* that was highly critical of Haynes' methods of dealing with the outbreak, and praised the appointment of O'Connor as health officer.⁵⁵ And, as usual, Edward Courthope was unhappy about the way the patients were being transported:

At present [the vehicles] pull out of Murray-street and then wait at my gate ... A few more pulls are accomplished and the patients' feet are dangling over the corner of my fence ... The direct route from the end of Murray-street would avoid all, or nearly all, habitations, and have availed itself of a nearly level road.⁵⁶

The smallpox epidemic continued to intimidate Perth's residents. The WA Turf Club's autumn meeting was poorly attended, due to fear of the disease, and Perth Ladies' College was not resuming classes until 1 May 1893 on account of

⁵¹WA 19.4.93, p 2. Mrs Montague's remains, along with others buried at Jolimont, were eventually moved to Karrakatta in 1906, but are today untraceable.

⁵²WA 21.4.93, p 4.

⁵³ *ibid.*

⁵⁴WA 20.4.93, p 2.

⁵⁵WA 20.4.93, p 3.

⁵⁶ *ibid.*

the epidemic. In the area of rental property, the smallpox epidemic had made its mark as well. Advertisements for rooms in the “most healthy part of the city” with their own bathing facilities suddenly began appearing, as well as an emphasis on in-house laundry facilities - the sending out of laundry was seen as a definite source of the spread of smallpox.

Many of the cases at the encampment were weakening. Mrs Macpherson, like Mrs Montague before her, delivered a stillborn child, and at least three other cases were not expected to last for much longer in the primitive conditions. Meanwhile, Traylen was urging the Board of Health to demand the reconvening of Parliament to extend the powers of the 1886 Health Act. Quarantine cases, he argued, must be forced to go to Subiaco, no doubt thinking of the case of Miss Sherlock of Mackie St, a smallpox case who had refused to leave her home. Inadequate resources were being stretched over the whole metropolitan area, and the risk of infection was multiplied.

There were other problems with quarantine enforcement in the city, which prompt questions as to how seriously some members of the population took the epidemic. A letter signed 'Citizen' complained that:

A smallpox case occurred near my house ... I saw the small-pox vehicle called by courtesy an ambulance - call and take away the patient. Immediately on its departure one of the inmates of the infected house came out and chatted with a neighbour over the fence ... The process of disinfecting and fumigating by an official did not take place for some hours afterwards, and not the smallest suggestion of quarantine or caution existed.⁵⁷

If this were the case, then it was fortuitous that by 22 April, the new infectious diseases hospital was due for completion. On the same day, Fremantle recorded its first death from smallpox, at the Woodman's Point Quarantine Station.

The following description of the hospital at West Subiaco was offered in the *West Australian*:

The building is situated upon the brow of a hill, about a quarter of a mile from the present encampment. In front is a valley in which the well is sunk providing a sufficient supply of water. At the rear is a second hill upon which a convalescent's ward may be erected at some future time.⁵⁸

But the luxury of a real hospital building was not to be enjoyed by some of the patients who had lain on the ground in tents for nearly two weeks. Stacey had died, aged about 18 or 19, and Crook was weakening daily. By April 25, Mrs McPherson died also, and was buried at night at Jolimont. But unlike Mrs

⁵⁷ WA 22.4.93, p 2.

⁵⁸WA 22.4.93, p 2.

Montague, her family and her own clergyman - the Anglican Dean - were present at the burial. Perth's sectarian feeling, always present just below the surface of civic life despite quite good inter-denominational relations, threatened to spill over. A letter signed 'Justice' protested at this apparent double standard, focusing on Mrs Montague's lonely burial and demanding some explanation.⁵⁹ As it turned out, Dr O'Connor himself had authorised the presence of the Dean, with appropriate precautions taken. As O'Connor was himself a Roman Catholic, this may have helped to defuse the issue.⁶⁰

The moving of the patients into the new hospital appeared to have taken a great load off the minds of many. Combined with the good news that the number of cases was diminishing, the relief found its way out in dubious jokes about the 'picnic' atmosphere at the hospital. A Ladies' Committee was created by Mrs Alexander Forrest and Mesdames Burt, Lefroy, Goldsmith and Sholl to send custards and jellies to the patients at Subiaco, but this admirable effort was faced with the inevitable problem of first-off enthusiasm and then positive famine.⁶¹ A cow had strayed on to the hospital site and had been kept there for the duration, and, once coaxed into co-operation by Agnes Seymour, provided fresh milk for the camp's inhabitants. When the cow's owner, Mr Golding, attempted to have the Perth Local Board of Health pay him for this 'use', it flatly refused.⁶²

Reuben Adams was the next victim of smallpox, despite the fact that he had been vaccinated twice, which did not bode well for the proclaimed benefits of preventative medicine. Herbert Crook followed him two days later, and the *West Australian* reported a total of five deaths at this stage from the disease. This may have tempered talk of merry behaviour at the hospital site. Merry behaviour, in fact, was just what some citizens of Perth were concerned about: rumours of drunken nursing staff, and dissipation among the jellies and custard, caused the Board of Health to investigate. Apparently one orderly had overindulged one night, and this had created the rumour that the hospital's new medical officer, Dr Louis Wheeler from Fremantle, did his best to play down. One of his first moves as superintendent of the hospital was to have it fenced off at a distance of two hundred and fifty yards, protecting the public from accidental infection. Two constables also patrolled the site for the public's protection.

After Crook's death the camp was subdivided. The iron building housed the acute cases, while separate 'suspect' and convalescent camps were formed. The dining tent doubled as the chapel, where Sunday services were held. By this stage, the track to the hospital had been cleared, and was easier to navigate. As more cases joined the convalescent camp, the atmosphere did improve a little, with campfire singing and scrub-clearing.⁶³ When the time came for recovered cases to leave the site, no special arrangements had been made, so Seymour and those going with her that day made their way through the

⁵⁹ WA 27.4.93, p 3.

⁶⁰ WA 28.4.93, p 2.

⁶¹ WA 25.4.93, p 2.

⁶²WA 23.5.93, p 6.

⁶³Seymour, op cit.

bush, led by a couple of recovered convalescents who knew the way to the railway line. There they simply waited, and then caught the next train to Perth.⁶⁴

As Perth drew its breath, the inevitable complaints began to arise. W E Stacey claimed that his son was sent to the Subiaco encampment without his parents being informed, and that they heard nothing of him until his death.⁶⁵ The Stacey affair was to become one of the most bitter elements of the epidemic - the public hearing which was held to enquire into Mr Stacey's claims showed up the weaknesses and division of the Board of Health as never before.

Stacey *père's* claims amounted to charges of malpractice on the part of O'Connor as health officer to the epidemic, and of manslaughter. Claiming that his son was without medical attention for up to two days, Stacey also demanded to know why the ambulance had taken four hours to reach Subiaco. When the matter was investigated, it was discovered that the trip had taken nowhere near four hours to complete, and that several witnesses could testify to the responsible care which was taken in transporting young Stacey to the site. Stacey withdrew most of the accusations at the hearing's conclusion, but not before Dr Haynes had to be reprimanded for prompting Mr & Mrs Stacey's solicitor as he was questioning Dr O'Connor.⁶⁶ Witnesses burst into tears in the stand, insulting language was exchanged between solicitors, and charges of strong-arm tactics on the part of the medical profession were freely hurled. The epidemic had taken its toll on the Board of Health, and the results were not flattering.

This was not helped by the revelation of the undertaking scandal involving the burial of the smallpox victims. Councillors Chipper and Haynes were accused by another councillor of having charged £20 for each burial conducted at Jolimont.⁶⁷ On 1 May 1893, Chipper presented the Council with a bill totalling £250 - £40 for each of six adults and one child at £10. The Perth Council was horrified, and called tenders for cheaper burials. Eventually Chipper was able to underbid his fellows, and the cost was substantially reduced.

To cap this off, it was revealed that Dr Haynes had cabled Sydney on April 15 - about the time that he was defeated by O'Connor for the position of health officer. The telegram stated in no uncertain terms that the Perth health authorities were incompetent, and that the Sydney government should intervene to assist the city in the epidemic. In a newly self-governing colony that had already sown the seeds of secession within its borders, such a demand would have appeared at best disloyal. Haynes' behaviour was not forgotten after the epidemic ended, especially by his fellow doctors. He was rejected in the election of honoraries to the Hospital some years later, while O'Connor, his reputation made, became a member of the Legislative Assembly and a prominent honorary at the Hospital. Haynes did get in the last written word: the

⁶⁴ibid.

⁶⁵WA 27.4.93, p 3.

⁶⁶WA 29.4.93, p 2.

⁶⁷WA 27.4.93, p 2.

Australasian Medical Gazette published his account of the epidemic in July 1893, but the seeds of bitter dissent were already growing to fruition in Perth's medical community.⁶⁸

By early June the epidemic had ended, leaving behind nine dead and forty-three survivors. The government lifted quarantine restrictions on the colony, and Perth slipped back into its old routine.⁶⁹ In a way, the Central Board of Health could be described as the forty-fourth survivor: when Parliament reconvened later that year, the Board came under bitter attack.⁷⁰ Traylen called for the Central Board of Health papers relating to the epidemic to be shown to the Legislative Assembly, and Alexander Forrest announced that "We all know that the Central Board of Health did little or nothing".⁷¹

Smallpox had officially left Perth by 10 June 1893. Four days later, on 14 June, Patrick Hannan and Tom Flanagan hit what became known as the 'Golden Mile'. The subsequent gold rush in Western Australia brought with it deadly typhoid fever, which tore through the population, killing over a thousand people in a four-year period, and forcing further amendments to the colony's public health policy. Given the arguments and attacks surrounding the construction of the isolation wards, one can only wonder how many people saw the following letter in the *West Australian* of 4 May 1893:

Allow us to convey through the medium of your paper our warmest thanks to the matron, nurse Bedford, and Mr Martin, the manager of the quarantine station, for their extreme kind attention to us during their sojourn there ... we, who were confined in the convalescent ward, are perfectly satisfied that they did their very utmost for those entrusted to their care.

J Morris, Samuel Proctor, J McAllen, J Targess, - Eleanes, Robert Healey, W Sutcliffe, Mrs Mitchell, M Sairey, Misses Sellenger, Stamp and Sherlock.⁷²

The tiny hospital which had been built amid controversy and panic still stood on a hill west of Subiaco.

⁶⁸Haynes op cit; Bolton, Joske, op cit, p. 65.

⁶⁹Snow, op cit, p 64.

⁷⁰Western Australia. *Parliamentary Debates* [WAPD], vol 4 n.s., 10 Aug 1893, pp 311ff.

⁷¹ibid, p 312. After a chequered career, the CBH was finally dissolved in 1911 under the revised Health Act. See Snow, op cit, ch 5 passim.

⁷²WA 4.5.1893.

Chapter Two: Six Shillings a Day



Thomas Lovegrove

Bolton and Joske,
*History of Royal Perth
Hospital, Perth: UWA
Press, 1983*

Smallpox did not return to haunt the inhabitants of Perth after 1893.¹ The little quarantine camp, dubbed the Victoria Hospital, fell into use as a too-hard basket.² Thomas Lovegrove, Western Australia's Principal Medical Officer from 1896, used it to isolate children affected with measles during an outbreak at the Subiaco Industrial School in 1896-7.³ When Western Australia experienced its worst typhoid epidemic, from 1895-1898, the Victoria Hospital was again used to accommodate the overflow of patients from the former Colonial Hospital, now Perth Public Hospital.⁴ Transport to the site was actually less amenable than in the days of the smallpox epidemic, and in the absence of regular ambulance deliveries, patients with typhoid-induced temperatures of over 100°F had to walk the mile and a half (nearly two kilometres) from Subiaco station along the dirt track to the hospital site.⁵

In 1897, Lovegrove was also able to report that the Victoria Hospital was closed, presumably due to lack of demand, as of 9 July.⁶ Dr O'Connor provided a rudimentary annual report for Lovegrove after the closure, which outlined medical practice in the tiny hospital:

we had on an average 50 [patients] in April and May and from 44 to 20 in June. There were 234 patients treated with 19 deaths ... I also admitted 4 natives from Claremont of whom three died within three days from acute inflammation of the lungs on top of phthisis.⁷

¹There were outbreaks in Western Australia in 1901 [1 case], in 1904 [10 cases in Broome], and 1914 [7 cases in Bunbury]. Perth was unaffected. Snow, *op cit*, p 140; also *Medical Journal of Australia*, 1914(2), p 210. The 1893 epidemic inspired the poem 'The Graves in the Lone Forest Glade', by Margaretta Dore, which can be found in Aveling (ed), *op cit*, pp 213-215, doc 5.6. Dore's historical accuracy is questionable.

²It is unclear as to when and by whom the hospital was actually named. Newspaper reports during the smallpox epidemic term it the 'fever hospital' or the 'fever encampment'. I was informed by one person that it was named in Queen Victoria's jubilee year, which would appear to be a feasible explanation. The hospital site appears on George Rotton's map, entitled 'Victoria Hospital' - Rotton's map is dated, I believe, inaccurately by Spillman as 1883, *op cit*, pp 62-3, because of the legend reading "Marked out and opened for sale October 1883". The Rotton map used by Spillman certainly depicts the land made available in 1883, but the map itself is a later version, drawn after 1893.

³CSO File 1458/04, pp 43-4. There seem to have been regular measles outbreaks in WA at this time, cf. WA 2.9.93, p 4f; WA 10.11.93, p 4e.

⁴As far as death from typhoid is concerned, this period was the most grievous, with 325 in 1895, 400 in 1896, 407 in 1897, and 296 in 1898, Snow, *op cit*, p 160. The Perth Hospital admitted, between July 1896 and June 1898, 1387 typhoid patients, yet by 1898 the hospital had only 198 beds, Bolton, Joske, *op cit*, pp 57-8.

⁵Bolton, Joske, *op cit*, p. 57.

⁶CSR File 2123/97.

⁷CSR File 2123/97, 29.7.97.

According to the report, O'Connor had fever patients on a diet of three pints of milk a day, while other patients had a pint of broth a day. For diarrhoea, he gave three pints of alum whey, instead of milk. Patients with a normal temperature were fed on custard and arrowroot. The Perth Public Hospital Committee had requested that the Victoria Hospital be used for convalescent fever patients "with neither money nor friends", as "If necessity arose they could be turned out into the street again as at present."⁸ This was sadly consistent with the perception of the Perth Public Hospital as a public provision for the desperate and indigent sick poor; the fee-paying wards had recently been closed by order of S H Parker, the Colonial Secretary.⁹

In 1899, the Anglican Church Office in Perth expressed some dismay at the fact that the smallpox graves in the tiny reserve set aside for the victims of the epidemic were in no way protected or fenced.¹⁰ After quite a lot of bureaucratic dithering over the responsibility for this task, the fencing of the graves was completed in January 1900, some six months after the original request was made.

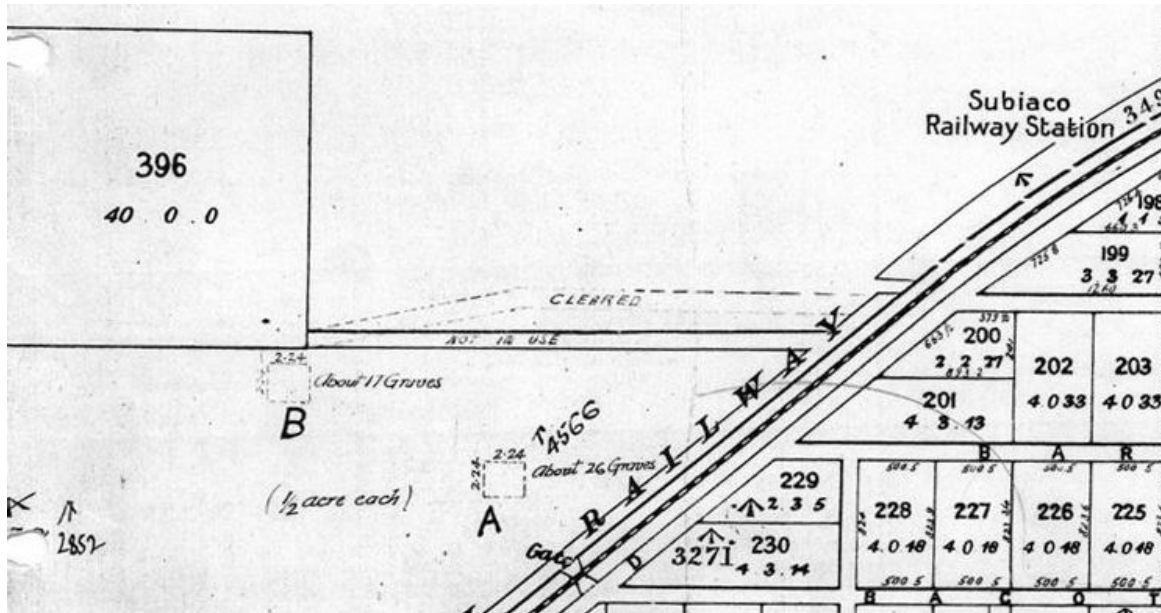
It must not be supposed that the length of time taken to complete this task in any way reflected an unwillingness to go near the infectious diseases hospital or its graveyard. It came rather from an inability to locate a government body willing to take on the responsibility for the fencing. This is an issue which is critical to an understanding of the hospital's history up to 1908, as an emotive dispute was to break out over just this question: who actually owned the hospital?

Until this matter was settled, three major bodies in Perth alternately sought control of, and tried to shift responsibility for, the Victoria Hospital. They were the Perth Public Hospital Board of Management, the Perth City Council (acting in its Gilbertian double capacity of Council and Local Board of Health), and the state government, in the form of the Colonial Secretary's Office, the Central Board of Health and the Department of Lands and Surveys. For the next eight years, these three wrangled, bickered, threatened and argued, leaving tangled archival paths of plot and counter-plot over who was to have control of the tiny crop of buildings.

⁸CSR File 630/98, 14.3.98.

⁹Bolton, Joske, op cit, p 55.

¹⁰CSO File 1194/93, 8.6.99. There were two plots - one under what is now Jolimont Primary School, and one under what is now Serra Reserve, both in Jolimont. Both sites were exhumed and the remains transported to Karrakatta Cemetery in 1906. Some graves, such as Crook's, are still visible, but most are unmarked and several have now fallen into disrepair. Their locations in Karrakatta Cemetery are: Ellen Amelia Montague, RO CA 287; Reuben Adams, AN DA 128; Herbert Crooks, AN DA 127; and two lots of unknown persons, totalling 15, at GE AA 8 and GE AA 10.



The map of the grave sites near the Hospital.

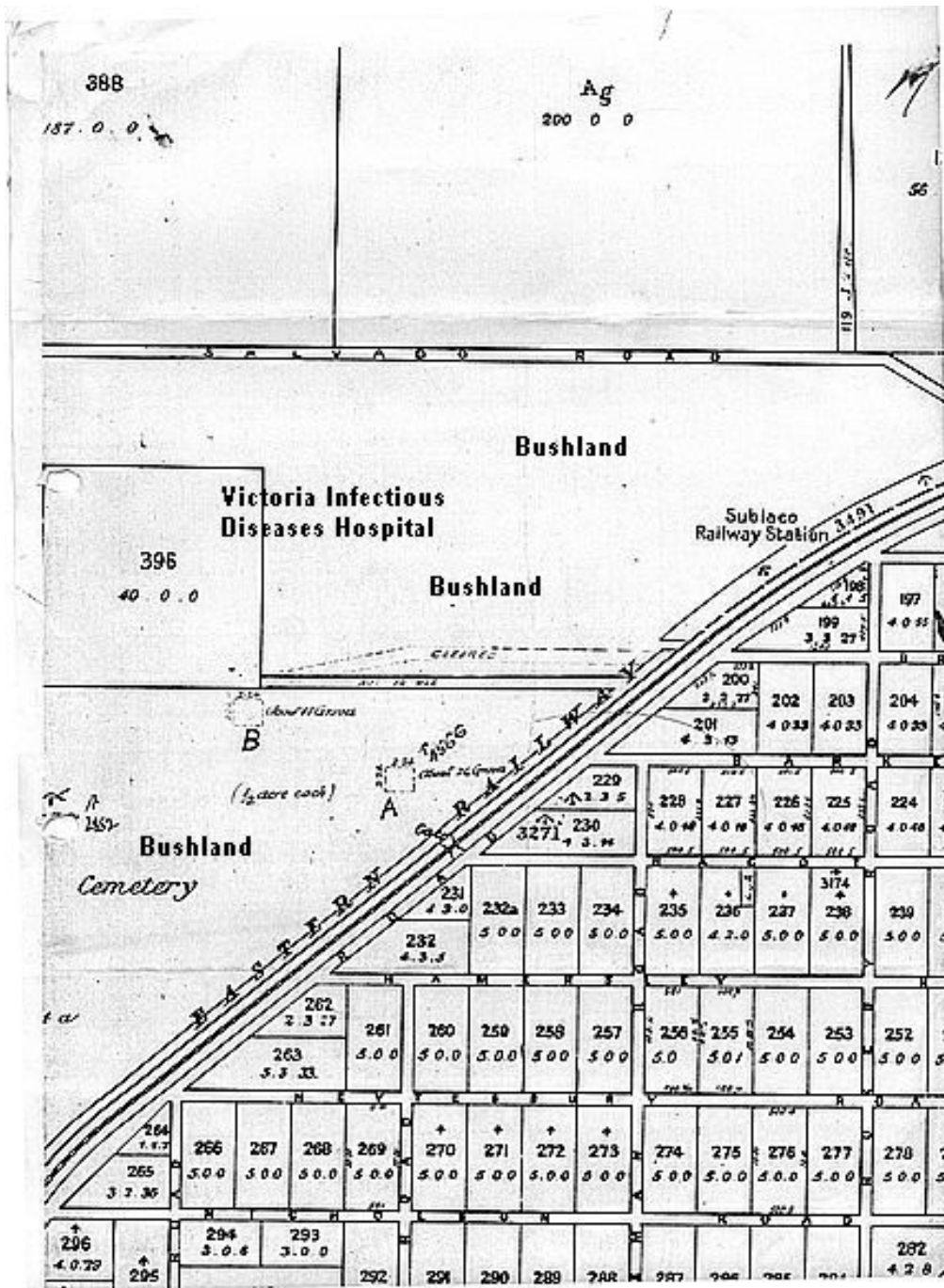
State Archives of Western Australia. File CSO 1823/96. 1896 plan for general cemetery near railway station.

The Victoria Hospital was built on the Perth Commonage, which belonged to the Crown. In 1901 the Central Board of Health recommended to the Colonial Secretary's office that control of the hospital be resumed, insisting that the hospital should be ready and available at a moment's notice for any outbreaks of infectious diseases, particularly bubonic plague, which was worrying the health authorities at the time.¹¹ Earlier that year, a domestic servant who contracted scarletina and who had sought admission to Perth Public Hospital was turned away, and was instead referred to the Victoria Hospital. She was refused admission to the Victoria Hospital because she "had not the necessary authority from the officer superintending the Hospital (which is under the control of the Perth Local Board) for admittance."¹²

The state government was at the time contemplating spending £300 on a disinfecter for the hospital, and wanted to know who actually held tenure on the land before it did so. The Central Board of Health assured the government that the Perth Board of Health hardly ever used the Victoria Hospital, and recommended that it be turned into the state infectious diseases hospital. Perth Public Hospital would not take the infectious cases, and the other local boards of health were not paying for their cases to be cared for. The whole matter clearly needed to be placed under government control.

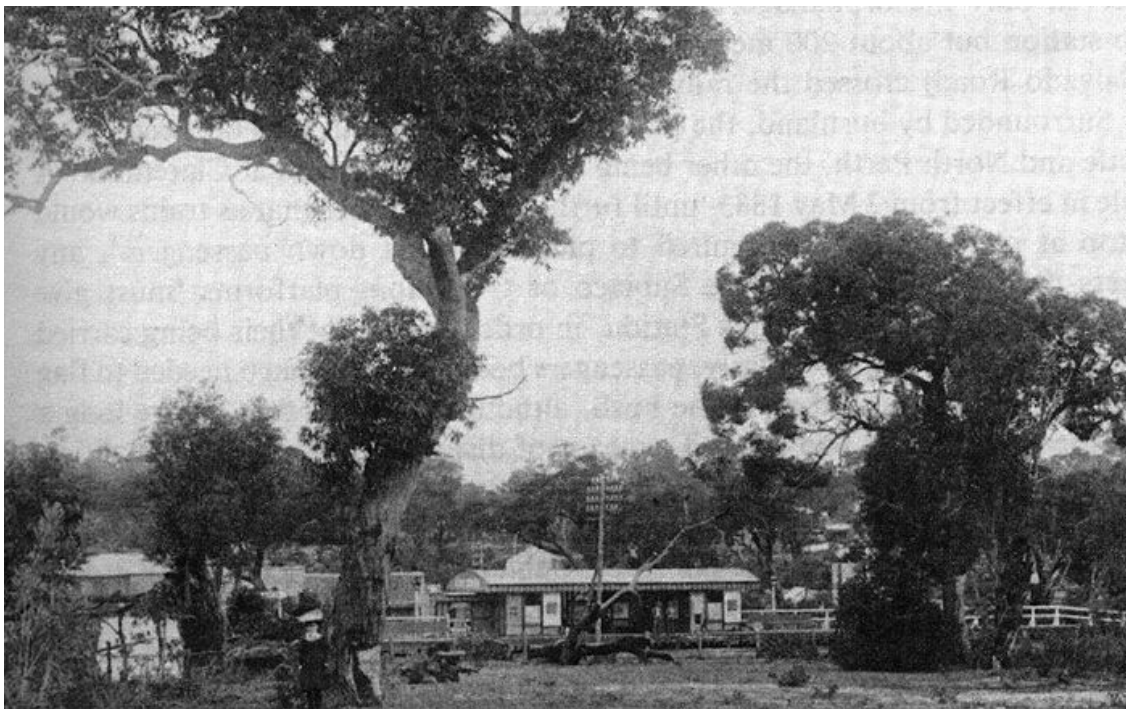
¹¹Public Health Department [PHD] AN 120/4 Acc 1003, #140, 1901, Sec CBH to US CSO, 15.5.01. Bubonic plague-related files can be found in the same archives, PHD, AN 120/4, Acc 1003: #110, #296, 1900; #135, 1903; #179, #271, #382, #743, #1112, 1906. These are only some of the PHD files on the subject, and to the best of the authors' knowledge, none of these has been cleared for public access as yet.

¹²PHD, AN 120/4, Acc 1003, #28, 1901, Sec CBH to US CSO, 18.2.01.



Map showing Victoria Infectious Diseases Hospital in relation to Subiaco Railway Station.

State Archives of Western Australia. File CSO 1823/96. 1896 plan for general cemetery near railway station.



Subiaco Railway Station, c. 1900.

Spillman, *Identity Prized: a history of Subiaco*, Perth: UWA Press, 1985.

So the Colonial Secretary's office wrote to the Perth City Council, asking if it would hand over the Victoria Hospital. The reply received was a flat 'no'. The Council, acting in its capacity as the Perth Local Board of Health, felt that *it* should retain control of the Hospital in case of infectious diseases emergencies.¹³ The Perth Local Board of Health also had the supreme advantage of producing a previous decision to justify its claim - in June of 1893, after the smallpox epidemic subsided, the Board had asked the government to take over the hospital, but the government refused, stating that "they did not wish to deprive the citizens of the means of treating their infectious sick."¹⁴

The wrangling continued into 1902. In June, the Perth Public Hospital Board of Management requested that the state government take over, prepare, equip and maintain the Victoria Hospital as an infectious diseases hospital.¹⁵ Neilson Hancock, the secretary of the Perth Public Hospital, pointed out that Perth Public Hospital could not take in infectious diseases cases, according to its revamped regulations.¹⁶ Under pressure to provide some sort of temporary infectious diseases accommodation, Perth Public Hospital finally reopened the

¹³PHD AN 120/4 Acc 1003 #140, 1901, US CSO to Actng TC, Perth,17.5.01; Actng TC to US CSO, 8.6.01.

¹⁴PHD AN 120/4 Acc 1003 #140, 1901, Sec CBH to US CSO, 18.12.02.

¹⁵PHD AN 120/4 Acc 1003 #777, 1902, news clipping WA, 6.6.02.

¹⁶PHD AN 120/4 Acc 1003 #777, 1902, Sec PPH to Perth LBH, 1.5.02. The regulation in question appears to have been article 21, section (v) which concerned the endangering of other patients. See (also included in this file) the copy of PPH's 1901 annual report, which includes a report from the Board of Management on the dangers of diphtheria and measles from Boer War soldiers who had been cared for in Perth Public Hospital. To add fuel to the fire, at the end of May 1902 PPH turned away a measles case, Sec Perth LBH to Sec CBH, 29.5.02. See also WA, 11.6.02.

cottage at the rear of the building, abandoned during the smallpox epidemic, and made it available for infectious diseases cases other than pronounced smallpox or bubonic plague.¹⁷

Now a second wrangle began. Who was to pay for the care of the cases? According to the Health Act of 1886, persons ill with a notifiable infectious disease were to be quarantined and cared for at the expense of their Local Board of Health. If cases were being sent to the Victoria Hospital, and it were owned by the state government, then who was to pay? If the Perth Local Board of Health owned it, who was to *be* paid, especially as the hospital would, in an emergency, be staffed from the Perth Public Hospital?

In September 1902 Hancock was looking for some answers as to who was to remunerate the main hospital for the care of these dangerous cases. The Perth Local Board of Health had refused to be responsible for infectious cases unless the Colonial Secretary paid for them.¹⁸ The following month, Hancock tried again, this time providing a test case for the Perth Local Board of Health to chew over. Four infectious cases had arrived at Perth Public Hospital, and he wanted them transported to the Victoria Hospital immediately, including the bill for their treatment at Perth Public Hospital so far, a total of £5/2/-.¹⁹ The Perth Local Board of Health refused to pay.

Thomas Lovegrove, the Principal Medical Officer, was of a quite different opinion as to what should be done with the Victoria Hospital:

So far as I am aware this hospital was built by the government and was used for the onflow of patients from the Perth Hospital in 1896-7 and was also used by me ... for cases of measles from Subiaco Industrial School in 1898 ... I do not know how the Municipal Authority can claim this hospital. If this building and the reserve on which it stands is handed on to them I presume it will be clearly understood that they receive and maintain all infectious cases which may be sent to it.²⁰

In December 1902 the Colonial Secretary had received a deputation consisting of Drs Frank Tratman and H F Harvey, representing the Perth Public Hospital, and urging the takeover of the Victoria Hospital by the state government. According to the Health Act, each Local Board of Health had to provide facilities for the treatment of infectious cases. Tratman and Harvey believed that the Perth Local Board of Health had been “generously treated” in the past, and it should either be made to accept responsibility for all metropolitan infectious cases, or the government, which would take on all future cases, should build a new infectious hospital.²¹

¹⁷PHD AN 120/4 Acc 1003 #777, 1902, pp 9-10.

¹⁸PHD AN 120/4 Acc 1003 #777, 1902, Sec PPH to Sec CBH, 29.9.02, p 15.

¹⁹PHD AN 120/4 Acc 1003 #777, 1902, Sec PPH to Sec Perth LBH, 3.10.02, p 24.

²⁰CSO File 1458/04, pp 43-4.

²¹ibid, p 37.

The Central Board of Health, meanwhile, was powerless to retrieve the money left unpaid to Perth Public Hospital. By this stage the whole dispute had been through the Crown Law Department, where it was decided that the Perth Local Board of Health could not be reimbursed until all efforts to extract the money from the patients themselves had been exhausted.²² Finally, the Central Board of Health gave up and paid up, mercifully - but only temporarily - cutting short what was threatening to become an ongoing saga. The Central Board of Health now insisted upon receiving from the Perth Local Board of Health a detailed monthly report of activities at the Victoria Hospital.²³

Table 2.1

Infectious Diseases at Perth Public Hospital, 1908

Disease	Cases	Deaths	% Mortality
Diphtheria	350	19	5%
Typhoid	283	23	9%
Tuberculosis	161	35	21%
Influenza	158	2	1%

But infectious diseases in Western Australia were not going to go away, at least not in the near future. In 1908, Perth Hospital was overrun with infectious cases (see Table 2.1). In the previous year, the number of typhoid cases had risen to 445, with 46 deaths, as the horrific typhoid epidemics of the gold rush slowly ebbed in Western Australia. Diphtheria, a killer respiratory disease, was on the increase with a total of 1 719 cases notified with 111 deaths in the State in 1908.²⁴ It had also hit Perth Public Hospital hard, forcing the Board of Management to insist on the inoculation of all staff working on the diphtheria wards - too late for some, including the matron, Kate Ryan, who had to be isolated and nursed.²⁵ Timothy Quinlan, as Chairman of the Board of Management at Perth Public Hospital, had every right to be concerned: the Hospital had spent over £224 of its budget on diphtheria anti-toxin alone.²⁶ Diphtheria is unlike other infectious diseases in that its development is little affected by hygiene or sanitation, and the most effective weapon against it was, from the 1890s, the use of anti-toxins, which managed to slow the appalling death rate in Australia by the 1930s.²⁷ While the death rate fell, the incidence did not, and it was most likely to strike children between the ages of 5 and 15. Inoculation against its effects was to remain a low priority with West Australians until the Second World War.²⁸

²²PHD AN 120/4 Acc 1003 #1428, 1902, p 33. See p 54 of this file for evidence of the Perth LBH's efforts in this direction.

²³PHD AN 120/4 Acc 1003 #1428, 1902, Sec CHB to Sec Perth LBH, 5.10.04, p 44.

²⁴Snow, *op cit*, p 146.

²⁵Perth Public Hospital Board of Management Minutes (hereafter RPH BM Min), 23.2.06, 10.12.06.

²⁶Perth Public Hospital Annual Report, (hereafter RPH AR), 1908, p 4.

²⁷C Thame, 'Health and the State', PhD, ANU, 1974, p 73. Thame's figures give the drop in mortality: 10% to 20% at the turn of the century; 5%-10% by 1920, and 2%-5% by 1930.

²⁸*ibid*, p 82, citing Western Australia. *Public Health Report, 1937-8*, p 5.

Infectious diseases also bring with them particular problems. In the first place, they are just that: infectious. Perth Public Hospital's mortality rate was relatively low, compared with eastern states hospitals, and infectious diseases posed a threat to this.²⁹ The hospital had already come under fire for its poor quarantine standards during the smallpox epidemic. After the initial illness of an infectious disease, long convalescence was often necessary, which, if the patient were without family or friends, occupied valuable bed space. Staff who had had diphtheria could not resume duties until 21 days after their discharge from the diphtheria ward.³⁰ How then could the Board and medical staff be expected to cope with the demands on space, time and resources that were posed by infectious cases?³¹

The solution was simple: use the Victoria Hospital. This had been going on since 1893, with the *de facto* use of the hospital by whoever needed it, including Thomas Lovegrove with the Subiaco Industrial School's measles epidemic, and Michael O'Connor's convalescents. The time had come, according to Perth Public Hospital, to make that usage *de jure*. The serious diphtheria outbreak of 1906-7 forced the Chief Resident Medical Officer at Perth Public Hospital to turn away cases, and O'Connor (now the City Health Officer) and the Mayor of Perth, Sydney Stubbs (who was also on the Perth Public Hospital's Board at the time³²), gave 'permission' for the Victoria Hospital to be used, on condition that Local Boards of Health paid for the treatment of their cases, a cost of six shillings per day.³³

Finally in February 1908, the Perth Public Hospital Board of Management was told that it would soon be advised as to the takeover of the Victoria Hospital. Lovegrove had contacted the Colonial Secretary's office, insisting that something be done:

in regard to increased accommodation and possibly removal to Subiaco of Perth Public Hospital's isolation wards]. It has been found necessary at times to put two patients in one bed: this cannot possibly be allowed to continue.³⁴

Unless an infectious ward could be built on the site reserved for the planned Children's Hospital, there would be "no other alternative but to reserve a portion of the Commonage near Subiaco or to utilise the building at the Victoria

²⁹According to the figures published in the Annual Reports, Perth Public Hospital's mortality rate averaged out over the first decade of the twentieth century to about 8.5%. In 1911, Melbourne's Homoeopathic Hospital was averaging 6%, the Melbourne Hospital 10% and over, and the Alfred Hospital nearly 10%. In 1900, these were even higher. J Templeton, *Prince Henry's: the evolution of a Melbourne hospital, 1869-1969*, Melbourne: Robertson and Mullens, 1969, pp 79-80.

³⁰RPH BM Min, 10.12.06.

³¹ The congested state of the main hospital had already prompted a special board meeting in January 1906. RPH BM Min, 22.1.06.

³²Bolton, Joske, op cit, p 74.

³³RPH BM Min, 31.5.07.

³⁴PHD AN 120/4 Acc 1003 #994, 1908, Lovegrove (PMO) to CS, 4.2.08, p 11.

Hospital.”³⁵ Later that February, the acting Principal Medical Officer, Dr John Cleland,³⁶ was able to describe concrete plans for the Victoria Hospital:

a number of small wards, isolated from each other, to allow of the segregation of the different diseases, and the various complications of these, which occur from time to time. It is of advantage that such wards be of a somewhat temporary character, so as to allow of easy extension. Another advantage is that they can be removed or destroyed at small cost, should necessity so require, in order to stamp out any particular disease.³⁷

The Perth Public Hospital was owed, by this stage, a total of £546/19/6 by various Local Boards of Health who were not honouring their side of the Health Act agreement - a sum of money which would almost have paid for an entirely new infectious diseases hospital, as the under-secretary of the Colonial Secretary's Office was quick to point out.³⁸

This time, the Colonial Secretary did some investigation of his own, and what he found out prompted an angry letter to the Premier:

I find that the Perth Local Board of Health have not, as they state, been saddled with the maintenance of infectious cases; but they certainly have not done their duty and borne their full share of the burden of infectious cases.³⁹

Out of the over £500 owed to the Perth Public Hospital, the Perth Local Board of Health alone owed about £170, and “through mismanagement on the part of the Perth Hospital Board we cannot legally recover this amount ... the metropolitan local boards have been getting rid of their responsibility in this matter altogether.”⁴⁰ Either the boards would have to pay for the erection of a joint infectious diseases hospital, or they would have to “make a proper arrangement with the Perth Hospital.”

In early March 1908, Dr Herbert Tymms, Chief Resident Medical Officer at Perth Public Hospital, inspected the site of the Victoria Hospital in the company of Drs Cleland and Lovegrove.⁴¹ The Chief Architect described the site:

³⁵ibid.

³⁶Cleland was at that time working as the Health Department's bacteriologist. Wise's West Australian Post Office Directory (hereafter WAPOD), 1908, State Government section.

³⁷ibid.

³⁸PHD AN 120/4 Acc 1003 #994, 1908, US to CS, 10.2.08, p 18.

³⁹PHD AN 120/4 Acc 1003 #994, 1908, CS to Premier, 20.2.08, p 24.

⁴⁰ibid.

⁴¹PWD, 19061, 1917 - Proposed new infectious diseases hospital, 6.10.17. The Chief Architect accompanied them, and was able to prepare a sketch plan of the site, as there was no existing map of the site available in government records. The present buildings were shown in grey, and suggested alterations and additions in red. While this 1908 sketch does not appear to exist any longer, a 1917 plan of the site may be based upon it.

The present buildings consist of a central block of galvanised iron, with two Wards, and central office and kitchen and pantry accommodation, with bath rooms and linen stores. The floors are bad and should be covered with linoleum. White ants have destroyed a good deal of the linings and joinery, and the whole place wants cleaning and painting. There are also two canvas camps which are in a very dilapidated state, though the floors and framing are in fair order. These will require overhaul and restoration if they are to be used.⁴²

Whoever was supposed to be in charge of the site had not been spending a great deal of money on its maintenance. As a result, after the site had been gone over thoroughly and assessed, the Chief Architect was able to supply F L Stronach, the under-secretary for Public Works, with a detailed costing of the amount of work needing to be done to turn it into a working infectious diseases hospital, housing a total of sixty patients, mostly diphtheria but including measles and scarlet fever. It came to a whopping £4 200.⁴³

Stronach immediately pointed out that there was no allowance for anything like that sum of money to be spent.⁴⁴ But not a penny could be spent of any budget on the Victoria Hospital until the government held the full control of the site. The Colonial Secretary's under-secretary noted at the end of March 1908 that:

The City Council have not yet replied to my request to hand over the control of the Victoria Hospital. It is of course possible that they may refuse to do so ... as both the site and the building belong to the Government I do not anticipate any legal trouble.⁴⁵

But four days later, he had changed his tune, stating to the Colonial Secretary that "from the facts it is plain that the Local Authorities are passively resisting."⁴⁶

While representatives of local boards and councils were being rounded up to meet the Colonial Secretary and explain their tardiness in payment, working drawings of the renovated hospital were being planned.⁴⁷ The Colonial Secretary could now make the councils an offer they could not refuse - by simply asking each Local Board of Health if it intended to provide an infectious diseases hospital in the manner laid down by the Health Act, and if so, in what form. He made it quite clear that he wanted to know if:

they intend to provide hospitals or accommodation for their infectious cases, as I do not wish it to be said afterwards, if we provide a hospital, that we did not give them the opportunity of providing one themselves. Then directly we know they will not

⁴²PHD AN 120/4 Acc 1003 #994, 1908, Chief Architect to US Public Works, 14.3.08, p 45.

⁴³ibid, p 46.

⁴⁴PHD AN 120/4 Acc 1003 #994, 1908, US PW to US CSD, 16.3.08, p 47.

⁴⁵PHD AN 120/4 Acc 1003 #994, 1908, US CSD to CS, 26.3.08, p 50.

⁴⁶PHD AN 120/4 Acc 1003 #994, 1908, US CSD to CS, 30.3.08, p 51.

⁴⁷ibid.

provide one, we can proceed in the way previously mentioned with the Victoria Hospital.⁴⁸

The responses from the Local Boards of Health were mixed.⁴⁹

But while deputations dithered and corresponded, the situation at the Perth Public Hospital was becoming worse every day. Plans had to be drawn up quickly for the new nurses' quarters, to be built on the site of the old isolation cottage.⁵⁰ In the meantime, the hospital was operating at capacity - Dr Lovegrove had recommended that diphtheria patients not be released from isolation until they had provided two 'negative' swabs, which placed more pressure on convalescent bed space. The CRMO, Dr Tymms, had had to turn away more measles cases, and the Board of Management's secretary reported to the Colonial Secretary that:

Today [30 April 1908] there are 31 cases of Diphtheria, all of which are being treated under such crowded and unfavourable conditions as to retard their recovery and prove a menace to others and this state of affairs threatens to cause a public scandal.⁵¹

Tymms backed this up with his own appeal to the Colonial Secretary, describing the isolation block at the back of Perth Public Hospital. It had three wards, one being a cottage of two rooms, each 16' x 18' x 12', designed to accommodate a total of 16 infectious cases, which actually held twice that number.⁵² Men, women and children were bundled in together, those with two or more infectious diseases housed with the rest, and there was nowhere else to put the 18 convalescents.⁵³

The day Tymms' letter was sent, the undersecretary to the CSD contacted his opposite number in Public Works, stating that "It has been decided to take over the Victoria Hospital, Subiaco", and asking for the road to be properly metalled.⁵⁴ While Bolton and Joske state definitely that the takeover took place in 1907, when the Hospital was "formally placed under the Board of Management of the Perth Public Hospital",⁵⁵ this 1908 letter appears to be the closest thing to a decision made over the future of the Victoria Hospital in this

⁴⁸PHD, AN120/4, Acc 1003, #994, 1908, CS to US CSD, 2.4.08, p 52.

⁴⁹PHD, AN120/4, Acc 1003, #994, 1908, Sec Board of Manag, Fremantle Hosp, to US CSD, Perth, 30.3.08, pp 59, 61a; also Fremantle LBH 28.4.08, p 78; Victoria Park letters 22.4.08, 20.5.08, pp 70, 113; Leederville 23.4.08, p 71; Bayswater 24.4.08, p 75; Subiaco 1.5.08, p 80; Claremont Roads District 4.5.08, p 81; Midland Junction, 8.5.08, p 94; Maylands 11.5.08, p 99; Peppermint Grove, 7.5.08, p 90; Queens Park, 9.5.08, p 98; South Perth, 11.5.08, p 100; Claremont LBH, 6.5.08, p 82; East Fremantle, 8.5.08, p 95. The latest responses, however, were from West Guildford and North Perth, who simply stated that they would give the matter due consideration. West Guildford, 22.4.08, p 72; North Perth, 30.4.08, p 79.

⁵⁰PHD AN 120/4 Acc 1003 #994, 1908, US CSD to CS, 5.5.08, p 83.

⁵¹PHD AN 120/4 Acc 1003 #994, 1908, Sec PPH to US CSD, 30.4.08, pp 85-6.

⁵²PHD AN 120/4 Acc 1003 #994, 1908, Tymms, CRMO PPH to CS, 8.5.08, p 91.

⁵³ibid, p 92.

⁵⁴PHD AN 120/4 Acc 1003 #994, 1908, US CSD to US PWD, 8.5.08, p 93. It is actually quite difficult to pinpoint the takeover. See RPH BM Min, 27.3.08 and 29.5.08 - there is a leaf (pp 90-1) missing from the Minutes.

⁵⁵Bolton, Joske, op cit, p 82.

period. The point at which Perth Public Hospital was given this authority, if at all, is not clear - nearly a month later, the Hospital was trying to clarify its role in the infectious hospital's future, demanding control of the land and building.⁵⁶

A full inventory of the site's needs was sent to the Colonial Secretary's Department - repainting, refitting, the building of a new kitchen, covering the floors, conversion of wards, tree-logging, fitting up a mortuary and laying a suitable road. The £4 200 originally proposed was pruned to a lean £865, less than a quarter of the original assessment.⁵⁷ This was approved finally by 19 May 1908, and several days later, the Perth Local Board of Health's ambulance was appropriated to transport patients to the 'new' infectious diseases hospital.⁵⁸

Next on the list were staff and furnishings. Dr Burkett had indicated that he would be prepared to do his share of working with the infectious diseases cases, and was encouraged to apply for the post of Medical Officer to the Infectious Diseases Hospital, involving a daily visit, at £50 annually. The position of 'Nurse in Charge' was also to be advertised, at a salary of £65, with three probationers.⁵⁹ But furnishings were proving less easy to find. The inventory was horrible: cracked and damaged enamel and crockery, musty pillows, worn linen, useless cutlery, the old box covered with green baize masquerading as a 'medicine chest' thoroughly moth-eaten, and only three useable bedsteads, with nine others old and rusty and "the balance represented by a rusty heap of pieces."⁶⁰ They had been found in an outbuilding,⁶¹ and had been given to the caretaker, Mrs Tollard, when she had taken the job three years earlier, at which stage the bedsteads were already old.⁶² By August, most of the fixtures had been replaced with goods from the main hospital.⁶³

The new arrangement meant that diphtheria cases were still to go direct to Perth Public Hospital. If they were not tracheotomy cases or in need of constant care, they would then be sent on by ambulance to the Infectious Diseases Hospital, Subiaco. Upon recovery, they would be returned to Perth and then discharged. Nurses were to go up to the main hospital four times a week for lectures, the CRMO and secretary were to make regular visits, and there were to be daily supplies of essential medications from the main Hospital's dispensary.⁶⁴ To cater for the constant civilian traffic, Perth Public Hospital bought a buggy. A station had been settled on at Subiaco by 1883,⁶⁵ and during 1894 and 1895, two surfaced roads made transport as far as the railway

⁵⁶PHD AN 120/4 Acc 1003 #994, 1908, Sec PPH to US CSO, no date, rec'd 3.6.08, p 118.

⁵⁷PHD AN 120/4 Acc 1003 #994, 1908, 'Subiaco Victoria Hospital' inventory, undated, unsigned, p 102; Chief Architect to US PWD, 14.5.08, p 104.

⁵⁸PHD AN 120/4 Acc 1003 #994, 1908, US CSD to Sec PPH, 19.5.08, p 111; US CSO to CRMO PPH, 23.5.08, p 110.

⁵⁹PHD AN 120/4 Acc 1003 #994, 1908, US CSO to Sec PPH, 5.6.08, p 122; Sec PPH to US CSO, 9.6.08, p 125.

⁶⁰PHD AN 120/4 Acc 1003 #994, 1908, Sec PPH to US CSO, 23.6.08, pp 146-151.

⁶¹PHD AN 120/4 Acc 1003 #994, 1908, Lovegrove (PMO) to US CSO, 11.6.08, p 124.

⁶²PHD AN 120/4 Acc 1003 #994, 1908, Sec PPH to US CSO, 23.6.08, p 151.

⁶³PHD AN 120/4 Acc 1003 #994, 1908, Sec PPH to US CSO, 11.8.08, pp 159-60.

⁶⁴ibid.

⁶⁵Spillman, op cit, p 58.

line a little easier.⁶⁶ Passengers who chose to travel by rail could disembark at Subiaco station and walk over a mile along Railway Road to the hospital. If they chose to strike out through the bushland, they could lessen the distance a little, while no doubt increasing their travelling time. A station was built during 1908 at West Subiaco, as the area was then known, being outside Subiaco's municipal boundary.⁶⁷



The early wards at the Children's Hospital, c. 1914

Marshall, *Starting with Threepence*, Fremantle: Fremantle Arts Centre Press, 1997.

Perth Public Hospital was in 1909 facing serious financial problems. Subscriptions to the hospital were falling, as were charitable donations, which had to help meet the day-to-day running of the hospital as well as future needs, such as new kitchen and laundry facilities and nurses' accommodation. The newly built Children's Hospital was popular, absorbing most of the public's subscriptions and donations.⁶⁸ A special meeting held in August 1909, between the management of the Perth Public Hospital and the representatives of Local Boards of Health, had decided that each Board would offer the Hospital a per annum sum for the treatment of infectious diseases cases from their districts, eventually settled upon at six shillings a day.⁶⁹

But any hopes of using the Victoria Hospital to turn a profit were quickly cooled by a request from the Colonial Secretary, wanting to know how much the local Boards were to pay, so that an appropriate amount could be deducted from Perth Public Hospital's government grant of £13 000. The Board had understood that it would be allowed to have its infectious diseases money on

⁶⁶ibid, pp 72-73, the roads being Broome Road (now Hay Street West) and Rokeby Road linking Broome Road with the railway line.

⁶⁷Spillman, op cit, p 183; Dept Lands & Surveys, map 75, 1909. This is now Shenton Park Station.

⁶⁸Bolton, Joske, op cit, p 83; J Marshall, *Starting with Threepence: the story of Princess Margaret Hospital for Children*, Fremantle Arts Centre Press, Fremantle, 1996.

⁶⁹RPH BM Min, 28.8.09, p 127; 27.9.09, p 133. Only those diseases notifiable under section 118 of the Health Act were to be accepted.

top of the grant, but it was quickly corrected.⁷⁰ Recovering those precious six shillings a day became even more crucial to the main hospital, with the result that the hospital superintendent recommended that infectious cases not be admitted unless they brought with them an order from their Local Board of Health, involving some statement of responsibility for the six shillings per day.⁷¹ The unkindest cut of all came in July 1910, when, in a stroke strongly reminiscent of Morton's Fork, the Colonial Secretary informed the Perth Public Hospital that, as it had done such an excellent job of keeping within its £13 000 annual budget, it would be cut to £12 000 the following year.⁷²

The Local Boards still continued to seek loopholes in the Health Act allowing them to dodge their six shillings, with again Perth featuring as the worst offender, to the extent that the Board of Management complained bitterly, insisting that Local Boards:

take the responsibility instead of neglecting to provide for Infectious cases and exposing the Citizens to infection, or allowing the Hospital and others Charitably disposed to treat their cases ... the Mayor ... is morally bound not to go back on [the deputation's] promise.⁷³

A particular bone of contention was money owing for children from an orphanage under the jurisdiction of the Perth City Council, the £10/14/- eventually being written off.

Sick children posed a problem in other respects. Before the Children's Hospital was opened, Perth Hospital had to take in cases, but put them all together in Ward 3 with the female patients. The newly founded Children's Hospital, in the opinion of the Perth Public Hospital, should have made arrangements to have its infectious cases treated and paid for.⁷⁴ The Colonial Secretary instead stated that Children's Hospital patients were to be treated free at the Infectious Diseases Hospital.⁷⁵ Insult was added to injury when the Children's Hospital management insisted that provision be made at the Infectious Diseases Hospital, where adults with acquired venereal diseases were treated, for the treatment of children with congenital versions of the same disease.⁷⁶

In 1910, other new problems arose. A case of measles, found aboard a recently arrived immigrant ship, was sent to the Infectious Diseases Hospital, forcing Perth's District Medical Officer to declare that the Subiaco hospital was for the quarantining of diphtheria and scarlet fever cases only.⁷⁷ James Hope, the Principal Medical Officer, suggested the shifting of one of the old isolation

⁷⁰RPH BM Min, 29.11.09, p 137.

⁷¹RPH BM Min, 30.5.10, p 160.

⁷²RPH BM Min, 5.7.10, p 164.

⁷³RPH BM Min, 17.7.11.

⁷⁴RPH BM Min, 30.10.11.

⁷⁵RPH BM Min, 30.1.12.

⁷⁶RPH BM Min, 31.12.12.

⁷⁷PHD AN 120/4 Acc 1003 #1864, 1910, Dist MO, Perth, to Chief Quarantine Officer, 27.7.10, p 1.

buildings at the rear of the main hospital to the Subiaco site,⁷⁸ which ended up costing Perth Public Hospital £207/7/6 - just under half of which had to be spent on making the building fit to be used, replacing and re-fitting damaged material.⁷⁹ Added to its original task, the Infectious Diseases Hospital was now also to be used as a metropolitan quarantine station. Ships with suspected quarantine candidates sent them either to Woodman's Point or to Subiaco, which to an extent helped to control the spread of infectious diseases brought in by sea - but on condition that the Immigration Department paid the all-important six shillings a day.⁸⁰



Children among the patients at the Infectious Diseases Hospital, c. 1919

Bolton and Joske, *History of Royal Perth Hospital*, Perth: UWA Press, 1983

As the tiny settlement of Subiaco grew across the railway line, it brought the city a little closer to the hospital. Subiaco was proud of its standard of health: from 1896, the newly appointed health inspector, W W North, worked to ensure that the methods of sanitation - dry-earth and the 'nightman' - were carried out as carefully as possible. Sewage from the settlement was carted to a burial deposit just east of the Karrakatta reserve, where it provided nearby residents in Aberdare Road with some local colour, blending with the smell of the slaughteryard south of the municipal boundary.⁸¹ Fortunately for the IDH's inhabitants, the sea breeze at least placed them firmly upwind in the summer

⁷⁸PHD AN 120/4 Acc 1003 #1864, 1910, Hope (PMO) to US CSO, 14.9.10, p 3.

⁷⁹PHD AN 120/4 Acc 1003 #1864, 1910, 11.10.10, p 8.

⁸⁰Western Australia. *Medical, Health, Factories and Early Closing Departments, Annual Report to December 1912*, p 14; RPH BM Min, 27.3.11, p 186.

⁸¹Spillman, *op cit*, pp 82-3, 95-6.

months. In the meantime, traffic in the other direction was common: in 1912, the Police Department reported that “it is the practice of some of the patients at the Subiaco Consumptive Ward to visit the Shenton Park Hotel daily”, contrary to hospital isolation - and hospital morality.⁸²



Top: View of Subiaco from the Shenton Park side of the railway, c.1914

Bottom: The Shenton Park Hotel c.1914

Spillman, *Identity Prized: a history of Subiaco*, Perth: UWA Press, 1985.

The staff at this time consisted of two visiting medical officers, with the rest of the main hospital staff dividing any extra work between them. Infectious cases would usually peak in winter, and by 1911 the hospital was serving a slowly increasing average number of patients.⁸³ The visiting medical officers in 1911 were Drs F Gordon and H Gill, who arranged for nursing staff at the hospital as required. When Gill was promoted in 1912, Dr H Gray, a Melbourne graduate,

⁸²RPH BM Min, 27.5.12.

⁸³RPH AR, 1911, p 23.

took his place. Gordon was to remain the honorary Physician for Infectious Diseases until 1916.



From 1908, the nursing supervisory staff underwent constant changes, and over the next ten years the Victoria Hospital proved to be an arduous training-ground for three future matrons.⁸⁴ The position of acting matron was held four times by Maida Balding (left) between 1908 and 1912, before she resigned from Perth Public Hospital in 1914 to begin her distinguished twenty-five year career as matron of Fremantle Hospital. Sister James became the hospital's first Sister-in-Charge, a position created by the Perth Hospital Board of Management in July 1914. James resigned in May 1915 to take up military service, and made way for Eleanor Harvey, another Perth Public Hospital graduate (1911) who had gone on to work as the main hospital's theatre sister. Harvey also trained as an

obstetrics nurse in Dublin, and worked in Kent Fever Hospital, returning to Western Australia just as the Great War broke out in Europe. Her experience with fever patients led to her being appointed the sister-in-charge at the Infectious Diseases Branch, but this was a short-lived appointment. Harvey was to become the first matron of the new Maternity Hospital in Subiaco, opened in 1916 (renamed King Edward Memorial Hospital). A senior nurse, Sister Isabella Gill, in turn replaced Harvey at the Infectious Diseases Hospital in 1916.⁸⁵ Gill had been trained in Melbourne, and had arrived at Perth Public Hospital to take over as Matron following Grey's move to Melbourne. While waiting in the wings until her appointment in 1920, Gill served as senior sister at the Infectious Diseases Hospital.⁸⁶

1913, oddly enough, seems to have been quite a lucky year for the hospital, with no record of major disasters or crises, and the happy accident of obtaining an ice chest from the Perth Public Hospital.⁸⁷ Even the one traceable maintenance hiccup, when the hot water system was out of action for three weeks, seemed to leave the patients "happier and more contented there lately."⁸⁸

1914 was less auspicious. The world was about to go to war, and the floor had just fallen through on Ward I, the building that had been moved from Perth

⁸⁴Appendix 1 provides details of the early medical and nursing staff. All information is taken from RPH BM Min for the years covered.

⁸⁵RPH BM Min, 3.7.16.

⁸⁶Bolton, Joske, op cit, p 97.

⁸⁷ PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to US CSD, 30.12.13, p 1.

⁸⁸RPH BM Min, 29.9.13.

Public Hospital to the Subiaco site. Even the new secretary of Perth Public Hospital, George Taylor, had to admit that "it has now done about sixteen years' service, and was in a very poor condition when removed from the grounds of the Perth Hospital to Subiaco."⁸⁹ Although some improvements had been made to the Infectious Diseases Branch, there were some problems that could not be built over. One of these was the ramshackle running of the entire establishment: the auditor's report for 1914 revealed that not only was the supply of goods irregular - either shortage or surplus - but the receipt books were missing. Perth Public Hospital was not impressed.⁹⁰



This photograph, taken much later (c1940), shows that the underside of the building is still exposed. It also shows the blinds on the verandahs which helped convert them to makeshift wards.

From the collection of Rosalind Denny.

⁸⁹PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to US CSD, 24.3.14, p 3.

⁹⁰ibid, 1914, p 27.

In 1914, a litany of decay and ruin began to make its way to the Colonial Secretary's Office. The flooring of the verandah on Ward 2 was about to give way, having rotted through.⁹¹ The kitchens and pantries were not fly-proofed.⁹² The performance of the bath heaters was considered not entirely satisfactory:

Some months ago two or three people were overcome with the fumes from these heaters in the Nurses' Quarters ... [two children were] seriously affected by fumes in the bath of the Infectious Wards, and ... stringent regulations have had to be enforced for the safe bathing of these patients.⁹³

White ants were attacking the orderlies' quarters (the orderlies were the hapless recipients of one of the discarded bath heaters), and the path to the morgue was impassable at night because of the lack of lighting.⁹⁴ Bath heaters continued to haunt the hospital throughout 1914, as patients had to be warned by the staff not to attempt lighting the heaters with matches, but to use tapers instead to avoid sudden explosions. Finally, when the main hospital's baths were replaced, the old ones were sent down to the infectious diseases hospital, as "many of them are in a better condition than the present baths at the Branch."⁹⁵ One can only hope, for the sake of the patients and staff, that it was not an unusually cold winter.

Complaint of cats making their home underneath the hospital wards was sent to the Principal Medical Officer, along with a request that the underneath of the buildings be wired in to prevent this.⁹⁶ Rigid economy dominated the management of the Perth Public Hospital throughout the pre-war and wartime years, so despite the unsanitary nature of the Infectious Diseases Hospital, it was able to maintain only running repairs. The cats and the rubbish under the wards would have to stay put, despite pleas from the Perth Public Hospital Board of Management and complaints in the *Sunday Times* about the state of the site.⁹⁷

The combined efforts of medical and nursing staff at the Perth Public Hospital and the Infectious Diseases Hospital could not control the community-wide scourge of tuberculosis. Consumptives had first been sent to the Infectious Diseases Hospital in June 1910,⁹⁸ and by 1913, the number of beds available for consumptive patients had risen to sixty-six. But by 1914, despite the extra beds, the number of cases was increasing beyond the Hospital's capacity, with the daily average now over 100. Work had already begun on the projected sanatorium at Woorloo, but the Hospital had simply to cope with the

⁹¹PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to US CSO, 22.5.14, p 10.

⁹²PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to US CSO, 21.5.14, p 11.

⁹³PHD AN 120/4 Acc 1003 #500, 1915, US PPH to PMO, 10.6.14, p 16.

⁹⁴PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to PMO, 23.6.14, p 22.

⁹⁵PHD AN 120/4 Acc 1003 #500, 1915, US PWD to US CSO, 2.7.14, pp 25-6; Sec PPH to PMO, 10.7.14, p 31.

⁹⁶PHD AN 120/4 Acc 1003 #500, 1915, Sec PPH to PMO, 17.7.14, p 35.

⁹⁷RPH BM Min, 27.4.14; *Sunday Times* (ST), 26.4.14.

⁹⁸RPH BM Min, 27.6.10, p 163.

consumptives until the sanatorium was ready. In the meantime, leaking taps, worn-out laundry troughs, a fumigator that was inoperable for months because it had not been connected to a supply of hot water, and a run-down laundry, would not have contributed to the maintenance of strict tuberculosis sanitation.⁹⁹

Added to this were blocked toilets, defective gas rings in the operating theatres, a broken kitchen range, disintegrating window screens, white ants destroying one of the bathrooms, an overflowing shower, and defunct bath heaters - these were not connected with the water supply, so nurses and others using them had to fill them by hand using basins, and then empty them by hand into the sinks.¹⁰⁰ No sooner was one repair approved than the next was necessary - the bath heaters and waste pipes of Wards 1 and 4 were approved for repair and paid for on 11 August, and the next day, the kitchen range broke down.¹⁰¹

At around the same time, Ivy Curwood began her nursing career, on 9 August 1915, going straight on to ward duty at the main hospital. The war had had a considerable impact on the number of doctors available:

We had none of them half the time. Sometimes one, two, four at the most, four was a full complement. IDB didn't have a doctor except a resident who slept there. He would be there from nine o'clock in the morning when he got up. He did the rounds of the wards and then went off to lunch in town to give anaesthetics in Perth. He arrived home somewhere around midnight and that was all we saw of him.¹⁰²

Because of the loss of medical staff to the war in Europe, the honorary physicians to the Infectious Diseases Branch had to make their own talents go further. Dr Watch was now working as both anaesthetist and physician for infectious disease, and Dr Gordon was also doubling as the ear-nose-and-throat surgeon, a post he took on full-time in 1915, leaving Watch with the double workload.¹⁰³

Matron Grey, a strict disciplinarian, would brook no argument, and unwilling nurses went to the site.¹⁰⁴ What they encountered there was a very unusual hospital, the like of which had never been mentioned in their nursing lectures.

Then I went out there and on the first day I was attacked by a man who said that he hadn't had a singlet for a month. Somebody else said they hadn't any pajamas or their beds hadn't been changed ... 'Scarlets' were nursed in tents ... when I

⁹⁹PHD AN 120/4 Acc 1003 #500, pp 51-90, detail the many repairs needed at the site.

¹⁰⁰PHD AN 120/4 Acc 1003 #500, pp 51-90, especially p 90.

¹⁰¹PHD AN 120/4 Acc 1003 #500, pp 73, 76, 80.

¹⁰²Interview with E I Curwood, by V Hobbs, Battye Accession OH 183, p. 4 transcript. Contemporary comment on the impact of staff shortages in Australian hospitals during WWI can be found in *Medical Journal of Australia*, 1917(2), p 426, "Health of Western Australia - Hospitals".

¹⁰³RPH AR, 1915, pp 1-2.

¹⁰⁴Bolton, Joske, op cit, p 90. They add that Grey's resignation to enlist "may have averted almost as many problems as it created."

first went there. You didn't even have a floor. It was an awful place, really. The frogs would jump in front of me and I'd want to scream you know, I was terrified ... Dogs howled and knocked tins over ... There were a few times I thought I'd like to give up and go home.¹⁰⁵

But public tolerance of the hospital seemed to be increasing. From 1915, an auxiliary had been providing the infectious diseases patients with books and papers, and this work was to play an ongoing role in the IDH's relations with the wider community. Perth Public Hospital's Visiting Committee, which included Bessie Rischbieth and Edith Cowan, reported on the site from time to time - Rischbieth promoted an appeal in 1915 for toys and spare clothing for the children at the Hospital, which received a good response.¹⁰⁶

The war also brought an increase in measles cases in the military camps and transports, with 198 cases having to be dealt with by the Infectious Diseases Hospital in 1916. In 1915:

trouble had been caused by soldiers suffering from measles which necessitated several special visits by the CRMO with the result that the Military Authorities had been notified and that one of these patients as a result was discharged for breaking the rules of the Institution ... no more cases of measles could be received until further notice as the Ward was over full, also an Officer had been deputed by the Military Department to make a daily visit to West Subiaco to keep order and discipline among the Military Patients.¹⁰⁷

The crowded and dilapidated conditions at the site were still a potential menace, not only for the patients already there, but for those to come. When Dr Sidney Sweet made a tour of the site in 1915, he found a great "necessity and urgency" for repairs and alterations:

as to providing for the unforeseen contingencies more likely to arise now that so many of our soldiers are living in camps and also returning from foreign lands from where they will probably bring back infectious diseases. No reserve accommodation is provided to meet emergency cases.¹⁰⁸

Sweet was exactly right. Only a few weeks later, in early 1916, there was a serious outbreak of cerebro-spinal meningitis¹⁰⁹ (CSM) in Western Australia,

¹⁰⁵Interview with Mrs E W Morris by V Hobbs, 1975, Batty OH 81, pp 9-10 trans. Marjorie Lund, who worked at the Home of Peace during the Great War, also describes the frogs which plagued Subiaco at this time, interviewed by C Jeffrey, OH 1987, p 6.

¹⁰⁶RPH BM Min, 30.8.15.

¹⁰⁷RPH BM Min, 30.8.15.

¹⁰⁸PHD AN 120/4 Acc 1003 #500, p 109.

¹⁰⁹Dudley Snow comments that "data concerning the history of meningococcal infection in Western Australia is unsatisfactory" due to the fact that these infections have been classified as "inflammation of the brain or its membranes", "cerebro-spinal meningitis" in both epidemic and non-epidemic forms, and "cerebro-spinal fever". Snow, *op cit*, p 169.

and the demand on space at the Infectious Diseases Hospital led to the Health Department quarantining the consumptive wards, moving their inmates to Wooroloo and using the space for cerebro-spinal cases. Military men were the primary suspects in the search for carriers of CSM.¹¹⁰

One of the added difficulties that came with the outbreak was the nature of the disease itself. While most infectious diseases patients were in their acute stage too ill to move about, the cerebro-spinal meningitis cases were only too active. With the onset of delirium, the patients - mostly men from Army training camps - would roam around the hospital at night, and were difficult to control, especially if they wandered into the bushland.¹¹¹ The emergency conditions also placed a strain on the accommodation for nursing and domestic staff, necessitating an appeal to the Minister controlling the Hospital.¹¹²

In 1916, Dr Lionel Robertson became the honorary physician for infectious diseases, a post he was to occupy for the next sixteen years until taking on consulting status.¹¹³ Dr Gilbert Barker could be relied upon, in the case of emergency tracheotomies for diphtheria patients - Barker would arrive as soon as possible, by which time the nursing staff would have the operating theatre ready for him. "As far as transport for the doctor was concerned", recalled Curwood, "we only had a car. But strangely enough there were very few deaths from diphtheria. They got better. [Robertson] was a great believer in hitting it hard by putting in plenty of anti-toxin with the initial dose."¹¹⁴

Diphtheria patients, mostly children, required intensive nursing. In the days before steam tents at the Infectious Diseases Hospital, diphtheria children (or 'dippy kids', as the nurses sometimes called them) who had undergone emergency tracheotomies were "specialled", looked after by one nurse, whose sole job it was to keep the child from choking:

The staff used to come in and find me with my head down near a little child and helping to clear the airway. Someone said, "Nurse, will you please keep further away from those children. I don't want you to get diphtheria." I said, "I won't get diphtheria, don't worry about me."¹¹⁵

¹¹⁰ibid, p 14.

¹¹¹A conversation with Mrs Betty Bell (nee Ross), recollecting her training in the 1930s at IDB with cerebro-spinal fever patients, revealed this aspect of their care.

¹¹²RPH AR, 1916, p 6.

¹¹³Interview with E I Curwood, by V Hobbs, Battye Accession OH 183, p 4 transcript.

¹¹⁴ibid.

¹¹⁵Interview with Mrs E W Morris, by V Hobbs, 1975, OH 81, p 12 transcript.

It was also in 1916 that the first qualification associated with the Hospital came into being - all nurses who spent three months at the site out of their three years' training received a certificate of infectious diseases nursing.¹¹⁶

Plans were made to improve the Hospital throughout 1916, but never came to life because of the tight budgets of both state government and Perth Public Hospital.¹¹⁷ By this stage, everything but the kitchen sink had broken down, and that gave way in March 1916, resulting in it being supported by hastily-improvised props.¹¹⁸ When part of the hospital caught fire in early 1917, it could have been a blessing in disguise, but the fire brigade was too quick for this, and saved the burning building, recommending at the same time that some sort of firebreak be made around the site, located in the heart of the bushland.¹¹⁹

The hospital was still being used to solve the overcrowding problem at Perth Public Hospital, and in May 1917 venereal diseases wards were being erected at West Subiaco.¹²⁰ This sparked an outcry from the already overworked staff, who were coping with an unexpected scarlet fever outbreak:

At present there are at Subiaco 26 Scarlet Fever Cases whilst the provision is only a small ward for about 6 cases. This means that to cope with great overflow there are two cases in some beds and verandahs have been boarded in & blinds put up to try & give them some shelter. In the wet weather we have just had it has been very hard to keep the children dry ... if the Public realise what is going on there will be a big outcry against the management of the Perth Hospital.¹²¹



The response, the following month, was typically frugal. The government authorised the transportation of an old ward from the Coolgardie tuberculosis sanatorium and its re-establishment at West Subiaco.¹²² While due economy was observed in this transfer, the fact that this building was intended as a permanent addition to the hospital rather than temporary accommodation was to draw public fire after the war had ended.¹²³ It also turned out to be extremely expensive, comparatively speaking –

Commissioner for Public Health Everitt Atkinson (left) and the Principal Architect both travelled to Coolgardie to supervise the move, and the building needed extensive repairs.¹²⁴

¹¹⁶RPH BM Min, 3.7.16.

¹¹⁷PHD AN 120/4 Acc 1003 #500, Sec PPH to PMO, 16.2.16, p 132.

¹¹⁸PHD AN 120/4 Acc 1003 #500, Sec PPH to Sec, Medical Department, 1.3.16, p 135.

¹¹⁹RPH BM Min, 26.2.17.

¹²⁰RPH BM Min, 28.5.17.

¹²¹RPH BM Min, 30.7.17.

¹²²RPH BM Min, 27.8.17.

¹²³Hobbs, *op cit*, p 62.

¹²⁴PHD AN 120/4 Acc 1003 #136 , 1917, Atkinson to Matthews, 12.7.17, p. 90.

The Coolgardie ward was to become the basis of one of the most enduring shaggy-dog stories about the site, recurring in any thumbnail sketch of the Hospital's history, to the extent that in some cases it appeared the entire hospital was constructed of buildings moved from Coolgardie. As far as can be ascertained, only the one building was ever moved thus, but it became an enduring byword for administrative tight-fistedness towards the Infectious Diseases Hospital.

So by the end of the Great War, the Infectious Diseases Hospital at West Subiaco had held patients with measles, scarlet fever, cerebro-spinal meningitis, whooping cough, and acquired and congenital venereal diseases. Whether it had the facilities to provide for even one of these groups of patients is questionable, but the lifting of wartime strictures was not to improve the standing or condition of the Hospital. The hospital was to stagger along for another twenty years before something was done.

Chapter Three: A Piecemeal Accumulation

The First World War ended in November 1918, a year which had seen some improvements made at the Hospital. But the hot water system was still very shoddy, especially when called upon to deal with fifty-three children, all of whom had to be bathed at least once daily.¹ Despite this, and the smelly septic tank, the site was beginning, slowly but surely, to take on a more human face. The 1919 visiting committee to the site asked for the vigorous grass to be cultivated into a lawn, where nurses (with only three hours off-duty during the day, if that) could play tennis, and for some shade and fig trees to be planted.²



The tennis court at the Hospital, 1920s

From the collection at the Royal Perth (Rehabilitation) Hospital.

With the ending of hostilities in Europe, the Australian troops came home. With them came the deadly 'Spanish' influenza, spreading from December 1918 until the following spring of 1919. Common influenza was still potentially fatal at this time, but the last major outbreak before 1918, in 1908, claimed only 37 lives.³ By the end of 1918, Western Australia had lost 69 people to the epidemic, and by its sudden subsidence in October in 1919, a further 544 had died.

¹PHD AN 120/4 Acc 1003 #136 , 1917, Atkinson to Matthews, 12.7.17, p. 90.

²ibid.

³Snow, op cit, p 158.

The main hospital was faced with an epidemic disease with a short incubation period and a high attack rate, swamping available facilities. The Spanish influenza pandemic caused public panic as medical authorities struggled to deal with the outbreak, improvising temporary accommodation for cases at the Blackboy Hill military camp. Nursing staff were stretched to the limit, with the emergency conditions drawing in unqualified young women to put their rudimentary domestic nursing skills into practice. Dr Gill personally recruited nursing staff, telling one woman to send her two daughters to “go and help”.⁴

Influenza was a notifiable infectious disease. Why, then, was the Infectious Diseases Hospital not used as a quarantine camp? The site's inadequacies were well-known; the pot-pourri of cases already there - venereal diseases, children with scarlet fever and diphtheria - would have to be moved somewhere else. It made more sense to send medical cases from the main hospital down to West Subiaco, and to convert three wards of the main hospital into a quarantine hospital. This is exactly what happened.⁵

The epidemic brought to light a great many problems in the hospital system in the State. Perth Hospital's wartime and epidemic costs were making it impossible for the administration to stay within budget, and this was further complicated by the fact that the secretary and bookkeeper had to be removed from office in 1919 on charges of embezzlement. The main hospital was overcrowded; the staff were worked to the limit of their abilities. The State Government's response to these problems was to cut the hospital's budget from £25 000 to £20 000 in 1920-1. The constant struggle of the Perth Hospital's⁶ Board of Management to keep the institution afloat, combined with other complaints and concerns about hospital funding in the State, eventually resulted in the 1922 Royal Commission into the hospital system in Western Australia.

The war had also brought home other problems - the need for medical treatment of war-related injuries - so the Commonwealth government authorised the spending of £25 500 on repatriation wards for Perth Hospital.⁷ What was to be set up at the main hospital was a very rudimentary rehabilitative ward. It was to be equipped with modern electro-therapeutic equipment, hydrotherapy facilities, a staff of massage practitioners and “all those modern methods of treatment which have originated during the war.”⁸ 'Rehabilitation' in the current sense did not exist in Australia at this time, but treatments which were to become known as 'rehabilitative', did exist. Electrotherapy and massage (later physiotherapy), in partnership with orthopaedics, were the basis of all later developments in physical rehabilitation in Western Australia.

⁴Bolton, Joske, *op cit*, p 98.

⁵RPH BM Min, 3.11.19.

⁶Perth Public Hospital changed its name to simply 'Perth Hospital' in November 1921, partly to escape its poor record and public mistrust built up since the turn of the century. Bolton, Joske, *op cit*, p 102.

⁷*ibid*, p 2.

⁸*ibid*.



The massage department at Perth Hospital

McKellar Hall, *Reflections of an Orthopaedic Surgeon*, Perth: Hesperian, 1983

Massage practitioners had worked at both Perth and Fremantle Hospitals since massage first became acknowledged in Australia as a suitable form of medical treatment, in the early years of the twentieth century.⁹ The formation of the Australasian Massage Association in 1906 sparked greater interest in massage as well as greater trust of its credentials, and Dr George McWilliams had attempted in 1906 to form a branch of the Association in Western Australia, which never got beyond the planning stage.¹⁰



If 'official' certified massage practitioners were in short supply in Perth, local medical practitioners did not hesitate to patronise the untrained but experienced practitioners, of which there was a small but thriving industry in Perth in the 1920s.¹¹ Dr Alexander Juett (left), a former Rhodes Scholar and Western Australia's first orthopaedic practitioner,¹² was appointed as an

⁹One of the first masseuses to work at PPH was Miss Crooks, working in 1906, and also Miss Macauley and Miss Andrews, RPH BM Min 28.12.06, 27.3.07. The first masseur seems to have been Gosta Linderstam, RPH BM Min, 31.7.11. The earliest honorary massage practitioner at Fremantle Hospital traced by Garrick and Jeffrey is Miss Jean Lewis, who practised up till 1921, when she was replaced by Mr Chivers. P Garrick, C Jeffrey, *Fremantle Hospital to 1987: a social history*, Perth: FH/UWA Press, 1987, p 187.

¹⁰*Una Nurses Journal*, 30.11.06, p 142. McWilliams died in early 1907, and the branch progressed no further, 28.2.07, p 182.

¹¹I use the term 'massage practitioners', because female dominance of this industry had not yet been extended to Western Australia. There is no evidence to link massage practice with prostitution in Western Australia at this time. R Davidson, "As good a bloody woman as any other bloody woman": prostitutes in Western Australia, 1895-1939', in P Crawford (ed), *Exploring Women's Past: essays in social history*, Victoria: Sisters Publishing, 1983, pp 171-201.

¹²Juett (appointed as PH's orthopaedic surgeon April 1923, RPH BM Min, 30.4.23) was not a qualified orthopaedic surgeon, but rather had an interest in and skill with orthopaedic care and practice. The only

honorary medical practitioner to repatriation cases in 1922.¹³ Juett often used local massage practitioners, as did his future partner, Dr Reg McKellar Hall, who arrived in Western Australia in 1926,¹⁴ and in 1921 the Perth Hospital employed an unqualified but experienced masseur on the recommendation of the then-CRMO, Dr Barker.¹⁵

In the meantime, the staff of the West Subiaco Hospital were busy tracking down their more active patients, for whom any sort of bed-rest was proving elusive. Barker's report to the Board of Management meeting in January 1920 stated resignedly that:

Ever since we had CSM cases in Wards 1 & 2 I have always recognised the possibility of delirious patients escaping from ward & getting lost in bush at back of Hospital. My reason for bringing this up is that last Sunday, 30th ult. an influenza patient who also developed D.T's escaped from Ward & could not be found for some time. The nurse actually saw him leaving Ward but by time she had obtained help the patient had disappeared in scrub.¹⁶

The nearby hospital for returned servicemen with war-related mental instabilities was also a cause for concern, especially to the nursing staff. Talk of real or imagined nocturnal stalkings, and 'visits' from the inmates of Lemnos Hospital, was constantly circulating at the site, not helped by the poor fencing which was supposed to protect the public from the Infectious Diseases Hospital, and *vice versa*.

Between disappearing patients, cockroaches scuttling through the hospital kitchen, and a nurse catching fire, it was business as usual at the Infectious Diseases Hospital.¹⁷ Amid this disrepair, it should come as no surprise that, for the nurses, the food remained at the same standard:

I had a sister in law at Subiaco then and when we were on night duty, she used to do us up a rabbit and come and leave it at a certain place for us. Oh some of the meat was terrible ... I did a dinner once with chops that were bad. The junior nurse always had to cook the dinner.¹⁸

qualified orthopaedic surgeon in Australia up to the end of the Great War was Dr Max Herz, who was interned for the duration of the war while the NSW British Medical Association tried to have him deported. D Le Vay, *History of Orthopaedics*, Carnforth, UK: Parthenon, 1980, p 343.

¹³RPH BM Min, 16.1.22. According to the Post Office Directory, there were about twenty massage practitioners working in the Perth metropolitan area throughout the 1920s, *Wise's Western Australian Post Office Directory*, Trades Section, 'Massage'.

¹⁴Copies of certification provided by these two doctors for at least one practitioner, C S Southcott, were found in the Australian Physiotherapy Association (Queensland) archives. These have been reproduced as Appendix 2. See also R McKellar Hall, *Reflections of an Orthopaedic Surgeon*, Perth: Hesperian, 1983.

¹⁵RPH BM Min, 21.4.21.

¹⁶RPH BM Min, 5.1.20.

¹⁷RPH BM Min, 30.8.20; 17.7.22.

¹⁸Interview with Miss Taylor, by V Hobbs, OH 136, p 7 transcript.

The cost of running the hospital had also remained fairly stable for the last five years, at nearly £6 700. The total number of nursing staff had by 1922 risen to 14, the same year that Ivy Curwood - described by a nurse who trained under her as "marvellous"¹⁹ - officially became the Sister-in-Charge²⁰. The nursing staff were run off their feet - sickness among the staff in early 1922 meant that day staff were working a 12-hour day from 6.30 am to 6.30 pm, with a total of an hour and a half for meals. The night staff worked only slightly less, from 9 pm to 7 am, with supper in the ward pantry.²¹

The main hospital was so pressed for money that in 1921-22 the 'special passes' system was introduced, charging visitors 6d per visit to see their sick friends and relatives.²² The 'rigid economy' of the wartime years was continued, this time called 'efficiency', and in 1923 the Board of Management was pleased to announce that due to staff changes and other efficiencies practised at the Infectious Diseases Branch, "a gratifying decrease in the maintenance costs has been brought about."²³ And indeed it had. The outer fence had been knocked down during a storm in 1921, and was not repaired. Consequentially, livestock tended to stray on to the site, and "in fact, on one occasion", wrote the secretary of Perth Hospital to the Medical Department, "a cow almost entered one of the wards."²⁴ Boilers, bathheaters, leaking verandahs and broken duckboards, broken washing machines, faulty and slapdash contract work - the pleas for repair were so numerous that eventually in September 1922 the Medical Department asked the Hospital to submit a monthly list for attention, unless the matter were urgent.²⁵ Helpless in the face of mounting disrepair, it is no wonder that, paradoxically, small triumphs of economy were celebrated. The CRMO, Dr MacKenzie, was able to report in August 1922 with almost Scroogelike cheer that because of the fewer number of patients at the site, the number of orderlies had been reduced by two, and as a result, "the laundry boiler was only fired three times per week thus effecting a saving in firewood."²⁶

It was left to the kindness of the public to help to cover some of these expediencies. When, in June 1924, there was a large number of babies under the age of two years at the Branch Hospital, the Red Cross, the Women's Auxiliary of the Immigration League, and Messrs D & W Murray had donated clothing for them.²⁷ The Infectious Diseases Hospital had become the place of training not only for infectious diseases nursing, but for the nursing of children: "It was practically all children in those days, so we got our children's nursing experience out there."²⁸

¹⁹Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 5 transcript.

²⁰RPH BM Min, 27.3.22.

²¹ibid.

²²RPH AR, 1922, p 11.

²³RPH AR, 1923, p 13.

²⁴PHD AN 120/4 Acc 1003 #2171, 1918, Sec PH to Sec MD, 4.8.21, p 125.

²⁵PHD AN 120/4 Acc 1003 #2171, 1918 - this entire file is full of reports of numerous breakages and serious damage at the site from 1918-1923 alone.

²⁶RPH BM Min, 26.8.22.

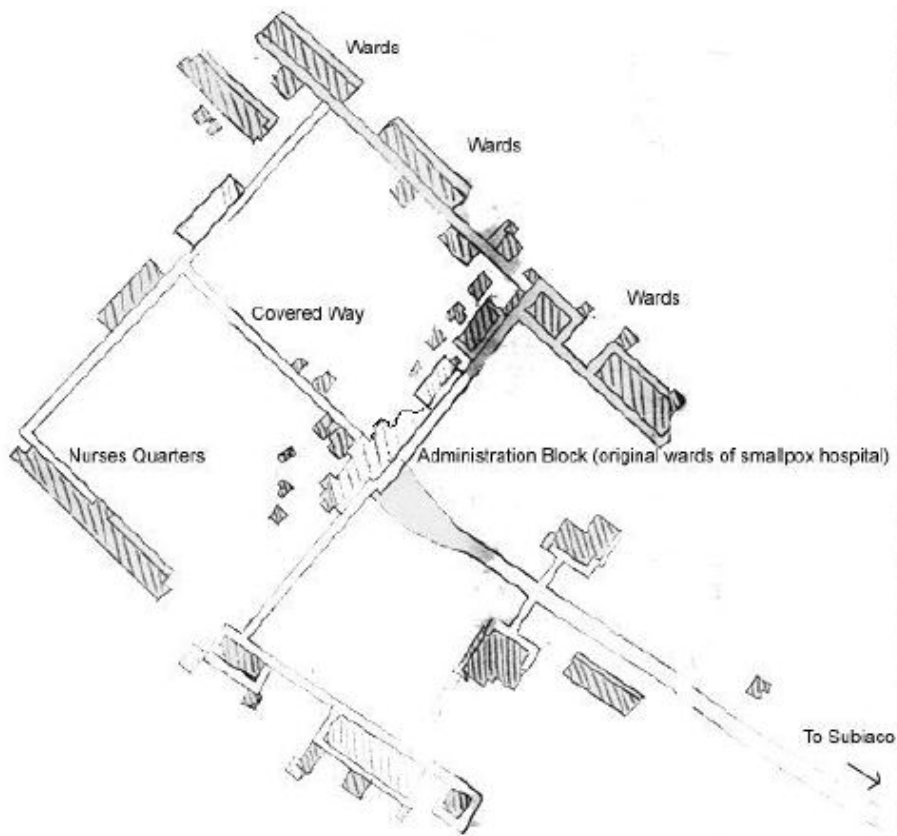
²⁷RPH BM Min, 25.6.24.

²⁸Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 3 transcript.



The original fever ward, now converted to the office and administration building, c. 1919

Bolton and Joske, *History of Royal Perth Hospital*, Perth: UWA Press, 1983



Victoria Infectious Diseases Hospital, c. 1917.

A reconstruction of the 'piecemeal accumulation'

From a Public Works Department (WA) map of the site, traced by the author and annotated

With a hospital in the middle of the bush, full of children and with nurses barely out of their teens, the nights could be frightening. By the late 1920s, an orderly had been appointed to meet the nurses at the station, and to do night rounds - one nurse recollected "how much we looked forward to him doing his rounds because we were terrified."²⁹ Another added:

We were alone on the wards, young girls, no adults, young children and babies. The hospital was nothing, and we were really scared. It was just after the first war and we were close to the Lemnos Hospital ... We knew that the place was full of mental cases.³⁰

There was also fear of the delirious venereal diseases cases, who were cared for by orderlies and 'attendants', male rather than female nurses - "Oh my dear, when walking from those duckboards you were more or less looking at every tree."³¹

The conditions were aggravated by problems within the nursing community itself. An episode of petty thefts at the Hospital in November 1924 led the nurses to produce a broadsheet detailing their vulnerability and concerns about the site:

The girls are far removed from male protection, the men attendants' quarters being relatively a great distance from theirs. The surrounding bush is lonesome to a forbidding degree. From nine o'clock at night till six in the morning the nurses are without the assurance of protection [from] intruders; that comes in the knowledge of the proximity of trusted attendants. Added to this, they cannot even lock their doors ...³²

The male staff, on the other hand, were quite happy in their surroundings. One former orderly recollected that "we three men were quite contented, spending the winter evenings by the fireside reading or playing indoor games - quite cheerfully answering phone calls for duty when required."³³

It is tempting sometimes to present the constant shabbiness of the hospital as something to be deplored, which, by modern standards, it is. But the hospital ward's conditions, no matter how appalling, were possibly better than those of the patient's home. Many of the patients were children, not ones to begrudge the breakdown of the hot water system if it meant avoiding the dreaded daily bath. Elderly patients and the chronically ill were, it seems, in many cases

²⁹Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 4 transcript; RPH BM Min, 29.3.28, p 4.

³⁰Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 4 transcript.

³¹ibid, p 10 transcript.

³²Quoted in Bolton, Joske, op cit, p 122.

³³ibid, p 123.

happy to live out their last days at the Infectious Diseases Hospital, cared for and at peace.

The division between patient and nurse was often abandoned when the nurses themselves contracted infectious diseases. One nurse caught measles while training in the early 1920s, and was nursed in one of the open verandah beds, with the rain coming in through the canvas blinds. Complications in her case led to an operation one evening, out on the verandah in the middle of winter.³⁴

The patients were treated on verandahs too as well as in the wards, in all weathers If it rained, all we did was pull the blinds down and attach them. It was amazing how we managed and we didn't think it was unusual.³⁵

Patient life at the site was never more clearly evidenced than in the maintenance of the Hospital buildings and what passed for grounds. Where the Public Works Department would not help, the patients would. Since the early 1920s, there had been complaints from government bodies about repairs being done at the Branch Hospital by patients or other "unauthorised persons".³⁶ Bored convalescents and long-term patients appear to have been quite willing to do odd jobs around the site, and in 1925, when the Public Works Department refused to paint Ward 8, the adult patients in the ward did it instead. Wards 7 and 8 at this time housed old men with advanced facial cancer and other skin conditions, otherwise with no means of support. These patients had also taken an interest in the garden, and were paid in kind with a small amount of tobacco.³⁷ After this, there was no stopping them - they carted sand for top-dressing the lawn which was to be turned into a tennis court, and got hold of a roller to prepare it.³⁸ By early 1926 they were growing vegetables.³⁹ One elderly inmate had a fat old horse to keep him company, and a few hens.⁴⁰

The Board of Management was finally in a position to look a little ahead and ask for new quarters to be built in brick, rather than just expanding the old wooden rooms.⁴¹ Wooden wards at the hospital were not just more likely to fall victim to the ever-present white ants; fire was also a constant danger at the site. It was with a note of pessimism that the Board asked for the employment of an orderly with a fireman's certificate, so that the boilers could keep up a supply of hot water throughout the winter nights.⁴² This signalled the end of the economy on wood consumption - and also produced the hasty construction of a firebreak around the buildings.⁴³

³⁴Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 26 transcript.

³⁵Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 26, p 7 transcript.

³⁶PHD AN 120/4 Acc 1003 #2171, 1918, US Works to US CSO, 19.11.21, p 146.

³⁷RPH BM Min, 27.8.25.

³⁸RPH BM Min, 29.10.25.

³⁹RPH BM Min, 25.3.26; 28.7.26.

⁴⁰M Leschen (nee John), "IDB", *Royal Perth Hospital Journal*, September 1965, p 213.

⁴¹RPH BM Min 28.7.26.

⁴²ibid.

⁴³RPH BM Min, 28.10.26.



During an epidemic at the Hospital, a masked nurse holds a baby. Note the sandy scrublands in the background.

From the collection of Kathleen Johnson

Elizabeth Spring graduated from the Perth Hospital's nursing training school in January 1916, and appears to have been appointed as assistant matron in about 1925, remaining the senior sister at the Branch Hospital until her resignation in 1938. For years, she was not only Assistant Matron, but was also in charge of all the clerical work at the site, the catering for both staff and patients, and the domestic and laundry staff. Matron Ethel McNevin, who was Matron of Perth Hospital from 1928-1938, had the greatest confidence in Spring's abilities - "Any problems and difficulties were readily presented to her and received the utmost consideration and fair judgement."⁴⁴ When the Nurses' Award was introduced, Spring was also responsible for compiling rosters. Her

⁴⁴Reference written by E McNevin for Elizabeth Spring, New South Wales, 20.8.38, author's collection, reproduced from original for history display at Royal Perth (Rehabilitation) Hospital.

20th August 1938.

TO WHOM IT MAY CONCERN:

During the ten years I was Matron at Perth Hospital Sister E. Spring was very well known to me, being the Assistant Matron in charge of the Infectious Diseases Branch at Subiaco.

This Hospital carried up to 140 patients, mainly children, and only on occasions was a Medical Officer in residence. Most of the cases required skilled nursing attention, and frequently urgent surgical treatment. As the Wards were old and scattered and lacked modern facilities the position was one of considerable responsibility to the Assistant Matron.

For many years Sister Spring was in charge of the whole of the clerical work connected with a hospital of this type, as well as the catering for all the patients and the various staffs.

I had every confidence in Sister Spring both as a Nurse and Administrator. Hundreds of nurses gained their experience in Infectious Nursing under her supervision and were well trained and disciplined.

The Domestic and Laundry Staffs were immediately under her control. Any problems and difficulties were readily presented to her and received the utmost consideration and fair judgment.

On the advent of the Nurses' Award, Sister Spring was responsible for the compilation of the rosters, a task demanding much patience and intelligent application of the requirements of the routine of the Wards and the Nursing Staff. I found Sister Spring quite adaptable to these new methods, making the necessary appropriate adjustments during epidemics and busy periods. She was most helpful to me personally when faced with a shortage of staff.

I can thoroughly recommend Sister Spring to any position of responsibility and trust where qualifications such as hers are essential.

E. McNEVIN,

Matron.

Matron Ethel McNevin's reference for Sister Spring.

From the collection at the Royal Perth (Rehabilitation) Hospital.

discipline was firm and her supervision thorough, so when accidents occurred - such as when a nurse accidentally set fire to one of the ward chimneys - Spring's response would be lively.

Oh you should have seen Sister Spring, she was dancing with rage, almost. She was a funny little thing. We thought she was old as a tree. She was probably about thirty or something like that.⁴⁵

Part of the Perth Hospital's nursing training was the two periods spent at the Branch, each of up to three months. The student nurse's schedule was unrelenting: work at the Branch interspersed with lectures at the main hospital, to be attended in 'spare time'. This would entail a walk across the duckboards to the little station at West Subiaco, and then a train ride to Perth station, then walking to Perth Hospital at the top of Murray St.⁴⁶ Care of the patients at the Infectious Diseases Hospital was also physically very demanding. The croupy symptoms of diphtheria cases could be treated with steam, a complicated procedure involving the shrouding of the patient's bed in a steam tent made of sheets. Special brass kettles with long spouts could then be filled with water and kept boiling on a little primus stove outside the tent, and the spout was put through a small gap in the sheets, filling the tent with steam. One former nurse wondered "how we didn't start terrible fires. There were wobbly old tables".⁴⁷ As well as patient care, some cleaning duties were also the responsibility of the nursing staff, including sweeping wards, lighting fires and cleaning the lockers. But the nurses training at the Infectious Hospital in the 1920s still managed to enjoy themselves - one night Molly John and her fellow trainees found the meat safe unlocked. Respect for hospital cuisine had never been high, and the string of sausages in the safe became an impromptu skipping rope in the dining room.⁴⁸

Main meals were provided by the domestic staff, but supper was the nurses' responsibility, and spaghetti and toast became a favourite. Caring for the children suspected as carriers was partly nursing and partly child-care - the children could be taken on bush rambles to pick wildflowers, or, more pragmatically, to collect wood in winter for the ward heaters.⁴⁹ The care and imagination put into nursing the patients, under such trying conditions, is greatly moving.

In 1927, Dr Everitt Atkinson, the Commissioner for Public Health, had stern words to say about the Infectious Diseases Branch:

it must be pointed out that this institution is the result of a piecemeal accumulation of more or less temporary buildings. The actual beginning of the hospital was in relation to the

⁴⁵Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 18 transcript.

⁴⁶Leschen, *op cit*, p 211, 213.

⁴⁷Interview with Mrs K Loton, Mrs E Joubert and Miss A Smith, by P Martyr, 1993, p 5 transcript; Leschen, *op cit*, p 211.

⁴⁸Leschen, *op cit*, p 211.

⁴⁹*ibid*, p 213.

smallpox outbreak which occurred in 1893. In turn the hospital has been a plague hospital, a meningitis hospital, and an influenza hospital; and to meet the various emergencies in relation to these and other diseases, various wards and other buildings of a temporary character have been erected hurriedly. The result is a heterogenous arrangement of generally unsuitable buildings, some of which have long ceased to have any right to exist as a hospital.⁵⁰

As far as Atkinson could see, there was only one possible course of action. Steps must be taken to plan and build a new infectious diseases hospital “on reasonably modern lines.” Atkinson's words were prophetic. In the same year that Western Australia played host to aviator Bert Hinkley, saw the opening of the Adelaide-Perth air route, and had a visit from the Prime Minister, Stanley Bruce, the Branch Hospital was struck by “one of the most trying winters ever experienced”, wild and stormy weather, and with a double epidemic of scarlet fever and diphtheria. Despite the nursing staff having “managed splendidly”,⁵¹ the Board was forced to take action. A subcommittee was appointed in 1928 to investigate the hospital, and its report roundly condemned the entire site, from the leaking roofs and soaked verandahs to the deep sewerage.⁵²



A view of the Hospital in the 1920s, with verandah blinds down.

From the collection at the Royal Perth (Rehabilitation) Hospital

⁵⁰Western Australia. Medical and Health Department. *Report for 1927*, p 9.

⁵¹RPH BM Min, 31.5.28.

⁵²RPH, AR 1928, p 9; RPH BM Min, 28.6.28, p 4, 26.7.28, p 2.

Unfortunately, waiting just around the corner was the Great Depression, which seems to have hit Perth Hospital even before the Wall Street crash of late 1929. In January 1929, the Financial Committee of Perth Hospital met, and calculated the hospital deficit - £6 671. The Committee went cap in hand to the Minister for Health, Selby Munsie, who was unable to increase the hospital subsidy, although he deplored "the unfortunate financial position of the hospital, and recognis[ed] the seriousness of the situation and [the fact] that drastic steps would have to be taken to make ends meet."⁵³ And those drastic steps were to include the closure of the Infectious Diseases Branch, "in view of the fact that the provisions of the Health Act provide the only statutory authority for the carrying on of hospitals for infectious diseases", leaving it in the hands of the local health authorities, who were to be notified of the hospital's closure. This, it was estimated, would save Perth Hospital about £6 000 per annum, one-fifth of its total grant from the State Government. But more was needed, so two wards at the main hospital were also closed, to save a further £2 000.⁵⁴

The old battle was on again between the Perth Hospital and the local health authorities, this time to the slightly quicker tempo of 8/- a day. The plan to close the hospital on 24 February 1929 had to be extended to 5 March, with the added threat that until the local boards took responsibility for the wards, the Perth Hospital would ensure that no more patients made their way there. By April 1929 there were ninety patients in the hospital, and the bills were mounting. At the £300 mark, and with a deafening silence from the local health boards, all the Hospital could do was threaten to refuse entry to patients from the erring boards' districts.⁵⁵

Dr Ian Thorburn had arrived in Perth on 22 February to become Perth Hospital's Medical Registrar.⁵⁶ A Melbourne medical graduate, Thorburn had worked at the Melbourne, Children's and Women's Hospitals before returning to Western Australia to take up the position of registrar. He left the following year to take up postgraduate study in London at the Royal Chest Hospital, and also became a member of the Royal College of Physicians.⁵⁷ When he returned to Western Australia in 1934 to become Perth Hospital's Medical Superintendent, he took on the responsibility for infectious diseases, and the Branch Hospital.⁵⁸ In 1936 Thorburn went into private practice in Victoria Park, and became the honorary Physician to Infectious Diseases - a position he held until his retirement from that position in 1963, twenty-seven years later.

Health care in 1930s Western Australia could be called the decade of 'hospitals that never were'. The Infectious Diseases Hospital was eventually to be rebuilt, at the close of the decade, but this was achieved only through a combination of luck, hard work and concerted pressure from within the Perth Hospital

⁵³RPH BM Min, 24.1.29, p 4.

⁵⁴ibid, pp 4-5.

⁵⁵RPH BM Min, 26.4.29, pp 6-7.

⁵⁶ibid.

⁵⁷Address given by Dr J B Stokes on the occasion of the naming of Thorburn House, Royal Perth (Rehabilitation) Hospital, 28 May 1986, author's copy.

⁵⁸Conversation with Mrs Pat Thorburn, 27.5.91.

management. Two other hospitals were planned for the metropolitan area in the mid-1930s - a new and separate infectious diseases hospital for Fremantle and its environs, and a large, brand-new orthopaedic hospital for children, to be built by the sea, modelled on Frankston Orthopaedic Hospital in Victoria. Both of these proposed hospitals that never came into being have their fates intertwined with that of the Infectious Diseases Branch at West Subiaco.

There was a new movement in Western Australia's hospital community in the mid-1930s, arising from concern among the philanthropically-minded at the increasing numbers of crippled children in the state. Poliomyelitis did not become a major problem in Western Australia until after the Second World War, but in the 1930s its impact on Australia's eastern coast was devastating. F J Huelin, the under-secretary for health, kept in close contact with his eastern counterparts over the latest developments in poliomyelitis treatment. Among these was the work of a little-known Queensland nurse, Sister Elizabeth Kenny, who was, according to C E Chuter of the Home Secretary's Office in Brisbane, working wonders:

Now with regards to Sister Kenny. The miracle has happened. She has made good with an absolute vengeance. Sister Kenny claimed to me that if her methods were put into operation immediately the disease had abated, there would be no crippled children. In all the years which she has been carrying on her work, all her cases have been cases of long duration, in other words, cases which have long since been declared to be hopeless.⁵⁹



Elizabeth Kenny demonstrates her method

<http://www.thehistorynet.com/NationalHistoryDay/teacher/kenny.htm> - accessed 1998

⁵⁹PHD AN 120/4 Acc 1003 #513, 1935, C E Chuter, Home Secretary's Office, Brisbane, to Huelin, US PHD, 6.10.34, pp 1-2.

Kenny's treatments included abandoning the metal and plaster splints deemed essential to proper poliomyelitis treatment, a move which horrified the orthodox medical profession. Kenny believed that the immobilisation was causing paralysis, not preventing it.⁶⁰ Her practice of what were considered unorthodox methods - hydrotherapy, and the rigorous maintenance of a positive attitude to instil optimism in the patient - was apparently proving successful enough to attract government interest. Kenny had been given permission to set up a clinic in Townsville under medical supervision.⁶¹ The Minister for Health, Selby Munsie, was personally impressed with Kenny's achievement, noting that if these results were correct it was "very remarkable, and very gratifying."⁶²

In June of 1935, a meeting was held at the rooms of Mr Sinclair McGibbon, then president of the Perth Rotary Club, to make plans to care for and treat the growing numbers of Western Australian crippled children. What it actually produced was the Western Australian Crippled Children's Society, and the beginnings of an attempt to register all crippled children in the state.⁶³ Interest in providing a hospital which would, for the most part, be taking in children suffering from the paralysing after-effects of an infectious disease, had once again made it quite clear that the Infectious Diseases Hospital could not cope with any kind of major emergency. It could barely provide adequate acute care and isolation, let alone the long convalescent care needed for those crippled by poliomyelitis. The planned orthopaedic hospital would possibly ease some of the overcrowding experienced by the major metropolitan hospitals.



Would it be a 'Kenny' type of facility? Reg McKellar Hall (left) was a supporter of Kenny and her methods, and if the hospital had gone ahead, it is entirely possible that this would have been the case. In April 1936 he accompanied the new Minister for Health, A H Panton, to the Federal Conference on Crippled Children held in Canberra, where he met Kenny and was impressed by both her attitude and her methods.⁶⁴ Kenny was already incurring the wrath of the Australian orthodox medical profession and the massage profession, and would eventually leave Australia for the United States, where her career blossomed. Raphael Cilento, who had been seconded to the Queensland

⁶⁰Kenny went on to write her autobiography, which details not only her methods but the opposition she faced from Australia's medical establishment. E Kenny, *And They Shall Walk*, London: Robert Hale, 1951.

⁶¹The report of this investigation can be found at the Queensland State Archives, R Cilento, 'Report on the Muscle Re-Education Clinic, Townsville (Sister E Kenny), and Its Work', 24 August 1934. Dr Dungan submitted his report to Cilento, and it appears as an appendix to the main report.

⁶²PHD AN 120/4 Acc 1003 #513, 1935, Huelin to Munsie, p 3. Munsie has annotated the copy of Chuter's letter with this comment, and has signed and dated it as 25.10.34.

⁶³McKellar Hall's reminiscences, op cit, are not entirely accurate on this matter. The meeting in 1935 was held to discuss the establishment of the reconstruction branch of the Children's Hospital, and the discussions which established the Crippled Children's Society dominated the period from 1936-7, during which the reconstruction hospital appears to have been sidelined. Public Health Department File # 513 of 1935 contains a great deal of relevant information on this matter.

⁶⁴McKellar Hall, op cit, p 39. He describes how Dr Harold Crawford, the President of the Queensland branch of the Australasian Massage Association, denounced Kenny in terms which he describes as "worked up and almost fanatical", p 40.

government to report on Kenny's Townsville Clinic, had made the mistake of not damning Kenny immediately, with the result that he was cast as one of her supporters. This was proving embarrassing, and led to explanations such as the following, from Cilento to Atkinson, in December 1935:

Sister is an optimist, and is in the habit of using chance remarks or expressions meant merely as courtesies with perhaps an undue significance, and has quoted me in several places as the strong advocate of her work.⁶⁵

Cilento nonetheless wanted this information kept confidential unless his views on Kenny were called into question in Atkinson's presence.

But the hospital never came into being, either before or after the Second World War. The Children's Hospital would not proceed with any work on the reconstruction branch because the State government would not commit itself to providing continued financial support for the proposed hospital.⁶⁶ It had perhaps learnt from the bitter experience of Perth Hospital and its Infectious Diseases Branch, forced to pursue each missing shilling through a maze of conflicting authorities and responsible bodies.

So if the children's orthopaedic hospital - clearly wanted and needed - never came into being, what hope was there for the Infectious Diseases Branch at West Subiaco, a hospital which had no public sympathy and no current cause with which to associate itself in order to raise money and improve the site? A combination of elements allowed the Infectious Diseases Hospital to triumph where more popular causes failed - one, paradoxically, its dreadful conditions. It may have been only just standing, but it was, nonetheless, standing. And a hospital which already exists has a small advantage, in times of tightened belts and reduced government spending, over any number of paper hospitals, which can represent nothing but financial risk.

At the end of November 1932 fire once again partially destroyed one of the unoccupied wards, which placed even more pressure on the Hospital's ability to accommodate future outbreaks of infectious disease.⁶⁷ The *West Australian* produced a telling condemnation shortly after this, by 'Hygiene'.

The main drive - a sand and gravel affair - takes one to the administrative building. Low, built on ground level, and with walls, roof and some ceilings composed of corrugated iron (of a dingy white and only too obviously showing signs of extreme

⁶⁵PHD AN 120/4 Acc 1003 #513, 1935, Cilento to Atkinson, 13.12.35, p 28. Includes copy of letter from himself to Dr Ruth Gault, Committee for Combatting Infantile Paralysis, Adelaide. Other Kenny-related material in this file includes a copy of the 'First Report By the Committee Inquiring Into the Results Obtained at the Elizabeth Kenny Clinic for the Treatment of Paralysis at the Royal North Shore Hospital', pp 72-82, and two newspaper clippings from the *West Australian*, one dated 20.4.37 and the other undated, on pp 88-9 of this file.

⁶⁶PHD AN 120/4 Acc 1003 #513, 1935, Gen Sec CH BM to Johnston, 8.3.41, pp 211-12.

⁶⁷RPH BM Min, 22.12.32, p 6.

old age) this portion of the hospital houses the matron's office, resident doctor's quarters, ... kitchen and nurses' dining room. These rooms are connected by small and almost completely dark passages.⁶⁸

The kitchen managed to keep up the fight with little encouragement:

With few windows giving insufficient light and blackened, tin walls which, in places, were rusted almost through, this kitchen yet managed to show a cleanliness which spoke eloquently of hours of extra work done in an endeavour to make the best of a very bad job. Tables, utensils, pots, pans and crockery were spotless and the wooden floor, though uneven, bore a well-scrubbed appearance.⁶⁹

The walls of the wards (corrugated iron, of course) are painted green, of a somewhat pale and bilious hue. Verandahs surround them, and from here patients sufficiently interested may watch the men on the sewerage works, or from another angle gaze on the inspiring sight of the charred remains of [a] portion of the hospital, which was destroyed earlier in the year.⁷⁰

Not surprisingly, the overall opinion of the journalist was damning:

Here it is that hundreds of patients, mainly children, recover from serious complaints yearly. After an informal visit to the institution yesterday, one was forced to the conclusion that only the excellence of the nursing standard and the well known recuperative powers of children are responsible for this state of affairs.⁷¹

Instead of making temporary allowances yet again, the Medical Superintendent and Dr Barker were now both recommending that a new Infectious Diseases Hospital be built, this time along permanent lines. By January 1934 they had triumphed. The Public Health Department had been persuaded of the desperate need for a new Hospital, and Atkinson now had the Chief Architect, Mr A 'Paddy' Clare, drawing up possible plans for the site.

Any plans to build a new Infectious Diseases Branch had to involve the local health boards, and predictably this led to disagreement and trouble. The meeting of the Perth Hospital Board of Management turned acrimonious when it learned that the Perth City Council had "declined to contribute its quota towards the building of a new Infectious Diseases Hospital."⁷² All seemed to agree that

⁶⁸Infectious Diseases - Impressions of the present 'Hospital', by 'Hygiene', *West Australian* (?), c 1933, Battye Library Ephemera Collection, PR 11336.

⁶⁹ibid.

⁷⁰ibid.

⁷¹ibid.

⁷²RPH BM Min, 31.5.35, p 5.

the Hospital needed to be rebuilt in a modern form, except for one man - Dr Michael O'Connor, by this stage in his sixties and a consulting physician at Perth Hospital, who made his opinions known on a visit to the site in February 1935, in the company of the Perth City Council's Town Clerk.⁷³

Patients defaulting on their fees were as epidemic as any infectious disease. So the Minister for Health circulated a proposal, settled on 7 May, that the Infectious Diseases Branch be handed over to the local councils at the end of three months, in August-September 1935.⁷⁴ The Perth Hospital was shocked into action, and distanced itself from this decision as far as possible, moving that the main hospital, "realising the position in regard to the patients in that hospital, decline to accept the responsibility of so closing the Infectious Hospital".⁷⁵

There was no doubt something had to be done, and soon - nurses were falling ill with diphtheria, despite encouragement to be immunised against the disease. Four of the five staff members who contracted diphtheria in the previous twelve months were found to be not immunised against the disease.⁷⁶ But still nothing had been settled - apart from the name of the new Hospital. The characteristic clutching at small details, when all around major matters were seriously out of order, manifested itself once more - a request had already been sent to Buckingham Palace to ask if the new Infectious Hospital could be named after the late King, George V.

Still nothing was done. The Infectious Diseases Hospital remained, as Atkinson had described it, a piecemeal accumulation of buildings, while the local authorities met and re-met, arguing and debating. Two members of the Perth Hospital Board met with local councillors on 26 July 1936, at which no resolutions were permitted, and "the delegates left the meeting in a state of dejection."⁷⁷ The Councils wanted the Hospital to take all responsibility, and, preferably, all the expense as well. Once again, desperate threats and an ultimatum ensued:

that in view of the delay in arriving at a decision in respect to the provision of a new Infectious Diseases Hospital by the Local Governing Authorities, and the impossibility of the Board of Management of the Perth Hospital to carry on the administration of the present hospital with any degree of satisfaction, either to the hospital or to the public, notice be given to the Local Authorities of the intention of the Board to relinquish control of the hospital in its present state as from the 31st December 1936, and that the Secretary be instructed to circularise the Authorities accordingly.⁷⁸

⁷³RPH BM Min, 28.2.35, p 3.

⁷⁴ibid.

⁷⁵RPH BM Min, 25.7.35, p 2.

⁷⁶ibid.

⁷⁷RPH BM Min, 6.8.36, p 2.

⁷⁸ibid.

Yet by February the following year, the Hospital was still open, and still doing a brisk trade in infectious patients. What had, for once, gone right?

What seems to have saved the Infectious Diseases Hospital was its proposed rival at Fremantle. The plans for the children's orthopaedic hospital were not the only currents stirring in the hospital community, this time south and west of Perth. The Town Clerk of Fremantle was seeking information about a certain block of land at the corner of Attfield and Fothergill Sts, with of course the proviso that "It must be understood that the question has not yet been definitely decided as to whether the hospital will be erected ...".⁷⁹



The original infectious wards at Fremantle Hospital c.1919

Garrick and Jeffrey, *Fremantle Hospital: a social history to 1987*, Perth: UWA Press, 1988

Fremantle Hospital was the obvious base from which another infectious diseases hospital could be run. The new hospital could be built as a group of wards practically next door to the Fremantle Hospital, unlike the comparatively distant West Subiaco branch hospital. It could serve southern local health boards and coastal suburbs, with the Perth Hospital controlling what had now become the inner city area and metropolitan suburbs.

But there were other reasons behind this move as well. Fremantle Hospital, from its official opening as a public hospital in 1897, had been woven into the complex pattern of port-capital relations - the relationship between Fremantle and Perth. Part of this pattern worked itself out in medical practice. Fremantle medical practitioners seem to have developed and maintained an identity separate from that of the Perth medical community, with their own patterns of social relations and medical partnerships. Their hospital, at which honorary

⁷⁹PHD AN 120/4 Acc 1003 #253, 1936, TC Frem to J B Sleeman, MLA, 12.3.36, p 2. In modern Fremantle, Attfield and Fothergill Streets no longer form an intersection: the land was resumed for extending Fremantle Hospital, during which part of Attfield St was closed.

service could be performed, was at The Knowle, not at the top of Murray St.⁸⁰ The question of a Fremantle infectious diseases hospital was a small but significant challenge to the central health care authority.

The Fremantle City Council planned to go ahead with the hospital, if they could secure the Commissioner for Public Health's blessing.

As the Fremantle City Council Local Authority has at all times been desperately anxious to promote the provision of proper Hospital accommodation for Infectious cases, will you indicate generally what action you propose to take to see that the provisions of the Health Act, in regard to this important work, are carried into effect.⁸¹

Everitt Atkinson saw the choice before him:

A new hospital for the metropolitan area is sadly needed and I would prefer that there should be one hospital to deal with cases for the whole of that area, rather than that two or more such hospitals should be set up ... Should it happen, however, that a comprehensive scheme for the metropolitan area proves to be out of the question, I would feel it impossible to refuse approval, if a scheme, otherwise acceptable, were submitted by the Local Authorities in the Fremantle area.⁸²

So the plans were drawn up, and immediately faced the firing line in the form of F J Huelin, the under-secretary for Public Health. Huelin opposed the Fremantle scheme tooth and nail, in favour of a centralised infectious hospital based in the Perth area. He advised the Minister for Public Health that the Fremantle scheme was not a wise one - "from a hospital point of view there are several holes in it, as you will see if you care to read my long letter to the Fremantle Hospital dated the 30th October."⁸³ So in early January Atkinson wrote to the Fremantle City Council.

[A]s you know the feeling of the Hon. Minister of Public Health and of the Department is that it is very much preferable for one infectious hospital for the whole metropolitan area to function rather than for the infectious work to be split amongst two or more units.⁸⁴

Support for the Fremantle scheme began to fall away, and it was abandoned by April.⁸⁵

⁸⁰P Martyr, "Such an amicable number of doctors': Fremantle doctors and honoraries, 1880-1914", *1991 Western Australian Intersociety Barebones Symposium, Proceedings*, 1992, pp 29-34.

⁸¹PHD AN 120/4 Acc 1003 #253, 1936, TC Frem to CPH, 15.8.36, p 7.

⁸²PHD AN 120/4 Acc 1003 #253, 1936, Atkinson, CPH to TC Frem, 21.8.36, p 8.

⁸³PHD AN 120/4 Acc 1003 #253, 1936, US PHD to Min PH, 23.11.36, p 26. There are articles from the *West Australian* on the matter in this file also, WA 14.12.36, 16.12.36, 21.3.37, pp 30-1, 35.

⁸⁴PHD AN 120/4 Acc 1003 #253, 1936, CPH to TC Frem, 12.1.37, p 33.

⁸⁵PHD AN 120/4 Acc 1003 #253, 1936, no page given, WA 9.3.37.

So the Infectious Diseases Hospital at West Subiaco stayed open, thanks in part to the collapse of the Fremantle plans. The collapse of these plans was greatly assisted by F J Huelin, who in 1939 became Chairman of the Board of Management of Perth Hospital. The only reminder of the failed project was that from 1937, nurses at Fremantle no longer had to go to the Subiaco Infectious Diseases Branch for their infectious diseases training, as experience at Fremantle was considered sufficient.⁸⁶

From the end of the First World War, the Hospital had had to battle for money, equipment and space to accommodate patients. The Perth Hospital did its best under trying circumstances - non-payment of bills, rack and ruin, and sudden debilitating epidemics which could take the nursing staff with them - to keep the Infectious Diseases Hospital at least open. They could not afford to do otherwise - closing the Hospital would have brought the infectious cases back to Perth, which simply could not accommodate them. The six shillings a day, which theoretically kept the wolf of bad debts from the door, simply never worked as a means of maintaining patients, and had set the pattern for acrimonious relations between the Perth Hospital and local government in future years, permeating the 1920s and 1930s. The plans for a new Infectious Diseases Hospital were getting under way at long last, but under the approaching shadow of another world war.

⁸⁶Garrick, Jeffrey, *op cit*, p 224.

Chapter Four: The Metropolitan Infectious Diseases Hospital

The Branch was a ruin, but the fact that it had always been that way was part of the trouble. Familiarity may not have bred contempt, but it did breed tolerance and resignation. It took a pair of outside eyes to bring the appalling state of the Branch home to the authorities. Dr Roy Le Page Muecke was appointed Medical Superintendent of Perth Hospital in 1937, and his involvement with the Infectious Diseases Hospital was to be a full and often controversial one.¹ The management of Perth Hospital had undergone some shaking-up itself in 1936, when the fourteen-member board was disbanded and reconstituted into a five-member Board of Governors. The state government put the Hospital on a regimen of £55 000, which would cover wages and salaries. The rest of the expenses, about £30 000, would have to come from patients' fees, donations, public appeals and the repatriation subsidy received by the Perth Hospital.²



Muecke (left) was appalled by what he found at the Infectious Diseases Hospital: "At present in the old hospital the outlook is dreadful - there is rubbish everywhere."³ The budget cuts constantly effected, usually concerning the future Hospital, also frustrated Muecke terribly. The money for the project was continually reduced until "Mr Clare [the Principal Architect] has had to build a hospital of 90 beds, as well as provide for its equipment, with £40 000. With this amount, it is obvious that such a hospital of such dimensions could not be built and properly equipped."⁴ Muecke had a few other bones of contention to pick with the overall management of the Infectious Diseases Hospital:

in this State ... patients who are isolated at the Infectious Disease in order to prevent their being a source of danger to the rest of the community, have to pay 9/7d. per day for this privilege. It is not right that these patients should be forced to be nursed in a hospital where the equipment is inadequate and/or second class.⁵

The Board Meeting of 9 December 1937 was a crucial one, at which Muecke courageously outlined every single detail of the mess that was the Infectious Diseases Hospital. He accused the authorities of skimping on equipment, one of the "aspects which will still be left on our hands despite the new buildings."⁶ He had lists drawn up by the Public Works Department of the equipment that would

¹RPH BM Min, 11.3.37, p 1.

²Bolton, Joske, op cit, p 124.

³RPH BM Min, 9.12.37, p 11.

⁴RPH BM Min, 21.10.37, p 2.

⁵ibid.

⁶RPH BM Min, 9.12.37, p 7.

be supplied and the repairs necessary. Muecke was a staunch supporter of the Sub-Matron of the Branch Hospital, Sister Elizabeth Spring, and enumerated her duties as he saw them: "Matron, Night Superintendent, Sister, Housekeeper, Resident Medical Officer."⁷ By this stage, the Board members may well have been shifting uncomfortably in their seats, but Muecke was relentless.

There is only one conclusion I can come to and that is the Infectious Diseases Branch, through the continued ignorance and false economy of the bodies responsible for providing the money is following in the footsteps of the Perth Hospital.

Who was to blame? Not the Principal Architect - "Mr Clare knows my opinions, but asked me to let things go on and get something done before it could be stopped or held up another ten years."

Muecke also submitted a report to the Public Health Department complaining of the unsanitary state of the Infectious Diseases Hospital. "Should any of those persons responsible for the health of the community visit the Infectious Diseases Branch as it stands today" he thundered,

they will see children, despite their mosquito nets, just a mess of itching weals, traumatised by the child's nails and in many cases infected; they will see flies abounding on the meal plates, on the corners of the eyes and mouth, in the nose of these children as they eat their meals. In any community it is not a pleasant sight, but in an infectious diseases hospital it is a filthy sight. The flies are about this hospital in their multitudes ... The site was not wisely chosen in the first place."⁸

The old wards themselves were equally repellant: "Despite the march of hospital progress, for the last fifteen years not one change has been made; not one coat of paint has brightened their dinginess or expelled their dirt." The Hospital stood at West Subiaco "as a condemnation of those responsible health authorities, as a proof of culpable casualness towards the sick of an infectious disease, who are forced to be isolated in these dismal surroundings as a means of protection of the community as a whole."⁹

He won a small victory. At the 9 December meeting, the Board, impressed by Muecke's outrage backed up by hard evidence, moved to have the Hospital properly equipped and to arrange for more nursing staff, and for another special meeting of the Board to decide upon the future of the Infectious Hospital.¹⁰ Muecke had Spring's support, and the Special Meeting confirmed once more that the new hospital should be equipped as the Matron and Medical Superintendent recommended.¹¹ Another special meeting was held in January 1938, attended by the Board, Muecke, the Lord Mayor of Perth and Mr Clare,

⁷ibid, pp 10-11.

⁸PHD AN 120/4 Acc 1003 #6675, 1962 , Muecke's report on state of site, 30.12.37.

⁹ibid.

¹⁰RPH BM Min, 9.12.37, p 14.

¹¹RPH BM Min, Special Meeting, 13.12.37.

the architect. The £40 000 budget remained, despite pleas for the consideration instead of a more realistic £80 000. The local governing bodies were in favour of the more expensive plan, and resolved to carry the costs of equipping the hospital properly. The meeting agreed that “it was better to bring the new 90-bed unit up to a standard” instead of spreading the resources more thinly over the entire site.¹²



Proud nursing students and sisters at the porch of the new Hospital. L-R, rear: Sister Molly John, Sister Appleton, Sister Melrose, Nurse Johnson. L-R, front: Nurses Butcher, Leahy, Palmer and Scarlett.

From the collection of Kathleen Johnson.

What were the local bodies going to get for their money? A building of an almost star-shaped design at ground floor level, with second stories on some wings. It also got a new name - the new Hospital was being paid for by the state government and the local health authorities, and was thus called the Metropolitan Infectious Diseases Hospital. But old habits die hard, and the nickname of the site as 'IDB', which comes more easily to the lips than 'MIDH', tended to stick.¹³

By June 1938, the new Hospital was still nowhere near completion. Muecke was furious, and submitted a lengthy report to the Board. Not only was the Hospital already three months behind schedule, but “I have it on good authority that at least another three months will pass before we may think of occupation.”¹⁴ What was worse was that overall there was so little improvement - “The depression that the dinginess and dirt of the old infectious disease

¹²RPH BM Min, 4.1.38, pp 1-2.

¹³Throughout this work, which is a history of the treatment of infectious diseases at the site, and later its rehabilitative role, we have used the name 'MIDH', unless quoting directly from RPH sources, which continue to call the hospital 'IDB' or 'the Branch'. The role of the local authorities has been integral to the Hospital's development, and this is more honestly reflected in the title 'MIDH'.

¹⁴RPH BM Min, 2.6.38, p 3.

hospital gives one is only equalled by the depression that a viewing of the new hospital causes."¹⁵

The Infectious Diseases Hospital had, in its early years, trained three future matrons, and now a fourth was added to the list. Kathleen Johnson began her nursing training in December 1938, and went on to become Matron of Perth Hospital in 1962, and then Director of Nursing from 1975-1978. She described the life of a trainee nurse at the MIDH:

The nurses' quarters consisted of a row of rooms in a long wooden building with a corridor down the outside I cannot recall them having any amenities whatsoever. I can't remember a sitting room or a pantry or any amenities. Our working conditions were pretty stringent. As staff at an infectious hospital, we had to have Lysol in our baths, and wash our hair with Lysol in the water before we left the building, so we didn't go out that much!¹⁶

Living-in was an essential part of nursing training: "It was fun - we were like a big family and we made our own fun. We made friendships that have lasted a lifetime. Because there is something to be said for living in - there was a closeness. You shared your problems. I think there is a great deal going for it."¹⁷



Trainee nurses in 1939-40 at the new MIDH. L-R, rear: Nurses Butcher, Johnson, Staff Nurse Bessie Wilmott (later killed on Banka Island during WWII), Nurses Georgie Clark and Betty Ross. Front: Nurse Eleanor Moir.

From the collection of Kathleen Johnson.

¹⁵ibid.

¹⁶Interview with K Johnson, by P Martyr, 1991, pp 1-2 transcript

¹⁷Interview with K Johnson, by P Martyr, 1991, p. 6 transcript.

And there were the same old problems at the Hospital, all of which were being aggravated by the new buildings, particularly in its administration, about which Muecke was emphatic:

My own view of the state of affairs at IDB is that inefficiency, laxity and the refusal of those responsible to face facts is a scandal which should be made public.¹⁸

Under the Muecke onslaught, wheels did turn, but slowly. The issue of the Nurses' Quarters was to be taken up again. The reason Muecke was so concerned with this issue was that, because of the overcrowding, nurses were sharing rooms, which was spreading the inevitable infections among the staff. A nurse who worked at the site described the situation:

I can remember when I came back from Melbourne, the Matron came out (to IDB) and was doing a round with me. I can remember her saying (and I had been at one of the leading Melbourne hospitals) - 'Sister, I feel terrible sending you out here' ... The lavatory was just sitting in the bush, it was terrible, without a cover, just a toilet sitting in the bush.¹⁹

Finally Sister Spring could take no more, and tendered her resignation. Sister Railton carried on in an acting capacity, and Molly John put in an application for the position, being appointed Charge Sister in August 1938.²⁰ Rosalind Denny, a young trainee nurse at the time, recalls her as being rather dragonish - Denny left some gristle on her plate once, and John reprimanded her, reminding her that good nutrition and care of her own health was vital at an infectious diseases hospital. Denny was sent to pick figs for fig jam as a punishment.²¹

Problems with the new infectious diseases hospital, even before its completion, were numberless. What should have been insignificant details, such as the ward chairs for the Hospital, became sources of constant stress to Muecke, and therefore to the Board. Muecke had asked for simple tubular metal-type chairs, which could be wiped clean easily and effectively to prevent cross-infections, and which would be long-lasting. But the Tender Board wished to unload a stockpile of cheaper wooden chairs, totally contrary to Muecke's specifications, on to the Hospital.²² Again, Muecke's desire for "true economy", saving future expenses by providing the right material as soon as possible, clashed head-on with faceless bureaucracy - "there seems to be no responsible head in the whole sorry affair".²³

Despite all the problems, Muecke was able to report that

¹⁸ibid, p 4.

¹⁹Interview with Mrs E Joubert, Mrs K Loton and Miss A Smith, by P Martyr, 1993, p. 8.

²⁰RPH BM Min, 25.8.38, p 5; Leschen, op cit, p 213.

²¹Conversation with R Denny, by P Martyr.

²²The details of this fracas can be found in PHD AN 120/4 Acc 1003 #6675, 1962, pp 149-157.

²³RPH BM Min, 13.12.38, p 4.

The new building in this block is now nearing completion, and I look forward to our being able to move in early in the new year. Christmas preparations are being made in the old wards, and all will be ready for the visit of Santa Claus on Christmas Day.²⁴



Santa Claus at MIDH, c1944.

From the collection of Kathleen Johnson.

Christmas Day at the Metropolitan Infectious Diseases Hospital throughout the war years was always a special occasion, especially for the children away from their homes. It was also very special for the staff, as it was the one day of the year they had to show the best face of the often-notorious Branch to the Board of Management. Almost all the Perth Hospital sisters, administrative staff, F J Huelin, Matron Gertrude Siegele, and Muecke, all came down from the main hospital at about 11am in taxis. Molly John, in charge of the site, had everything running like clockwork - "They donned carefully saved and selected clean gowns and trailed around the decorated wards with Santa Claus, who gave gifts to each patient, chatting cheerfully as they went." Then it was photo time, on the front porch of the new building, and then the visitors went back to the main hospital for Christmas dinner, while those at the MIDH turned to serving Christmas dinner to their own staff. One year,

the resident doctor stayed and had dinner "happily seated in the centre of a crescent of nurses, rather than dine alone in the Medical Officer's quarters."²⁵

By early 1939, the new Metropolitan Infectious Diseases Hospital was ready for occupation. There was to be no official opening of the Hospital, as the Local Government Association did not consider it necessary. The staff simply spent a week in February 1939 moving premises; a hot and hard-working week during which Molly John lost half a stone which she never had time to regain.²⁶ The patients were transferred on 8 February, and the next day the Board confirmed John's position as Assistant Matron in charge of the site.²⁷ The first week at the new building was a nightmare - nursing and domestic staff fell ill, and there were drastic staff shortages. By arranging for six beds on verandahs and using every room for two nurses instead of one, more could be housed, and Muecke had to ask Clare to arrange for the verandahs to be made weather-proof.²⁸

The isolation experienced by the live-in trainee nurses a decade earlier was just as intimidating in the late 1930s:

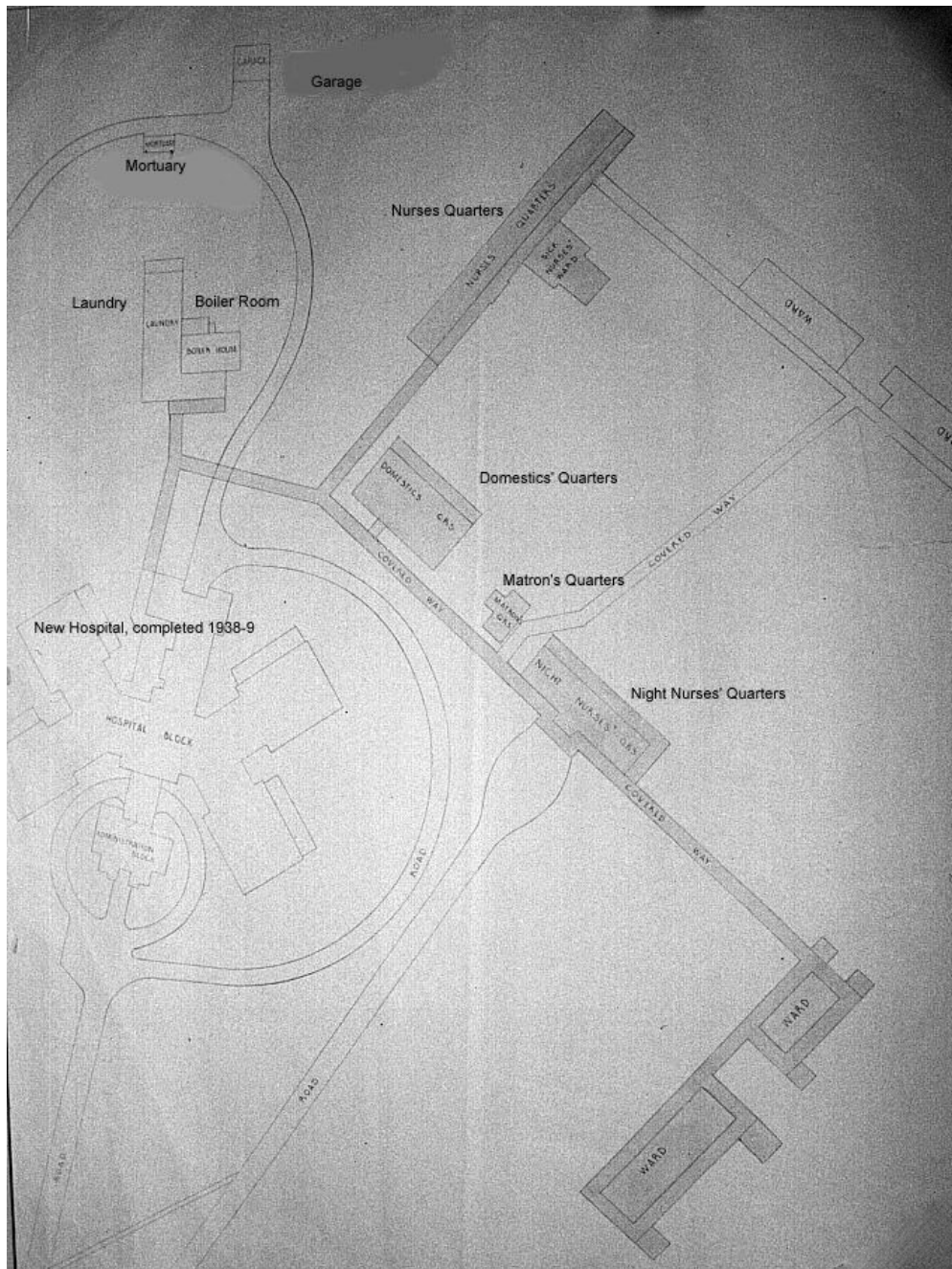
²⁴ibid, p 6.

²⁵Leschen, op cit, p 216.

²⁶ibid, p 213.

²⁷RPH BM Min, 9.2.39, p 3.

²⁸RPH BM Min, 23.3.39, p 4.



Photograph of Public Health Department plan of the proposed new hospital, showing its relationship with the existing 1897-1920s hospital site.

The Night Nurses' Quarters is the old administration block from the original hospital (the site of the present-day radiology building and operating theatres), while the laundry and boiler room are on the site of the present-day C Block.

Present-day occupational therapy and physiotherapy blocks are on the site of the old wards from the 1920s hospital, in the bottom right of the photograph.

We had to be in by ten o'clock at night if we were on day duty, and it usually meant walking down a long catwalk from the Shenton Park station That was bush everywhere We used to walk almost to City Beach through the bush. But that was just at the back of the Hospital. It was very isolated but very beautiful. It was a bit scary in the quarters because there was nothing between you and the bush. You couldn't lock your doors.²⁹

Rosalind Denny recollected a time when a strange man was found sleeping on the verandah of one of the buildings.³⁰ On the other hand, there were consolations. "It was good really. We felt that we were going on holidays as far as the surroundings were concerned, you were out in the bushland and it was quite relaxing."³¹ This is notwithstanding the rigors of nursing education at the same time –

we had to go to the lectures when we were on duty, or get special permission if we were on duty but if we were on a day off we had to come back for the lectures ... we would just have to go, or get up from night duty to go to lectures if it clashed with night duty.³²

The customary mischief seems to have been got up to, practically identical to John's own trainee days at IDB - Rosalind Denny had a unique method of lighting difficult wood, which involved draping a lot of paper in its vicinity. She was teaching this technique to a fellow trainee when the chimney caught fire. Molly John promptly arrived with a workman to put out the fire, and caught the trainee - Denny had escaped.³³



Better days for Rosalind Denny (centre) with Eleanor Moir (left) and Letty Lee (right).

From the collection of Rosalind Denny.

²⁹Interview with K Johnson, by P Martyr, 1991, p 2 transcript.

³⁰Conversation with R Denny, by P Martyr.

³¹Interview with Mrs B Bell (nee Ross), by P Martyr, 1991, p. 1 transcript.

³²Interview with Mrs B Bell (nee Ross), by P Martyr, 1991, p. 4 transcript.

³³Conversation with R Denny, by P Martyr.

With mounting debts snapping at their heels, and furious at the Minister for Health for his perceived refusal “to grant any more money for the proper carrying on of the institution”, the entire Board of Management of Perth Hospital resigned in protest.³⁴ This came in the wake of a meeting with A H Panton, the Minister for Health, who had savaged the Board's performance in the management of the Perth Hospital. Having followed Muecke's lead in resigning, the Board members spoke warmly of their good relationship with the Medical Superintendent, and of how “his advice to them had been listened to with attention and due regard to his recommendations”, if not always with the greatest of enthusiasm.



Trainee nurse Kathleen Johnson in front of the newly-completed MIDH, c. 1939

From the collection of Kathleen Johnson.

Panton entrusted the Perth Hospital to a three-member committee consisting of F J Huelin, the under-secretary for Public Health; Everitt Atkinson; and A J Reid, representing the Treasury.³⁵ Once the matter was settled with the state government, business continued as usual.³⁶ The main hospital was slowly being rebuilt, creating a new building at the top of Victoria Square, opposite the Roman Catholic Cathedral. The turmoil this created was worrying Muecke, concerned as always for the welfare of the staff under his command. The bad old days of the Perth Hospital were, he decided, to be put behind it, and this new main building could mark the beginning of some major changes in organisation and morale.

³⁴RPH BM Min, 16.6.39, p 1.

³⁵Bolton, Joske op cit, p 129.

³⁶This is outlined in Bolton, Joske op cit, p 129.

Problems at the Infectious Diseases Hospital at this time were simply a reflection of those at the main hospital, but with less attention paid to them. Wartime had again brought military cases of infectious diseases, this time mumps and measles.³⁷ Muecke himself always came to the Infectious Diseases Hospital whenever he was needed, if the nurses were concerned about a particular patient, or if there was no resident available at the site:³⁸ “Sometimes if they didn’t have a resident doctor there, if there was an emergency he had to rush out for trachys.”³⁹ Molly John later recollected that Muecke “was loved by everyone both as a friend and counsellor, giving fully of his time and interest to IDB, so that he really was the Chief figure there, working with us as a team.”⁴⁰ He was in the habit of making a full round of the Metropolitan Infectious Diseases Hospital each Wednesday afternoon and on Sunday mornings, and the children would be washed, brushed and beribboned in preparation for his visit.⁴¹



Trainee nurses enjoy the 1940s sunshine in the bush near the MIDH

From the collection of Kathleen Johnson

³⁷RPH BM Min, 20.3.40, p 3; 27.8.40, pp 3-4.

³⁸RPH BM Min, 25.7.40, p 2; Leschen, op cit, p 216.

³⁹Interview with Mrs E Joubert, Mrs K Loton and Miss A Smith, by P Martyr, 1993, p. 6 transcript.

⁴⁰Leschen, op cit, p 215.

⁴¹ibid.



Trainee Nurse Bessie Ross picking wildflowers in the bush around the MIDH, c. 1940

From the collection of Kathleen Johnson.



Nurse Gloria Williams with a tiny patient at the MIDH.

From the collection of Kathleen Johnson.

In September 1940, a year after the outbreak of war, measles became epidemic in Western Australia, closely followed by cerebro-spinal fever. Muecke emptied the convalescent wards of the Metropolitan Infectious Diseases Hospital in preparation for the epidemic of measles, which came with dangerous complications such as pneumonia. Cerebro-spinal meningitis was no laughing matter - Molly John recollected that it was "hard work requiring concentrated

attention to patients and a high degree of nursing skills, as well as eternal vigilance for the protection of nurses."⁴²

The meningitis patients were housed on the top floors of the building, and both adults and children were difficult - the children would refuse to take the new sulphonamide compound '693', which came in large and nauseating tablet form. Kathleen Johnson described it as "very effective in the treatment, but had dreadful side effects. You can't get patients to keep it down and it takes the ingenuity of the nursing staff to devise ways and means for anyone to keep the stuff down."⁴³ The adults could attack nurses –

a sturdy male patient was found standing in the doorway of a single room with each arm firmly round the necks of two nurses who were valiantly holding him back. At sight of Sister, he dropped them and slipped to the far corner of the room, dragging the bed across as if for protection, while a relieved little nurse rang for Doctor, none the worse for the ordeal.⁴⁴



Masked nurses during the meningitis epidemic of 1940-41: L-R: Nurses Plenderleith, Urquart and Johnson.

From the collection of Kathleen Johnson.

⁴²Leschen, op cit.

⁴³Interview with K Johnson, by P Martyr, 1991, p. 5 transcript.

⁴⁴Leschen, op cit.

As 1940 drew to a close, sarcasm dominated the Board meetings. A recent collection of £95 worth of infectious diseases fees from military patients had eased the financial strain a little, but “the decrease in the payments made by the Local Governing Bodies is due to the small number of notifiable cases at the Infectious Diseases Branch as compared with the large number of cases for which they will not accept responsibility.”⁴⁵ A week later, Muecke was too ill to continue to work as Medical Superintendent, and Dr Lawson Smith was appointed as his temporary replacement. The Board knew what had pushed Muecke over the edge - “his onerous duties under abnormal conditions had contributed to his sickness”, and Huelin argued that extra honorary attendance at the MIDH would have obviated the need for Muecke to be down at the Branch treating patients.

Muecke did not recommence work until June of 1941.⁴⁶ When he did, it was with a gesture that rocked the Board - he refused his pay-rise. Muecke had been due for a salary increment, and turned it down because “he did not need the money and ... the hospital would be passing through difficult times and he felt that this was the least he could do to alleviate matters a little.”⁴⁷ Within a month he was back to forcing the Board to improve matters for the MIDH, refusing to allow the old ambulance to take patients to the convalescent wards at the Branch because it was not fit for the road.⁴⁸ Wartime stringencies made the Hospital even less appealing:

During the war years we were only allowed to use the hurricane lanterns and we had those shielded so we didn't get much light on our path. There was an old chap who used to come in every now and then to shoot the rats, and he always seemed to do it at night. He had a peg leg. He was always giving us frights, you would hear this clomp, clomp, clomp down the ramp at night when the rat shooter arrived.⁴⁹

Diphtheria nursing with limited light was a nightmare - Rosalind Denny recalls the difficulty of checking the throats of diphtheria sufferers to see if the membrane that formed across the throat had disappeared. With only dim torches or hurricane lamps, this was practically impossible to the nursing-trained eye.⁵⁰

The manager of the Hospital, W M Powell, reported that “additional accommodation for 30 patients was provided” by extensions at the Metropolitan Infectious Diseases Hospital.⁵¹ By March 1943, some of the child patients had to share beds, and two nurses were sick with scarlet fever.⁵² It was also in 1943 that the fence surrounding the Metropolitan Infectious Diseases Hospital

⁴⁵ibid, p 2.

⁴⁶RPH BM Min, 19.6.41, p 1.

⁴⁷ibid, p 11.

⁴⁸RPH BM Min, 10.7.41, p 3.

⁴⁹Interview with Mrs B Bell (nee Ross), by P Martyr, 1991, p. 3 transcript.

⁵⁰Conversation with R Denny, by P Martyr.

⁵¹RPH BM Min, 17.11.42, Report on Edward Millen Home, p 1.

⁵²RPH BM Min, 18.3.43, p 4.

was finally made stock-proof, so there would be no more visits, diurnal or nocturnal, of wandering cows and horses.⁵³ This did not stop trainee nurse Rosalind Denny being terrified one night when a horse put its head through the kitchen window.⁵⁴

The debate over the compulsory or voluntary status of diphtheria immunisation had already received considerable attention. The Road Board Association's secretary had written to Huelin in 1940, asking that diphtheria immunisation be made compulsory, and Atkinson had had to inform Huelin that there was no civilised nation in the world which had compulsory immunisation against any disease.⁵⁵ Vaccination laws had proved unenforceable, and not since the days of the smallpox epidemic in Western Australia - which had revealed the extent of the unvaccinated population, despite the laws of the state - had there been any real attempt to do so.

By August 1943, the numbers of diphtheria cases at the Metropolitan Infectious Diseases Hospital had increased, especially severe and fatal cases, which could have been avoided with immunisation - as Muecke pointed out, diphtheria was a preventable disease.⁵⁶ Anti-toxins had reduced the mortality rate by up to 80 per cent, but the incidence continued to be high. Muecke provided the figures for the Metropolitan Infectious Diseases Hospital over the last five years (see Table 4.1.) Diphtheria immunisation was at this time a complicated procedure, involving one injection to test for allergies and reactions, and then a number of repeat injections over a period of months. Even then, it would not necessarily guarantee full immunity, but would at least ensure that the child would contract a less virulent form of the disease.

Table 4.1

Diphtheria and Immunisation at the Metropolitan Infectious Diseases Hospital, 1938-1943

Year	Immunised	Not Immunised
1938-39	33 - 1 death	406 - 8 deaths
1939-40	16	227 - 7 deaths
1940-41	42 - 1 death	302 - 9 deaths
1941-42	40	306 - 11 deaths
1942-43	41	470 - 17 deaths
Total	172 - 2 deaths	1 711 - 52 deaths
Mortality	1.2%(approx)	3%

⁵³RPH BM Min, 6.5.43, p 2.

⁵⁴Conversation with R Denny, by P Martyr.

⁵⁵PHD AN 120/4 Acc 1003 #573, 1942, Sec RBA to US PHD, 23.9.40, p 1; Atkinson to US PHD, 2.10.40, p 2.

⁵⁶RPH BM Min, 5.8.43, p 3.



Nurses coming off night duty at MIDH c. 1940. Top photo: Margaret Bird, Diana Davey, Eileen Brady, Kathleen Johnson, Bernice Sutton, Joan Trappit.

Bottom photo: Bernice Sutton, Kathleen Johnson, Joan Trappit, Bessie Ross, Eileen Brady, and Diana Davey (later Muecke).



From the collection of Kathleen Johnson.

The situation for local councils was not as dire as they would have the Perth Hospital administration believe. If a local board would establish a clinic where numbers of children could be immunised at a given time and place, the Public Health Department would supply 'Anatoxin', the serum used, free. The Local Board of Health had to provide needles, syringes and cotton wool, and pay a doctor £1/1/- per hour for the work, as approved by the British Medical Association in Western Australia. Most local authorities did not charge parents for immunisation. The child was to attend the clinic four times, firstly for a preliminary injection to test the child's sensitivity to Anatoxin, and then three more injections at three-week intervals.⁵⁷ In 1944, journalist Mary Ferber, of the *Daily News*, admitted in a letter to the Commissioner for Public Health that she had fabricated two letters in the paper for "propaganda" purposes, advocating diphtheria immunisation.⁵⁸

In 1943 the Board of Management of the Perth Hospital was officially nominated as the managing committee of the MIDH. A check-up of the MIDH's status as far as Perth Hospital was concerned revealed that there was no record of the MIDH "being vested in any person or body", a leftover from the turbulent times of 1908, when the Infectious Diseases Hospital had been the focus of a savage battle between local, state and hospital authorities.⁵⁹ Huelin did some investigation and outlined a rudimentary history of the site, beginning with the wrong year for the smallpox epidemic, in an attempt to establish just who did 'manage' the MIDH.⁶⁰ What he found convinced him sufficiently to ask Panton to have the Lieutenant Governor "appoint the Perth Hospital Board to be the Board of Management of the Infectious Diseases Hospital, and to vest Reserve No 2290, being Swan locations 3235 and 3240, in the said Board, under the provisions of the Hospitals Act, 1927."⁶¹

But there were a number of problems with this. In the first place, the Metropolitan Infectious Diseases Hospital was not in any way covered by the Hospitals Act of 1927. It was built and administered under the Public Health Acts. The appointment of the Perth Hospital Board of Management as the Board of Management for the MIDH was valid enough, but in practice, the Perth Board held no separate minutes to confirm that they were acting in this capacity, nor did they have a separate seal for specific matters dealing with the MIDH. To the Board, the MIDH was always the Infectious Diseases *Branch* - it was so used to behaving as if it were not only the managing but the actual owning body of the MIDH, that none of these measures were taken. The Lieutenant-Governor had done the legally impossible when he vested the MIDH in the Board under the Hospitals Act, and the entire matter was to cause legal

⁵⁷PHD AN 120/4 Acc 1003, #827, 1942, CPH to Sec Canarvon LBH, 10.7.43, p 29.

⁵⁸PHD AN 120/4 Acc 1003, #827, 1942, Ferber to CPH, 19.9.44, p 153. Ferber included a copy of an anti-diphtheria immunisation letter which had been sent to her at the newspaper.

⁵⁹PHD AN 120/4 Acc 1003, #469, 1943, ? Dean to US PHD, re West Subiaco Infectious Diseases Hospital, 27.5.43, p 1.

⁶⁰PHD AN 120/4 Acc 1003, #469, 1943, US PHD to Health Minister, 29.5.43, p 2. Huelin placed the epidemic in 1894 instead of 1893.

⁶¹PHD AN 120/4 Acc 1003, #469, 1943, p 3. This was gazetted 4 June 1943.

mayhem in the 1950s, when the question of who actually owned the MIDH was once again resurrected.



Medical staff at the MIDH, c. 1944. Dr Murray is on the right.

From the collection of Kathleen Johnson.

With the MIDH now securely under its administrative wing - or so it believed - the Board could go ahead with agreements with local health authorities over the care of their infectious diseases cases. These were generally fairly standardised, and obliged the Perth Hospital to manage the MIDH, take in the cases, supply the MIDH, maintain an ambulance, endeavour to collect fees from the patients at its own cost, prepare statements of expenditure and send them to the local authority each month. In return, the local authority had to pay any left over monies not collected from patients.⁶²

It was a tangled and confusing affair. A good example of what the local councils had to deal with can be found by examining one local Board's report of their attempts to recoup fees from patients. Out of 15 patients, four stated that they were going to pay directly to the office at the Public Health Department, three had left the district and were being traced, one was untraceable altogether, two were unable

to pay because they were pensioners, one refused to pay any further, one claimed to have paid the full amount to the hospital, one was paying weekly at the PHD, and one was unable to pay any more till the following year. Only one person had paid in full.⁶³ The matter was further complicated by the admission to the MIDH of more and more rural patients, with whose local authorities there were no agreements. The increased costs incurred were being calculated as expenditure, and accordingly converted to a per diem figure that was passed on to the local authorities who did have agreements with the MIDH.⁶⁴

On a more human level, the Board of Management let the Metropolitan Infectious Diseases Hospital have its windows back - all the glass in all the windows had been removed as an air raid safety measure earlier on in the war.

⁶²I have selected three files which seem to be generally representative of the agreements: PHD AN 120/4 Acc 1003 #738, 1943, Nedlands Road Board; #817, Mundaring Road Board; #1084, Rockingham Road Board.

⁶³PHD AN 120/4 Acc 1003 #531, 1945, Sec Canning Road Board to Accountant, PHD, 6.12.48, p 95.

⁶⁴PHD AN 120/4 Acc 1003 #531, 1945, circular from Cook, CPH to all local health authorities, 23.12.48, p 98.

Finding a firm to replace the glass was another story.⁶⁵ The provision of a small kiosk at the Metropolitan Infectious Diseases Hospital and its supply was also approved, for £120, but the hospital charge then rose to 15/9 per patient per day.⁶⁶

This kiosk was integral to what John called the “encouragement to do for themselves” urged upon the convalescent patients - “The wards were rough, but the staff took much trouble to make them comfortable and homely, with pots of flowers and odd cooking on the primitive kitchen stoves (usually in the night).”⁶⁷ Children's nursing was often recreational as well as practical:

They used to have red pillow cases on the lounges and red shades around the lights. Well, we had all these children hanging around that were well but they were not allowed to go home until they got their three negative swabs. We would tie all these red things around their hair and send them out in the bush to play. That's how we could go and find them all and count them all.⁶⁸

Long-stay patients were a considerable concern to the main hospital - Muecke believed that, with more and more patients staying for longer than 60 days in the Perth Hospital, some form of occupational therapy should be introduced, and the Board asked him to inquire more fully of the Australian Physiotherapy Association as to what could be done.⁶⁹



Staff and diphtheria patients on the steps at the MIDH. L-R: Sister Eakins, Nurse Fricker, Sister Melrose. Left, Dr Leo Healy.

From the collection of Kathleen Johnson.

⁶⁵RPH BM Min, 7.9.44, p 2; 2.11.44, p 3.

⁶⁶RPH BM Min, 5.10.44, p 1; 11.1.45, p 2.

⁶⁷Leschen, op cit.

⁶⁸Interview with Mrs E Joubert, Mrs K Loton and Miss A Smith, by P Martyr, 1993, p. 27 transcript.

⁶⁹RPH BM Min, 25.7.45, p 3.

But as these changes were taking place, and plans made for the future of the Metropolitan Infectious Diseases Hospital, Roy Muecke, worn out by the endless exigencies of wartime hospital work, died in February 1946. He was aged only thirty-seven. In nine short years of supervision, he had overseen the rebuilding of both the Metropolitan Infectious Diseases Hospital and the new Perth Hospital. He had fought the Board and demanded action, and had been rewarded with the visible signs of his work. During those nine years,

he served the hospital, and its patients whole heartedly and with single minded purpose ... in his relations with the honorary medical staff he gained the respect and appreciation of the profession, and by his consistently helpful attitude towards the resident staff, he has earned the affection and high regard of the very many men and women who have served under him.⁷⁰

His widow, Diana Muecke, a former nurse at the hospital, presented his textbooks to the Perth Hospital Library, and a staff memorial was to be held for the 'Chief'.⁷¹ In the meantime, Lt Col Roland R Anderson had been contacted and was willing to take on the post of Acting Medical Superintendent from March 1946.



Christmas photo c1945 – a weary Roy Muecke, centre right; Rosalind Denny, extreme right (in cape).

From the collection of Rosalind Denny.

⁷⁰RPH BM Min, 6.3.46, p 1.

⁷¹ibid, p 5.



Would Anderson prove as resolute and hard-headed on the subject of the Metropolitan Infectious Diseases Hospital as Muecke had been? Trouble had already begun in earnest over the issue of nurses' quarters. The Board had suggested converting Wards 9 and 10 at the site into nursing accommodation, but Matron Siegele (left) had to inform the Board members that "there was a strong rumour that nursing staff would refuse to live in them". The new Commissioner for Public Health, Dr C E

Cook, came up with a scheme to kill two birds with one stone - build nurses' quarters which, when they had outlived their usefulness, could be converted to convalescent or chronic wards.⁷² Huelin knew that the Board members had not been near the site for some time, and were not fully aware of the layout and the nature of the buildings, and so he suggested a visit before any decisions were made.

Sure enough, when the Board members actually visited the site for an inspection, they found that the location proposed was totally unsuitable. The area marked out had been on the hill towards the back of the Metropolitan Infectious Diseases Hospital, overlooking the sewerage works. This would not do at all, and several other sites in the city were suggested as alternatives. To complicate matters further, the new 44-hour week meant that yet more staff would be needed, in the vicinity of another two hundred nurses alone. And this meant that simply simply putting beds on verandahs could not provide more accommodation.

There was one other option, and that was employing more men as nurses. Men who nursed were non-resident at hospitals where the nursing staff was predominantly female, which effectively solved their accommodation problem. War service had drawn more men into assistant nursing, and the Nurses' Registration Board granted them accreditation so that if a man wished to continue training, he could do so at an accredited school. The work of men in nursing in Western Australia had been largely restricted to the insane, to tuberculosis patients at Wooroloo, and repatriation cases, in most cases with patients who needed physical restraint or who were themselves male.⁷³ This narrow spectrum of work could not and did not attract men to nursing, but those already working fought for greater representation and recognition in Australia after the Second World War. The Male Nurses' Association was formed in 1946, accepting as members both trained and 'assistant' nurses, and later merging with the Western Australian branch of the Australian Nursing Federation.⁷⁴

In September 1946 the authorities at Woodbridge, the government-run Old Women's Home, had asked the Board if the wards could be used to accommodate women from the Home while alterations were made to Woodbridge.⁷⁵ Huelin was able to confirm with the Medical Department the

⁷²ibid.

⁷³Hobbs, op cit, p 130.

⁷⁴ibid.

⁷⁵RPH BM Min, 12.11.46, p 4.

moving of 43 bedridden elderly women, ostensibly to make more room at Woodbridge for the accommodation of rural elderly women.⁷⁶

The already mixed authority of the Metropolitan Infectious Diseases Hospital was about to be diluted a little further. The matron of Woodbridge, Matron Powell, wanted to remain matron of both Woodbridge and the wards at the Metropolitan Infectious Diseases Hospital, but there had to be a sister at the site to take responsibility. The Matron of the Metropolitan Infectious Diseases Hospital, according to the Public Health Department, would neither supervise nor take any interest in the elderly women.⁷⁷ The wards were fairly isolated from the Metropolitan Infectious Diseases Hospital, being part of the old infectious site, and were dubbed Carinya Women's Home.⁷⁸

What was put forward as a temporary move soon turned out to be more long-term. In 1948, there were 22 women at Carinya, and room was needed for more. But sufficient staff could not be found for the wards, and so Carinya was facing closure, the women to be transferred back to Woodbridge and put on the verandahs.⁷⁹ The Infectious Diseases Hospital's truly long-term inhabitants, the white ants, had struck again, and were eating away the wards.⁸⁰ Another constant fear, that of fire, was fulfilled again, in January 1949, when fire raged out of control in the bush near Carinya, and the helpless bedridden women were rescued by staff from the Metropolitan Infectious Diseases Hospital.⁸¹ By late 1949, the 'temporary' arrangements had begun to intrude upon the functioning of the Metropolitan Infectious Diseases Hospital. Heavy scarlet fever numbers meant that the branch had to employ extra staff, and the nurses were sleeping two to a room and on the verandahs.

Time was running out for Carinya. Part of the bathroom floor in one of the wards had broken away, and nothing had been done about it despite complaints from the sister in charge of Carinya that the patients had had some nasty falls on its account.⁸² There simply was not enough accommodation for the women back at Woodbridge, nor was there accommodation elsewhere.

I cannot too strongly urge our needs for aged women and stress the difficulties we are encountering. In the past 6 months our embarrassments in temporary accommodation at Carinya have been accentuated. Our staff problem has always been difficult, but of late these difficulties have increased. Threats of walk-outs and other incidents are a constant source of worry, and, as a result, the patients suffer.

⁷⁶PHD AN 120/4 Acc 1003 #176, 1947, US PHD to AUS MD PHD, 9.12.46, p 1.

⁷⁷PHD AN 120/4 Acc 1003 #176, 1947, US PHD to AUS MD PHD, 9.12.46, p 2.

⁷⁸PHD AN 120/4 Acc 1003 #176, 1947, US PHD to Sec Premiers Office, 25.6.47, p 11; US PHD to Sec PO, 24.7.47, p 16.

⁷⁹PHD AN 120/4 Acc 1003 #176, 1947, US PHD to Health Minister, 28.4.48, p 55.

⁸⁰PHD AN 120/4 Acc 1003 #176, 1947, US PHD to US PWD, 26.5.48, p 59.

⁸¹PHD AN 120/4 Acc 1003 #176, 1947, US PHD to US RPH, 24.1.49, p 66; US PHD to Sister Wade, Carinya Women's Home, 24.1.49, p 69.

⁸²PHD AN 120/4 Acc 1003 #176, 1947, Actng US PHD to US PWD, 10.2.50, p 75.

More families were finding it hard to cope with the aged, private hospitals were full, and in metropolitan and country hospitals there were beds occupied by aged women which were keeping out cases for curative treatment. The women stayed at Carinya, but under protest, until April 1951, when the emptied wards were designated as vacant by the Board.⁸³

Muecke's work as Medical Superintendent had overseen the building of an entirely new hospital, the Metropolitan Infectious Diseases Hospital, ostensibly owned by the local authorities and run on their behalf by the (Royal) Perth Hospital. But the same problems seemed to persist, perfectly correlated by the presence of the old hospital next door to the new, and by its continual use, despite the sometimes-appalling state of the old wooden wards. The move of the aged women to two of the old wards speaks volumes not only about the role the MIDH and the old hospital were expected to play, but also for the poor state of care for the aged in Western Australia. Care for the aged was not going to improve in the near future. A new presence had been making itself felt at the MIDH, one which would be integral to its future as a rehabilitation hospital - poliomyelitis.

⁸³RPH BM Min, 3.4.51, p 4.

Chapter Five: Intermezzo

The years from 1948 to 1954 are, in retrospect, something of an intermezzo in the history of the hospital complex now known as the Royal Perth (Rehabilitation) Hospital. Experiments with physical and vocational rehabilitation were already taking place in Western Australia, with tuberculosis patients, paralysed war veterans and crippled children

Rehabilitation in Australia was used to describe the medical and vocational re-education of a returned soldier. Military work in both wars, and the after-care of children in the Eastern States during the poliomyelitis epidemics of the 1930s, had contributed much to the scientific processes of physical repair. But there was a strong 'social repair' element still undone. Many Australians did not like to see the disabled in public places, and the complicated and laborious medical attendance often required, before modern orthopaedics eased the burden with new equipment and an emphasis on self-care, was beyond the abilities of many families.

After the Great War, the physically disabled in Australia, particularly men, were relegated by labour exchanges to the bottom of the pile, seen as having little or nothing to offer. It took years of work on their behalf, by concerned medical practitioners and voluntary associations like the RSSILA (later the RSL) and the Red Cross, to change this attitude. It was vital that the medical and the vocational sides of the rehabilitation team co-operated. Without medical care, the person could not be re-employed. Without vocational care, the person's cure was not complete. The two were to be interdependent, in order to maximise the disabled person's chance of a 'normalised' future. But the division of services meant that a rehabilitation unit in a hospital could be miles from a vocational centre, and there could be either overlapping of services such as physiotherapy, or a complete dearth of them, depending on state and federal funding.

As the Second World War ended, Western Australia's hospitals experienced a crisis of patient overcrowding as never before. Once again, the MIDH was about to take on its familiar role of combined pressure-valve and too-hard basket. In 1947, the state government had begun its campaign against tuberculosis, under the medical administration of Dr Linley Henzell, superintendent of the Wooroloo Sanatorium.¹ Henzell asked for the upper floor of the MIDH, which had 30 beds - the under-secretary for Health commented that "It is some years since any of these beds were occupied for their original purpose, and with the advancement of medical science there is reason for the hope that there will not again be the heavy demands which have occasionally arisen in the past."²

In late September 1947, Cook himself inspected the site. Cross-infection would not prove a danger, according to his report, but there were structural problems

¹Snow, *op cit*, p 24.

²PHD AN 120/4 Acc 1003 #888, 1947, US PHD to Mr E H Rosman, Sec Local Govt Assoc, 29.7.47, pp 1-2.

which would need addressing, and which would impair future use of the hospital as a regular infectious diseases hospital, let alone a tuberculosis hospital. The Department had been caught before by Royal Perth Hospital, which was - in the face of intransigent local councils and their notorious casualness about bill-paying - naturally always on the lookout for a means of refurbishing and maintaining the hospital at separate government expense. It was not going to happen this time. In fact, Cook was musing upon a new future for the entire site.

Furthermore I have, for some time, been giving serious consideration to transferring the administrative and medical control of the Infectious Diseases Hospital to the Children's Hospital. This, of course, is a matter on which the Boards of these respective hospitals must be consulted, but in the event of their acquiescence the proposed transfer would definitely and finally dispose of any suggestion that the upper wards be used as a Tuberculosis Hospital.³

In 1937, Roy Muecke had predicted that poliomyelitis would strike Western Australia soon, and strike it hard.

The last epidemic of poliomyelitis did not touch WA. It will not happen always thus and when it does come, and come it will, I would hate to predict its consequences in such an unsalted community as this. By that I mean a community that, because it escaped the last epidemic, can only have a very poor degree of immunity to this disease.⁴

In 1948, two years after Muecke's death, widespread epidemic poliomyelitis finally came to Western Australia. Isolated by the natural quarantine of the Nullarbor and the ocean, the staggering numbers of poliomyelitis victims in the East in the 1930s were a continent away. Now, after the War, the virus was to fall upon a largely vulnerable population, with no acquired immunity from widespread previous outbreaks. Generally considered a 'summer' disease, poliomyelitis struck Western Australia most heavily in the winter of 1948. 311 cases were notified, the majority of which were children under ten years old. It ultimately killed 25 of those cases, mostly young adults, and left about forty per cent of the survivors with substantial residual paralysis.⁵

Muecke has called for iron lungs to be made ready at the old Infectious Diseases Hospital, while the new building was still at the planning stage. The artificial respirator, or 'iron lung', as it was more commonly known, has strong associations with epidemic 'infantile paralysis', although its use is not limited to these cases - episodes of near-drowning, overdoses and other accidents which impair a person's capacity to breathe normally, could all be treated in iron lungs with considerable success. The lungs themselves were rather sinister-looking

³PHD AN 120/4 Acc 1003 #888, 1947, CPH to Min PH, 26.9.47, p 52.

⁴PHD AN 120/4 Acc 1003 #6675, 1962, Muecke's report on state of site, 30.12.37, p 72.

⁵Snow, op cit, pp 66-7.

cabinets, out of which only the head could protrude, sealed by a rubber flange around the neck. Attached to the lung itself by a flexible cable was the large motor that operated the unit. The idea behind the lung was to support breathing until the muscles of the diaphragm had become sufficiently strong to manage for certain periods of time outside of the lung.

Pamela Bennett (nee White), who began her nursing training in the 1950s at the Hospital, described the procedure at the MIDH, in Wards 1 and 2 in the mid-1950s.

You knew that the patient could only breathe, say, for 30 seconds, outside the lung. You could put them on to hand-held respiratory care while you washed them, but most of them hated that - once their face was covered they got very frightened and panicked.⁶

Because of the panic caused by use of the hand-held respirator, "most of them liked to be washed without air, so you had as much time as they didn't need to take a breath, because they couldn't breathe themselves."⁷

So you had everything ready, the towels and everything positioned. You opened the lung, the big wooden box, and then one [nurse] did one arm and one leg and the other person washed the other arm and leg. You actually washed the patient in 30 seconds flat, changed the sheet and closed the lung, and then the patient started breathing again. If the patient got upset or looked like they were distressed, they would mouth "I can't breathe", and you closed the lung and gave them a few breaths and then opened it up again and finished the job.⁸

But most Western Australian poliomyelitis sufferers did not end up in iron lungs. Residual paralysis was a more likely effect, especially of the lower limbs. The lack of rehabilitation equipment and staff was staggering - one man who contracted polio in the 1948 epidemic recollected that at Shenton Park there was only one physiotherapist and two wheelchairs for thirty recovering polio patients.

We used to have to ask the nurse in advance if we could have a wheelchair for half an hour on a certain afternoon ... The food was also terrible, and little of it. Tea from the ward kitchen - at 4pm mind you - consisted of tomato, lettuce and a slice of bread. When we kicked up a stink we got cold meat as well.⁹

⁶Interview with Mrs P Bennett, nee White, by P J Martyr, pp 5-6 trans.

⁷Interview with Mrs P Bennett, nee White, by P J Martyr, p 6 trans.

⁸ibid.

⁹Roy Scarr, in M McKimmie, 'Polio', *West Australian, Big Weekend*, 26.11.94, p. 3.

So little was effectively known about the way in which the disease was spread that general isolation of children, seen as the most vulnerable, was enforced, with the attendant problems of quarantine being broken.¹⁰

Confronted with a serious epidemic, the Western Australian authorities did what they could. Part of the means of combating the epidemic's crippling toll came in the form of a visit from Dame Jean Connor, who, in her working role as Dr Jean Macnamara, had become one of Australia's foremost authorities on poliomyelitis. Macnamara duly arrived and reported, and her report and recommendations were then amended and revised for Western Australian conditions by Dr Elizabeth (Betty) McComas. She was highly critical of the method of staffing the MIDH - "I would suggest that the method of staffing the Infectious Diseases Block by one or sometimes two residents who return to the Perth Hospital after a very short period of experience is not planned to provide for West Australia future leadership in the care of Infectious Disease."

Macnamara was particularly interested in the work of repatriation practitioner Dr Oswald Corr at Hollywood Hospital, who "has demonstrated his interest and humanity in another group of patients he is rescuing from the scrap heap - paraplegics. He has battled for them and obtained modern apparatus to enable them to walk."¹¹ Corr's interest in turn had been sparked by that of plastic surgeon Dr Leslie Le Soeuf, who had visited Ludwig Guttmann's clinics at the British Ministry of Pensions Hospital at Stoke Mandeville, England. Guttmann was trying to put principles of teamwork and total care into practice with paraplegic patients, and was having astonishing and impressive results. On his return to Perth in 1946, Le Soeuf gave a paper on his travels at a BMA(WA) meeting, where Corr heard about these methods. Corr had two paralysed patients at Hollywood about whom he was deeply concerned, and so with the help of Le Soeuf, who performed any necessary plastic surgery, and Mr James P Ainslie's neurosurgical work, the rudimentary rehabilitation 'team' put some of the principles learnt into practice.¹²

In 1948, at the Perth session of the Australian Medical Congress held by the BMA, Corr read a paper entitled 'Paraplegics Can Walk'. Macnamara obtained a copy of the paper, and had been impressed by Corr's conviction, especially his determination to begin rehabilitation while the patient was still bedridden.¹³ The role of light work, such as occupational therapy, in physically and psychologically preparing a patient for activity again, had been noted by another Western Australian surgeon, Alexander Juett, as early as 1921.¹⁴ Corr had the paralysed men's knees, fixed in an angle from sitting in the wheelchair, straightened with physiotherapy, and then splinted so that the men could try standing - oddly enough, a Kenny-style practice, where Kenny had placed great

¹⁰PHD AN 120/4 Acc 1003 #944, 1948, appendage file, circular from Cook to all local health authorities, 31.5.48, p 5.

¹¹PHD AN 120/4 Acc 1003 #1290, 1948, File 1 - 1190, 1948, p 26.

¹²McKellar Hall, op cit, pp 71-2.

¹³O Corr, 'Paraplegics can walk', Dame Jean Macnamara Collection, Australian National Library, MS 2399/12/155.

¹⁴A Juett, 'Muscle atrophy', *Medical Journal of Australia*, 1921(2), pp 213-17.

emphasis on the psychological benefit of 'standing' even when paralysed.¹⁵ Corr was quite explicit - "It is not the distance that a man can walk that matters, but the fact that it makes him more independent and the great psychological effect of being on his feet again."¹⁶ This led to walking with callipers and crutches, and from there occupational and vocational training.

Macnamara's interest in the Hollywood project was thus understandable, but her report in general angered many, including Reg McKellar Hall - who had disagreed with Macnamara over the Kenny issue in the 1930s¹⁷ - and the Commissioner for Public Health. Physiotherapists were trained differently, and practised differently in Western Australia. The Advisory Committee on Poliomyelitis in Western Australia had not been in favour of even inviting Macnamara in the first place.¹⁸ Anderson maintained that "Perhaps if Dame McNamara [sic] had approached me, or some other responsible person before issuing reports, everybody might have been saved a lot of unnecessary work."¹⁹

Anderson was to open two wards at the MIDH for long stay cases, with one practitioner in charge - Dr Pearson was recommended - and with a physiotherapist. They also needed efficient transport, and extra buildings "(one for Physiotherapy Dept., which could be a hut)".²⁰ These were under the direction of the honorary orthopaedic staff at RPH. The Committee asked for Alec Dawkins to be made director of the 'special orthopaedic section' of RPH, but also asked that the wards be equipped by the Department rather than by the Hospital, and then have the enterprise vested in Dawkins, the Medical Superintendent and the Commissioner for Public Health.²¹ As president of the St John's Ambulance Association in Western Australia, Dawkins was able to arrange for the free transport of poliomyelitis patients, from aftercare wards to and from their homes, even on weekend leave.²²

So the gradual shift of after-care facilities to the MIDH began. This immediately posed a host of administrative problems. Powell, as manager of RPH, wanted to know if poliomyelitis cases admitted to wards 7 and 8, the IDH wards, as after-care patients, were to be considered normal hospital cases, or as 'infectious diseases', and thus a liability of local authorities.

Powell was wise to be concerned. By the end of the year, the wards at MIDH held 10 acute inpatients and 23 more in after-care. PMH had a total of 42 inpatients and 37 outpatients, including those at Lady Lawley Cottage. The Aftercare Ward at MIDH was too hot and needed ceiling fans, and for long-term

¹⁵McKellar Hall, op cit, p 43.

¹⁶Corr, op cit, p 5.

¹⁷ibid, p 47.

¹⁸PHD AN 120/4 Acc 1003 #710, 1948, minutes of meeting ACP, 27.5.48, p 1. Present at the meeting were: Cook, R R Anderson, Ian Thorburn, Reg McKellar Hall, and Dr Edmonds, who was the medical superintendent of the Children's Hospital.

¹⁹PHD AN 120/4 Acc 1003 #336, 1940, CPH to Chief Health Officer, PHD, Vic, 18.8.48, p 128; CPH to Med Supt, Fairfield IDH, Vic, 18.8.48, p 129; Anderson, RPH to Cook, 20.8.48, p 137.

²⁰ibid.

²¹PHD AN 120/4 Acc 1003 #1290, 1948, Cook to Min PH, 4.10.48, p 99.

²²PHD AN 120/4 Acc 1003 #1369, 1949, Dawkins to Abbott, 3.8.49, p 1.

use a better building, but it had to be permanent and in “another more desirable situation”.²³

How were these wards to be staffed, especially in the new climate of ancillary care? During the Second World War, the Australasian Massage Association had changed its name to the Australian Physiotherapy Association, and in the post-war world of rehabilitation, physiotherapy was rapidly mobilising its forces. Western Australia had very few trained physiotherapists, even immediately after the Second World War - the poliomyelitis epidemics of the 1930s had helped to consolidate physiotherapy's professional standing in the East, rather than in the West. In 1927, the Chief Resident Medical Officer of Perth Hospital had reassured Huelin that that institution only employed massage practitioners who were members of the AMA.²⁴ Officially, only the trained massage practitioner could work with the medical profession, as Everitt Atkinson pointed out: “Without a Diploma a masseuse would not be recognised by the medical profession as competent, and unrecognised training is therefore of no value.”²⁵

A Canadian chiropractor inquired in 1951 as to whether s/he could come to Perth and practise, and the Commissioner of Public Health, Linley Henzell replied, “Chiropractors are not registered in Western Australia, and may therefore practise without hindrance provided that they confine their operations to chiropractic, and do not practise physiotherapy or any of its branches.”²⁶ In 1954, Perth naturopath and chiropractor Richard Todd inquired from the Minister for Health, Emil Nulsen, about the possibility of offering his services to treat poliomyelitis patients. Henzell had apparently ignored his request for an interview. Nulsen replied: “The treatment of paralysis due to poliomyelitis is, in the opinion of my professional advisers, a responsibility which should be left to specialist orthopaedic surgeons and to properly qualified and registered physiotherapists.”²⁷

Still others, although trained physiotherapists, did not hold the necessary AMA membership. One case came to light of an ex-serviceman, a trained masseur who had worked in Perth before the war, and then with the AIF overseas as a physiotherapist. Upon returning to Australia, he applied for commission, but when it was found that he was not a member of the AMA/APA, it was refused him and he was not permitted to continue practising.²⁸ Wage structures and institutional attitudes also worked against men seeking employment as physiotherapists, as it was the policy of at least one Perth hospital to employ female practitioners only²⁹ - to the extent that its Board made a special point of

²³PHD AN 120/4 Acc 1003 #710, 1948, meeting 2.12.48, p 39.

²⁴PHD AN 120/4 Acc 1003 #1621, 1948, incorporating #1924 , 1918, CRMO PH to US PHD, 3.8.27, p 13.

²⁵PHD AN 120/4 Acc 1003 #1621, 1948, incorporating #1924 , 1918, CPH to C Taylor, Dept Commissioner, Repat Dept, WA, 1.7.32, p 21.

²⁶PHD AN 120/4 Acc 1003 #1621, 1948, 12.2.51, p 94.

²⁷PHD AN 120/4 Acc 1003 #689, 1952, pp 210-212.

²⁸PHD AN 120/4 Acc 1003 #1621, 1948, incorporating #1924 , 1918, J R Huelin, Legal Service Bureau, A-G's Dept, Cwlth of Aust, to US PHD, 25.8.44, p 52.

²⁹PHD AN 120/4 Acc 1003 #1621, 1948, Powell to US PHD, 3.10.49, p 81.

PERTH HOSPITAL

CONDITIONS OF APPOINTMENT OF HONORARY MEDICAL STAFF
AS FIXED BY THE BOARD OF MANAGEMENT

1. The appointments are for a term of three years commencing from 5th May, 1941.

Officers appointed will be eligible for reappointment but liable to removal at any time by the Board of Management. Vacancies in the positions of Surgeons to Inpatients or of Physicians to Inpatients occurring during their currency will be filled for the unexpired term of the office by an appointment being made, by the Board, from the Outpatient Staff, the post so becoming vacant to be filled by advertising; the appointees to hold office until their successors are selected.

2. Applicants must be under the age of sixty years at 5th May, 1941.
3. Any person applying for a senior position will be regarded as applying also for a junior position unless he states to the contrary.
4. Honorary Medical Officers are subject to control under the Rules and Bylaws of the Board of Management.
5. Honorary Medical Officers attending Outpatients are required by the Board to attend not later than 10 a.m. or 3 p.m. as the case may be, but arrangements may be made for Honorary Medical Officers to attend at an earlier hour should they desire to do so. Attendances must be regular and punctual.

Applications accompanied by copies of testimonials addressed to the Manager of the Hospital must reach the undersigned not later than 15th April, 1941.

BY ORDER OF THE BOARD

W. H. POWELL
MANAGER.

31st March, 1941.

Regulations governing honorary appointments, 1941.

From RPH archives.

justifying the employment of a male physiotherapist in 1948.³⁰ By 1951, plans were being made for the opening of a physiotherapy training school in Perth.³¹

Table 5.1

After-care statistics for poliomyelitis as on 16.6.50³²

	IDB	RPH	PMH	G'Age†	Total
INPAT	12	-	19	15	46
OUTPAT	7	4	56	6	73
Total	19	4	75	21	119

By July 1952 the poliomyelitis infectious ward was empty, having discharged its last patient on 19 June 1952.³³ In November of the same year, the paper reported on the work of Dr Neil Crosby, who had joined the staff of UWA as their first medical doctor, with the projected medical school not far from completion. Crosby reported several leads in the race to find a vaccine for the virus, in particular the preservation of the virus under lab conditions that allowed it to be studied more closely.³⁴

In the meantime, after-care was needed, especially hydrotherapy. The Nedlands hot pool, notorious in the 1920s for scandalous episodes of 'mixed bathing', had been used in the rehabilitation of both ex-service personnel and civilians in recent years. It had been found a great help in treating rheumatic and orthopaedic cases, as had the use of sea beaches for swimming.³⁵ By 1954 Henzell had permission to go ahead with a permanent hot pool at MIDH.³⁶

Work at the site with the poliomyelitis patients continued to increase. Alison Hardie, the occupational therapist at the Melville rehabilitation centre, was finding it harder and harder to come to Perth because of the work with the Commonwealth service, and could only work for half a day per week with poliomyelitis cases at MIDH.³⁷ Eventually the demand on the splintmakers was so great that a sheet-metal worker was also employed, and plans were made to move the entire unit from Royal Perth Hospital to Princess Margaret Hospital, because the greatest demand for splints was for child patients.³⁸

³⁰RPH BM Min 24.8.48, p 2.

³¹PHD AN 120/4 Acc 1003 #1621, 1948, p 93.

³²PHD AN 120/4 Acc 1003 #1700, 1948, no page, no date.

† For archival information on the 'Golden Age' venture of poliomyelitis Accommodation, see PHD AN 120/4 Acc 1003 # 322, 1949, 'Use of delicensed Hotel 'Golden Age' for purposes of after-care treatment of cases'. PHD AN 120/4 Acc 1003 #112, 1949 has some financial and statistical information on the 'Golden Age' as well.

³³PHD AN 120/4 Acc 1003 #1700, 1948, WA, 4.7.52.

³⁴PHD AN 120/4 Acc 1003 #1700, 1948, WA 14.11.52.

³⁵PHD AN 120/4 Acc 1003 #106 , 1949, C W Anderson, Dept Co-ord Rehab, Perth to Cook, 22.8.49, p 36.

³⁶PHD AN 120/4 Acc 1003 #106 , 1949, H Colebatch to A R G Hawke, Premier, 22.10.53, p 64; Henzell to Moyle, Chairman Nedlands Road Board, 25.3.54, p 77.

³⁷PHD AN 120/4 Acc 1003 #112 , 1949, C Anderson, Dept Co-ord Rehab, WA to R Anderson, RPH, 20.5.49, p 22.

³⁸PHD AN 120/4 Acc 1003 #112 , 1949, J Clarkson, asst manager, RPH, to US PHD, 12.11.49, p 39;

'Waste not, want not' might be the motto of the history of the hospital which is now the Royal Perth Rehabilitation Hospital, and by the end of 1949, what was planned is a classic expression of this.

After careful investigation and consultation with the specialists responsible for the treatment of the patients referred to, the Medical Superintendent recommends to the Board that the unit be used to the fullest extent for the treatment of:-

1. Cases of Poliomyelitis.
2. Cases of Paralysis from other causes.
3. Post operative tuberculosis.
4. Cases of peripheral neuritis, etc."³⁹

It is here that one can see the origins of a rehabilitation hospital, through the decision by the Medical Superintendent of Royal Perth Hospital, Dr Anderson, to have the MIDH facilities for poliomyelitis after-care put to full use for other cases.

The MIDH remained for the time being as it had begun - an infectious diseases hospital. There were even minor disasters at the new 'unit' that were strongly reminiscent of the 1920s dilapidation of the Infectious Diseases Hospital. The physiotherapy bathroom had been lined with plasterboard, but no ventilation had been allowed for in the room, with the result that the plasterboard had turned into "saturated, sagging pulp, which is falling away from its fastenings."⁴⁰ As in the old days, there was a regular coming-and-going of senior nursing staff - Monger's temporary resignation, and then her study leave, meant that from time to time there was no official Sub-Matron at the Metropolitan Infectious Diseases Hospital. Ivy Wells filled in, and took the position of Acting Sub-Matron in 1951.⁴¹

Cook finally recommended that the hospitalisation of infectious diseases be taken over completely by the Public Health Department. But could Royal Perth Hospital cope with the site, as well as the pressures put on the hospital by the new extensions to the main building in Murray St? Cook had resigned his post as Commissioner for Public Health, and the Acting Commissioner, William Davidson, penned a few words to Stitfold, the under-secretary for Health, in another letter - "Subject to approval by State Health Committee it is proposed to run IDB as an extension of Princess Margaret's. Infectious diseases would then be a minor part of its work. Does this simplify the financial responsibility?"⁴² The reply was non-committal, so Davidson pushed for more clarity - "What I meant was: - Could taking over responsibility be used as a lever to get full control of

Powell to US PHD, 30.11.49, p 41.

³⁹PHD AN 120/4 Acc 1003 #112 , 1949, Powell to US PHD, 15.12.49, p 44. This was approved, p 47. See also RPH BM Min, 13.12.49, p 2.

⁴⁰PHD AN 120/4 Acc 1003 #112 , 1949, J Anderson, supt engineer, to Manager RPH, c.June 1951, p 164.

⁴¹RPH BM Min 21.11.50, p 3; 16.1.51, p 2.

⁴²PHD AN 120/4 Acc 1003 # 1065 , 1949, p 9, 21.11.49. The note is in pen on this sheet, to the US PHD from the acting CPH, 3.12.49.

the buildings for “nothing”.⁴³ This time, the message was received and understood. What is most remarkable - or perhaps not - is that the Royal Perth Hospital Board had not even been consulted at this stage.⁴⁴

The local health authorities kept up the pressure. The Claremont Council told the Minister for Health at the end of 1949 that the government should take full responsibility for the treatment of infectious diseases cases - “The treating of infectious disease patients in such an institution represents a means of safeguarding the health of the entire community - the community, as a whole, does not subscribe to the revenue of a Local Authority.”⁴⁵ When Stitfold asked Davidson if he intended to reply, he declined, adding that “Personally I am in favour of Gov. paying the full amount & obtaining full control of the hospital.”⁴⁶ He was cautioned by the under-secretary, who advised him that the Minister for Health, the previous Commissioner and himself were all agreed that full control should not be assumed - “Apart from other considerations, it is necessary, as a disciplinary measure on the Health Authorities, for the Health Authorities to bear portion of the cost because an infectious disease is likely to follow in a more or less automatic fashion from neglect to apply the health laws.”⁴⁷

Davidson was acting Commissioner only, in the wake of Cook's resignation, so the problem was transferred to Linley Henzell when he took over the job in 1950. Henzell read through the matter and decided to cut the Gordian knot.

I have given this matter considerable thought and am of the opinion that it would be in the best interests of all if the responsibility were assumed by this Department. I am aware that objections have been raised to this course by Dr. Cook and yourself and agree that these are valid. Nevertheless, there does not appear to be any other solution that would be free from grave anomalies.⁴⁸

But this would involve repealing part of the State's Health Act. There was to be no easy solution to what Stitfold called “this vexed matter”.⁴⁹

⁴³PHD AN 120/4 Acc 1003 # 1065 , 1949, memo from US PHD to A/CPH, 12.12.49, p 10; again, a note in pen written on the bottom and dated 13.12.49.

⁴⁴RPH BM Min, 13.12.49, p 1.

⁴⁵PHD AN 120/4 Acc 1003 # 1065 , 1949, Town Clerk Claremont to Min PH, 9.12.49, p 12.

⁴⁶PHD AN 120/4 Acc 1003 # 1065 , 1949, US PHD to A/CPH, 19.12.49, p 14. This comment is signed and dated 20.12.49.

⁴⁷PHD AN 120/4 Acc 1003 # 1065 , 1949, US PHD to A/CPH, 29.12.49, p 21.

⁴⁸PHD AN 120/4 Acc 1003 # 1065 , 1949, CPH to US PHD, 1.8.50, p 43.

⁴⁹PHD AN 120/4 Acc 1003 # 1065 , 1949, US PHD to Sec LGA, 24.8.50, p 44.

46

Metropolitan Infectious Diseases Hospital

Address—C/o Royal Perth Hospital, Murray Street, Perth

MONTHLY STATEMENT

In Account with **DEPARTMENT OF PUBLIC HEALTH** 30.10.48 19.....

Particulars	Days	Debit	Credit	Balance
OCT.				
	To A/c rendered	6 9 6		6 9 6*
		6 9 6		6 9 6*

23 DEC 1948
RECEIVED

A typical bill tendered by MIDH to a local authority for care of patients.

Because poliomyelitis was likely to result in the need for long-term aftercare, it differed from other infectious diseases. Its possible crippling effects, which may hinder the individual from leading a full and 'useful', or wage-earning life, led to its mental re-categorisation by health authorities. Their cure was not 'cure', but 'rehabilitation'. Was after-care part of infectious diseases treatment? This question had come up in 1948, as the Board was alerted to the availability of a Canadian-trained professional occupational therapist for poliomyelitis after-care at the MIDH. But who was to pay for Miss Oldham? The cases in Wards 7 and 8 were not apparently a local government matter, and would have to be paid for "from some other source".⁵⁰ That source, according to Huelin and Cook, was to be the Department of Public Health.



Mobile polio immunisation service

Snow, *The Progress of Public Health in Western Australia*, Perth: UWA Press, 1981

By the early 1950s, poliomyelitis rehabilitation was well-established at the Metropolitan Infectious Diseases Hospital. The shabby state of the poliomyelitis wards was consistent with most of the Hospital's history, and the raffishness of the site was matched by the behaviour of one of its associates, the Princess Margaret Hospital splint-maker, G R Clark. Clark had taken advantage of the funding mayhem to demand exorbitant amounts for his work, charging individuals for work done on Hospital time and with Hospital money. He was dismissed in 1952 for failing to perform his work satisfactorily, and had left the state by 1953, but it was not until several months later that the Public Health Department was able to unravel the tangle of fraud he left behind. Having a splint or prosthesis made was covered by some health insurance funds, and so many of Clark's customers, upon making cash payments, had asked for receipts, which he refused to give. Queries about this eventually reached the Department, which was able to find that Clark, as 'departmental head' of the splintmaking operation, was not supervised by the administration of Princess Margaret Hospital. He had also managed to intimidate his co-workers and office staff so thoroughly that no questions were ever asked about his unorthodox

⁵⁰RPH BM Min, 12.10.48, p 2.

billing procedures. Approximately £350 had been lost, with a possible extra £120 which could not be directly attributed to Clark. All efforts to locate Clark in the Eastern States failed.⁵¹

Poliomyelitis rehabilitation, paid for by the State government out of a special hospital grant known as the 'Post Polio Vote', provided many of the essential services and infrastructure upon which the future rehabilitation hospital built its achievements. It was responsible for the shift in perspective, gradual but consistent, which allowed the site to be earmarked as a possible site for physical rehabilitation. But at the same time as rumours were being heard abroad of a vaccine which would eradicate the spectre of poliomyelitis, other significant changes were taking place in the rear wards of the Metropolitan Infectious Diseases Hospital. Oswald Corr's work with paralysed veterans at Hollywood was to be built upon in a new and astonishing way by a recent arrival in Western Australia, George Bedbrook. The intermezzo was over, and Act II was well and truly ready to begin.

⁵¹PHD AN 120/4 Acc 1003 #1157, 1952. This file details the whole investigation.

Chapter Six: Back On Their Feet

The changes at the Metropolitan Infectious Diseases Hospital since the war were creating a new profile for the Hospital. The process of rebirth, from predominantly acute and convalescent infectious diseases care, to full-scale rehabilitation hospital, had already begun in the late 1940s. This slow transition was to challenge the Hospital's administration, staff and patients, trying them and testing them in new ways. What happened at the site of the MIDH, and its outlying wards which had been for so many years a dumping-ground for difficult and hopeless patients of many descriptions, was part of a much wider movement in Australian medicine and health care taking place in the 1950s. At the administrative level, hospitals with teaching units and practitioners interested in furthering knowledge about rehabilitation felt left out of the picture.

These practitioners included Dr Selwyn Nelson,¹ Dr Rodney Meyers,² and Dr M Naomi Wing, who had herself been experimenting with a rehabilitation scheme at Royal South Sydney Hospital, based on her experience touring overseas rehabilitation facilities. Wing commented that Australia was lagging behind seriously in both its outlook and facilities:

It seems to be generally accepted in Australia that one needed millions of pounds and elaborate buildings to carry out the techniques which had been described ... That was not so. Many of the best centres overseas had very humble beginnings and commenced with the facilities available at the time.³

The reference to humble beginnings could have been coined from a glance at the site upon which had rested the original Victoria Hospital and its successor, the Metropolitan Infectious Diseases Hospital. It was in this turbulent administrative and economic climate that the MIDH's own change of direction began to take shape.

In the early 1950s, some of the major themes of the Hospital's history were still generating administrative mayhem. With a newly-opened nine-storey block in Victoria Square to match the change of name effected in 1946, Royal Perth Hospital's management was keeping up the pressure on the State government for extensions to the Metropolitan Infectious Diseases Hospital.⁴ The problem they were faced with was spread far wider than just the metropolitan area; the Board noted that there was in fact a state-wide shortage of hospital accommodation, which had prompted the formation of a special government committee. The Acting Premier, David Brand, had indicated his personal interest in the establishment of an 100-bed convalescent hospital at the site, and this probably speeded the decision-making process considerably, to the

¹MJA, 1955(2), p. 532.

²R Meyers, "Rehabilitation: problems and prospects", MJA, 1955(2), p. 760; "Aspects of rehabilitation", MJA, 1957(2), p. 721; "Medical rehabilitation - some wider issues", MJA, 1959(2), p. 554.

³ibid; see also M Wing, "Medical rehabilitation", MJA, 1955(1), pp. 705-710.

⁴RPB BM Min, 13.2.51, pp 2-3; 3.4.51, p 4; 5.6.51, p 1. The new building was opened on 3 June 1948, Bolton, Joske, op cit, p. 137.

extent that by June 1951 this plan had been approved by Cabinet.⁵ By August of the same year, plans were placed before the Board, for the construction of three blocks, each with three Bristol-type prefabricated buildings, to house twelve beds each, making a total of 108 new beds. By October 1951, the long-term and rehabilitative aspect of the Metropolitan Infectious Diseases Hospital was coming more to the fore, as the planned convalescent beds were also to make “a contribution towards the [Public Health] Department's problem of finding provision for the chronic sick”.⁶

Individual links with the Department could often be productive: in the early 1950s, a young man called Ted Barrow, who had been left quadriplegic after poliomyelitis in 1948, wanted to develop for himself a trolley that would convert into a wheelchair. He and Dudley Snow set about doing it, with the help of the splint maker Mr Benfall, at Princess Margaret Hospital. Barrow had effectively been adopted by a Christian couple, and with Snow's help and some money from John Dunne's 'Strike it Rich' radio session, they were able to meet basic costs.

The new demand for physiotherapy created by post-war rehabilitation trends was still far from being met in Western Australia. The Physiotherapy Department at the Royal Perth Hospital was under pressure from the Medical Superintendent, R R Anderson, to reduce its staff because of the shortage of trained physiotherapists, although some hope was placed in the eventual development of Western Australia's own training school. Estimates were being made for the amount of accommodation needed for the School in 1951, and in a step which recognised the importance of teamwork in rehabilitation, the School was to be built at the site, where it could serve the rehabilitative facilities there.⁷ The accommodation, according to physiotherapists who trained at the time, was appalling, one former physiotherapist referring to it as a “chook shed”. Under these conditions, it is not surprising that the newly-formed Physiotherapists' Registration Board sought better premises for its prospective students.⁸

In the meantime, remedial gymnasts like John Johnson supplied much of the impetus for physical rehabilitation among convalescents at the Metropolitan Infectious Diseases Hospital. Johnson conducted exercise classes at the Hospital for convalescents, and on the recommendation of both Dawkins and Anderson, Johnson was encouraged to continue in this line of work, as he “was getting patients on their feet in very much quicker time than average and the hospital was being saved considerable expense because of his efforts.”⁹ This 'farming out' of long-term physiotherapy work helped to keep the main Hospital's in-patient treatment figures low, and the introduction of apparatus-treatments - using wheels, pulleys and slings to exercise wasted muscles -

⁵RPH BM Min, 19.6.51, p 4; 3.7.51, p 2.

⁶RPH BM Min, 9.10.51, p 3.

⁷RPH BM Min, 9.10.51, p 5.

⁸RPH BM Min, 3.6.52, p. 2.

⁹RPH BM Min, 16.1.51, p 5.

meant that some patients could treat themselves at home, which “must have beneficial results”.¹⁰

In 1951, Joseph Griffith became the new Hospital manager/administrator, and his background in England as chief executive officer for the united hospitals of Sheffield may not have prepared him for the shabby state of the Metropolitan Infectious Diseases Hospital.¹¹ Between 1955 and 1960, the Board underwent changes, including an increase of numbers from four to eleven, and a shift away from public service domination and towards greater representation of medical staff.¹²



Joseph Griffiths, around the time of his appointment as MIDH administrator.

From the collection at RPRH.

But still more beds were needed. This time, the State Health Council took a trip into the archives and found that the main buildings of the MIDH had actually never been fully completed. So Dr W S Davidson, standing in for Linley Henzell at the Board meeting, put forward the Council's recommendations for the completion of the main buildings, as an economical means of increasing bed space.¹³ The plan was timely, because by February the following year (1954) poliomyelitis had struck in epidemic form again.

The existing buildings were in their customary state of disrepair. The Medical Registrar, Dr John Colebatch, had made recommendations for immediate changes, including the conversion of Ward 9 to accommodate the occupational therapy facilities, and an overhaul of the existing physiotherapy rooms.¹⁴ New staff were also going to be needed. An experiment had been tried for a period, in which the staff of the new School of Physiotherapy had been responsible for all physiotherapy at the MIDH. The amount of work, however, soon exceeded their capacity, and more physiotherapists would be needed on the hospital staff.¹⁵

¹⁰RPH AR, 1951, p. 8.

¹¹Bolton, Joske, op cit, p. 141.

¹²Bolton, Joske, op cit, p. 141.

¹³ibid.

¹⁴ibid.

¹⁵ibid.

If 16 May 1954 signalled the semi-official rebirth of the MIDH as a fully-functioning comprehensive rehabilitation hospital, the date of its christening and the nomination of its godparent could be pinpointed as 13 December of the same year. At the meeting of the Honorary Medical Staff of Royal Perth Hospital held on 8 December, the staff resolved to recommend that the Board set up a Paraplegic Unit “within the ambit of and under the jurisdiction of the Orthopaedic Department and under the control of Mr G M Bedbrook, F.R.C.S.”. The most important question asked was, naturally, how much this was going to cost the Hospital administration. Bedbrook had twelve paraplegic cases under his supervision at the MIDH at the time, and could present the following financial requests: £250 up front for hospital equipment, an estimated £1000 over the next year for callipers, splints and other impedimenta of rehabilitation designed to help a return to function and mobility, and finally £100 worth of tools and equipment to help those who were to be rehabilitated participate in light work. The Board created the Paraplegic Unit as a section of the Orthopaedic Department, gave Bedbrook the £250 and opened the way for negotiations with the Commonwealth government, under whose jurisdiction any social service and vocational rehabilitation schemes lay.¹⁶

Bedbrook was a Melbourne-trained surgeon. While working towards his fellowship of the Royal Australasian College of Surgeons, he decided on his future specialisation: “I knew then that I wanted to go into orthopaedics. I started off by just wanting to go into surgery ... I didn't want to just be, you know, a cutting surgeon.”¹⁷ After undertaking postgraduate studies in England with the National Health Service, he returned to Melbourne, towards the end of 1953, but could not find satisfactory private practice opportunities, and so canvassed Perth as an option.

From one surgeon in Perth I had a dismal answer - “Don't come, there's no opportunity”, but from Mr McKellar Hall I had the optimistic letter saying “Come, there's every opportunity, particularly if you don't mind starving for two or three months, and go to Fremantle.”¹⁸

Alexander Juett, McKellar Hall's former medical partner, had died, and McKellar Hall offered Bedbrook a place as his assistant, at £100 a month, with the prospect of an appointment at Royal Perth Hospital as well.¹⁹ Bedbrook accepted, and went into practice with McKellar Hall in November-December 1953 - only to be separated for several months from his wife and children, still in Melbourne, by another outbreak of poliomyelitis in Western Australia. McKellar Hall's own contribution to rehabilitation, particularly that of Western Australia's crippled children, was substantial, and now his partner in practice was to take on the rehabilitation of adult paraplegics.

At about the same time, a major medical furore had erupted in the pages of the *Medical Journal of Australia* over the future of rehabilitation. Was it to remain

¹⁶ibid, p. 9.

¹⁷Interview with Sir George Bedbrook (1), by P Martyr, p.? transcript.

¹⁸Interview with Sir George Bedbrook (1), by P Martyr, p.? transcript.

¹⁹Interview with Sir George Bedbrook (1), by P Martyr, p.? transcript.

split in half, with hospitals discharging 'fit' patients who may have to wait several months for admission to a vocational training centre? Or were hospital-based rehabilitation units the way of the future? The debate attracted Bedbrook's attention, and he wrote to the *Journal* in 1955 that:

We in the Paraplegic Unit of the Royal Perth Hospital are trying to commence retraining of patients whilst they are in the precincts of the unit. We feel that medical management and retraining must proceed concurrently. The Commonwealth Rehabilitation Department is helping to take our patients after they leave hospital, but by that time it is essential that some progress should have been made towards replacing them, either in their previous position, or in retraining towards a new occupation.²⁰

The Paraplegic Unit appears to be the first of its kind in Australia - medical rehabilitation units had been set up in some eastern states hospitals, and the Commonwealth Rehabilitation Service handled vocational training, but for the first time an attempt was being made to combine the two for a specific group of rehabilitation patients, those who had spinal injuries.

Paraplegia patients, once they survived their initial injuries, were still largely a mystery to medical practitioners. They were in limbo - expected to be grateful for having their life saved, but at the same time doomed to a future of unemployability and uselessness.

I think in those days, when the Spinal Injury Unit had just started to get going, the patients were actually classed as "There is not much you can do for them, they are paralysed", so I never felt that there was a great deal of interest. The doctors would come down and write out orders for bladder infections and medicines and that sort of thing.²¹

In early 1954, while Bedbrook was on a ward round with Alec Dawkins, they came across a man who had been left paraplegic at T-5 - almost at breast level.

Mr Dawkins said to me, "Look, what do you know about paraplegia? You must have visited Ludwig Guttmann in England" ... And I said "Well, I don't know much about paraplegia, but I know a bit more about it than most people round here", and he said "Right. You look after them."²²

This may have been a compliment to Bedbrook's skill, or alternatively Dawkins may have felt the young clinical assistant was perhaps too big for his boots, and needed a sharp put-down. Either way, the assignment of Bedbrook to care for paraplegic patients was thus accomplished, a last link in the chain forged by

²⁰G Bedbrook, letter to MJA, 1955(1), p. 893.

²¹Interview with Mrs P Bennett, by P Martyr, p.5 transcript.

²²Interview with Sir George Bedbrook (1), by P Martyr, p. ? transcript .

administrative puzzlement over what to do with these long-term patients, and the changing status of the Metropolitan Infectious Diseases Hospital.

That change in status was about to be influenced by another external factor. In the early 1950s, Jonas Salk had been experimenting with the cultivation of the virus that caused poliomyelitis, and as a result he had developed a vaccine that was under trial in the United States - the largest controlled trial of its kind in the history of modern medicine up to that point.²³ By 1955 the results were known, and the vaccine appeared to be extremely effective. Supplies of the vaccine, however, were produced slowly, and were first used in the United States. Australia moved to produce its own supplies, under the authority of Dr Percival Bazeley, at the Commonwealth Serum Laboratories in Melbourne. Because of protocols, procedures and red tape, the vaccine could not be made safely available until June 1956.

Before then, polio struck in Western Australia again, in January 1956, ending in May of that year. This outbreak brought an unusually high proportion of paralysis of the respiratory muscles, and had a special tragedy in that it struck after the development of a successful vaccine, but before its distribution.²⁴ One of the epidemic's victims was Paul Berry, who contracted polio at age 27, and spent the rest of his life at the Hospital, becoming one of its most well-known disabled artists. He was the last poliomyelitis patient in the state to still use an iron lung regularly.²⁵

30 000 doses of Salk vaccine were sent to Western Australia by the end of June 1956, and on 1 July 1956 the program was launched, as Linley Henzell and Emil Nulsen, commissioner and minister for health respectively, volunteered for the first inoculations - a publicity stunt, as the vaccine was at first limited to children and pregnant women. As the supply increased, the rate of immunisation followed suit, and eventually the school-child population was fully immunised. Over the next ten years over 2 million doses of Salk vaccine were administered, half a million West Australians had undergone the three injections, and only three of those who had had the full course contracted poliomyelitis. With the development of the orally-administered Sabin vaccine, which did not require successive injections, poliomyelitis vaccination in Western Australia was an outstanding success.

Bedbrook's plan was to build upon the experimentation of Dr Oswald Corr at Hollywood Hospital, and also to incorporate Corr's chosen plans for rehabilitation, which were based upon the work done at Stoke Mandeville Spinal Injuries Hospital. Accordingly, in 1954 the eight long-term paraplegics at Royal Perth Hospital were moved down to West Subiaco, as were the paraplegic cases from Hollywood Repatriation Hospital. The Paraplegic Unit was thus formed, and was housed in Wards 7 and 8 at the old Metropolitan Infectious Diseases Hospital. The British Medical Association in Western Australia had also been asked to arrange for the transfer of all cases of paraplegia in the

²³Snow, op cit, p. 68.

²⁴Snow, op cit, p. 69.

²⁵M McKemmie, 'Polio', *West Australian, Big Weekend*, pp. 2-3.

state to the Unit.²⁶ Out of this, in 1955, the Paraplegic Association of WA was formed, which fostered sporting activities, accommodation and welfare concerns.²⁷

Occupational therapists had been working with the nascent Commonwealth Rehabilitation Service at Melville from the late 1940s, as well as with the Crippled Children's Association and at Claremont Hospital.²⁸ In 1949, they had formed their own Occupational Therapists' Club, with three members, and spent the next four years liaising with hospital almoners and speech therapists, and exploring employment opportunities in industrial health. In 1952, the group affiliated with the federal professional association, and became the Western Australian division of the Australian Association of Occupational Therapists.²⁹ In a remarkable achievement for an association with only a handful of practitioners, the division had by 1957 organised the passage through state parliament of the Occupational Therapists Registration Act.³⁰ In 1955, Wylie had requested the expansion of facilities and the increased provision of staff and equipment for occupational therapy at the MIDH, and had won the strong support of the Registrar, Dr John Colebatch. The Board looked to the state government's fund for poliomyelitis rehabilitation to provide at least part of this.³¹ Part of the need was met by the Swanbourne branch of the Red Cross Society, which made a donation of £150 towards setting up an occupational therapy kitchen, which had been requested by Bedbrook.³²

Colebatch was reappointed in 1955 as a second-year registrar, eventually becoming known as the Deputy Medical Superintendent, which helped lend stability to the MIDH's staffing arrangements, in the past always a cause for concern.³³ In 1957 he furnished a full report to Griffith on the condition of the site:

It has been the policy in the past to fill the remaining beds with patients from Royal Perth Hospital for whom no further special treatment was required. At least a quarter of these were merely disposal problems and of very little medical interest. If this policy is continued, I think it will be impossible to obtain staff on a permanent basis.³⁴

In the 1955 Royal Perth Hospital *Annual Report*, Elizabeth Wylie described the temporary use by the Occupational Therapy Department of Ward 9, "with its historic background associated with its use as a fever hospital in the Goldfields in the 1890s."³⁵ While Ward 9 was certainly old and fairly disreputable, it may

²⁶McKellar Hall, op cit, pp. 74-6.

²⁷PQAWA, *Paraplegic Quadriplegic Association of WA (Inc)* - a brief history, c.1981.

²⁸Hardie, op cit, pp. 3-4.

²⁹ibid, p. 5.

³⁰ibid, p. 6.

³¹RPH BM Min, 18.4.55, p. 6.

³²RPH BM Min, 22.8.55, p. 4.

³³RPH BM Min, 13.6.55, p. 1; 18.7.55, p. 2.

³⁴PHD, AN 120/4, Acc 1003, #1062, 1952, Colebatch to Administrator, 7.3.56, p. 94.

³⁵RPH AR, 1955, 'Occupational therapy'.

not have been that historic ward - fire had destroyed several wooden buildings on the site at various times, and the 1938 hospital was built on the site of two other old wards, which were demolished. Ward 10 may be this old isolation ward from the main Hospital; where on the site the Coolgardie ward was placed, in 1917, there is no hint or diagram surviving in the archives of the Public Health Department. The shaggy dog story indicates two important points clearly: that oral history is sometimes unreliable, and that the old wards were in an atrocious state.

Consistent with plans to attract outside funding and assistance for the Paraplegic Unit was Bedbrook's proposal to demonstrate the workings of the Unit to representatives of state and local government and industry.³⁶ Bedbrook also enlisted the help of the Hospital almoner to assist the Paraplegic Unit, as "these patients have many social as well as medical needs for present and future planning".³⁷

Medical matters were weighing heavily on the minds of the State Government. Medical practitioners in Western Australia were either locals who had trained elsewhere, or were 'imported' from other states and countries to treat the State's growing population. The first attempt at fundraising for a Western Australian medical school - the Sir James Mitchell memorial fund, in 1951-2 - had not been encouraging.³⁸ In 1955, a fresh attempt was made, when the State government convened a committee to estimate costs and development. Griffith threw in his lot with the new medical school, and by March 1956, the money raised totalled £562 000.³⁹ A medical school meant that future practitioners could be trained in rehabilitation in Western Australia - the establishment of rehabilitation units at teaching hospitals had been a dream of the medical rehabilitation specialists of the 1950s.⁴⁰

In April 1956, the Shenton Park Annexe House Committee was officially appointed. The Committee members all reflected the established order of the site's major functions, as well as its new direction. Dr Ian Thorburn's seniority as honorary physician to infectious diseases made him an obvious choice. Orthopaedic surgeons Harry Hill and George Bedbrook reflected the Annexe's new commitment to rehabilitation of the physically disabled. Griffith and Anderson represented the long-term interest of Royal Perth Hospital in the site, and the Deputy Commissioner for Public Health, Dr W Davidson, in turn represented the controlling interest of the state government in the establishment and running of the Metropolitan Infectious Diseases Hospital.⁴¹ There was a vacancy left for a non-medical member of the Committee, and suggestions for this included Claude Hotchin and William (Bill) Brine, whose contributions to Royal Perth Hospital's links with the wider Perth community were well-known.⁴²

³⁶RPH BM Min, 24.10.55, p. 4.

³⁷RPH AR, 1954, p. 22.

³⁸Bolton, Joske, op cit, p 142.

³⁹Bolton, Joske, op cit, p. 143.

⁴⁰Martyr, 1994 op cit, 201-206.

⁴¹RPH BM Min, 9.4.56, p. 4.

⁴²Bolton, Joske, op cit, p. 147.

The Annexe House Committee held its preliminary meeting on 19 April 1956, appointing Brine as the seventh member of the Committee and its chair.⁴³



Bedbrook and Griffiths attend a meeting, c1960.

From the collection at RPRH.

The first thing the Committee did was report on the site. Russell, the secretary of the Committee, had inspected the site and reported that “Present facilities are barely sufficient to store everyday hospital requirements such as linen, cutlery, crockery and cleaning gear ... Unused beds, cots, mattresses, lounges etc. were found stored in patients' clothes' store-rooms and in the theatre anaesthetic room.”⁴⁴

Eileen Monger, as Annexe Matron, was an asset to the Committee: she made practical and sensible suggestions that would improve the life of nurses at the site immeasurably, such as a pantry in the night nurses' quarters so that they could make hot drinks to supplement the inadequacies of daytime sleep.⁴⁵ The nursing staff at the Annexe in the late 1950s largely consisted of young junior nurses. Pamela Bennett described some of the contradictions of the Annexe: “... in some ways it was like a holiday except that the work was heavy on the paraplegic side of it.”⁴⁶ Improving job prospects for women outside of nursing was beginning to make itself felt as well: “There were 33 started in the June 1954 school and only 8 of us graduated.”⁴⁷

A House Committee was only a step in the right direction, rather than an end in itself. What was earnestly sought by staff members of the Shenton Park Annexe (as the post-polio and paraplegic units were now known⁴⁸) was a proper medical establishment in the form of salaried staff. There was one Deputy Medical Superintendent, John Colebatch; two senior resident medical officers

⁴³RPH BM Min, 23.4.56, pp. 2-3.

⁴⁴PHD AN 120/4 Acc 1003 #5407, 1956, 7.6.56.

⁴⁵PHD AN 120/4 Acc 1003 #5407, 1956, Matron's report, probably 26.5.56.

⁴⁶Interview with Mrs P Bennett, by P Martyr, p.3 transcript.

⁴⁷Interview with Mrs P Bennett, by P Martyr, p. 4 transcript.

⁴⁸RPH BM Min, 23.4.56, p. 3.

on roster; and one rostered junior resident medical officer. Alternative sources of funding had to be found for the Annexe, and Colebatch and Sarfaty put in an application to the National Health and Medical Research Council for a research grant, for support with investigation into artificial respiration in poliomyelitis.⁴⁹

It was firmly maintained by the Annexe House Committee that the future of the Annexe should be as a rehabilitation hospital, especially given the current climate in Australian rehabilitation that separated the medical from the vocational aspects. With this in mind, the Committee was in favour of a proposed scheme for a 320-bed hospital, which would encroach upon the university endowment land adjacent to the site.⁵⁰ This would be largely dependent upon the closing of a road in Hollywood, and also upon the University's own plans for the land.⁵¹ What was also of concern was the title of the new section of the hospital. Dr Henzell had some qualms about the use of the term 'Annexe' in the title. Did this imply that the site was in fact an extension of Royal Perth Hospital, when in fact the buildings had been built and paid for in part by the State and by local health authorities? The matter was referred for discussion between Griffith and the under-secretary for health.⁵²

What was fundamental to the issue was this battle between the administration of Royal Perth Hospital and the Public Health Department, over ownership of what was every year becoming more and more valuable real estate, reserved for hospital purposes and conveniently close to the city. Royal Perth Hospital had precedent and years of support of the site on its side; the Public Health Department had the law behind it, in the botched edict of the Lieutenant-Governor which vested the MIDH under the wrong Act of Parliament. The establishment of the Paraplegic Unit drew the site a little closer to Royal Perth Hospital - Griffith, unlike his predecessor, was not going to be left in the dark about the Annexe's future.

Much of the work done at the site was technically post-poliomyelitis rehabilitation, paid for out of a special State fund for that purpose only. Some of the equipment, however, seemed to be finding its way into other areas. The clerk in charge at the Health Department eventually wrote to Dudley Snow:

I feel there is something not quite right about the 'set-up'. We seem to be paying the Royal Perth Hospital large sums of money for items which may not even be used for Polio after-care and there are no means whereby I can check the actual receipt of the equipment.⁵³

Snow noted in pen "I am uneasy about the arrangement too. I suggest you discuss this question with the A[cting]/U[nder]/Secretary (Med[ical])."⁵⁴ Whatever the problem, it seems to have been smoothed over. How problems

⁴⁹ibid, p. 6.

⁵⁰RPH BM Min, 28.5.56, pp. 4-5.

⁵¹RPH BM Min, 2.7.56, p. 5.

⁵²RPH BM Min, 2.7.56, p. 2. See also RPH BM Min, 23.4.56, p. 3.

⁵³PHD AN 120/4 Acc 1003 #1062, 1952, Clerk in charge, Health, to Director Epidemiology, 6.6.57, p. 178.

⁵⁴PHD AN 120/4 Acc 1003 #1062, 1952, note in pen on file, 10.6.57, p. 178.

like this arose can be exemplified through examining the files on the hydrotherapy block. The work could be paid for via the Post-Polio Vote, but there were crossovers between the hospitals - if, for example, material was made by the Princess Margaret Hospital splint maker for use in conjunction with the hydrotherapy pool at the MIDH, it was billed via PMH on the Post-Polio Vote.⁵⁵ Clarke's exploitation of his position as splint maker had made everyone more cautious.

The Annexe House Committee wanted a superintendent physiotherapist on site, involving maximum cooperation with the Director of Training of Western Australia's physiotherapy school.⁵⁶ Bedbrook had far-reaching plans for the site, including a hostel for discharged paraplegic patients, and a superintendent physiotherapist at the Annexe would assist in the care and supervision of these individuals as well.⁵⁷ The establishment of the position of 'instructor in occupational therapy', to be held by Mr J Quigley, was another significant step in improving the educational side of the Annexe's work - education in rehabilitative techniques was a major battle-cry of the pro-hospital based rehabilitation movement in Australia.⁵⁸ Patients, while at the Annexe, also worked as part of their occupational therapy, and earned money towards the purchase of motorised wheelchairs, providing themselves with greater mobility in any future workplace. Tasks from which patients earned money included sharpening hypodermic needles for the Polio Immunisation Unit at Royal Perth Hospital, recovering Thomas and other splints for hospitals, assembling fishing tackle for outside firms, boot repairing and heavy wicker work.⁵⁹

By January 1957 Bedbrook had coaxed sporting clubs to donate sufficient funds for obtaining twelve sporting wheelchairs for paraplegic patients. The role of sports in rehabilitation of the physically disabled was not widely known about in Australia, despite being a major factor in work done at Stoke Mandeville. Basketball, fencing and archery were all suitable in various degrees for the wheelchair-bound or the newly-mobile, and were taught at the Annexe. Dr Ludwig Guttmann, the director of the National Spinal Injuries Centre at Stoke Mandeville, was to visit Western Australia in early 1957.⁶⁰ Bedbrook organised a program of events for his visit, including a Field Day involving the Paraplegic Association.⁶¹ Guttmann was impressed with what he saw, and suggested that five paraplegics from the Annexe be invited to take part in the Paralympics at Stoke Mandeville the following year. Accordingly, Bedbrook turned his genius for fund-raising to good use, inviting Sir Ross McDonald to become a patron of the Appeal Fund, which the Board accepted.⁶² In July and August of 1957, a paraplegic team accordingly went to London, as invited.⁶³ Frank Ponta and Bill Mather-Brown won the Welsh Challenge trophy in fencing, and Alan Quirk

⁵⁵PHD AN 120/4 Acc 1003 #5138, 1954, Walters to Bedbrook, 25.5.55, p. 13.

⁵⁶RPH BM Min, 22.10.56, p. 5.

⁵⁷ibid, p. 6.

⁵⁸RPH BM Min, 10.12.56, p. 1.

⁵⁹RPH AR, 1957, p. 41.

⁶⁰RPH BM Min, 5.11.56, p. 6.

⁶¹RPH BM Min, 18.2.57, p. 7.

⁶²RPH BM Min, 15.4.57, p. 5.

⁶³RPH BM Min, 1.7.57, p. 5.

finished second in the junior swimming event. It was a monumental achievement for a Paraplegic Unit founded only two years earlier.⁶⁴

The Public Health Department was to install an X-ray section at the Annexe, which would involve the need for further clarification of the status of the land title.⁶⁵ What was found by the investigation into the title was the old problem - who did own the land and title? No title was found to exist, nor was the land vested in any authority under the Land Act. The land had been vested in the Board of Management of Royal Perth Hospital under the Hospitals Act in 1943, but the Crown Solicitor believed that this was *ultra vires*. The Public Health Department wanted to use part of the site, Reserve 2290, which had been set apart for quarantine purposes for the Metropolitan Infectious Diseases Hospital. After lengthy discussion, the Board made the only decision it could - that the entire matter would have to be resolved with regard to both Government policy and the Hospital's own position in the matter, as it "was thought that with the ultimate advent of a Rehabilitation Hospital the hospital organisation at Shenton Park Annexe will have to become independent."⁶⁶

The impact of this question upon Bedbrook was considerable. The prospect of an independent Rehabilitation Hospital, the first of its kind in Australia, fired his enthusiasm. As a member of the newly formed medical sub-committee of the Annexe House Committee, Bedbrook could make his voice heard. In August 1958, the medical sub-committee recommended autonomy for Shenton Park hospital in association with Royal Perth Hospital, and "eventually complete autonomy in this connection should be expected." It also recommended that the Annexe's future take the form of a complete orthopaedic hospital, with private beds to meet private practitioners' needs and to accommodate all workers' compensation and third party insurance claims.⁶⁷

Bedbrook was further consolidating his position at the Annexe by taking on a part-time salaried position as Director of the Paraplegic Unit, at approximately the same time that Bill Gilmour, honorary orthopaedic surgeon, and F A Yeates, the general manager of F H Faulding & Co, were invited to become members of the Annexe House Committee.⁶⁸ Bedbrook, true to his policy of thinking several steps ahead at all times, had in part helped to secure his position by placing a request for research funding of £6500 to examine haematological and biochemical developments in acute paraplegia.⁶⁹ Confirmation of the Unit's slowly-growing reputation came when the Board received a request for a Queensland patient to enter the Unit.⁷⁰ The Unit also had a visit from a member of the board of management of the Austin Hospital (Heidelberg, Victoria), which was forming its own Paraplegic Unit.⁷¹

⁶⁴RPH AR, 1958, 'Paraplegic Patients Visit England'.

⁶⁵RPH BM Min, 20.5.57, p. 1.

⁶⁶RPH BM Min, 17.6.57, pp. 6-7.

⁶⁷PHD AN 120/4 Acc 1003 #5467, 1962, minutes, medical sub-committee, AHC, 27.8.58, p. 99.

⁶⁸RPH BM Min, 18.11.57, p. 6; RPH BM Min, 2.12.57, p. 2.

⁶⁹RPH BM Min, 2.9.57, p. 7.

⁷⁰ibid, pp. 5-6; 10.3.58, p. 8.

⁷¹RPH AR, 1958, p. 36.

Rehabilitation in the national context, as always, was high on the agenda for the Annexe and other interested members of staff at Royal Perth Hospital. The Pan Pacific Rehabilitation Conference, held by the International Society for the Welfare of Cripples, was to be held in Sydney in 1958, and Freda Jacob, the Hospital's senior occupational therapist, sought a week's leave to attend, even though the Hospital would not help her with expenses.⁷² Frank Dargan, in charge of speech therapy - another new discipline - was granted a week's leave, without pay, to attend the Sydney conference as well.⁷³ The Conference included visits to Wing's clinic at Royal South Sydney Hospital, Selwyn Nelson at Royal Prince Alfred Hospital, the Mt Wilga CRS centre, Sydney Hospital rehabilitation centre and Dr R F Kaye-Webster, facilities for crippled children, speech therapy, industrial rehabilitation, and innovations in the treatment of hemiplegics, arthritics and rheumatics.⁷⁴

Patients themselves rarely appear in the minutes of Royal Perth Hospital's Board of Management unless they misbehaved, which is how we know of the tubercular patients' trips to the Shenton Park Hotel before the First World War. A difficult patient appeared again in 1958, this time described as a 'half-caste' who was paraplegic and causing trouble at the Annexe.⁷⁵ Although the Hospital Almoners did as much as they could, the demand for social welfare arrangements and counselling at the Annexe was considerable. The appointment of an Industrial Officer in 1958 helped to ease some of the burden in the Paraplegic Unit,⁷⁶ although patient conditions in the Unit throughout the 1950s were far from desirable - Wards 7 and 8 were very run-down, and a slow but steady battle was being waged between Griffith (with Bedbrook on his side) and the Board over the ablution blocks adjoining these wards. The wards desperately needed useable toilet blocks, because the old wooden wards were originally built as infectious diseases accommodation for patients confined to bed.⁷⁷ What eventually happened to the old toilet blocks was executed in true MIDH style:

And we were putting up new toilet blocks, and we built these toilet blocks as experimental blocks, knowing that ultimately we would get a new ward. We built them out of asbestos ... and we used the old toilet block (which had to be seen to be believed) - we pulled all the inside out of that and made a seminar room in 1955-6 ...⁷⁸

Some things read like stories from the distant past of the Infectious Diseases Hospital in the 1920s - doors would not accommodate trolleys, benches were not wide enough for kettles meant to be placed on them, and the floor level in the bathroom attached to Wards 1-2 was several inches *below* ground level. So

⁷²RPH BM Min, 29.9.58, p. 4; 10.11.58, p. 2..

⁷³RPH BM Min, 8.6.59, p. 4. PHD AN 120/4 Acc 1003 #1304, 1956, is on the development of speech therapy in Western Australia, and is an excellent primary source of material.

⁷⁴PHD AN 120/4 Acc 1003 #860, 1958.

⁷⁵RPH BM Min, 10.11.58, p. 6.

⁷⁶RPH AR, 1958, p. 44.

⁷⁷RPH AR 1960, p. 29.

⁷⁸Interview with Sir George Bedbrook (1), by P Martyr, p ?.transcript.

the ground was dug away from the outside, and a little wall had to be built to prevent the bathroom from becoming an *ex officio* stormwater drain.⁷⁹

The situation of long-term patients at the Annexe was a difficult one. Although, in theory, their situation had been improved by the focus of facilities and staff on constructing a rehabilitation unit-hospital, in another sense it was made more difficult. Rehabilitation implied a cure; a process designed to lead to eventual discharge and some measure of independent living. Many long-term patients, who were accepted as part of the Infectious Diseases Hospital in the 1920s, no longer had a real place at the Annexe - they could not be transferred to the main hospital, as part of the Annexe's function was to alleviate pressure on bed space, so the other option was transfer to other institutions. In Colebatch's absence, Bedbrook continued in his campaign to have paraplegic patients made the priority of the Annexe. He had shrewdly written to Linley Henzell in 1956:

I feel certain that much more could be achieved by developing the Shenton Park Annexe, particularly on the Orthopaedic side, to help with the early rehabilitation of Orthopaedic problems, thus relieving the acute situation at the Royal Perth Hospital.⁸⁰

Guttmann's visit in 1957 had fired an enthusiasm in Bedbrook for the role of sport in physical rehabilitation, and he fostered the idea of a Paralympics held in Perth, planned for 1962, to coincide with the Commonwealth Games. The Board nominated a sub-committee to investigate, consisting of Brine, Griffith and Sten, at least two of whom Bedbrook could count upon for support.⁸¹ It met with the chairman and secretary of the 'Paraplegic Empire Games Committee', Hugh Leslie and George Bedbrook respectively, who obtained from the Hospital a promise that it would act as treasurer for fund-raising, and that it would give its full support without any promise of financial support. Bedbrook, as usual, was well advanced into the planning stage: the Annexe site had to be made presentable for future visitors, and this was high on his agenda, but lower on that of the Hospital Board.⁸²

All seemed to be running smoothly, despite these difficulties, but a new factor then entered the picture. Dr John Colebatch was continuing his special leave as a research fellow in Sydney, and Dr A M Burnford replaced him as Deputy Medical Superintendent.⁸³ Burnford's relationship with Bedbrook was to prove a stormy one, and battles over the direction of the Annexe were integral to the development of future facilities. Burnford was, in some ways, the voice of Royal Perth Hospital - alarming independence moves at the Annexe had to be moderated with a firm voice from the parent Hospital. Part of this task lay with Burnford. Bedbrook, on the other hand, wanted an ultimately independent rehabilitation hospital, mostly orthopaedic, and able to serve all hospitals, not

⁷⁹PHD AN 120/4 Acc 1003 #5407, 1956, 17.10.56, Russell to AHC - report.

⁸⁰PHD AN 120/4 Acc 1003 #5407, 1956, Bedbrook to Henzell, 15.11.56.

⁸¹RPH BM Min, 18.5.59, p. 9.

⁸²RPH BM Min, 6.7.59, p. 7; 7.9.59, pp. 4-5.

⁸³RPH AR, 1959, p. 26.

just Royal Perth. Both had fiery tempers and stubborn personalities. Under these conditions, a civil war was inevitable.

Chapter Seven: The Royal Perth (Rehabilitation) Hospital)

The 1960s revolutionised the Shenton Park Annexe. The tiny Paraplegic Unit established in the 1950s had become the core of a widening network of medical services and specialisations organised around rehabilitation. The complete refurbishment of the Unit with the opening of a new building was a major triumph for the development of rehabilitation at the site. Internal frictions notwithstanding, the Annexe grew to be recognised as a rehabilitation hospital barely ten years after Bedbrook started work with paraplegic patients. The profile of the Hospital was also changing.¹ Chronic illness and disease were becoming major health priorities, and the ageing population was also placing pressure on acute bed space - needed as the young population also expanded, with a corresponding increase in accidents and injuries.

Hemiplegia is a paralytic condition, sometimes caused by a stroke, which leaves the left or the right side of the body useless. Long-term intensive care patients, such as those living with the effects of a stroke, were not allowed to occupy precious acute bed space at the main Hospital. There is a note of desperation in the Annexe House Committee meeting of 6 December 1958, before the Unit became fully functional, in their discussion of an honorary physician to take over hemiplegic rehabilitation - the Annexe deputy medical superintendent could not possibly take over the cases in addition to his other work.²

In 1959, a significant addition was made to the Annexe House Committee, to replace orthopaedic surgeon Bill Gilmour. She was Dr Mercy Sadka, a doctor who had served her internship at the Metropolitan Infectious Diseases Hospital in 1948, during the first widespread poliomyelitis outbreak in Western Australia.³ Sadka had a distinguished research career: she obtained membership of the Royal Australasian College of Physicians in 1955, and applied for study at the National Hospital for Nervous Diseases in London for two years. Appointed the RPH travelling fellow in neurology, she acquired expertise in electroencephalography and clinical neurology, while under a bond to return to the Hospital after two years to work there.⁴ Her work overseas after the first year was funded not by the Hospital but by the Harkness Fellowship, a United States fund, which was tenurable in Boston and at the medical school at Harvard University. While continuing her EEG studies, she spent 1957 as Clinical Fellow in Neurology and 1958 as Clinical Fellow in Neuropathology.⁵

When the creation of a hemiplegic unit at the Annexe, with an honorary director, was mooted in 1959, Professor Eric Saint, foundation professor of medicine at

¹P Weindling, 'From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries', in A Wear (ed), *Medicine in Society: historical essays*, Cambridge: CUP, 1992, pp. 303-316.

²PHD, AN 120/4, Acc 1003, #5407, 1956, 6.12.58.

³Notes compiled by Dr Sadka outlining her career, in possession of the author.

⁴RPH BM Min, 24.10.55, p. 1; 7.11.55, p. 3.

⁵RPH BM Min, 1.10.56, p. 4; notes compiled by Dr Sadka outlining her career, in possession of the author.

the new medical school opened at the University of Western Australia, put Sadka's name forward for the position.⁶ Already very busy at the main Hospital - Sadka's duties also included work for the pathology department under Professor ten Seldam, foundation professor of pathology - she was reluctant to take on the directorship, having training in acute stroke care, but not in stroke rehabilitation. The possibilities of neurological work, however, were tempting, and Sadka was appointed.⁷ By February 1959, a newly-established Hemiplegic Unit was regarded as functional, focused around Wards 5-6.

While the rehabilitative work at the Annexe had begun with poliomyelitis rehabilitation (which involved muscle atrophy), spinal injuries and paraplegia had largely taken over and now ruled supreme - thanks to dynamic and dedicated leadership by Bedbrook, who was not above a little networking with Hospital authorities sympathetic to the work being done. The balance of power now shifted a little - hemiplegia required a different approach. Neurology, Sadka's specialist field, had much to offer, while for spinal paralysis, orthopaedics and urology were more in demand. Sadka's appointment to the Annexe House Committee was a significant recognition of this shift, and accordingly the battle for resident staff began. In 1959, the Medical Advisory Committee urged that registrars be appointed in both neurosurgery/neurology and in paraplegia/urology, with an additional two new resident medical officers to be appointed to the Annexe.⁸

Bedbrook's role as director of the Paraplegic Unit was proving increasingly diversified, and the dispatch of a team of paraplegic athletes to the 1960 Rome Paralympics was a further incentive to develop the Unit.⁹ The Annexe continued to seek further specialist provision of care, especially at the new Hemiplegic Unit, where speech therapy could be used to assist stroke patients.¹⁰ Bedbrook was nominated by the Hospital's clinical staff to be their representative on the Occupational Therapy School Committee.¹¹ The School finally opened on 6 February 1961, with eight students.¹²

The years 1959-1962 were in particular active years of plan and counter-plan in the history of the Annexe. In 1961, the Stephenson Committee on hospital planning was set up by the State Government, to direct the future of Western Australian health care.¹³ Linley Henzell saw the proposed development of a teaching hospital at Hollywood as significant, considering the future of the Annexe site, and the Board agreed:

For some years the Board has felt the need to define the future of the Annexe, first in broad terms of function and thereafter by a scheme to replace the inefficient and uneconomic wooden

⁶Notes compiled by Dr Sadka outlining her career, in possession of the author.

⁷Notes compiled by Dr Sadka outlining her career, in possession of the author.

⁸RPH BM Min, 7.9.59, p. 5.

⁹RPH BM Min 2.5.60, pp. 3-4; 6.5.60, p. 1.

¹⁰RPH BM Min, 11.1.60, p. 6.

¹¹RPH BM Min, 19.9.60, p. 9.

¹²RPH BM Min, 6.2.61, p. 8.

¹³Bolton, Joske, op cit, pp 144-5.

buildings of ancient origin ... the Board has frequently been obliged to embark on unplanned expenditure in a continual process of "mending and making do" with old and unsuitable wooden buildings.¹⁴

By now, the old scheme - a 320-bed rehabilitation hospital at the Annexe - had been abandoned. Plans had been constantly drawn up and neglected for the last four years, among them: the provision of nursing quarters, a gymnasium, a full therapeutic service encompassing occupational therapy, physiotherapy and speech therapy, ninety additional beds, diagnostic services, extensions to the kitchen, rehousing administrative services and an outpatient clinic.¹⁵ Everybody involved in the Annexe at a high level felt that they had a stake in its future, and drew their own plans accordingly - with controversial results.

There was still simply not enough room at the Annexe. A waiting list had had to be drawn up to account for patients suitable for transfer from Royal Perth.¹⁶ New buildings - and extra beds - thus became a priority.¹⁷ The School of Physiotherapy, despite having lodged protests about the appalling state of the buildings, renewed its twelve-month lease on the premises from the Annexe.¹⁸ The new nurses' quarters had, however, become the first item on the agenda for any new buildings, as the nurses were currently living in disposal huts that had been adapted by the hospital tradesmen. True, the Physiotherapy School and the Occupational Therapy School were also in huts, but the nurses were bound to live in these, rather than just work and train in them.¹⁹

The main Hospital had plans for its own future - hopes were still high that a new hospital at Hollywood would relieve much of the pressure on Royal Perth Hospital's acute care facilities. In the meantime, the Board of Management began to eye thoughtfully the land lying opposite the main building, across to the north side of Wellington St.²⁰ The possibility that the new hospital might also be a teaching hospital was of great interest. Bedbrook had, up till now, been prepared to consider the Annexe as a suitable post-acute rehabilitation hospital only. But in the current discussions of the devolution of acute care to an as-yet-unbuilt new teaching hospital, it was inevitable that the idea of the Annexe as an acute hospital for paraplegics would develop.²¹ In the mid-sixties, acute patients did make their way to the Annexe, as Pamela Bennett recalled:

When we first started taking acute [patients] to Shenton Park, it would have been about 1963 or 1964. I lived in Claremont, and I was the one they would ring and say 'there is a new patient coming in at 1 or 2 in the morning'.²²

¹⁴RPH AR 1961, p. 27.

¹⁵RPH BM Min, 28.3.60, p. 3.

¹⁶RPH BM Min, 11.4.60, p. 9.

¹⁷See also RPH BM Min, 1.8.60, p. 7.

¹⁸RPH BM Min, 30.5.60, p. 5.

¹⁹RPH AR 1959, p. 39.

²⁰RPH BM Min, 19.9.60, p. 8.

²¹RPH BM Min, 7.11.60, p. 7.

²²Interview with Mrs P Bennett, by P Martyr, p. 16 transcript.

Acute care placed different demands on nursing and medical staff.

I would actually go to the ward and help get the patient admitted, help with the tracheotomy or something, because we had a turnover of resident doctors who weren't familiar with the system. It was vital that the first treatment that they had was instrumental in knowing how much movement they had when they came in. Then I would go home, maybe at 3 in the morning, and get up and come on duty at 6 ...²³

The forthcoming conference of State Health Ministers, to be held in Perth in January 1961, was also a golden opportunity to push for greater treatment of interstate patients at the Annexe²⁴ - in 1960, there had been one from Tasmania, four from NSW, five from South Australia and two from Queensland.²⁵ One patient taken in by the Annexe was, according to Pamela Bennett, "a reject from one of the eastern states hospitals who had been left just, virtually, to die."²⁶ The Annexe had already been very influential in Australian rehabilitation - like the Austin Hospital, the Royal Adelaide Hospital was grateful to the Board for the work done by the Annexe team in establishing the RAH's Paraplegic Unit.²⁷ In 1962, Bedbrook was also instrumental in establishing a Paraplegic Unit in New Zealand.²⁸

The plans for a large rehabilitation hospital had been abandoned, according to Bedbrook's recommendations after he had examined thirty-three rehabilitation hospitals in other parts of the world. Overall, he thought that the scheme planned from the early 1950s - of building a rehabilitation hospital with expensive beds - should be abandoned. Facilities such as pathology, theatres, laboratories, and outpatients' clinics were unnecessary for general rehabilitation. This did not include paraplegics, who should be in a separate unit of a general hospital. The rehabilitation unit should be run in conjunction with a teaching hospital. Geriatric rehabilitation should be developed separately, away from younger patients - a necessary element at the Annexe, as in the past, paralysed patients had been treated effectively as geriatrics:

To my recollection, it wasn't that they thought it was real medicine, if you know what I mean, it was just general aged care ... even though the patients were quite young.²⁹

Ultimately, Bedbrook came down to three major recommendations: more geriatric beds away from the Annexe, more orthopaedic emphasis at the Annexe, and a resettlement officer on site. Part of these requirements was met in 1959, when Angus Golding joined the Occupational Therapy Department

²³Interview with Mrs P Bennett, by P Martyr, p. 16 transcript.

²⁴RPH BM Min, 21.11.60, pp. 5-6; 16.1.61, p. 7.

²⁵RPH AR 1960, p. 38.

²⁶Interview with Mrs P Bennett, by P Martyr, p. 12

²⁷RPH BM Min, 18.12.61, p. 13.

²⁸RPH BM Min, 16.4.62, p. 18.

²⁹Interview with Mrs P Bennett, by P Martyr, p. 5 transcript.

staff, to work as a trade instructor and to manage industrial liaison and job placement.³⁰ The Department also had the assistance of the Friends of Royal Perth Hospital, a voluntary association whose members helped to supervise patients in occupational therapy activities.³¹ By 1960, forty disabled individuals had been placed in full employment through the Annexe.³²

It was with this in mind that Bedbrook urged, and at times bullied, into existence the Annexe rehabilitative structure. It is important to understand this, because it may well provide much of the background information needed to decipher the Burnford mystery. Dr A M Burnford's three year initial appointment, as deputy medical superintendent of the Annexe, was renewed in 1961, for a period of three years, with a possible extension of two further years, up to 1967.³³ Yet by the end of 1962, he had been summarily removed from the post of Deputy Medical Superintendent at the Annexe, "owing to incompatibilities".³⁴ What had happened?

Burnford's role as Deputy Medical Superintendent at the Annexe was one fraught with conflict. It is quite hard to pick up written information about the controversy that led to Burnford's removal, but Bedbrook later insisted that Burnford had experienced serious clashes with John Johnson, the remedial gymnast who also had a ready temper, and who had a sound working relationship with Bedbrook. At one stage, according to Bedbrook, Johnson had to be moved to the main Hospital for six months until Burnford could be removed.³⁵ Both Bedbrook and Johnson spoke of at least one physical brawl at the Annexe, one Saturday morning when Johnson had arrived at work not wearing a tie.³⁶ Bedbrook also attributed Burnford's clashes to his military background, and Burnford's insistence that his orders be obeyed immediately and to the letter. Down at the Annexe, things were done a little differently.

Burnford seems to have been cast in the role of 'his master's voice', the voice of the parent Hospital, pulling the 'rabble' of the Annexe together into a streamlined unit. He was not familiar with the background of the Annexe's history, having come from England to take up the position. Linley Henzell dissented at this meeting to remove Burnford, but the minutes are unclear as to whether he dissented from Burnford's removal, or from the Board's decision to keep Burnford on in "some other capacity elsewhere at Royal Perth Hospital."³⁷

One of the rocks upon which Burnford's ship of state soon foundered was geriatric care, which was proving to be a minefield of problems in state health planning. As early as 1959, Davidson had been involved in plans to turn part of

³⁰RPH AR, 1959, p. 52.

³¹RPH AR 1960, p. 50.

³²RPH AR, 1960, p. 52.

³³RPH BM Min, 27.3.61, p. 12.

³⁴RPH BM Min, 17.12.62, p. 7.

³⁵Interview with Sir George Bedbrook (2), transc p 20. Bedbrook's memory is unreliable in this area - for example, he insists that 'Mac' Carruthers was the preceding DMS at the Annexe, and who had to be replaced by Burnford, after he died in that office. It is in fact the other way round - Carruthers replaced Burnford.

³⁶Interview with Sir George Bedbrook (2), p. 20 transcript; conversation with J Johnston, by P Martyr.

³⁷RPH BM Min, 17.12.62, p. 7.

the Annexe into a short-stay geriatric hospital, and had made a preliminary study of the matter, finding that public hospitals were being filled with long-term geriatric cases. "Investigation had shown that only a limited number could be satisfactorily catered for in lesser hospitals or institutions. Further long stay beds being provided at Sunset and Woorloo should alleviate the position." Davidson added that there was a real need to reconsider the original plans for the MIDH. The introduction there of a short stay geriatric unit would deal with cases less serious than those requiring general hospital care and with cases convalescing after treatment in a general hospital.³⁸

Davidson and Burnford consulted on this, and in a letter of 19 November 1959, Burnford included handwritten notes and plans for the Annexe, these notes forming a summary of a conversation held between them.³⁹ Burnford saw four major factors affecting the development of the Annexe: an increasing accident rate, the need for acute geriatric beds and rehabilitation, an increase in the numbers of hemiplegics being presented for treatment at the Hemiplegic Unit, and the eventual need for more beds for short-term paraplegic complications. So what was needed was a new hospital block - two paraplegic wards, two wards for acute geriatric care and two for 'advanced rehabilitation'. He anticipated putting the geriatric patients into the existing wards, and building new ones for rehabilitation. The new hospital would need an x-ray unit, a plaster room and other facilities. A new nurses' home was essential - it could even house nurses from other hospitals "but under one roof and in charge of qualified warden would be a great advance and an economy."

Some of Burnford's suggestions were very good ones - the nursing staff establishment needed a serious overhaul. Nursing paraplegia patients placed a heavy burden on a nurse, some of which may have paradoxically enhanced the quality of patient care:

You are not just dealing with somebody who is in hospital for 10 days. They're in hospital for 8 or 10 weeks or six months, or then they come back and you become part of their lives. You know their whole families and you know when they have their kids ... They ring you up and say "what do we do about this".⁴⁰

The barrier of etiquette between nurse and patient would come down. "Everybody in Ward 7 and 8 called the nurses by their christian name, which was unheard of anywhere else ... You were never called by your christian name, except by those patients."⁴¹

Overall, there would be only a small increase in the actual number of staff, "as RPH still would control many aspects". The medical staff was to consist of a deputy superintendent, a medical registrar, and three resident house officers - one more than was planned at present. The physiotherapy establishment was

³⁸PHD, AN 120/4, Acc 1003, #5467, 1962, extract from minutes of meeting of State Health Council, 7.12.59, between pp. 116-117.

³⁹PHD, AN 120/4, Acc 1003, #5467, 1962, Burnford to Davidson, 19.11.59, pp. 117-126.

⁴⁰Interview with Mrs P Bennett, by P Martyr, trans p. 18.

⁴¹Interview with Mrs P Bennett, by P Martyr, trans p. 4.

to be upped from 11 to 15, with a possible increase in the occupational therapy staff also - although Burnford did note that "we may have to face the loss of the School of Physiotherapy to the new University Hospital."⁴²

Despite opposition to the independence of the Annexe, both Burnford and Davidson believed in the decentralisation of health care.⁴³ Griffith was more cautious, reporting to the Principal Architect that "The possibility is also being investigated of introducing a geriatric day hospital at the Annexe", but adding that "this should not affect the position as a building for this purpose can be sited, planned and proceeded with concurrently with the main development if it is finally decided to establish such a unit."⁴⁴ Bedbrook did not believe in decentralisation, which he condemned a year later as "the erection of small hospitals around the Suburban area, which cannot give the facilities to seriously ill patients, that are demanded in these days of highly specialised techniques in medicine and surgery."⁴⁵ So what was to be done? Bedbrook was eventually reconciled to the idea of a day hospital, but the question of extensive geriatric care at the site was still a stumbling-block.⁴⁶ Bedbrook's vision of a Paraplegic Unit, given full and preferential treatment as the nucleus of an orthopaedic and rehabilitation hospital, possibly independent, and definitely with teaching capacity, did not concur with Burnford's. Burnford's vision did not encompass the unique culture that had grown up around the paraplegic wards 7 and 8:

really Wards 7 and 8 were quite different sections of the whole area. It was almost like two totally different areas. People either hated or loved 7 and 8. They either got on with the patients and didn't mind the heavy work, or they hated the fact that the patients told them how to treat them, and what to do, and when to do it.⁴⁷

By August 1962, Bedbrook had accelerated his plans for the Paraplegic Block - "The urgency of this particular project had been emphasised, having regard to the existing sub-standard accommodation available for Paraplegic patients in Wards 7/8 at the Annexe."⁴⁸ He had Griffith's guarantee that this would be the first work undertaken after the first stage of the new nurses' home was opened on Friday 10 August 1962.⁴⁹ By September 1962, Ross Hutchinson, the Minister for Health, had approved a grant of £100, 000 for the financial year to go towards the paraplegic block, while the geriatric hospital idea had been once again deferred.⁵⁰ The Commonwealth Paraplegic Games were to be held in Perth in November of 1962, a further incentive to develop paraplegic facilities.⁵¹

⁴²PHD, AN 120/4, Acc 1003, #5467, 1962, Burnford to Davidson, 19.11.59, pp. 117-126.

⁴³PHD, AN 120/4, Acc 1003, #5649, 1962, Davidson to Burnford, 30.3.62, pp. 9-10.

⁴⁴PHD, AN 120/4, Acc 1003, #5649, 1962, Griffith to PA, 3.7.62, p. 16.

⁴⁵PHD AN 120/16, Acc 1556, #5571, 1964, Bedbrook to Hutchinson, Min Hlth, 30.8.63, p 7.

⁴⁶PHD, AN 120/4, Acc 1003, #5649, 1962, Med Dept to Assist US, 15.7.65, p. 31.

⁴⁷Interview with Mrs P Bennett, by P Martyr, trans p. 4.

⁴⁸RPH BM Min, 20.8.62, p. 7,

⁴⁹RPH BM Min, 18.6.62, pp. 6-8.

⁵⁰RPH BM Min, 20.8.62, pp. 7-11; 17.9.62, p. 2.

⁵¹RPH BM Min, 17.9.62, p. 4.

These proved to be a major *coup* for Bedbrook, with athletes coming from the other Australian states, and from England, Rhodesia, Scotland, New Zealand, Wales, India, Singapore, and Northern Ireland, to participate.⁵²

Pamela Bennett also offered an insight into the Burnford-Bedbrook clash, based around Burnford's idea of a 'good' patient - many paraplegics did not fit this pattern. Their forbears at the Infectious Diseases Hospital, the long-term tuberculosis patients, were the 'cripples' of their time, unemployable and often shunned, and yet with familiar human needs which could be met at the now well-known watering hole nearby:

They would occasionally go out and get drunk on a Friday night. They would wheel themselves up to the Shenton Park Hotel and get drunk, and [Burnford] was always grounding them, and they were always having these great military trials ... I think there was a bone of contention between him not accepting the fact that Shenton Park was their home, basically - there was no Quadriplegic Centre as there is now at Shenton Park, and this was ... their way of trying to have some sense of normality or something.⁵³

The pressure of the Games may have been all it took for Burnford to be removed from his post. But Burnford did not take the matter lying down. He went to his solicitors in order to avert "an awkward situation".⁵⁴ There were interviews and discussions with Tom Sten (the Chairman of the Board) and Mr Reilly (the chair of the Annexe House Committee), Griffith, and the Medical Superintendent, Dr Dougan. Some staff members had contributed positive responses to Burnford's work - the physiotherapists, the speech therapist and the dieticians all liked him.⁵⁵ Burnford's post was to terminate on 28 February 1963, but he would remain at the main hospital to participate in the Work Study program, initiated to work towards better hospital efficiency and administration.⁵⁶ It was an ironic outcome.⁵⁷

Meanwhile, a new Deputy Medical Superintendent for the Annexe had to be appointed. This came in the form of Dr Malcolm 'Mac' Carruthers, a former senior registrar at Royal Perth, who was then holding a senior appointment at the Perth Chest Hospital. The appointment was to last for one year, allowing for any legal problems and considering that "such an appointment at this time would not be prejudicial to the Hospital's interests."⁵⁸ His contract was renewed in early 1964 for another three years.⁵⁹ Carruthers was a gentle, well-loved figure, and was also comparatively young. While he may have been an ideal

⁵²RPH AR, 1963, pp. 30-31.

⁵³Interview with Mrs P Bennett, by P Martyr, p. 9 trans.

⁵⁴RPH BM Min, 21.3.63, p. 10.

⁵⁵RPH BM Min, 21.3.63, p. 10.

⁵⁶RPH BM Min, 18.2.63, p. 9.

⁵⁷One former staff member, in conversation with the author, took great delight in the fact that Burnford ended up timing lifts in the main hospital.

⁵⁸RPH BM Min, 21.1.63, p. 11.

⁵⁹RPH BM Min, 17.2.64, p. 10.

compromise candidate, the pressure of filling the shoes of one such as Burnford must have been immense. The bad feeling left behind with Burnford's being 'kicked upstairs' seems to have persisted, leaving the Annexe in a dubious position - and possibly cementing its reputation as a 'holiday camp', where the RPH rules did not apply.

Carruthers had suggested that the Annexe House Committee should consider the allocation of a number of beds in Ward 2 for the rehabilitation of cardiac patients when the paraplegics, now in Ward 2, were transferred to the new building. This was in place by September - seven beds in Ward 2 were made available for cardiology rehabilitation. They had been formerly reserved for infectious cases, and could be made available for this use in an emergency. It was resolved that Ward 2 be made available for general medical patients requiring rehabilitation, and the specific types of cases involved could be decided at a later date.⁶⁰ The need for a section at the Annexe for surgical footwear and leg iron adjustments was also discussed. The small appliance repair section was to go ahead - all part of the plan to make the Annexe a self-supporting rehabilitation unit with multi-disciplinary services available to patients.⁶¹ The other therapies still had to be incorporated, especially their educational facilities.⁶² The possibility of incorporating a Commonwealth Rehabilitation Centre on the site was also raised.⁶³

Rehabilitation nursing was also becoming a specialist field in its own right - in 1962, Sister Pamela White had been given study leave to allow her to visit the Spinal Unit in Longbeach, California.⁶⁴ White had had considerable overseas experience with rehabilitative facilities - she had accompanied two paraplegic patients overseas, and while in England she completed a postgraduate course in spinal injury care at Stoke Mandeville.⁶⁵ From England, White went to Toronto, another world-class centre of rehabilitative experiment, and nursed with the Canadian Paraplegic Association, at Lyndhurst Lodge, a Toronto paraplegic hospital. White was also able to work and study at the New York Institute of Physical Medicine, directed by Dr Howard Rusk, a rehabilitation pioneer.⁶⁶ With White's return in 1963, and the near-completion of the Paraplegic Block, the Annexe could now offer a post-basic course in paraplegic nursing - the first breakthrough into specialist nursing teaching, based around rehabilitation at the Annexe, had been achieved.⁶⁷

When White left in 1965, four people took over the job that she had done single-handedly: "One couldn't help getting involved with ... George [Bedbrook] because he was such a vital person who inspired you. He expected you to give as much to your work as he did. You either did that or you got out."⁶⁸ Other

⁶⁰RPH BM Min, 16.9.63, p. 5.

⁶¹RPH BM Min, 15.7.63, p. 6.

⁶²RPH BM Min, 19.8.63, p.7.

⁶³RPH BM Min, 15.7.63, p. 7.

⁶⁴RPH BM Min, 20.11.62, p. 1.

⁶⁵WA 11.1.64, p. 18; interview with Mrs Pamela Bennett (nee White), by P Martyr, transc. p. 8.

⁶⁶WA 11.1.64, p. 18.

⁶⁷RPH BM Min, 16.9.63, p. 1.

⁶⁸Interview with Mrs P Bennett, by P Martyr, p. 11 transc.

breakthroughs, such as changing social attitudes, were slower to develop. Pamela White, now Pamela Bennett, later recollected attitudes within the hospital to the paraplegic patients:

people had trouble accepting that Ward 7 and 8 was quite different from the rest of Shenton Park. It was really totally different, and people did have trouble accepting that there was one rule for one part of the hospital, and one rule for the other.⁶⁹

Other social factors co-existed: disabled people had different ways of life before disability affected them. Many were manual workers who had suffered industrial accidents, and “they were very difficult to rehabilitate because of their scholastic standards ... you couldn't make them into teachers or anything like that because they just didn't have the ability.”⁷⁰ But there were times when educational and intellectual advantage would turn against a patient:

I remember one particular patient who was slightly brighter, and had a brighter background than some of the others, who never accepted his disability. He was quite difficult to get along with. Some of the nurses wouldn't nurse him - they refused because of his abrupt rude manner and that sort of thing. You get that ... with people going through the different areas of accepting their disability, and being angry with the world, and that it was everyone else's fault.⁷¹

The disabled themselves could increasingly find a voice in their own rehabilitation, including both medical treatment and employment prospects. The Annexe itself had to make a special note in its House Committee minutes, when a part-time telephonist's job became available in 1960, that “consideration be given to the appointment of a suitable handicapped person, if available.”⁷² Four years later, a paraplegic former patient was working as caretaker for the Annexe workshop. Another patient - one of orthopaedic surgeon Harry Hill's - had been employed by the Annexe while able-bodied, but was now refused re-employment on a light-duties basis. Hill felt that this was inconsistent with the hospital's policy of employing handicapped persons.⁷³

⁶⁹Interview with Mrs P Bennett, by P Martyr, p. 9 trans. Mrs Bennett actually met her husband through George Bedbrook, when he asked her to attend an early meeting of the Paraplegic-Quariplegic Association, of which her future husband was then vice president (1964).

⁷⁰Interview with Mrs P Bennett, by P Martyr, p. 10 trans.

⁷¹Interview with Mrs P Bennett, by P Martyr, p. 10 trans.

⁷²RPH BM Min, 5.9.60, p. 4.

⁷³RPH BM Min, 16.3.64, p. 6, p. 8.



The new nurses' quarters building shortly after its completion (now Thorburn House).

From RPH archives.

Minister for Health Ross Hutchinson opened the new Paraplegic Block on 23 November 1963.⁷⁴ In true Annexe-history style, the plans for the Physical Therapy Block did not include air conditioning, but thankfully this was pointed out and remedied.⁷⁵ Eventually, the Board decided that the Physical Therapy Block plans were too small, and that they should be reconsidered “with particular regard to the serious overcrowding problems at the parent Hospital with a view to providing a further 100-bed ward area at Shenton Park”.⁷⁶

The new Sir Charles Gairdner Hospital at Hollywood was drawing nursing candidates away from the traditional Royal Perth Hospital training. Kathleen Johnson commented:

Now by the sixties, ... the Charles Gairdner School of Nursing started. That's significant, because from that time a brand new hospital - a brand new school of nursing - had glamour, and the recruitment for nurses at Royal Perth tended to drop off, and we had all the problems with staffing, coping with the competition and so forth.⁷⁷

This, combined with vanishing staff, building projects and the pressures of coordinating a large and diversified hospital, was beginning to tell on Carruthers. He inquired about his long-service leave arrangements in April 1965.⁷⁸

⁷⁴RPH BM Min, 16.9.63, p. 8; 21.10.63, p. 8.

⁷⁵RPH BM Min, 17.2.64, pp. 6-7.

⁷⁶RPH BM Min, 18.5.64, p. 4.

⁷⁷Interview with K Johnson, by P Martyr, p. 12 transcript.

⁷⁸RPH BM Min, 24.6.65, p. 4.



Matron Kathleen Johnson.

From the collection of Kathleen Johnson.

Up till now, Bedbrook had focused on paraplegia, and had been awarded an OBE for his work.⁷⁹ His interest was expanding to include quadriplegia, and in 1965, the Board considered a request from the Paraplegic Association that land near Selby St should be used to build a Quadriplegic Centre, a hostel and residential facility for quadriplegics. As the hostel would be used by the Annexe, this initiative was approved. 5 acres of land were on offer, fronting on to Selby St.⁸⁰ A funding appeal was established, the 'Quadriplegic Hostel Appeal', and during Hospital Week 1966, the Chairman of the appeal committee visited Royal Perth Hospital, which added impetus to the appeal. Bedbrook stressed the need for quadriplegic accommodation, especially given that "a serious situation could arise at the Rehabilitation Hospital as far as beds for spinal injury cases were concerned."⁸¹ Bedbrook arranged for a clinical visit to the Paraplegic Unit, from the Australian Medical Association Congress then meeting in Perth.⁸²

Dr Phyllis Goatcher had been working at the Hospital from the mid-1950s, and had a specialist interest in rheumatology. She had trained at the School of Medicine for Women in England, and was married to a medical practitioner, Phillip Goatcher. Women in the workforce were still not widely recognised, women in medical practice even less so, and married women who practised medicine alongside their husbands were a rarity. Yet Phyllis Goatcher's calm manner and dedication to her practice won over patients and fellow practitioners alike - with a few exceptions, such as being called 'nurse', and being told by one patient that "I can afford to keep my wife at home!"⁸³

Building on early work by Dr James Young (who had died in October 1952, before Goatcher arrived in Perth) in the area of rheumatology and arthritis, Goatcher was instrumental in having the Rheumatic Diseases Department of Royal Perth Hospital moved down to the Annexe, with the creation of an outpatients' department in November 1967.⁸⁴ Goatcher was an honorary

⁷⁹RPH AR, 1965, p. 22.

⁸⁰RPH BM Min, 16.8.65, p. 15.

⁸¹RPH BM Min, 7.11.66, p. 6.

⁸²RPH AR 1966, p. 68.

⁸³Conversation with Dr P Goatcher, by P Martyr.

⁸⁴RPH BM Min, 6.11.67, p. 8.

practitioner, and yet by 1966 her workload in the Rheumatic Unit was steadily increasing.⁸⁵ In recognition of this, Goatcher was appointed to the RP(R)H House Committee in July 1966.⁸⁶

As early as 1953, Young had insisted to the Commissioner for Public Health that "It is my belief that there is a definite need in this State for a Rehabilitation Centre where patients with arthritis and other crippling conditions could receive vocational training to enable them to become either totally or partially self supporting."⁸⁷ Henzell replied that he would put the matter before the State Health Council, and did so on 12 April 1953. Young could not be present at the meeting due to illness, but the Council moved nonetheless that early consideration be given to establishing domiciliary service for hemiplegia, arthritis and allied conditions, and attention be put into setting up an institute for their treatment, with the MIDH an ideal location.⁸⁸ At the time, it was anticipated that an arthritis service could be combined with a hemiplegic rehabilitation service, as the two were seen primarily as older persons' diseases. In 1964, Sister Margaret (Peg) Waddell became Ward Sister at the Annexe, and her working relationship with Goatcher was also instrumental in advancing the cause of arthritis and rheumatology research in Western Australia, and the care of those suffering from these conditions.

The shortage of trained nursing staff was again causing problems. The new ward block would require additional staff, but Kathleen Johnson, as Matron, expressed concern that the shortage may not be met. The end result was that ten trained nurses, twenty-six nursing aides, and one ward assistant increased the establishment.⁸⁹ And by May 1966, as the pounds in the Board Minutes turned, overnight, into dollars, the Annexe name was changed. Some suggested reverting to 'Victoria Hospital', and others 'Royal Perth Hospital Rehabilitation Branch'. These better reflected the "present and future function of the Annexe" as focused on "rehabilitation of disabled and handicapped patients". Finally, the Annexe House Committee settled on 'Royal Perth Rehabilitation Hospital'.⁹⁰ But before the next meeting, the name had acquired parentheses - "Royal Perth (Rehabilitation) Hospital", a name that fixed the former Annexe even more firmly as a part of the parent Hospital.

The combined ward and therapy block was ready for opening by the middle of 1966, and the second stage block and gymnasium were to follow, only to be delayed again by a question mark over the availability of government funding.⁹¹ Authority was finally given for work on the second 66-bed block in November 1966.⁹² The old wooden therapy buildings - that last remaining link with the old Infectious Diseases Hospital of the 1920s - were to be demolished.⁹³ No more

⁸⁵RPH BM Min, 30.5.66, p. 12.

⁸⁶RPH BM Min, 4.7.66, p. 6.

⁸⁷PHD, AN 120/4, Acc 1003, #353, 1953, Young to CPH, 26.1.53, p. 1.

⁸⁸PHD, AN 120/4, Acc 1003, #353, 1953, extract from SHC meeting minutes, 12.4.53, p. 3.

⁸⁹RPH BM Min, 21.3.66, p. 1.

⁹⁰RPH BM Min, 2.5.66, p. 8.

⁹¹RPH BM Min, 5.9.66, p. 8.

⁹²RPH BM Min, 7.11.66, p. 7.

⁹³RPH BM Min, 20.6.66, p. 9.

could physiotherapy staff shake their heads over the 'chook shed' and the 'hut'. The old Infectious Diseases Hospital was now gone for good, as its remaining wards, 8 and 10, fell to the bulldozer. The multi-purpose hospital was expanding its workload of patients as well, and eventually had to be provided with an orthopaedic registrar to help cope with the staffing shortage.⁹⁴ The changes were further demonstrated with the retirement of the Head Orderly, Hugh Marshall, after thirty-seven years' work at the site, from the days of the Infectious Diseases Hospital.⁹⁵ Another link with the past, Sub-Matron Ivy Wells, was also due to retire at the end of 1966, prompting the appointment of a new Sub-Matron to the RP(R)H.

Rosalind Denny was the new appointee, a nurse who had trained at the MIDH during the Second World War, and who had a career at Royal Perth Hospital following that.⁹⁶ Denny was Sub-Matron through some troublesome times - she had not seen the Hospital since her staff nurse days, and was appalled at the condition of the site. Shortages of nursing staff also led Denny into her campaign to promote the re-employment of married nurses in the hospital workforce. Her relationship with the administration of Royal Perth Hospital, and her mastery of her nursing staff, were such that the Nursing Advisory Committee at the main hospital generally refrained from 'poaching' the better staff.⁹⁷

Distinguished visitors were making their way to the RP(R)H in increasing numbers - in 1966, these included Major General Sir Douglas Kendrew, the Governor of Western Australia; Dr Dudley Longmore, Commonwealth Director of Social Services (Rehabilitation); Dr J Chandy, Professor of Neurology and Neurosurgery, Christian Medical College, Vellore, India; The Hon A H Jago, MLA, NSW Minister for Health; Dr H Selle, the chairman of the NSW Hospitals Commission; and Mr J D Rimes, undersecretary from the Public Health Department of NSW.⁹⁸

Meanwhile, with the demolition of the old Wards 8 and 10, the way was clear for new Wards 8 and 10.⁹⁹ This required ministerial intervention, when it was discovered that work could not begin on the wards, in the normal course of events, until August or September 1967.¹⁰⁰ Minor works, such as the provision of covered ways between the wards, continued as usual.¹⁰¹ Wards 3 and 4 were being remodelled, but work was intermittent due to non-availability of day labour and rising costs.¹⁰² A chapel was also being planned for the RP(R)H, an aspect of patient life which had been largely neglected since that first tent at Subiaco - doubling as the dining tent - in which Fr Prendergast and Rev Wallace held their Sunday services for the smallpox encampment. The main

⁹⁴RPH BM Min, 1.8.66, p. 5.

⁹⁵RPH AR 1966, p. 68.

⁹⁶RPH BM Min, 1.8.66, p. 10.

⁹⁷Conversation with R Denny, by P Martyr.

⁹⁸RPH AR 1966, p. 32.

⁹⁹RPH BM Min, 6.2.67, p. 5.

¹⁰⁰RPH BM Min, 3.4.67, p. 7.

¹⁰¹RPH BM Min, 3.7.67, p. 3.

¹⁰²RPH BM Min, 6.2.67, p. 5.

hospital had chaplains, the Roman Catholic cathedral next door, and the Anglican cathedral a short walk away, but the Shenton Park site was further from any religious amenities.¹⁰³ Further funding for the chapel was allocated at the beginning of 1968, and it was finally blessed and opened on 3 November 1968.¹⁰⁴ In 1969, the Quadriplegic Centre was ready for opening, registered as a C-class hospital, and to accommodate both quadriplegic and paraplegic patients.¹⁰⁵

Bedbrook had not forgotten that the matter of the possible independence of the RP(R)H had never been resolved. Accordingly, he kept up the pressure via the RP(R)H House Committee, especially "with relation to the rehabilitation needs of this State". The Board replied that "it considers that a further approach so soon after the earlier one would serve no useful purpose."¹⁰⁶ The put-down was sweetened with the offer to have Bedbrook made a member of the Board of Management of the main Hospital.¹⁰⁷ Bedbrook did become a member of that Board shortly afterwards, and also of the Medical Advisory Committee in July 1967.¹⁰⁸ But in nursing, the RP(R)H was excluded - the Nursing Advisory Committee at the main hospital did not extend its membership to allow direct representation from the RP(R)H nursing establishment.¹⁰⁹

In keeping with the RP(R)H's commitment to improving staff qualifications, Lynne Cox, sister in charge of the Paraplegic Unit, was granted leave and funding to visit eastern states hospitals, to gain knowledge which would improve the standards of paraplegic nursing at the RP(R)H.¹¹⁰ There was again a crucial shortage of nursing staff at RP(R)H, even though the site had been approved by the Nurses' Registration Board as a training school for nursing aides in its own right.¹¹¹ This shortage did open up the way for the employment of more part-time sisters at the RP(R)H, including, by the 1970s, more married women. Other staffing problems were directly related to the comparative novelty of rehabilitation as a medical specialisation in Australia. An advertisement for an honorary visiting physician at the Rehabilitation Hospital was unanswered, so the Board had to consider appointing a salaried staff member instead.¹¹² The physiotherapy establishment at the RP(R)H also had to be increased in 1967, from sixteen to eighteen - a far cry from the days when one remedial gymnast worked for the whole hospital.¹¹³

The Board decided against supporting Bedbrook's plan for a sports medicine clinic at the RP(R)H,¹¹⁴ but other specialisations were making their way - by fair

¹⁰³RPH BM Min, 27.2.67.

¹⁰⁴RPH BM Min, 8.1.68, p. 4; RPH AR, 1969, p. 28.

¹⁰⁵RPH AR 1969, p. 28.

¹⁰⁶RPH BM Min, 3.7.67, p. 9.

¹⁰⁷RPH BM Min, 3.7.67, p. 13.

¹⁰⁸RPH BM Min, 3.7.67, p. 14.

¹⁰⁹RPH BM Min, 4.12.67, p. 4.

¹¹⁰RPH BM Min, 7.8.67, p. 1.

¹¹¹RPH BM Min, 7.8.67, p. 1; RPH AR 1963, p. 60.

¹¹²RPH BM Min, 7.8.67, p. 6.

¹¹³RPH BM Min, 4.9.67, p. 7.

¹¹⁴RPH BM Min, 4.12.67, p. 7.

means or foul - into the RP(R)H. The speech therapy department did not deal exclusively with stroke rehabilitation, but also with head injuries and post-neurosurgical patients.¹¹⁵ Peg Waddell recollected some of the secrecy involved in the treatment of head-injured patients, especially with the watchful eye of Bedbrook maintaining strict territorial control over orthopaedic practice:

I can remember before I went into rheumatology and we were looking after the head injuries patients, and ... George, he was a very powerful fellow then, but he was very one-minded about spinal injuries, which I can understand, and I admired him for that, because I am one-minded about rheumatology ... we would bring [head injured patients] in sometimes over the weekend for respite, and ... we used to have to hide them, because they would shout ... Dr Carruthers was down there, and he was a very humane person, and providing he didn't know about it, he would certainly look the other way. He was a fine, fine man ... Mac [Carruthers] had compassion for the head injured people, I think. And so he looked the other way.¹¹⁶

Goatcher was also adept at securing beds for her rheumatology patients, even if it involved rearranging entire wards to continue her work.¹¹⁷

Plans for the unified training college for ancillaries foundered by the late 1960s.¹¹⁸ The Public Works Department had not been helpful, and the Physiotherapy Registration Board wanted the site to be at Hollywood. The Occupational Therapy School was prepared to support this, as long as the School of Occupational Therapy became an autonomous body.¹¹⁹ By 1969, the site of the combined School of Occupational Therapy and Physiotherapy was fixed as RP(R)H, but work would not begin in earnest on this until the 1970s.¹²⁰ It was not to be a genuinely combined school, as the Western Australian Institute of Technology was to control the physiotherapy course, and the Hospital the occupational therapy course, but the joint training facility was seen as a means of overcoming professional tensions.¹²¹

By the end of the 1960s, the Annexe had become the RP(R)H. The last of the old buildings from before the Second World War had been demolished, and new ward blocks and units were rising in their place. Staffing was increasing, and yet the new nurses' quarters could not be filled at times, because of the shortage of nursing staff. The plans for a Quadriplegic Centre were taking on concrete form, and new wards devoted to specialist conditions were now operating at the RP(R)H. But the real future of the site was still in question - the old battle over the future direction of the RP(R)H was on again, and would

¹¹⁵RPH BM Min, 2.10.67, p. 9.

¹¹⁶Interview with Mrs M Waddell, by P Martyr, p 9 transcript.

¹¹⁷RPH BM Min, 1.4.68, p. 6.

¹¹⁸RPH BM Min, 5.2.68, p. 12.

¹¹⁹RPH BM Min, 6.5.68, p. 8.

¹²⁰RPH AR 1970, p. 27.

¹²¹PHD AN 120/16 Acc 1556 #5711, 1965, Box 11, Bedbrook to Devereux, 17.1.66, pp. 28-29; MacKinnon to Devitt, PT Reg Board, 26.9.69, p. 80.

remain so until the early 1980s. The sacking of Burnford at the Annexe was a scandal many remembered. Just what would become of this ramshackle, complicated hospital at Shenton Park?

Chapter Eight: Things Old and New

By the 1970s, the Royal Perth Rehabilitation Hospital had a record of established success and a far more attractive, safe and substantial establishment than it had enjoyed for decades. Yet it is remarkable how many of the old problems and issues revived in the 1970s and 1980s - the question of independence; the overcrowding of beds; fire; infectious diseases outbreaks. These were at times complicated by new problems, such as the decline in nursing staff numbers in the 1970s, as the profession grappled with its identity in a changing medical world. There was also a change of administration at the main Hospital, as Griffith retired in 1968.¹ Griffith's replacement was Victor Driscoll, and this signalled an end to the 'golden years' of sympathetic administration and personal good relations between Bedbrook and the management of Royal Perth Hospital. Things became a little tougher, the channels of communication a little more complex, and some of Bedbrook's plans for the RP(R)H thus had to die a natural death.

The national development of rehabilitation had continued on a Federal as well as a State level. The late 1960s and early 1970s produced important investigations and expressions of dissatisfaction with Australia's health care system, beginning with the 1969 Nimmo Report on health insurance in Australia.² Following this was the Hospitals and Health Services Commission's Report *on Hospitals in Australia* in 1974.³ The regional planning recommended by the Sax Report was greatly influential in the move towards community-based health care that characterises this period. For rehabilitation, community-based care had several implications. Although still hospital-based, community rehabilitation facilities were to be "based close to local communities in order to ease gradual resumption of a normal social and working life."⁴

In Western Australia, rehabilitation was affected by all these changes. Building plans increased, as a planned operating theatre and radiology block were costed at \$520 000⁵ - a cost which, by mid-1969, had crept up to \$545 000.⁶ At the same time, a medical officer's basic starting salary at the Hospital was \$7 034, and a salaried senior specialist could earn the staggering sum of \$10 310.⁷ By the time tenders had closed on the new block, in December 1969, the price tag had risen to \$572 914. It is no wonder that the under-secretary of the

¹RPH BM Min, April 1972, p. 9.

²Australia. *Committee of Enquiry into Health Insurance. Report of the Commonwealth Committee of Enquiry, March 1969*, Canberra: AGPS, 1969.

³Australia. Hospitals and Health Services Commission. *A Report on Hospitals in Australia*, Canberra: AGPS, 1974.

⁴ibid, p 106.

⁵RPH BM Min, 7.10.68, p. 3. See also 14.4.69, p. 5.

⁶RPH BM Min, 5.5.69, p. 9.

⁷RPH BM Min, 3.11.69, p. 6.

Medical Department urged "that this project should be proceeded with as quickly as possible"⁸

Individual staff were consolidating their positions as well - Dr Mercy Sadka was appointed to the position of Neurologist to the Hospital, from 1 November 1968.⁹ Dr F Mastaglia, senior lecturer in Medicine (Neurology) at the University of Western Australia's School of Medicine, had also been involved with neurological patients at the RP(R)H, and was in 1971 given visiting staff status in recognition of this.¹⁰ The educational future of other disciplines essential to rehabilitation also looked more secure: the state Cabinet had decided to locate the possible 'joint school' of occupational therapy and physiotherapy at the Hollywood Medical Centre - the nucleus of the new Sir Charles Gairdner Hospital - and that the school would be under the control of the Western Australian Institute of Technology (WAIT).¹¹

The role of the Western Australian Arthritis and Rheumatism Foundation, which grew out of the Rheumatology Department at RP(R)H and in particular Ward 10, which housed these patients, was instrumental in drawing greater public attention to the large numbers of people suffering from arthritic and rheumatic conditions. It also challenged the idea that arthritis and rheumatism were conditions of the elderly only, and in recognition of her work in this area, Dr Phyllis Goatcher was nominated as Western Australian Citizen of the Year in 1975.¹² 1977, World Rheumatism Year, was opened in Perth, and RP(R)H nursing staff Margaret Waddell and Miss L Thurston both attended a seminar on WRY in early April.¹³ Eleven members of the nursing staff - eight from RPH and three from RP(R)H - attended a 1978 seminar on arthritis held by the Royal Australian Nursing Federation.¹⁴ Mrs Margaret Waddell, who worked in the new Ward 10 from its opening in 1968, described the feeling of working in an authentic rehabilitation team:

And it was during this time, when we were able to concentrate solely on rheumatology, that I realised the needs of patients. Because it was being established we learned the need for so many people to be involved, first of all the rheumatologist and then the nurse who was looking after the patient, the physiotherapist, the occupational therapist, the dietitian and those wonderful people who were creating the aids there ... They were all really so enthusiastic and keen.

This rubbed off onto the patients:

The patients were so happy to know that at last they were being recognised as a specialty. And so altogether there was a great

⁸RPH BM Min, 1.12.69, p. 4.

⁹RPH BM Min, 4.11.68, p. 5.

¹⁰RPH BM Min, 8.2.71, p. 4.

¹¹RPH BM Min, 4.11.68, p. 9.

¹²RPH BM Min, 9.6.75, p. 7.

¹³RPH BM Min, 14.3.77, p. 2.

¹⁴RPH BM Min, 1.5.78, p. 5.

bond and a great feeling about - we were all working towards something exciting. If you can call it exciting! I often heard Dr Goatcher say "This is exciting" and I used to think "Gosh, fancy thinking this is exciting", but I could understand how she felt.¹⁵

Ward 10 had innovative ideas about occupational therapy, extending even to an annual fete to raise funds for arthritis research.

almost the last few months of the year, all those patients would be making dolls and stuffed toys and one of them used to get honey. We used to get a big container of honey and everyone had to fill honey jars to be sold on the day of the fete. This was how it went on. Really, the administration of RP(R)H were wonderful because no-one else would have got away with all this clutter on the floor and under beds and in the lockers ... They just looked the other way.¹⁶

George Bedbrook, too, was not wasting his time - the Board agreed to have the main Hospital act as the host for the 29th Annual General Meeting of the Australian Orthopaedic Association in August 1969.¹⁷ Further to this, he pointed out that the RP(R)H was not admitting patients from either Sir Charles Gairdner Hospital or Fremantle Hospital - his plan to have the site made into an independent hospital, which would meet the rehabilitative needs of all major metropolitan and even state hospitals, had not waned.¹⁸ The orthopaedic staffing at the RP(R)H was further improved by the appointment of Ellis Griffiths as a member of the visiting staff, in the position of Assistant Orthopaedic Surgeon.

The RP(R)H's links with other Australian disability associations were also improved. Bedbrook had represented the Hospital at meetings of ACROD held in Launceston, and suggested that the Hospital support ACROD with funds. He also wanted the Board to meet occasionally at the RP(R)H site, so that they could have a clearer idea of the many changes and improvements which had taken place, but the Board preferred the idea of group visitation rather than meetings.¹⁹ Maintaining the momentum was a never-ending task for Bedbrook, especially in the face of declining attendances at RP(R)H House Committee meetings - in June 1969 a set of minutes could not be accepted as recommendations due to the absence of a quorum.²⁰ And he was temporarily defeated on another matter: the Board wanted it made quite clear that all future medical staff appointments were to be made to Royal Perth Hospital, "and not specifically to any part of the Hospital complex." The prospect of a separate establishment, which Bedbrook had been quietly working at, was finally

¹⁵Interview with M Waddell, by P Martyr, p. 1 transcript.

¹⁶Interview with M Waddell, by P Martyr, pp. 7-8 transcript.

¹⁷RPH BM Min, 6.1.69, p. 6.

¹⁸RPH BM Min, 3.2.69, p. 8.

¹⁹RPH BM Min, 5.5.69, p. 10.

²⁰RPH BM Min, 9.6.69, p. 6.

uncovered.²¹ Nonetheless, the Board still felt that Bedbrook would cause less trouble if he were kept in sight all the time - he, Mr J P Ainslie and William Davidson were all re-appointed to the Board until 31 July 1972.²²

Education remained vital to the survival of rehabilitation as a medical discipline. A seminar on rehabilitation was to be held on 12-13 July 1969 as part of the University Extension Service at the University of Western Australia, with the help of the Council of Social Services (WA) and the WA Committee on Sheltered Workshops.²³ The Rehabilitation House Committee also recommended sending an occupational therapist to a speech therapist conference, on the specialist subject of aphasia, in Brisbane in May 1969, followed by her attendance at the ACROD conference in Sydney.²⁴ Dr J Bloomfield, head of Physical Education at UWA, requested that his students be permitted to participate in the rehabilitation program, in order to give them experience in physical education for the disabled. Bedbrook continued to be active with ACROD well into the 1970s, and the RP(R)H hosted a rehabilitation seminary in April 1975.²⁵

The often-stormy question of student nurses had re-arisen. Social changes in Western Australia, common to the rest of the country, were leading to a decline in the perceived status of the nurse. As the workforce opened up more and more positions to women, fewer girls felt drawn to the now less-glamorous work of nursing. Whereas in the past, nursing candidates had to be at a certain level of competence and 'suitability' - 'young ladies' doing work appropriate to their class - the increasing demands on nurses, and a corresponding rise in union activity, were essentially removing from nursing its professional aura, and making it into a job, or a technical trade. Nursing may still have clung to its status as a profession, but other medical professions were available to girls - physiotherapy, occupational therapy - that had shorter hours, better pay, more freedom and greater career opportunities. The 'cream of the crop' who would, in the past, have gone into nursing, now went instead into these fields.

In order to remedy this, the RP(R)H sought the reintroduction of student nurses at the site, and it would also provide a chance to make up for having the site officially brought under the control of the main Hospital in future appointments - student nurses from other hospitals could train at the RP(R)H in rehabilitative nursing.²⁶ Sister Nora Hider was a charge sister at RP(R)H for many years, and had a thorough but practical approach to nursing staff discipline:

She was one of the last old warhorse sisters. One time a nurse arrived late for work and reported to her - you had to do that. She gave her a dressing down ... 'There are sick people here relying on you. Get yourself here on time.' Then she paused, looked at the youngster and said: 'Have you had any

²¹RPH BM Min, 7.7.69, p. 5.

²²RPH BM Min, 4.8.69, p. 11.

²³RPH BM Min, 7.7.69, p. 2.

²⁴RPH BM Min, 7.7.69, p. 5.

²⁵RPH BM Min, 7.10.74, p. 6.

²⁶RPH BM Min, 7.7.69, p. 6.

breakfast?' 'No sister.' 'Then get off to the kitchen and get some coffee and toast, you can't work on an empty stomach.'²⁷

A further change was made to the nursing establishment in 1970, as the title of Sub-Matron at the RP(R)H was changed to Deputy Matron, and it was suggested that perhaps even the full title of 'Matron' of the RP(R)H would not be inappropriate - a suggestion which was smoothly bypassed.²⁸ Rosalind Denny had accepted the position of Matron of King Edward Memorial Hospital, and the new Deputy Matron was Pamela Edmonds-Hill (now Pamela Norcott), appointed in 1971.²⁹ Edmonds-Hill continued the tradition of well-qualified senior nursing staff, having trained at the Royal College of Nursing in Edinburgh, and also serving as assistant Matron at RPH - a reversal of the older practice of Matrons training at the Infectious Diseases Hospital and then moving to senior positions in major hospitals.

The Quadriplegic Centre had done much to ease the crowding at RP(R)H, and in recognition of its quadriplegic membership, the Paraplegic Association of WA became the Paraplegic-Quadriplegic Association of WA, or Para/Quads for short.³⁰ In 1970, Royal Perth Hospital was able to advertise for a specialist in rehabilitation medicine, and Dr Phyllis Goatcher was invited to assist the committee that would be instrumental in choosing a candidate.³¹ The ideal of rehabilitation as a field in itself, supported by medical and research infrastructure, was dear to Bedbrook's heart, and after his overseas trip to inspect other internationally successful spinal units, he urged the compilation of extensive private orthopaedic records, based on work done at the RP(R)H. The orthopaedic surgeons were willing to volunteer clerical staff for the necessary filing, and had plans for a more detailed classification of conditions than was normally the case with Royal Perth Hospital records.³²

The need for rehabilitation to extend into people's homes had, however, been recognised by the Hospital, which agreed to have Hospital tradesmen install hand rails, ramps and other modifications in the homes of discharged patients.³³ Initiatives like this were to be more fully developed by the creation of the Independent Living Centre.

Bedbrook was still active in research, obtaining grants from the Medical Research and Special Clinical Purposes fund at the main Hospital to study the physical characteristics of spinal cord tissue (\$1 700) and also for illustrating a textbook on paraplegia (\$1 000).³⁴ But there was no doubt that Joseph Griffith's retirement in 1968 had signalled a profound change in the prioritisation of RP(R)H requests. For example, there was a delay in ordering equipment for the new radiology unit at RP(R)H - this would have required a conversation with

²⁷'Nora's spirit soars on in Neds', *Subiaco Post*, 29.10.91, obituary article, p. 63.

²⁸RPH BM Min, 7.12.70, p. 1.

²⁹RPH BM Min, 8.3.71, p. 1.

³⁰PQAWA, *Paraplegic-Quadriplegic Association of WA: a brief history*, c. 1981.

³¹ RPH BM Min, 7.12.70, p. 8.

³²RPH BM Min, 11.1.71, p. 5. Permission was granted 8.3.71, p. 5.

³³RPH BM Min, 5.7.71, p. 2.

³⁴RPH BM Min, 14.6.71, p. 6.

Griffith, and the problem would have been fixed. Now the matter had to be put in writing and raised with the new Administrator, Victor Driscoll, more formally.³⁵ The problems with the block were not addressed until August.³⁶

Matters came to a head in July 1971, when the Board openly addressed the matter of any future independence of the RP(R)H. A considerable stack of evidence had been accumulated: Bedbrook's report on overseas rehabilitation hospitals, a memo of the views of the orthopaedic surgeons, a report from the RP(R)H clinical staff, and comments from Ellis Griffiths. The main recommendations put forward were:

- (a) that the Board should support the development of specialised sub-units (as it had done in the past)
- (b) that the RP(R)H be run by an independent Board of Management, and that it have its own administration
- (c) the development of teaching and research facilities at the RP(R)H
- (d) the provision of additional beds at the RP(R)H
- (e) the establishment of a Day Hospital.³⁷

Driscoll was opposed to these moves. He noted the general trend towards centralisation of hospital services, and the Board's recent moves to strengthen inter-hospital co-ordination, especially with the new Sir Charles Gairdner Hospital in Hollywood/Subiaco. Unless there was one co-ordinating authority, the co-operation between "the two hospitals" would decrease. The RP(R)H was too reliant upon RPH facilities, and it would be difficult to staff it fully, including providing a good administration. Duplication of facilities would be inevitable.

The clearest indication of Driscoll's real opinion can be seen in his resolution that, when the committee investigating possible independence conduct its investigations, it pay particular attention to the "name and function (if any) of the House Committee" at RP(R)H.³⁸ This was a blow aimed at the whole process at which Bedbrook and others had been working since the foundation of the Paraplegic Unit in 1954. Getting a House Committee for the Annexe, as it then was, was a major breakthrough in achieving recognition of the work of the hospital as a rehabilitation facility. And yet legally, for the whole time, the Board of Management of RPH had no real claim to the RP(R)H. Nothing had changed since the incorrect investiture under the Hospitals Act by the Lieutenant Governor in 1943. Subsequent investigations had still revealed that, as far as the Crown Law Department was concerned, the RPH Board had no legal title to the RP(R)H or the land upon which it stood. It was still the property of the State Government, and nominally of the Local Government Association and the local councils that had paid for the construction of the 1939 Metropolitan Infectious Diseases Hospital. Royal Perth Hospital had staffed and supplied the RP(R)H for all that time, but that appears to be its sole claim.

³⁵RPH BM Min, 5.4.71, p. 7.

³⁶RPH BM Min, 2.8.71, p. 11.

³⁷RPH BM Min, 5.7.71, p. 7.

³⁸RPH BM Min, 5.7.71, p. 8.

The RPH management was far from unsympathetic to rehabilitative work: it funded displays from the RP(R)H and other disability groups for the World Rehabilitation Congress to be held in Sydney in August 1972 - the RP(R)H's display eventually a prize-winner.³⁹ The Medical Department (Public Health), in conjunction with the teaching hospitals, eventually organised an interdisciplinary team of six to attend the conference.⁴⁰ But Bedbrook persisted in his efforts to obtain greater research facilities at the RP(R)H - and this time, to be paid for by the main Hospital. A prefabricated building donated to the RP(R)H had been partially funded by the Paraplegic Association, and the Department of Orthopaedic Surgery, and the Department of Rheumatology had indicated a willingness to contribute also. Bedbrook calmly asked for the main Hospital to provide tables, chairs, couches and filing cabinets for this facility, and also requested that the main Hospital arrange for the connection of electricity and payment of maintenance costs for future running.⁴¹ The Paraplegic/Quadriplegic Association eventually took up the maintenance funding for the first twelve months.⁴² It is obvious that Bedbrook intended to take the Board at their word, for the time being.

Teaching prospects at the site were also dealt a heavy blow in March 1972, as the fifth year medical students who had, up till then, studied neurology and rheumatology at the RP(R)H, were withdrawn. This was because, the Board noted, "the facilities at Shenton Park were not sufficient to justify continuation of attachments of students there", and all future classes would be held at Sir Charles Gairdner Hospital.⁴³ The members of the Clinical Staff Committee were angry at the lack of consultation with them prior to this decision being made, and asked for the re-establishment of teaching at the Rehabilitation Hospital.⁴⁴ They complained to the Dean of the Faculty of Medicine, Professor G G Lennon, who investigated the matter. Lennon reported that "teaching had not ceased but had been reduced, the real problem being a lack of Clinical Teachers rather than a shortage of teaching material and inadequate facilities."⁴⁵ There had also been no success in filling the post of Specialist in Rehabilitation Medicine.⁴⁶

Temporarily defeated, Bedbrook resigned as Head of Department of Paraplegia. He continued as Senior Surgeon to the Department, but wished Ellis Griffiths to take over as Head. The fact that Bedbrook had founded the original Paraplegic Unit in December 1954 was noted, and "a high tribute was paid by members of the Board to his outstanding work in developing the Department to its present high standard and world recognition."⁴⁷ In recognition of this standard, the Senate Standing Committee on Health and Welfare visited

³⁹RPH BM Min, 4.10.71, p. 10; RPH BM Min, 4.12.72, p. 9.

⁴⁰RPH BM Min, 12.6.72, p. 9.

⁴¹RPH BM Min, 4.10.71, p. 9.

⁴²RPH BM Min, 10.1.72, p. 7.

⁴³RPH BM Min, 13.3.72, p. 8.

⁴⁴RPH BM Min, 13.3.72, p. 9.

⁴⁵RPH BM Min, April 1972, p. 7.

⁴⁶RPH BM Min, 2.10.72, p. 7.

⁴⁷RPH BM Min, April 1972, p. 8.

the RP(R)H as part of the Woodhouse and Meares investigation into compensation and rehabilitation in Australia.⁴⁸

The National Rehabilitation and Compensation Scheme Committee of Inquiry was launched at the same time as the Sax Commission, and was chaired by Mr Justice A O Woodhouse and Mr Justice C L D Meares. It reported after fifteen months of intensive legal and medical investigation into the “desirable scope and form of a nationwide system of rehabilitation and compensation for all injured persons”, including those incapacitated by sickness or congenital defects.⁴⁹

The planned scheme never came into being, a casualty of the Whitlam government's downfall in 1975. However, the National Advisory Committee for the Handicapped that was set up as a result of the Report, survived until 1983, when the Disability Advisory Council of Australia replaced it.⁵⁰ The incoming Fraser government commissioned a Task Force on Coordination in Welfare and Health, which recommended that the federal interest in rehabilitation should be progressively transferred to the state governments.

At the RP(R)H, major changes were taking place in the organisation of the units, especially in their nomenclature. The units were now titled: Neurosurgical Department (Rehabilitation Unit), Neurological Department (Rehabilitation Unit), Orthopaedic Department (Rehabilitation Unit), Rheumatic Diseases Department, Spinal Department, and Infectious Diseases Department - the RP(R)H still preserved this link with the past in continuing to accommodate infectious diseases patients.⁵¹ A reorganisation of the Physiotherapy Department in 1972 also brought Eric Stovell the administrative control of both the RPH and RP(R)H departments.⁵² When Stovell left to take up an appointment with the Western Australian Institute of Technology, in 1973, a new Superintendent Physiotherapist had to be found. It was eventually decided to re-divide the two hospitals' physiotherapy resources into two separate departments, with Miss P O Wilkinson as Superintendent of Physiotherapy at RPH, and Mrs M Powell in the same position at RP(R)H.⁵³

Keeping not only the Board but the public interested in the RP(R)H was a constant activity. In April 1973, a program of monthly luncheons was proposed, with invited guests interested in the work of the Hospital. The luncheons were to be hosted by senior administrative staff from both RPH and RP(R)H.⁵⁴ The WA branch of the Australian Medical Association was also interested in information on the work of the RP(R)H, which Bedbrook was willing and able to produce.⁵⁵ And in May 1973, the Rehabilitation Hospital was honoured with an informal

⁴⁸RPH BM Min, April 1972, p. 9.

⁴⁹Australia. Committee of Inquiry into the National Rehabilitation and Compensation Scheme, *Compensation and Rehabilitation in Australia*, vol 1, July 1974, Canberra: AGPS, 1974, p xv.

⁵⁰Tipping, op cit, p 133.

⁵¹RPH BM Min, 12.6.72, p. 9.

⁵²RPH BM Min, 7.8.72, p. 5.

⁵³RPH BM Min, 5.11.73, p. 9.

⁵⁴RPH BM Min, 2.4.73, p. 3.

⁵⁵RPH BM Min, 2.4.73, p. 5.

visit from Crown Princess Michiko of Japan, who accepted one of polio artist Paul Berry's paintings.⁵⁶ The Federal Minister for Health, Dr Everingham, also visited the Hospital, in June 1973.⁵⁷

One of the recurring problems of the RP(R)H was the recruitment of suitable specialist staff. Now that rehabilitation was becoming a discipline in its own right, the Hospital wanted staff experienced in this discipline. But rehabilitation had not made the inroad into teaching that had been hoped for, and it was all too often that the Electoral Committee would receive a single application for a rehabilitative position. Such was the case with R J (Bob) Oakeshott, when he applied for the position of Associate in Paraplegia.⁵⁸ Oakeshott was well-qualified, and was appointed, but the single applicant for the position of Specialist in Rehabilitation was turned down. Oakeshott himself, who in 1975 also gained a postgraduate qualification in Physical and Rehabilitation Medicine, finally filled this second position in 1974.⁵⁹

In the effort to produce its own well-qualified rehabilitation nursing staff, it was suggested that RPH combine the six-month paraplegia post-graduate course with the very popular orthopaedic post-graduate nursing course. The Nursing Education sub-committee disagreed, noting that "twelve month post-graduate courses were not popular."⁶⁰ In 1976, Pam Edmonds-Hill also spent 11 weeks studying overseas techniques of rehabilitation nursing.⁶¹

Carruthers was finding his position of Deputy Medical Superintendent increasingly difficult, especially his obligation to chart a safe course between the various demanding senior staff members and the administration of Royal Perth Hospital. As Bedbrook later commented:

Mac was an awfully nice person ... but no motivation, no stamina. Wouldn't take a decision, whereas Ellis Griffiths made a decision and that was the end of it and it was done ... I felt sorry for [Carruthers] in the long run.⁶²

The last thing on anyone's mind in 1973 at RP(R)H was infectious diseases. The advent of sulfa drugs, and then penicillin and other antibiotics, combined with widespread immunisation, had practically made deadly infectious diseases a thing of the past for Perth's inhabitants. And yet, in February 1973, the RP(R)H was asked to prepare for a possible cholera emergency. In a delightful twist of history, the complete changeover of the Hospital's function was made clear in the request to examine "the role of the Rehabilitation Hospital as an

⁵⁶RPH BM Min, 7.5.73, p. 10; RPH AR 1973, p. 27..

⁵⁷RPH BM Min, 11.6.73, p. 22.

⁵⁸RPH BM Min, 4.12.72, p. 9.

⁵⁹RPH BM Min, 7.10.74, p. 8; RPH BM Min, 9.6.75, p. 8.

⁶⁰RPH BM Min, 2.7.73, p. 1.

⁶¹RPH BM Min, 5.1.76, p. 1.

⁶²Interview with Sir George Bedbrook (2), by P Martyr, p. 21 transcript.

'infectious diseases hospital' ".⁶³ This became even more important with the closure of the Woodman's Point Quarantine Station in 1977.⁶⁴

A problem perpetually faced by any rehabilitation facility is its very function. Medicine and nursing have, in modern times, taken much of their prestige and authority from acute care - brushes with death, lives saved, or miracle surgery. Chronic illness, and long-term rehabilitative care which may not result in a 'cure' easily recognisable as such, have less to offer in the way of medical 'glamour'. The work is arduous, and involves a long-term commitment to the same patients, day in and day out. In a culture that is reliant upon quick fixes for most problems, health included - antibiotics and pain-killers - the longer, slower demands of rehabilitative care seem to be almost unendurable. And yet thousands have endured them, both patients and staff. Nonetheless, the lack of 'glamour' attached to rehabilitative care began to show in the 1970s, as fewer nurses sought to train in this area. When the proposal came up for combining paraplegia nursing training with the orthopaedic post-graduate course, the first complaint was that this would detract from the popularity of the orthopaedic nursing course.

The expansion of the RP(R)H site was continuing - WAIT asked for an extension of property around the Therapy Training Schools to create further car-parking space, and the Para/Quad Association requested an extension of their facilities also, particularly the Quadriplegic Centre. If the latter was granted, the Board noted that this would reduce the RP(R)H site to a mere forty acres - oddly enough, the original size of the first Victoria Hospital site.⁶⁵ Other old problems, dating from before the rehabilitation facilities were even thought of at the site, were re-emerging, notably overcrowding. The Rehabilitation Hospital Committee (the renamed House Committee⁶⁶) expressed concern that "two Departments at the Rehabilitation Hospital were having to place additional beds in areas not designed for patient accommodation."⁶⁷ The Board could do little to help, except to point out that there was no way of restricting admissions according to capacity. Part of the problem was RPH's own overcrowding - there was an acute shortage of orthopaedic beds at the main hospital, and up to 60% of the beds allocated to orthopaedic surgery at RP(R)H were being occupied by acute patients.⁶⁸ And the cholera outbreak concerns showed no signs of abating.⁶⁹ In 1978, \$208 000 was allocated to be spent on the construction of a five bed isolation ward at the western end of Ward 8 at RP(R)H.⁷⁰

Hard on the heels of this was the revelation that Sir Charles Gairdner Hospital was undertaking plans towards its own independent rehabilitation facilities. The Rehabilitation Hospital Committee was appalled at what they clearly perceived to be a breach of trust on the part of SCGH, which had up till then been an

⁶³RPH BM Min, 5.2.73, p. 6.

⁶⁴RPH BM Min, 1.8.77, p. 6.

⁶⁵RPH BM Min, 3.9.73, p. 8.

⁶⁶RPH BM Min, 1.10.73, p. 6.

⁶⁷RPH BM Min, 1.10.73, p. 7.

⁶⁸RPH BM Min, 3.12.73, p. 11.

⁶⁹RPH BM Min, 1.10.73, p. 2, 5.11.73, p. 1.

⁷⁰RPH BM Min, 5.9.77, p. 8.; RPH BM Min, 1.5.78, p. 6.

active partner in joint hospital activities. The staff of the RP(R)H had even been approached to give advice on rehabilitation needs, which indicated quite clearly that “practical steps were being taken at the Sir Charles Gairdner Hospital to establish a rehabilitation unit.”⁷¹ The Rehabilitation House Committee accepted the changes to the extent of proposing that a member of the clinical staff of SCGH be invited to join the Committee.⁷²

What was on the agenda for RP(R)H was a Day Hospital. Plans of this were drawn up in 1976, and were accepted by the Board, with funding to be sought as soon as possible - the estimated cost was \$2.3 million.⁷³ The building combined outpatients' facilities and day hospital care, and construction was under way in 1980, due for completion in May 1982.⁷⁴ While the Hospital contemplated creating another position of Specialist in Rehabilitation Medicine, they lost their present one - Oakeshott resigned in 1976.⁷⁵ The additional post was established nonetheless - in fact, three Specialists were now needed, one of whom would be Director of the State Rehabilitation Service. Each Specialist would have patients at RP(R)H, but would be assigned to different hospitals - RPH, SCGH and Fremantle Hospital.⁷⁶ “Strong pressure”, the Board noted, “was being exerted for Rehabilitation Specialists to be appointed to Royal Perth (Rehabilitation) Hospital rather than to Royal Perth Hospital”, a pressure which needed correction.⁷⁷

Bedbrook kept up his gruelling round of conference attendances, overseas investigations and professional meetings.⁷⁸ In 1978, he was knighted in recognition of his ground-breaking work in orthopaedics, paraplegia and quadriplegic rehabilitation.⁷⁹ Sir George now became the only knight serving on the staff of the Royal Perth Hospital, in his capacity as Head of the Department of Orthopaedic Surgery. He was also awarded a medal by the International Medical Society for Paraplegia for his work in the same year, both of which did much to vindicate his often-confrontational approach in obtaining resources for patient care.⁸⁰ Sir George resigned from his post as Head in June 1979, continuing to work as an orthopaedic surgeon to the RPH.⁸¹ Only a few months earlier, Kathleen Johnson retired as Matron (from 1975, Director of Nursing) of the hospital.⁸² In September 1978, Phyllis Goatcher also resigned, as Head of the Department of Rheumatology, to be replaced by Dr Colin Bayliss.⁸³ Goatcher was awarded the Order of Australia in 1979, in recognition of her

⁷¹RPH BM Min, 7.1.74, p. 7.

⁷²RPH BM Min, 6.5.74, p. 11.

⁷³RPH BM Min, 6.9.76, p. 4.

⁷⁴RPH BM Min, 3.11.80, p. 9.

⁷⁵RPH BM Min, 4.10.76, p. 5; 1.11.76, p. 6.

⁷⁶RPH BM Min, 6.12.76, pp. 6-7.

⁷⁷RPH BM Min, 10.1.77, p. 8.

⁷⁸RPH BM Min, 5.9.77, p. 5.

⁷⁹RPH BM Min, 3.7.78, p. 1.

⁸⁰RPH BM Min, 7.8.78, p. 9.

⁸¹RPH BM Min, 12.3.79, p. 11; RPH BM Min, 11.6.79, p. 9.

⁸²RPH BM Min, 9.1.78, p. 7.

⁸³RPH BM Min, 4.9.78, p. 8.

clinical and community work, at Ward 10 and with WAARF.⁸⁴ On a sadder note, Malcolm Carruthers, the gentle Deputy Medical Superintendent of RP(R)H, died suddenly in July 1980, after twenty-five years' work at the combined Hospitals.⁸⁵

1981 had been designated the International Year of Disabled Persons, and projects around the theme 'Access and Prevention' were to be adopted by the Hospital.⁸⁶ The International Year of Disabled Persons in 1981 generated a great amount of publicity of the situation of the disabled in Australia - the work of ACROD in assisting mobility of the disabled, through lobbying for practical changes such as access-ways to major buildings and improved parking, also received more media attention. The Year's theme of 'Breaking Down the Barriers' did not just apply to practical availability of facilities for the disabled in an able-bodied society, but also attempted to address social barriers which existed between disabled and non-disabled individuals. The RP(R)H, having been committed to doing just that since the opening of the Paraplegic Unit in 1954, was actively involved in IYDP - staff, patients, and former patients, all participated in various ways, including sporting events and workshops. Sir George was invited to address the 1981 Royal Perth Hospital Annual Meeting, as a mark of his long-standing work with rehabilitation and disability in Western Australia.⁸⁷ Mrs Lyn Tinsley, senior physiotherapist in rheumatology at RP(R)H, was awarded a Winston Churchill Fellowship in 1981, to study rheumatic diseases treatment overseas.⁸⁸

IYDP proved to be a spark which re-ignited the great independence battle. The Board was warned that "consideration was being given to making the Royal Perth (Rehabilitation) Hospital independent in the Year of the Disabled".⁸⁹ An article had appeared on 18 March 1981 in the *West Australian* on this subject, so Driscoll wrote to the newspaper, outlining the reasons for the two hospitals remaining united. Sir George had also seen the article, and a letter from him was published in the *West Australian* on 6 April 1981. Driscoll was furious: "The statements made by Sir George Bedbrook were inaccurate and highly derogatory to the Board and it was regrettable that he should choose to publicise them in this way." The personal nature of the attack on Driscoll was not overlooked.⁹⁰ Bedbrook was summoned before a party representing the Board, to hear of their dismay, especially over what they saw as incorrect and deliberately mischievous statements.⁹¹ The clinical staff of RP(R)H, throughout the 1970s, had on the whole not wanted separation, and this decision was reaffirmed in the early 1980s.⁹² What the staff did seek was greater autonomy, through special representation on the Medical Advisory Committee, the Clinical

⁸⁴RPH BM Min, 5.2.79, p. 1.

⁸⁵RPH BM Min, 3.8.81, p. 14.

⁸⁶RPH BM Min, 3.9.79, p. 6.

⁸⁷RPH BM Min, 14.4.80, p. 10.

⁸⁸RPH BM Min, 5.1.81, p. 4.

⁸⁹RPH BM Min, 9.3.81, p. 14.

⁹⁰RPH BM Min, 6.4.81, p. 2.

⁹¹RPH BM Min, 4.5.81, p. 1.

⁹²RPH BM Min, 4.5.81, p. 10.

Staff Executive and the Board of Management itself.⁹³ Bedbrook himself retired from the RP(R)H Committee after 26 years of almost continuous service on it.⁹⁴

Low bed occupancy and the change in nursing accommodation requirements left vacant buildings at RP(R)H, and the Independent Living Centre, together with the appliances and aids section of the Civilian Maimed and Limbless Association, requested some of this to rehouse their facilities. WAARF also put in a bid for the old outpatients' building, no longer needed as the new Day Hospital/Outpatients Building was opened.⁹⁵ The old nurses' quarters were renamed Thorburn House in 1986, in honour of the Hospital's longest-serving honorary physician to infectious diseases, after Ian Thorburn's death in 1985. He was greatly missed - a popular clinical teacher, a conservative practitioner and a firm believer in the tradition of honorary service, Thorburn saw the introduction of paid sessions as a disaster for the independence of the medical profession.

The Independent Living Centre had its origins in October 1977, when businessman John Livie joined a working party (including RP(R)H staff members) to establish a facility which would provide advice and assistance for people with disabilities living in their own homes. It was officially opened in 1978, at its original headquarters in Havelock St, and in its first year of operations dealt with nearly four thousand inquiries - one fifth of these relating to independent living for those with arthritis. In later years, one of the most significant client groups was the RP(R)H outpatient group 'Life after Stroke'. The ILC also deals with carer groups, and provides information, sample equipment and support for people with disabilities.⁹⁶

Bedbrook's own health was failing, and he was hit hard by a series of sudden deaths - those of his wife, Jess, and of his old friend and colleague Joseph Griffith. In 1986, he retired from the RPH staff after over thirty years' work. Of all those who found Bedbrook difficult and confrontational, one man alone seemed to have found him a constant delight - Reg McKellar Hall, who was Sir George's medical partner in Perth for over thirty years, and who reported in 1983 that "we have worked together for approximately twenty-nine years and we have not had a cross word!"⁹⁷ McKellar Hall died in the late 1980s, his place in Bedbrook's medical partnership taken by Ellis Griffiths. As Bedbrook's health deteriorated further, he grew more and more interested in the history of the RP(R)H - the hospital he had found as a mix of brick and ruins in 1953. The mysterious life story of early Perth orthopaedic surgeon Alec Juett fascinated him - it was in fact his childhood reading of the life of heroic surgeon Richard Grenfell that motivated his desire to study medicine. When a stroke finally took his own life in Sir Charles Gairdner Hospital in October 1991, St George's Cathedral in Perth was crammed with over 500 people - former patients, staff members and others who had known Sir George throughout his career. The RP(R)H now administers the Sir George Bedbrook Spinal Unit, a tribute to his

⁹³RPH BM Min, 3.8.81, p. 13.

⁹⁴RPH BM Min, 2.8.82, p. 7.

⁹⁵RPH BM Min, 8.3.82, p. 18.

⁹⁶Independent Living Centre of Western Australia, *15th Annual Report*, 1992, p. 21.

⁹⁷McKellar Hall, *op cit*, p. 79.

pioneering work. His death was followed, in a matter of days, by Sister Nora Hider, who had worked for years with him at RP(R)H. Altogether, it seemed the end of an era.

The hospital complex has grown in a comparatively short time from a neglected isolation hospital to a world-class rehabilitation facility, which was able to celebrate its 100th birthday in April 1993, with a re-enactment of the transportation of the first smallpox cases to the site. The history of the hospital - one of the most unusual stories in Western Australian medical history - was still comparatively unknown outside the Hospital itself. Sometimes outrageous, occasionally ridiculous and frequently tragic, the hospital west of Subiaco has truly come of age. Dr Michael O'Connor would not believe his eyes, if he could have seen what would become of his "fever hospital in a suitable position". When infectious diseases were no longer considered as life-or-death as they had been, many wrote the Hospital off as useless. But instead it adapted to new conditions, and found a new lease of life. It is a living symbol of rehabilitation itself.

Epilogue

The Hospital – now Royal Perth Hospital (Shenton Park campus) – has undergone some changes since this book was first written. Some of these are outlined below. This is not an exhaustive list, but more in the way of an update on different things which reveal how the past influences the present, and how some present-day changes can be understood in their historical context.

There have been improvements and added services, among which was the sojourn at the site of the Perth Bone and Tissue Bank. In 1993, after a grant of \$223,500 from the Lotteries Commission, the Bank relocated to a laboratory at the Hospital, where it remained till 1998 when it moved to Hollywood Hospital. Also moving offsite was the School of Physiotherapy, after some 30 years in the Hospital grounds. In 2002, the School of Physiotherapy and the Department of Podiatry both moved to a new purpose-designed building on Curtin University's Bentley campus.

Issues from the past continue to re-emerge. In 2006, Dr Graham Jacobs tackled the issue of wheelchairs and waste at the Shenton Park Campus. A leaked Royal Perth Hospital document obtained by then-leader of the Liberal party (in opposition), Paul Omodei, indicated that at least 200 wheelchairs had been literally thrown away because there was no storage space left at the Hospital site.¹ A series of questions in State parliament followed:

- (1) Is the minister aware that from 2003 to March 2006, the average waiting time for a temporary loan wheelchair at Shenton Park has doubled from three to 6.3 days?
- (2) Is the minister aware that these wheelchairs are essential for safe hospital discharge, the facilitation of patient therapy and mobility replacement when permanent wheelchairs are being repaired?
- (3) Why has the minister allowed the waiting time for the delivery of temporary loan wheelchairs to blow out to almost a week?²

Chapter Five might have provided all those concerned with some hints as to the longstanding nature of the problem, when in the 1940s one of the only two wheelchairs available had to be booked ahead for half an hour's use at a time.

Other issues that refuse to go away include the vexed question of accommodation for physically disabled young people, who do not thrive in settings designed for the elderly (see Chapter Seven). In 2003, the West Australian reported the case of former nurse Marlene Groothedde, whose son James had suffered extensive physical and head injuries. James spent three

¹ Dr Graham Jacobs MLA, media release 21 June 2006,
<http://www.grahamjacobs.com.au/mediareleases06/wheelchairs.html>

² WA Parliamentary Debates, Wednesday 21st June 2006,
<http://www.grahamjacobs.com.au/speeches06/rphwchair2.html>

months in a nursing home, and then five years at Royal Perth Rehabilitation Hospital. He finally reached an out-of-court settlement on compensation which allowed him to build his own home and live there with 24-hour care.³ Another younger patient, 'Matthew', who sustained a head injury, describes his experience of being cared for at RP(R)H:

I do remember doing some rehabilitation at Royal Perth Rehabilitation hospital. I remember being in Ward 1 where they would try and teach me to walk again. I enjoyed my rehabilitation sessions. When I was doing rehabilitation at Shenton Park, the people there continued to get me to be able to walk and talk again. Though I think there should be more speech therapy.⁴

But there are some positive reminders of the past in the Hospital's present-day structure. Thorburn House still stands as a reminder of the generous service of the infectious diseases physician Ian Thorburn. Carruthers Block is a testimony to the gentle 'Mac' Carruthers. Ellis Griffiths House, Goatcher Block, Muecke Walk, Mercy Sadka Square, and the Sir George Bedbrook Spinal Unit all ensure that the hard work of each of these talented people will not be forgotten. Berry Loop remains to remind all who pass it of the patients who spent years, and sometimes the remainder of their lives, in the Hospital.

And still, what will become of the hospital? The election of the Liberal government in Western Australia in 2008 placed an embargo on the planned closure of the main campus of Royal Perth Hospital. A new committee was then formed to oversee the redevelopment of Royal Perth Hospital, including preserving the hospital's heritage precinct, adding a new west wing for 200 beds, and considering "incorporating the rehabilitation hospital at Shenton Park into the Royal Perth Hospital precinct".⁵

The hospital which was established under such dramatic conditions looks set to have an equally dramatic future. If any reminder of this was needed, a visitor need only walk up Victoria Drive, past Seymour House (named for the courageous Agnes Seymour, first nurse on the site) to Victoria House – the old Metropolitan Infectious Diseases Hospital, still at the heart of the campus. The earliest name for the hospital on this site was the 'Victoria Infectious Diseases Hospital', a name which appears on maps, but which was never really adopted by the staff or the public. Victoria House stands as a reminder that things have a way of turning out in ways other than anyone expected. With this in mind, we can possibly hope that the hospital's next one hundred years promise to be as interesting as the first.

³ 'Disabled clog aged homes', *West Australian* 13 August 2003, www.thewest.com.au, archived by the Physical Disability Council of WA at <http://www.pdcnsw.org.au/media/03/0814.html>

⁴ HeadWest web site, <http://www.headwest.asn.au/personal.htm>

⁵ ABC Perth website, 22 October 2008, <http://www.abc.net.au/news/stories/2008/10/22/2398519.htm?site=perth>

Appendix 1 - Senior Staff at the Infectious Diseases Hospital

Doctors

1893 (smallpox)	Dr Michael O'CONNOR Dr Louis WHEELER
1896-7 (measles)	Dr Thomas LOVEGROVE
1895-7 (typhoid)	Dr Michael O'CONNOR
June 1908	PPH takes control of site Dr BURKETT (Honorary Medical Officer to Infectious Diseases Hospital)
November 1908	Burkett resigns; replaced by Dr FLECKER
August 1910	Dr OFFICER (honorary physician to TB patients) Dr AMBROSE (honorary physician to diphtheria, scarlet fever etc)
April 1911	Officer & Ambrose resign
May 1911	Dr GORDON (honorary physician to TB) Dr GILL (honorary physician other IDs)
February 1912	Dr H J GRAY (honorary physician, TB and VD)
October 1913	Gray resigns as ID physician
February 1912	Dr J E GORDON (honorary physician other IDs)
November 1913	Dr HARVEY appointed ID physician
August 1914	Harvey resigns
October 1914	Dr WATCH appointed
1916	Dr Lionel ROBERTSON
April 1917	Dr MATENSON (?) JRMO at IDH
May 1934	Dr MOSS

1936

Dr Ian THORBURN

Senior Nursing Staff

1893

Agnes SEYMOUR

July 1908

? POTTEN, Charge Nurse

June 1910

Potten resigns as Charge Nurse

August-Sept 1908

Maida BALDING, Acting Matron

April 1911

Frances PHILLIPS, Staff Nurse in charge of IDBH

June 1912

? SHOOBRIDGE, temporary charge sister diphtheria + scarlet wards

November 1912

Maida BALDING, Acting Matron

March 1914

? ROSS, charge nurse

July 1914

? JAMES, First holder of newly created (June 1914) position of Sister-in-Charge

May 1915

James resigns (military service)
Eleanor HARVEY appointed May 1915 as Sister in Charge

May 1916

Harvey resigns to become Matron of Maternity Hospital
Sister Isabella GILL appointed senior sister at IDH

August 1916

Gill appointed Matron as from July 1916
Sister BENNETT on leave of absence (family illness), to be appointed sister in charge at W Subiaco upon return (unclear as to whether took position)

1916-17

Sister YOUL was to have been appointed, but was ill; then enlisted 1917.

December 1916

Sister Henrietta JARVIS

March 1922

Sister YOUL seems to have been in

	charge 1922; went to relieve matron at PH
March 1922	Sister CURWOOD temporarily in charge
1925	Sister Elizabeth SPRING appointed Sub-Matron
May 1928	'Miss MACDONALD' mentioned as Sub-Matron in Board minutes
November 1928	Sister BRUCE made Sub-Matron
1938	Sister Molly JOHN (later Leschen)
1945	Sister Eileen MONGER
1958	Sister Ivy WELLS
1967	Sister Rosalind DENNY
1971	Sister Pamela EDMONDS-HILL (now Norcott)
1975	Title changed to Director of Nursing

Appendix 2 – Copies of Masseur Certification

Copies of certification of the masseur C S Southcott provided by Perth medical practitioners. No formal training or certification existed in Western Australia for massage practitioners until the foundation of the Australian Physiotherapy Association (WA) in the early 1950s, so these recommendations were the only form of confirmation of the person's competence. These documents were found in the Australian Physiotherapy Association (Queensland) archival collection. The author has xeroxes of the original copies.

2.1 From Dr D D McCowan

15.11.49

TO WHOM IT MAY CONCERN

This is to certify that I first recommended patients for physiotherapy treatment to Mr Southcott in 1928. Since that time he had treated by physiotherapy a great number of patients under instruction from me. I have always found that he conscientiously carried out the treatment recommended in an efficient manner and with satisfaction to the patient and myself.

D D McCowan, MBBS.

2.2. From Dr F A Hadley

No 8 Australian General Hospital, Fremantle, 13.2.1920

To whom it may concern

S/Sgt Southcott, C.S.

The above Massuer has been on my staff since September 1918. His work has been thoroughly satisfactory and I recommend that he be assisted to carry on similar work when he takes up civil life.

F A Hadley, Lieut.Co, MRCS, LRCP, FRCS,
C.O. No 8 AGH Fremantle

2.3 From Dr Donald MacKenzie

Perth Hospital, Western Australia, 1.7.1925

I have pleasure in stating that for the past three years Mr Southcott has been working in this hospital as Masseur. He is well trained and has a splendid knowledge of electrical and Orthopaedic apparatus. I can thoroughly recommend him as a skilled, painstaking Masseur.

D MacKenzie, MB BS

CRMO Perth Hospital

2.4 From Dr Alexander Juett

Copy 22.9.1942

Mr C S Southcott was engaged as a Masseur at No 8 AGH under my supervision until the Repatriation Dept assumed control. He then continued his work at the Perth Hospital for the Repatriation Dept for several years. His work in all branches of physiotherapy has been of a standard at least equal to that of the certificated Masseur. His technical knowledge of the Electro-Medical apparatus is more advanced than that expected of a certificated masseur. He has been practising in private for many years and I have always found his work efficient and satisfactory. At the present time he is treating cases for the Repatriation Dept who cannot attend Perth Hospital during the set hours.

A Juett.

Appendix 3 – Daily Rates Charged Per Patient, IDH

* From the late 1930s, the rate was calculated according to how much had been spent in the last six months on maintaining infectious diseases cases.

Year	Amount
1906-7	6s
1929	8s
1937 (Jan-Jun)	10/7d*
1937 (Jul-Dec)	9/7d
1938 (Jan-Jun)	7s
1938 (Jul-Dec)	9s
1939 (Jan-Jun)	11/4d
Jul 1939-Jun 1940	9s
1940 (Jul-Dec)	12/6d
1941 (Jul-Dec)	14/9d
1943	12s
1945 (Jan-Jun)	15/9d
Jul 1946-Jun 1947	17/3d
Jul 1947-Dec 1947	21s (£1/1/-)
Jan 1950-Jun 1950	40s (£2)
Jun 1950-Dec 1950	45s
Jul 1951-Dec 1951	35s [°]
Jan 1952-Jun 1952	70s (£3/10)
Jul 1952-Dec 1952	63s [§]

[°] Later reviewed and changed to 41s.

[§] Later reviewed and reduced to 63/-, providing a refund of credit of 7s to all local councils involved.

Sources: Royal Perth Hospital Board of Management Minutes; PHD, AN 120/4, 1004, File #241, 1944 - Arrangements for charges for treatment at IDB

Appendix 4 - Comprehensive Hospital Rehabilitation Facilities, 1975

Source: Australia. Committee of Inquiry into the National Rehabilitation and Compensation Scheme, *Compensation and Rehabilitation in Australia*, 1975, Vol 2, 'Rehabilitation and safety', Appendices 1, 2, pp. 131-142.

Hospital	Location	Teaching	Physio	OT	Speech Th	Rhb Unit*
NEW SOUTH WALES						
Royal Nth Shore	Urban	•	•	•	•	•
Royal Prince Alfred	Urban	•	•	•	•	•
Prince Henry	Urban	•	•	•	•	•
Prince of Wales	Urban	•	•	•	•	•
Royal Newcastle	Rural		•	•	•	•
Broken Hill	Rural		•	•	•	•
Orange	Rural		•	•	•	•
Woden Valley	Rural		•	•	•	•
VICTORIA						
Alfred	Urban	•	•	•	•	•
Royal Children's	Urban	•	•	•	•	•
Horsham	Rural		•	•	•	•
Traralgon	Rural		•	•	•	•
QUEENSLAND						
Princess Alexandra	Urban	•	•	•	•	•
SOUTH AUSTRALIA						
Queen Elizabeth	Urban	•	•	•	•	•
WEST AUSTRALIA						
Royal Perth	Urban	•	•	•	•	•
Fremantle	Urban	•	•	•	•	•
Royal Perth Rehab	Urban	•	•	•	•	•
Bunbury	Rural		•	•	•	•

* At rural hospitals, the question deals with the provision of 'rehabilitation facilities' rather than a rehabilitation unit.

The categorisation of a hospital as 'urban' or 'rural' is based on the Report's categories.

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(b) Taped interviews: P J Martyr

Miss Kathleen Johnson
 Mrs Betty Bell nee Ross
 Mrs Margaret Waddell
 Mrs Pamela Bennett nee White
 Sir George Bedbrook (2)
 Mrs Kath Loton, Mrs Eileen Joubert and Miss Alison Smith

(c) Unrecorded interviews (P J Martyr)

A number of those contacted about their experiences at the Hospital were unwilling to have their reminiscences tape-recorded for various reasons. I chose to respect their intentions in this case. These conversations provided valuable opportunities to collect original documents and photographs, as well as to discuss informal impressions of the Hospital and its history.

Mrs Pat De Castilla, 24.4.91
Miss Rosalind Denny, 28.5.91
Mrs Kath Garden, 30.4.91
Dr Phyllis Goatcher, 25.6.91
Mr Brian Gower, 24.4.91
Miss Freda Jacob, 28.5.91
Mr John Johnson
Dr Rex Joyner, 10.4.91
Mrs Clare Lamb, 10.4.91
Mrs Lucy Lockett, 27.5.91
Mrs June Rankine-Wilson, 29.5.91
Dr Mercy Sadka, 13.5.91
Mrs Grace Sedgley, 10.5.91
Mr Eric Stovell, 23.5.91
Mrs Pat Thorburn, 27.5.91

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Index

- Aborigines, 23
 ACROD, 158, 159, 168
 Adams, Reuben, 13, 18
 aged care, 58, 97, 134, 135, 136,
 137, 143, 157
 almoners, 120, 121, 127
 ambulance, 14, 15, 16, 17, 19, 22,
 35, 89, 93, 104
 Anderson, Roland, 95, 96, 103, 104,
 108, 115, 122
 Anglicans, 12, 18, 23, 145
 antibiotics, 165, 166
 anti-toxin, diphtheria, 30, 48, 90, 92
 arthritis, 143, 157, 158, 169
 Atkinson, Everitt, 49, 50, 63, 68, 69,
 70, 72, 73, 85, 90, 104
 Austin Hospital, 127, 133
Australasian Medical Gazette, 9, 20
 Balding, Maida, 41
 Barker, Dr, 69
 Barker, Gilbert, 47, 53
 Bayliss, Colin, 167
 Bedbrook, George, 113, 117, 118,
 119, 120, 121, 122, 125, 126,
 127, 128, 129, 130, 131, 133,
 134, 135, 137, 138, 140, 142,
 145, 146, 148, 158, 159, 160,
 161, 162, 163, 164, 165, 167,
 168, 169, 170
 Bennett, Pamela, 101, 123, 133,
 138, 139, 140
 Berry, Paul, 119, 164
 Blackboy Hill, 51
 Bogue, Amelia, 7, 14
 Brine, Bill, 122, 129
 bubonic plague, 24, 28, 63
 Burkett, Dr, 35
 Burnford, A M, 129, 134, 135, 136,
 137, 138, 139, 147
 Carinya Women's Home, 98, 99
 Carruthers, Malcolm 'Mac', 138,
 139, 142, 146, 147, 165, 168
 Central Board of Health, 3, 5, 20,
 24, 25, 29
 cerebro-spinal meningitis, 47, 49,
 63, 87
 child patients, 3, 9, 12, 14, 16, 17,
 20, 22, 28, 30, 31, 34, 37, 38, 44,
 46, 48, 49, 50, 51, 55, 57, 58, 62,
 65, 66, 67, 68, 69, 71, 76, 81, 85,
 87, 89, 90, 92, 94, 99, 100, 102,
 108, 118, 120, 127
 chiropractic, 105
 cholera, 2, 165, 166
 Cilento, Raphael, 67, 68
 Clare, A E, 69, 75, 76, 77, 81
 Claremont, 7, 23, 34, 109, 120, 133
 Cleland, John, 31, 32
 Colebatch, John, 116, 121, 123,
 124, 128, 129
 Cook, C E, 94, 96, 100, 108, 109,
 112
 Coolgardie, 1, 49, 121
 Corr, Oswald, 102, 103, 113, 120
 Courthope, Edward, 10, 15, 16
 Cowan, Edith, 46
 Cox, Lynne, 146
 Crook, Herbert, 13, 18
 Curwood, Ivy, 45, 47, 54
Daily News, 92
 Dargan, Frank, 127
 Dawkins, Alec, 104, 115, 119
 Denny, Rosalind, 43, 80, 83, 89,
 144, 160
 diphtheria, 2, 28, 29, 30, 31, 33, 34,
 35, 38, 47, 48, 51, 62, 63, 70, 89,
 90, 92
 disinfectants
 burnt sulphur, 11
 Condy's fluid, 11
 eucalyptus, 11
 Lysol, 78
 Dore, Margaretta, 13, 22
 Driscoll, Victor, 148, 161, 162, 168
 electrotherapy, 51, 52
 Elgee, William, 4, 5, 16
 fires, 48, 54, 59, 62, 68, 69, 83, 98,
 121, 148
 Forrest, Alexander, 6, 8, 20
 Fremantle, 1, 3, 4, 6, 7, 8, 13, 17,
 19, 34, 52, 65, 71, 72, 73, 117,
 158, 167
 Fremantle Hospital, 41, 52, 71, 72,
 73
 Geraldton, 3
 germ theory, 2, 6, 14

- Gill, Isabella, 41
 Gilmour, Bill, 127, 130
 Goatcher, Phyllis, 142, 143, 147, 157, 158, 160, 167
 gold rush, 1, 8, 21, 30
 goldfields, 1, 2, 4, 6, 121
 Gordon, Dr, 40, 45
 Griffith, Joseph, 116, 121, 122, 124, 128, 129, 136, 137, 138, 148, 161, 169
 Griffiths, Ellis, 158, 161, 163, 165, 169
 Guttmann, Ludwig, 102, 119, 125, 126, 129
 Harvey, Eleanor, 16, 41
 Haynes, E J A, 9, 11, 14, 15, 16, 19, 20
 head injuries, 146
 Healey, Robert, 14, 21
 Health Acts, 3, 17, 21, 28, 29, 32, 33, 37, 64, 72, 110
 hemiplegia, 127, 130, 131, 136, 143
 Henzell, Linley, 99, 105, 107, 109, 116, 120, 124, 128, 132, 135, 143
 Hider, Nora, 160, 170
 Hill, Harry, 122, 141
 Hollywood Hospital, 102, 103, 113, 120, 124, 132, 141, 147, 157
 Hope, James, 8, 13, 38
 Huelin, F J, 65, 72, 73, 81, 85, 88, 90, 92, 96, 97, 104, 112
 Hutchinson, Ross, 141
 hydrotherapy, 51, 66, 107, 125
 Ibrahim, 4, 5, 9, 12
 immunisation. *See* vaccination
 Independent Living Centre, 161, 169
 infectious diseases. *See* individual diseases
 influenza, 2, 50, 51, 53, 63
 International Year of Disabled Persons, 168
 iron lungs, 101
 isolation
 distance from railway station, 22, 26, 36, 62, 83
 fences, 16, 17, 19, 53, 54, 89
 firebreaks, 48, 59
 growth of Subiaco district, 39
 patients visiting surrounding districts, 39, 54
 Jacob, Freda, 127
 John, Molly, 62, 79, 80, 81, 83, 85, 87
 Johnson, John, 115, 135
 Johnson, Kathleen, 77, 78, 79, 85, 87, 88, 91, 95, 141, 143, 167, 181
 Jolimont, 15, 16, 18, 20, 23
 Juett, Alexander, 53, 103, 117
 Kalgoorlie, 1
 Karrakatta, 7, 16, 23, 39
 Kelsall, Harvey, 5, 16
 Kelsall, Henry, 11
 Kenny, Elizabeth, 16, 66, 67, 68, 103
 Keough's, Miss (boarding house), 4, 5
 King Edward Memorial Hospital, 41, 160
 Kings Park, 6
 Le Soeuf, Leslie, 102, 103
 Lemnos Hospital, 53, 57
 Local Boards of Health, 6, 31, 34, 37, 64, 65, 70, 73, 78, 88, 92, 93, 94, 100, 109, 112, 124, 162
 Perth, 5, 6, 7, 11, 12, 17, 18, 19, 20, 24, 25, 27, 28, 29, 32, 35, 37, 92
 Lovegrove, Thomas, 22, 28, 31, 32, 34, 35
 Macnamara, Dame Jean, 102, 103
 Macpherson, Mrs, 17
 maintenance, 1, 32, 33, 35, 41, 42, 44, 45, 48, 49, 54, 55, 58, 63, 73, 98, 99, 108, 116, 128, 139, 162
 by patients, 58, 94
 Mather-Brown, Bill, 126
 McAllen, John, 12, 21
 McKellar Hall, Reg, 53, 67, 103, 117, 118, 169
 McNevin, Ethel, 59
 McPherson, Mrs, 18
 McWilliams, George, 16, 52
 measles, 2, 3, 4, 22, 28, 31, 33, 34, 38, 46, 49, 58, 85, 87
 Miller, Alfred, 15
 Monger, Eileen, 108, 123
 Montague, Ellen, 9, 10, 14, 15, 16, 17, 18
 Morris, John, 13
 Mount Eliza, 6, 7, 9, 10, 11, 12, 15

- Muecke, Roy, 75, 76, 77, 78, 79, 80, 81, 84, 85, 87, 88, 89, 90, 94, 95, 96, 99, 100, 101
- mumps, 85
- Munsie, Selby, 64, 67
- Neeson, Mrs, 14
- Nelson, Selwyn, 114, 127
- Norcott, Pamela, 160, 165
- Nulsen, Emil, 105, 120
- nurses' quarters, 34, 44, 78, 79, 96, 123, 132, 147, 169
- nursing staff, 1, 4, 5, 7, 9, 12, 18, 21, 34, 35, 36, 40, 41, 44, 45, 46, 47, 48, 50, 51, 53, 54, 55, 57, 58, 59, 62, 63, 66, 69, 70, 73, 77, 78, 79, 80, 81, 83, 85, 87, 88, 89, 94, 95, 96, 97, 98, 101, 102, 108, 123, 132, 133, 136, 137, 139, 140, 141, 143, 144, 145, 146, 147, 148, 157, 159, 160, 165, 166, 169
- male nurses and orderlies, 9, 19, 44, 55, 57, 59, 97, 144
- Oakeshott, Bob, 164, 165, 167
- occupational therapy, 94, 103, 107, 112, 116, 120, 121, 125, 127, 132, 134, 136, 147, 157, 158, 159
- O'Connor, Michael, 5, 11, 13, 15, 16, 18, 19, 20, 22, 23, 31, 70, 170
- orthopaedics, 52, 53, 65, 67, 68, 71, 99, 104, 105, 107, 117, 126, 127, 129, 130, 131, 134, 137, 140, 144, 146, 158, 161, 165, 166, 167, 170
- Paralympics, 126, 129, 131
- paralysis, 66, 101, 105, 119, 131
- paraplegia, 102, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 133, 134, 136, 137, 138, 139, 140, 141, 142, 145, 146, 160, 162, 163, 168
- Paraplegic Games, 137
- Paraplegic/Quadriplegic Association, 162
- Parsons, John, 14
- Perth City Council, 20, 23, 27, 37, 70
- pests
- cats, 44
- cockroaches, 54
- dogs, 46
- flies, 76
- frogs, 46
- mosquitoes, 76
- rats, 89
- white ants, 32, 44, 45, 59, 98
- physiotherapy, 51, 52, 53, 99, 103, 104, 105, 107, 108, 115, 116, 125, 132, 136, 144, 146, 147, 157, 159, 164
- pneumonia, 87
- poliomyelitis, 66, 67, 99, 100, 101, 102, 104, 105, 107, 108, 112, 113, 115, 116, 118, 119, 120, 121, 124, 130, 131
- Ponta, Frank, 126
- Prendergast, Father, 12, 145
- Princess Margaret Hospital for Children, 108, 109, 112, 113, 115, 125
- Children's Hospital, 31, 36, 37, 38, 68, 100
- Proctor, Samuel, 12, 21
- quadriplegia, 115, 138, 142, 145, 147, 160, 166, 167
- quarantine, 1, 2, 5, 6, 7, 8, 9, 15, 17, 20, 21, 22, 30, 38, 47, 51, 100, 102, 126
- Quinlan, Timothy, 6, 7, 11, 30
- Quirk, Alan, 126
- rehabilitation, 52, 99, 101, 103, 104, 107, 108, 112, 113, 114, 115, 117, 118, 120, 121, 122, 124, 125, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 139, 140, 143, 144, 145, 146, 148, 157, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 170
- repatriation, 51, 53, 75, 97, 102
- rheumatology, 142, 143, 146, 147, 157, 162, 163, 167, 168
- Robertson, Lionel, 47
- Roman Catholics, 12, 15, 18, 85, 145
- Rowland Jones, John, 10
- Royal Perth Hospital, 100, 108, 109, 114, 115, 117, 118, 120, 121, 122, 124, 125, 126, 127, 128, 129, 132, 134, 135, 141, 142,

- 143, 144, 148, 159, 160, 162,
165, 167, 168
- Colonial Hospital, 1, 3, 4, 5, 6, 7,
9, 11, 12, 13, 22
- Perth Hospital, 42, 51, 53, 54, 55,
58, 59, 62, 64, 65, 68, 70, 71,
73, 75, 76, 78, 81, 84, 85, 92,
93, 94, 95, 99
- Perth Public Hospital, 8, 13, 22,
23, 24, 25, 27, 28, 29, 30, 31,
32, 34, 35, 36, 37, 38, 39, 41,
42, 44, 46, 48, 49, 52, 72
- rubella, 4
- Rusk, Howard, 139
- Ryan, Kate, 30
- Sadka, Mercy, 130, 131, 157
- Salk, Jonas, 119, 120
- scarlet fever, 2, 33, 38, 46, 48, 49,
51, 63, 89, 98
- scarletina, 24
- Scott, Edward, 2, 5, 6, 7, 8, 9, 11
- Seymour, Agnes, 4, 5, 12, 18, 19
- Shenton Park Campus
- chaplaincy, 19
 - choice of site, 7
 - Day Hospital, 161, 167, 169
 - description of site, 17
 - drinking, drunkenness, 19, 39,
138
 - first deaths of smallpox, 15
 - food, 18, 54, 62
 - graves, 15, 18, 20, 23
 - 'holiday' atmosphere, 18, 78, 83,
123, 139
 - livestock on site, 18, 54, 58, 89
 - original plans, 8
 - temporary buildings, 9, 31, 49, 63
 - tents, use of, 6, 8, 9, 10, 12, 13,
18, 33, 46
 - verandahs, use of, 43, 44, 49, 54,
58, 63, 64, 69, 81, 83, 97, 98
- Shenton Park Hotel, 39, 40, 127,
138
- Sherlock, Miss, 17
- Siegele, Gertrude, 81, 96
- Singapore, 4, 137
- Sir Charles Gairdner Hospital, 141,
157, 158, 162, 163, 166, 170
- smallpox, 1, 2, 3, 4, 5, 6, 9, 10, 11,
12, 13, 14, 15, 16, 17, 18, 20, 22,
23, 27, 28, 30, 63, 90, 92, 145,
170
- soldiers, 28, 46, 47, 50, 53, 85, 88,
99
- speech therapy, 120, 127, 131, 132,
146
- Spring, Elizabeth, 59, 60, 62, 76, 77,
79
- SS *Saladin*, 4
- Stacey, Mr, 12, 14, 18, 19
- Stovell, Eric, 164
- Subiaco, 7, 9, 10, 11, 13, 15, 17, 18,
19, 21, 22, 26, 27, 28, 31, 34, 35,
36, 38, 39, 40, 46, 49, 51, 54, 65,
68, 76, 92, 145, 170
- Sullivan, William, 12
- sulphonamides, 87, 165
- Sunday Times*, 44
- Sweet, Sidney, 47
- Targress, Mr, 14
- Thorburn, Ian, 65, 122, 169
- Tinsley, Lyn, 168
- tracheotomies, 35, 47, 48, 85, 133
- Tratman, Frank, 29
- Traylen, William, 3, 6, 17, 20
- tuberculosis, 23, 29, 39, 44, 45, 47,
49, 97, 99, 100, 108, 138
- Tymms, Herbert, 32, 34
- typhoid, 2, 6, 9, 15, 21, 22, 30
- University of Western Australia, 131,
157, 159, 163
- vaccination, 3, 9, 11, 12, 16, 18, 30,
70, 90, 92, 107, 113, 119, 120,
165
- venereal diseases, 38, 48, 49, 51,
57
- Waddell, Peg, 143, 146, 157
- Wallace, Reverend, 12, 145
- Waylen, 5, 16
- Waylen, Alfred, 3, 4, 5, 6
- Wells, Ivy, 108, 144
- West Australian*, 5, 7, 9, 10, 11, 13,
15, 16, 17, 18, 21, 31, 68, 69, 168
- Western Australian Institute of
Technology, 147, 157, 164
- wheelchairs, 102, 103, 115, 125,
171
- Wheeler, Louis, 19
- whooping cough, 49
- Woodbridge, 97, 98

Woodman's Point, 6, 8, 13, 17, 38,
165
Wooroloo Sanatorium, 45, 47, 97,
99, 135

workers' compensation, 126
Wylie, Elizabeth, 121
X-rays, 126, 136