Launceston General Hospital
Historical Committee

Historical figures and their impact on medicine in Launceston

Dr Francis Drake
Miss Milne, Lady Superintendent
Dr William Prout Homan

Papers and Proceedings
Historical Seminar
October 2012
Volume 13
The Historical Committee of the Launceston General Hospital was established in 1988 following the successful 125 year celebration of the founding of the Launceston General Hospital in 1863.

The aim of the committee is threefold:-

- Report and record important events that occur in the life of the LGH on an annual basis.
- Preserve equipment that has become obsolete along with historical records
- Maintain a photographic archive record and scrapbook of the daily events at the hospital as recorded in newspapers

The committee meets from time to time, however sub-committees meet on a more regular basis when specific celebrations and historic functions are being planned.

LAUNCESTON GENERAL HOSPITAL
HISTORICAL COMMITTEE

Chairman: Dr J.C.H. Morris
Secretary: Mr P.A.C. Richards
Members: Dr J.Paull
Dr D.Huon
Mr B. Duncan
Mr P. Keefe
Mrs K.Carson (DHHS Library)

Ex Officio members: J. Kirwan, L. Partridge, L. James & C. Matthews

Ex Officio: LGH Sesquicentenary: B. Valentine, J.Burgess, T. Haas, D. Ellis, A. Williams, K.Finch, R. Beardsley Art Subcommittee C.McQuiston, T.Dunning, D.Campbell, D. Quilliam and F.Madill

Contact

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All papers were delivered in the Frank Stevens Lecture Theatre, Level 2, Launceston General Hospital on Sunday 25 March 2012

Chair/Moderator: Mr Paul A.C. Richards

OPENING REMARKS

Mr Paul A.C. Richards (Historical Committee-LGH)

Official Welcome Dr J.C.H. Morris Chairman, Launceston General Hospital Historical Committee

SPEAKERS

Paul A.C. Richards : Dr William Prout Holman

Deanna Ellis : Miss Jeanette Milne, Lady Superintendent

Dr Dan Huon : Dr Francis Drake

Dr John Paull : Closing Remarks & Vote of thanks :
**WELCOME**

Dr John C.H. Morris

**LGH HISTORICAL COMMITTEE**

Dr Morris welcomed a small audience on this occasion who had gathered to hear about three more Launceston General Hospital personalities as part of our summer series of seminars leading up to the Sesquicentenary planned for 12-19 May 2013.

He went on to comment on the work that has already been done by the LGH Historical Committee in preparing the foundation to what will be an exciting week of celebrations.

### LGH SESQUICENTENARY SCHEDULE

#### Sunday 12 – Sunday 19 May 2013

**SUNDAY 12**  
International Nurses Day Breakfast & Keynote address-N. Ellis, ANF  
10am Sunday Service, St Paul’s Chapel  
Sunday Roast Lunch – LGH Cafeteria – Cost $15 : 12.30-1.30pm  
Luncheon address Mrs Helen Bryan, Director of Nursing THO-N  
Conducted tours of the 1897 Nurses Home 2pm  
LGH conducted tours by LGH volunteers 10.30 & 2pm  
To continue throughout the week 13-19 May

**MONDAY-13**  
Opening of the Sesquicentenary Art Exhibition  
ATRIUM ART SPACE – NICS, LGH  
‘Colonial Tench to Launceston General Hospital’  
‘History of Medicine through Art’  
6.30 for 7pm Official Opening  
Drinks nibbles, music

**TUESDAY-14**  
Cocktail Party (LGH- Cafeteria) 7 for 7.30pm LGH Cafe  
String Quartet  
Launch of LGH Sesquicentenary Book  
Short address (Invited Speaker)

**WEDNESDAY-15**  
Medical History & Research Seminar (Registration $60)  
Civic reception

**THURSDAY-16**  
Medical History & Research Seminar

**FRIDAY-17**  
Medical History & Research Seminar  
Clifford Craig/LGH Sesquicentenary Dinner & Ball

**SATURDAY-18**  
10am (Princess Square) Conducted Medical Walk with  
Dr Dan Huon & toast to Dr William Russ Pugh

**SUNDAY – 19**  
Conducted public tours of LGH:- Art in public spaces  
(LGH Volunteers) / St Paul’s Chapel (LGH Volunteers  
Hospital Departments & Spaces (Staff)
OPENING REMARKS

Thursday 31 October 2002

Mr Paul A.C. Richards
Historical Committee LGH

Ladies and Gentlemen

Good Afternoon. My name is Paul Richards and I am the secretary of Launceston General Hospital Historical Committee.

Today we welcomed members of the Launceston Historical Society, The Northern Branch of the Royal Society of Tasmania, staff of the Launceston General Hospital, and members of the community of Launceston.

Today’s programme celebrates three personalities in the vast repertoire of historical figures and their impact on medicine and nursing in Launceston but in particular the Launceston General Hospital at the turn of the 20th century and a little beyond. We have a full program for you today but before we start I have a few words to say about the Launceston General Hospital’s Sesquicentenary scheduled for 2013.

The members of the Committee are actively involved in establishing a repository of historical medical equipment, photographs and memorabilia as well as this year playing a leading role in the 150th anniversary of the hospital next year. We have also been engaged in staging a number of historical seminars as a lead up to the celebrations which will occur between the 13-19 May 2013 coinciding with the official opening of the hospital on the 14 May that year.

The Committee this year has expanded their ex-officio membership and appointed an art and book sub-committee. The art committee is working on the establishment of a permanent art gallery and art exhibition and the Publishing Committee is working on a book to celebrate the 150th anniversary of the LGH.

Today we are bringing you three papers relating to three outstanding personalities of the LGH: Dr Francis Drake who introduced “Big Surgery to Launceston and was instrumental in training Dr John Ramsay, Miss Jeanette Milne, one of the Institution’s most respected Lady Superintendents of Nursing and Dr William Prout Holman who came at Clifford Craig’s request as the first appointed Radiologist and who went on to become the Medical Director of the Peter MacCallum Cancer Hospital in Melbourne in the early 1950s.
LGH Sesquicentenary
12-19 May 2013

150 years of caring for the community of Northern Tasmania

Paul A.C. Richards

In May 2013 we will be celebrating the 150th anniversary of the Launceston General Hospital. I joined the LGH in its Centenary year, 1963 and in 1988, Australia’s bicentenary year we celebrated the LGH’s 125th anniversary. It was in this year that the Historical Committee was established.

Membership was gathered from the various medical, surgical, anaesthetic, nursing, allied health disciplines and was chaired by Ted Clancy the then Administrator. Ted like many of the members stayed on the committee after retirement maintaining a close relationship with the hospital and was replaced as Chairman by Dr John Morris in 2002.

Next year a milestone of 25 years will be celebrated by our contributions to the Sesquicentenary of the Launceston General Hospital

Our colonial past

Today I would like to briefly talk about our colonial past and the development of the Launceston General hospital.
During the first fifty years of white settlement in Tasmania, the government provided a medical and 'hospital' service of sorts, mainly to soldiers and convicts. With the growing number of free citizens, a joint community-government hospital situated in the former British Hotel became the Cornwall Hospital and Infirmary. It had many inadequacies, including beds taken up by the chronically ill (a problem that now, 150 years later, governments have neglected to overcome).

In 1859 a decision to move the hospital was taken and tenders were called. A tender from Messrs. Miller and Francis for 14,334 pounds were accepted and a substantial building that included an infirmary with 110 beds was erected on the corner of Frankland and Charles Street "Mulgrave Square". On 26 January 1863 the Hospital moved into the new building and the trustees became a Board of Management on the 5 May 1863 when the name was changed to Launceston General Hospital and on 14 May 1863, the new hospital was officially opened with 102 beds.

The advent of general anaesthesia for surgical operations, and understanding of the bacterial cause of infections, meant safe and painless surgery advanced quickly. With a succession of highly regarded surgeon superintendents, notably Dr Francis Drake, Sir John Ramsay and Dr Clifford Craig, the hospital became one of the few provincial hospitals to compare favourably with those in capital cities. Ramsay performed one of the first successful treatments for cardiac arrest by internal heart massage, and the hospital was one of the first to install an X-ray machine purchased by Drake in 1896 whilst in the UK and shipped back to Launceston.

During the years that followed the hospital encountered several fearsome epidemics; typhoid in the 1890s, smallpox in 1887 and 1903, the flu pandemic of 1918 and poliomyelitis in 1933 (minor) and 1937 a major epidemic repeated in the early 1950s.

Over the years many additions to the hospital occurred, however in 1937 the first portion of a new hospital was...
completed on the original site with remaining portions gradually built until 1942.3

**Salient Features (External Staircase) & changes to the façade to "The Charles Hotel c2011"**

The 1949 amendment reduced the board members to seven of which five were to be appointed by the Governor, of the five one would be appointed as Chairman, one as vice chairman, one was to be a women, one a doctor and the fifth was to be nominated after election by the Northern Tasmanian Friendly Societies' Association. The other members were to be elected by the City Council and Women's Auxiliary Organisation and under this Act the Board was to be known as the Launceston Public Hospitals Board.

In June 1968 No97, dated 25th June, reconstituted the District by adding the Municipalities of Deloraine, Evandale, George Town, Westbury, Lilydale and St Leonards were added and in 1987 No123, dated 3rd June added the former Flinders Island Public Hospitals District and deleted the Lilydale and St Leonards Municipalities which had ceased to exist having been absorbed by the City of Launceston.

Statutory Rule 1968 N097 had also transferred management of the Perth Chest Hospital and the Westbury, George Town, Deloraine and Mole Creek District Nursing Centres from the Department of Health Services to the Board.

In 1981 following an election promise by the (1972-1975) Whitlam Labor Government the first stage of a brand new hospital was completed and occupied on the opposite side of Charles Street that was bounded on the eastern side by Ockerby Gardens, the old Launceston Cemetery and on the western side by Frankland Street.4

**New Hospital 1981-2012 Looking west-east**

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3 Plate: Launceston General Hospital c 1940s: QVM:1992:P:2363

4 Launceston General Hospital, c 1960s & 1990s [QVM 1988:P:695 & ]  
Statutory Rule 1987 No157 dated 6th August, brought the Queen Victoria Hospital under the control of the Board from 19th August.

As an interim step in the reorganisation of the State's Health Services, the Public Hospitals Districts were amalgamated into three regional bodies in 1990. This saw the amalgamation of the Beaconsfield, Scottsdale/Ringarooma, Longford, St Helens, St Marys and Campbell Town / Ross Districts into the Launceston Public Hospitals District.

In February 1996 the Queen Victoria Hospital was moved onto the Launceston General Hospital site and a new era in the history of the Hospital commenced.

The first fifty of which culminated in the golden years of “big surgery” under the leadership of Drs Francis Drake and John Ramsay, the second fifty years culminated in such breakthroughs as penicillin, and other anti bacterial drugs but perhaps the most notable was the introduction of the polio vaccine, first by Dr. Jonas Salk (intravenous version), and later followed by an oral version by Dr. Murray Sabin. Vaccines against measles and rubella were also developed in the 1950’s and 1960’s and as we enter the third phase we all owe gratitude and thanks to Dr. Christiaan Barnard, the first to perform a human-to-human heart transplant in Cape Town, South Africa, in 1967. If this procedure was not performed when it was, heart transplants as we know them would not have progressed to what they are today and in the same timeframe the oral contraceptive, Enovid, developed by Polish-born chemist Frank B. Colton in the late 1960s.

Today advances in technology have been formost in the public’s eye for the diagnosis and treatment of human disease processes. The Launceston General Hospital built its reputation on its progressiveness through medical professionals who have been at the forefront having many firsts in the development of medicine as we know it today. The hospital has become a recognised training centre for undergraduate and postgraduate doctors and nurses. It is now a tertiary referral hospital for a variety of specialities, and provides a wide range of specialist and ancillary services. The Launceston General Hospital is regarded as one of the leading regional hospitals in Australia.

Thank you.

**Papers & Proceedings**

*Before I introduce our three speakers I would like to draw your attention to the publication of Papers & Proceedings of today’s Seminar.*

*If you wish to purchase a copy then please leave your name on the sheet that will be circulating. You will be contacted when they are ready and you can forward a cheque to cover payment at that time.*
Dr William Prout Holman
Radiologist

Presenter: Mr Paul A.C. Richards
A distinguished student of Scotch College Melbourne, and a graduate in medicine of Melbourne University, Dr William Prout Holman\(^1\) had spent two years studying radiology at the Royal Melbourne Hospital with the legendary Barbara Wood. In 1925 he arrived at Kings wharf on the *Nairana* to take up a contract to work with X-Rays for Dr John Ramsay, the leading surgeon of the day at St Margarets Private Hospital in Frederick Street, Launceston. Thus arrived Launceston's and Northern Tasmania's first radiologist.

With enthusiasm and an incisive mind, the young Dr Holman quickly became a powerful force for the good practice of medicine in this district. His consulting room, just inside the old front door of the hospital (many years later becoming St Vincents Hospital run by the Sisters of Charity) became an
academic mecca for doctors, where the diagnosis and management of difficult cases could be debated and determined.

A pen picture from Audrey Shoobridge (nee Jacobson) who worked in the department of radiology during the 1940s perhaps best sums up this gifted man.

Dr Bill Holman, lovingly known as W.P.H., Tall, erect and a model of sartorial elegance. He was the only man I have known who wore spats. The attitude of all his staff was one of reverence to a great man and there was almost a hush when his crisp steps came down the passage for his morning reporting sessions. Dr Holman's reporting sessions were a feature of life at the L.G.H. The room was always crowded with visiting and hospital medicos who made a special point of attending whenever possible. In addition, resident medical staff and technicians added to the crowd when time permitted. Dr Holman was fascinated by his work and his enthusiasm infectious. I shall always remember standing behind him during a barium meal screening and hearing his delight at seeing reverse peristaltic waves in the patient's stomach, with the inevitable drastic results to Dr Holman's head.5

Dr Holman’s love of the theatre soon delighted Launcestonians when he produced a well known play Nothing but the Truth in 1927. His critics were acceptionally kind and the local newspaper reported:-

Having had two crowded houses for their performances of 'Nothing but the Truth' on behalf of the Free Kindergarten and the Girls Home. The Players closed their season at the Academy last night with a third showing designed, to benefit the Queen Victoria Hospital and the Mayors Radium Fund6.

Holman7 has had a great deal of experience in Victoria in amateur stage work for war efforts, and experience coloured his performance. He was delightfully natural and clear in his speech and facial expressions and gesture always fell into line with the situation. His enthusiasm on stage is infectious and he plays his part throughout with satisfying aplomb. Dr Holman certainly looked the poet and as usual, his task was well done. In the latter part of the comedy when those artistic locks were shorn, I liked him even better." Dr Holman ably fulfilled the dual role of producer and leading man and to him must be given unstinted praise for this, the apex of the players achievement.

5 Personal communication Mrs Audrey Shoobridge, 1980
6 Proceeds were distributed for the support of:- The Children’s Hospital, Queen Victoria Hospital, Baby Clinic and to Bush Nursing. An extra performance allowed further donations to Ministering of Children’s League and the Girls Friendly Society.
7 Carature courtesy Mrs Mollie Holman (Melbourne)
Interestingly enough the female role of Betty the maid was played by Miss Mollie Bain who was later to marry W.P Holman.

The Launceston Players' Society was formed at a meeting held in the previous year in September 1926. Interestingly the amateur theatre throughout Australia was expanding and the inaugural production *Nothing But The Truth* proved to be a huge success establishing the society as the cities cultural institution. The Launceston Society commenced with nineteen members, the founders being Mrs R.J. McIntyre, Mrs G.R. Reid, Mrs G.R. Field, Mrs Thyne, Misses M. Bain and A. Clemons, Doctors W.P. Holman and F.J.Drake, Messes R.M. Collins, W.L. Brown, W.R. Rolph and Bain.

A new sub-specialty of radiotherapy was becoming accepted world-wide, and in 1937 there was installed Tasmania's first Deep X-Ray treatment machine in the then new wing of the Launceston General Hospital.

It was generally accepted at that time for a radiologist to become the radiotherapist, and Dr Holman lost no time in acquiring skills and putting them into good effect for cancer patients, who came from all parts of the state.

In 1930, Holman submitted a paper of his radon needle treatment for carcinoma of the breast to the Faculty of Radiologists in London. This aroused international interest and resulted in his being elected a Fellow of the Faculty of Radiologists in London.

In the years that followed Holman was to publish but one paper on his own in the medical journal of Australia; 1:809, 1939 - "Early Breast Cancer" However in association with Drs John Grove and Clifford Craig other publications in 1936 and 1944 were published whilst he was at the Launceston General Hospital.\(^8\)

An illustrated lecture, 'A Short History of the Application of Rays in Medicine' was given by Holman on the 26 June 1939 to the Royal Society of Tasmania\(^9\).

Abstract:-

*Dr Holman introduced his subject by a chronological outline of the early history of irradiation in its clinical application. Illustrating his observations with some interesting pictures of pioneer methods of treatment of patients. The story then traced through the successive stages of evolution to medium therapy, and to the modern practice of deep therapy. Present-day technique and installation were considered in some detail.*

*The speaker emphasised the importance in the rapid development of X-ray therapy of the co-operation of workers in various fields of science. The parts played by the physicist, the electrical engineer, and the biologist were described and assessed; and a broad sketch given of the general superstructure erected by the medical radiologist. Dr Holman illustrated his subject with numerous diagrams and lantern slides.*

In 1947 at the insistence of Holman the first intravenous administration of radioactive phosphorous was given to a patient suffering from polycythaemia rubra vera. On that day the medical


\(^9\)Papers and Proceedings of the Royal Society of Tasmania for the year 1939
discipline of Nuclear Medicine was born, however it was not until some twenty years later that the discipline would be recognised in its own right as an independent department within the Launceston General Hospital.

With two other Northern Tasmanian "greats" in medicine, Clifford Craig and Keverall McIntyre, Dr Holman helped Launceston to become one of the leading medical centres outside of Melbourne.

He remained at the Launceston General Hospital until 1952. He was appointed Medical Superintendent, Peter MacCallum Clinic, Melbourne and died in 1972.

Dr Clifford Craif wrote:\(^{10}\):

The death of "Bill" Holman removes one who made a great contribution to medicine both in Tasmania and in Victoria. My own friendship with him extended back to the time, sixty years ago, when we were pupils at Scotch College, Melbourne. He was some years younger than I was, but we had many interests in common, and I always looked forward to and enjoyed meeting him. As it happened we were to be associated for the greater part of our professional lives. He became a resident medical officer at the Melbourne Hospital in 1923. I had lost time at the war, for which he was too young, and when I became a resident medical officer at the "Melbourne" in 1924, Bill was senior to me and had moved into the radiology department under Dr Clendinnen.

Following the "great dispute" between the British Medical Association and the Tasmanian Government in 1917 and its ultimate defeat by the government a period of renaissance was to ensue for both the Launceston General and Royal Hobart Hospitals.

Bill Holman arrived in 1925 at the invitation of Dr John Ramsay to establish a radiological practice at St Margarets Private Hospital owned by Ramsay. Although Holman's rooms were at St Margarets his services were available to all medical practitioners of the area. He was the first radiologist to practice this speciality in northern Tasmania. He was radiologist at the Launceston General Hospital first in an honorary capacity and then later as a part-time paid officer.

He was considered a first-class renaissance man. His clear intellect, his command of the art of scientific exposition and his great enthusiasm made him a leader from start to finish. Although Bill had commenced as a diagnostic radiologist, he very soon turned his attention to radiotherapy. In 1927, Ramsay acquired 5mg of radium in the form of needles. These were made in Brussels from Holman's prescription. In 1929, the Commonwealth Government distributed 10mg of radium to public hospitals in capital cities. An exception was made of Launceston, which also received a ration. In the mid 1930's Holman submitted a paper to the Faculty of Radiologists in London on the treatment of carcinoma of the breast with radon needles. For this work he was awarded a Fellowship of the Faculty. Although the Faculty advised him to publish the paper, it was never submitted for publication.

In the 1930's also, Bill organised a public appeal for funds to buy an advanced type of deep therapy component, which was installed at the Launceston General Hospital in 1937. To

\(^{10}\) Medical Journal of Australia, 1972, 2:966 21 October
achieve this end, he and his fellow committee members induced the Government to found the Tasmanian Cancer Committee, a statutory body. In 1943, as a result of a visit to Australia of Ralston and Edith Paterson of Manchester, the Tasmanian Government agreed to develop their radiotherapy services in Launceston and Hobart towards an amalgamation with a centralised institution in Victoria. In 1952, the Peter MacCallum Clinics were established at Launceston General Hospital and Royal Hobart Hospital, and Bill Holman moved to Melbourne to become Assistant Medical Director of the new Cancer Institute Board.

It so happened that, when Bill went to Melbourne, my own career as a surgeon had come to an end, because of the development of dermatitis of the hands. I therefore took over the diagnostic side of Bill's practice. I was also appointed to his position as Chairman of the Tasmanian Cancer Committee. By virtue of this position, I became a Tasmanian member of the Cancer Institute Board of Victoria. As Bill became Medical Director of this body in 1954, I was able to continue to enjoy meeting him at intervals. His great success was that he was a first-class committee man. His mind worked with great rapidity, and often he reached a correct decision before others did. However, he never forced a decision. Rather, by means of a clear and penetrating analysis, he would gradually bring the other members to see things as he did.

Bill played a pioneer's part in the founding of the Australian Association of Radiologists of Australasia. It was founded in Tasmania during an Australasian Medical Congress, and its first Articles of Association were printed in Launceston. Bill enjoyed many things in life, but above everything else he enjoyed his wonderful happy family life". 
Miss Jeannette Milne
Lady Superintendent

Presenter: Deanna Ellis
Thank you for the opportunity to reflect on the life of Nurse Jeanetta Helen Milne and the importance of her time at the Launceston General Hospital.

In presenting this paper I wish to acknowledge the research undertaken by the late Doctor Clifford Craig and contained in his book titled ‘Launceston General Hospital the First 100 Years’ research undertaken by Barbara Valentine and Gwenda Webb, members of the Launceston Historical Society, related to the residence at 52 Frankland Street, Launceston, Mark Bostridge’s research contained in his publication ‘Florence Nightingale: The Making of an Icon’ and Linda M. Brown’s book ‘History and Memories of Nursing at the Launceston General Hospital.

Miss Milne’s exact birth date is unknown, it is thought to be 1863 as records show she was 24 years old in 1877 when she commenced nursing under Miss Pringle. Miss Pringle was a close friend of Florence Nightingale.

In reflecting on Miss Milne’s time as Lady Superintendent of Nursing at the Launceston General Hospital it is worth considering the work of Florence Nightingale and how this influenced Miss Milne’s nursing career.

Florence Nightingale was born to wealthy parents in Florence; fluent in Greek, Latin, French, German, and Italian and also versed in history, philosophy and mathematics having been educated by her father; however she questioned the purpose of life and it concerned her that there was poverty and unemployment and the need for charity.

Florence was motivated to commence nursing following a meeting at St Bartholomew’s Hospital Blackwell London with the first women to qualify as a Doctor in the United States, Elizabeth Blackwell. Elizabeth encouraged Florence to overcome prejudice to achieve her ambition as nursing was seen as work for the working class woman at this time.

Finally in 1851 her father gave his permission for her to commence training in Kaiserweth, Germany. Two years later she was appointed resident Lady Superintendent of a hospital for invalid women in Harley Street, London.

We are familiar with the significance of Florence Nightingale’s work in the Crimean War when in 1854 she left for Turkey with a group of nurses and was appalled at the condition of the soldiers and the conditions in which they were being nursed.

The death rate of the British soldiers was extremely high, one in six was due to war wounds, however the majority were attributed to diseases such as typhus, cholera and dysentery.

During her relatively short time at the Scutari Barrack Hospital in Turkey, Florence identified that cleanliness was fundamental to preventing infection and that the total care of the patient was essential to their recovery and quality of care.

Many of the major support departments of the modern hospital today were initiated by Florence, establishing:

- Hospital Medical records, pharmacy and nutrition departments
- Hospital linen and housekeeping departments
- Numbering of beds in wards
- Establishing hospital kitchen specifically for the preparation of invalid food that was appealing and met patients’ special dietary requirements
- Establishing classroom and library facilities to promote the patient’s intellectual stimulation and entertainment.

Other firsts attributed to Florence Nightingale and also still in place in modern day nursing were:

- The establishment of Home Care Nursing
• Advocacy for the rights of soldiers and patients
• Medical triage based on clinical needs as opposed to military rank, religion or social standing or wealth
• She was recognized for her work as the first hospital epidemiologist being the first woman to be made a Fellow of the Royal Statistical Society.

Florence was strong willed and determined and insisted on absolute cleanliness and despite great skepticism and minimal acceptance of the theory that germs were responsible for disease and infection, she established the first real hospital infection program.

In 1857 the re structuring of the administrative department of the War Office and the establishment of a Royal Commission into the Health of the Army was a direct result of Florence’s report on her return from the war in 1856, titled ‘Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army.’

On her return, the Government presented her with 250,000 pounds, with which she funded the establishment of the first purpose built building - St Thomas Hospital, one of the first to adopt the “pavilion principle” which Florence popularized in her ‘Notes on Hospitals’ written on her return from the war and published in 1859, which took account the need to improve ventilation and sanitation by the separation and segregation of patients with infectious diseases with six separate ward buildings, 125 feet apart, linked by low corridors and set at right angles to the river frontage.

Within St Thomas Hospital the first professional school of nursing was established, the graduates of which were sought after throughout the world and became the next generation of leaders in nursing. More than any other person Florence defined what it means to be a nurse and established nursing as a legitimate profession; nursing was no longer seen to be the work of lower class women.

Housebound at the age of 38 from Crimean Fever, Florence continued to be an advocate for health care reform and during the US Civil War was frequently consulted in relation to the management of field hospitals. Florence died in 1910 aged 90.

It was these nursing concepts that Miss Milne bought to the Launceston General Hospital in 1886 having trained under Miss Pringle, a close friend of Florence Nightingale.

When Miss Milne entered the nursing profession the Register of the Royal Infirmary states that she lived at her stepfather’s residence in Alford Aberdeen shire, was a domestic servant, single, aged 24 and commenced her nurse training on the 4th October 1877 completing her course on the 30th September 1878

Her training included experience in surgical and medical wards, the Fever House and one month with a private case.

The record states that she was a very valuable nurse, thoughtful, thorough and kind, however her health was not very good having been ill and absent for two months.

At the conclusion of her training she commenced the following day as a staff nurse on night duty in Ward 4M till July 1879 then was appointed charge of the ward on a day basis till it closed. She then worked as an extra nurse till being appointed charge of Ward 33.
After an appointment in England in September 1884, she left as one of a party of three to become ‘sisters’ at the Government Hospital Hobart Town Tasmania in 1885. In 1886 she was appointed as Lady Superintendent of the Launceston General Hospital.

**SLIDE OF CORNWALL HOSPITAL**

The first facility for the care of the sick in Launceston was the Cornwall Hospital and Infirmary in what was previously the Old British Pub in Wellington Street, as far as can be determined, Dunorlan Terraces in Wellington Street built in 1887 is where the Cornwall Hospital and Infirmary stood. The Terraces still stand today opposite Coles Supermarket. The Launceston General Hospital was purpose built in 1863 on the eastern side of Charles Street and between 1937 and 1942 a new hospital built on the same site.

Five years after the opening of the Launceston General Hospital, the 1868 Hospital Annual report states ‘that even though the best persons were selected to care for the sick they were poor substitutes for those who had been specifically trained for the purpose’ and a request for trained nurses was made to the Government.

The first of these nurses to work at the LGH was Miss Troy, employed in 1879. The salary she received was the same as the male employees….. 36 pounds and 10 shillings per annum. Equal pay for work ……

It was also recorded that a Matron was required and Miss Milne was the third Matron to be appointed, her predecessors being Miss Windred and Mrs. Wane.

Miss. Windred incurred the wrath of the Dean for burning the Roman Catholic bibles, whether this was due to religious motivation or desire for cleanliness it was unclear, however she was reprimanded and ordered to replace the bible. I tend to think perhaps it was her motivation for cleanliness.

During Mrs. Wanes’ period at the LGH the title changed to Lady Superintendent of Nursing and she resigned in 1886 to take a position as Lady Superintendent of Nursing at the Hobart Hospital. Miss Milne commenced as Lady Superintendent of Nursing in 1886.

She was faced with an extremely dismal situation at the hospital and in 1887 saw the first outbreak of small pox in Launceston with 11 of the 35 reported cases dying. The state of the conditions at the hospital were recorded in a letter written in 1942 by an unnamed elderly man, who had as a young boy been hospitalized with typhoid fever prior to Miss Milne’s appointment.
His letter describes that he was given up as hopeless; the only contact with his family was allowing them to speak to him from the doorway.
Disinfection methods were primitive, a canvas bag filled with disinfectant was slung across the door, the constant dripping of the disinfectant into a tin basin he describes as torture and haunted him throughout his life. The wards were rarely cleaned except occasionally by an old lady and this was the only female he saw during his hospitalisation as only male nurses worked on his ward.
The iron beds, with a sheet of tin painted black as the bed head were covered with old fashioned red and white quilts.
In later years he broke his leg, there was no operating theatre and he recalls his curiosity overcoming his desire to eat his dinner, crawling down the bed, peeping through the small black screen to watch an amputation in the next bed…….
He heard the limb drop into the dish below and states he was ‘deprived of his appetite’.

Miss Milne however, approached her task with great energy having the support of four outstanding Surgeon Superintendents namely; Lavington Grey Thompson, James Pardey, Francis Drake and John Ramsay. Her professional relationship with Dr Ramsay extended over 30 years and he frequently made documented reference to Miss Milne and matters relating to standards of nursing and the introduction of training students of nursing.

The 1889 Hospital Annual Report states that Miss Milne had put forward a proposal for lady pupils to be admitted to the Hospital to gain experience and a certificate in nursing.
The following year the records show that she made a strong plea to the Board for a new nurses’ home, (this was built in 1897) and in the same minutes there were key statements related to the admission of lady nursing pupils and I quote:
“All candidates for admission to the Nursing Staff have now to sign articles of agreement binding them to serve as probationers for a term of two years.
No candidate is required to sign such articles until after one month’s probationary service.
In consideration of their signing these articles the Board of Management, in addition to their receiving remuneration, take care that a regular system of training and instruction shall be given, and that on completion of the said two years, the Nurse shall be allowed to present herself for final examination and on receipt of a satisfactory certificate of proficiency shall be entitled to receive a formal certificate from the Board of Management.
A form of certificate has been designed and approved by the Board of Management. The Board have caused to be provided a distinctive out door uniform to be worn by Nurses when off duty”
End of quote.

The Nurses Home still stands today behind the Charles Hotel and is currently used for student accommodation.

Miss Milne left the LGH in 1912 to work with Dr Ramsay at St Margaret’s Hospital, Frederick Street till she retired in1928. The St Margaret’s Hospital building still stands today.
Miss Oakes, one of Miss Milne's pupils succeeded her.

It is Miss Oakes account of Miss Milne which gives more of a picture of the person Miss Milne was. She had been described as a powerful woman and by some as formidable and I quote from Miss Oakes account of her first meeting with Miss Milne and some subsequent occasions in the wards.

Miss Oakes describes how she arrived on the 4th April 1896 feeling both excited and nervous as she was to begin three years training as a nurse.

She drove from the railway station to the Hospital in a four wheeled cab increasing nervous as she neared the Hospital as she had not been interviewed before having come over a thousand miles from her home.

She was immediately ushered into Miss Milne's office and found Miss Milne quite pleasant but looked severe. The only words that she recalled was that Miss Milne said “Nuss, you look very anaemic” in her strong Scottish accent.

Miss Oakes reassured that she was very strong but had a sense of foreboding.

She was taken to evening meal and then handed to a senior Nurse to begin duty in Wards 3 and 4.

As no provision had been made for her uniforms she had to wear her good navy serge dress for the first two to three weeks till her uniforms arrived.

There were three lilac haircord uniforms with six aprons of pure linen and lawn caps that were rather ornamental, trimmed with real Honiton or some such lace and inch wide. The cap stood up high in the front and was gathered in at the back, there were six white collars and cuffs provided with the uniforms.

The wearing of outdoor uniform was compulsory. And this was made of very good black rain proof material, tailored style, fitting easily back and front, with little half moon shaped sleeves, like small wings, which used to flap in the wind.

The small bonnet was of black velvet with a fall at the back of dull silk.

How tired we got of this uniform, although when nicely kept and with neat black shoes and gloves it looked smart and professional

I believe we were sometimes called by the public, “the black crows”

Special leave was necessary for the privilege of wearing private dress.

Matron was Scottish and Miss Oakes state that she found it difficult at times to understand some of her words.

On her second day on duty she was sent to feed a helpless patient with a feeding cup.
As she was feeding the patient Miss Milne came and stood watching me. Miss Oakes became numb with nervousness and Miss Milne said “Nuss you are very awkwid”

Miss Oakes meekly said, “I beg your pardon Matron?”

Miss Milne repeated most severely, “You are very awkwid”

Miss Oakes was no wiser and felt helpless thinking it must be something pretty bad.

Then Miss Milne said, more gently, ‘go to the other side of the patient and, raise his head with your left hand, and feed him with your right.

Miss Oakes stated that she never forgot that.

Miss Oakes realized that she had said she was ‘awkward” which she felt was bad enough, but had thought she might have meant something worse.

Miss Oakes state that Matron generally did the rounds twice daily and even though she was supposed to be short sighted everyone thought she had very keen vision.

One evening during her round a senior Nurse had been out in the afternoon and had not removed all of her face powder........Matron spied it and said, “Nuss you have a dirrrrty face, go and wash it”

I am sure during the next 94 years of nurse training at the LGH many students experienced the same nervousness as they neared the hospital to be interviewed, though the mode of travel was more civilized, many also would have experienced the keen eye sight of their Matron or Lady Superintendent of Nursing and wondered how they knew that there was a speck of dust or spot of blood, or a pillow placed incorrectly, and that they also had a sense of what was happening behind the ward pantry door.

Talking with some of these older nursing colleagues in later years you realize they knew where to look because they had been down the same path and done the same things.

Miss Milne established the LGH Nursing School in 1890, delivering lectures along with the Surgeon Superintendent, the students were required to attend lectures in their own time and The length of training varied over the next 102 years.

Initialing the training period was 2 years, extending to 3 and then reduced to 2 years during the war. Following the war, training increased to 4 years and at one stage in the early 50’s to 5 years.

A return to a 3 year training program was established in 1959 and remained till the LGH nurse education hospital based program ceased in 1990.

Nursing lecturers were delivered in a variety of settings over the 102 years of the training school; in ward environments, the Children’s Ward and finally at 52 Frankland Street.

Many of us believed the Nurses Training School building, purchased in June 1952 by the Public Health Department, was called Ridges, however research has established that is was called Woodram.

The house was built in 1861 for John Horwood Barrett and occupied by his family till 1884. A number of people lived in the property till it eventually passed to John Barrett’s son, also named John Horwood Barrett.

In 1910 Woodram was owned by Albert John Ridge, a well known antique dealer and collector with an extensive and valuable personal collection. Following his death in 1941, his widow continued to live there till 1951 and one would presume that this why many thought the property was known as Ridges.
Extensions were made to the front of the property initially and in 1969 further extensions to the rear which extended the full length of the building. The building today has been renamed “Viewpoint” and is occupied by the Mental Health Community Program and Day Centre.

A block system for nurses training was introduced in the 1950’s, students then attending lectures in work time, though for many years the practice continued where students were required to undertake ward work prior to breakfast each day, and then attend lectures in the training school.

Initially the majority of lecturers were delivered by medical staff, with a strong medical focus, supplemented by lectures by the tutor sisters. A nursing model was introduced in the early 1980’s with an increased focus on the sciences, humanities, pathophysiology and psychology. A problem orientated approach to planning patient nursing care was also included and incorporated a holistic approach to patient care.

In 1982 tertiary nurse education was introduced at the Tasmanian Institute of Technology, Launceston and the LGH based program continued along side the tertiary program till 1990, when the final LGH nurses graduated having commenced their 3 year program in 1987. Enrolled nurse training continued till 1992.

Miss Milne died in 1933 and was buried at St Helens, however her influence at the LGH was maintained with the establishment in 1936 of the Milne Memorial Medal, awarded initially for the best practical nurse who gained full marks for conduct. The inaugural medal in 1936 was awarded to Sister Healey. At the final graduation in 1990 the medal was awarded to Nurse Alison Vines, Carol Northeast and Mr. Craig Shennon. The gold medal incorporated the Maltese Cross which also was incorporated in the LGH Nurses Hospital Badge.

The motto..., is a quotation from the Latin poet, Virgil: "Miseris Succurre Disce," which can be translated as "I learn (or endeavour) to succour the distressed." or, more simply, "I learn to help those in need."

Latin phrase an excerpt from the book, The MacMillan Endeavour, The Story of the Clan, by Christopher W. McMullen:

Miss Oakes memory was also maintained in the form of the Oakes Memorial medal awarded for the nurse who demonstrated excellence in bedside care in her/his final year.

It was first awarded in 1958 to Nurse J Widdowson, at the final graduation in 1990 it was awarded to Nurse Alison Vines, Linda Rosevear, Melissa Good and Janet Hoare. This also was a gold medal in the form of the Maltese Cross.
Throughout its 150 year life, the LGH has been recognized nationally and internationally as an excellent training hospital for undergraduate and postgraduate nurses and doctors. It is noted for a number of firsts in medicine and notably for the work of Sir John Ramsay and Dr Clifford Craig.

The importance of sharing and recording history was bought home to me in the late 1980’s when I overheard my Mother say Miss Milne was her Great Aunt, it is significant that Miss Milne founded the LGH Nursing School and that the significant part of my nursing career was in education and I held the position of Director of Nurse Education when the LGH Department of Nurse Education closed in 1992.

Had I not overheard my Mother share that with her friends the strong bond I had with my training hospital would have had more significance had I been aware of the connection I had with Miss Milne.....

I would like to close on a light note....... My granddaughter when she first started school said to me....‘Grandma we are going to visit your hospital tomorrow, will you be there to see me?’.... She always referred to the hospital Enquiry Desk in the main foyer, Level 3, watching her get off the bus; on entering the hospital of course she broke ranks, ran across and gave me a big hug..... That night she said to me........‘Grandma I saw you at the hospital’ and I said ‘yes I know you did darling’.....she said ‘yes I told the teacher.......that’s my Grandma there’....

However she wasn’t referring to me standing at the Enquiry Desk but to the model of Miss Milne in the glass class in the foyer. Her father had always said as he went past......‘that’s Grandma there’.

A few months ago together with my sons and grandchildren, now in their teens, we were walking out of the hospital after visiting their Grandfather ....... and they all said as they went past the glass case........‘There’s Grandma’!

Perhaps my grand children should be saying...... there’s Great, Great, Great, Great Aunty!

Thank you!

The First and Last Educators

Miss J. Milne

Mrs Deanna Ellis (Nee Sturgess)
Dr Francis Drake

Presenter Dr Dan Huon
How did the General Hospital at Launceston evolve from an infirmary for the poor in the 1860s to begin to be a scientifically-oriented medical institution with a reputation in surgery during the 1890s? For much of the 19th century medicine was not a respected profession. By the 1890s and early 20th century public opinion had reversed. The Australian colonies absorbed their medical culture and ideas on hospital practice directly from the mother country via immigrant British medical practitioners. But Melbourne University Medical School, founded in 1862, began to provide competent young graduates to the hospital at Launceston, the first being employed in 1886. Can we claim that the devotion and enthusiasm from 1890-1898 of a Melbourne graduate, Dr Francis Drake, laid the foundations for the Hospital to become a substantial 20th century hospital? And was the perception of safety in surgery at the Hospital a reason for the increasing respect for the medical profession? Because the reputations of hospitals and the medical profession moved in tandem from the 1860s, let us look at the evolution of British and Australian colonial hospitals during the 19th century.

**PERSPECTIVE**

1. **Phases in the evolution of British and Australian hospitals in the 19th century**

British hospitals, and their counterparts in the Australian colonies, expanded through three broad phases in their handling of in-patients; each phase continuing elements from the previous phase:

- **The hospital as a charitable “refuge” until the 1860s:** those who could afford it had their operations at home where their servants could nurse them. Poor people who had acute and curable conditions could go to one of the charitable hospitals or infirmaries. Hence the stigma of pauperism attached to being reduced to going into a hospital. The risk of death in hospitals from filthy conditions and contaminated surgeons was high. If in-patients developed into an incurable case (as in tuberculosis) they would be discharged. In Van Diemen’s Land in 1854 the Cornwall Hospital and Infirmary at Launceston served as a charitable refuge.

- **The hospital as a repair and curing institution for urgent accident and sickness cases in the second phase of the 1860s-1880s:** hospital authorities improved the
cleanliness and expanded the kinds of in-patient cases, and sought to improve the nursing of patients with trained female nurses. The formidable Florence Nightingale (1890-1910) sustained her drive for nursing to become a trained skill for women and that the effect of hospital cleanliness was to control disease as advocated in her influential Notes on Nursing and her Notes on Hospitals, both published in 1859. The first Nightingale trained nurses arrived in Sydney in 1867. Nightingale believed in the chemistry–based theory of miasma – that bad smells generated diseases: this erroneous theory directly influenced the location and design of the new 1863 hospital in Launceston.

- **The third stage from roughly the late 1880s- 1890s**: hospitals began to be transformed with more skilled female nursing than could be got at private homes, and of more accurate diagnoses by doctors with improvements in medical education: the germ theory of disease causation with the new science of bacteriology (a term coined in 1884) began to shape medical policies and actions, including clean surgery and clean separate operating theatres. The stigma of public hospitals as being repositories only for lower class patients began to shift gradually as well-to-do patients began to seek access for surgical operations. Hospitals began to evolve into more expensive scientific and clinical institutions with research and teaching functions – the prototype of the hospital of the present.\(^\text{11}\) The good news: hospitals had arrived at a place of greater safety where they could actually help people.

This rough model approximates the story of the public hospital in Launceston.

### 2. The new General Hospital at Launceston 1863

The new 1863 Hospital replaced a decrepit dirty and dilapidated building inherited from the imperial authorities with the advent of self-government in 1856. Built mostly of brick with a slate roof, with spacious double verandahs around three quarters of its extent, the new Hospital itself stood on 4 acres of land “greatly elevated above the crowded parts of the town….From the western verandahs a beautiful panorama is always visible.” The new hospital at Launceston opened on 26 January 1863 still named as the Cornwall Hospital and Infirmary, a title indicating the concept of the hospital as a charitable refuge: the majority of its in patients were poor. The quick adoption of the new name, General Hospital, on 5 May 1863 indicates the shift from Infirmary towards a curative function for urgent accident cases and sickness. It initially had beds for 102 patients: 74 in the male ward, and 28 in the female ward\(^\text{12}\), consulting rooms, and a dispensary. But importantly it had no designated operating theatre: surgical operations were to be performed in the wards as a desperate last resort. The

\[^{\text{11}}\text{See FB Smith, The People’s Health 1830-1910, ANU Press, 1979, p. 259. Smith’s work is a patient–centred exploration up to the great decline in mortality in the early 20th century, intending to assess whether medical science had a great impact on the health and life-chances of 19th century people in Britain, especially the poor. The economic problem that emerged for medical practitioners in private practice is that the growing reputation of hospitals as safe and curative organisations is that they lost potential patients (and income) to the hospital.}\]

\(^{\text{12}}\text{The ratio of male to female beds at this time reflected the larger proportion of elderly male convicts in the total population.}\)
risk of infection and death by surgery was high: surgeon Joseph Lister reported that he had had a death rate of 46% at the Glasgow Royal infirmary in 1864\textsuperscript{13}.

The hospital site was chosen with miasmatic principles in mind because its “supplies of pure air” at a distance from the gas works and industrial smoke in the port area of Launceston to the north – which from 1871 was to have smoky tin smelting works. Located in “the quietest part of the Town” the new Hospital lay just beyond the southern town boundary at Frankland Street, and opposite the town General Cemetery in Charles St. which had been opened in 1841 – an addition to the several existing separate cemeteries of the Anglican, Wesleyan, Catholic, and Presbyterian churches\textsuperscript{14}. The new Hospital’s “fine, salubrious situation, and the airiness and cleanliness of its interior elicited the admiration and approval of all who visited it.”\textsuperscript{15}

The presence of Florence Nightingale flowed also into Hospital architecture: the design owed itself to the belief in the miasmatic theory of disease causation – that bad smells and putrefaction generated infections. The theory, a chemical one, owed its life to the prestige of German chemist Justus Liebig (1803-1873) whose great success in unravelling mysteries in what is now called biochemistry in the 1830s to the 1850s promoted the putrefaction theory. Many influential British people were convinced that this theory explained the facts. They included the statistician William Farr in the new 1836 secular Registry of births, deaths and marriages who devised an influential set of statistics which were adopted empire-wide, and modelled from Liebig’s zymotic or miasma theory. The Hospital at Launceston published annual statistics according to this erroneous concept up until 1902. Florence Nightingale, with her Crimean War experiences of high death rates of soldiers from diseases in filthy accommodation, also became convinced of the truth of miasma and so used her great public prestige as nursing heroine in the aftermath of Crimea to advocate the pavilion design in her 1859 \textit{Notes on Hospitals}, which argued for proper cross ventilation, warmth through ward-based chimneys, thorough cleanliness, and windows for patients. She too was an advocate for facts, calling statistics ‘the most important science in the world.’\textsuperscript{16} The new General Hospital thus bore the imprint of Nightingale’s pavilion principle designed to prevent miasmatic diseases: the wards had 17 feet high ceilings and ample windows for

\begin{itemize}
  \item \textsuperscript{13} Joseph Lister (1827-1912) – by experimenting with carbolic acid (a by-product of the industrial chemistry from coal tar) – Lister reduced his surgery death rate from 46% in 1864 to 15% in 1870. In 1865 he used carbolic acid on a patient’s compound wound. He published some of his findings in “The Antiseptic Principle in the Practice of Surgery” in the \textit{British Medical Journal} in 1867.
  \item \textsuperscript{14} Britain’s first General Cemetery – it was non-denominational - opened in London in 1833. In Launceston the newly arrived Congregational minister, Rev. John West, had advocated the formation of the General Cemetery outside the southern perimeter of the town.
  \item \textsuperscript{15} Clifford Craig, \textit{Launceston General Hospital: the first hundred years}, Hobart, Government Printer, 1963, p.6.
\end{itemize}
patients, allowing free ventilation of air: “The apartments of the sick are disinfected by admitting as much fresh air as possible.”

The southern extension was completed in 1883 on identical principles. At the central part of the Hospital’s now were “three spacious vestibules superimposed one above the other” – the ground vestibule served as a waiting room, with a “capacious stairway leading to the vestibule on the second floor”. The upper vestibule “has domed sides and a flat roof and was designed for an observatory where meteorological notes might be made.” And later: “perhaps, ere long, attempts will be made in this laboratory to determine why cycles of erysipelas, typhoid fever, croupous pneumonia and the minor ailments, are almost epidemic during certain seasons.” (William Farr’s miasma theory included looking for correlations of epidemics with weather patterns). “A powerful hydraulic lift raises patients to the first floor, and the wings are provided with fire escape stairways.” The Hospital had 20 wards of varying sizes, some with brick chimneys in the centre (also part of the Nightingale design) - and 90 beds (the original plan of 102 beds space was apparently needed for other functions). By 1890 112 beds were available, which rose to 122 in 1892, then to 134 in 1898 at the end of Dr Drake’s tenure. The kitchen and apartments for the nursing staff were 40 feet from the Hospital main building, connected by a viaduct which was to become the first separate operating theatre in 1892.

But there was a significant problem caused by one category of patient. By the 1870s and 1880s frail, chronically ill and elderly ex-convicts transported between 1817-1853, sought refuge in the new Hospital. The prolonged infirmity of many occupied too many beds in the General Hospital – threatening bed shortages and thus compromising the hospital curative function for urgent accident and sickness cases. It is important to know that the elderly ex-convicts were not being removed to create beds for the well-to-do: the Annual Report of 1883 noted that “the majority of the indoor patients are paupers.”

What was to be the solution? The former imperial military barracks in Paterson St. were refurbished and re-labelled as the Invalid Depot in 1868. In 1882 of its 300 inmates, 91% (272) were former convicts. Such numbers would have overwhelmed the General Hospital beds needed for urgent cases in younger patients who also were poor. Through all the annual reports of the Hospital in the 1890s

18 Ibid., 1883, p.4. Erysipelas is an acute communicable disease caused by species of streptococcal bacteria.
19 General Hospital, Launceston: Annual Report for the year 1883, p.5. (copies in LGH John Ramsay Library).
20 The British Army withdrew the last of its troops from the Australian colonies in 1870.
21 The Invalid Depot in Paterson St. was demolished in 1914 (at the same time as the other nearby remnants of the convict past – the 1836 Female Factory and 1829 Gaol making way for the new High School) in favour of a Home for Invalids in Mulgrave St. In turn this was moved to Cosgrove Park in 1948.
22 Anne Green, A Model Municipality, Launceston City Council, 2007, p. 30. Commonwealth of Australia old age pensions came in 1909 via the Deakin Liberal government. The invalids were transferred to a new Home for Invalids in Mulgrave St., which in the course of time became the site for the Nelumie Flats for LGH staff; See Barbara Valentine, “The Nelumie Flats: a history of the site from 1912” in the Archive Newsletter, LGH Historical Committee, No. 12, July 1997.
is written the same refrain: “the attention of the Wardens of country districts should again be called to the practice of sending chronic invalids to the Hospital, instead of forwarding them direct to the Depot for Invalids.”

Yet the Invalid Depot remained as a kind of outpost to the General Hospital because part of the Surgeon-Superintendent’s job as a publicly employed officer was to visit and minister to the invalids (and prisoners in the nearby HM Gaol) and to dispense medicines as well. Dr Drake or his house surgeon made 158 visits in 1891 (dispensing 1462 medicines) – roughly 3 visits a week - and 114 visits in 1898 to the Invalid Depot.

3. The Board of Management at the General Hospital: staff and hygiene in the 1880s

The second phase, combining the curing and repairing function with the improvement in nursing at Launceston began with the appointment of an active Board of Management (with 13 members) under the General Hospital at Launceston Act of 1878. This Board was to have some very long serving members: four of them collectively served 136 years on the Board. It set about improving the Hospital during the 1880s.

“On women we must depend, first and last for personal and household hygiene for preventing the race from degenerating in as far as these things are concerned”, wrote Miss Nightingale. One of the Board’s very first decisions was to begin to employ women as nurses: two female nurses were hired in place of two male nurses in 1879 (there were seven other nurses, all male). This was the beginning of the feminisation of nursing at the Hospital. It is important to observe that “nurse” did not begin to carry the connotations of professional training, skill and competency – the need for training was the gist of Nightingale’s Notes on Nursing of 1859 - until the rule of the Lady Superintendent and professional training at Launceston took root from 1890.

But who was to be in charge of the hospital nurses? In keeping with the Nightingale dictums of 1859 the Board of Management decided in 1880 to appoint a Matron in charge of the nurses, male and female; Miss Windred from Sydney arrived in 1881. The name of the matron was changed to that of Lady Superintendent in 1884 for the second occupant; a change that reflected exactly Florence Nightingale’s own title, Lady Superintendent, in her school of Nursing at St Thomas’s, London, a title that in the Launceston context indicates the authority needed over untrained male nurses, and some of them being ex-convicts. The next Lady Superintendent was Miss Jeannette Milne, from the Royal Edinburgh Infirmary and trained in Nightingale methods. From 1886 to 1912 Miss Milne made a significant contribution to the General Hospital, notably in her suggestion for a Training School for Nurses. Regular lectures for nurses began in 1891 during the tenure of Dr Francis Drake as Surgeon-Superintendent. Recruits to that school could only be women – in the words of the day “lady pupils”. The hierarchy of the Hospital was in place.

There was also a serious problem in medical responsibility: who was in charge? The new Board of Management under chairman George Collins decided by 1881 that the experiment of relying on several honorary

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23 General Hospital, Launceston: Annual Report for the year 1891, p.5. (copies in LGH John Ramsay Library).
24 Craig, op.cit., p.7.
25 Florence Nightingale, Notes on Nursing, 1859.
medical officers to service their Hospital without any Surgeon-Superintendent being appointed from 1879 to 1881, was ineffective and unsatisfactory: “there being no means of fixing responsibility on anyone, and differences constantly occurring”. The Honoraries, with calls on their time from private practice patients, proved inefficient so that the public patients in Hospital had been neglected. The Board returned to the former regime and re-appointed a Surgeon-Superintendent as the chief, with the honorary staff of consulting surgeons to be subordinate. A second resident doctor was also required by 1885: “the work of the hospital having increased of late years, the appointment of a House Surgeon is deemed necessary.” Dr James Pardey (a Melbourne graduate of 1884) became the first House Surgeon in 1886.

Control of hygiene was a priority. A new wash house for hospital sheets, clothing and laundry was commissioned in 1880 (previously laundry was done off site at HM Gaol in Paterson St.). A mortuary of brick walls, slate roof and concrete floor was built in 1883. The Hospital was lit by gas. The Hospital was connected to the Telephone Exchange (a new invention in 1876) and also serge uniforms were provided to nurses and attendants in 1884. Rules for regular baths of in patients on arrival and weekly were promulgated in 1886. Cleanliness became institutionalised. Hot piped water – vital for hygiene - became available in 1887 (with over 1000 feet of piping, and up to 3000 gallons of water in circulation) when a new Boiler House opened. The Board had proved their worth in their constant improvements.

4. Dr Francis Drake’s contribution to the General Hospital at Launceston

Francis Drake’s father, John Drake (1826-1910), was a schoolteacher at Kew, Victoria. Like many others he was a gold era immigrant from Britain: a John Drake, age 27, is recorded as arriving in Victoria in 1857 aboard the ship Mt Stuart Elphinstone. He and his wife Anne (1833-1911) had four children; Francis John being the third child born in St Kilda, Melbourne in December 1860.

His father’s profession as a teacher may have influenced Francis to enter the University. Francis was an employee of the Melbourne Public Library for a period from 1879, graduating with a BA degree in 1886, then as a Master of Arts in 1887 from Melbourne. As the Melbourne Medical School conducted a five year course, he probably enrolled in 1884 (aged 23 years), so Drake finally graduated MA MB BS

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26 See Annual Reports of the General Hospital, Launceston, for 1881, 1882, 1883. The report notes that the Hospital administration was similar in medical and surgical functions to the Columbia Hospital for Women in Washington DC in the USA, with a Surgeon-Superintendent and supported by an honorary staff of consulting surgeons.

27 Information obtained by Karen Carson of the John Ramsay Library at LGH from the Kew Historical Association.

28 Obituary, Dr Francis Drake, The Examiner, 21 September 1929. See also Blue Book of Victoria, 1880, p. 31: FJ Drake employed as a messenger at £50 per year from 28 April 1879. The BA degree had six schools (languages; philosophy; political economy and history; mathematics etc.); no information can be obtained as to which school Drake attended; his friend Dr Edward Gault also was a BA graduate in political economy and history, so this seems likely for Drake also. The MA involved a heavy duty reading course. Walch’s Almanack of 1899 gives Dr Francis Drake’s MA date as 1887. Bachelor of Arts students could enrol in the Faculty of Medicine at the third year medicine, provided they had attended lectures and passed all the exams in the prescribed subjects for years 1 and 2 in Medicine, which could be done in any order.
from the University of Melbourne Medical School\textsuperscript{29} in 1888. After one year as a Resident Medical Officer at Melbourne Hospital, he came to the General Hospital in Launceston in January 1890 (aged 29), first as House Surgeon and Dispenser and then after 16 months – enough to learn the ropes - was elected as Surgeon-Superintendent from July 1891. Drake remained unmarried until August 1898 (his successor John Ramsay also remained unmarried until 1913): as a single man he was able to devote considerable energy and enthusiasm to his job as chief of the Hospital.

The following are some of the major changes achieved at the General Hospital at Launceston during his period as Surgeon-Superintendent:

- First lectures for the new Nursing school 1891 & the feminisation of nursing
- appointment of a full time Dispenser of medicines in 1891 (the pharmacy function)
- The first operating Theatre 1892 instead of conducting operations in the wards
- Re-organising wards into surgical and medical wards
- separate wards for boys and girls (the first in Tasmania)
- Reception House for the Insane and Inebriates, 1892
- extension of nurse training from 2 years to 3 in 1893
- purchase of bacteriological equipment during visit to England in 1896
- purchase of x-ray equipment in 1896 immediately after Roentgen’s announcement
- recommendation of electric lighting at the General instead of gas lighting
- separate building completed for Isolation Wards for Infectious Diseases (16 beds) in 1897
- new Nurses Home completed in 1897

Because the Annual Reports are terse and are a minimalist record of events, the details of initiators are not revealed. But the Board followed the advice of the Surgeon-Superintendent on medical issues which most of these changes substantially are. So obliquely the evidence testifies not only to Drake’s organisational flair (continued in his founding and managing a Sanatorium for Tubercular patients c.1906-26), improving patient care, and supporting the female nursing staff in the new Nurses Training School, but also in putting into practice at Launceston what his recent medical education from Melbourne University and his year as a resident medical officer at Melbourne Hospital guided him to do.

That these changes were achieved is strong evidence that Dr Drake had a personality to engage congenial allies at the Hospital on several levels:

- first, in the Board of Management headed by equity and criminal lawyer George Collins\textsuperscript{30} (1839-1926), chairman from 1880 to 1898

\textsuperscript{29} see KF Russell, The Melbourne Medical School 1862-1962, MUP, 1977, for complete list of all medical graduates up to 1962.

\textsuperscript{30}George Collins, b. Launceston 1839, son of publican William Collins. Educated Launceston Church of England Grammar School. Law Articles with Adye Douglas (who married his mother Martha in 1858 following the death of his father), &
second, his junior medical colleagues who acted as House Surgeons, and third, and not least, the nursing staff who did the detailed work with the patients who were led by the Lady Superintendent from 1886 to 1912, Miss Jeannette Milne, a graduate from the nursing school at the Royal Infirmary at Edinburgh.

The innovations of the 1890s substantially changed the functions of the General Hospital, setting it on a course of scientific-based medicine that his immediate successor as Surgeon-Superintendent, Dr John Ramsay (1898-1912) could follow and build on. Ramsay had also graduated from the Melbourne Medical School in 1893. Importantly, both Drake and Ramsay were beneficiaries of significant curriculum changes in the Medical School in the mid 1880s and making it more scientific which Pardey would have missed out on as an earlier graduate. Therefore for a deeper understanding of these 1890s changes at the General Hospital in Launceston it is worth considering medical education obtained at Melbourne University.

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31 A position as House Surgeon at Launceston was first created in 1885 and Dr James Pardey appointed in 1886-1889: Dr Francis Drake 1890 (Melbourne graduate 1888); Dr WH Jermyn 1891 (Melbourne graduate 1889); Charles Parker 1892 & Acting Surgeon Superintendent 1895-96 during Dr Drake’s 16 months leave overseas; Dr CA Hogg 1895; Dr John Ramsay 1896-1897 (Melbourne graduate 1893), who became Surgeon-Superintendent 1898-1912.
5. The Medical School at the University of Melbourne established in 1862

Victoria, founded from Launceston in 1836, became a separate British colony from NSW on 1 July 1851. Sydney University – the first in Australia - was established in 1852 and Melbourne University soon after in 1855 as the gold rush boomed. But Melbourne was to found the first Australian Medical School in 1862, twenty years before Sydney.

The champion for creating a Medical School at Melbourne was Dr Anthony Brownless (1817-1897), who became Vice-Chancellor in 1858 and as chairman of the Medical School Committee, against considerable opposition, pushed successfully for its establishment. Brownless had graduated as a member of the Royal College of Surgeons & Licentiate of the Society of Apothecaries in 1841; MD St Andrews in 1847. Poor health induced him to travel widely (Russia, Norway and Denmark in 1834; USA and Canada in 1835; Portugal and Spain in 1837; Belgium in 1845) where he also visited hospitals. For health reasons – probably he was tuberculous – he had emigrated to Victoria in 1852 as a ship’s doctor to pay his passage to the colony. He was appointed physician to the Benevolent Asylum and elected as a physician to the Melbourne Hospital in 1854. He built up an extensive private practice.

By good fortune, Brownless had studied at St Bartholomew’s Hospital in London with Dr James Paget (1814-1899) – who emerged in the 1850s as an eminent physiologist and surgeon and a key founder of scientific medical pathology (with Rudolph Virchow) - the microscope and meticulous observation and publication of his researches linking biology with medicine enhanced the claim of medicine to be scientific. Paget’s eminence gained him the post of surgeon extraordinaire to Queen Victoria in 1858. Acting on Vice-Chancellor Brownless’s request for help in finding for the Medical School in Australia a man possessing “eminent knowledge” and also to “be an able and eloquent lecturer”, Paget recommended Dr George Halford (1824-1910), who arrived in December 1862 as Professor of Anatomy, Physiology, and Pathology: the three key areas in basic medical science. George Halford proved a good choice. In his 33 years service he built a Medical School with great strength in its teaching.

Vice-Chancellor Brownless also gave another strength to the Melbourne Medical School. Despite opposition, Brownless based the medical teaching at Melbourne on a 5 year

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33 St Bartholomew’s Hospital in in London dates from 1123; St Thomas’s from c.1215; these hospital buildings thus coincided with the era which founded universities of Oxford and Cambridge and built cathedrals.
34 Rudolph Virchow, Die Cellularpathologie, 1858, laid the foundations of cellular pathology.
36 Dr George Halford gained his MRCS in 1852; LSA in 1854 [Licentiate of Society of Apothecaries of London]; MRCP in 1859; and MD from St Andrews. He trained at St George’s Hospital & Westminster Hospital, London, and at the Liverpool Infirmary; see KF Russell, The Melbourne Medical School 1862-1962, MUP, 1977, p.26.
37 Anatomy is about structure of bodies & learned by dissection; Physiology is about function – the healthy function of the body & basic to medical science; Pathology is about malfunction – the causes & changes produced by disease. The renaissance French physician Jean Fernel (1497-1558) coined the terms “physiology” and “pathology” in 1554, see Porter, The Greatest Benefit to Mankind, op. cit., p. 174.
curriculum: by contrast, all the medical schools in the English-speaking world (except Dublin) had 4 year training. Brownless’s long term view proved correct. As medical knowledge expanded rapidly in from the 1870s to 1890s and beyond, the 5 year course proved valuable and necessary. Subsequently in 1892 – 30 years after Melbourne - the General Medical Council in Britain (established in 1858) incorporated many of the features of the Melbourne’s five year model for medical education.\textsuperscript{38}

Professor Halford after 18 years at Melbourne left in November 1880 to visit “the home Universities, Medical Schools and Colleges” (such as Cambridge and St Bartholomew’s Hospital in London) to review medical progress there, returning in August 1882 and immediately proposed “a scheme for the more practical teaching of the Science of Medicine” including a physiological laboratory.\textsuperscript{39} Important changes were afoot. Melbourne’s Medical School moved to a more science-based medical curriculum from 1883: these are the medical years of Francis Drake. But just what was considered “scientific” medicine by the 1880s?

6. The rise of the medical profession and “scientific” medicine

For much of the 19\textsuperscript{th} century medicine was not a respected profession. By the 1890s and early 20\textsuperscript{th} century public opinion had reversed. This social evolution is called the rise of professional society\textsuperscript{40} in which the rise of the medical profession is an archetypal example. The Melbourne University Medical School got under way in 1862 at a time when the emerging political power of the educated middle classes was gaining traction in the hierarchical society of imperial Britain. They sought to enhance their status in the social hierarchy by the claim to knowledge including scientific knowledge - in effect part of the prolonged argument for meritocracy against aristocracy and its long established and entrenched patronage system.\textsuperscript{41} The claims of science became entwined as a weapon in the class contest between the merit principle and the patronage practice.

The claims of science became entwined also in the emergence of the new medical identification as a “general practitioner” during the 1840s and 50s – at that time usually a combination of apothecary and surgical qualification. But entangled with the evolution in medical education and qualifications was the question of status: were medical practitioners to have the standing as gentlemen? The arbiters of status were the English upper classes, who employed for home visits physicians (gentlemen) educated at the unreformed Cambridge and Oxford; for patricians the

\textsuperscript{38} Russell, op.cit., p. 36.
\textsuperscript{39} See University of Melbourne, Annual Report 1881-82.
\textsuperscript{41} On the slow reform in the British civil service 1830 to c. 1885, for open competitive examinations (the merit principle) versus patronage in appointments for jobs, see Oliver MacDonagh, Early Victorian Government 1830-1870, London, 1977, ch. 11.
high status professional occupations were deemed to be the church, the bar, the army, the navy and the civil service\textsuperscript{42}. Medicine was excluded, for many of the patricians considered apothecaries and surgeons to be the equivalent of tradesmen. As Lady Chettham declared in George Eliot’s \textit{Middlemarch} (published in 1871): “For my own part, I like a medical man more on a footing with the servants.”\textsuperscript{43} But the growing number of general practitioners – combining medicine and surgery - made up the vast majority of the expanding profession of medical doctors from the 1860s. Respectability – that potent watchword of Victorian age Britain - and acknowledgement of their standing as gentlemen was a part of their aspirations. The simmering class tensions played out in many ways, including the championing by medical reformers from the middle classes of their training and knowledge as “scientific” and by implication, intellectually superior. Doctors organised a pressure group, the British Medical Association (BMA) formed in 1856 with its \textit{British Medical Journal} in 1857. The BMA came to the Australian colonies with the migration of medical men – the NSW branch being formed in February 1880; the BMA was to remain so named in Australia until 1962. Many medical reformers had been educated at the Scottish university medical schools and the new London University College (established 1826\textsuperscript{44}) which set the standard for improvements in medical education. Democratic reformers like the surgeon Dr Thomas Wakley (1795-1862) with his journal \textit{The Lancet} established in 1823 also vigorously campaigned for reform. Public recognition of the status of medical general practitioner depended in part upon public regulation. In 1858 the British Medical Act established a licensing system via the General Medical Council (regulating medical training and the medical curriculum, and medical ethics) and the Medical Register which defined for the first time who was to be considered a “legally qualified medical practitioner” both in Britain and in its empire. The system of medical registration, as with much 19\textsuperscript{th} century legislation in Britain, translated to the Australian colonies (Van Diemen’s Land had enacted registration of medical practitioners in 1842.) The fudge was that the so-called “quacks” (with nil medical or non-university training) who also claimed healing powers and remedies, could also continue to practice in the field of medicine. Equally, with newspapers advertising pills and potions and their makers claiming their efficacy in relieving or even curing a range of ills, self-medication as an alternative to consulting a medical practitioner was culturally widespread. Each edition of the \textit{Launceston Examiner} displayed an array of advertisements for over the counter medications all through the 1890s.

\textsuperscript{42} See David Cannadine, \textit{The Decline and Fall of the British Aristocracy}, 1996 rev. ed., London, p. 296; see Ch.6 The demise of patrician professionals.

\textsuperscript{43} See George Eliot, \textit{Middlemarch}, (1871), Penguin edn. 1994, p.91. \textit{Middlemarch} is also an exploration of medical practice in a midlands provincial town in the reform era of 1832, with protagonist Mr Tertius Lydgate, one of the new “general practitioners” combining surgery and apothecary, whose new ideas of medical reform (adding a fever hospital to the existing infirmary and turning it into a teaching hospital and conducting medical research; using the new fangled stethoscope; a resolve not to prescribe drugs as a placebo etc.) creates a falling out with other rival local physicians and apothecaries, and a falling into debt. The intellectual Mary Ann Evans (aka George Eliot) has a good feel for medical history – she had been editor of the Westminster Review from 1851-1854, a utilitarian journal founded by Jeremy Bentham in 1824, with faith in scientific progress. FB Smith, \textit{The People’s Health 1830-1910}, op. cit., for examples of callous practices at p. 274.

\textsuperscript{44} University College, London in Bloomsbury, was founded as the first secular university in Britain in 1826 by two Scotsmen, James Mill (1773-1836) and Henry Brougham (1778-1868), who were influenced by the utilitarian Jeremy Bentham (1748-1832). It admitted students regardless of religion and was the first university to admit women in 1878. The University College Hospital for medical teaching, opened in 1834.
The existence of “quacks” and the wide-spread practice of self-medicating exposes a significant question: within the function of health and disease who really understood the maladies afflicting the suffering patient? Who could be trusted as an accurate diagnostician? Who could be trusted to mitigate suffering? Many made claims, but just what was reliable and trustworthy as medical aid and surgical procedures? In this context, the claim for “scientific” medicine – by implication intellectually superior and offering “real” medical help - emerging in the 1860s to the 1890s needs to be briefly appraised. These three decades are the founding years of the new Melbourne University Medical School; and the 1880s is the decade of Dr Francis Drake’s medical education.

The claim for “scientific” medicine is an interesting one. “Science” from the Latin scientia or knowledge began a big shift in meaning during the 19th century so that by the 1860s science as a rational process came to be associated with the natural or physical sciences; “scientist” coined in the 1840s likewise had that connection. To advance the claims of the physical sciences the British Association for the Advancement of Science was formed in 1831. The illuminating and fruitful exploration of the physical notably in chemistry, biology, physics, botany, zoology and geology helped to identify these as “science”. Induction was the scientific method – by the accumulation of vast amounts of facts it was hoped would spark the emergence of a pattern from which could be deduced a theory to account for the facts, along the lines of Isaac Newton’s Principia Mathematica of 1687, calculations from which in 1781 and in 1846 had yielded with great excitement the discovery of two unsuspected planets, named Uranus and Neptune respectively. The assembly of vast amounts of data, measurement and assessment can be seen in the research work of chemists (Liebig, Wohler); of medical practitioners fact-finding in physiology and pathology (Paget, Virchow); or in bacteriology (Pasteur, Koch); or in biology (Darwin).

Applying scientific method to the field of medicine particularly in physiology and anatomy (helped by the Anatomy Act in 1832) – behind the scenes work in the medical schools, but things were not at all clear cut in the public domain during the mid and late 19th century either to medical and or to lay opinion. Within the profession there remained much room for dispute about the causes and prevention of diseases, about what constituted standard medical treatment for a range of procedures, about agreement on clinical symptoms for particular diseases, and so on.

In the absence of proof such as that furnished by Dr Robert Koch, famously in the case of tuberculosis in 1882 - a variety of theories flourished as to the causes of diseases. And some of these theories were also taught in medical school curriculums. In particular the great prestige of chemistry in the 1830s-1840s and the influence of the German chemist Justus Liebig (1803-1873) and his ideas on disease causation had a long lasting impact into the

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45 The rational process as a tool in the sciences: (1) must be able to predict and control all variables; (2) must be able to quantitatively measure the events; (3) must be able to precisely define the variables; (4) must have both (a) complete and (b) adequate information. - See Concept: Synergy, Intuition, 1985. Dr Robert Koch’s bacteriological explorations in the 1870s and 1880s seems to match these criteria.
Liebig’s train of thought - derived from his work in biological chemistry - was that during the fermentation of decomposing organic matter in the environment the chemical particles so generated could create pathological symptoms in another body. The influential statistician William Farr took Liebig’s general theory of zymotic diseases (from the Greek zymotic as fermentation) and developed a set of disease classifications which shaped the collection of statistics from 1837 in Britain and Australia. Farr’s category of zymotic diseases had as its first sub-set the miasmatic diseases. The miasma theory assumed that the chemical gases given off by putrefying organic matter so generating acute diseases – in short, that “bad smells” somehow caused a range of diseases. Farr’s miasmatic diseases included smallpox, chicken pox, measles, influenza, (all found in the 20th century to be caused by viruses); scarlet fever, whooping cough, mumps, diphtheria, cerebro-spinal fever, typhoid fever (all caused by bacteria); typhus, relapsing fever (louse borne) as well as other diseases not listed here. This statistical classification appeared in the annual reports of the hospital at Launceston until 1902.

As noted above, the miasma theory shaped the views of influential public health reformers such as Edwin Chadwick in the 1840s in Britain: the prevention of sickness, a major cause of urban poverty, was their great aim. The theory of miasma through the agency of Florence Nightingale’s Notes on Hospitals (1859) also influenced the design, function and siting of hospitals, including that of the 1863 General Hospital at Launceston. The miasma theory is a case of an erroneous idea shaping the collection and interpretation of facts, directing the allocation of vast funds for underground sewers and piped water supplies, and hospital building and design. Erroneous, but paradoxically for an error, it produced a great deal of public good.

Equally, a variety of other theories existed as to the causes of illness which were also vague and ill-defined. Did endemic illness such as tuberculosis arise from constitutional defects and hereditary weaknesses of individuals? Or were illnesses spontaneously generated in the body? Was illness transmitted by contagion, by touching infected persons with examples like smallpox and syphilis? And so on. There was a great deal to sort out by comparing pathological states with normal anatomical states. Hence the great stress on anatomical dissections and microscopic examination, and on post-mortem examinations in scientific medical education. Adding to the complexity were differences in perception and diagnosis by medical practitioners, so that what eventually turned out to be identified as a particular disease might also carry several totally different labels for example, tuberculosis could also be called phthisis, consumption, wasting disease and other labels. Typhoid (a term first used in public to account for the death of Queen Victoria’s beloved husband Prince Alfred in 1862) also has a long list of names such as enteric fever, prolonged fever. And diagnosing required accurate knowledge: typhoid was not clinically distinguished from typhus until 1849.

\[46\] Justus Liebig had a big reputation as a chemist: in the 1830s and 1840s he made significant contributions to biological chemistry in the chemical analysis of inputs and outputs of respiration and digestion of animals (and therefore of humans); and similar analyses with plants gave rise to the chemical fertiliser industry.

\[47\] Sir William Jenner (1815-1898) Professor of Pathology at the University College Hospital in London, differentiated typhoid from typhus by post-mortem examinations in 1849; see Porter, The Greatest Benefit to Mankind, op. cit. p.349.
Above all, science was not accepted by the majority of the population as the consensus standard by which to appraise medical knowledge and treatment. It probably still isn’t. Being “scientific” in other words, was a battle of ideas largely confined within the educated minority. And as usual the advocacy of new ideas, such as the germ theory of disease causation in the 1860s-1880s, provoked debate, denial, and resistance.

Science had to be accepted as a social “good” and absorbed into consensus thinking over a very long period of paradigm shift. And compulsory primary school education (which did not include science) only began in the 1870s. But physical sciences and the possibilities of their being applied to fields such as medicine could be acknowledged by the 1890s. For example, the Launceston Examiner in 1898 could praise the meeting in Sydney of the Australian Society for the Advancement of Science which put “science” on a higher plane of understanding: “Science and knowledge are sometimes regarded a synonymous terms, but the scientific man has advanced a step further than the mere well-informed one, for he has not only mastered his facts and principles, but he has marshalled them in proper order. ….The late discovery of [diptheria] antitoxin and the Rontgen ray was but a few weeks old before both were demonstrated in the Australian colonies.”

(The Launceston Examiner had published a special supplement with objects x-rayed by two Launceston local photographers.)

The 1860s to the 1890s saw significant practical application of scientific techniques that unravelled some of the mysteries in biology and chemistry. Improvements in microscopes from the 1830s—the key instrument for making medical discoveries - their affordability by the 1870s, and curriculum requirements that medical students possess microscopes for studies in pathology, anatomy and physiology enhanced the claim for medicine to be regarded as “scientific”. The advent of the germ theory of disease causation would have been impossible without high quality microscopes; the germ theory was first added to the Melbourne medical curriculum in 1884. it evolved into the new science of bacteriology in the 1890s with its practitioners housed in hospital laboratories. Melbourne University Medical school led by Professor Harry Allen (a teacher of Dr Drake), began classes in bacteriology in 1892.

But university education occurs behind the scenes. Publicity about the growth of “Listerism” in surgery – with surgeons taking sides for and against in Australia, Europe and North America in the 1870s and 1880s – probably did more to join – slowly - the notion of science with medicine in the arena of public opinion because it had a reportable result, namely, a radically diminished the death rate in surgery. Infection was the key obstacle in surgery. Joseph Lister’s (1827-1912) methods in surgery at the Royal Glasgow Infirmary from 1865

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48 The Australian 8 October 2012, p. 2: the Chief Scientist of the Commonwealth, Professor Ian Chubb, formerly ANU Vice-Chancellor, wants to foster “the creation of a scientifically literate general public.”
49 See Launceston Examiner, editorial, 14 January 1898,
using carbolic acid (phenol) derived from coal tar distillation he found to be an effective antiseptic (killing infective agents in the wound) for a compound wound. Lister also applied a ritual using carbolic acid sprays in the theatre (asepsis – preventing infective agents getting into the wound) which he later abandoned in 1890 when Koch and others demonstrated that steam was a more effective sterilizing agent. The death rate in Lister’s Glasgow theatre dropped from 46% in 1864-1866 to 15% by 1870.\textsuperscript{51} Lister’s reading of Louis Pasteur’s (1822-1895) researches that air-borne microbes were infective agents illuminated why the carbolic acid sprays had potency. But microbes under the microscope came in myriad forms. Pasteur’s discovery of streptococcus bacteria (1880) and meticulous research by Dr Robert Koch and colleagues which demonstrated that specific organisms caused specific diseases (anthrax 1877; typhoid 1880; tuberculosis and diphtheria in 1882; cholera 1883; tetanus and pneumonia in 1884) honed the issue of cause. Isolating causes but what of surgical practice? Lister’s ideas spread to surgeons in France and Germany who came to observe at Glasgow in the aftermath of the Franco-Prussian War of 1870-71. They had been shocked by the huge death rate of their wounded troops at the hands of surgeons: French surgeons had amputated over 13 000 limbs but of these some 10 000 soldiers died of gangrene and fever – a 76% death rate.\textsuperscript{52} Two German surgeons who had worked with Koch in 1885 introduced the sterilisation of all items entering the operating theatre; the use of autoclaves and steam sterilisation of equipment began in the late 1880s.

The new takes time to seep in. We can imagine how these findings applied to surgical practice must have inspired Melbourne medical students and intending surgeons like Francis Drake in the 1880s: his surgery teacher at Melbourne, TH Girdlestone, was a convinced practitioner of aseptic and antiseptic measures. As an indicator of that inspiration even in 1905 Francis and Alice Drake named their third child Lister Drake.

Germ theory gave a scientific reason for a range of activities which began gradually to permeate into the practices of medical staff within hospitals, such as in the separation and isolation of infectious disease wards. Very importantly, germ theory reinforced the message of prevention that Florence Nightingale had been advocating and trained Nightingale nurses had been drilled in – that of enforcing personal hygiene of medical and nursing staff and patients and initiating hospital regimes of cleanliness (Rules for Baths in the Hospital at Launceston 1886). The application of aseptic methods in hospitals which became the main site for surgery, offered safer operations and so enhancing the reputation of surgeons by the 1890s. Safer operations meant that surgeons could attempt cases that had been deemed impossible. The safer reputation of hospitals emerging in the 1890s is a big public link associating science and medicine. Surgery, allied with pain free operations with the use of anaesthesia, began to alter hospital budgets, resource allocation and operating costs (the free list) which included the provision of separate operating theatres.

Changes in medicine filtered through to the Australian colonies by the emigration of British born and educated medical practitioners, particularly in the burst of the gold rush years of the 1850s, when the new colony of Victoria became the epicentre of wealth creation. Not only

\textsuperscript{51} Joseph Lister, “The Antiseptic Principle of the Practice of Surgery”, British Medical Journal, 1867; and publication of results in The Lancet, 16 March 1867.

emigration: but most importantly the circulation of ideas and sharing of medical experiences and innovations through medical journals such as The Lancet and the British Medical Association and its publications, as well as Australian publications like the Australasian Medical Gazette from 1881 and the Australian Medical Journal from 185653. The sense of being on the fringe from a distant Britain perhaps was stimulus for many to keep abreast of medical discussions and innovations. (In Launceston, the example of Dr William Pugh who published his anaesthetic operations in the Australian Medical Journal on 1st July 1847.) By 1869 with the opening of the Suez Canal and the advent of steamships and convenient European railways, access to Britain to keep up to date was more feasible for those who could afford to return54 there as did the Dean of Medicine at Melbourne University, Professor George Halford in 1880-82. He returned with enthusiasm to revamp the medical curriculum into a more scientific one.

7. Dr Francis Drake MA MB BS graduate of Melbourne University Medical School, 1888

The medical education Francis Drake received at Melbourne was a thorough one over five years with group of able teachers. Appendix 1 reproduces the 1885-86 medical curriculum – with both theory and practical components – that he would have studied until his graduation in 1888. The grounding he got academically in medicine and surgery at Melbourne University and practical experience gained at Melbourne Hospital oriented him in the key decisions he made at the General Hospital in Launceston.

Several Melbourne University medical graduates worked at the General Hospital in Launceston during its transition into the 20th century model of a hospital:

- Dr James Pardey, graduated 1884, and the first appointee as House Surgeon from 1886-89; then Surgeon-Superintendent 1889-91; then private practice in Launceston 1891-1932
- Dr Francis Drake, graduated 1888, House Surgeon in 1890, Surgeon-Superintendent 1891-98; then private practice in Hobart 1898-1903
- Dr Walter Jermyn, graduated 1889, House Surgeon 1891-92
- Dr John Ramsay, graduated 1893, House Surgeon 1896-97, Surgeon-Superintendent 1898-1912; private practice from 1912; chairman of the Board of Management 1933-44

However, James Pardey, the first Melbourne graduate at Launceston, missed out on some of the important changes made to the medical course: for example, his 4th year class on the Theory and Practice of Medicine (in 1883) dealt with the (later deemed erroneous) zymotic diseases (of which miasmatic diseases were considered the main class; germ theory was not included. By contrast the revamped medical course available to Drake (and to later

53 The Australasian Medical Gazette 1881-1914 published by the NSW branch of the British Medical Association (BMA), and the Australian Medical Journal 1856-1914 published by the Medical Society of Victoria. On their amalgamation they became the Medical Journal of Australia from 1914. The Australian Medical Association (AMA) separated from the BMA in 1962: 50th anniversary in 2012.

54 Dr Francis Drake in 1896 and 1914, and Dr John Ramsay in 1902 also ventured to Britain and Europe to refresh and reflect on their medical practice.
graduates) put the very new germ theory of disease causation into the 3rd year course on Pathology (for Drake in 1886) – but “zymotic” diseases remained in the list of topics in the 4th year Theory and Practice of Medicine. In short, the bacteriological researches of Pasteur and Koch (notably in Koch’s public demonstration and lecture on the tuberculosis bacterium in 1882) and the surgical success of Lister helped shift opinion in medical education at Melbourne, but uncertainty about disease causation is reflected in the medical curriculum – this is the usual case with new ideas of a minority overlapping the old beliefs in the majority of people’s conceptions. So often it is the younger generation, with no hard pre-set beliefs to override, who find new ideas congenial, particularly if their teachers at Melbourne such as Girdlestone in surgery and Allen in pathology and anatomy explore, embrace and articulate the new.

Dr Drake as innovator at Launceston and Dr Ramsay as expander of those innovations can be attributed to their Melbourne medical teachers, the thorough medical education with its science orientation, as well as to their personalities, organisational flair and drive for improvement. The discovery and acceptance that specific bacteria caused specific diseases was exciting news for it had immediate practical relevance in hospitals and in surgery, for it reinforced and gave understanding to the hygienic regime advocated by Nightingale.

Let us look at the changes in Melbourne University medical training which influenced Francis Drake’s world view of medicine.

As we have seen, during the mid and late 19th century, science and medicine began to be seen as complementary fields of knowledge, and which academics such as Professor George Halford sought to have reflected in medical school training soon after his return from Britain in 1882. From 1883 the Melbourne University medical education curriculum was revamped with a greater emphasis on science. Science occupied all the first year of medical training (most of these classes met thrice a week):

- Natural Philosophy part 1 (ie. Physics)
- Elementary Biology and practical work (replacing comparative anatomy and botany)
- Chemistry
- Practical Chemistry

As well, compulsory attendance of students was required at post mortem demonstrations; practical physiology and histology (3rd year students supplying their own microscopes, glass slides, scalpels, forceps etc. for cell pathology) were introduced; and compulsory attendance at clinical medicine and clinical surgery (for both in and out patients) was required: two lecturers appointed to these disciplines. A large collection of 4000 anatomical and pathological specimens built up at Melbourne Hospital (particularly by Harry Allen) was donated to the Medical School in 1883 and housed in a museum at the School.

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55 This analysis is based on comparing the Medical School curriculum and noting the changes in each of the years at Melbourne University as published in their University Calendar (available on line.)

56 In 1876 Melbourne University had created a Faculty of Medicine. In 1876 the Bachelor of Medicine (MB) degree was added to the Bachelor of Surgery (BS) degree for all Melbourne medical graduates. This made them “general practitioners” in the 19th century sense of being trained to perform a wide range of medical functions and therefore maximise the chances for income.

Medical Building was completed on campus in 1885 with a Pathology Museum and a dissecting room. A graded sequence of anatomical dissections was required over three years.

A surge in University enrolments during the 1880s (181 medical students in 1882, roughly half of the total students in the university) necessitated a reduction in Dr Halford’s workload by the creation in 1882 of a new chair in Surgical Anatomy and Pathology, with Dr Harry Allen (a Melbourne graduate of 1875) appointed. Allen, as University demonstrator in anatomy and pathologist at Melbourne Hospital from 1876, introduced regular instruction in post mortem room at the University, and also began systematic teaching of pathology there. Three courses of anatomy dissections were required over three years on cadavers (with certificates that they had done so) for the 2nd, 3rd and 4th years. Allen became Dean and therefore leader of the Faculty of Medicine in 1886. He took leave in 1890 to visit Europe and catch up on the advances in histology, pathology and bacteriology. He returned determined that practical bacteriology should be taught in his classes. They began in 1892.

Also influential to Francis Drake’s medical education was the lecturer in Medicine 1881-1887, Dr Samuel Bird. KF Russell writes: “Bird was an excellent physician, very popular with his colleagues. As a lecturer he had a terse and lucid style which greatly impressed his students. He was a physician at the Benevolent Society and on the staff of the Alfred Hospital.”

Another writer noted that Samuel Bird raised the teaching of medicine at Melbourne “to a high standard.” Dr Drake’s third career change after leaving Launceston in 1898 was to found a Tuberculosis sanatorium in Victoria. Dr Samuel Bird had arrived in Melbourne in 1862 in search of a cure for tuberculosis. Bird had published *Australian Climates and their influence in the prevention and arrest of pulmonary consumption* in 1863: in the absence of a cure for tuberculosis, warmth and pure air were held to ameliorate that disease.

On the surgery side of teaching at Melbourne in the 1880s, Tharp Mountain Girdlestone (1823-1899) was appointed lecturer in surgery 1880 until he resigned in 1896. Trained at St Bartholomew’s in London (MRCS 1845, FRCS 1849) he arrived in Melbourne in 1850, and was MLA for Ararat (1862-65). On appointment to his surgery lectureship Girdlestone “at this time was probably the best surgeon in Melbourne. An active exponent of the new antiseptic method of surgery [Lister] he obtained excellent results with it both in his private

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58 Ibid., p. 58.
59 See KF Russell, op. cit., pp.80-81. Instruction in anaesthesia was given at Melbourne Hospital from 1895, but not compulsory; Russell, p. 95. The teacher was Dr Embley, a fellow graduate with Dr FJ Drake. A revamping of the medical course in 1906 made anaesthetic training compulsory.
60 Ibid., p. 45. Bird trained at King’s College London; he had served with British medical staff with the Turkish Army in the Crimea in the 1850s. See article on Thomas Cherry (1861-1945) in *Australian Dictionary of Biography*, vol. 7, 1979, appointed first to lecture in bacteriology at Melbourne Medical School in 1892. He visited Europe to learn bacteriology in 1891 and 1894.
and hospital practice”62. Girdlestone worked at The Alfred and later at Melbourne Hospital “where he rapidly gained his reputation”63. Francis Drake would have had practical training as a student at Melbourne Hospital and upon graduation spent a year as House Surgeon there, so Girdlestone stands as a likely model for Drake’s interest in surgical practice, and Joseph Lister’s fame in bringing safety to patients in surgery an ideal. More controversially, was Francis Drake also interested in the kind of surgical cases undertaken at Melbourne Hospital by the flamboyant James George Beaney MLC (1828-1891) – known also as “Diamond Jim” because of diamonds displayed on studs, rings and watch, and provider of champagne to students at his surgical lectures? “The evidence of contemporary observers indicates that he was a bold surgeon, perhaps rash and rough at times…yet often successful when others less daring would have failed.”64

In short, the Melbourne Medical School in the 1880s had gifted teachers in all the major subjects headed by Halford, Allen, Girdlestone, and Bird; it had a thorough five year medical curriculum that had been made more science oriented. Francis Drake’s knowledge of surgery and medicine via academic and practical work was sustained during his five years. Although there is no evidence of Drake’s participation, a sense of the esprit de corps of the times occurring with the rapid increase in medical students can be seen in the formation of a Medical Students Society in 1881 and their journal Speculum begun in 1884.65

To give a sense of the thoroughness demanded by Melbourne’s Medical School here are two excerpts from the new curriculum as published in the 1885-86 University Calendar:

**Pathology (3rd year Medicine)**
The cell theory and the history of cells; the laws of healthy nutrition and growth; atrophy, gangrene, and death; degenerations and infiltrations; hypertrophy; tumours; congestions, active and passive; inflammation and its results; inflammation of the various tissues; fever; repair of injuries; scrofula and tubercle; phthisis; syphilis; thrombosis and embolism; septicemia and pyemia; dropsy; haemorrhage; specific diseases; the germ theory; parasites; diseases of special organs; the pathology of urine.

**The subjects of the FIFTH YEAR Examination shall be—**
(1) Theory and Practice of Medicine.
(2) Surgery.
(3) Obstetric Medicine and Diseases of Women and Children.
(4) Forensic Medicine and Psychological Medicine.

- Candidates who have passed in these subjects will be required as part of this Examination to give proof of their practical knowledge of Medicine and Surgery—

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62 KF Russell, op. cit., p. 60; K Thompson & G Serle, *A Biographical Register of the Victorian Parliament 1859-1900*, ANU Press, Canberra, 1972, p. 75. Girdlestone was the City Health Officer for Melbourne 1868-1873; and a member of the Royal Commission on the Sanitary Condition of Melbourne, 1888.

63 KF Russell, op. cit., p. 60.


65 KF Russell, op. cit., p. 61.
(1) By examining and prescribing for patients **at the bedside**.
(2) By writing a brief history of at least one Medical and one Surgical case selected by the Examiners.
(3) By performing Operations on the dead subject and by the application of surgical apparatus.

- **During the fifth year Candidates shall produce certificates that after completing the third year they have**—
  1. Attended during nine months the Surgical Practice of a Hospital recognized by the University of Melbourne, such attendance to include Clinical Instruction and Lectures on Clinical Surgery.
  2. Attended in another year during nine months the Medical Practice of a Hospital recognized by the University of Melbourne, such attendance to include Clinical Instruction and Lectures on Clinical Medicine.
  3. Acted as Surgical Dressers during six months of their Surgical Practice.
  5. Acted as Medical Ward Clerks during six months of their Medical Practice.
  6. Attended Post-mortem Demonstrations during six months.
  7. Attended during three months the Midwifery Practice of a Lying-in Hospital, or attended apart from such practice twenty cases of Midwifery under the direction of a Registered Medical Practitioner.
  8. Acquired proficiency in Vaccination under the direction of a Public Vaccinator.

[Small pox outbreaks occurred in Australia in the 1880s, including at Launceston 1887 & 1904.]

**Anatomy by Dissections (5th year Medicine)**

At this examination students will have to dissect before the Board of Examiners and demonstrate any parts dissected by themselves or by other candidates.

**Dissections.—** **Certificates will be given to those students only who shall have minutely and skilfully dissected the whole body.**

Also in the late 1880s Melbourne University directed more resources into the teaching of science: a new Faculty of Science and a new three year science course was introduced in 1886 with the new appointee to the chair in Chemistry (previously part of the Faculty of Medicine) being David Orme Masson66 MA BSc Edinburgh – most of his first year students were medical students. Also a new chair in Biology was created – Walter Baldwin Spencer (1860-1929) being the appointee. A third appointee (1889) to the chair in Natural Philosophy (it was originally the Chair of Physics) was Thomas Lyle (1860-1944)67. All three lectured in

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66 David Orme Masson (1858-1937) visited chemist Friedrich Wöhler’s (1800-1882) famous chemical laboratory in Göttingen in 1879; and worked with William Ramsay (1852-1916) at Bristol University College in 1880. (Ramsay was the discoverer of the “noble” gases – argon, neon, krypton, xenon in 1894 and radon in 1910. He received the Nobel prize for Chemistry in 1904.)

67 Lyle was a keen photographer. In February 1896 when Röentgen’s discovery of x-rays was announced, Lyle assembled the apparatus to take some of Australia’s first X-ray photographs.
first year medicine. These three radically transformed and elevated the standard of science at Melbourne. All three were brilliant lecturers within the University and in public lectures as well in addition to being distinguished researchers.

To sum up: the five years of medical education of Francis Drake from 1884 to 1888 at Melbourne (and that of his successor John Ramsay graduating in 1893) was firmly grounded in the application of the scientific method to medicine and to surgery and applying complex medical theory to the facts of suffering in which medical students were compelled to undertake a range of practical work in several hospitals, in dissecting rooms, and with in patients and out patients, including practice in bed side examinations and prescribing. Added to this, the new Faculty of Science and its energetic professors imparted an academic authority to the sciences.

Francis Drake graduated with a BA degree on 1 May 1886, his MA in 1887 (a heavy duty reading program) and MB BS on 18 December 1888. In 1889 he was Resident Medical Officer at Melbourne Hospital (then on the corner of Swanston and Lonsdale Sts.), and we can conjecture that his preference for surgery - (built on his practical parts of his medical education) - emerged during this year.

DRAKE AT THE GENERAL HOSPITAL AT LAUNCESTON

8. Dr Francis Drake at the General Hospital in Launceston 1890-1898

The pattern at Launceston by the mid-1880s was the appointment of young age doctors who were new graduates to both positions, first as House Surgeon and then to Surgeon Superintendent, where they accumulated experience at the hospital of a variety of cases both surgical and medical, and from this base proceeded then to set themselves in private practice. Francis Drake’s superior on arrival in Launceston was Dr James Pardey (1862-1944) two

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68 See Melbourne University Calendar 1888-89, pp. 416-417 (available on line) FJ Drake graduated MA in 1887.
69 See Dr Drake’s Obituary, Medical Journal of Australia, 8 March 1930, p. 337.
years younger than Drake and a Melbourne medical graduate in 1884\(^{70}\) – who had come
came to the Launceston as House Surgeon in 1886 (and confronted a smallpox epidemic in
Launceston in 1887); and became the Surgeon-Superintendent 1889-1891, but resigned to
enter private practice in Launceston.

Why inexperienced young doctors as Surgeon-Superintendents? The patients were
predominantly poor: “the majority of the in-door patients are paupers”, declares the 1883
Annual Report. Such people therefore had little choice - either they suffered and self-
medicated, or to sought help at the Hospital. The Hospital, in short, was a place for medical
experiments by young doctors where they could acquire experience that could later be turned
into the main game, a successful private practice\(^{71}\). With the reality of safer surgery, the
humanitarian test was to build a patient-centred institution and to turn the system focussed
on charitable cases into one trusted by the wider community.

The opportunities offered at the General Hospital at Launceston to the Surgeon-
Superintendent “to a man with an aptitude for surgery are well known and it is small wonder
that Francis John Drake acquired exceptional skill and dexterity as a operator during the
eight years’ service.” The notice concluded: “In addition he proved himself a highly
competent diagnostician and a sound practitioner.”\(^{72}\) At the end of Dr Drake’s service in
1898 the Launceston Examinin - which regularly printed short reports on the Hospital -
reviewed the years since 1882: “it has been the good fortune of the Board to secure as
resident medical officers men of capacity, clever at their profession, and endowed with high
administrative ability.”\(^{73}\)

The junior post of House Surgeon was a good base from which to learn the ropes of the
Hospital routine, managing the variety and range of cases, coping with emergencies such as
epidemics of infectious disease, or to accidents caused at work or home. Dr Francis Drake
came to Launceston as House Surgeon and Dispenser at the General Hospital from 1 January
1890. It was a live-in position at the Hospital: he was paid £250 per year (with quarters,
rations, fuel, light, and water). He was elected to the position of Surgeon-Superintendent –
also a live-in position (salary £400, with quarters, fuel, light, and water) on 9 July 1891 upon
the resignation of James Pardey, and began duties on 1 October.\(^{74}\)

Dr Drake remained unmarried while at Launceston, so much of his life at this time as a
resident at the Hospital would revolve around his medical duties and supervision of the staff
and patients of General Hospital. How much of his time was absorbed in medical duties? We
have no records, but the fact of the changes wrought under his jurisdiction and the fact that
the Board was to allow him 15 months study leave in England testifies to his energy and

\(^{70}\) JM Pardey gained first class honours in his fourth year of Medicine at Melbourne, see University of Melbourne Annual
Report 1883-84 (some annual reports in the University Calendar are available on line).

\(^{71}\) Advertising was against “medical ethics” and banned by the BMA, private practice was economically precarious, so
reputation by word of mouth acquired importance.

\(^{72}\) MJA, 8 March 1930, p.337.

\(^{73}\) Launceston Examiner, editorial, 3 February 1898, p. 4.

\(^{74}\) General Hospital, Launceston: report for the year 1891, p.6. (Bound copies in the John Ramsay Library at the LGH). There
is no mention who elected Dr Drake; presumably the Board of 13 elected the Doctors to their posts.
application. We don’t know for example, whether he and the House Surgeon were on call on nights, and the frequency with which he had to attend urgent medical and surgical cases after hours. Nor do we know anything about his hours of work, but they were likely to be long. We do know that a permanent Dispenser - based at the Hospital but also serving the Invalid Depot and HM Gaol - was appointed in 1891, indicating that time was needed for other duties, including the increased time devoted to surgery. For surgery began in earnest at the general in 1890. Dr Edward Gault, a consultant ophthalmologist at The Alfred Hospital, a friend and 1888 fellow Melbourne BA and medical graduate noted “the arduous life he had lived” prior to his diagnosis of TB.\(^{75}\)

What sort of personality did Dr Drake project? Dr Edward Gault again: “he was a true friend, a man of cheery optimism and the possessor of the gift of whimsical humour which made him tolerant of the follies and weaknesses of his fellows.”\(^{76}\) Certainly the Board thought highly of him, by warmly welcoming him back from Britain in November 1896, cheering his speech\(^{77}\).

The Annual Reports of the General Hospital in the 1890s (presented as parliamentary papers) are interesting but not illuminating as to who were the prime movers of change, but it is a fair bet that the Board of Management relied upon the advice of the Surgeon-Superintendent who would be the prime advocate of medical change. And if the Surgeon-Superintendent demonstrated a notable flair for good management and medical acumen, then the Board would come to trust the soundness of his judgment. We can argue from the many changes wrought in the Launceston Hospital from 1890 that there is a marked shift towards an acceptance of increased authority of the doctors. And that authority was based on the acceptance of scientific medical training as the arbiter of policy making.

Changes began in 1890 during Dr Drake’s year as House Surgeon. The Board reports: “infectious cases have been isolated for the first time during the past year.”\(^{78}\) In 1890 came the first published details (type, number, age, sex, and results) of operations performed at the General Hospital. And from this “The need for an operating theatre is severely felt, as it is undesirable both for patients and surgeons that operations should be done in the general wards.”\(^{79}\) And to facilitate caring of patients, wards were classified into surgical and medical wards also in 1890. Separate wards for girls and boys were created in 1890, the first in Tasmania. Can we infer that the appearance of Dr Francis Drake in Launceston created

\(^{75}\) *MJA*, 8 March 1930, op. cit.

\(^{76}\) Ibid.

\(^{77}\) See *Launceston Examiner*, 27 October 1896, p. 6

\(^{78}\) *General Hospital, Launceston: report for the year 1890*, p.6.

\(^{79}\) Ibid.
these reorganisations? The 1891 report states: “A large number of operations have been performed, many of them of conservative and reparative character.”

From the evidence of the Annual reports, it is a fair claim that Dr Francis Drake, in conjunction with the Board and with the Lady Superintendent, in the 1890s laid the foundations for the General Hospital at Launceston to become a substantial 20th century hospital with a scientific grounding. Whether it was at his initiative or in union with others, we can see that changes which began during his term as House Surgeon from January 1890, continued during his tenure as Surgeon Superintendent:

1890: first set of annual statistics published on number & types of operations at Launceston
1890: re-organising wards into surgical & medical wards
1890: separate wards established for sick children (separate wards for boys and for girls) the first in Tasmania
1890: new Training School for Nurses established at the General Hospital
1890: infectious cases isolated in separate wards in Hospital for the first time
1890: Hospital Visitors system inaugurated by 10 ladies “to relieve the tedium necessarily attendant upon sickness.”
1890: first Dental department to provide free “advice and surgical aid in all diseases of the teeth to every poor applicant”
1891: first lectures to the Training School for Nurses (established in 1890)
1891: first appointment of a trained pharmacy Dispenser to the Hospital (Mr. G. Miller)
1892: first separate Operating Theatre – nearly 30 years after the building of the hospital
1892: Reception House for the Insane and for Inebriates
1893: extension of nurse training at the Hospital from 2 years to 3 years
1896: purchase of bacteriological equipment and agitation for a laboratory
1896: purchase of x-ray equipment
1896: recommends electric lighting for the Hospital instead of gas light
1897: separate building for the Isolation Wards for Infectious Diseases (16 beds) opened
1897: new Nurses Home opened

Let us look more closely at some of these changes made to the General Hospital at Launceston in this period of the 1890s.

9. The General Hospital as a Teaching Hospital: the Training School for Nurses

Florence Nightingale had a dual influence on the General Hospital at Launceston built in 1863. The first was in the design of the Hospital through her Notes on Hospitals of 1859. The second, and well known, is her radical impact on the training of women as nurses and despite opposition, establishing this as a profession for women. Her training school at St

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80 Melbourne Hospital failed to establish a nursing school in 1889; the Royal Prince Alfred hospital began staff lectures to nurses in 1894. See FB Smith, Illness in Colonial Australia, Aust. Scholarly publishing, Melbourne, 2011, pp.315-16.
81 Ibid. 1890, p.4, and 1891, p.4. Authorised under the Dentists Act 1884. Also the Act enabled dental students to “obtain a practical and theoretical education in their profession.”
82 John Stuart Mill MP when he published On the Subjection of Women (1867) he was ostracised by former friends for his advocacy on behalf of women, and lost his seat as MP in 1868 because of it. See Richard Reeves, John Stuart Mill: Victorian Firebrand, London, 2007.
Thomas’ Hospital in London took the first students nurses in June 1860. But these were to be the cream. Her aim was to train matrons who could then train – “to produce graduates who would drill raw hospital staff. Control of hospital nursing had to be removed from men’s hands and placed in the hands of the matron.” Nurse training was hierarchical and quasi-military: Dr Craig records that Miss Milne and Dr Ramsay were of similar temperaments: “both were supremely capable, both were martinets.” (Both were also born in Scotland; Ramsay emigrated at the age of 6). The first Launceston Matron was appointed in 1881; and renamed Lady Superintendent in 1884 – the title indicates the function as an overseer and director not only of the nursing staff, but also the wardsmen and women.

In 1890 the Board of Management decided to begin a Nursing school for “lady pupils” (i.e. no males) at the Hospital, the lectures to be given by the medical staff and the Lady Superintendent, Miss Jeannette Milne, who had trained at Royal Edinburgh Infirmary under Nightingale conditions for one year (October 1877 to September 1878, age 24) and worked on staff there 1878-1884; she left for a post in Hobart, but came to Launceston in 1886, staying at the Hospital for 26 years. Her salary was £150 p.a. with quarters, rations, fuel, light and water. It was she who proposed to the Board that the Hospital start a nursing school in 1889. The first permanent Night Sister was appointed in 1890, together with two permanent Day Sisters.

Nurses Home 1897

The importance of trained nurses needs to be emphasised. It is highly likely that Dr Drake set the pattern of strong support for nurses and their training and their central importance of their unglamorous work to the functioning of the General Hospital, a pattern that was continued by his successor Dr John Ramsay. Nightingale’s advocacy had shifted the meaning of “nurse” to that of an acquired skill got through a training regime. Nurses spent more time with patients than did doctors like Dr Drake, so that their observations about patients was of great practical value to them. Doctors relied on competent nurses for a range of functions such as assisting with anaesthesia and surgery, for practicing antiseptic measures, ensuring patient cleanliness, and for exact administration of prescribed

83 “Florence Nightingale’s work in the Crimea (1854-56) took fifteen years to have an impact in Britain itself. The nurses trained were fewer than 15 a year during the 1860s, and only 20 a year in the 1880s.” see FB Smith, The People’s Health:1830-1910, ANU Press, 1979, p. 260. St Thomas’s (founded.1215) was re-built (to make way for a railway station) opposite the Houses of Parliament in the 1860s in the pavilion style as advocated by Nightingale.
86 Ibid., pp.74-75.
87 General Hospital, Launceston: report for the year 1889, p. Miss Milne’s salary (as was the Surgeon-Superintendent’s) was reduced with financial cutbacks to £138 p.a.
drugs. Moreover nursing was a hazardous occupation: three Launceston nurses died from typhoid in 1885-86, contracted presumably from their nursing duties. Given the turnover of house surgeons and Surgeon-Superintendents, the longevity of nurses on the job at Launceston made them a repository for institutional memory and no doubt many of the incremental improvements made at Launceston arose from their suggestions. But the Annual Reports are largely silent on who recommended any improvements.

The table showing the number of in patients and out patients 1889 to 1898 at the Hospital indicates the heavy work load of the nurses – 16 nurses in 1890 with 24 being employed in 1898, with in patients averaging over 30 days in hospital.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. treated</th>
<th>No. died</th>
<th>Av. daily No.</th>
<th>Av. Days in Hospital</th>
<th>No. treated</th>
<th>employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1889</td>
<td>896</td>
<td>95</td>
<td>76</td>
<td>38</td>
<td>750</td>
<td></td>
</tr>
<tr>
<td>1890</td>
<td>928</td>
<td>68</td>
<td>69</td>
<td>38</td>
<td>805</td>
<td>16</td>
</tr>
<tr>
<td>1891</td>
<td>1057</td>
<td>85</td>
<td>95</td>
<td>32</td>
<td>874</td>
<td>18</td>
</tr>
<tr>
<td>1892</td>
<td>819</td>
<td>58</td>
<td>88</td>
<td>38</td>
<td>809</td>
<td>18</td>
</tr>
<tr>
<td>1893</td>
<td>850</td>
<td>65</td>
<td>78</td>
<td>33</td>
<td>850</td>
<td>18</td>
</tr>
<tr>
<td>1894</td>
<td>848</td>
<td>60</td>
<td>70</td>
<td>30</td>
<td>956</td>
<td>18</td>
</tr>
<tr>
<td>1895</td>
<td>852</td>
<td>77</td>
<td>69</td>
<td>30</td>
<td>1084</td>
<td>18</td>
</tr>
<tr>
<td>1896</td>
<td>850</td>
<td>83</td>
<td>76</td>
<td>35</td>
<td>1178</td>
<td>18</td>
</tr>
<tr>
<td>1897</td>
<td>872</td>
<td>83</td>
<td>77</td>
<td>33</td>
<td>1358</td>
<td>21</td>
</tr>
<tr>
<td>1898</td>
<td>965</td>
<td>91</td>
<td>79</td>
<td>30</td>
<td>1301</td>
<td>24</td>
</tr>
<tr>
<td>1899</td>
<td>985</td>
<td>71</td>
<td>77</td>
<td>28</td>
<td>1043</td>
<td>24</td>
</tr>
<tr>
<td>1900</td>
<td>911</td>
<td>64</td>
<td>80</td>
<td>32</td>
<td>987</td>
<td>26</td>
</tr>
<tr>
<td>1910</td>
<td>1879</td>
<td>156</td>
<td>140</td>
<td>27</td>
<td>1706</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: compiled from the Annual Reports of the General Hospital at Launceston

At first the nursing course was for two years. The lady pupils, so designated in the Annual Reports, had to sign articles agreeing to serve two years as probationers, subsequently increased to three years in 1893. Their course consisted of six components on which marks were awarded: lectures on General Physiology; on Minor Surgery; Nursing (junior) and Nursing (senior); an examination of their practical work; and sixthly, marks for their Conduct. On passing they gained a certificate from the Hospital as “Trained Nurse”.

Dr Francis Drake as Surgeon-Superintendent described the course of study and the texts in the 1891 Annual Report. Six years later The Nursing Record and Hospital World, 24 April 1897 reprinted the whole course with Dr Drake’s name below it and praised its quality:

“It is with the most sincere satisfaction that we print in detail the above Curriculum of Nursing Education, proving as it does how surely progress is being made in our Colonial Empire. Many hospitals at home are still satisfied with a standard far lower than that which is adopted abroad, and we heartily congratulate the Medical Surgeon-Superintendent and the Matron of the Launceston Hospital Tasmania upon the
splendid results for good which must accrue from their combined efforts to provide efficient training for their nursing staff. These reports are most hopeful.”

The full course devised for the Launceston General Hospital Nurses in 1891 is given in Appendix 2. Dr Francis Drake gave Lectures on two themes: General Physiology “with demonstrations where practicable”, and on Minor Surgery. Here are his list of topics:

**Lectures on General Physiology**

- The skeleton
- The joints
- The arteries and veins
- The position of the Thoracic and Abdominal Viscera
- The general and Distinctive Characters of Living Animals
- The Structural Composition of the Human Body
- Elementary tissues
- Muscular tissues
- The Blood
- The Circulation
- Respiration
- Animal heat
- Digestion and Absorption
- Secretion and Excretion
- The Nervous System

**Lectures on Minor Surgery**

- Arrest of haemorrhage
- Bandaging: triangular; roller;
- Trusses
- Use of adhesive
- Splints etc.
- Fractures
- Dressing of Wounds
- Prevention & treatment of
- Certain emergencies
- Anaesthetics
- Surgical instruments

Some 33 nurses achieved their certificates of completed training during in Dr Drake’s period at the General.

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**Table 2 Launceston General Hospital 1891-1898**

<table>
<thead>
<tr>
<th>Trained Nurse certificates awarded</th>
<th>Female nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td></td>
</tr>
<tr>
<td>1890 Training School for Nurses begun</td>
<td>16</td>
</tr>
<tr>
<td>1891 6 nurses</td>
<td>18</td>
</tr>
<tr>
<td>1892 3 nurses</td>
<td>18</td>
</tr>
<tr>
<td>1893 7 nurses</td>
<td>18</td>
</tr>
<tr>
<td>1894 5 nurses</td>
<td>18</td>
</tr>
<tr>
<td>1895 4 nurses</td>
<td>18</td>
</tr>
<tr>
<td>1896 nil</td>
<td>18</td>
</tr>
<tr>
<td>1897 4 nurses</td>
<td>21</td>
</tr>
<tr>
<td>1898 4 nurses</td>
<td>24</td>
</tr>
</tbody>
</table>

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88 General Hospital, Launceston: Annual Report for the year 1891, p.18.
As noted above, with the establishment of the nursing school in 1890 came the feminisation of the nursing staff at the General Hospital. Sixteen nurses were employed in 1890; they increased to 24 in 1898, Dr Drake’s departure. However, extra casual nursing staff on occasion “have been employed when the work of the wards became unduly heavy.”

10. The General Hospital as a Teaching Hospital: Dentistry and the Medical Students

The General Hospital also fulfilled two more teaching functions for dental students and for medical students. Both came in small numbers and not every year. Authorised by the Dentists Act 1884 dental students could attend the General Hospital to “obtain a practical and theoretical education in their profession.” Lectures to dental students given in 1892 include: anatomy and physiology; chemistry and metallurgy as applied to dentistry; dental material medica and therapeutics; lectures on the administration of anaesthetics and the signs of asphyxia and syncope.

<table>
<thead>
<tr>
<th>Year</th>
<th>Extractions</th>
<th>Fillings</th>
<th>Operations under chloroform</th>
<th>Miscellaneous ops.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1895</td>
<td>717</td>
<td>64</td>
<td>44</td>
<td>143</td>
<td>1110</td>
</tr>
<tr>
<td>1896</td>
<td>568</td>
<td>76</td>
<td>28</td>
<td>184</td>
<td>977</td>
</tr>
<tr>
<td>1897</td>
<td>1019</td>
<td>90</td>
<td>49</td>
<td>268</td>
<td>1725</td>
</tr>
<tr>
<td>1898</td>
<td>957</td>
<td>155</td>
<td>35</td>
<td>53</td>
<td>1889</td>
</tr>
<tr>
<td>1899</td>
<td>962</td>
<td>135</td>
<td>53</td>
<td>261</td>
<td>1576</td>
</tr>
</tbody>
</table>

Source: compiled from the Annual Reports of the General Hospital at Launceston

Honorary Dental Surgeons who had been appointed to the General Hospital attended there twice a week - Wednesdays and Saturdays, 9.30 to 10.30 am, and as required. Dentistry proved to be a significant service: the Annual Report for 1893 records 1359 cases were treated in that year - “a valuable help to the poorer classes.” The number of cases was more significant than surgery which in 1893 recorded 69 cases. The first statistical report on dentistry was given in the Hospital’s 1895 report (see Table 3.)

11. The first Operating Theatre at Launceston

Perhaps the greatest service for in patients initiated by Dr Drake was in surgery. His successor Dr John Ramsay, himself a surgeon with an Australia-wide reputation, “always acknowledged his indebtedness to Drake.” He expanded the number and type of operations, and very importantly, secured the first operating theatre. Nurse E.I. Oakes, who

89 General Hospital, Launceston: report for the year 1890, p.9.
90 General Hospital, Launceston: Annual Report for the year 1893, p. 4.
91 Clifford Craig, LGH The First Hundred Years, op. cit., p. 34.
began as a trainee in 1896 (and became Lady Superintendent 1912-28) wrote “with such surgeons as Doctors Drake, C. Parker, J. Ramsay and WB Heyward, theatre technique was perfect. How thrilled we were when we were allotted to do this special duty. One felt so superior!”

To support surgery the hospital wards were reorganised into surgical and medical wards, and the training of nurses by Dr Drake included lectures on anaesthetics and surgical instruments. The Surgeon-Superintendent, observed the Launceston Examiner in 1898, is the medical head of the Hospital: “In professional matters he is supreme and it remains with him to decide whether he shall perform operations himself, entrust them to others [the house surgeon] or claim the assistance of consulting medicos.”

In 1890 117 operations (86 males; 31 females) were performed in the General Hospital. This is the first time that the recording of operations at the General Hospital occurs in the Annual Report in a statistical table indicating the type of operation, ages, and results. Operations (which were done in the wards) were relatively infrequent prior to 1890. So increased reporting of surgery coincided with the arrival of Dr Drake as House Surgeon in Launceston. The inference is that he was the catalyst for increasing the number of surgical operations at the General. The afternoons were preferred as operating times, and often only a few operations would be performed in a month. By 1898 the annual total performed was 284 – more than double the 1890 total, but interestingly, female operations in 1898 (156) now exceeded operations on males (128).

But in 1890 surgical operating conditions at Launceston were defective according to the proven advances in operational hygiene revealed during the previous decade. In Germany two surgeons who had worked with bacteriologist Dr Robert Koch adopted his 1881 suggestion and introduced the practice of sterilising all items entering the operating theatre in 1885; the use of autoclaves and sterilisation of equipment began in the late 1880s. So a separate clean room for operations in hospitals had become the standard. The Board of Management records in 1890: “The need of an operating theatre is severely felt as it is undesirable both for patients and surgeons that operations should be done in the general wards.”

But in the early 1890s a severe economic depression wracked Australia. Out of the blue the Board’s prayers were answered. In 1890 the Board acknowledged “the generous gift of £1000 from the late Mr Arthur Leake towards the Endowment Fund”. Undoubtedly the new Surgeon-Superintendent Dr Francis Drake argued cogently and forcibly for such an operating theatre, and given his style of adapting rooms and places to accommodate different functions, it is likely that he chose the connecting bridge. The legacy of the deceased Ross grazier Arthur Leake allowed modification of part of the Hospital into a suitable operating Theatre. The Annual Report in 1892 declares that ”plans and estimates for an operating

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92 Ibid. p. 73.
93 Launceston Examiner, editorial, 3 February 1898, p. 4. External consultants were trying to increase their control over patients in the Hospital by decreasing the role and power of the Surgeon-Superintendent (reverting to the failed 1879-1881 model) at a time when Dr Drake had just resigned and Dr Ramsay had taken over as the chief. They did not succeed.
94 See General Hospital, Launceston: Annual Report for the year 1890, item 18, p.6, Item 32, p.7, Tas. Parl. Papers, No. 4, 1890. An Endowment Fund suggests a capital fund earning interest. See also the Launceston Examiner, Sat. 22 August 1891.
theatre to be built on the bridge connecting the Hospital with the Nurses Home” were approved and “I am now pleased to state that the Hospital now possess an operating-room in every way suitable to the requirements of the institution.”

In 1892 – some 45 years after Dr William Pugh’s experiment in Launceston with ether anaesthesia – Dr Francis Drake could take advantage of the knowledge of the germ theory and thus combine the techniques of aseptic surgery with the anaesthetic discoveries that had been made in the previous generation. Very little information is given in the Annual Reports on the use of anaesthesia with patients, apart from one footnote in 1890: “Chloroform has been administered without mishap 155 times during the past year.” Dr Drake has anaesthetics listed as a topic for the lectures to nurses, and Dr Jermyn as House Surgeon is recorded as giving four lectures on anaesthesia in 1892. Whether this implies that nurses acted as anaesthetists or as anaesthetic assistants is a moot point. At some stage in the 20th century ether was mostly used at Launceston. (There was no specialist anaesthetist on staff in Launceston until 1949.) This lack of information is also reflected in University medical school training: anaesthesia training at Melbourne was not specifically given as part of the medical course until 1895.

Let us look at the number of operations performed at Launceston in Dr Drake’s time. The descriptions relieved, cured, died, and unrelieved were standard hospital classifications used in Britain as well as in Australian hospitals and are a rough guide rather than a precise review to what was accomplished in the year: they had to say something! But this was the surgeon’s assessment, not the patient’s, and that assessment was probably built around the

95 See General Hospital, Launceston: Annual Report for the year 1892, item 10, p.6, Item 32, p.5, Tas. Parl. Papers, 1892. The Board of Management Reports do not contain evidence either of the cost or for the source for the funding of the operating Theatre. However, the Board published in each annual report a figure relating to the gross total of the estimated expenditure for extensions and improvements (a running total with each year added on). The difference between 1891 and 1892 is an expenditure of £1313 – which is pretty near the mark of Arthur Leake’s £1000 bequest.

96 In Launceston Dr William Pugh seeing a diagram of “The apparatus for rendering surgical operations painless” in the London Illustrated News of 9 January 1847, had boiled alcohol and sulphuric acid and condensed the ether vapour in his own still, and had conducted the first (and safe) use of anaesthetics in Australia in two successful operations on 7 June 1847. See DJ Paull, Anaesthetic Intensive Care, 2011, July, 39 Suppl. 118-26; ADB 1788-1850, vol. 2 entry for Dr William Russ Pugh. The London Illustrated News was first published in 1842.

97 The emerging specialty of anaesthesia in Australia was represented by the formation of the Australian Society of Anaesthetists in 1934. Anaesthetist Dr Colin Chilvers informs me that this occurred at Hadley’s Hotel, Hobart. In 1952 the Faculty of Anaesthetists was formed within the Royal Australasian College of Surgeons for training in the specialty of anaesthesia. In 1992, with 2100 Fellows, the anaesthetists formed their own college – the Australian and New Zealand College of Anaesthetists (ANZCA) with HQ in St Kilda Rd., Melbourne.

98 General Hospital, Launceston: Annual Report for the year 1890, p.16.

99 During the Great War on the western front some 200 army nurses (Australian, NZ, Canadian, South African, British) were given 2 months training (January & February 1918) to be anaesthetists by a US nurse anaesthetist Miss Penland who worked for Dr Mayo. My great aunt Elsie Tranter (Australian Army Nursing Service) was so trained and worked as an anaesthetist on Casualty Clearing Stations, see In all those lines: the diary of Sister Elsie Tranter 1916-1919, JM Gillings & J. Richards (eds.), Launceston, 2008.

100 Craig, op. cit., p.64.

101 The anaesthetic lecturer at the Melbourne Hospital was Dr Edward Embley, who had trained as a pharmacist and had been in the same year of medicine as Drake. Embley graduated MB BS in 1889 at Melbourne. See KF Russell, The Melbourne Medical School, op. cit., p. 95.
degree of pain and discomfort suffered or “relieved” by the procedure. The 19th century definitions may well have different connotations – “relieved” may have meant mitigation of pain without necessarily meaning the restoration of the patient’s bodily capacity. Nonetheless the three fold increase of operations 1890 to 1899 is a testimony that patients had come to trust the quality of the surgery at the General Hospital. Figures for Dr Ramsay’s time up to 1910 are also provided to indicate the strong trajectory for surgery – 927 cases in 1910, made possible by the building of a new and larger Theatre.

Table 4 Operations at the General Hospital 1890 to 1910

<table>
<thead>
<tr>
<th>Year</th>
<th>M</th>
<th>F</th>
<th>Total Relieved</th>
<th>Cured</th>
<th>Died</th>
<th>unrelieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>86</td>
<td>31</td>
<td>117</td>
<td>32</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>1891</td>
<td>73</td>
<td>31</td>
<td>104</td>
<td>38</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1892</td>
<td>42</td>
<td>36</td>
<td>78</td>
<td>28</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>1893</td>
<td>49</td>
<td>20</td>
<td>69</td>
<td>45</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>1894</td>
<td>60</td>
<td>52</td>
<td>111</td>
<td>74</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1895</td>
<td>63</td>
<td>57</td>
<td>120</td>
<td>83</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>1896</td>
<td>81</td>
<td>47</td>
<td>128</td>
<td>77</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>1897</td>
<td>153</td>
<td>140</td>
<td>290</td>
<td>159</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>1898</td>
<td>128</td>
<td>156</td>
<td>284</td>
<td>207</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>1899</td>
<td>159</td>
<td>168</td>
<td>327</td>
<td>273</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>1900</td>
<td>166</td>
<td>150</td>
<td>310</td>
<td>36</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>1908*</td>
<td>306</td>
<td>432</td>
<td>738</td>
<td>46</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>1910</td>
<td>453</td>
<td>474</td>
<td>927</td>
<td>67</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: compiled from Annual Reports 1890-1909/10
*new Theatre opened 2 October 1907 with large steam sterilizer.

As well as operations, post mortem examination of in-patients who died could be performed in the Mortuary by the Surgeon Superintendent and/or the House Surgeon. Some information on the number of postmortems is recorded in the annual reports for five years only, from 1890 to 1894 (see Table 5). Dissecting bodies was an established part of the Melbourne University medical course. Presumably, as there is no evidence given in the Annual reports, the post mortems were needed to confirm diagnoses, or to check pathology. It is also not clear as to whether as part of their training that nurses were educated on anatomy and disease via post mortem examinations.

Table 5 Deaths of in-patients & Post mortems performed 1890-94

<table>
<thead>
<tr>
<th>Year</th>
<th>M</th>
<th>F</th>
<th>Total deaths</th>
<th>Total Post mortems</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>55</td>
<td>13</td>
<td>68</td>
<td>24</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>1891</td>
<td>70</td>
<td>15</td>
<td>85</td>
<td>34</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>1892</td>
<td>35</td>
<td>23</td>
<td>58</td>
<td>11</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>1893</td>
<td>46</td>
<td>19</td>
<td>65</td>
<td>37</td>
<td>32</td>
<td>5</td>
</tr>
<tr>
<td>1894</td>
<td>47</td>
<td>23</td>
<td>60</td>
<td>18</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Source: compiled from Annual Reports 1890-1894
To give an example of the patients chosen for post mortems, the five females in 1893:

<table>
<thead>
<tr>
<th>Age</th>
<th>Disease</th>
<th>Days in LGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>meningitis</td>
<td>10</td>
</tr>
<tr>
<td>16</td>
<td>sarcoma of chest</td>
<td>15</td>
</tr>
<tr>
<td>54</td>
<td>cancer of stomach</td>
<td>76</td>
</tr>
<tr>
<td>14</td>
<td>hydatid of lung</td>
<td>52</td>
</tr>
<tr>
<td>8</td>
<td>heart disease</td>
<td>8</td>
</tr>
</tbody>
</table>

Dr Drake also systemised the reporting of the surgical operations in 1894 at Launceston by allocating them into categories. In the 1894 and the 1898 annual reports these are as follows (table 6) and indicate the general breadth of surgery performed:

<table>
<thead>
<tr>
<th>Operation</th>
<th>1894</th>
<th>1895</th>
<th>1896</th>
<th>1897</th>
<th>1898</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Removal of tumours</td>
<td>9</td>
<td>9</td>
<td>17</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Amputations</td>
<td>1</td>
<td>74</td>
<td>4</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>On respiratory system</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>On lymphatic system</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>On digestive organs</td>
<td>13</td>
<td>12</td>
<td>11</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>On genito-urinary organs</td>
<td>19</td>
<td>22</td>
<td>28</td>
<td>82</td>
<td>86</td>
</tr>
<tr>
<td>On bones and joints</td>
<td>24</td>
<td>14</td>
<td>24</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>On the eye</td>
<td>14</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>On nervous system</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Integumentary system</td>
<td>2</td>
<td>1</td>
<td>--</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>On circulatory system</td>
<td>---</td>
<td>--</td>
<td>1</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Incisions</td>
<td>11</td>
<td>30</td>
<td>15</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>Miscellaneous*</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: compiled from *Annual Reports of the General Hospital, Launceston, 1894, 1898*
*includes hydatids cases

| Table 7  Tuberculosis patients in the General Hospital 1890-98
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patients with TB</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>TB</td>
</tr>
</tbody>
</table>
Because Dr Drake was diagnosed with pulmonary tuberculosis in 1903, it is possible that he became infected via his patients. Did he pick up a TB infection while working at Launceston? The TB cases recorded from 1890 to 1898 during his term show that the General Hospital had roughly 50 patients or more (in and out patients) each year, and 61 deaths. (see Table 7) Undoubtedly Drake ministered to many of these.

12. Controlling the Patients and visitors

One of Florence Nightingale’s suggestions in her 1859 Notes on Nursing was the necessity for peace and quiet for the patient. We have no detailed knowledge of the patients’ or of visitors’ behaviour and their impact on the female nursing staff. Were they smelly? Were they noisy in the large ventilated wards? Did they spit? Smoke and drink? Did visitors wander in at inconvenient times? Did they bring in alcohol, tobacco, or food that did not match the diet prescribed? Did they disobey nurses and doctors? Abuse nurses? Swear? In a hospital a range of emotions could be exhibited by patients and their visitors - from elation to despair, depression, anger, grief, pain and suffering. Although emotions are not discussed in the contemporary reports, the 1890 Annual Report contains several remarks that indicate the need by the authorities to bring a degree of decorum to the Hospital and to diminish the potential for disorderly behaviour that might occur in the Hospital. The wrought iron picket fence was completed around the Hospital in 1890, and so were the iron gates and gas lit lamps which were erected at the entrance. Also on 1st May of 1890 “a new system for the regulation of visitors came into force…, by which the control of patients and their friends was rendered more easy and complete, and a register of all visitors and persons passing through the gates is kept.”

Similarly regulation occurred within the Hospital: “Copies of the Rules for patients, visitors, and the separate members of staff, printed and framed, have been hung in conspicuous places in the Hospital””, records the Board Chairman. If we can find copies of these they might indicate some of the behaviours that were seen as desirable to mitigate. In 1891 the Board reported that “the system of regulating the admission of visitors to the Wards of the Hospital” begun the previous year “has been found to work

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102 General Hospital, Launceston: Annual Report for the year 1890, p.7.
103 General Hospital, Launceston: Annual Report for the year 1890, p.6.
well and has greatly facilitated the control of the patients and their friends.” The orderly and clean hospital regime came into being.

But the Hospital was not run on rigid “peace and quiet” lines. Every Annual Report in the 1890s refers to regular concerts performed by Launceston citizens for the benefit of Hospital in-patients; and we note the musical interests of the Chairman, George Collins, who was president of two local musical groups. Dr Drake wrote to the Launceston Examiner on “behalf of the sick and suffering” in June 1897:

For some time now we have been in want at the hospital of a small piano suitable for ward concerts. If we possessed such an instrument many a pleasant afternoon or evening could be passed by the patients who are unable to leave their beds to attend the more formal concerts usually given in the hall. The piano we possess is too bulky to be conveniently carried from ward to ward.

His appeal to “the generous public of Launceston” brought a quick reply from F. Birchall of the local firm AW Birchall (AW Birchall had been on the Board until his death in 1893): he would reduce the price of a lightweight Bord piano (down from £36 to £26) in the firm’s possession as the firm’s donation to the Surgeon Superintendent’s request.

THE VISIT TO BRITAIN 1895-96

13. “to prosecute my studies in medicine and surgery & hospital hygiene”

After three and a half years service as Surgeon Superintendent, Dr Drake wrote to the George Collins, Chairman of the Board on 30 January 1893 requesting a leave of absence for 12 months, and offering to stay 18 months to two years on his return. He also requested that his salary be retained at £400 (which he had received on taking the job) – the economic depression of the 1890s had forced the Hospital to lower his salary to £360.

Dear Sir,

I have the honour to lay before you the following application for the consideration of the Board of Management.

For sometime I have been desirous of visiting Europe, and it has appeared to me that I could best serve the interests of both the hospital and myself by obtaining leave of absence sufficient to allow me to spend twelve clear months in Europe. During that time it is my intention to further prosecute my studies in medicine and surgery as well as hospital hygiene.

It is possible that during my absence my plans may be altered by circumstances I cannot at present forsee and I ask that six months from the time of leaving be allowed me to say definitely whether I shall remain or not in the service of your board.

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104 General Hospital, Launceston: Annual Report for the year 1891, p.5.
105 Launceston Examiner, 16 June, p. 6; and 17 June 1897, p. 6
I have now been three years and a half Surgeon Superintendent and as the work and responsibilities have considerably increased I also ask that my salary be raised on my return to what it was when I first took office as Surgeon Superintendent viz 400 pounds per annum.

I hope by that time to have materially increased my knowledge and efficiency.

I am prepared on my return to agree to stay eighteen months or two years as the Board may see fit to determine.

I shall be glad if you will place this matter before the members of the Board of Management as early as possible so that I may make definite arrangements for leaving on the 30th June next.

I am
Yours faithfully
F.J. Drake
Surgeon Superintendent
General Hospital
Launceston

The Board approved, and further negotiations increased Dr Drake’s absence to 15 months leave of absence. He left for England on 30 June 1895. It is of interest that Dr Drake stated his particular interest in “hospital hygiene” and not just in medicine and surgery, for hygiene and cleanliness related to the recently proven existence in the 1880s of microorganisms known as bacteria.

14. **Dr Drake returns in 1896: bacteriology equipment for a proposed laboratory**

At his return, Dr Drake was cheered at the beginning of the Board meeting after chairman George Collins MLC, “with great pleasure” made short speech welcoming him “back to the colony.” Collins continued declaring that Dr Drake’s “labours in the future would be of great benefit to the city and to the colony generally”. Board members responded: “hear hear.” Dr Drake told the Board that he had visited all the leading hospitals in London, Glasgow and Edinburgh and also several provincial hospitals “and devoted a good deal of time to the various sanitary museums in and around London.” As well “I devoted a considerable time to the study of some special departments of medical and surgical work.”

Dr Drake thanked the Board for their prompt attention to his request that the Hospital “establish a bacteriological laboratory.” (He had requested that the Hospital Board in Launceston forward £100 to him in Britain to purchase the bacteriological equipment. At the Board meeting of 23 April 1896, Drake’s request was agreed to and the money sent). Hatton and Laws the Launceston homeopathic chemists allowed him to use their English agent, thus securing a discount. The apparatus had been shipped to Melbourne and would...

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106 Correspondence from the "Letter Book". Launceston General Hospital 30th Jan, 1893 - 1st April, 1896. I owe this reference to Paul Richards.

107 *General Hospital, Launceston: Annual Report for the year 1895*, p.4


arrive in Launceston in a few days. “But there appears to be no room in connection with the hospital that is suitable for this work,” he told the Board. He provided a solution: convert the existing mortuary into a laboratory and a dark room for photography.

The mortuary is very inconveniently situated and a new one should be built in a more unobtrusive position….near the back entrance of the hospital. This would obviate all the funeral arrangements being made in full view of the patients as is now the case.

The Mortuary had been built in 1883: it remained until demolition in the 1940s\textsuperscript{110}. As we have seen, Dr Drake would have performed 24 to 36 post-mortems each year.

No reasons were given to the Board for the need of a bacteriological laboratory, but we can assume that Dr Drake was thinking of using such a facility to test for specific bacteria-borne diseases where the methods for testing had been already been published. Dr Robert Koch, for example, who had done so much to invent these techniques, had isolated and grown the causative organism of anthrax (1877), tuberculosis (1882) and cholera (1883) while colleagues and associates had isolated the pathogens causing typhoid (1880); diphtheria (1882) and pneumonia (1884). Tuberculosis, diphtheria, pneumonia, and typhoid were diagnosed in many patients at Launceston in the 1890s. Moreover Koch’s postulates – a system for testing for the existence of a particular disease - formulated in 1884 and refined and published in 1890 could be used to determine whether a given organism can cause a given disease.\textsuperscript{111} And we have noted above that Melbourne Medical School began systematic teaching of bacteriology from 1892. As Dr JSC Elkington, (former Chief Health Officer of Tasmania 1904-09) wrote in 1912: the microbiological laboratory “is an essential part of the armament for the practice of our profession under modern conditions” for “the physician depends upon the microscope and the culture tube for conclusive diagnosis of diphtheria, of typhoid fever, of tuberculosis, of malaria … and of many other possibly obscure infections.”\textsuperscript{112}

What was in the bacteriological cabinet and was it a special item being assembled and sold to hospital administrations? We don’t know, but it is likely it contained equipment devised by Koch and others in the microbiological field: microscopes, glass slides for placing stained bacteria under the microscope, chemicals for reagents and dyes, test tubes for cultures, and the like. Unfortunately, Dr Drake only remained at Launceston for another 15 months, resigning in

\textsuperscript{110} Craig, op. cit., p. 129. See also the Melbourne Medical School requirements of their students for three years of dissection.

\textsuperscript{111} Robert Koch’s postulates to establish whether a particular organism is the cause of a disease, it must be (1) found in all cases of the disease examined, while absent in healthy organisms; (2) prepared and maintained in a pure culture; (3) the culture must be capable of producing the original infection, even after several generations in culture; (4) retrievable form an inoculated animal and cultured again.

March 1898. The Board pressed on: “The need for some building to be used as a laboratory has been very much felt, the absence of which has prevented the use of the bacteriological apparatus recently purchased.” And in 1898 with tones of annoyance - the equipment “is still lying idle because of the absence of a suitable building in which to erect it and carry on the necessary bacteriological work. The necessity for such a building is becoming more and more evident.” Yet other building programs in the Hospital may have pushed the laboratory down in priority: both the 16 bed Infectious Diseases Ward and the Nurses Home were being built in 1897. Both had been priorities for the Board for several years.

Finally a bacteriological laboratory was built in 1901 at the request of Drake’s successor, Dr John Ramsay, who had won the Beaney prize for pathology while a student at Melbourne University Medical school. The laboratory was large and well equipped, and used by RMOs for examining urine, specimens of sputum, throat swabs etc. Dr W.B. Heyward (1874-1946), a graduate of Melbourne in 1898, was a Hospital staff member from 1900-1908. A photograph exists of him in the laboratory with microscope c. 1901.

15. Dr Drake and the purchase of the X-ray apparatus

Wilhelm Roentgen (1845-1923) discovered what he named as X-rays (X because their nature was unknown) on 8 November 1895; he gave a preliminary communication “On a new kind of Ray” to the Wurzburg Physical Medical Society on 28 December. His lecture and public demonstration on 23 January 1896 changed physics.

Dr Drake was in London when the exciting announcement of the discovery of X-rays was made. Alert to its diagnostic potential, he used left-over money from the purchase of bacteriological equipment. Drake told the Board on his return: “Although I had no formal authority from the board, I purchased an X-ray apparatus with the balance remaining after the bacteriological apparatus was provided for.” The 1896 annual report of the Board duly records this purchase of “scientific apparatus for the production of X-rays”: the Hospital thus potentially advanced the diagnostic ability of its medical staff. This machine was the nucleus of what became the oldest continuously operating X-ray department in Australia.

Apart from trust in Dr Drake’s acumen, it is likely that the Board members also supported the X-ray purchase because they had witnessed in Launceston the evidence of X-rays. Shortly before Drake’s return, two men in Launceston had also been busy experimenting with x-rays: homeopathic pharmacist and photographer Frank Styant-Browne (1854-1946) and Launceston Technical School teacher, architect and engineer Alfred Harold Masters (1874-1891). Their joint efforts with the LGH letter Book, Jan 1893-Feb. 1896.
1951). On Friday 16 October 1896 Browne gave a public lecture at the Mechanic’s Institute explaining Roentgen’s discovery and demonstrating with X-rays. Two radiographs, one of a human hand taken in December 1896, and another of a dislocated thumb taken in January 1897 are still extant.\textsuperscript{118} The \textit{Examiner} also published a special supplement showing reproductions of Styant-Browne’s X-ray photographs showing a mullet with its backbone, and a closed purse with a coin and medal exposed within, and a case closed with the spectacles revealed inside.\textsuperscript{119} This was a public revelation of science and the power of the new device.

Drake’s purchased X-ray equipment was installed in the General Hospital. Radiography began on 17 June 1897 with the medical diagnosis to locate a needle in a female patient’s hand, followed by its successful removal by Drake’s colleague, Dr John Ramsay, the House Surgeon. John Ramsay, who succeeded Drake as Surgeon Superintendent 1898-1912, and his successors were the makers of X-rays for medical diagnosis until the employment of the first X-ray operator, aptly named Mr Beams, probably in the Great War period. New X-ray machines for diagnostic purposes were added in 1900, 1915 and 1924. Subsequently with the arrival of Dr WP Holman at the Hospital in 1925, began the experiments in radiotherapy for cancer treatment.\textsuperscript{120}

16. The new building for the Infectious Disease and the Isolation Wards

In 1890 infectious disease cases at the General were isolated from other wards for the first time. This was a significant change informed by scientific medicine and better information about the causative organisms and modes of transmission. Yet despite this precaution an outbreak of scarlet fever in 1892 occurred “with no less than nine cases occurring within the Hospital.” Table 8 shows some of the infectious diseases of in-patients: the influenza cases

<table>
<thead>
<tr>
<th>Year</th>
<th>Typhoid Cases deaths</th>
<th>diphtheria cases deaths</th>
<th>scarlet fever cases deaths</th>
<th>influenza cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>96 6</td>
<td>28 3</td>
<td>3 0</td>
<td>84 6</td>
</tr>
<tr>
<td>1891</td>
<td>73 7</td>
<td>13 1</td>
<td>- -</td>
<td>141</td>
</tr>
<tr>
<td>1892</td>
<td>51 6</td>
<td>15 2</td>
<td>9 -</td>
<td></td>
</tr>
<tr>
<td>1893</td>
<td>49 4</td>
<td>27 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1894</td>
<td>46 2</td>
<td>9 2</td>
<td></td>
<td></td>
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Source: compiled from \textit{Annual Reports} 1890-1898

\textsuperscript{118} Paul Richards, op. cit. The extant X-rays are Queen Victoria Museum in Launceston.

\textsuperscript{119} \textit{Launceston Examiner}, special supplement of X-ray illustrations made in Launceston, 24 October 1896.

\textsuperscript{120} Clifford Craig, \textit{LGH The First Hundred years}, 1963, pp 57-59
of 1890-1891 were part of a world pandemic of influenza (which was not to be repeated until the deadly pandemic of 1918-19) – influenza itself was a viral infection with the responsible virus not isolated until 1933. The bacteria causing typhoid, diphtheria and scarlet fever were isolated and identified in the 1880s. Nurse Oakes records her experiences from 1896: “we had a great many typhoid cases; wards 10 and 17 were often full of such cases for months, with convalescent patients drafted on to wards 11 and 12 or on to front balconies. There were a great many sponges, cold packs and sometimes baths to be given, often four-hourly. There was constant anxiety lest a patient in his delirium, get suddenly out of bed….Symptoms of haemorrhage or perforation had to be watched for in some cases.”

The 1893 Report of the Board, informed no doubt by the Surgeon-Superintendent and his medical science, repeated the annual refrain: “The need for a separate building for the treatment of cases of diphtheria, scarlatina and septic diseases has been severely felt. A separate building will not only enable the treatment to be carried out more safely but more economically.” By 1897, aided by the £500 collected by the ladies of Launceston, a new building which was an Isolation Ward for Infectious Diseases was built in 1897, the year of Queen Victoria’s jubilee of 60 years. (The Queen Victoria Hospital for maternity cases also opened nearby in St John St. in 1897, as was the new Nurses Home).

17. Reception House for the Insane and Inebriates
The Board of Management noted in 1883 “It is apparent that sooner or later a reception house must be provided in the North for the interim accommodation of persons of unsound mind….The members of the Board have been witnesses of the disorder caused by insane persons or by those suffering from the chronic drink habit. As matters now stand at present, lunatic persons are sometimes lodged in the common gaol, and, after a period of observation, are forwarded on to the Asylum, 100 miles away.” The Board considered the issue in 1888, wanting the proposed Reception House to be excluded from the Hospital grounds but close to it. In 1889 they chose sites for the Nurses Home and for the Reception House.

The 1891 Report notes that the Reception House for the Insane was begun that year on a site adjacent to the Surgeon-Superintendent’s residence, and it was anticipated that it would be completed, furnished and ready for occupation. The funds had been provided by the government. It was opened in September 1892 with a male and a female attendant appointed. There was one padded cell in the reception House. An Act of 1892 gave legal

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121 See Sir Macfarlane Burnett & David O. White, Natural History of Infectious Disease, 4th edn., Cambridge Univ. press, 1972, pp. 202-05. Macfarlane Burnet, professor of Experimental Medicine at Melbourne University, and outstanding virologist, was jointly awarded the Nobel prize for medicine with Peter Medawar in 1960 for the discovery of acquired immunological tolerance, of great importance in grafts and transplants; see KF Russell, op. cit., p.199.

122 Clifford Craig, op. cit. p. 73.

123 Annual Report of the General Hospital, Launceston, 1893, p.4

124 Annual Report of the General Hospital, Launceston, 1883, p.4

125 Annual Report of the General Hospital, Launceston, 1891, p.4
sanction to the dwelling as an Asylum. Prior to this time those previously adjudged insane were locked in cells that were now used for accommodating the male hospital attendants. The annual report noted that these same cells “were highly unsuited as dwelling rooms, they being both insanitary and inconvenient.”126 Apart from the mention of the building, the annual reports are silent on details of the treatment such persons127. What were the proportions of alcoholics to those adjudged mad? Were they mainly males? What were their ages?

At the Melbourne Medical School fifth year medical students received lectures on the Outlines of Psychological Medicine; what this entailed in theory and how this helped in their pragmatic dealings with psychiatric patients the late 1880s is likely to have been sketchy at best because psychiatry and psychology were groping for understanding. As the Journal of Mental Science put it at the turn of the century: “though medical science has made great advances during the nineteenth century, our knowledge of the mental functions of the brain is still comparatively obscure.”128 In 1892 the recommended texts were Henry Maudsley’s Physiology of Mind and Maudsley’s Pathology of Mind; and Savage’s Insanity and Allied Neuroses. Henry Maudsley (1835-1918) had developed his views based on neurology and evolutionary biology, including the belief in hereditary degeneration in a family’s history that was cumulative over generations (for example, nervous hysteria leading to alcoholism and addictions, leading to criminality, leading to insanity.)129 Dr Freud’s speculations on infant sexuality and the unconscious (based on the Darwinian assumption that humans were nothing but evolved animals) and his psychological practice being developed for the wealthy in Vienna during the 1890s would have been useless for Launceston130.

Nonetheless, the Surgeon-Superintendent had to cope with psychiatric and alcoholic patients as well as the in and out patients at the Hospital.

18. The Invalid Depot and Her Majesty’s Gaol at Launceston

Finally, we should mention the medical work performed by Dr Drake and colleagues for other government institutions in Launceston that required medical care and the dispensing of medication. These were at the Invalid Depot and the Gaol (built 1829) both in Paterson St. (see table 9). Persons, mostly male, lodged there could be frail and needing regular checking. As the elderly ex-convict began dying of old age, the Invalid Depot visits began to diminish.

126 Annual Report of the General Hospital, Launceston, 1892.
129 Ibid., p. 512.
130 Dr Sigmund Freud’s (1856-1939) life-long agenda was to inculcate the belief that all reality was physical; that humans were nothing but evolved animals. Religion was a failure, but science and rational thinking might prove a success. In his atheism he was following chemist Justus Liebig, philosopher Friedrich Nietzsche (1844-1900); biologist Charles Darwin (1809-1882) among others. Freud in his The Future of an Illusion (1927) and Civilisation and its Discontents (1930) sought to demolish religion with psychoanalysis: his dismal lowest common denominator view was that humanity needed social controls to avoid as he put it, cannibalism, incest, and murder.
Table 9 Visits by General Hospital medical Staff

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<td>1910</td>
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Source: Annual reports of the General Hospital

WHAT WAS ACHIEVED IN LAUNCESTON BY DR FRANCIS DRAKE?

We have outlined the main achievements at the General Hospital in Launceston while Dr Drake had his medical residency there. To reiterate the physical changes:

1890: statistics published on operations at the General Hospital
1890: re-organising wards into surgical & medical wards
1890: separate wards established for sick children (separate wards for boys and for girls) the first in Tasmania
1890: new Training School for Nurses established at the General Hospital
1890: infectious cases isolated in separate wards in Hospital for the first time
1890: Hospital Visitors system inaugurated by 10 ladies “to relieve the tedium necessarily attendant upon sickness.”
1890: first Dental department to provide free “advice and surgical aid in all diseases of the teeth to every poor applicant”
1891: first lectures to the Training School for Nurses (established in 1890)
1891: first appointment of a trained pharmacy Dispenser to the Hospital (Mr. G. Miller)
1892: first separate Operating Theatre – nearly 30 years after the building of the hospital
1892: Reception House for the Insane and for Inebriates
1893: extension of nurse training from 2 years to 3 years
1896: purchase of bacteriological equipment and agitation for a laboratory
1896: purchase of x-ray equipment
1897: separate building for the Isolation Wards for Infectious Diseases (16 beds) opened
1897: new Nurses Home opened

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We have noted that the trio of forces of the Surgeon-Superintendent, an activist Board of Management, together with a dedicated and efficient nursing staff worked together to produce these results. Perhaps we can put down some definite initiatives to Dr Drake because they would require someone with medical authority to argue the case:

- The isolation of infectious cases in the Hospital, and by 1897 an exterior Isolation Ward
- The first Operating Theatre 1892 (at a time of severe economic depression)
- The bacteriological equipment 1896
- The x-ray apparatus 1896
- The design of the lectures for the Training School for Nurses.

Regrettfuly what we do not have is much subjective information on Drake’s personality and relationships with nurses, with the House Surgeon, and only obliquely can gauge his activities through the annual reports the Board. His friend from university days Dr Edward Gault wrote that he was “a man of cheery optimism and the possessor of the gift of whimsical humour which made him tolerant of the follies and weaknesses of his fellows.” Cheerfulness is an attitude can be very helpful to patients. We have seen that he asked for help in getting a small piano that could be moved around the wards for entertaining in patients, an indicator of his interest in their mental well-being. We can surmise that Drake was administratively decisive, a good leader, open to changes that would improve the Hospital for patients; that professionally as surgeon and general practitioner he enjoyed an enduring reputation – his successor Dr John Ramsay, who became one of the acknowledged premier Australian surgeons, “always acknowledged his indebtedness to Drake.” And the Launceston Examiner observed near the end of Drake’s tenure in 1898, that the Board had been fortunate in recruiting men “clever at their profession, and endowed with high administrative ability”. There is no doubt that Dr Drake significantly contributed both to the enhancing the medical profession in public opinion within the Launceston region and improving the perception of the General Hospital as a place of safety and trustworthiness.

19. Completing the work of Dr Drake 1900-1907

By 1900 the Hon. George Collins MLC resigned after 20 years as Chairman of the Board, because as Chief Secretary in the Tasmanian cabinet and with ministerial jurisdiction over public hospitals, he had a conflict of interest. Yet the Board could report in 1900: “The bacteriological laboratory erected over the boiler-house is now nearing completion”. One third of the money to build this was contributed by the Board from its private funds (The Board was given financial freedom from the Tasmanian government in 1898). The laboratory was completed early in 1901 “and has been found to be of great service in carrying on the work of this department.” But more to come: “The Operating Theatre has been renovated and completely refitted with up-to-date furniture and apparatus, which will compare with those of the most modern hospitals, though the building itself could well be

132 Obituary, MJA, 8 March 1930.
133 Craig, op. cit. p. 34.
134 Launceston Examiner, 3 February 1898, p. 4.
modernised, were means available.” The Board report continues: “A complete apparatus for X-ray work has been obtained, and a room provided for this special work.” 135

Finally, after Dr John Ramsay had inspected major surgical centres in Europe and America in 1902, a suite of operating rooms were built in 1905-06 on the top of the service block with a hydraulic lift to bring patients from the wards. Surgery transformed the Hospital: from 284 surgical operations in 1898 (Drake’s last year) they rose to 738 in 1908 and then to 927 in 1910.

And what of the pauper patients who comprised the majority of patients in the 1880s and into the 1890s? Surgery patient numbers are a key indicator of trust. The safety of the hospital and the extension of the range of procedures able to be performed, the quality of the nursing meant that patients from Launceston and its region, both rich and poor, had come to trust the Hospital as a place of excellence. Who funded the 1906 operating Theatres? Five anonymous citizens donated £500; the Board found another £500 from its private funds; the citizens of Launceston raised another £500; and the Tasmanian government the final £500.

To build an institution that inspires trust is noble work. That the people of the Launceston region financed 75% of the new Theatre is testimony to that trust. But trust is not given without evidence: it is earned by demonstrated skill, competence and dedication to excellence by the relatively small medical team of two resident doctors, nurses (24 in 1898) and backed by a Board of Management and an able chairman George Collins MLC who saw the Hospital as their communal asset. An unsung hero at the General Hospital at Launceston is Dr Francis Drake, who at a time of severe economic depression in Australia – with strikes, unemployment, despair - he invested his skill in surgery, and with the generous bequest of midlands grazier Arthur Leake, modified the walkway into a Operating Theatre with a successful record of safety on a variety of operations. He gave hope to the citizens of the city of Launceston and pride in their Hospital.

During the 1890s the stigma of the Launceston public hospital as being repositories only for lower class patients began to shift with more well-to-do patients seeking access for surgical operations. The General Hospital at Launceston had decisively evolved into a more scientific and clinical institution with research and teaching functions – the prototype of the hospital of the present day. The economic problem that emerged for medical practitioners in private practice is that the growing reputation of hospitals as safe and curative organisations is that they lost potential patients (and income) to the Hospital.

135 Annual Report of the General Hospital, Launceston, 1900, p.5; and 1901, p. 3.
LIFE AFTER LAUNCESTON: DR FRANCIS DRAKE - TUBERCULOSIS SPECIALIST 1903-1926

Because many of the biographical facts of Dr Drake are missing, it is worth pursuing aspects of his life after Launceston, for his founding of a Tuberculosis Sanatorium in Victoria throws light on his compassion as a doctor for sufferers of a disease, his interest in improving medical care and making his sanatorium the best it could be in the light of international comparisons – he visited international sanatoria in 1913-14 - and for revealing again his organisational and medical skills that were evident at Launceston.

Dr Francis Drake resigned from the General Hospital in Launceston on 31 March 1898 to devote himself to private practice surgery. He moved to Macquarie St., Hobart where he apparently gained a reputation as one of Tasmania’s leading surgeons.

Aged 37 he married Alice Maud Atchison (age 33 years, a resident of St Kilda) on the 6 August 1898 in the Wesleyan Church at Balaclava, near St Kilda in Melbourne. They had a family of four children: Francis James Bain Drake (1899-1949); Jon Drake (1902-19?); Lister Drake (1905-1990), and Nancy Eleanor Drake (1909-1982).

Diagnosed with pulmonary tuberculosis in 1903, possibly acquired from his sick patients, Dr Francis Drake was forced to relinquish his private surgical practice within five years of leaving Launceston. He put aside all engagements to focus on his own health – he probably was using the Nordrach system of cure established by Dr Otto Walther (see below). “He accepted a rule of absolute silence and for eighteen months communicated with his friends only by the signs of the deaf and dumb language. Treatment was partially successful”, wrote his friend, Dr Edward Gault.

Drake now had a young family to support. What did he do? For twenty years from 1906 to 1926 Drake began a third career as a specialist in tuberculosis. He returned to Victoria, bought land at Mont Albert (adjacent to Box Hill), located on the railway some 13 stations from the central station at Melbourne’s Flinders St. Here he built a house and remained the rest of his life. Along the railway about 6 km east of Mont Albert lay the village

Site of Sanatotium

Drake was excluded from being an Honorary Surgeon at the Hobart General by an in-group clique, claimed Dr ET McGowan at a 1914 Tasmanian Royal Commission on public hospitals, see Michael Roe, Life over Death: Tasmanians and Tuberculosis, Tas Hist Res Assoc., Hobart, 1999, p.80.

Sir Joseph Lister (1827-1912) was the pioneer of antiseptic surgery. FJB Drake graduated MB BS Melbourne in 1922, & later a house surgeon in 1925-26 at the General Hospital at Launceston and then a general practitioner at Swansea.

Obituary of Dr Francis Drake, Medical Journal of Australia, 8 March 1930, p. 337. Dr Edward Gault had been a BA student then medical student with FJ Drake in the 1880s.
of Mitcham where he bought several properties: some as short term investments which when sold shortly after probably went into improving his sanatorium; of the others, one became his consulting surgery (1909-1921); and on a larger 132 acre block\(^{139}\) on hilly bushland he built a sanatorium for tuberculosis sufferers. This was claimed to be the first modern sanatorium in the state. He “planned the institution with care and devoted much attention to the proper organisation and conduct of the establishment.”\(^{140}\) This he presided over from 1906 to 1926.

20. **Tuberculosis and the Sanatorium Idea**

Medical science had one of its defining historic moments in March 1882. The lecture by Dr Robert Koch (1843-1910) established two things: first, he identified a major killer, the bacterium that caused tuberculosis (*Mycobacterium tuberculosis*); and second, important for the long term, he gave the germ theory a solid scientific grounding. Melbourne University was to incorporate the germ theory into its medical curriculum in 1884. Koch presented his discovery declaring that tuberculosis was more important than the feared infectious diseases of bubonic plague and cholera: “One in seven of all human beings dies from tuberculosis. If one only considers the productive middle-age groups, tuberculosis carries away one-third, often more.” Koch sought to persuade and to overwhelm strong resistance to and scepticism of the germ theory of disease causation by the weight of evidence. So he brought his laboratory to the lecture room: microscopes for people to view the bacteria, test tubes with cultures, glass slides with stained bacteria for microscopic inspection, dyes, reagents, glass jars with tissue samples. His thorough presentation of his methods including his methods of staining, and the intricate chain of proof (bacteria from infected person; test tube culture of bacteria; tests on guinea pigs etc.) educated many beyond his audience: his words were rapidly translated into English and published in *The Times* and the *New York Times* of April and May 1882. Dr Koch received the Nobel prize for medicine in 1905 for his work on tuberculosis.\(^{141}\)

An exciting path for medical science thus opened, linking the new science of bacteriology, with pathology and epidemiology. The infective organism revealed, its transmission as an infectious air-borne disease understood (via coughing and air borne droplets) and the pathology explored - the infected site being mainly in the lungs, but if passed into the blood can set up infection in the meninges of the brain, in the bones or joints usually the spinal column or hips. (Drake at Launceston did a successful excision of a tubercular elbow joint on a female patient aged 32 in 1892; and a tubercular amputation at the hip joint for a male also aged 32 in 1893 who died.) But there was no cure for TB. For medical practitioners, what could they do? TB was predominantly a disease of the poor, of overcrowding and malnourishment. And given the recorded infection rates, TB could be written off as a hopeless cause. Many incurables, as bread winners, sought to hide their infection until they were too

\(^{139}\)This 132 acre site was subsequently bought by the Catholic church. On the UBD Melbourne Street Directory, 2006, p. 258 at Mitcham the site on Park Road is marked as Whitefriars Park training & Conference Centre.

\(^{140}\)Dr Gault, *Obituary*, *MJA*, 8 March 1930, p. 337. An undated Melbourne newspaper, c. early 1980s, claims that Francis Drake had a brother Fred Drake working in real estate in the Mitcham region.

weak to work. Their families became severely impoverished. This was the era when 30 to 40% of the workforce were unskilled labourers; old age pensions did not exist in Australia until 1909.

But an avenue opened for the optimists. Many had long pondered the suggestion that climate could ameliorate the disease in individuals. Dr Samuel Bird, Drake’s lecturer in Medicine had published *Australian Climates and their influence in the prevention and arrest of pulmonary consumption* in 1863. In Germany Herman Weber in 1868 claimed that high, dry mountain air could arrest or even cure TB. 142 The concept of the sanatorium - derived from the Latin verb *sano*, to heal - took off once the infectious nature of TB (as distinct from beliefs about “hereditary” constitutional causes) was established and the primary mode of transmission of the bacteria via coughing and spitting suggested ways in which transmission could be diminished or even prevented: the late 1890s and 1900s saw the establishment of sanatoria in Europe, North America and Australia.

There were many kinds and sizes of sanatoria with differing regimes and clientele; some were probably harmful to their patients. The Nordrach sanatorium for the wealthy in the Black Forest region of southwest Germany opened in 1902 gained a reputation to copy: established by Dr Otto Walther for the treatment of advanced tuberculosis, he made claims of curing near 30% of patients and improving 65% more. Patients were given ample diets (milk, meat, cheese, starches, fruits) to counter the “wasting” (consumption), regulated rest, a graduated exercise regime, and exposure to cold “pure” air with many open windows. At the other end of the scale were the Poor Law hospitals established in the 1900s in Britain, essentially places of confinement for poor TB sufferers.

The need for sanatoriums in Australia was raised in Hobart in 1902 while Dr FJ Drake worked there in private practice: he was to discover that he had TB in 1903. At the Australasian Association for the Advancement of Science Congress, Dr AH Gault of Adelaide discussed tuberculosis and the lack of sanatorium treatment, criticising Australians for doing virtually nothing either for the wealthy or for the poor: “On the part of the public there is a rooted objection to all kinds of institutions, which nothing will overcome, but the firm attitude of the profession, backed up by actual results.” Gault discussed the results of the Nordrach sanatorium 144. As it happened, tuberculosis became a major subject for public discussion in Australia as “the white plague”; more sanatoria were established in the early Commonwealth – in Victoria in Mt Macedon, Warburton, Marysville, Mt Buffalo, Echuca, and Dr Drake’s at Mitcham outside Melbourne (1906); in NSW at Thirlmere and Wentworth Falls in the Blue Mountains; Dalby in Queensland; Belair in the Adelaide Hills, and in Tasmania in 1906 on land behind the former convict Orphan School at Creek Rd., Newtown in Hobart’s suburbs. Several of these admitted “early” cases but also took “advanced” cases.

142 See FB Smith, *The People’s Health*, op. cit., p. 290

143 Wide variations in climate existed for sanatoria: Arizona and its town of Tucson were in arid desert; Davos in Switzerland in the mountains. German novelist Thomas Mann (1875-1955), Nobel prize winner for literature in 1929, set his novel *The Magic Mountain* (1924) in a Swiss TB sanatorium, the main character being forced through infection, to remain there 7 years.

144 See Michael Roe, *Life over Death*, op. cit., pp.39-40. Dr Walther’s Nordrach sanatorium was closed by the Nazis in the 1930s, for he was a Jew.
Two Victorian sanatoria existing in 1905 took 552 patients between 1900-1905: 247 or 44% were dead by 1905\textsuperscript{145}. There was a medical and administrative problem: how to sort the advanced cases from the early stages of TB? Should the advanced cases be regarded as incurable? Melbourne Hospital had excluded consumptive patients in 1887 because they occupied beds for long periods. At the opening of a Sanatorium in NSW in 1903 (probably in the Blue Mountains), the entry of only early onset sufferers – the opposite end to the spectrum from Nordracht’s advanced cases - was spelt out:

Only those suffering from the disease in the early stages will be admitted so that the sanatorium will be put to its best use in seeking to compass the cure of those still in a curable stage. The results obtained at sanatoria in Great Britain and Europe are remarkable…\textsuperscript{146}

The \textit{Australasian Medical Gazette} summed up the case for Australian sanatoria in 1906:

The great value of fresh air and an outdoor existence in the treatment of tuberculosis is now universally recognised; but to be effective fresh pure air must be constantly applied, without regard to the season of the year…although a certain degree of protection should be afforded during climatic extremes and under different conditions of disease\textsuperscript{147}. The writer continued that such diseases “we know now …is really an acute infection by a microorganism for which at present we have no specific remedy or serum, and we have to depend upon our resisting forces. One of the foremost of the natural agencies which help to fortify the human system against the invasion of disease is pure fresh air…”\textsuperscript{148} Florence Nightingale could not have said it better.

\textbf{21. Dr Drake defends the Mitcham sanatorium: education, prevention, and cure}

Dr Drake’s sanatorium established in 1906 on its 132 acre site at Mitcham near the railway line drew noticeable numbers of visiting patients from its early days. It appears as if Drake took all kinds of cases, including advanced cases. The sanitorium also provoked complaints. In November 1908 writing anonymously to the \textit{Box Hill News}, a correspondent, “Health”, declared: “The alarming spread of the dreaded white plague (consumption) is now receiving such universal notice” so that Mitcham is exposed to “great danger” and that “every precaution should be taken to protect healthy people from the scourge.”

The Mitcham …sanatorium has a constant stream of people to and from the institution, and numbers of people are receiving open-air treatment in the locality. Infected people travel up and down in the trains, and the local

\begin{flushright}
\textsuperscript{145}FB Smith, \textit{Illness in Colonial Australia}, op. cit. pp130-31. The Tasmanian Sanatorium for Consumptives was adjacent to the former convict era Orphan School at St John’s Park, which in 1906 housed the Charitable Institution, and thereby elderly frail ex-convicts, similar to the Invalid Depot in Launceston. My father’s parents both suffered from TB and attended the sanatorium on and off, probably from about 1914 or 1915; both subsequently died of TB at the 42 years of age c. 1921, leaving four orphaned children who were separated and sent to the care of two sets of relatives.

\textsuperscript{146}“The Sanatorium Treatment of Pulmonary Consumption”, \textit{Australasian Medical Gazette}, 20 March 1903, p. 115.

\textsuperscript{147}“Fresh Air and respiratory disease”, editorial, \textit{Australasian Medical Gazette}, 20 September 1906, pp. 462-63

\textsuperscript{148}Ibid.
\end{flushright}
railway station is the rendezvous of many of them. Dr Drake, being an expert in the disease, is, of course, the chief attraction for these unfortunate people… The writer demanded that Mitcham be declared a consumptive area and that the local board of health take “stringent precautions” to see that the “law is strictly enforced, otherwise a popular and picturesque district will speedily become depopulated.”

Dr FJ Drake MB (his surgery degree was not included) responded with a long letter on 19 November pointing out that “more modern conceptions of the danger of pulmonary tuberculosis (consumption)” contradicted the fears raised by the earlier letter.

Now, this disease is not spreading but, on the other hand, diminishing rapidly….It will probably be as rare as smallpox within the next 40 or 50 years. When the public are better educated in the means of prevention, the disease will have lost its terrors.

Drake was correct: the tubercle bacillus in the lung multiplies only slowly, but is difficult to kill. But there was a slow and persistent fall in TB mortality from 1850 to the 1950s – sanatoria began to close in the 1950s and 1960s. Medical treatment probably had little effect in mortality changes, but public education in elementary hygiene – substantially helped by sanatoria – diminished the chances of sufferers infecting others.

Drake chose to quote from the latest textbooks on tuberculosis in order to address “faulty understanding of the disease” – “My personal opinions, though corroborating those expressed below, may be considered biased.”

The most dangerous consumptive is the one who does not know he has the disease or who tries to deceive himself and make himself believe that he does not have it. He is dangerous because he will not take precautions. On the other hand, the one who knows he has the disease and takes proper precautions, is a perfectly safe companion with whom to associate (from Pettinger Pulmonary Tuberculosis).

Drake quotes another authority on German and Swiss villages all with long established sanatoria like Davos as “proof of the fact that sanatoria are not dangerous to the community”: Davos with 4000 inhabitants has 8 sanatoria and is visited by some 20 000 people annually, most of whom were affected with tuberculosis. Yet the Davos TB mortality rate is “exceedingly low” (9.7 per 1000 compared with Germany 22.5 per 1000) and mortality is not increasing. At the sanatoria “the patients are educated in the care of their sputum” - “Such institutions should be welcomed – 1. They are dealing with the tuberculosis problem scientifically. 2. They are treating the tuberculosis patient humanely and offering him the best chance of recovery. 3. They are protecting the healthy from becoming infected.”

Drake quotes a third author: “There is little if any danger from transient exposure to contaminated places. Physicians are in little danger from their examination of and attendance on the tuberculous sick. One cannot contract consumption from riding in a street car…or railroad train”.

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149 Anonymous correspondent “Health”, Box Hill News, 3 November 1908. This information obtained by Karen Carson of the John Ramsay Library at LGH.

Drake concludes in his own words born of self-reflection: “The ordinary consumptive has quite a heavy burden enough to carry in his own illness without being made to feel that he is a “leper” to be avoided as a constant source of danger. Ignorance of this question will only breed needless scares.”

What methods did Dr Drake employ in his sanatorium? Undoubtedly they were organised around pragmatic medical reasons: what would work for patients? Having been infected with TB himself undoubtedly gave him fellow feeling with his TB patients, who included advanced cases of the disease. Drake’s methods were modelled on the Nordrach system of regulated diet, graduated exercise, and fresh air, judging from a letter of July 1908 written by a Marine Board pilot, Mr Evans at Low Head on the Tamar River.

We discovered a couple of years ago, after spending a considerable sum of money on them, the futility of using so-called remedies with which the market is flooded by unscrupulous quacks. Mrs Evans is now carrying out Dr Drake’s instructions by sleeping out in the open air and regulating her diet and exercise also noting her temperature and she has improved considerably...I think we shall give the sulphuric cure a trial, providing it can be done without making my wife cough too much.

22. “I would like to tell you much about this doctor”: scientifically graduated rest & exercise

The detail of Drake’s methods remain elusive, but were probably those published as “A Cure for Tuberculosis” by the Australian magazine The Lone Hand in August 1911. The author, Lt. Aldridge Evelyn RN (a writer of sea stories for Lone Hand), wrote of the methods used by an Australian doctor to “completely cure” his own case of advanced pulmonary TB, and discusses the detail of the regimen he experienced at what is likely to be Drake’s sanatorium at Mitcham. The editor criticises the fact that “the etiquette of the medical profession does not permit us to mention the name of the doctor”, and Evelyn declares “I would like to tell you much about this doctor...but he wouldn’t thank me if I did. Suffice it to say that he himself was a victim of the dread bacilli, and before curing others had first to learn how to cure himself” – a statement that we can take as a clue to Drake’s presence. Evelyn tells us that he began suddenly coughing blood while on the China station at Hong Kong in 1900; he consulted 26 doctors in England, USA, West Indies, Canada, NZ, and Australia (presumably while in the Royal Navy); each year rendered him worse: by 1910 “I gave myself up as dying”. He met that impressive doctor No. 27 running a sanatorium on the Nordrach principles “and this one cures, and by the simple method of scientifically graduated rest and exercise.” He spells out the regime so that others might work it for themselves - Evelyn’s writing - the appearance, order and style of which suggests that he may have had at hand

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151 FJ Drake MB Mitcham, in Box Hill News, 19 November 1908.
152 Another medico who suffered TB who administered a TB sanatorium was Dr HW Palmer (1877-1956), who graduated from Sydney University medical school in 1906. In 1909 he was appointed the first superintendent of the Home for Consumptives at Waterfall south of Sydney remaining until 1939; see ADB, 1891-1939, vol. 11, 1988, pp. 128-9.
153 Quoted by Michael Roe, Life over Death: op. cit, p. 43.
154 Aldridge Evelyn, The Lone Hand, 1 August 1911, pp. 304-12 (copy in Hobart State Library). This reference and suggestion taken from Roe, op. cit. p. 58. The Lone Hand, an illustrated monthly published 1907-21 was planned by JF Archibald, editor of The Bulletin, and under Bulletin management for much of its life.
the guidelines written by Dr Drake for patients at his sanatorium. Given that in the 21st century reports that many cases of TB are resistant to anti-biotics (as among Papua-New Guinean people) will we see a return to the methods of the sanatoria? Evelyn’s words - much abbreviated here - provide the gist of the treatment regime and help to give the illustrations of the Mitcham sanatorium meaning. Evelyn writes:

**Diagnosis:** probably 80% of people have tuberculosis of the lungs; most remaining dormant. The difficulty of early onset of diagnosis of pulmonary tuberculosis. “Examinations under X rays have produced good results” in diagnosis.

**Climate:** “it is not where you live, but how you live”. And “Pure air, by no means a cure in itself, is nevertheless indispensable.”

**Food:** “To get well you must eat, at first, probably a good deal more than you want”; “Don’t nibble between meals; have three meals and let five hours elapse between each – that gives your digestion a chance”; “before each meal (except perhaps breakfast) lie prostrate on a lounge chair or bed for one hour, during which time smoking and talking are prohibited – reading is allowed…” “Watch your weight. Half a stone above normal is a good mark to aim at”; “Alcohol is poison to you; but tobacco may be used, provided it is not inhaled, in moderation, though not if it makes you cough”.

**To avoid infecting others:** “arm the consumptive with a spitting flask and a butter-muslin rag (burnt daily) in lieu of a handkerchief.” “in the morning take either a cold shower or a cold sponge; but avoid anything like rubbing down afterwards. Don’t stoop more than is absolutely necessary, make no rapid movements with arms or legs, treat all well-meant suggestions that you should go in for…breathing exercises with the scorn they deserve. As well counsel a man with a broken leg to play football.”

**Temperatures:** “I come now to what may be the designated kernel of this treatment. Buy a registered clinical thermometer; that is, one with which they give you a certificate, for by its readings your mode of life for at least six months must depend. Soon you will learn to regard it for what it is - the consumptive’s Best Friend.”…”For the purposes of the treatment we fix 98.6 deg. F as the mark it must not exceed in the morning. If it is above you must remain in bed, and it’s bed, bed, bed until your temperature is below 98.6 degrees F in the morning, and until it does not go above 100 deg.F during the day. Don’t mistake that point… Until you get the above defined grip on your temperature, keep in bed, see no visitors, talk as little as possible, never for more than five minutes at a time, worry about nothing…stick to your bed as if glued there”.

**Exercise:** “in this treatment the ‘exercise’ half is every wit as important as the ‘rest’” Temperatures are to be taken in the morning, at noon, at 5 pm, and at 9 pm, and assuming it is not above 98.6 F in the morning or above 100 deg. F during the day. “Before starting, get the place you intend walking in marked off in distances of 50 yards. The ideal track is one in which gently, very gently slopes upwards – walking up grades tends to strengthen the heart muscle….You must not attempt to tackle anything resembling a hill.” “On the first day, having had a lounge chair placed at station 1, walk to it, starting half an hour or so after breakfast; rest in the chair until, say 11.30, and then walk the same distance back, and immediately take your temperature.” Evelyn then sets out 6 gradations of exercise as measured by the recorded temperature:

Over 100 deg.F: Go to bed for the rest of the day (“wisest not to walk at all the following day”)
At 100 deg.F: Walk no more for the rest of the day; decrease your distance the next day
At 99.8 deg. F: Walk the same distance the next day
At 99.6 deg. F: increase next day’s distance by 50 yards
At 99.4 deg. F: increase ditto by 100 yards
At 99.2 deg. F (or under): increase ditto by 150 yards
“The same rules apply to the walk you should take half an hour after dinner, returning in
time for the 5 pm temperature, only it will be found in practice that the temperature is
much ‘tenderer’ in the afternoon, necessitating a corresponding shorter walk.” …”here I
want to urge the extreme necessity of never allowing yourself to do anything which will
increase your respirations above the normal, a minute and a half walk to walk 50 yards
must be your pace until you are a well man. Walk, in other words, as slow as you possibly can…”

How to take your temperature: “there is but one accurate method, they must be bowel
temperatures ie. Taken in the rectum” “All the figures given here are for bowel
temperatures, which are decimal 6 deg. F higher [0.6] than mouth temperatures.” “You
want to know what your temperature is from when you return walking” - mouth
temperatures take 20 minutes to register [ie would occur after 20 minutes of resting and
therefore be an inaccurate measure of the immediate post-walk temperature]. “Finally, no
matter whether you have a half-minute or a two-minute thermometer, to get an accurate
reading you must allow it to register for at least four minutes.”

Haemorrhages: “Unfortunately one cannot put a game [sic] lung in splints, consequently
we must do the next best thing, and put our game selves in bed. At the first sign of
‘staining’ seek your couch; if the ‘staining’ is very slight, stay there for 48 hours after all
signs of red, pink and even brown have vanished; if otherwise, eight clear days from the
last stain must be spent there. In the case of a haemorrhage, two weeks is not too long. It
takes eight days for a clot to become part of a blood vessel, and continual ‘staining’ is
often due to the fact that people by not resting in bed, refuse to give the injured spot a
chance to heal.” “Haemorrhages, except in advanced cases, are never dangerous; also of
the many kinds of phthisis, the haemorrhagy one yields most readily to treatment. The
harm done by a bleeding is always more mental than physical.”

Drugs: “Amyl Nitrite, Trinitrin, and Calcium Lactate practically compose the
consumptive’s pharmacopoeia. In addition, Pin-Heroin or Glyco-Heroin may be used for
a troublesome cough, but with extreme care. Remember that clearing your lungs is a
necessity, and any drug – like the awful patent medicines so much advertised, which ease
your cough at the expense of that clearing process – are deadly, deadly poison”.

Progress: “Naturally the most tedious part of the treatment will be the first few weeks, or
months, which may have to be spent in bed…. Be in bed until your Best Friend
[thermometer] allows you to get up, as much as if you had both legs broken.”
“Astonishing, too, will be your observations as to the small things which can send up
temperature; the sight of a visitor, an exciting novel, a moment of irritation, a minute’s
conversation…” “Again, after once you get up, you may experience setback after
setback, be on your feet one week, and in bed the next, ad nauseam, but persevere, and
progress, however slight, is all you really require.” …. “And now comes the question: How long should one keep it up? It is impossible to speak dogmatically. Generally speaking, six months of it should be endured by everyone who once finds it necessary to start.”

**A Last word:** “I have spoken. Clearly I hope, and if you think too dogmatically, I can but plead that I have assiduously practised what I preach, and have seen all around me, men and women, cured by this same doctrine.” “The people’s mind needs educating, I might say re-educating, on the whole grim subject.” …”A stiff upper lip is needed, a certain amount of brains is needed, character is needed; a little money is needed; also a mind and imagination kept pure from contaminating thoughts and desires. All these things are needed, and yet the treatment is not a hard one; some may deem it so simple that they will refuse to give it a trial.”155

155 From Aldridge Evelyn “A Cure for Tuberculosis”, *The Lone Hand*, 1 August 1911, pp. 304-12. Evelyn also wrote a second article with supplementary information “Fighting Consumption with Modern Weapons”, in *Lone Hand*, 1 August 1912, pp. 312-21.
The Mitcham Tuberculosis Sanatorium

Dr Francis Drake

Individual Chalet / Tent

Dining Room
From the extant photographs Dr Drake’s Sanatorium at Mitcham consisted of
- A weatherboard house of four rooms and a bathroom; verandahs (probably around the house)
- Detached bungalows of 3 rooms
- 12 detached weatherboard and fibrocement one roomed chalets

What do the extant photographs tell us about Drake’s Sanatorium at Mitcham? The construction materials of the one room chalets of fibrocement indicate isolation of patients and also of rapid construction and cheapness to keep capital costs down. Another shows a tent structure – also enabling quick and cheap extension for more patients. The “pure” air treatment is evident in the rural bushland surrounds, in the open design of the chalets, and in the open dining room (at least 2 tables with six chairs are visible – perhaps a maximum clientele of 20 or so patients). Another depicts regulated rest on long cane chairs with blankets over patients, once again in the open air on a verandah with corrugated iron roof that is adjacent to the dining room and the verandah probably encircles the whole house. Two nursing sisters in white with veils show the availability of trained nursing staff; and broad pathways following contour lines indicate graduated walking for exercise.

In 1913 Drake travelled to Europe and America visiting many well known TB sanatoria, returning to Australia in 1914 soon after the outbreak of the Great War. In 1918 he joined the Australian Army Medical Corps Reserve with the rank of major, and was in charge of the army’s sanatorium at Mont Park.

The Mitcham sanatorium closed in 1926. Dr Frank Drake died three years later, aged 69.

Dan Huon
Administration
Department of Anaesthesia
Launceston General Hospital

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156Source Andrew Hillier, Nov.1983, typescript (with unreliable dates) “A brief biography of Dr Francis Drake…”, copy with Nunawading Historical Society. Thanks to Karen Carson, John Ramsay Library for finding this source and photos of Drake’s TB sanatorium.
APPENDIX 1 Subjects for MB & BS University of Melbourne Medical School 1885-86

Source: Annual Report 1885-86 University of Melbourne

Regulations, Chapter VIII combined with Subjects of Examination
"Of the Degrees of Bachelor of Medicine and Bachelor of Surgery"—
1. Candidates for the Degrees of Bachelor of Medicine and Bachelor of Surgery shall, subsequent to their Matriculation, pursue their studies for five years and pass five Examinations.
2. During the first year Candidates shall attend Lectures on—
   (1) Natural Philosophy, Part I, thrice a week during three Terms.
   (2) Elementary Biology, with practical work therein, thrice a week during three Terms.
   (3) Chemistry daily during the February Term and thrice a week during the July and October Terms.
   And shall attend the Course of Practical Chemistry thrice a week during the July and October Terms.
3. The subjects for the First Examination shall be—
   (1) Natural Philosophy, Part I.
   (2) Elementary Biology.
   (3) Chemistry.
   (4) Practical Chemistry.

NATURAL PHILOSOPHY—Part I
The Elements of Dynamics, Heat, Magnetism, Electricity, Sound, Light, treated experimentally.
Text books:—
Deschanel's Natural Philosophy, by Everett, ninth or later edition, the easier parts.
Elementary Mechanics, by Professor Lodge

BIOLOGY—PART I—
This course will include Lectures and Laboratory work.
(1) Zoology.—In the Lectures the characters of the chief divisions of the animal kingdom will be given, and the anatomy and development of one or more typical examples of each will be described. In the Laboratory, the following or some similar forms will be studied:—Amoeba, Paramaecium, Vorticella, Hydra, Astacopsis, Unio, Mustelus, Rana, Columba, Phalangista,
(2) Botany.—The Lectures will deal with the elementary morphology and physiology of plants. The characters of the chief groups will be given, and typical examples of each described.
In the Laboratory, the following or some similar forms will be studied:—Bacterium, Protococcus, Penicillum, Chara, Pteris, Vicia,

Books recommended for practical work:—
Marshall, The Frog.
Marshall and Hurst, Practical Zoology.
Huxley and Martin, Biology.
CHEMISTRY OF THE MEDICAL COURSE—
General Laws of Chemical Combination and the circumstances which influence chemical affinity. Crystallography as far as the fundamental forms. Principles of Chemical Nomenclature including the use of Formulas and Symbols.
Chemical characteristics of the elements and their more important combinations used in Pharmacy. The Cyanogen series of compounds.
The constituents of Vegetables and Animals including the Chemistry of the chief healthy and diseased secretions, Blood, Milk, Urine, Bile, Calculi, &c.
Chemistry of food and poisons.
The more important Sugars, Alcohols, Ethers, Fats and Oils, and Organic Acids and Alkaloids.
The Systematic Course of Lectures on Chemistry, with experimental demonstrations, embraces the elementary doctrine and general principles of the science, the elements and their most important compounds, with their preparation and properties.
The uses of the elements in nature, medicine, and the arts; also, the chemistry of the proximate constituents of animals and vegetables, and of the vegetable acids and alkaloids, with especial reference to such as are used in medicine.
A portion of the course is devoted to Organic Chemistry generally. The course extends to about 111 Lectures.
Class Books recommended :—
Fownes' Manual of Chemistry (10th edition) or Professor Attfield's Medical and Pharmaceutical Chemistry.
Students desirous of further information may consult—
Day's Physiological Chemistry.
Robin and Verdeil—Traite de Chimie Anatomique et Physiologique.
Students are also recommended to peruse Deschanel's Natural Philosophy.

PRACTICAL CHEMISTRY—
The determination of the specific gravity of solids, liquids, and gases.
The qualitative analysis of inorganic compounds.
The principal tests for the detection of metallic poisons.
The qualitative examination of Urine and Calculi,
The ultimate analysis of organic bodies.

This Course of Lectures (between 50 and 60 in number) embraces the preparation of the principal gases and re-agents, the passing through an extended system of qualitative chemical analysis, and the detection by chemical means of the principal inorganic and organic poisons. The essential processes in qualitative chemical analysis will be indicated and illustrated.
Each Student provides himself with the necessary apparatus as follows, viz :—
Platinum Foil 3 x 1 inch. Wire 9 inches. 1 Berlin Dish. 1 Crucibl.1 Blue Glass.1 lb. German Glass Quill Tubing;1 doz. Test Tubes. 1 Blowpipe. 1 File.1 Test Tube Stand with Drainers. 1 Funnel. 2 doz. Pill Boxes.2 Beakers.3 Test Glasses on Stand. 3 Test Watch Glasses. 1 Spoon for Blowpipe. 1 Test Tube Brush. Packet Blank Labels. Filter Paper. Flask.
Class Books recommended :—
*Scherer on the Blowpipe*, edited by Blandford.

**Medical Students are recommended also to peruse**—
Taylor on *Poisons* or Guy's *Forensic Medicine* (3rd edition).

**Students desirous of further information may consult**—
Fresenius' *Chemical Analysis*, and Dr. Keale's works on *Urinary Deposits* and *On the Microscope*.

4. **During the second year** Candidates shall attend Lectures on—
   (1) Junior Descriptive and Surgical Anatomy thrice a week during three Terms.
   (2) Physiological Chemistry and Histology, with practical work therein, twice a week during the February and July Terms.
   (3) Materia Medica, Medical Botany, and Elementary Therapeutics thrice a week during three Terms.

**Shall perform a first course of Dissections,**
And shall produce the following certificates—
(i.) Of having received instruction in Practical Pharmacy during a period of six months in some School of Pharmacy or other institution approved by the Council on the recommendation of the Faculty of Medicine and of having acquired therein a practical knowledge of the preparation of Medicines.
(ii) Of having attended during nine months the Surgical Practice of a Hospital recognized by the University of Melbourne, the certificate specifying attendance in the out-patient and casualty departments, with instruction in Minor Surgery and in the application of surgical apparatus.

5. The subjects of the Second Examination shall be—
   (1) Junior Descriptive and Surgical Anatomy.
   (2) Physiological Chemistry and Histology.
   (3) Materia Medica, Medical Botany, and Elementary Therapeutics.

**DESCRIPTIVE AND SURGICAL ANATOMY**—(Second Year)—
The Bones, Ligaments, and Muscles.
These Lectures comprise the Descriptive and Surgical Anatomy of the whole body, but Students of the Second Year are recommended to devote their time to acquiring a practical knowledge of the Bones, Ligaments, and muscles only and to this end it is recommended that each Student should possess the separated bones of an entire skeleton. A knowledge of the Ligaments and Muscles, Vessels, Nerves, Viscera, etc., can only be gained by dissection, in which assistance will be given by the Demonstrator of Anatomy.
Dissections.—Certificates will be given only to those students who shall have dissected all the muscles and ligaments.

**PHYSIOLOGICAL CHEMISTRY AND HISTOLOGY, AND PHYSIOLOGY AND PRACTICAL PHYSIOLOGY**—
Students attending these classes should have previously passed in Natural Philosophy, Part1.

**Books recommended** :
McKendrick's *Outlines of Physiology.*
Foster's *Text Book of Physiology.*
Carpenter's *Human Physiology.*
Practical Histology—
Harris and Power's *Manual for the Physiological Laboratory.*

**Apparatus to be provided by students:**—
Practical Histology—
Microscope, a pair of scissors, a pair of fine forceps, 
two scalpels, needles mounted in handles, razor, glass slides and thin cover-glosses, 
watch-glasses (6), section lifters (2), labels, filter papers, a box or cabinet for mounted specimens.

**Physiological Chemistry**—
Twelve test tubes, test-tube stand, retort stand, platinum foil and wire, three Berlin dishes, 
three beakers, sand bath, filter papers and funnels, six small stoppered bottles, one dozen 
2-oz. bottles.

**MATERIA MEDICA, THERAPEUTICS, AND MEDICAL BOTANY**—
The scope and aim of Materia Medica and Therapeutics.
The various forms in which medicines are administered, and the channels through which they are introduced into the system. The art of prescribing medicines. Incompatibility. 
Circumstances which modify the action of medicines. 
The natural history, preparations, doses, modes of administration, and actions and uses of all the medicines officinal in the British pharmacopoeia. An account is also given of the most important drugs of other pharmacopoeias, as well as of recent important medicinal substances, together with such agents as heat, cold, electricity, and galvanism, in so far as they are available for the diagnosis and treatment of disease.

**The Lecturer on Materia Medica recommends to Students the undermentioned works as Text Books:**— .
Garrod's *Materia Medica and Therapeutics.*
Farquarson's *Guide to Therapeutics.*
Students desirous of further information are recommended to consult—
Bentley and Trimen's *Medicinal Plants.*
Phillips' *Materia Medica and Therapeutics.*
Bartholow's *Materia Medica and Therapeutics.*
Ringer's *Therapeutics.*

6. **During the third year** Candidates shall attend Lectures on—
   (1) Senior Descriptive and Surgical Anatomy thrice a week during three Terms.
   (2) Surgery thrice a week during three Terms.
   (3) General Anatomy and Physiology daily, except Saturday, during three Terms. Shall attend the course of Practical Physiology with Demonstrations twice a week during the October Term. Shall perform a second course of Dissections. And shall produce certificates of having—
   (i.) Attended during nine months the Medical Practice, in-patient and out-patient, of a Hospital recognized by the University of Melbourne, the certificate specifying instruction in the methods of examining medical patients.
   (ii.) Attended Post-mortem Demonstrations during six months.
7. The subjects of the Third Examination shall be—
   (1) Senior Descriptive and Surgical Anatomy,
   (2) General Anatomy and Physiology.

**DESCRIPTIVE AND SURGICAL ANATOMY—(Third Year)—**
The Bones including their Development and Growth; the Ligaments, Muscles, Vessels, Nerves, and Viscera.
Dissections.—Certificates will be given only to those students who shall have dissected the whole body.
Books recommended :
Morris' *Anatomy of the Joints*.

**SURGERY**—
Inflammation; Abscess; Ulceration; Mortification.
Diseases and Injuries of the Skin and its appendages; Effects of Heat and Cold; Wounds; Septic poisoning: Erysipelas; Pyemia; Hospital Gangrene. Animal Poisons. Syphilis.
Tetanus. Delirium Tremens. The employment of Antiseptics and Anaesthetics. Haemorrhage. Diseases of Arteries and Veins, of Muscles, Tendons, Joints and Bones. Fractures and Dislocations. Gun-shot wounds. Injuries and Diseases of the Head and Brain, the Face, the Eye, the Ear, the Nose, the Month and Gullet, the Larynx and Trachea, the Spine, the Thorax, and Abdomen; Hernia; Stone. Diseases of the Male and Female Organs, the Rectum, and Anus.
Surgical operations on the dead subject.
The following books are recommended :
*System of Surgery* edited by Holmes.
*Bryant's Practice of Surgery*.
*Enchsen's Science and Art of Surgery*.
*Smith and Walsham's Operative Surgery on the Dead Body*.

8. During the fourth year Candidates shall attend Lectures on—
   (1) Theory and Practice of Medicine thrice a week during three Terms.
   (2) Pathology thrice a week during three Terms.
   (3) Therapeutics, Dietetics, and Hygiene thrice a week during three Terms.
   (4) Obstetric Medicine and Diseases of Women and Children thrice a week during three Terms. And shall perform a third course of Dissections which shall have reference to Regional and Applied Anatomy. .

9. The subjects of the Fourth Examination shall be —
   (1) Regional and Applied Anatomy, with dissections and demonstrations by the Candidates.
   (2) Pathology.
   (3) Therapeutics, Dietetics, and Hygiene.

**THEORY AND PRACTICE OF MEDICINE—(Fourth Year)—**
Nature of Disease; Etiology; Semeiology; Manner of determining the Nature of Disease, or Methods of investigation; Different modes of its fatal termination.

Inflammation:—Its symptoms, nature, phenomena, theories, effects, or products; ultimate events; varieties; treatment. Doctrine of Change of Type in Disease.

Zymotic Diseases:—General characteristics; the Exanthemata; Continued, Intermittent, Remittent, and so-called Mucous Fevers.

Parasitic Diseases.

Special Diseases affecting the Blood, the Brain and Nervous System, the Organs of Circulation and of Respiration, the Alimentary Canal and Viscera of the Abdomen.

The following works are recommended as Text Books—
Aitken's Science and Practice of Medicine
Bennett's Principles and Practice of Medicine.
Watson's Lectures on the Principles and Practice of Medicine are also recommended for perusal.

PATHOLOGY—
The cell theory and the history of cells; the laws of healthy nutrition and growth; atrophy, gangrene, and death; degenerations and infiltrations; hypertrophy; tumours; congestions, active and passive; inflammation and its results; inflammation of the various tissues; fever; repair of injuries; scrofula and tubercle; phthisis; syphilis; thrombosis and embolism; septicemia and pyemia; dropsy; haemorrhage; specific diseases; the germ theory; parasites; diseases of special organs; the pathology of urine.

THERAPEUTICS, DIETETICS, AND HYGIENE—

Therapeutics—
General rules of treatment. Therapeutic meaning and requirements of the different functions and organs. The officinal drugs, their mode of action and uses. The more important non-official drugs, with their actions and uses. The therapeutics of air, climate, baths, mineral waters, massage, electricity, &c.

Prescription writing and selected prescriptions.

References:—
Mitchell Bruce's Materia Medica and Therapeutics.
Lauder Brunton's Pharmacology, Therapeutics, and Materia Medica.
Farquharson's Guide to Therapeutics.
Scoresby-Jackson's Note Book of Materia Medica.
Martindale and Westcott's The Extra Pharmacopoeia.
Wood's Therapeutics

Dietetics—
The Physiology of Digestion. The Alimentary Principles, their classification, chemical relations, assimilation, and dietetic uses. The Dietaries of infants, children, adults, and the aged. The therapeutic dietaries of temperament, acute and chronic disease, and convalescence. The position of beverages, stimulants, and peptonised foods.

References:—
Pavy's Treatise on Food and Dietetics.
Smith's Practical Dietary.
Hygiene—


Legal Hygiene.—The State and its relations to health. Duties of medical officers of health.

References:—
Parkes' Practical Hygiene.
Wilson's Handbook of Hygiene.
Pridgin Teale's Dangers to Health.
Husband's Forensic Medicine (portion styled "Medical Police."

10. During the fifth year Candidates shall attend Lectures on—
   (1) Theory and Practice of Medicine thrice a week during three Terms.
   (2) Surgery thrice a week during three Terms.
   (3) Forensic Medicine and the Outlines of Psychological Medicine thrice a week during three Terms.

11. The subjects of the Fifth Examination shall be—
   (1) Theory and Practice of Medicine.
   (2) Surgery.
   (3) Obstetric Medicine and Diseases of Women and Children.
   (4) Forensic Medicine and Psychological Medicine.

12. Candidates who have passed in these subjects will be required as part of this Examination to give proof of their practical knowledge of Medicine and Surgery—
   (1) By examining and prescribing for patients at the bedside.
   (2) By writing a brief history of at least one Medical and one Surgical case selected by the Examiners.
   (3) By performing Operations on the dead subject and by the application of surgical apparatus.

13. During the fifth year Candidates shall produce certificates that after completing the third year they have—
   (1) Attended during nine months the Surgical Practice of a Hospital recognized by the University of Melbourne, such attendance to include Clinical Instruction and Lectures on Clinical Surgery.
   (2) Attended in another year during nine months the Medical Practice of a Hospital recognized by the University of Melbourne, such attendance to include Clinical Instruction and Lectures on Clinical Medicine.
   (3) Acted as Surgical Dressers during six months of their Surgical Practice.
   (4) Attended demonstrations of Operative Surgery on the dead subject.
   (5) Acted as Medical Ward Clerks during six months of their Medical Practice.
   (6) Attended Post-mortem Demonstrations during six months.
   (7) Attended during three months the Midwifery Practice of a Lying-in Hospital, or attended apart from such practice twenty cases of Midwifery under the direction of a Registered Medical Practitioner.
(8) Acquired proficiency in Vaccination under the direction of a Public Vaccinator.

**THEORY AND PRACTICE OF MEDICINE—(Fifth Year)—**
Continuation of subjects remaining to be considered at termination of Fourth Year—the course occupying two years.

**OBSTETRIC MEDICINE AND DISEASES OF WOMEN AND CHILDREN—**
Anatomy of Female Pelvis; Anatomy of Unimpregnated Uterus and Ovaries; Utero Gestation; Signs of Pregnancy; Contents of Gravid Uterus; Mechanism of Labour; Natural Labour; Tederous, Difficult, and Abnormal Labours; Obstetric Operations; the various forms of Uterine Haemorrhage; Puerperal Fever; Puerperal Convulsions; Diseases peculiar to women; the diseases to which the newly-born Infant is liable.

**Class Books recommended :—**
- Playfair's or Irishman's *Midwifery.*
- West and Duncan, Edis, or Graily Hewitt on *Diseases of Women;*
- West, or Tanner and Meadows on *Diseases of Children.*
- Additional for Honours.
- Barnes' *Lectures on Obstetric Operations.*

**ANATOMY BY DISSECTIONS—**
At this examination students will have to dissect before the Board of Examiners and demonstrate any parts dissected by themselves or by other candidates.

Dissections.—Certificates will be given to those students only who shall Have minutely and skilfully dissected the whole body.

**FORENSIC MEDICINE—**

**Books**
- Taylor's *Principles and Practice of Medical Jurisprudence.*
- Beck's *Elements of Medical Jurisprudence,*
- Casper's *Handbook of Forensic Medicine.*
- Tidy's *Legal Medicine.*
- Maudsley's *Physiology of Mind.*
- Maudsley's *Pathology of Mind.*

14. In each of the five Examinations Candidates will be required to pass in all the subjects of such Examination within the same Term.
16. Candidates shall in addition to the written Examination, if any, be examined viva voce in the following subjects:—
   - Elementary Biology.
   - Descriptive and Surgical Anatomy, Junior and Senior.
Materia Medica, Medical Botany, and Elementary Therapeutics.
Physiological Chemistry and Histology.
General Anatomy and Physiology.
Pathology.
Obstetric Medicine and Diseases of Women and Children.
Practical Medicine and Practical Surgery.

And may at the discretion of the Board of Examiners be examined viva voce in any of the other subjects of examination.

16. Candidates who shall have passed all these Examinations, and complied with all these Regulations, may be admitted to the Degrees of Bachelor of Medicine and Bachelor of Surgery.

APPENDIX 2
Nursing School lecture program 1891 at the General Hospital, Launceston

**Dr Francis Drake: Lectures on General Physiology** “with demonstrations where practicable”
- The skeleton
- The joints
- The arteries and veins
- The position of the Thoracic and Abdominal Viscera
- The general and Distinctive Characters of Living Animals
- The Structural Composition of the Human Body
- Elementary tissues
- Muscular tissues
- The Blood
- The Circulation
- Respiration
- Animal heat
- Digestion and Absorption
- Secretion and Excretion
- The Nervous System

**Lectures on Minor Surgery**
- Arrest of haemorrhage
- Bandaging: triangular; roller; elastic
- Trusses
- Use of adhesive strapping
- Splints etc.
- Fractures
- Dressing of Wounds
- Prevention & treatment of bed-sores
- Certain emergencies
- Anaesthetics
- Surgical instruments

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157 *General Hospital, Launceston: Annual Report for the year 1891*, p.18.
Miss Milne lectured on Nursing, the subjects including:
Hospital etiquette
The Distinction between the work of Doctor and Nurse
Bed-making
The nursing of helpless patients
Preparation of dressings
Prevention of Infection
Various methods of administering drugs
Method of observing the symptoms of disease & manner of reporting same to Physician or Surgeon
Operations
Nursing of infectious cases
Ventilation, warmth & lighting of the Sick Room
The use of the clinical thermometer

The text books recommended for the Nursing program:
Christopher Heath, *Minor Surgery and Bandaging* [1880]
Walter Pye, *Elementary Bandaging* [and surgical dressing ..for house surgeons, dressers… 1880]
Florence Nightingale, *Notes on Nursing:*[what it is, and what it is not, 1859]
Edward Domville, *Manual for Hospital Nurses* [1885]
Arthur Brinckmann, *Notes on the Care of the Sick*, [1879]
Anderson, *Medical Nursing* [no information]
Eva Luckes, *Lectures on Nursing* [1884. Luckes was the Matron of the London Hospital 1880-1919]

158 Ibid. p. 18.
159 Christian name of author & date of publishing obtained via internet searches.
Mr Chairman and guests, as a medical student who started at the University of Melbourne Medical School in 1954 today's wonderful presentations have been a nostalgic trip for me. In my three student clinical years at Melbourne’s Alfred Hospital, the Women’s Hospital and the Children’s Hospital we were taught in the wards that we have been shown today; Florence Nightingale style wards in each of those old hospital buildings, long gone. There were 10 or 12 patients in a row of beds on each side of the main ward and the same numbers on each outside balcony, protected to a degree from the weather by louvred windows and flapping canvas blinds. Down the centre of the ward a row of steam radiators, each topped by a marble slab, provided a place where students could lounge at night, chatting up the night nurses and hoping they would take pity on us make us a cup of coffee or cocoa.

As one who detested history as a high school student and regarded it as a mere collecting of facts, often seemingly unrelated, and almost exclusively about imperial history, I have found myself drawn into a much greater appreciation of history, particularly through my association with Dr Tom Dunning’s Department of History and Classics at UTAS, and the Centre for Tasmanian Historical Studies, which he chairs, and through attending and contributing to the Australian Historical Association annual conferences. I have come to realise that history is about relationships, motives, means and consequences, and today’s presentations have illustrated that perfectly. Each speaker has delved into the reasons why each character took certain actions, their motives and the outcomes which resulted and has brought to life the character of those they were speaking about. This has been history at its most interesting and best.

Please join with me in thanking the three speakers, Paul Richards, Deanna Ellis and Dan Huon for their presentations.

Two other people deserve our recognition and thanks. Firstly Dr John Morris, chair of the Launceston General Hospital Historical Committee which is the driving force behind these historical activities and secondly the Honorary Secretary of that committee, Mr Paul Richards, who organised today’s seminar and has drawn together a most remarkable program for the celebration of this hospital’s 150th birthday, in May next year, an event which Launceston can really look forward to. Please thank them both.

Dr John Paull
Member,
LGH Historical Committee.
SPEAKER PROFILES

Paul A.C. Richards

Paul was born in Sydney in 1945. He was educated at the Launceston Church Grammar School 1949 – 1962 and gained his tertiary education in the field of Nuclear Medicine Science and Radiotherapy at the Royal Melbourne Institute of Technology, Peter MacCallum Cancer Institute and Johns Hopkins University in Maryland, USA. He took postgraduate studies in Business, Practice Management, Agricultural Science at the University of Tasmania and New England University and Visual Arts & Design at the Polytechnic and holds a Master of Science degree in Radiological Sciences.

Paul was a Rotary Fellow in 1972 and Sir Robert Menzies Scholar in 1978.

He is recognised as a medical historian and author of numerous peer reviewed scientific and historical articles. He is a foundation member of the Launceston General Hospital’s Historical Committee established in 1988.

In 1997 he had accepted an academic post at Charles Sturt University establishing a Bachelors and Masters degree in Nuclear Medicine Science where he was Senior Lecturer and Course Coordinator. He returned to Launceston in 2001 from New South Wales and has since that time authored several historical books and publications. Today in retirement he continues as a tutor in Radiological Sciences at Sydney University, researching iodine deficiency and exhibiting art works in Tasmania.

Paul’s talk today centres on Dr William Prout Holman, Radiologist/Thespian and graduate of Melbourne Universities Medical School from which so many great personalities have graced the corridors of the Launceston General Hospital- Drake/Pardy/Ramsay/Craig/Grove and many others that followed them.

Mrs Deanna Ellis

Deanna commenced her nurse training at the Launceston General Hospital in October 1959 graduating in the 100 year celebration Graduation Ceremony in 1963.

On completion of her training Deanna remained at the LGH working across a range of practice settings, Ward D, Specialist Clinics and as Pathology Sister.

In 1964 she worked for two year as a Registered Nurse in a General Practice.

In 1968 to 1970 Deanna returned to the LGH undertaking part time relief work as Pathology Sister and also as registered nurse in the Angiography Unit.
In July 1970 Deanna returned to permanent work as a Clinical Teacher and in 1972 as Tutor Sister at the LGH Nurses Instruction School.

Deanna gained a Diploma in Nurse Education and remained in a teaching role with the Department of Nurse Education seeing the end of general nurse training in 1990 and enrolled nurse training in 1992. During this time she held positions as tutor sister/nurse education, Assistant Director of Nursing Education and Manager of Nurse Education.

Deanna remained in a teaching role in the LGH Nursing Staff Development unit and over time till her retirement in 2010 saw the unit change and evolve to include staff development for general staff as well as nursing staff with the implementation of a range of generic programs.

With structural changes the LGH staff development unit evolved to become the Regional Staff Development Unit – North encompassing all nursing and general staff in the northern region.

The unit gained National Accreditation as a Training Organization, delivering a range of nationally recognized health related programs for nursing and non nursing staff including enrolment to these programs and courses for the private sector and general practice areas.

Eventually the unit became a state wide unit however with further restructuring the unit ceased to function in the late 1990’s.

Deanna returned to the LGH as Staff Development Manager and in 2000 gained a position as Staff Development Nurse for the Chief Nursing Officer, a statewide role that saw her coordinate Re Entry to Practice and Refresher Programs for Registered and Enrolled Nurses, Medication Endorsement Program for Enrolled Nurses and Graduate Nurse Transition to Practice Programs for newly graduated registered nurses.

Dr Dan Huon

Dan Huon was born in Launceston, but grew up on farms at Forth and the East Tamar attending school at Forth primary, and Launceston High School. Dan studied a BA at Utas with honours and on graduation was conscripted into the Australian Army by lottery in 1965. He graduated from Officer Training School at Scheyville, NSW in 1967.

Dan completed his PhD at ANU in history on Australia during the Great War 1914-18 in 1974. He was then a Research Fellow on Professor NG Butlin’s interdisciplinary Botany Bay Project investigating Sydney’s pollution control & environmental management from 1974-78 returning to ANU’s Department of Economic History from1978-82. Dan was the author of Sydney’s Environmental History 1851-1981.
Dan joined the Department of Humanities at the TSIT and University of Tasmania at Launceston 1990-1998 and with Dr Tom Dunning founded the History Honours course at the Launceston campus in 1993.

From 1999 to 2012 in the Tasmanian Department of Health at the Respite Unit, Disability Services and currently in administration, Department of Anaesthesia at the Launceston General Hospital.

Dan is a past president of the Launceston Historical Society.

STATISTICS

Historical Symposium Attendance 22

ADDRESSES OF CONTRIBUTORS

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Sir John Ramsay Library
Level 2, LGH
PREVIOUS PUBLICATIONS

VOLUME 1

Historical Symposium 1994

Dr Anthea Hyslop  'Writing The History of a Hospital'
Dr Phillip Ogden  'Historical Account of Anaesthetics in Launceston or the Story of Ether'

VOLUME 2

Centenary Celebrations

Celebrating the Centenary of the Discovery of X-rays
1895-1995

Mr Paul A.C. Richards
Dr W.P. Burden
Dr Stan Gauden

VOLUME 3

Centenary Celebrations

Celebrating the Centenary of Nurses' Home 1
1897-1997

Mrs Mary Simons
Miss Berenice Parker
Mrs Win Killworth
Mrs Deanna Ellis
Ms Clarisa Young
Mrs Ruby Wells
Mrs Marjorie Gardner
Miss Joan Woolley / Mrs Ida Atkins

VOLUME 4

Centenary Celebrations

Celebrating the Centenary of the Queen Victoria Hospital
1897-1997

Dr L. Hardy Wilson
Mrs Barbara Ruttelle
Mrs Barbara Payne
Dr John Grove Jnr
Miss Joan Woolley read by Mrs Mary Harper
Mr Albert Huizing
Miss Jenny Gill
Mrs Elaine Smallbane
Prof Bruce Dunphy
VOLUME 5

William Barnes
(1832 - 1898)
and
The Gift of the Cataract Gorge Reserve

Mr Paul A.C. Richards
Mrs Ruth Burrows
Mrs Lynn Blackwood
Mrs Mary Cameron
Mr Tim Kingston
Mr Rod Sweetnam

VOLUME 6

Master Surgeons
October 2002

Paul A.C. Richards
Sir John Ramsay: Launceston General Hospital
Dr John C.H. Morris
Clifford Craig: A Man for All Seasons
Mr Alan Scott
Max Clemons

VOLUME 7

Public Health Issues
February 2005

History of Senile Dementia
Dr Anthea Vreugdenhil
History of Iodine Deficiency in Tasmania
Paul A.C. Richards
History of Hydatid Disease in Tasmania
Joe Bramble

VOLUME 8

Medical Men and Apothecaries

History of Pharmacy
Patrick Keefe
My Pharmacist Family: The Browne’s
Mr Bevan Warland-Browne
Saint or Sinner R.J.D “Spot” Turnbull
Dr Frank Madill

VOLUME 9

Popourri - Launceston Medical History
July 2005

The Evolution of Hospitals & Caring for the Sick
Assoc Prof Berni Einoder
Two Colonial Surgeons: Messrs Jacob Mountgarrett and John Smith
Mrs Anne Bartlett
Pestilence & Disease: The Last Polio Epidemic
Dr Sheryl Brennan
Politics in Medicine
Assoc Prof Berni Einoder
VOLUME 10
A Mixed Bag of Medical History
November 2005

Convict Health
*Dr Hamish Maxwell- Stewart*
Smallpox & Launceston
*Dr Murray Johnson*
Looking behind the Pugh
*Dr John Paull*

VOLUME 11
Commemorating the Community
$10
March 2012

Mr Paul A.C. Richards
Mr John Addison
Dr Dan Huon
Mrs Louise James

VOLUME 12
Historical figures and their impact on medicine in Launceston
October 2012

Mr Paul A.C. Richards
*Dr William Prout Holman- Radiologist Thespian*
Mrs Deanna Ellis
*Miss Jeanette Milne- Lady Superintendent*
Dr Dan Huon
*Dr Francis Drake – Surgeon Superintendent*

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