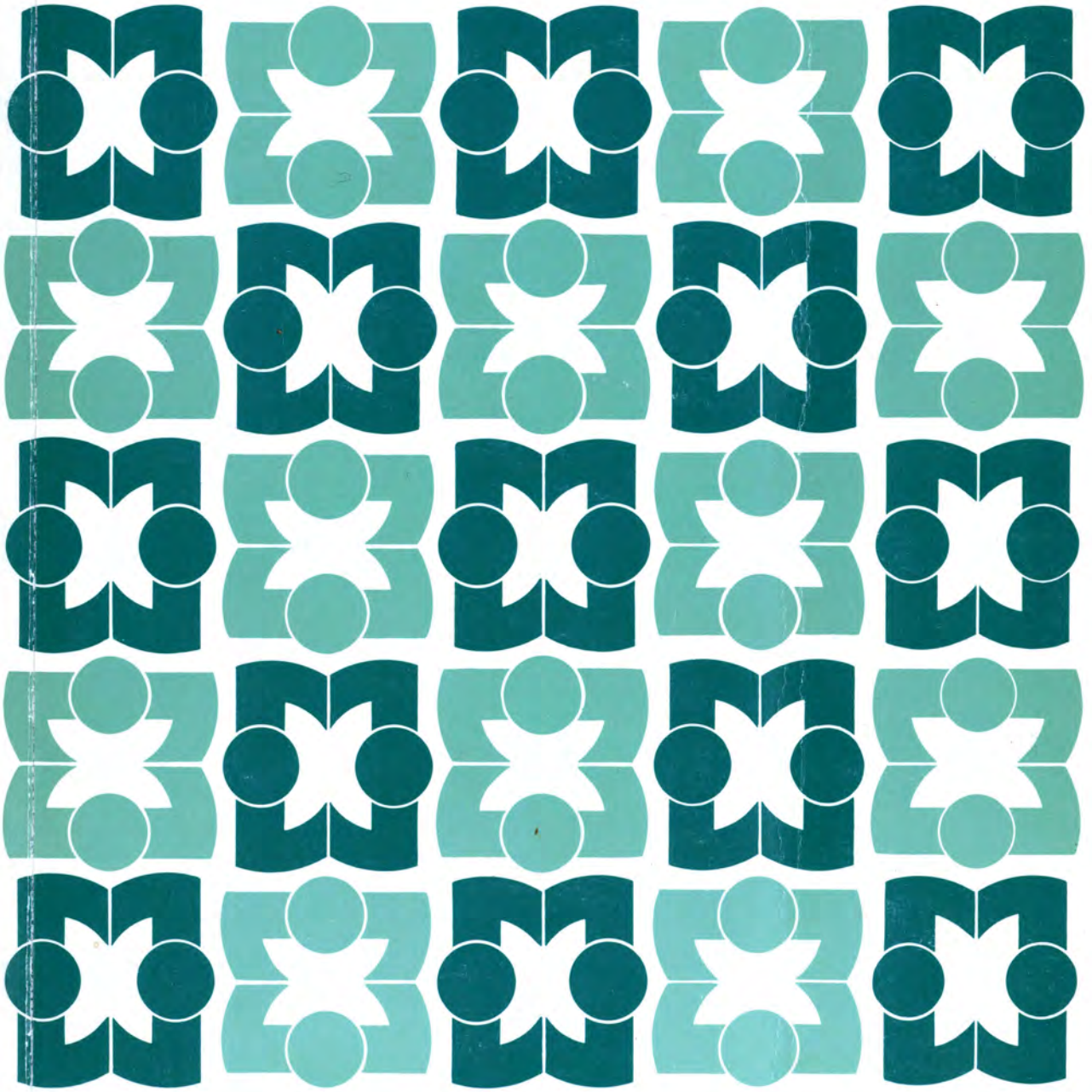
ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report
Volume 2



ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report
Volume 2

Contents of the report

Introduction, summary and recommendations	Part I in Volume 1
Education for human relationships	Part II in Volume 2
Health and medical education	Part III in Volume 2
Sexuality and fertility	Part IV in Volume 3
The family	Part V in Volume 4
Equality and discrimination	Part VI in Volume 5
Rape and other sexual offences	Part VII in Volume 5

ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report
Volume 2

Part II
Education for human relationships
Part III
Health and medical education

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ROYAL COMMISSION
ON HUMAN RELATIONSHIPS

100 William Street
Sydney
21 November 1977

Your Excellency,
In accordance with Letters Patent, dated 21 August 1974, we have the honour to present to you the Final Report of the Royal Commission on Human Relationships, prepared as at April 1977.

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Anne Deveson

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Contents

II. Education for human relationships

1. **Introduction** 1
   - The learning process 2
   - Early learning experiences 2
   - Formal education 2
   - The role of government 3
   - The Commission's evidence 5
   - Overseas experience 6
   - The family as educator 6

2. **Programs for parents** 10
   - Needed developments 11
     - Conclusions 14

3. **The role of the media** 15

4. **The role of the school** 18
   - Criticisms of the school system 18
     - Discipline and punishment 18
   - Rigidity or freedom 20
     - Conclusions 21
   - The aim and scope of human relationships programs 21
   - Controversial issues 24
   - Selection and training of teachers 27
     - Conclusions 30
   - Communication within the teaching profession 30
     - Conclusions 31

5. **Present education programs** 32
   - The training of teachers presently employed 33
   - Teacher education preferences 34
   - Resources 34
   - Voluntary associations 34
     - Conclusions 36
   - The effectiveness of present education programs 36
     - Conclusions 38

6. **Social sexual behaviour: implications for education** 39
   - Sources of sexual knowledge 40
     - Conclusions 43
   - Early sexual activity and its risks 43
   - Scope and content of programs of education for human relationships 45
     - Sex roles 47
   - Social sexual relationships in adolescence 48
     - Communication skills 50
     - Parenthood 51
     - Conclusions 51
   - An open approach 52
   - What young people in schools say about the issues 53
     - Conclusions 55
   - Resources 56
     - Conclusion 56

7. **Implementation of programs at the various levels of education** 57
   - The young child: primary school 57
     - Parental involvement and the right to withdraw 57
   - Tertiary education and further training 58
     - Conclusions 59

8. **Learning beyond formal education** 60
   - Where does education end? 60
   - Education for living 60
   - Adult education 61
     - Conclusion 64
   - Preparation for marriage 65
     - The need 65
   - Who should provide education for marriage? 66
     - Who should attend? 68
     - Goals 68
       - Intercultural marriage 69
     - How should it be taught? 70
       - Professional training 70
     - Conclusions 70
   - Counselling 72
     - School counselling 73
     - Other counselling services 73

9. **General conclusions** 74

Recommendations 75

Annexe II.A Summary of proposed guidelines for sex education in the Swedish school system 78

Annexe II.B Statement on behalf of the 'School without walls', ACT 86

Annexe II.C Examples of resource materials used in human relationships education 87

III. Health and medical education

1. **Introduction** 91

2. **Australian health, health services and personnel** 95
Introduction 95
Measures of health and resulting patterns 95
Conclusions 104
Approaches to health care 105
Research and information 106
Support services in community health 108
Health services for women, infants, schoolchildren 110
Health care personnel 112
Women in the health workforce 113

3. **Human relationships issues for medical practice** 122
Introduction 122
Problems in the doctor–patient relationship 123
Women 125
Cultural differences 127
Migrants 127
Aboriginals 129
The doctor's role in human relationships 130
Violence in relationships: the doctor's role 133
Sexuality and medical practice 135
Conclusion 138
Medical education and fertility control 139
Pregnancy and childbirth: medical attitudes 141
The doctor and sexual variations 143
Conclusion 144
Mental illness and community health 144
Conclusion 146
Medical practice and drug dependency 147
Conclusion 148
The health care of the handicapped 148
Conclusion 150
Children in hospital 150
Institutional care 150
Conclusion 151
The medical profession and death 151

4. **Undergraduate medical education** 154
Human sexuality 154
Fertility control 159
Community and social health 162
Conclusion 166

5. **Post-graduate and continuing medical education** 168
Introduction 168
Post-graduate medical education 169
The Colleges and post-graduate education 169
Interdisciplinary post-graduate education 171
Short courses in post-graduate education 172

6. **Medical students** 176
Characteristics of medical students: social background and some attitudes 182
Attitude changes during medical school 183
Conclusion 185

Recommendations 186

Annexe III.A Commission research report, no. 1, Medical education, survey questionnaire, 1976; ANU Survey Research Centre, technical report 188

Annexe III.B Summary of courses in sexuality in Australian medical schools 207

1. Introduction

1. Education has been a major concern throughout our inquiry. Our brief required us to look at:

> . . . the extent of relevant existing education programs, including sex education programs, and their effectiveness in promoting responsible sexual behaviour and providing a sound basis in the fundamentals of male and female relationships in the Australian social environment.

2. We have noted many signs of technological and social change that are a feature of modern western society, such as rapid urbanisation, improved methods of contraception, automation and cybernation. There is a 'knowledge explosion', which has had the effect of drawing into question or making obsolescent many old beliefs and norms. Our store of knowledge is estimated to be doubling every 10 years and the rate of increase is accelerating with the consequence that each succeeding generation learns about areas unknown to its parents and grandparents.

3. These changes include a marked increase of women in the workforce, and a program of immigration that has altered the composition of our society. Today, over one million Australians do not regard English as their mother tongue, and one in four Australians was born of non-Australian parents.

4. We need to think of education as a continuing process for people of all ages regardless of their formal educational attainment. Above all, we need to find education programs which are appropriate to rapid social change. We are faced by a new society in search of new conventions and values which will provide a framework within which we can live. It was suggested to the Commission by a Sydney doctor that:

> . . . we all are falling short of our creative and productive potential.
>
> We are now living in a world facing problems demanding every bit of creativity and intelligence we can muster. The nation's human talents are our most critical resource. We can no longer afford to allow them to remain underdeveloped.[1]

5. Our task has been to evaluate sex education programs to assess whether they provide a sound basis in the fundamentals of male and female relationships. Evaluation cannot be confined to formal education programs in isolation from other influences which affect the developing awareness of young people; it has therefore been our task also to examine family and media influences.

6. It might be thought that education in human relationships is a contradiction in terms, since knowledge of human relationships is learnt from experience rather than from formal education programs. While experience is a teacher, the lesson learnt from it is not always a happy one, and it may be long in the learning. Throughout this part of the report we use the term *human relationships education* to include not only sex education and health education but all the wider aspects of human relationships and personal development.

7. Many of our submissions expressed a general anxiety that young people are being inadequately prepared for the challenges of modern life. For example, an Adelaide father told us:

> Our lives are moulded in the early years. Yet in almost half a century I have waited in vain to see an education system that prepares children on how *to live* properly. Sure enough we teach them how to earn a living but not how to live.[2]

1. Submission 827, Dr Robert Pigott.
2. Submission 191, Mr Max Costello.

8. We are nevertheless convinced that people can be taught and can learn about behaviour, thus being helped to understand both themselves and others, and also to appreciate the attitudes and values, religious, moral and social, which affect such relationships and behaviour.

The learning process

9. The behavioural and biological sciences are agreed that learning is a lifelong and complex process, limited by basic genetic endowment (nature) and influenced by the social, economic and physical environment (nurture) of the individual, especially in early childhood. There is no agreement on the relative contribution of each. Important institutions embody society's history and values—family, school, education systems, work, social networks, government and the church; each in its organisation, customs and attitudes offers a continuous learning experience. Together they provide a totality of influences constantly changing throughout life. The significant learning institutions of childhood are the family and the school. The media, especially television, are also a significant influence on the development of children.

Early learning experiences

10. The family is the first educator of children in establishing models of behaviour and values as well as through the experiences it affords the learner. Individuals learn through the giving or withholding of love and approval, by reward and punishment, by observing, hearing and experiencing the resolution of conflict and by the giving or withholding of physical care and service. Children learn the use of language according to the models which parents and the immediate family circle provide. Through observing behaviour and gesture and through listening, they learn what is the behaviour expected of parents, children, males and females.

11. Early childhood learning is seen as vital to mental health for the rest of life. Unhappy childhood experience may contribute to later dysfunctional behaviour.

Formal education

12. The traditional role of formal educational institutions has been to transmit group culture, including its religious, social and artistic values, and to develop competence through literacy, numeracy and marketable skills. It has had a conservative tendency. Some basic assumptions have been that:

(a) education can modify skills, attitudes and behaviour for good or ill;
(b) education can influence the future of individuals and society;
(c) the family and church are the natural educators of children in the formation of attitudes and values.

On the basis of these assumptions, society met the cost of education budgets for their children's education. Programs were developed and certain subjects were excluded from the secular school which concentrated on the delivery of formal instruction. There was little attention given to examining or questioning social attitudes and values.

13. Evidence to the Commission suggests that many people now consider that the education system could play a more positive role in shaping attitudes, values and social behaviour, provided that the school evolves a more friendly climate.

The role of government

14. The trend in educational thought is to see governments as overall planners, sponsors of research, developers of guidelines, sponsors of new structures, collectors and providers of funds.

15. Government policies reflect this trend. They demonstrate the consensus of informed educational opinion, in favour of the devolution of control to the local educational institution and community, the classroom teacher and the parents, within the broader national and State co-ordination of planning and funding.

16. Recent Commonwealth and State government publications reflect overseas opinion in rejecting uniformity, promoting equality of education and opportunity, and encouraging diversity.

17. Thus the Karmel Committee report of the Australian Schools Commission of 1973 reads:

> The Committee favours less rather than more centralised control over the operations of the schools. Responsibility should be developed as far as possible upon the people involved in the actual task of schooling, in consultation with the parents of the pupils they teach and at senior levels with the students themselves . . . The role of the Australian government . . . is supplementary to that of the States, but its national responsibility may become increasingly important in ensuring an adequate level of resources and their equitable spread . . . The Committee values the principle that the standard of schooling a child receives should not depend on what his parents are able or willing to contribute directly to it . . . No single pattern is best; diversified forms of schooling are an important part of the search for solutions.[3]

18. Similarly in New South Wales in 1973 a committee of representative academics, administrators and teachers from both public and private school systems published a document entitled *Aims of secondary education in New South Wales.* After consultation with 166 individuals and groups covering the whole spectrum of education, the committee reported:

> As matters such as skills, attitudes and methods of thinking underlying a subject have been given new prominence in subject after subject, the boundaries between subjects have become less definite than in the past. This has given rise to fresh consideration of the curriculum as a whole and to the various ways in which individual school subjects or areas of experience and study may fit into the total pattern of a school program.[4]

19. The underlying assumption is that the role of government is to facilitate and guide, rather than to prescribe. Both reports accept that it is the government's responsibility to promote equality and individual development, but place responsibility for implementation on schools, on teachers in collaboration with parents, rather than on a central or government authority. Both documents suggest central funding, planning of buildings, planning and co-ordination of educational services as the role and function of government in education.

20. The trend of educational opinion is to develop a form of professional autonomy, similar to that long enjoyed by universities. This is already happening in colleges of advanced education, adult education colleges and in some independent school systems.

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3. Interim Committee for the Australian Schools Commission, 1973, *Schools in Australia* (AGPS, Canberra, 1973), pp. 10–11.
4. NSW Department of Education, Directorate of Studies, *Aims of secondary education in New South Wales* (1973).

21. The professionals at the local level are often better placed to assess the specific educational needs of their district and to develop appropriate programs; in so doing they extend their professional skills. Less responsibility and supervising expense are required of the central planning authority.

22. The educational structure in Australia now reflects these concepts. The government has set up various statutory bodies such as the Schools Commission, the Universities Commission and the Technical and Further Education Commission to oversee Australian education and provide funds for all tertiary institutions and assist State institutions. Further it has established central bodies such as the Curriculum Development Centre whose function is to develop curriculum research and the necessary aids. State school systems are being regionalised and teachers are gaining greater responsibility in the classroom. The recently constituted school systems of the ACT and the Northern Territory were designed to provide local communities with systems suited to their needs, and they will develop the professional skills of teachers.

23. At the school and classroom level, some teachers are already taking advantage of the opportunities offered; others have been slow or reluctant to do so, unprepared for the new tasks they feel inadequate to tackle.

24. R. T. Fitzgerald, in a study for the Australian Council for Educational Research (1976), remarked on the constraints on the Victorian school system:

> Though Victorian secondary schools are now, especially since the late 1960s, allowed a greater degree of autonomy than previously, their scope for action is limited by several external forces. These may be categorised as social, bureaucratic and professional in nature. Thus, both the general public and those living in the immediate neighbourhood have definite socially determined expectations of the schools and to these teachers respond in various ways. They also respond to the State-wide bureaucratically organised system of rewards and sanctions which is shaped and maintained jointly by agencies at the centre. In this respect the education department holds only limited influence since it must negotiate with teachers unions, both through the teachers tribunal which decides salaries and conditions, and outside it in direct confrontations. The schools are, therefore, subject to uniform schemes of staffing and promotion. In the professional sphere the curricula and teaching methods of the high schools are affected by the policies followed by the State examinations authority . . .
>
> Moreover, political constraints arising out of direct government control of the public school system remain strong. So long as the Minister for Education is responsible for the day-to-day operation of the schools, an outbreak of controversy or conflict will usually oblige head office to intervene. Such a procedure may amount literally to using a sledge hammer to crack a nut. Yet the general effect is to deter school principals from taking decisions concerning the educational direction of their schools which might cause conflict, and persuade them to follow safe courses and procedures.[5]

25. Parallel to the government systems are the Catholic education system and the independent schools. Liaison exists at local and national levels, though only the Roman Catholic Church is involved directly in tertiary education and then mainly through its teacher training colleges.

26. The role of the Commonwealth government includes:

(a) acting as a 'clearing house' or a source of information about current programs in Australia and overseas;

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5. R. T. Fitzgerald, D. W. Pettit, P. W. Musgrave, E. Ward, *Participation in schools: five case studies* (Australian Council for Educational Research, Series No. 98, Melbourne, 1976), pp. 42–4.

(b) stimulating and providing resources for research aimed at defining the objectives of particular education programs in the light of the needs of young people and of community values;
(c) researching and assessing particular education programs;
(d) assisting in the development of curricula and resource material;
(e) the funding or part funding of any of the above.

A potential role exists for co-ordinating the health education programs of the Department of Health with the various levels of education.

The Commission's evidence

27. Education ranked high in the subject matters raised in evidence to the Commission, including sex education, education for human relationships and family life, the roles of the family and school, the selection and training of teachers, the school as a model of human relationships and research.

28. Many people feel that family life is threatened and is in need of social and economic supports. In support of their views, they referred to a mounting divorce rate, increased ex-nuptial births, the tendency for married women to work and place their children in child care, increasing rates of VD, increased production of pornographic material, earlier and more adolescent sexual activity and more violence against the person. These and other reasons lead to widespread support for the proposition that young people should learn responsible attitudes and behaviour and that positive steps are needed to give them effective education in human relationships. Differences of view emerged about the form and content of this education and responsibility for it. It was proposed to the Commission that:

> . . . an advisory committee be set up, as a matter of urgency, which will co-operate with appropriate people and organisations in devising and introducing an 'Education for living' program for schools.[6]

29. Many thought that parents should be or are the 'natural' educators of their children in forming values and attitudes and determining sex roles and sexuality, but that many needed suitable education themselves.

30. There was considerable support for the view that any education in human relatonships program should involve parents. Many said that if parental attitudes were not in harmony with the school, any programs the school might attempt would probably fail.

31. Some opposed sex education in school because they saw it as the sole prerogative of parents, or because it might lead to sexual experimentation and promiscuity. Others supported education for human relationships and gave their views on the content of programs, on the results they expected from parents and pupils education, and on financial and material support for such programs.

32. Many in favour of formal education in human relationships qualified their support—questioning the ability, maturity and ethical values of teachers, the adequacy of their training and the authoritarian structure of the school.

33. A few saw doctors as the appropriate educator in sexual matters. Some thought voluntary organisations should be responsible for setting up education programs, or saw them as continuing participants in sex education.

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6. Submission 827, Dr Robert Pigott.

34. Many, on the other hand, saw the family and the school as providing, through their customs and structures, models of behaviour that were anachronistic; they provided learning situations which were self-defeating.

Overseas experience

35. We were able to make some study of overseas experience through our reading. An International Planned Parenthood Federation report on the status of sex education in European member countries shows wide differences in the extent to which sex education is provided in European countries.[7] We have also studied an impressive paper *Proposed guidelines for sex education in the Swedish school system.*[8] We have summarised in Annexe II.A aspects of the report with which we are in agreement.

The family as educator

36. People from a wide variety of backgrounds believe that the family is the primary educator in human relationships through the models of behaviour and experiences it affords to children. The quality of childhood experience, when learning is most rapid, was seen as crucial to later adult ability in personal relationships.

37. Opinion was divided on the quality of the learning experience in the family. While some were emphatic that parents should be the sole educators in family roles and sexuality, others realised that some families were unable, unwilling or unfit to do so. Therefore many witnesses and submissions urged that parents should receive education in child development, and in parental skills.

38. The view that parents should be the sole educators of their children in matters of sexuality tended to be brief and emphatic. A Queensland woman wrote:

> Sex education of the children is a very personal matter and should be left to individuals. It is not a government matter.[9]

A mother from Condoblin wrote:

> Sex education belongs in the home. What is so good about an embarrassed 20-year-old, with many varied sexual experiences, but no experience of love, teaching children the mechanical aspects of sex.[10]

A father wrote:

> Sex education belongs in the home and not in the school; kids will practise what is preached.[11]

39. The view urging support for the parent in sex education was put by both expert and community groups. While stressing the parental role they yet reflect a widespread community unease about the competence of some parents and lack of confidence in others.

40. The National Council of Women (NSW) wrote that responsible parents rear their children in an environment to promote total health, one which:

> . . . not only has to meet all the child's immediate needs but sets a standard of behaviour, health measures and personal relationships that set a pattern of living for the child's lifetime.[12]

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7. *A survey on the status of sex education in European member countries* (International Planned Parenthood Federation, London, 1975).
8. A summary of the recommendations contained in the official report of the Swedish State Commission on Sex Education, Stockholm, 1974.
9. Submission 88, Miss Marie Ferguson.
10. Submission 913, M. Peters.
11. Submission 932, W. S. MacPherson.
12. Submission 460, NCW (NSW).

41. The Christian Television Association Womens Auxiliary said:

> The ideal place for a child to learn about his sexual nature is in the home, where parents can best gauge the time and way to do this. However, many parents feel quite inadequate in this matter, so that whether or not sex education is made part of the school curriculum, education for parents on this subject would be of real value.[13]

42. Another submission said:

> . . . parents contribute by their attitudes to each other in front of their children—affectionate or not, and verbally by readily answering questions without evasion or delay.[14]

43. A Catholic mother of five from NSW spoke of the qualities of a home where the children are set on the right path, with the right attitudes to male-female relationships. She felt parents needed support through education to play their roles.[15] St Joan's International Alliance (Qld) supported this view in a paper they submitted, which stated:

> Sex education rightly belongs within the family itself, but taking into account the climate of insecurity and lack of confidence and not knowing how, and feeling left out and feeling not quite as good education-wise as their children, many parents are very reluctant or very hesitant to bring up topics of this nature.

Hence, they recommend parent education, beginning when children are of pre-school age, so that parents become 'the confidantes and the advisers within a relationship of warmth'.[16]

44. The Australian Festival of Light (SA) questioned the value of human relationships education in schools and suggested:

> . . . that children can be taught individually by informed parents who understand their natures and needs. We recognise, however, that in many homes sex education is not done well. We therefore suggest that parents be given sex education and help in passing it on to their children.[17]

A Canberra mother of four children believes family life and sex education is:

> . . . the prerogative of parents but if the parents abdicate their role, then the state has to intervene today . . . it is the parents who need education.[18]

45. The National Catholic Education Commission wrote:

> The home is decisively important in establishing the basis of sex education, which at one level is largely completed before a child goes to school. In the home, the child first perceives, identifies with, and interiorises the roles of man or woman, of father or mother . . . In the home the child perceives (or fails to perceive) love given and love received . . . It follows that any help given to parents to support and perfect their relationships, and to understand the way children interiorise male and female roles, is an important contribution to effective sex education.[19]

46. Dr Jules Black, a Sydney gynaecologist, wrote of the problems (due to ignorance) seen in his clinical work.

> Every single patient I have seen . . . vows that it will be different for their own children. However admirable this may seem, in the absence of resource information these parents may still find the task difficult.[20]

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13. Submission 291, Christian Television Assoc., Womens Auxiliary.
14. Submission C49, confidential.
15. Submission 243, Mrs Robin Filpczyk.
16. Submission 402, St Joan's International Alliance (Qld).
17. Submission 413, Aust. FOL (SA branch).
18. Submission 318, Mrs Pat Jenkins.
19. Submission 816, National Catholic Education Commission.
20. Submission 29, Dr Jules S. Black.

The National Council of Women, ACT, wrote:

> The family is of prime importance in the preparation of children for adolescence and adulthood, and it could be considered that any education in human relationships . . . would be more successful if both parents and the community could be involved with teachers.[21]

Similar views were expressed by the national Catholic Social Welfare Commission[22], the Baptist Union of NSW[23] and the South Australian Medical Womens Society.[24]

47. A Canberra nurse stated:

> I realise that the coping with life techniques and responses has been largely left as the responsibility of parents to date, but nowadays . . . the teenager is neither given the time nor attention he requires in order to discuss his future.

She went on to criticise the models some parents present to their children:

> Their [the children's] sexual education, both biological and emotional, has been entirely overlooked; affiliation relationships and communication with others is a complete enigma to them . . . contraception and the venereal diseases still remain unmentionables in some households.[25]

48. Dr Ron Farmer, a clinical psychologist, wrote:

> In my opinion those who are concerned with sex education should downgrade the possible role of sex eduation in the school and turn their attention to the education of parents.[26]

49. These extracts indicate considerable disquiet about the competence of some parents in matters fundamental to their children's mental health and future happiness.

50. One submission, from a Sydney paediatrician, was particularly concerned with the lack of education for parenthood of young people today and the effects this could have on the next generation:

> There is no need (I am sure) to stress to the Commission the effect of altered social circumstances and the absence of extended families on the attitudes and behaviour of young people embarking on their first pregnancy. The Commission must surely be aware that these young people do not have a firmly established experience in child rearing and go into parenthood with tremendous fear, doubt, guilt, and other problems.[27]

51. One of the Commission's research studies, which explored decisions surrounding family formation, revealed that for many couples the advent of the first child was a worrying and, at times, frightening experience because they were totally unprepared for parenthood. Of the sixty couples who were interviewed, not one regretted having had a child, but many of the women talked about feeling 'they hadn't been warned' and 'they couldn't cope'.[28]

52. The main points made in the submissions are:

(a) the parental role is of primary importance as it sets a pattern of relationships, attitudes and beliefs for the child;

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21. Submission 565, NCW (ACT).
22. Submission 992, Australian Catholic Social Welfare Commission.
23. Submission 571, Baptist Union of NSW.
24. Submission 143, SA Medical Womens Society.
25. Submission 1199, Miss N. Edwards.
26. Submission 433, Dr Ron Farmer.
27. Submission 52, Dr Michael James Harris.
28. Lyn Richards, Having families, Commission research report, no. 14, 1976, ch.10.

(b) many parents lack knowledge and confidence and the necessary skills and some provide inadequate or inappropriate models;

(c) not all parents are willing to exercise their role;

(d) help is needed for parents to improve their own relationships, to understand how their children learn about sex and their roles and relationships;

(e) the absence of readily available resource material makes the parental task difficult;

(f) the education of parents should be a priority.

We agree with these points. We believe that it is futile to argue about ascendancy between home and school; they are complementary.

2. Programs for parents

1. Such parent education as at present exists is done by State health departments, voluntary associations such as the Family Life Education Movement, Mental Health Associations, Marriage Guidance Councils, adult education organisations and church education departments.

2. The programs tend to be fragmented, uncoordinated and concentrated in the major cities and towns. No statistics are available as to how many mothers or parents make contact with health department programs.[1] Statistics from baby health centres where mothers can obtain guidance on behavioural matters do not distinguish between new mothers, later contacts or length of association with the centre.[2]

3. The annual reports of organisations do not give us much more information. Their financial statements, however, indicate their slender resources and suggest that their programs of parent education reach few people.

4. The balance sheet of the Canberra Marriage Guidance Council[3] shows that only $2380 was spent on family life education for the year ended 30 June 1974. One State health education officer[4] estimates that in his State very few groups—a dozen or so—would provide a systematic course on parenthood in any one year. He estimated that approximately 1500 people would participate.

5. Another health educator[5] said that in the Western Metropolitan Region the NSW Health Commission has just begun parent effectiveness training (PET)[6] (as was recommended by others[7] to this Commission), and that it is hoped to extend this work if the program adapts well.

6. Discussions with these officers indicate that it is difficult to motivate parents to attend parent education groups. To attend requires an act of will on the parents' part, and those motivated will usually be those aware of their deficiencies.

7. Government agencies state that it is difficult to provide programs at times when the parents are not working and to obtain professionals who will undertake this work, if it frequently requires them to be away from home during the evening. Voluntary agencies have less difficulty here.

8. The Health Education Council of Western Australia[8] has community-based health education programs, which in some cases include child rearing and child development. They depend on local initiatives for their content. These programs provide a model for parents' involvement in their own development; they are based on a view of public health which is both preventive and developmental.

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1. Discussion, Senior Research Officer in health education, NSW Health Commission, 10 November 1976.
2. ABS, *Year book of Australia,* No. 60 (1974).
3. Submission 949, Canberra Marriage Guidance Council.
4. Discussion, Senior Research Officer in health education, NSW Health Commission, 10 November 1976.
5. Discussion, Health Educator, Western Metropolitan Region, NSW Health Commission, 10 November 1976.
6. Thomas Gordon, *Parent effectiveness training* (Peter Wyden, NY, 1970).
7. Submissions 949, Canberra Marriage Guidance Council; C1009, confidential.
8. Evidence, pp. 1970–85, Mr Jim Carr.

Needed developments

9. The Commission opposes compulsion in this area, and sees the need to develop new strategies in Australia which will reach parents where they are, at home or in the family's neighbourhood, and use established social networks.

10. Parenthood has been written about by a succession of doctors and other experts on child rearing–ranging from the rather authoritarian regime of Dr Truby King, through the early prescriptive work of John Bowlby to the writing of Spock and Jolly. These experts were all admirable in intent. Their work, however, by setting high standards has made it appear that child rearing is a job to be supervised by experts. They have also emphasised the mother's role and responsibility in child rearing and sometimes by implication have seemed to reduce the father's role and responsibility.

11. Aspects of child rearing have thus become a branch of preventive medicine. Parents do not have a broad knowledge of infancy, child care and child development against which to assess professional advice. Therefore they need to have their confidence restored and their competence and integrity respected so that parenthood becomes pleasurable.

12. The behavioural sciences have useful insights into child care and parent-child relationships. Parents need opportunities to learn about these matters and to integrate the information into their own system of values and beliefs. In this way confidence and skills which parents were once assumed to possess automatically may be returned to them. Extensive parent education of this type already exists in the United States involving fathers and mothers; the cost is well below any professional advice.

13. The Australian and New Zealand College of Psychiatrists recommended that sex education commence at pre-school, and that:

> To parallel the sex education of the young, the Australian Government . . . should . . . provide continuous and imaginative adult education programs on these issues particularly through TV. Serials such as 'No. 96' which have a viewing audience of over a million Australians . . . should have a mental health consultant working with the script writers to incorporate into the story lines genuine problems of human relationships with health problem solving. This has been successfully tried in a token way in several of the most popular USA serials.[9]

14. The Right to Life Association (SA Division) recommended that:

> Family life education centres which provide adequate courses for people of all age groups should be established as soon as possible. Existing courses and facilities in this area should be co-ordinated, reviewed and expanded. Organisations like the Family Foundation (SA) Inc. and Birthline should be asked to assist in the drafting of a policy governing the activities of family life education centres.[10]

15. These suggestions about present services are valuable but the problem remains of getting the unmotivated parent to use them.

16. One time of high motivation is when parents are expecting their first child. Sydney paediatrician Dr Clair Isbister who has been involved with parent education programs for many years, and is Chairman of the Parent Education Committee, Royal North Shore Hospital, said:

> At this time they are strongly motivated to preserve their family and they are concerned with each other's needs and the needs of their baby . . . I think people should be behind that, and a great many previous mistakes and a lot of previous unhappiness could be eradicated if they have someone to help [parents] take a positive approach.[11]

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9. Submission 785, ANZ College of Psychiatrists.
10. Submission 131, Right to Life Assoc. (SA division).
11. Evidence, p. 3050, Dr Clair Isbister.

17. The Royal North Shore Hospital in Sydney is one of the few hospitals in Australia conducting comprehensive parent education programs as part of their prenatal classes. The classes are always full and sometimes people have to be turned away. A part-time nurse educator is employed to work with mothers once they are hospitalised and to maintain telephone contact after they return home. Six months after the baby is born, parents are invited to return for group discussions on child care.

18. The Commission heard about another parent education program from Dr Michael Harris, of the Royal Hospital for Women, Sydney, who said hospital programs should be seen as an introduction to ongoing parent education.

> I believe the majority of first mothers just do not have the background from extended families, and therefore their own contact with children before their own maternity is limited. They therefore do not have a tradition in child rearing, and they go into pregnancy with fear, without certainty, and they potentially get themselves into terrible trouble; so it is a hobby horse that [these programs] should be available to all.[12]

19. Various voluntary organisations such as the Nursing Mothers Association also assist in parent education programs based around the time a child is born.

20. The Commission endorses the view of Dr Isbister and Dr Harris that more Commonwealth funds should be available for parent education programs in hospitals. As we have already discussed, one of the major problems in parent education is getting parents to attend. Yet the time when mothers are expecting a child, and particularly the time when they are confined, is the one period when a captive audience is ensured, and when motivation is at its highest. At present, those few programs that exist throughout Australia depend largely on voluntary services. A few get small grants. Even a large hospital such as Sydney's Royal North Shore can employ only a part-time nurse educator who is hard-pressed to meet demands. The hospital has new buildings, yet those who are involved in parent education do not have an office. In our view, this kind of experience is yet another instance of our failure to support preventive services. If we really are serious about our concern for the quality of family life, we should make a far greater commitment to parent education programs of this kind. The problem clearly does not solely depend on funding, although this is of major importance. It also demands a recognition on the part of hospital staff that health care should embrace more than care of the sick. Health care involves the prevention of sickness and family breakdown by a commitment to education and family support.

21. At a later stage the one community resource common to both parents and children in every community is the local primary school. It is a contact point for parents most likely to need assurance and guidance in child development, and we think it should be used for this purpose. No capital expenditure or rental charges need be involved. Parent education at present is not part of the school's function, nor do schools have the personnel trained or available for parent education. Schools need to develop new functions, and other local institutions should provide appropriately trained workers and programs.

22. An added reason for associating parent education with the primary schools is that the teaching profession in its helping, caring and nurturing role is the only one which is not 'problem oriented' or 'illness oriented'. Its members ideally are familiar with individual difference, with the whole range of 'normal behaviour'.

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12. Evidence, p. 150, Dr Michael Harris.

23. The Schools Commission[13], State governments[14] and many educators[15] speak of the need to involve parents and communities in the school environment. The objective is to provide a variety of educational experiences to children outside the classroom, to improve parent-community-teacher communication, and, in turn, to use the resources of the schools to provide adult education and post-school opportunities for the adjacent community. Where there is real communication between school and community, the total educational experience of pupils, parents and community is enhanced. An added merit is that public property is used more intensively and economically.

24. There are some public funds available for parent-school programs or community education programs. The Schools Commission's Special Projects (Innovations) Program has funded a variety of school-community interaction programs in all States and proposes to continue to fund individuals and organisations who submit suitable projects.[16]

25. It seems to us that the competence and self-confidence of parents would increase if voluntary agencies, professional bodies and government agencies co-ordinated their activities to provide a regular service to parents at a time and place suitable to both parents—fathers as well as mothers—and where child care is available. It seems desirable that the various bodies should work together and seek funds for the salary of a community education officer, whose task would be to co-ordinate the work of professional and voluntary agencies and promote programs to enable parents to have a fuller appreciation of the social and sexual development of children.

26. Parents will more readily come if they are welcomed and treated as partners in their children's education, and not patronised. The NSW Teachers Federation-South Australian Institute of Teachers study of community involvement in Sydney and Adelaide says of this situation and of the type of worker needed:

> The challenge will be how to involve the 'silent majority' of parents and students; how to involve and incorporate the interests, needs and skills of blue collar workers and various disadvantaged groups . . . The effect of having an enthusiastic and perceptive teacher or aide in the school whose function it is to provide a bridge between school and community can be dramatic, particularly if that person comes from a disadvantaged sector of the community were there is a communication problem. This is particularly so in the case of an ethnic aide working in a migrant community. The main equipment these officers need is human understanding and the ability to communicate with both the community and the school. They need to be fully respected, appreciated, drawn into the staff team and assisted in practical ways.[17]

27. The Tasmanian Education Department introduced a sub-unit in social studies-personal relations and set up seminars on Saturdays for parents. The object was to dispel fears and misunderstanding as to the context and aim of the courses. They resulted in an almost 100 per cent acceptance of the program.

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13. Australian Schools Commission, *Report for the triennium 1976-78* (AGPS, Canberra, 1975), pp. 112-18.
14. 'School's out—and community groups move in', *Australian,* 15 March 1976; *The community and its schools* (NSW Dept of Education, January 1974).
15. Ray Watson (ed.), *Parental involvement in Australian schools* (The Hills education study group, 1976); L. N. Short, Educating the whole person: the community school as the grass roots agency (paper delivered at Australian Association of Adult Education Conference, Canberra, August 1975).
16. Schools Commission, Report 1976-78, pp. 115-17.
17. M. Adams & C. Lloyd-Wright, *Who's involved? Aspects of community involvement in education, Sydney and Adelaide: a brief study* (NSW Teachers Federation, Sydney, 1975).

28. Apart from using the school resources, other means have been presented to us for helping parents. A voluntary organisation in NSW, Future Lobby, was formed for the purpose of education in child rearing because, as they testified:

> . . . a group of concerned people, both professional and lay people, wanted to see the orientation in child services more towards families and neighbourhood . . . [as a] way of giving confidence and competence to parents and to the family.[18]

They work with mothers and schools in Sydney's western suburbs; the mothers come to the primary school, are shown films on early child development and participate in discussions while their small children are minded by high school students, boys and girls, from a nearby high school. We would like to see such programs extended to other areas and planned to enable fathers to attend.

29. Parent education for high school students generally occurs as part of personal development courses. Although students of this age are often highly motivated in terms of finding out about themselves and their relationships, it is often difficult to make the prospect of parenthood have any reality. A 15-year-old doesn't readily relate to the idea of walking the floor with a screaming baby and is more likely to view parenthood as some romantic ideal where babies gurgle all the day long, as they do in the advertisements on the television screen. The fact that families are now smaller and that children are born closer together means that young people are less likely to have contact with small children than they had in the past. This means that it is important to develop ways in which young people can have actual practical experience of child rearing. Future Lobby's scheme in Sydney whereby high school students look after small children whose parents are attending parent education classes is therefore an excellent one as it achieves parent education at two levels. We believe further ways should be sought to encourage supervised participation of high school students in child care centres, ideally as part of the personal development course.

Conclusions

30. Voluntary associations experienced in working with small groups should be enlisted to evolve parent programs. Some of these should be scheduled for Saturday afternoons, or at times when child care facilities could be provided, and when both parents, and single parents who work, could attend.

31. Each school district or local government area should employ a community education officer to work with the P & C, the school and the voluntary associations to promote such programs. Parent education programs should be funded in hospitals.

32. Parent education programs in schools should be arranged early in each school year, both parents being encouraged to attend when their child enters infants school or pre-school, again on entry to primary school, and again at the age of puberty. Ways should be sought to enable secondary school students to have supervised practical experience of child rearing as part of their personal development course.

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18. Submission 620, Future Lobby; Evidence pp. 2436–46, Dr Joanne Cornwall, Mrs Mary Lane, Dr Anne Banning.

3. The role of the media

1. Next to the influence of both family and school, the media, particularly television, play a powerful role in shaping the behaviour and attitudes of young people. This influence extends into adult life.

2. In 1974 a United Nations report stated:

> Most governments and non-governmental organisations have expressed their awareness of the tremendous potentialities that the mass media have as vehicles for social change. If the influence of the mass media is progressive, the potentialities of the different countries and peoples will be expanded; if it is regressive, human potential together with the social institutions will diminish.[1]

3. In Australia, children watch a great deal of television. We were told that by the time children have left school, on average they will have spent more time watching television than in the classroom. Radio, childrens comics, books and films are perhaps less pervasive but also send constant messages about the way a society behaves, or is expected to behave. For example, how much will children learn about adult behaviour, about male and female roles, about sexuality from television? What can be done to help them to understand the influence of the media and to cope with it?

4. Many of our submissions expressed concern at media influence on children and adolescents.[2] The National Council of Women of NSW wrote:

> Children are being exploited in advertising and by exposure to the sensational and even abnormal in sex and violence.[3]

The Festival of Light wrote that much of the material that appears on television, radio and in newspapers is (among other things) 'anti-child', 'anti-family', and 'anti-human'.[4]

5. The question of the actual harm done by media portrayal of sex and violence is an important one. The only justification for restricting material portrayed by the mass media should be that it does real social harm. If the material is not harmful there should be no question of its restriction. The mass media, at some time or another, are bound to offend many people in the community by the display of ideas, attitudes or events with which some people disagree. If the offensiveness of material were grounds for its restriction, there would be very little left for the media to broadcast or print. As the Council for Civil Liberties, NSW, submitted:

> Many people are repeatedly confronted by other things, such as dishonest advertising or flaunted wealth, which they find equally offensive or disgusting but from which society gives them little or no protection . . . A society which is protected from seeing its ugly side is less likely to reform itself; thus television programs on famine are not banned, despite their sickening impact.[5]

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1. Report of the Secretary-General, *Influence of mass communication media on the formation of a new attitude towards the role of women in present day society* (UN Social and Economic Council, Commission on the Status of Women, 1974).
2. e.g. Submissions 611, Anglican Diocese of Sydney; 386, Richard See; 586, Catholic Womens League, NSW.
3. Submission 460, National Council of Women, NSW.
4. Submission 1147, Australian Festival of Light.
5. Submission 436, Council for Civil Liberties, NSW.

6. Precise empirical evidence on the effect of exposure to sex and violence via the media is very difficult to obtain. For example, the Advisory Committee on Program Standards to the Australian Broadcasting Control Board said, of violence and the media:

> More research has been done on this subject than any other in the work on media effects. However, it is still possible to make a case for either side of the argument . . . Given the lack of definitive data on a clear link between media violence and aggressive behaviour, this Committee cannot answer such questions as: Is a viewer better or worse off for the vicarious experience of violence? Is violence in some contexts potentially more harmful than others? Nor can we answer whether prohibition of television violence would achieve greater social harmony. We would be simply guessing at consequences and such prohibition may have greater inherent dangers for the public good than television violence . . . To censor violence on the screen means that a significant part of life experience is being censored. Society has never functioned without wars, socially sanctioned violence and violence by deviants. To portray a world without violence or without showing the effects of violence may be ultimately more harmful.[6]

7. Dr Patricia Edgar, senior lecturer at the School of Education, La Trobe University, told us in evidence that the critical factors are whether what is being shown or portrayed fits into existing social norms. Violent programs on television are likely to have less effect on children than programs about family life because there are so many sanctions in our society which operate against teaching children to be violent.

> It is when you get a constant portrayal of something that is socially acceptable and reflects social reality that television reinforces. This is where what is being put across in roles to do with the family and sex stereotypes does have a considerable influence . . . what is put across in these programs that children enjoy and find so popular is extreme stereotypes of the male and female roles. There is little variety in the female role model for children. She tends to be the middle-class American mother at home who deals with everything that comes along in a most unreal way.[7]

8. An insidious view of marriage often comes across in television programs whereby the marriage situation is constantly 'sent up'. For example, a young girl in the *Mary Tyler Moore Show* asks:

> If you love somebody, do you have to have sex?

The answer is:

> Of course not, just look at any couple who have been married 10 years.[8]

9. We agree with Dr Edgar that television is probably the most unused resource available to society for reform in many of the areas we are concerned with, and that popular programs such as *No. 96* and *The Box* have more influence than deliberate 'education' programs.

> Overseas there is a recognition that these films can be used to deal with and tackle a wide range of problems like health problems, alcoholism, drug problems, abortion, child pregnancies, sex crimes. A whole range of things can be incorporated into the soap opera format so that you are not simply teaching in an 'educational' sense, educational being put in inverted commas. Many, many people—and we know this—just turn off the educational programs. The majority do not watch Channel 2; they prefer to watch the commercial stations. Rather than attempt to do this by documentary and current affairs formats, I think this could be built into the very programs that they like to watch.[9]

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6. Advisory Committee on Program Standards, Report to the Australian Broadcasting Control Board (February 1976), pp. 24–6.
7. Evidence, p. 686, Dr Patricia Edgar.
8. ibid., p. 688.
9. ibid., p. 681.

10. Similarly, comics can and have been used most successfully to teach young people about health issues such as venereal disease and contraception. We discuss this in more detail in Part IV.

11. The use of mass media as a potential for social change is still insufficiently explored in Australia both by governments and by private organisations working in the educational field.

12. As far as television stations are concerned, we believe that, as major institutions which are permitted to conduct business via a publicly accountable licence, they should accept the concept of social responsibility as one of their licensing contingencies. This is a matter which undoubtedly will be discussed by the Australian Broadcasting Tribunal. A Senate Standing Committee on Education and the Arts is also holding an inquiry into the impact of television on the development and learning behaviour of children.

13. The notion of censorship is not one which has any appeal for us. What particularly appeals to us is that education programs in human relationships should include material which would help young people to become aware of the influences which shape their lives and to exercise discrimination and choice between the different attitudes and values which are portrayed to them.[10]

14. Sydney social worker Helen McNamara said in evidence:

> They should really learn about these things. They should learn things like how to be critical of advertising, to be aware of the psychology and the techniques of advertising and to analyse advertisements, both the way they appear in the newspapers and also the sort of things that appear on television. I think they should learn to be critical of those sorts of advertisements. I think they should be able to criticise the voice on TV which is yelling urgently 'Come and buy a car, you have to the end of the week to do it' and to recognise this urgency gets a message across to the unaware.[11]

15. Further, the media should be encouraged to play a part in this process of evaluation and in preparing programs which have a positive rather than a negative effect in developing responsible behaviour and attitudes. The government, in our view, has a responsibility to encourage the media to do this—especially TV—and to provide funds for the development of appropriate material. It seems to us that when so much money is being spent on formal school education something should be spared for TV and radio programs which could reinforce positive values rather than erode them. Stories about people facing human relationship problems and moral dilemmas could make good popular programs; so could stories depicting people in a variety of family situations and life styles.

16. We believe that, in the field of parent education, more could be done by television and radio stations to provide information via popular programs, or by mounting programs specifically related to the subject, but presented in an entertaining manner.

17. In our view the government in collaboration with education and broadcasting authorities should explore ways of developing programs to support and supplement school human relationships programs.

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10. See Part VII, ch. 2, re male and female stereotypes and portrayal of women.
11. Evidence, pp. 99–100, Helen McNamara.

4. The role of the school

1. While many submissions dealt with the school and its role in providing education for human relationships, some went further and looked at the institution of the school itself and its effects on the development of young people.

Criticisms of the school system

2. Many witnesses saw the school as isolated from the community, lacking parental involvement, sometimes bureaucratic and authoritarian, with a powerless captive population not developing into morally responsible adults.

3. The Australian Catholic Social Welfare Commission in a submission stated:

> We note the Statement of Principles of the Departmental Committee appointed to review policy relating to sex education in New South Wales Government secondary schools. While we would agree with much that is said, we question the ability of the school to tackle the task broadly and effectively . . .
>
> It may well be that the school is being asked to respond to some needs of children which it is not appropriately placed to fulfil. The impressive resources of the school and the time it has at its disposal can create false impressions for both parents and school.[1]

4. The Centre of Personal Encounter, a division of the Marriage Guidance Council of SA, stated that voluntary bodies are doing much of the work in human relationships and education for parenthood and urged their continuance because often the school does not seem to provide a comfortable and welcoming environment.[2]

5. The South Australian Institute of Teachers wrote:

> First, many of our schools are too large so that administrators are unable to build any real kind of personal relationship with the children or the teachers . . .
>
> Second, the majority of schools reinforce traditional roles since most principals are male–father figures–with female teachers in supporting, nurturing roles.
>
> Third, the double standard can be, and often is, upheld. Boys are tacitly encouraged to take aggressive roles. That is to say noisy and rough behaviour by boys, if not condoned, is often excused, while passive and gentle behaviour by boys can be held up to ridicule . . . Aggressive girls are not condoned and passive behaviour is encouraged in many cases.
>
> Stereotyping which prevents the natural development of the person, boy or girl, may be a fundamental cause of failure in relationships. To this end SAIT recommends textbooks and course content should be examined to see that they do not reinforce stereotyping.[3]

Discipline and punishment

6. The system of punishment in schools was a further subject of criticism. The Federation of Parents and Citizens Associations of NSW, representing 2000 affiliated groups, submitted that they were opposed to corporal punishment.[4] Some ninety of their affiliated associations wrote in equally strong disagreement and suggested that the affiliated associations had not been consulted.

7. The Federation's submission reviewed two Australian studies on discipline in schools, and two other studies on the effects of caning and other forms of punishment.

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1. Submission 992, Aust. Catholic Social Welfare Commission.
2. Submission 144, COPE.
3. Submission 147, SAIT.
4. Submission 459, Federation of P & C Assoc. of NSW.

8. The submission said schools punished children by verbal assault, detention and corporal punishment and:

> . . . that a child's attitude to violence and the use of force cannot fail to be affected by his observation of the use of violence and the physical assault by the authority figure formally appointed by the state.

The Federation concluded:

> The Minister for Education and other relevant authorities should appoint counsellors in primary schools, including infants departments, in much greater numbers to help identify the potential problems before they become entrenched. We suggest that corporal punishment, detentions and the various forms of humiliation which are now practised are no substitute for effective well-trained teachers, counselling and remedial teachers. Each punishment may be regarded as a failure on the part of the system.

9. Other submissions were also critical of the ways in which schools punished pupils.[5]

10. On the other hand submissions from some of the associations affiliated to the NSW Federation of P & C Associations raised the problem of what action could be taken in the case of the disruptive child and to safeguard the rights of other children in the class.

11. The Commission has not had the resources to undertake research in this matter. We do not think that corporal punishment should be considered in isolation from the humiliating punishment and treatment of children. We are certainly concerned about the relationship between corporal punishment and child abuse. This was discussed at the conference on 'The battered child' in Perth in August 1975. The point was made that if children can learn in school that there are other methods of child raising besides the use of corporal punishment, this knowledge alone will markedly reduce the self-righteousness which many parents now feel to justify corporal punishment.[6] The connection between physical punishment and child abuse is a complex one, but it is now acknowledged by research workers in this field (Gil, Carter, Kempe) that the extent to which physical punishment of children is socially condoned has disturbing implications.[7]

12. It is worth noting here that the first modern state to outlaw corporal punishment for children was Poland in 1783. Then followed Holland in the 1850s, Finland in the 1890s, Norway in 1935, Sweden in 1948, Israel and Japan in the 1950s, Denmark in 1968. In 1969, the English Plowden Report recommended the end of corporal punishment in all schools maintained by government funds. On this advice, the Inner London Education Authority banned caning as from 1973.[8]

13. We believe that as long as schools and others to whom the care of children is committed use physical means of punishment this will convey subtle messages to parents that such methods are appropriate, and not so subtle messages to children that society approves of authority based on force. We recognise that there will be occasions when a teacher will understandably resort to the use of physical punishment, but we believe that physical punishment is neither a suitable way of dealing with the disruptive child, nor is it an effective way of changing behaviour.

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5. Submissions 988, Rosemary Walters; 572, Pran Chopra.
6. *The battered child; proceedings of the first national Australian conference, Perth, August 1975* (Dept Comm. Welfare, WA, 1975), p. 7.
7. e.g. D. Gil, 'Unravelling child abuse', *Amer. Journal Orthopsychiat* 45, 3 (1975).
8. Submission to NSW State Labor Party Conference from Dee Why branch, June 1976.

14. Accordingly, we would like to see all schools and child care agencies relinquish physical methods of punishment. To assist this, educational authorities should research the best ways of handling the disruptive child, including the provision of alternative education. Established teachers should be given opportunities to undertake retraining in communication skills and in new approaches to the process of learning.

Rigidity or freedom

15. A number of submissions suggested the need for less rigidity and more freedom for pupils in secondary schools. For example, Dr S. D'Urso, of the University of Queensland, proposed an alternative type of secondary school open to all age groups, where curriculum and hours were not prescriptive, where staff, administrative and professional, accepted the learner as a self-motivated person and where:

> The young [could] discover their personal powers in communities of learning that are congenial to work in, free from unnecessary impositions and conducive to diversity of all kinds.[9]

16. Some government school systems have developed a few 'special' schools where less rigidity prevails. The ACT Education Authority funds the 'School without walls'. Its ten teachers are from the Commonwealth Teaching Service. Three of them told us about its organisation, philosophy and achievements:

> It is completely within the government education system. It is a school which has 100 official places for people aged 15 and over . . . This year we have people in their 30s and 40s. About 10 per cent of the students are really mature age students doing matriculation.
>
> . . . one of our essential aims is to . . . create an environment in which people can become aware of themselves and aware of what they are doing.[10]

They said that a small school is necessary to develop a feeling of community. Some detail is set out at Annexe II.B.

17. We were informed that the Victorian Education Department had also conducted experiments in five schools in which there has been community involvement from the early planning stages. A school council was set up which included educational experts, lay persons, including canteen workers, and two elected student representatives. The schools employ a co-ordinator of community programs including those for holidays and are funded by the Schools Commission.[11] This experiment deserves further study.

18. Research in progress in the United Kingdom shows that, contrary to much pessimistic thought, the school's own organisation can make a difference to the success or failure of a child. Reynolds, Jones and St Leger studied the delinquency and attendance rates, academic attainments and post-school employment of a group of adjacent schools. The school population studied were from nine schools in a working class community, with no system of parental choice or overlap in their catchment areas. The research group found that over the years the nine schools exhibited a consistency in their relative performance, the effective schools retaining their effectiveness and vice versa. The nine schools were producing, from a relatively homogeneous population, children who appear to be different, and consistently so, on four indices, and to vary independently of the social background of the pupils. The researchers wrote that:

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9. Submission 948, Dr S. D'Urso.
10. Evidence pp. 1085–97, Ms Elizabeth Ward, Beth Slatyer, Mr Harry Oldmeadow.
11. Fitzgerald et al., ACER.

> In our opinion, and even on the basis of our analyses so far, the belief that a school can only be as good or bad as the character and ability of the children entering it is simply wrong. It has had wholly adverse consequences for the teaching profession. We believe that teachers and head teachers have everywhere been encouraged to reduce their efforts to help the underachieving child by the growth of this climate of opinion. Children are not necessarily born to fail. What goes on in school between nine and five is an important determinant of the type of child that emerges at the end of the process.[12]

19. The Commission notes with interest the study, 'Essential learning about society', being conducted by the Australian Council for Educational Research (ACER) to investigate the body of social knowledge, skills and values which should be the essential possession of all pupils leaving school.

20. Some experimental schools often referred to as 'progressive schools' have been developed in the private system in recent years. Their emphasis is on a less authoritarian and hierarchical structure. They are fee paying and because of this only open to those prepared to make great sacrifices of both time and money on behalf of the school. Their existence challenges the established systems to reassess their practices and attitudes. They appear to attract a high level of parental involvement and concern.

Conclusions

21. The effects on personal development of the internal characteristics of the organisation and staff of schools should be investigated.

22. The compulsory, authoritarian quality of much education today causes many pupils to turn away. Human relationships education courses which develop self-motivated and socially responsible adults can be only partially successful if schools retain their authoritarian and hierarchical structures isolated from the community.

The aim and scope of human relationships programs

23. The general role of the school as an institution of education has a bearing on its role in education for human relationships. The key issues which divide opinion on the aim and scope of human relationships education are parental involvement, content of programs, age for its introduction, and the selection and training of teachers.

24. Supporters of human relationships education in schools uphold the idea that education authorities should develop programs which will give young people the chance to acquire the knowledge and skills necessary to live at a satisfactory level.

25. Views differ about what is needed in human relationships education and the emphasis varies: some see information and understanding about sex as the best weapon against the pressures of modern society, against teenage VD and against abortion. Others stress the need to develop the whole personality so that young people acquire a sense of responsibility in their actions. Yet others think it important to learn skills necessary for social and economic survival.

26. A father wrote of the lack of joy of modern family life:

> The basis for happy and contented living is not emphasised enough. Human relationships are not promoted. The introduction of sex education in the school curriculum would be incomplete in its usefulness unless it is a part of a much wider course of family relationships . . . Sex is only a small part of human relationships.[13]

12. D. Reynolds, D. Jones and S. St Leger, 'Schools do make a difference', *New Society*, 29 July 1976.
13. Submission 903, Mr F. M. Tottenhoffer.

27. The Royal Australian College of General Practitioners wrote:

> Bearing in mind that sexuality is an expression of the total personality as a man or a woman . . . the ideal of education should aim at an acceptance of what this means, hoping to produce a society of individuals each confident of his or her own identity and being tolerant of the differences which exist with others.[14]

Hence they recommended that the Commission emphasise 'human relationships rather than sex education' in our response to the terms of reference.

28. The Australian Council of Social Service wrote:

> Human relations education should aim to allow freedom to learn and discover norms and values about different sets of relationships which will combat the dehumanising of man by the existing social institutions. Such education should be aimed at countering the effects of oppressive social institutions . . . The education should be for the improvement of the human condition and aimed at human self-realisation, to liberate people so as to enable them to assert their right to meaningful responsible human relationships.

Hence the Council recommended:

> That the scope of the human relations and sex education program be broad and that there be no rigid curriculum but rather a set of guidelines laid down which consistently integrate sexual adjustment with interpersonal and social adjustment.[15]

29. The Adolescent Education Committee of Independent Girls Schools in NSW wrote:

> After eight years we have evolved a reasonably satisfactory scientifically supported program that can be adapted to the needs of individual schools from 5th class primary to the end of secondary school but we would like to emphasise that the course is constantly changing and being brought up to date with new medical, psychological and sociological data. We do not use the term sex education as we regard sexuality as part of total personality . . . We consequently deal with emotional, social and physical health according to the developmental stages of the children.[16]

30. A father from a Brisbane suburb wrote:

> Sex education is considered the essential prelude to an understanding of responsible parenthood . . . parents and teachers should endeavour to convey the wholeness of human personality.[17]

31. The Baptist Union of NSW supported parent education, commended the NSW Education Department personal development course and considered sex education to encompass the biological, emotional, social, spiritual and sexual functions of total personality and interpersonal relationships.[18]

32. Similarly the Australian and New Zealand College of Psychiatrists suggested:

> Thought could be given to an overall concept of education for living, in which instruction in bodily habits, family life, psychological needs, contraception and family planning could be incorporated.

They noted that there is:

> . . . little opportunity for individuals to view themselves, their family and society as whole units interrelating with each other in a meaningful fashion.[19]

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14. Submission 886, RACGP.
15. Submission, 591, ACOSS.
16. Submission 128, Adolescent Education Committee, Independent Girls Schools, NSW.
17. Submission 727, Mr R. Mathers.
18. Submission 571, Baptist Union of NSW.
19. Submission 785, ANZ College of Psychiatrists.

33. Others who looked to education to provide preventive information and remedial education saw certain factors at work in society, such as parental incompetence and the over-pervasiveness of the media, making it difficult to shelter children. They therefore thought that young people were seriously disadvantaged if they lacked more formal education.

34. Ms Petah Battersby, a Brisbane sociologist, previously a nurse, and Queensland President of Zero Population Growth, Australia, said:

> In our society there is a large degree of public ignorance and anxiety regarding sexual matters and a stifling of open discussion of sex by outmoded notions of morality. Because it is now possible to have sexual intercourse without fear of pregnancy as a result, society needs to rethink its attitude toward sexual morality . . . Rather than 'preventative' legislation of demonstrably doubtful effectiveness, public education of all age groups should be undertaken in order to develop a responsible and realistic attitude towards sex.[20]

35. The Australian Council of State School Organisations said:

> Sex education should be seen as a part of a child's right to knowledge. An understanding of the way in which his or her body functions is a fundamental need. ACSSO believes that greater emphasis should be placed on courses aimed at the emotional and social development of students. In particular, endorsement is given to the wider use at all stages of schooling of courses based on discussion groups which provide students with a facilitating environment in which they can acquire confidence in themselves, their values and their personal relationships and through which they attain greater stability, adaptability and a caring attitude to others.[21]

36. The Family Planning Association in London made available to us a paper on sex education, which saw it as belonging:

> . . . primarily to parents, to the churches for those interested and involved in religious activity, and to the schools . . . We suggest the following as objectives of sex education:
>
> (a) To provide people with an adequate knowledge of their own physical, mental and emotional maturation processes as related to sex.
>
> (b) To eliminate fears and anxieties about personal sexual development and adjustments.
>
> (c) To develop objective and understanding attitudes towards sex in its various manifestations.
>
> (d) To help people to develop insight in their relationships with members of both sexes and to recognise their obligations and responsibilities to others.
>
> (e) To foster an appreciation of the positive satisfactions that honest and considerate relationships can bring.
>
> (f) To build an understanding of the moral values needed to provide rational bases for making decisions.
>
> (g) To provide enough knowledge about the misuses and aberrations of sex to enable people to protect themselves against exploitation and against injury to their physical and mental health.
>
> (h) To provide an incentive to work towards a society in which archaic sex laws, irrational fears of sex and sexual exploitation are non-existent.
>
> (i) To provide the education and understanding that will enable individuals to use their sexuality effectively and sensitively in any role, whether as spouse/parent/community member/citizen.[22]

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20. Submission 1004, Ms Petah Battersby.
21. Submission 1062, Aust. Council of State School Organisations.
22. *Sex education, an FPA statement* (Education Unit, Family Planning Association, London, 1974).

37. The Australian Council of Social Service's comprehensive submission favoured a wide approach to education in human relationships:

> To ignore the fact that children are not being adequately prepared for family life (however defined) and their sexuality is to ignore the evidence. The solution does not appear to lie in the previous ways of coping, such as making divorce difficult, putting restrictions on youth . . . withholding birth control information or keeping women in the strictly traditional roles . . .
>
> The more appropriate response is to enable people to understand the problems they are likely to meet, to provide a basis for thoughtful . . . judgments and decisions, to have an understanding of their own reactions and those of others and to accept their sexuality with responsibility and realism . . . Without any programs in schools, children from an early age are being fed a great deal of information [and] misinformation about sex and human relationships. Much of the mass media information presents the negative aspects . . . and plays up the violent, deviant and sensational aspects. Commercial advertisements are even more subtle and devious.[23]

38. Mr H. F. Purnell, senior public defender for New South Wales, in a personal submission writing about sex crimes against women said:

> My confreres and I are left with the strong feeling after appearing in many sex cases that there is a pressing need for a program of comprehensive sex education for all young people, both male and female.[24]

39. Dr B. J. Phillips, senior medical director, Division of Youth, Welfare and Guidance in Queensland, said that keeping children in ignorance of biology:

> . . . is probably not a good idea. About half a series of promiscuous delinquent girls were considered to have quite inadequate sexual knowledge and many believed they could not become pregnant because they were not old enough.[25]

40. The Swedish Commission on sex education wrote that 'all essential facts should be imparted'.[26]

41. The report of the Poverty Commission and similar evidence to this Commission indicate that many people are still unaware of community services and welfare programs or how to approach appropriate government agencies. The schools do not appear to have provided the opportunity for children to acquire information basic to survival.

Controversial issues

42. Submissions to us asked whether teachers were adequately trained; capable of controlling their biases; likely to gain support for their own values and views on sexual morals and family life; able and likely to work in harmony with parents. Many doubted the adequacy of teacher preparation and emphasised the necessity for thorough training in human relationships education in schools. Many questioned the moral values that teachers project in the classroom.

43. A frequent demand was for Christian values to prevail. Thus the father of two adopted children in Sydney wrote:

> Christianity is to be regarded as the basis of our moral system, and this is to be emphasised in the schools.[27]

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23. Submission 591, ACOSS.
24. Submission 1206, Mr H. F. Purnell, QC.
25. Submission 439, Dr B. J. Phillips, Qld Health Dept.
26. *Proposed guidelines for sex education in the Swedish school system* (Swedish State Commission on Sex Education, Stockholm, 1974).
27. Submission 386, Mr Richard See.

44. A mother of six children wrote that sex education should be combined with a Christian maturity program that must have the approval of parents.[28] A doctor engaged in human relations and sex education in schools testified that such education should emphasise 'what is moral and what would be common Christian morality'.[29]

45. Most people and groups were aware of the multiplicity of information and attitude-forming experiences which come to the young, willingly or not, in and out of school, with a resultant confusion about values and behaviour.

46. The school, secular or religious, in its structure, cultural climate and customs, as well as in its formal curriculum, is inevitably involved in developing values and attitudes. The school has to accept the plurality of the society and develop its strategies within this framework.

47. The NSW Department of Education in 1973–74 carried out an inquiry into the need for sex education and the form it should take. It consulted a variety of community and church groups and individuals, and on the issue of moral codes and values reported thus:

> The formation of values raised controversy but we cannot accept this as sufficient reason for refusing to face the task.
>
> Research in moral education suggests that there are certain stages of moral growth through which we progress to the point of moral autonomy, which is the developmental stage at which a person makes responsible decisions controlled only by the principles he has and not by constraints of impressed authority, or fear of public opinion . . . The establishment of values is important but it presents many difficulties. Rigid and imposed rules have become less acceptable to modern youth and the educationists must approach the task of helping young people develop a system of values by which to live and standards by which to make important decisions by means other than prescription of rules and proscription of certain behaviour.
>
> Such values and standards must be based on the individual's understanding of his responsibilities in interpersonal relationships, his respect for his own worth and dignity and that of others, his ability to evaluate the consequences of his actions, his concern for others and his readiness to co-operate with them for the common good.
>
> There is reason to believe that a regular program of discussion of social problems and controversial issues . . . may offer a context most likely to lead to the recognition of values accepted as inherent in a democratic society . . .
>
> The pluralism of society and the divergence of opinions often found within the one institution have made it difficult to develop moral rules which are universally accepted. Yet in any civilised society the behaviour of its members must be governed by moral considerations. The sexual drive is strong and pervasive and the consequences of sexual behaviour rarely restricted to one individual. Both society and the individual must regulate and direct such behaviour for the benefit of both. It is difficult to envisage community life persisting as we know it were sexual behaviour simply subject to individual desires free from sanctions.
>
> This statement reaffirms that parents should accept responsibility for providing their children with values on which they can base a satisfying life. The role of the school is seen as complementary to that of parents. It is able to provide specialist supportive service in the fields of scientific knowledge, social education and health education—all matters in which it has expertise not always available at home. As mentioned earlier, it can also provide opportunities for the development of values because of the dynamic peer group interaction which the home cannot provide.
>
> For the sake of young people both the school and the home should provide an environment sensitive to their needs, honest in dealing with their problems and free from ignorance, apathy and bigotry . . . the vital importance of discussion and co-operation between home and school is again stressed.

28. Submission 437, Mrs Kath Miles.
29. Evidence, p. 132, Dr Jean Benjamin.

We would emphasise that for many parents a moral code must have its genesis in spiritual and religious beliefs. It will be essential to ensure that the school program should be designed to accommodate these views and not to set up conditions tending to be destructive of them. It will be the responsibility of parents, ministers, and other approved religious teachers to provide the specific religious component in the program for the children of each persuasion.

We recognise that religious groups are vitally interested in the spiritual welfare of their young people. The school should take notice of the wide range of attitudes to sex education including those arising from religious beliefs. Ministers of religion who visit the school might well be involved in introductory programs for parents. If visiting religious teachers were well informed about the aims and procedures of the school's program it should be possible for their special classes to be integrated with the school program and for parents who are adherents to provide complementary instruction in the homes.

Everyone should appreciate that the school serves a community with divergent views on the significance of spiritual and religious matters and its attempts to meet the needs and wishes of one group cannot deny those of another . . .

One of the skills that this program will demand of teachers will be the capacity to discuss different points of view in a manner which will not inevitably lead to the rejection of opposing views. Consideration of moral dilemma situations may be relevant to sex education programs.[30]

48. The NSW Department of Education arrived at its decisions after long consideration of the issues. The Anglican and Catholic churches have both favourably endorsed this program.

49. The National Catholic Education Commission, writing of moral education in a wider educational setting, 'i.e. of that 40 per cent of Catholic children enrolled in schools other than Catholic', said:

> There is a need to make the moral objectives of all kinds of education the subject of more explicit formulation. Without agreed normative ideals for human behaviour, other than a statistical average of present behaviour, it is hard to see how a process of moral education can be undertaken. It would be an unjustified criticism to imply that values are not available. As a specific instance, the 1973 report on sex education of the committee chaired by Mr E. N. Barker, and appointed by the New South Wales government, exhibited a high degree of responsibility and sensitivity to the values affecting the topic treated.[31]

50. The Board of Education, Church of England Diocese of Sydney, analysed the NSW Department of Education's report and identified twelve structural concepts, among which were:

> That personal development and sex education cannot be provided outside of a context of values and moral codes and that 'for many, but not all, these principles will be based on Christian beliefs' . . .
>
> That the school's fulfilment of its role in sex education must be complementary to and supportive of parental responsbility and the home in this matter.
>
> That sensitivity to religious and spiritual interpretations of values and moral judgments will be an integral feature of the program.[32]

The Church's report commended the report to the 'clergy, parishioners and especially parents of each parish in this province'.

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30. *Personal development in secondary schools—the place of sex education: a statement of principles* (Department of Education, NSW, 1974), pp. 16–18.
31. Submission 816, National Catholic Education Commission.
32. Board of Education, *Sex education in NSW schools* (Church of England, Diocese of Sydney, 1974), pp. 2–3.

51. The States of Tasmania[33] and South Australia[34] after consulting their communities have developed carefully articulated programs.

52. Educators have long understood the need to respect the integrity of the young in the context of teaching about controversial issues.

53. *Handling controversial social issues in secondary schools,* a report of a national conference in South Australia on the topic, in 1972, describes an issue as controversial if it:

(a) divides individuals and groups within the community;
(b) involves a challenge to existing practices in the community;
(c) . is rooted in values perceived to be in conflict.

54. The conference report, the whole of which we commend, contains the following valuable points:

(a) Communication between all persons and groups concerned should be as open as possible. Part of such communications is the opening of the classroom and its learning program to public scrutiny.
(b) As much as is possible all aspects of a controversy should be given equal emphasis and when this is not possible it should be clearly understood by all that this is the case.
(c) As far as possible, as many persons and groups holding contrary opinions, beliefs and values as possible should be involved in the planning and learning process.
(d) Teachers and schools must adhere to a well-publicised and rigorous professional ethic . . .
(e) Indoctrination has no place in the teaching of controversial social issues. It occurs when an individual or a group attempts to get its viewpoint accepted without having the facts and values on which it is based subjected to careful and rational analysis, and without its being considered side by side with other viewpoints.[35]

55. New South Wales, South Australia and Tasmania have carefully and deliberately introduced their programs with a high degree of community consultation, and with consequential widespread acceptance.

56. We mention here the Swedish suggestions for instructing on values and handling controversial issues. They categorise them into *fundamental values* and *controversial values,* and they urge that teaching on fundamental values should not be objective and that teaching on controversial values should be objective. Examples of fundamental values are the 'inviolability of human life and thus the right to personal integrity'; examples of controversial values are 'political philosophies, and different attitudes to certain questions of sexual morality'. (See Annexe II. A.)

Selection and training of teachers

57. The key role of teachers in the personal development of young people was emphasised by Dr Don Edgar who said that a good teacher can overcome a bad home environment. He told us:

> Many children from a low socio-economic background who find teachers treating them as human beings, as worthwhile, giving them encouragement, giving them positive help in

33. *Report on the effects and effectiveness of the social sciences personal relationships sub-unit in trial schools during 1973* (Curriculum Centre, Education Department, Tasmania, 1974); Exhibit 175.
34. Verbal advice, Neil Wardrop, SA Health Education Project.
35. Tulloch and Spring (eds), *Handling controversial social issues in secondary schools,* report of the first national workshop of the National Committee on Social Science Teaching, Raywood Inservice Centre, SA, 4–14 June 1972 (AGPS, Canberra, 1973).

relation to their work and trying to tie the school into the home-type relationships, those children are very positive about school and overcome the disadvantages their family provided them with.[36]

This is confirmed by the English research mentioned earlier (para. 18).

58. Those States which have advanced human relationships education programs (NSW, SA and Tasmania) have selected experienced teachers and given them specific training. Interested teachers are nominated by the school principal. Public acceptance of any program depends on a consensus that the professionals are qualified and are people of integrity.

59. Dr Delys Sargeant, School of Social Biology, University of Melbourne, who is involved in the education of teachers, medical students and other professionals in human sexuality, gave evidence about her work and the qualities needed in teachers.[37] She said there was no single suitable type of teacher for this work; but they must be people comfortable with their own sexuality.

60. We endorse this and also commend the NSW Department of Education's comments, viz.

> It is well-nigh impossible to define the qualities desirable in teachers to be involved in the program. To attempt to define requirements would almost inevitably exclude on some grounds people who would be valuable in the program. One would look for such qualities as social and personal maturity, sensitivity to the needs and problems of young people, a respect for their opinions and those of other concerned adults, a willingness to give serious thought to the most effective ways of meeting their responsibilities and a readiness to co-operate with other people also concerned with the education and welfare of young people.[38]

61. We also agree with the Department's observations on the problems that teachers face.

> Teachers have always faced a dilemma, when dealing with values, in deciding to what extent they should express their own views . . .
>
> While in general the teacher's personal views should not intrude into discussions there will be occasions when a statement may be necessary to help the students formulate their own views or to answer a request from students when such a request is relevant to the discussion. In such situations the teacher's statement should be balanced and restrained and presented as another opinion to be considered critically along with others . . .
>
> The occasions on which a teacher states his own views and the manner in which he does so will be also influenced by the maturity of his students and must at all times be appropriate to their readiness to receive such a statement and appreciate its significance.[39]

62. In the past not all teachers have been trained to teach human relationships; we hope that greater attention will be given to this.

63. Some colleges of advanced education have begun courses to develop teachers with a broad knowledge of man in his physical and social environment. Some courses are multidisciplinary, such as the 'life management' strand at the Riverina CAE. Other colleges, including Mount Gravatt in Queensland, and the University of New England are developing similar courses for teachers.[40]

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36. Evidence, p. 2772, Dr Don Edgar.
37. Evidence, pp. 2756–69, Dr Delys Sargeant.
38. *Personal development in secondary schools*, p. 13.
39. ibid., p. 18.
40. Evidence, pp. 1976–8, Mr Jim Carr; Submission 529, Mollie Campbell-Smith.

64. Some knowledge of health education is required in a teacher. Many student teachers elect to do the minimum course, however, and human sexuality is often only one topic among many. We wish to emphasise its importance. Undergraduate teachers appear to be no better informed than the public in general on sexuality and are therefore unprepared for their role in teaching human relationships.

65. We were informed of a number of recent studies about the attitudes and knowledge of student teachers about sexuality. The studies indicate that while their knowledge of vocabulary and physiology is adequate, they are confused about attitudes, sex roles, standards of behaviour required from males and females and about personal and professional responsibility. They did not consider themselves adequately prepared to undertake sex education, or to be involved in pastoral care of pupils.

66. Chopra and Warren made a study of 110 potential teachers at Newcastle University and indicated that:

> . . . teachers are no more likely to be well informed on matters of sexuality than their contemporaries . . .
>
> This implies careful attention to the selection of teachers for the program and, more importantly, serious concern for institutionalising yet another and very important area of human relationships.[41]

67. Along the same lines, Mrs Shirley Sampson, Faculty of Education, Monash University, studied final year trainee teachers to ascertain their sexual knowledge, their attitudes to sex roles and their ability to deal with the social issues that arise in school situations. In October 1975 questionnaires were given to 211 final year education students at three universities and fourteen state colleges in Victoria. Only three institutions provided compulsory sex education units, all under 6 hours in length. No college or university had included human relationships as a core part of their courses during the training period of final year students.

68. In response to the question, 'If a student in one of your classes were to tell you that her friend was pregnant, what action, if any, would you take?':

> . . . many of the students adopted what was considered an unsatisfactory position, in that a large proportion answered that they would do nothing. The best responses were felt to be those which offered to talk to the student concerned, the worst those who named recourse to the principal. About 20 per cent of all students suggested sensitive responses, rather than telling the girl's mother, etc. About half of these students mentioned telling her that she could get an abortion. We do not feel that this response was adequate. Most males *and* primary teachers opted out by announcing that it was unlikely to happen in their work!!

69. To the question, 'If there is no sex education course at the school at which you are teaching, (a) would you attempt to initiate one? Yes.....No..... (b) If yes, how would you go about it?' Mrs Sampson says:

> The responses were disheartening. Sixty-two per cent of respondents said that they would not take any action. Of those who answered 'yes', a few commented that they would take a sex education course themselves—or that they knew someone who had done so. One-third of all positive responses named consent of either staff or principal as a prerequisite for action. A few named only 'putting books in library'. Primary trainees were much more reluctant to act than secondary trainees. Approximately equal numbers of males and females rejected positive action. If ever there was a case for human relationships to become a core part of teacher education, this question proves it.

70. To the question, 'Where could you go for resource information on any or all of the following problems—contraception, abortion, child battering, family problems,

41. Submission 572, P. Chopra and W. Warren.

drug taking?' the answers were studied by an evaluation panel (of six students and the lecturer) who considered that they:

> . . . revealed both a lack of *knowledge* of local facilities which were available, and the *fact* that in October 1975 these facilities were *not* available generally. A majority of those who replied gave the same response to all questions—most frequently Social Services Dept. (Where respondents knew *one* resource they were more likely to know several.) We reject as inadequate responses such as 'social worker' for *all* problems as we believe teachers ought to know better than this.

71. When asked:

(a) how would you feel about the presence of a homosexual student (male or female) in your class?

(b) what, if anything, would *you* do if you thought that this student had been attacked physically by other students?

again primary trainees rejected this problem because they claimed it would not happen to them! The question should be amended to deal with 'alleged homosexuality' in any future study. On the whole, the answers to the first question were more heartening, as most responses indicated that teachers would not be upset by the presence of such a student.

Answers to the second question were very difficult to evaluate, e.g. does 'nothing' mean that teachers would allow any student, homosexual or not, to be beaten up?

The responses to these questions once again revealed some extremely well-intentioned and competent personalities, and others who either rejected action, or by the action indicated implied that homosexuality, to them, was deviant, if not abhorrent—'I would try to prevent anything physical happening in class'.

Mrs Sampson concludes:

> On the basis of this pilot study, it seems obvious that there is an urgent need to introduce human relationships as a core course for pre-service teacher education. By ignoring issues such as this, these institutions are perpetuating ignorance, and the 'undercover', 'shame-making' aura surrounding these social problems.[42]

Conclusions

72. Education authorities and many teachers are aware of the ethical problems of teaching in controversial areas, and departments are rightly cautious in their selection of teachers and curricula. Teacher education should emphasise the biology, psychology and sociology of social and sexual development; the variety of human behaviour in childhood, adolescence and throughout life. This will enable teachers to appreciate and respect the personal integrity of their pupils as social and sexual beings. Teachers should also be given information about community resources both in training and in service; the information should be kept up to date.

Communication within the teaching profession

73. Many teachers are aware of the isolation of their occupation. The South Australian Institute of Teachers expressed the dilemmas and insecurities of teachers and their need for aid from the behavioural sciences, and for life experience. We agree with them that teachers are forced into role playing often in conditions of considerable stress.

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42. Shirley Sampson, Report of a pilot study of the sex attitudes of final year teacher trainees in Victoria, 1975. (This pilot study was made in consultation with the Royal Commission on Human Relationships. Two visits were made to each institution by a group of five Dip.Ed. students—first to ascertain courses available and second to distribute the questionnaire. The latter was self-administered and given to students met on an assembly or exam day, and selected according to a table of random numbers. Only two students refused to fill in the questionnaire.)

They are particularly vulnerable, being expected by society to uphold values that same society has discarded. Teachers are often lonely. They have little real opportunity of talking to parents and many find this a considerable ordeal for which they have little preparation. Despite moves for more community involvement in schools, few are places that parents and interested persons care to visit . . .

Many would benefit from special leave to work in some other occupation.

SAIT considers that a nation-wide study should be undertaken to discover the incidence and causes of tension-produced illness among teachers . . .

Teacher training does not supply necessary training in leadership skills nor teach young teachers how to communicate with individual children or parents.

Few teachers have much knowledge of the background of ethnic, social or cultural groups other than their own . . .

Teachers know very little about means of modifying undesirable behaviour . . .

There is urgent need for an understanding of the phenomenon of violence; the way it works, its causes, its effects and consequences.[43]

Individual teachers wrote to us on similar lines.

74. Teachers have no national professional journal, as do doctors and other tertiary-trained occupations, although the Australian College of Education has tried to remedy the situation. Similarly school libraries do not as a matter of course have well-developed professional sections, tending rather to service subject areas of the curriculum. Educational publications tend to be organisational[44], subject oriented[45] or issue oriented.[46] Many are irregular, inward looking and dull.[47] Most do not reach the classroom teacher.

75. The Commonwealth Department of Education publishes a quality journal called *Education News*, with a circulation of 10 000 and a budget of about $60 000 in the current financial year. It provides a forum for academic and teacher opinion. It is bimonthly, and it is free to schools and other educational organisations, but tends to be deposited in libraries: schools should be encouraged to circulate it to staff rooms and to classroom teachers.

76. Teaching is an art, ever in need of refreshment, taking its insights from psychology, sociology and science, as well as from the particular subjects taught. Hence teachers need to be aware of developments in a variety of disciplines.

Conclusions

77. We think the government should contribute to a professional education magazine which could draw attention to education in human relationships, and should bring it to the classroom teacher throughout the nation with news and information on resource material.

43. Submission 147, SAIT.
44. e.g. NSW Education Gazette, Tasmanian Education Gazette.
45. e.g. *Teaching history*, History Teachers Association of NSW.
46. e.g. Speld Bulletin.
47. Some 200 are listed in *Current Australian serials*, 9th edition (National Library, Canberra, 1975).

5. Present education programs

1. We had information about current programs from all the State and Territory Education Departments[1] including replies to a questionnaire on human relationships education.

2. All States, except Queensland, have school programs at varying stages of development. In Queensland human relationships education is under review; there is some out-of-school-hours work by voluntary associations.

3. Human relationships education is being introduced in South Australian primary and secondary schools within a pilot program. New South Wales and Tasmania see such education as a matter of policy in secondary schools. In the ACT the matter is left to the local school board and in Victoria, Western Australia and the Northern Territory it is left to local teacher initiatives. Only one State, South Australia, envisages making such programs general and obligatory in the school in the future.

4. In Victoria voluntary associations provide more than half the school programs. In other States and Territories the work of voluntary associations is estimated not to exceed one-third of all the work in the schools. The Northern Territory estimates their contribution as well below one-third. Health Departments also contribute to the input of programs in all States to a greater or lesser extent.

5. Curricula appear to be centrally formulated in South Australia, NSW and Tasmania, but in NSW and Tasmania it appears that teachers are not obliged to adhere to the curriculum. In the ACT and Western Australia curricula seem to be defined by the health authorities.

6. In all systems parents are able to withdraw their children from classes if they wish. Most classes in government schools are given to mixed groups of boys and girls, though this is generally left to the teachers in NSW, Victoria and the Northern Territory.

7. Sex education is rarely taught in isolation in any school system. In NSW it is part of the personal development program which includes family and personal relationships, sexuality, sexual hygiene, personal development and communication skills. In Victoria it varies from being simply sex education to being part of a program including family and personal relationships, sexuality, sexual hygiene, personal development and communication skills; in a few cases it is part of health education. In the ACT social studies, biology and physical education are not related to sex education programs. In the Northern Territory it is part of the health education program and the science–biology strand. In Tasmania it occurs as a personal relations sub-unit in the social science course in the middle high school. In Western Australia the human relationships program emphasising human social interaction has been in use for some years and a program 'modern social issues' is also in use, as individual schools decide.

8. The States and Territories were asked to estimate at what level of the education system—primary, junior or senior high school—the bulk of their programs are delivered.

9. In South Australia the bulk of topics relevant to preparation of young people for puberty and adolescence are introduced in the primary school in its pilot schools, with

1. e.g. Submission 1104, NSW Dept of Education; Interview reports, SA, 1; Vic., 1; Evidence, pp. 1363–6, Ms M. de Zwart, SA Health Education Project; pp. 2331–40 Mr Brian Best, Tas. Ed. Dept; pp. 864–77, Mrs E. Campbell, Health Ed. Dept, ACT Health Services.

a view to State-wide coverage as the program develops. The ACT provides a somewhat less comprehensive program covering the essentials of puberty and male and female relationships, but leaves the bulk of the program to the secondary school.

10. In the Victorian primary schools where programs exist, the social aspects of male and female relationships, sex roles and marriage, are introduced. Most of the work is done in junior and senior high schools. Some of the controversial subjects are seldom discussed and only at the senior level.

11. In NSW, while the program appears broader, it is limited to pupils in the secondary school. Individual headmasters sometimes invite voluntary associations to give programs in primary schools. Controversial items are occasionally discussed, depending on local initiatives.

12. In Tasmania the program is directed at 15-year-olds, though some topics, such as marriage, divorce, parenthood, sex roles, the consequences of unplanned pregnancies, VD and pornography, are left till senior high school.

13. The States and Territories were asked to estimate the coverage of their programs. Table II.1 shows the result.

Table II.1 Estimated percentage of school population reaching statutory school leaving age who have received sex education in schools, 1973–75

	NSW	Vic.	SA	Tas.	Qld	NT
	%	%	%	%	%	%
1973	10	20	10	10	Nil	under 10
1974	20	20	20	20	Nil	under 10
1975	40–60	20	40	60	Nil	under 10

Western Australia and the ACT were unable to estimate.

14. The statutory school leaving age is 15 years in all States and Territories except Tasmania, where it is 16 years. In 1975, in Australia, 85 per cent of 15-year-olds and 56 per cent of 16-year-olds were at school.[2] It appears that the majority enter adolescence with little guidance on human relationships and sexuality from the adult Australian community, though the position is improving in some places.

The training of teachers presently employed

15. No States or Territories require teachers to complete a course which includes human sexuality before they are registered or allowed to work in state schools.

16. Asked from which general group teachers in sex education are selected, the authorities replied that they are using experienced teachers considered qualified by personal attributes; they are not from any particular subject area. Some found however that certain sources predominate. In Tasmania the principal source is social science teachers. Health educators are a source in South Australia, the ACT and Victoria; physical education teachers in the ACT and Victoria. Victoria listed biology teachers, health teachers and home economics teachers as their main source. In Western Australia class teachers do the work in those primary schools with programs.

17. It appears that emphasis is placed in the programs on the social aspects of sexuality, but not excluding health and biology.

2. Source: Aust. Dept of Education.

Teacher education preferences

18. Asked what was needed to improve human relationships education, all States except Tasmania would welcome funding to train experienced teachers. Tasmania, South Australia, the ACT and Victoria would welcome tertiary institutions providing post-graduate training for experienced teachers.

19. Victoria would welcome the funding of:

> . . . multidisciplinary courses in which teachers are in contact with other members of the community and thus come to see human sexuality in a community context, rather than one of classroom orientation only.

20. Tasmania would like to see pre-service teacher education in human sexuality as part of the normal teacher training institutions programs. Queensland indicated that, when in the future they develop a human relationships education program, they would welcome further funding for the training of experienced teachers and for the post-graduate training of experienced teachers in tertiary institutions.

Resources

21. Those States with programs centrally co-ordinated—Tasmania, South Australia and NSW—all used task forces to develop their programs. The personnel were drawn from experienced educators. Their tasks were to prepare printed and audio-visual materials for use in the school, develop guidelines on the various sub-topics and the total concept, review books, films and other commercially produced materials and promote the courses in discussions with parents and teachers. These are also supplied to the independent and Catholic schools on request. Annexe II.C lists some examples which we think are of high quality.

Voluntary associations

22. Much human relationships education in the past has been undertaken by voluntary organisations, in association with government departments. These organisations have presented courses by invitation of schools. In the early 1970s some Education Departments began to develop their own programs. The voluntary agencies still play an important but diminishing role in this area of education. The following voluntary agencies are now active.

23. The Family Life Movement[3], probably the oldest and most active, was established in 1925. It has been invited to work in all States. Its development has been careful and deliberate. Its programs tend to be one day or evening in a school, with parents and pupils together; they are an event in the school year. Considering the social climate in which this work was pioneered, the Family Life Movement showed considerable courage and foresight. It has suffered, like all voluntary groups, from inadequate funds to train its personnel, to research the results of its work and to develop resource materials. The Family Life Movement is a model for other voluntary organisations in the field, many of which tend to have a more definite religious or moral orientation.

24. The Christian Maturity Program[4], or its equivalent in the various States, is composed of Catholic doctors, laymen, teachers and clergy, and provides human relations courses in Catholic schools from kindergarten to sixth form. Their policy is to insist on both parents being present and participating fully.

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3. Submission 610, Family Life Movement of Australia.
4. Submission 816, National Catholic Education Commission; Interview report, NSW, 65.

25. The Catholic Family Life Centre (Catholic Family Welfare Bureau) in NSW, and other agencies in the various States, present programs in schools with small groups (eight to ten in each) from fourth to sixth forms. Catholic educators emphasise pupils' needs as the starting point of the educative process. Many of the Catholic organisations have pre-marital and marriage counselling services for adults also.[5]

26. The Adolescent Education Committee[6] in NSW, and its equivalent in other States, is a group usually of doctors and teachers who provide sex education in independent schools.

27. Marriage Guidance Councils[7] provide courses for schools, community groups, engaged couples, newlyweds and marrieds. The Council also provides courses for crippled childrens schools and for the mentally handicapped. The Council trains teachers for these groups and assists also in training teachers in Education Departments. It provides broadly based seminars and courses for groups such as doctors, social workers, medical students and lawyers. It finds that school pupils have knowledge of the abnormal, and poor knowledge of the normal. Courses include biological facts and project the view that sex is part of the whole personal development. The Marriage Guidance Council prefers to work with small groups; its work is hampered by lack of money.

28. The Family Planning Association[8] is active in each State, and has, since 1972, provided sex education courses in state high schools. Topics covered are child development, pregnancy, sex in society, sex roles and contraception. Sessions are of 2 hours and involve a lecture, a film and discussion. Class teachers are frequently involved in the discussions. Emphasis is on 'responsibility in all of one's life, including one's sexual life'. The FPA surveyed some students, who overwhelmingly favoured qualified persons, not necessarily teachers or doctors, to deliver courses.

29. Mental Health Associations in each State provide group leaders for adult groups, and are developing contacts with schools, primary and secondary, with programs having a human relationships emphasis. Many youth groups and youth services, such as the Youth Education Seminars, have graded programs for senior high school and post-school adolescents.

30. The Childbirth Education Association[9] and the Nursing Mothers Association[10] provide pre- and post-natal programs and co-operate with Health Departments and other organisations about childbirth and post-natal child care.

31. All the voluntary organisations work in schools by invitation. Parental consent is required and usually given. Little or no assessment of the work has been done. The courses are given only once a year and they do not provide more than an introduction to the topics discussed. Most activity is concentrated in urban areas or in large country centres.

32. All voluntary organisations suffer from lack of money. Schools usually contribute a small sum per pupil for visits to schools. Finance comes from subsidies, fees and, in some cases, membership fees of interested members of the public.

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5. Submission 816, National Catholic Education Commission.
6. Submission 128, Adolescent Education Committee, Independent Girls Schools, NSW.
7. Submissions 166, NSW MGC; 470, WA MGC; 533, Tas. MGC.
8. Submissions 612, Aust. Fed. FPA; 198, FPA ACT; 1171, FPA NT; 148, FPA SA; 253, FPA WA.
9. Submissions 118, CEA Aust.; 998, CEA (Vic. Branch); 999, CEA (NSW branch).
10. Submission 126, Nursing Mothers Association of Australia.

33. The private voluntary organisations are still providing a large part of human relationships education in Australia.

34. The Commission notes that the voluntary nature of the programs is an ingredient of their success. In this they point a lesson to the formal education institutions—that education, to be effective, must fulfil a perceived need or interest.

Conclusions

35. The voluntary associations have pioneered education in this field and have established techniques suitable for human relationships education. As a consequence they have built up teams of experienced and trained personnel which need to be encouraged and increased in numbers. We believe that the experience of the voluntary associations should be drawn upon by the formal educational institutions. They should be assisted by funding to develop as resource organisations for locally based programs. Educational aids should be made available for them to use.

The effectiveness of present education programs

36. Widespread discussion of sexual matters, over the last 10 years, has developed a public awareness hitherto unknown in our society. The random and sensational nature of much of the information and the growth of the pornography industry has not necessarily developed better informed individuals, although some believe it has. Many observers put forward the view that this sexual revolution has increased the vulnerability and insecurity of the young, and has devalued personal relations rather than enhanced them.

37. Some parents have been reluctant or unable to re-educate themselves and have not the skills or the vocabulary with which to talk on these matters with children. Many migrant parents do not speak English sufficiently to talk at length on complex or emotionally charged matters with their English-speaking children, and many come from cultures where subjects such as sexuality are not mentioned and public discussion is abhorred.

38. Religious belief and practice, once the close ally of the school in the educational process, appear less influential. This certainly was the view of many of the respondents to this Commission.

39. It is against these changes that the work of educators, formal and voluntary, has to be measured.

40. A Sydney social worker made these recommendations:

> I think we need to have some sort of a course in schools which is a sort of education for living in which people are taught opportunity for self-expression, they are educated about personal relationships and sex and they learn about how you can defer gratification and get more rewards from anticipation than too speedy gratification.[11]

41. If the incidence of teenage pregnancies and VD are seen as a measure, then the education programs have not been successful. However, if their efforts and resources are contrasted with those of the sexually exploitive industries, such as the cosmetic and dress trades or the pornography industry, and if the media are accepted as exploitive of sexuality[12], the education programs have at least provided a holding operation. To improve the situation, public policy must in our view accept the need to allocate substantially increased resources to education in human relationships.

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11. Evidence, pp. 99–100, Helen McNamara.
12. Submission 1104, NSW Dept of Education.

42. In schools, sex education programs of any depth are a recent development and hence cannot be fully assessed at this stage.

43. Some short-term evaluations have been attempted. The Curriculum Centre, Education Department of Tasmania, evaluated their personal relationships program through a questionnaire to Grade 9 pupils, teachers and parents. They found that:

(a) The outstanding feature was the agreement among the groups and not their differences.

(b) Twenty-one of twenty-two teachers indicated that most of their pupils had gained from the course.

(c) Parents were more convinced that . . . communication about sexual matters had improved than were the pupils.

(d) Pupils' attitudes showed no difference in 'liberalism' between pupils who did the course and pupils who did not.

(e) All groups agreed that such a course was needed, with the parents (95 per cent) most convinced.

(f) There was a strong feeling among teachers and parents that some teachers would not really be suitable and that willing teachers, not necessarily subject experts, should be also 'approved by someone in authority'.

(g) A feature of all the investigations was the small number of real objections raised . . . some 6 per cent of the teachers, 4 per cent of the pupils and just over 1 per cent of the parents did feel that the course should not be offered.[13]

The report is indicative of good prospects for success of such programs.

44. The NSW Department of Education said of its program:

> We believe that the work undertaken has been worthwhile, although it is early yet to assess its real value . . . We acknowledge shortcomings and admit mistakes, but feel optimism in the support accorded our attempts to give new emphasis to the school's contribution to the welfare of individuals and community in keeping with the aims of education throughout the history of society. We believe that better understanding of the roles of boys and girls, of men and women of all ages, is attainable and is being encouraged by the personal development programs.[14]

45. A formal evaluation of the work of voluntary associations working in sex education is not available, though the Family Life Movement has itself sponsored some research about the level of knowledge of young people. Many submissions spoke of the voluntary associations' work, saying that a one-lecture program was not enough to introduce young people to a complex subject.

46. In a research project funded by the Commission, Cole and Beighton reported on 110 male students attending the student health service at the University of Melbourne.[15]

> Two-thirds of the sample (66 per cent) reported some formal sex education. Those who attended a private secondary school were somewhat more likely to have had formal instruction (77 per cent) than those attending state secondary schools (61 per cent). Most subjects reported only one talk but 21 per cent had two. The great majority (88 per cent) had their formal sex education during the first 4 years of secondary school. Only 12 per cent reported instruction in the fifth and sixth forms and this figure includes those few subjects (three in number) who received some form of ongoing instruction rather than one, or at most two, brief talks.

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13. Exhibit 175.
14. Submission 1104, NSW Dept of Education.
15. F. Beighton & J. Cole, Attitudes of young males to contraception, Commission research report, no. 5, 1976.

The people giving the talks were: a speaker from the Family Life Movement (40 per cent), a chaplain or member of a religious teaching order (30 per cent), a teacher (17 per cent), a doctor (3 per cent) and persons of unknown status (9 per cent). Those attending Family Life Movement talks were often unaware of the exact status of the speaker. Subjects attending state secondary schools were far more likely to have gone to talks from the Family Life Movement than those attending private schools, where talks were usually given by a chaplain, priest or teacher.[16]

47. The following proportions recollected a comparatively unbiased coverage of abortion (14 per cent), contraception (28 per cent), venereal disease (17 per cent) and homosexuality (3 per cent).

Although a sizeable minority of the subjects reported overt moral biases, there was also a smaller group who noted that only carefully selected facts were given or that the style of presentation was extremely vague.[17]

48. The researchers commented:

The topics which appear to have been avoided: abortion, homosexuality, masturbation, contraception and sexual techniques, are at once those topics which may introduce ethical points and those with which the adolescent is particularly concerned.[18]

49. Hence they concluded:

Formal sex education, as described by these respondents, was limited to a single session covering reproductive biology and usually given in the first 4 years of secondary school. Despite the emphasis on biology, a sizeable group detected and resented moral biases and others commented that the selection of the topics was on moral grounds. Almost three-quarters (73 per cent) said that they gained nothing from their formal sex education.[19]

50. The study went on to discuss the impact of formal sex education on that 66 per cent of the group who reported receiving sex education.

As far as can be ascertained, sex education as carried out in the recent past had no overall effects on the total group who received it. There is a distinct possibility that it had a lasting deleterious effect on some more sensitive individuals.[20]

51. This conclusion may reflect a tendency of undergraduates to denigrate the value of their school experiences and, while we would not necessarily accept the conclusion as a valid assessment of the work done by the voluntary organisations, it clearly points to the need for comprehensive research and evaluation.

Conclusions

52. Since formal education in human relationships is in its infancy, longitudinal studies should examine a representative sample of school populations who have done a systematic sex education course and a parallel group who have not done so, to compare their attitudes, behaviour and life development in the 10 years after leaving school.

53. Comparative studies of different kinds of courses should also be undertaken.

16. ibid., p. 8.
17. ibid., p. 11.
18. ibid., p. 12.
19. ibid., p. 13.
20. ibid., p. 22.

6. Social sexual behaviour: implications for education

1. Failure to provide education in sexuality causes many people to suffer unnecessarily because of ignorance.

2. On this point Dr J. Black, obstetrician and gynaecologist, told us that in:

> . . . practically every patient that I see the basis of his or her problem is a lack of understanding of matters sexual . . . I have probably now seen 750, mainly women but also men . . . and there are only three women in that 750 who I felt were completely sexually aware.

3. On the patient's attitude to information, Dr Black said:

> Some women are shocked, some women are surprised and many women are upset but upset from the point of view of feeling they had been cheated all these years.[1]

Many of his patients were adherents of strict religion and their teachers and parents seemed to have suppressed information.

4. Dr B. Smithurst, Reader in Social and Preventive Medicine, University of Queensland, gave evidence about venereal disease and its increased incidence. He stressed the importance of education as a weapon against VD and spoke of the ignorance of youth:

> . . . in how the disease is contracted, how it manifests itself and can be treated.[2]

5. In an article in the *Medical Journal of Australia*, entitled 'The social background of 171 women attending a venereal disease clinic'[3], Dr Smithurst observed that the patients were of lower socio-economic origin, were less well educated than the Brisbane average, fourteen of them were prostitutes, and 15.2 per cent were of Aboriginal or part-Aboriginal origin. Dr Smithurst reported that:

> . . . 73.09 per cent showed a disturbing lack of knowledge of venereal disease . . . and treatment programs.

6. The Childbirth Education Association, Victorian branch, spoke of young women's fear of childbirth, because they knew so little about it.[4] Dr William Thomson, a Melbourne psycho-analyst, conducted a study in Darwin in 1975 of 122 adult women, aged between 21 and 38, who were all born and educated in southern or eastern States. All subjects had attained leaving certificate standard, and about 65 per cent had received tertiary education.

7. The questionnaire concerned six areas of sexuality: sexual anatomy, general knowledge, conception, pregnancy, contraception and male sexuality. The following factors emerged from the study:

(a) Few subjects were familiar with the names of sexual organs.

(b) There was a surprising lack of knowledge concerning the processes of pregnancy and about genetic factors.

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1. Evidence, pp. 33–48, Dr J. Black.
2. Evidence, pp. 1600–10, Dr B. Smithurst.
3. Exhibit 103.
4. Submission 998, CEA (Aust.) Vic. branch.

(c) Subjects were better informed concerning contraception than in any of the other areas covered by the questionnaire.

(d) There was a wide variation in individual scores which was unrelated to general educational factors.[5]

Results of this study tend to confirm the author's hypothesis, namely that the average Australian adult is naive concerning human sexuality.

8. Ms Petah Battersby, a Brisbane sociologist, said:

> Ignorance is not bliss. Ignorance creates confusion, unhappiness and resentment. It can also give rise to rebellion against those who encourage it.[6]

9. These are but samples of evidence which point to the need for comprehensive, non-evasive sex education, education which discusses cause and effect and respects the needs of others.

Sources of sexual knowledge

10. Peers appear to be the preponderant source of information on matters of sex for young people both in Australia and elsewhere, as is evident in Chopra and Warren's sample of 110 trainee teachers, of whom 96 per cent were under 30, 72 per cent were married, 34 per cent were male and 66 per cent were female.[7]

11. Asked 'Where did you get most of your information about sex when you were a youngster?' the subjects reported as the primary source of information:

	Males	Females
	%	%
Friends	66	47
Parents	0	21
Sex education books	18	13
Pornographic literature	3	0
School	5	1
The church	0	3

12. In this their experience is much as their contemporaries reported—no better, no worse. Asked 'What do you think is the best source of sex instruction for children?' the subjects replied:

	Males	Females
	%	%
Books	16	17
Friends	5	3
School	21	13
Parents	39	53
The church	0	0
A combination of the above	18	13

5. Wm Thomson, 'Sex education in Australia; a study concerning knowledge of human sexuality', *Betragen* (monograph supplement of *Clinical Psychologist*), Series No. 6 (1976).
6. Submission 1004, Ms Petah Battersby.
7. Submission 572, P. Chopra and W. Warren.

13. This may be variously interpreted. With hindsight, the young teachers may see their parents as having given more accurate information and provided examples more reliable than their friends; they may think parents ought to be the educators of children on these matters; or it may be an expression of unwillingness or inability to see themselves as future educators in this field.

14. Mr Stanley Johnson, lecturer in education at the Newcastle College of Advanced Education, gave evidence for the Family Life Movement and tendered a study in which 521 students aged 14 to 21 were surveyed.[8] They were drawn from four high schools, two teachers colleges, one technical college and one university.

15. A terminology test of fifty-five items and a test of thirty-seven true/false items relating to sex myths was employed. This reveals that some useful research is being done by the voluntary organisations.

16. The terms used in both tests were the technical–literary language terms, not the popular or vulgar terms and, in the circumstances, the results showed a fair level of knowledge. Johnson reported:

(a) Sex knowledge increases with age.
(b) Females have more sex knowledge than males.
(c) Socio-economic level does not affect sex knowledge.
(d) Peers are the third most frequently stated source of sex information for adolescents.
(e) Mothers are a more common source of sex information for their daughters than they are for their sons.
(f) Fathers are a more common source of sex information for their sons than they are for their daughters.

17. Johnson showed that parents were the preferred source of sex information for adolescents and reading the least preferred source. In the study already quoted, Smithurst said that 'friends and relations' (44 per cent) were the most frequent source of information about VD, that relatives were siblings and their ignorance included 'no knowledge of VD or false knowledge of the disease'.[9]

18. Cole and Beighton's already mentioned study of male undergraduates in Melbourne found that friends were mentioned by 73 per cent of the total sample as the source of information about sexuality, and 11 per cent quoted 'life' or experience, usually 'some form of experimentation with girlfriends'. Therefore 84 per cent derived some of their knowledge from their peers. The researchers remark:

> This confirms the work of others in finding friends as the most frequently cited source.

Friends (39 per cent) and books (17 per cent), in retrospect, were considered the most important source by this sample of young men undergoing tertiary education.

19. Cole and Beighton questioned the subjects on this experience, and report:

> Although most respondents referred to their discussions with their peers in such neutral terms as 'just other boys talking', 'just the normal smut children talk' or 'from dirty jokes', there were others who were more critical of the quality of the information, e.g.
>
> 'Friends mainly, but I didn't learn much. I was pretty ignorant until I got to the 6th form.'
>
> 'I had knowledge before going to secondary school from other boys about physiology, but it was all misleading stories at school.'[10]

8. Exhibit 210.
9. Exhibit 103.
10. Beighton & Cole, Commission research report, no. 5, pp. 14–15.

20. In a research project sponsored by this Commission, Wills, Cox and Antolovich reported discussion with some eighteen informal groups of adults, single sex and mixed groups, on attitudes to sexuality.[11]

21. Concerning 'formal' sex education it was reported:

28.7 per cent received sex education as part of general biology;

25.7 per cent as instruction on human reproduction;

11.8 per cent as instruction on human sexuality and interpersonal relationships;

26.5 per cent received no 'formal' sex education at all.

22. On the value of each source of information[12] they found:

	Source of *accurate* sex information		Source of *inaccurate* sex information	
	Male	Female	Male	Female
	%	%	%	%
None	2	1	20	27
Parents	18	5	6	13
Siblings	2	2	..	2
Lessons	2	2	2	2
Books	23	22	8	5
Friends	16	5	47	37
Partner	10	24	6	2
Experience	20	26	4	1
Many	8	12	8	10

23. The report says the participants described the misinformation they received with embarrassment.

24. Information in the course of the study shows girls beginning to menstruate without prior knowledge of what was happening to them, their fear of what was happening and, in some cases, parents' inadequate response to requests for reassuring information on menstruation, intercourse or childbirth with the result that misinformation or lack of information persisted until marriage in some cases.

25. The participants, drawing on their own experience, spoke of the need for parent education on sexuality and school programs on sexuality. This should begin in primary schools because children begin to pick up misinformation about sexuality at an early age.[13]

26. The Australian studies confirm research in other countries. A study by Reverend Tomas V. Mariano, testing the sexual knowledge of 6081 senior high school students in the Philippines, found that:

> . . . high school students had fairly good knowledge concerning sexual matters in general terms but were ignorant of specifically medical or technical details . . . Students scored badly in the questions relating to birth control, in spite of the frequency with which it was

11. S. Wills, E. Cox & G. Antolovich, Attitudes to sexuality, Sydney, Commission research report, no. 8, 1976.
12. ibid., p. 38.
13. ibid., p. 50.

discussed, and in questions relating to the sexual aberrations . . . in spite of the infrequency with which venereal disease was reported as a subject of discussion, knowledge concerning the nature of VD was accurate and scientific.[14]

27. Robert Chartham, in the UK, sent by mail 500 questionnaires to 'men and women who had been in touch with' him in his capacity as a marriage guidance counsellor; 278 men and 191 women replied.[15] The subjects were from professional or semi-professional occupations, aged between 22 and 31, and had passed through puberty and adolescence between 1954 and 1960.

28. Chartham describes the gradual discovery of boys of their sexuality and of the part of sex education in it. He says that no matter at which age boys were told the details of intercourse, 46 per cent reported not understanding and, among that 46 per cent, friends as informants ranked high; 62.2 per cent of the female subjects reported not understanding or only partially understanding what they were told:

> Of those who did understand, 42.8 per cent were given the information by contemporary friends; 28.5 per cent were instructed by teachers and doctors; and 21.4 per cent were enlightened by their mothers. Of those who did not understand, 71.1 per cent had been told by their mothers; 35.7 per cent by friends; 28.5 per cent learnt from books; 21.4 per cent had been instructed by teachers; and 21.4 per cent were told by fiances, who, within a short time, made everything clear by a practical demonstration.

Chartham remarks:

> Mothers and teachers, but especially mothers, must brush up on their instructing techniques!

29. In the mid 1960s Schofield interviewed 1873 London teenagers about their sexual knowledge, attitudes and activity.[16] He found that 62 per cent of boys and 44 per cent of girls learnt about conception from their friends, 'usually through jokes which were quite often smutty and obscene'. Twenty-seven per cent of the girls obtained this information from their mothers. Only 7 per cent of boys learnt of conception from their fathers and 7 per cent from books. Twelve per cent of boys and 18 per cent of girls learnt of conception from teachers. The main sources of knowledge for boys and girls were friends, TV and books.

Conclusions

30. Peers have a widespread influence and they often perpetuate misinformation and spread sexual myths. There is a need to provide accurate information to young people and to help parents to take a more positive role. To make peer influence more benign the skills of two significant institutions must be increased—families and schools, which we see always as complementary one to the other.

Early sexual activity and its risks

31. Evidence about early sexual activity, including intercourse, gives added support to the need for accurate information on sexuality to the young. Our evidence indicates that a minority of young people experience intercourse before 16 and that they do so either ignorant or reckless of the possible social, economic and health hazards for themselves and their partners.

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14. 'Sex knowledge and attitudes: a survey of Bulacan high school seniors', *Reproductions* (Information Bulletin, Institute for the Study of Human Reproduction, Faculty of Medicine, University of Santo Tomas) 2, 16 (1971)
15. R. Chartham, *Sex manners for the young generation* (New English Library, London, 1970), p. 35.
16. Michael Schofield, *The sexual behaviour of young people* (Pelican, Harmondsworth, 1968), pp. 82, 83, 95–6.

32. The Cole and Beighton study of male undergraduates indicates that:

> . . . the commencement of sexual activity occurred for 10 per cent prior to the age of 16 and for 66 per cent of the total sample by the age of 20.[17]

33. They compared this with an American study and with their own earlier study[18] of Melbourne female undergraduates, saying:

> When compared with Needle (1975) at an American east coast university, students at this university had sexual intercourse for the first time later than their American colleagues, 25 per cent of Australian and 51 per cent of American students having done so by the age of 17. The proportion of Melbourne University male students who were sexually active by the age of 17 is about the same as that reported by Schofield (1968) in a study of sexual behaviour of young people in Greater London.

34. Smithurst's study of 171 women with VD shows that the first coitus 'occurred around 16 or 17 years', and that the majority had coitus by 18 years.[19]

35. Chopra and Warren's study of 110 graduate student teachers showed:

> 66 per cent (M), 69 per cent (F) report heterosexual intercourse prior to the age of 23;
> 58 per cent (M), 56 per cent (F) prior to the age of 20;
> 29 per cent (M), 16 per cent (F) prior to the age of 17;
> 8 per cent (M), 0 per cent (F) prior to the age of 14.[20]

36. Zelnick and Kantner's survey of a national sample of the female population aged 15 to 19 in the United States in 1971 revealed that 27.6 per cent of unmarried females aged 15 to 19 had had intercourse.[21]

37. Schofield's sample of 1873 young Londoners, aged 14 to 21, in the mid 1960s, reported that:

> Less than 5 per cent of the teenagers had been out on their first date before they were 12 but by the age of 13 a quarter of the boys and almost a third of the girls had already had their first date. Before they reached 16, over 70 per cent of the boys and over 85 per cent of the girls had experienced dating. Therefore most teenagers make their first serious contact with the opposite sex between 12 and 13.

and:

> Among 15-year-olds, 6 per cent of boys and 2 per cent of girls had experienced sexual intercourse. Although every secondary school probably contains a few boys and girls who are sexually experienced, it is unlikely that they are more than a very small minority.[22]

This study shows how sexual behaviour develops along a recognisable pattern from dating to petting to intercourse. Each individual progresses at a different rate and many do not reach intercourse until marriage.

38. The ABC publication *The teens* contains accounts by young people, some in the 12 to 15 age group, of their growing sexual awareness and experiences; anxiety and ignorance and difficulties in obtaining accurate information seem to be a common feature of this stage of development.[23]

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17. Beighton & Cole, Commission research report, no. 5, p. 28.
18. Submission 556, J. B. Cole & F. C. L. Beighton.
19. Exhibit 103.
20. Submission 572, P. Chopra and W. Warren.
21. Melvin Zelnich & John F. Kantner 'Sexuality, contraception and pregnancy among young unwed females in the United States', in C. F. Westaff & R. J. Parke Jr (eds) *Demographic and social aspects of population growth* (US Government Printing Office, Washington (1972).
22. Schofield pp. 56–7.
23. *The teens*, a series of ABC radio broadcasts about the 12–15 age group (1974) pp. 22 ff.

39. Concerning the risks of early intercourse, the Australian Medical Association[24] and other experts[25] emphasise the need for girls to be acquainted with the possible consequences of early sexual activities.

> The association of early commencement of sexual intercourse, and promiscuity during adolescence, with the later development of carcinoma of the cervix is now sufficiently well established to advise widespread promulgation to the public . . . in the same way that warnings about smoking and lung cancer have been conveyed. Although we cannot be optimistic that such warnings are heeded by adolescents, it is nevertheless the duty of the profession to disseminate such information, and therefore this also should be discussed by the physician with 14–15-year-old children.[26]

Other evidence referred to the possible psychological and emotional harm which very early sexual experience can cause to the young girl.[27]

40. The risks of early pregnancy when young people have intercourse without contraception needs emphasis. There is also some risk in young girls taking oral contraceptives before bone growth is complete; it may lead to possible infertility.[28] The evidence suggests that ignorance and inaccessibility of information, advice and services contribute to teenage abortions and illegitimate births.

41. In this situation it is clear that ignorance, so far from protecting young people, actually renders them more vulnerable to the risks of early sexual experience.

42. Many of our submissions referred to the need for sex education to be given when the child is ready for it. Educators would not dispute this, since it is a fundamental of educational practice. Because education in human relationships is contentious, so too will the appropriate age be, particularly with those who assert that knowledge leads to experimentation. The Commission did not receive any evidence that sexual education in fact encourages such experiment.

43. The evidence shows that experimentation exists in any event and that in the absence of education it exists in ignorance of the consequences. There is a clear need for education that will inform young people and help them to be aware of their responsibilities and to act with concern for themselves and others in knowledge, not in fear and ignorance.

44. The soundest recommendation we have seen on achieving this is from Sweden where it was noted that:

> . . . many very early sexual relationships are started before the young people concerned can handle the situation emotionally, or cope with the responsibility, and this can have unfortunate consequences. Teaching in sexual and personal relationships should try to help reduce the number of such relationships, and mitigate their negative consequences.[29]

Scope and content of programs of education for human relationships

45. Evidence to us indicated a number of tasks for educators in human relationships. Some saw this as being broadly based, with emphasis on developing the whole personality appropriate to age and developing skills which will give an adult personal autonomy.

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24. Submission 1101, AMA.
25. Evidence, pp. 128–37, Dr Jean Benjamin.
26. Submission 1101 cites Coppleson, *Pre-clinical carcinoma of the cervix uteri* (Pergamon Press, Aust., 1967).
27. Evidence, p. 2385, Dr Elaine McKinnon.
28. Opinion of Dr B. Wren, obstetrician & gynaecologist.
29. See Annexe II.A quotations 5 and 13, for a fuller treatment.

46. Others saw such education, especially on sexuality, as preventative, so that young people might make fully informed and therefore responsible decisions about their sexual behaviour; or again as remedial, making up for the deficiencies of parents.

47. Our view is that sex education must be comprehensive, factual, frank, non-judgmental and, at the same time, sensitive to the age and the social and moral climate of the pupil. The young must feel comfortable and free to ask questions.

48. Many submissions listed topics necessary to a course on human relationships education.

49. The Adolescent Education Committee of Independent Girls Schools cover, among other topics, in their course:

(a) Male and female roles in modern society.
(b) Early emotional development.
(c) The family.
(d) Meaning of love; basic needs, emotional, social and physical.
(e) Sexual development, masturbation, homosexuality, necking, petting, going steady, parties, sexual intercourse.
(f) Obesity, diet, acne, posture; adolescence.
(g) Human reproduction, family planning, unwanted pregnancy, labour and childbirth; venereal disease.
(h) Drugs, alcohol and tobacco; medicines.
(i) Marriage and divorce; man–woman relationships and responsibilities.
(j) Statistics on births, marriages, divorces, VD.[30]

50. The South Australian and Tasmanian Education Departments have programs which cover many of these topics, with a slightly different emphasis. The New South Wales Education Department's personal development program comprehends practically everything mentioned by our respondents.

51. Because many of the community's helping agencies are not known, courses should ideally provide information about local resources.

52. Rather than treating human relationships education as a special and separate topic, we believe that a great deal of understanding can be conveyed through general school subjects. Home science should emphasise child care, child development and human maturation. Social science has the family as the central theme but should not exclude discussion about single, widowed, divorced, childless and homosexual persons and their life styles.

53. Some evidence indicates that our society disadvantages people not organised in family groups. Education should help young people to be tolerant of differences and to cope with different situations which they may experience directly. Commerce and social science should study the structure and function of government, the welfare system, business, banking and trade unions, personal economic planning, getting and holding a job, using credit, and exercising consumer rights.

54. It is clear from our evidence that the community would welcome such an integrated and comprehensive approach and would appreciate schools positively encouraging such programs.

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30. Submission 128, Adolescent Education C'tee, Independent Girls Schools, NSW.

Sex roles

55. Many people see the need for education to take active steps to reduce the severity of sex role differentiation in Australia and to break down the worst effects of traditional sex roles. Education should emphasise and appreciate the similarities and differences between males and females.

56. The Australian Council of State School Organisations argued that schools should take steps to treat boys and girls equally; that schools have a special responsibility to encourage female students; that the education system should abandon materials that portray women as inferior and develop balanced material on the family, child development and social relations.[31]

57. Dr D. Edgar, Department of Sociology, La Trobe University, reported on a study of 1214 boys and girls in Victoria. He noted the relatively low self-esteem of the girls in the sample and said that boys and girls were educated to a kind of social incompetence. He argued for comprehensive high schools, where a 'life skills curriculum' is taught, as part of the breaking down of polarised sex roles:

> The curriculum must be restructured so it does not lock the children into narrow subject choices: so that every girl can learn woodwork, metal work: so that every boy can learn cookery, needlework, if he wants . . .
>
> At that secondary comprehensive level I would much rather see a new course designed which would be called something like 'a life skills curriculum' meaning thereby that all boys and girls would learn in that course how to survive by themselves.[32]

58. Dr C. Noller, director of counselling, Life Line, Brisbane, wished to build up a new image of the male in our society. He thought that the:

> . . . emphasis on male achievement vocationally means that if the male is going to have a hard driving image and develop into a hard driving person, it is very difficult for him to slip back into a fairly sensitive role, so this may have some real implications in the way our whole society functions.

People are able to change, he suggested, if helped to gain insights into their own behaviour:

> If you can undermine this belief that all other men are hard you may get somewhere and you can do this best in marital groups.[33]

59. A Launceston mother, now a student of a CAE, wrote of men and women trapped in their roles, particularly of men who feel threatened by women's growing independence:

> I would suggest that the average Australian male ego is totally founded on this breadwinner role . . . and this in itself is extremely restricting to the development of both sexes. There develops the common situation, where a man refuses to let his wife work because her very working, and earning, makes his contribution no longer the total means of the family's continuance; his status as breadwinner is threatened . . .
>
> As a result of role conditioning, both men and women are frequently restricted from reaching their full potential as human beings and contributing members of society, simply because of society's expectations of the roles they should play within the family unit.[34]

60. A young married woman wrote in a lively style:

> I am surprised that any section of society really expects marriages to work. When one considers the separate upbringings (based purely on sexual differences) to which females and

31. Submission 1062, Aust. Council of State School Organisations.
32. Evidence, pp. 2769–80, Dr Donald Edgar.
33. Evidence, pp. 1484–7, Dr Charles Noller.
34. Submission 788, Mrs Joy Driscoll.

males are subjected (starting with sexual colour coding for babies etc.), I am amazed that some can firmly argue that pre-marriage apartheid is at all useful; at the same time, these same people throw up their hands in horror at the growing divorce rate, non-certified coupling etc.

She believed public education should:

> . . . attempt to abolish sexist language and jokes (the mother-in-law type especially). I see the abolition of sexism in schools (teachers, books, practices, mothers clubs etc.) as a prerequisite for unconditioning society.[35]

61. Sex role polarisation was also seen as hindering fathers from nurturing their children and it reduced their ability to relate to their children. The Nursing Mothers Association of Australia wrote:

> Fathers, as well as mothers, are the protectors of their families' emotional health and physical welfare and should be given education and social encouragement to enable them to find enjoyment and satisfaction in this role.[36]

Social sexual relationships in adolescence

62. A study of Sydney youth, aged 12–20, conducted by Professor Connell and others in 1969–70, showed some of the differences and parallels in adolescence for boys and girls.[37] Girls from age 12 have a greater concern for personal appearance and attractiveness, and lower self-esteem than comparable males; they are more prone to depression; more honest than boys; stricter in upholding principle; more conscientious churchgoers than boys; place a particularly high value on friendship; and have a higher sensitivity on conscience issues as well as a higher sense of concern and worry.

> Most teenagers are interested in the opposite sex. The 13–14-year-old girls start the process with an enthusiasm for the pop culture of the mass media, the 15–16-year-olds become keen on mixed dances and parties, and from the 17–18-year-olds the mating group of interests draws its keenest recruits.
>
> The boys follow not far behind the girls and through less clear-cut stages; they have some little interest in the pop stars and comparable attractions from the mass media; they show no great enthusiasm for dancing, though, if they have to go to dances, probably the 17-year-olds are the most attracted; and, finally, the 18–19-year-olds are those most ready to take up with the mating activities . . . Sex roles are enacted in a competitive situation, though here it is an informal competition for prestige, sexual pleasure and marriage partners. The self-choice marriage customs that practically all Australians adhere to throw a terrific pressure onto those who must get themselves chosen. That pressure is heavily towards those types of behaviour, those patterns of thought and interest, which are conventionally regarded as attractive to the other sex. Sex role behaviour is 'successful' behaviour in the marriage market just as intelligence is 'successful' behaviour in education competition.[38]

63. It is within this setting of traditional sex roles that early sexual encounters occur. The evidence before the Commission indicates that girls and boys need help to understand the peer pressures on them and the dangers to health and happiness attributed to early sexual activity, especially for girls.

64. These sexual relationships arise from pressures and other behaviour which girls are insufficiently assertive to refuse, frequently with detriment to themselves and not infrequently to a subsequent child.

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35. Submission 350, Ms Maggie Wilson.
36. Submission 126, Nursing Mothers Assoc. of Australia.
37. W. F. Connell et al., *12 to 20: studies of city youth* (Hicks Smith & Sons, Sydney, 1975).
38. ibid., pp. 192, 276.

65. Dr Elaine McKinnon, of the Adolescent Education Committee, testified to:

> . . . the pressure on the young adolescent girl by the time she is 14 to have a sexual relationship. This really concerns us very much because all the research that we can gather and our own observations would indicate that psychologically and emotionally it is disastrous to her further development as a person. It actually can limit and even destroy her personality development.[39]

66. The Commission on the Status of Women, NSW State Council, Australian Council of Churches, was disturbed:

> . . . that our society has an oppressive and strongly presented image of its women which prevents women from being true to themselves and relating fully and freely. We see these images as being powerfully affirmed by many forces, including the church.

They saw as some of the consequences:

> Girls from a very young age . . . conditioned to see . . . that only in motherhood will they find fulfilment, creativity, femininity and usefulness to society; downgrading of the childless and single women and problems in their capacity to see themselves as people of worth living full lives; downgrading of fatherhood as the mother tries to find her whole life in relation to her children.

They concluded:

> We believe that a deliberate effort must be made throughout society, particularly through the education system and the media, to break down sex role stereotyping.[40]

67. The South Australian Medical Womens Society gave similar evidence.[41]

68. It seems to be true that teenage girls are under pressure to be both virginal and sexy. A Sydney teacher writes of this phenomenon:

> From an early age girls . . . are encouraged to be at once cute, provocative and flirtatious, yet innocent and pure. The two demands are totally incompatible, and teenage girls find the resultant conflict confusing . . .
>
> I believe that rather than asking passively, 'How far should I go?' a girl should ask herself 'How far do I personally want to go?' The answer should be based on a real sense of self-worth and dignity, of responsibility to self as well as to others.[42]

There are also pressures on boys to conform to the sexual behaviour pattern of their peers even if they personally do not want to progress to sexual intercourse.

69. Girls and boys who have been given strong moral or religious beliefs are probably more readily able to resist the pressure to have sexual relations. A lower incidence of teenage pregnancy and abortion among migrant families (especially Greeks) suggests a more effective pattern of social controls at least in the transitional stage of integration.

70. Girls need to have their self-esteem boosted by approval from adults at home and at school; they should be led to realise that girls, as well as boys, are responsible sexual beings. To counter girls' socialisation to submissiveness, the school can assist girls to understand their needs and rights, and to learn to assert themselves[43] respecting marriage, contraception, abortion, adoption and the physical risks of early intercourse.

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39. Evidence, p. 2385, Dr Elaine McKinnon.
40. Submission 991, Commission on Status of Women, NSW State Council, Aust. Council of Churches.
41. Submission 143, SA Medical Womens Society.
42. Gail Shelston, 'Sex education for girls in the secondary school curriculum', *Education* 57, 16 (1976), p. 12 (Journal of the NSW Teachers Federation).
43. Evidence, p. 1482, Dr Charles Noller; Colleen Kelly, 'Assertion theory' in J. Pfeiffer & J. Jones (eds), *1976 Annual Handbook for Group Facilitators* (La Jola, Calif. University Associates, 1976); P. Jakibowski-Spector, 'Facilitating the growth of women through assertion training', *The Counselling Psychologist* 4, 1 (1973).

71. Girls as well as boys need to know their responsibilities in matters of carnal knowledge and rape, particularly what exactly is meant by consent and the age at which consent may be given lawfully. Boys are sometimes unaware that consent may be vitiated by threats or physical coercion. This is discussed at greater length in Part VII.

Communication skills

72. Ignorance of sexuality, common in Australia, is worst for people who have difficulties in communication.

73. Dr Noller spoke to us of the:

> . . . real resistance about intimate communication in the family—not so much verbally as in sensitivity, general sharing of intimacy at all levels.

He said:

> The general problem is that the male in the family is fairly insensitive to the needs and feelings and aspirations of the woman. I see this as bound up with our whole cultural stereotype in Australia and typical western society's view of the male, that he tends to focus on the instrumental roles of getting out and working and keeping the family—'I give her all the money she needs. I am a good father . . .'
>
> Typically from the wife we get, 'He does not understand me, never talks to me, never takes time to be interested in what I am doing and I feel isolated within the family . . .'
>
> By the time they are 3 or 4 years old boys are told that they should not cry . . . and so the male by school age is already very strongly socialised against really expressing his deeper feelings. It is not male or masculine to express your feelings.[44]

Dr Noller's observation was repeated in many submissions and is a theme in books about male–female relations in Australia, such as Conway's *The great Australian stupor*[45] and Bell's *The sex survey of Australian women.*[46]

74. Conway, a consulting psychologist, in another context said of boys studied in two large private schools that:

> . . . it was home environment and peer group expectation which mostly dictated their social attitudes and vocational choice. Moreover, it was apparent that the emphasis on physical skills, competitive peer group activity and materialistic object-centred ambitions in their homes and social milieux placed these boys at a positive emotional disadvantage when it came to coping with boy–girl relationships. These 17-year-olds, it became clear, were not ready to cope with the complexities of heterosexual role playing. Hence, the one-sex school milieu was almost necessary to provide them with the necessary 'moratorium' for adequate masculine identification.[47]

Conway saw the school as playing an 'ameliorating' role in changing the attitudes of parents, particularly mothers, to male upbringing and seeing a wider role for women in society.

75. To quote Conway again:

> In brief, our educational institutions should be conveying a deeper, broader concept of human relationships than one based simply upon sex information . . . Sex education is vitally necessary but, taken out of psychological context, its value is equivocal rather than certain.

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44. Evidence, p. 1481, Dr Charles Noller.
45. Ronald Conway, *The great Australian stupor* (Sun Books, Melbourne, 1974).
46. Robert R. Bell, *The sex survey of Australian women* (Sun Books, Melbourne, 1974).
47. Ronald Conway, 'On mutual liberation: the need for a liberated and liberalised male', *Education News* 15, 4 & 5 (1975), pp. 22–9.

76. Change can be wrought in the classroom by allowing children insight into the socialisation process. A teacher in the Sydney area said that, once the process of socialisation was explained to a group of teenage males, many expressed relief at understanding this aspect of themselves and the group's previous hostility or indifference to the sex education program was reduced considerably.[48]

Parenthood

77. Since 1970 the Child Health Service of the Department of Public Health, WA, has conducted a pre-parent course in some WA schools. The courses are taken by both boys and girls. The aims listed include:

(a) developing an interest in learning to understand a child's needs for an informed interacting parent;

(b) developing an attitude of tenderness and responsibility.

78. The courses are for children but have been given to 'people aged 12 years to adults'. In 1975, 2884 boys and 3190 girls undertook the course in twenty-six city and seventeen country schools. The course consists of ten sessions: bathing a life-size doll; means of communicating with small children; the mother's and father's role; how much behaviour is learnt, not instinctive; and how loving and caring interaction affects a child's personality. The course includes visits to kindergartens to observe the behaviour of small children.

79. The Child Health Service told us:

> Boys certainly appear to gain most from the course—they show a keen interest from the beginning. Both boys and girls gain an insight into, and an understanding of, the feelings of the opposite sex and see them first as people (often for the first time!)—then as either boys or girls.
>
> It is noticeable that boys are as interested, if not more so, than girls in the area of child nurturing and development.[49]

80. The children's evaluation sheets reveal clearly how willing they are to learn. Some typical boys' comments were:

> I think that the course has made me realise that some day I will get married or its equivalent, or that I will have children (Oh boy). When I become a parent I will try to avoid the pitfalls.
>
> I would like just to say that I appreciate your time and help which you have given me and I find it very interesting—a lot of good advice that will help me be a good Dad and husband to my wife.
>
> I would like a film—to see more films to show us how a baby grows up. I mean by that the different stages.
>
> . . . because if you dont no [*sic*] how, you can only watch your wife.

81. Films illustrating peer pressure and the pressure of sex role stereotyping can apprise boys and girls of the effects of these pressures. They provoke thought and discussion on the subject, without directing or threatening confrontation; peer pressure is seen as an imposition and an infringement of personal liberty.

Conclusions

82. Education should provide opportunities for boys and girls to:

(a) learn to appreciate the power of social forces and institutions to influence the development of individual personality and choice of life style;

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48. Interview report, NSW, 65.
49. Commission correspondence, file 75/1382.

(b) become aware of the varying attitudes to male and female roles in society and the ways in which these attitudes affect aspirations;
(c) discuss situations in their own lives and in society in which boys and girls, men and women are treated differently and to examine the origins of these differences and the reasons for their continuation in modern western society;
(d) assess the effect of peer pressure, sex stereotyping and sex role polarisation on their present activities and future lives;
(e) develop skills in communication and interpersonal relationships, and for this purpose
(f) acquire a correct vocabulary of sexuality;
(g) develop a knowledge and understanding of the functions of emotion, feeling and caring in relationships.

An open approach

83. The teacher needs to be sensitive to divergences of opinion and encourage the discussion and evaluation of such differences in a frank, unemotional, yet sympathetic spirit.

84. Young people resent it if teachers are biased and if topics are excluded. Some exclusions noted are contraception, VD, abortion, masturbation, pre-marital intercourse, laws relating to sexuality, homosexuality and sex roles.[50] Evasion on these subjects may result in sexual malfunction and anxiety[51], may induce brutalising attitudes to women which result in violence or rape, or to homosexuals which range from playground name-calling[52] through to violence, and even to murder.[53]

85. Sex education programs need to discuss the incidence, symptoms and treatment of VD in both men and women. The Australian Medical Association wrote about the role of the medical profession in this aspect of education:

> The introduction of the medical practitioner into this training program should occur preferably at the age of 14–15 years. Instruction in contraceptive techniques can probably be carried out adequately by paramedical personnel, but the physician carries more authority and may possess greater credibility.
>
> . . . in the field of venereally communicable disease, teaching by a physician is important. A superficial knowledge of syphilis and gonorrhoea perhaps is possessed by many adults, but the stigma still attached to these infections prevents open discussion by most people.
>
> . . . there is a complete lack of knowledge by the public of the minor venereal infections, such as pediculosis pubis, trichomonal vaginitis, venereal warts, non-specific urethritis, etc. Such diseases are widespread and must be expected to remain so with the frequent changing of sexual partners that sometimes occurs in young people.[54]

86. Any sexual hygiene program should not be confined to syphilis and gonorrhoea, but cover all sexually transmitted diseases. Simple hygiene as a preventive of some minor infections should be taught. Discussion needs to be directed to the morality of transmitting such diseases and the law relating to them.

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50. Beighton & Cole, Commission research report, no. 5, pp. 12–13.
51. Submission 29; Evidence, pp. 34–47, Dr Jules Black.
52. Wills, Cox & Antolovich, Commission research report, no. 8; Evidence, p. 2381, Dr Elaine McKinnon.
53. Evidence, pp. 3138–41, Mr Lex Watson.
54. Submission 1101, AMA.

What young people in schools say about the issues

87. While there were few submissions from young people, those that did write were remarkably thoughtful. A schoolgirl from Adelaide wrote:

> Much attention is paid to academic subjects at school but little or no attention is paid to subjects dealing with human relationships.
>
> I think a course in sex education should be introduced at grade 6 or 7 . . . Speaking as a teenager I feel this is what we need. I would like to approach parenthood with some background knowledge in how to bring up a loving and happy child.
>
> In books and films too much emphasis is put on sex, almost completely ignoring feelings and emotions. Young people are getting a distorted picture of what love and life really is. We need a course in school to put us straight.[55]

88. A 17-year-old schoolboy from Tamworth wrote:

> I believe contraception methods and ideas should be implemented from first form high school, at the age of around 13 years . . . sex education should begin very early from the time kids can talk. If not, children grow up with many hassles about sex, its place, its role, and many other things. It should be taught, because I believe many parents are a little weak on this topic, and the children would be more open on the subject with a well-informed teacher . . . We must be open with all issues of sex in educating children; not overprotective as the archaic Christian propaganda is pushed, especially in schools.[56]

89. The survey of school age pupils by Professor Connell received:

> . . . requests for 'love education', 'open discussions of what's going on in the world', and so on. Around 15, these become more common. Most of the curricula are still obviously based on the normal timetable, but they are now diversified with proposals for study of issues of personal relationships and social concern, e.g. from a girl, aged 15, on Monday 'sex education discussion group', on Tuesday 'lectures on being adolescent', and on Wednesday three periods called 'morals', 'love', and 'world' . . .
>
> Concern with sexuality, social relations, and socio-political problems as subject matter, and insistence on diversity and individual choice as a principle of planning, are the bases of most of the reform proposals from fifth and sixth years.[57]

90. In April 1974, 200 students from 150 secondary schools in New South Wales attended a seminar on 'Sex education' staged by the Division of Health Education of the New South Wales Department of Health. The report, expressing the views of the participants, read in part:

> The efforts of children and adolescents to gain information about themselves and their sexuality are generally foiled by the ignorance and embarrassment first of their parents and then of their teachers—an attitude which they quickly realise is a reflection of society as a whole. It is understandable that the young people themselves quickly learn to be embarrassed, to regard certain topics as 'taboo' and to fall prey to garbled and often terrifying legends. Even in the rare cases when an accurate or semi-accurate account of the basics is received, there still remains great ignorance, especially about the sexual characteristics of the opposite sex. Such details as contraception and abortion are hardly ever mentioned. This ignorance is exemplified in the case of girls who begin to menstruate and are terrified because they have received no warning or explanation of their own biological functions. The high rate of unwanted pregnancies and of venereal diseases is evidence that many children know very little about this complex subject. The fear and embarrassment which our whole society directs towards sex is demonstrated in the reticence which we apply in discussing such things as homosexuality and masturbation. This fear must be destroyed by education.

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55. Submission 156, Miss K. Jones.
56. Submission 577, Murray Fraser.
57. Connell et al., pp. 109–10.

Many people argue that sexual information must be accompanied by moral education. Since they invariably disagree as to the nature of moral content in sex education courses, the sum result has been that no sex education has been imparted, and a high level of ignorance on sexual matters has been maintained. Morals are a matter for the individual. Although many people behave in accordance with Christian or other rules of moral behaviour, few would advocate a policy of religious or political indoctrination. Sex education must be essentially factual—a course where moral and emotional overtones are discussed rather than taught. In this way, each individual will develop his or her own set of morals and codes of behavoiur. The school must have no part in forcing upon children particular philosophies and standards. A variety of codes should be presented for consideration and discussion in school . . .

There is a tendency to believe that sex education will corrupt the youth of Australia and lead to the prevalence of sex crimes and general moral decay. It is necessary to wipe out the widespread fear of sex which is so often expressed by Australians of all ages and to encourage understanding of all biological functions. It is not possible to eliminate these by ignoring them. Crime and unhappiness spread, not through knowledge and discussion, but through ignorance and rumour.

91. Some recommendations made in this report were:

Sex education should commence no later than in the earliest years of primary school. By the age of 10 all pupils should have a confident understanding of the basic facts of sex, namely—puberty, masturbation, menstruation, intercourse, conception, development of foetus, care of mother and child during pregnancy and childbirth.

Flexibility should be the keynote: not all children are ready for, or in need of, particular information at the same age. However, at all stages, any questions asked by the pupils should be answered frankly.

The teachers of sex education might, in secondary schools, be science, language, health or social studies teachers—it is their personal qualities that matter. In primary schools, sex should be taught by each class teacher. Some teachers may be unsuitable or may not wish to teach this subject: these factors should be accepted . . .

It is desirable that boys and girls should be taught sex together: life itself is co-educational. Where possible, sessions should be staged for groups of about fifteen students.

It is essential that all aspects of the course should be presented in as objective a manner as possible . . .

The teacher should be very largely a resource person: one who presents factual information, suggests possible lines of discussion, points out errors in reasoning and encourages responsible debate.

By no later than the first year of secondary school all students should have been taught about contraception and the types of contraceptives that may be used. Moreover, in the last 2 years of primary school, pupils must know that their teacher would be able and willing to provide this information to pupils asking for it . . .

Objectivity should be the keynote. Words like 'abnormal', which often imply moral disapproval, should be avoided. Medical, legal and social aspects of homosexuality and lesbianism should be presented.

It is believed that free discussion of masturbation will remove much misinformation and distress.

Teachers should be familiar with sexual slang and should beware of using polite terms that pupils do not know through their desire to avoid particular words that they may consider obscene . . .

No program of sex education can operate effectively without the full understanding and co-operation of parents. Consequently, literature explaining the sex education course and its underlying philosophy should be prepared for parents and their opinions and suggestions should be invited.

92. In conclusion, they wrote:

> It is believed by all of those involved in the preparation of this report that a program of sex education of the kind described is both necessary and overdue. This basic and vital subject is essential to the happiness of future generations and to the well-being of our society.[58]

93. Dr Sol Gordon, Associate Professor in Psychology, Yeshura University, New York City, experienced child guidance counsellor and sex educator, in introducing his book *The sexual adolescent* wrote:

> Society, by operating on the assumption that adolescents should not have sexual relations, effectively bars them from the information they want and need, the contraceptives they should have, and the laws which can be protective of their interests . . . The evidence seems to point to the fact that a great number of adolescents will engage in non-marital sexual relations no matter what adults think they should do.
>
> Admittedly, there are moral questions involved in whether teenagers should have sexual relations, and there is nothing wrong with society suggesting they should not, but it is wrong for society to avoid facing the fact that they do.[59]

94. Gordon sees such sex education programs as necessary in the development of a new personal sexual and moral code, a code which enhances and does not diminish sexual experiences and the personal relationships associated with it. He writes:

> Sexual freedom seems to be the battle cry of today's adolescent, and youth is correct in its judgment that freedom is a necessary component of healthy sexual adjustment. Some of the essential sexual freedoms are freedom from sexual stereotyping, freedom from sexual exploitation, freedom from sexual myths, freedom to control one's own body, and freedom to express affection.
>
> These freedoms are not without their corollary responsibilities, the moral and ethical standards that must accompany sexual freedom:
>
> (a) No one has the right to exploit another person's body, commercially or sexually.
>
> (b) No one has the right to bring an unwanted child into the world.
>
> (c) No one has the right to spread venereal disease.
>
> (d) No one has the right to exploit children sexually, or take advantage of mentally or physically handicapped people.
>
> (e) No one has the right to impose his sexual preferences, including with whom to have sex. Sexual choices must be voluntary.

Conclusions

95. Education Departments should develop comprehensive sex education programs that are:

(a) appropriate to age and tolerant of differences in background and origins;
(b) begun in the primary school and are completed by the school leaving age;
(c) factual and frank;
(d) comprehensive in the range of subject matter covered;
(e) given by specially trained teachers in small groups of boys and girls;
(f) constantly researched and evaluated.

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58. *Sex education: recommendations by school students* (Division of Health Education, Department of Health, NSW, 1972) pp. 2-3, 4-9.
59. S. Gordon, *The sexual adolescent* (Duxbury Press, North Scituate, Mass., 1973).

Resources

96. Submissions to us called for educational materials of high quality and of a style to compete for the pupil's attention with the mass media.[60] The State Education Departments are already producing resource materials for the programs available in their States. We saw some comics which are both instructive and thought provoking.

97. Because of costs, there is a case for Australia-wide co-ordination of publishing.

98. The Curriculum Development Centre, located in Canberra, is a Federal–State statutory authority, engaged in developing curriculum materials for use in schools.[61] The Centre is presently co-ordinating the 'Social educational materials project' (SEMP) initiated by the National Committee on Social Science Teaching in Secondary Schools (NCSST).

99. The SEMP project is funded equally by the Commonwealth and State governments.

100. The Curriculum Development Centre has already published *Re-educating a generation*[62]—which tells how to avoid sex bias in educational materials.

101. The Curriculum Development Centre has established a study group in health education in schools.

Conclusion

103. Research and continual evaluation is required for the problems of teaching human relationships, including the methods of delivering programs.

60. Evidence, pp. 1355–62, Valerie Edwards, SA Health Education Project; Submissions 1104, NSW Dept of Education; 1068, Dept of Education & Citizenship, Methodist Church; 816, National Catholic Education Commission; 571, Baptist Union of NSW; 6, WEL, Brisbane; 198, FPA ACT; 634, NSW Federation of Infants School Clubs; 785, ANZ College of Psychiatrists; 433 Dr Ron Farmer.
61. Commission correspondence, file 75/587.
62. *Re-educating a generation; avoidance of sex bias,* guidelines for the avoidance of sex bias in educational materials and media (Curriculum Development Centre, Canberra, 1976).

7. Implementation of programs at the various levels of education

1. In our view the question is no longer: should sex education be undertaken in schools, but how and at what stage to introduce it?

The young child: primary school

2. We have heard differing views about the age at which sex education at school should begin. Some parents are concerned about the possible harmful effects on young children if it is started too early. On the other hand it is sometimes said that sex education begins at birth and that the child reflects parents' attitudes learnt at very early ages.[1]

3. Parents are often advised to answer children's questions about sex simply and factually, not concealing and not becoming over technical. When parents can deal with children's questions and are comfortable about sexuality, the child will have far less need of formal education. Unfortunately many parents will not or are unable to fulfil this task.

4. Children's questions will not be confined to home, however, and teachers need the skills to deal with sexual questions in the classroom. Professor I. C. Lewis of Tasmania supported early sex education, saying, 'To delay means building on faulty knowledge.'[2] Other submissions also supported early sex education in schools.[3]

5. Our view is that human relationships education should be instituted in pre-school and continue through primary and secondary school.

6. To enable teachers to fulfil this task successfully they should become aware of the need to respond to their charges' questions factually, simply and in an appropriate vocabulary.

7. The Australian Medical Association said:

> Information about sex should be constantly put forward to children from the pre-pubertal age onwards: this is often the function of a school teacher, who should have adequate training in reproductive physiology and the psychology of interpersonal relationships and sexuality.[4]

They indicated the need for the classroom teacher to have access to 'resource material and advice'.

Parental involvement and the right to withdraw

8. Education is designed to fulfil the needs of the child; ideally it should involve co-operation between parents and teachers. The NSW Federation of Infants Schools Clubs said:

> The relationship between parent and child is greatly enhanced if there is a continuing parent-child-teacher relationship. This is widely recognised at the pre-school level but breaks down when the child enters formal schooling.[5]

1. See Annexe II.A, quotations 4 and 9.
2. Evidence, p. 2299, Prof. I. C. Lewis.
3. Submissions 1101, AMA; 634, NSW Federation of Infants Schools Clubs; Evidence, p. 1125, Dr Stephania Siedlecky; see also *Report of Commission of Inquiry into the Nature and Extent of the Problems Confronting Youth in Queensland* (Govt. Printer, Brisbane, 1975), recommendation 59.
4. Submission 1101, AMA.
5. Submission 634, NSW Federation of Infants Schools Clubs.

9. A great deal could be done to overcome parental suspicion and hostility by creating opportunities for them to meet teachers and to discuss these issues. If this were done we feel that few parents would oppose instruction.

10. Asked about the probable response by migrant families to a program teaching sex education or education in human relationships to their children, Dr Moraitis, President of the Australian Greek Welfare League, testified to the Commission that this would offend migrant parents, because it is not their cultural practice.

11. Dr Moraitis remarked, however, that hostile reaction to sex education for girls in schools is not confined to immigrant communities. He cited a meeting at Prahran High School, Victoria, where parents responded to such proposals with 'an uproar'. In response to a question about the best way to approach such a situation, Dr Moraitis said:

> Steady and slow education of the children. I think it has to go ahead because we are now living in a huge community, not a little village. The children must be taught about it. What the parents feel is if they know about it, they will do it.[6]

12. We believe that every child is entitled to education in human relationships and to knowledge about sex appropriate to age and understanding in properly planned programs and that no child should be deprived of basic information.[7]

13. At the same time we appreciate that sex education in primary schools and at preschool is an area of innovation and that content and methods have not been fully developed. We think that at this stage of development it is important to encourage and involve parents in the introduction of courses and that they will be more willing to co-operate in this if the education is given on a voluntary basis. At primary school level, and earlier, parents should be able to withdraw children from instruction.

14. Once a child has reached high school, however, his or her right to information about sexuality and to education in human relationships should, in our view, take priority. The risks attached to ignorance and lack of understanding are too serious to be disregarded. The child then entering on puberty should be entitled to receive education in this area and should also have the personal right to withdraw.

Tertiary education and further training

15. The Australian Medical Association sums up for many others in recommending:

> . . . education [in human sexuality] from primary school level right through to tertiary level. In particular, at the present time, advanced courses should be available at all tertiary institutions for trainee teachers, social work students and medical undergraduates.[8]

16. Tertiary educational institutions are providing courses in early childhood development and adolescence, teaching the range of behaviours normal at each stage. Teacher educators need to prepare their students to participate in activities which link parents, teachers and school and to enable them to be confident and competent in the community through their understanding of society. Handbooks of the seventy tertiary education institutions involved in teacher education indicate that a knowledge of human sexuality and its role in human well-being is not a major concern of those institutions; it does not seem to be a requirement of teacher education.

17. Universities ignore it, except as part of psychology or behavioural studies. Colleges of advanced education have health education, and some have courses in human relationships, the latter oriented to communication skills.

6. Evidence, pp. 757–8, Dr Spiro Moraitis.
7. See Annexe II.A, quotation 19.
8. Submission 1101, AMA.

18. A sexuality strand could be placed in the sociology of education to include the psychological, social and biological aspects of human relationships. Alternatively, health education or psychology could provide the subject umbrella for this strand.

19. Educational sociology under a variety of names appears in most teacher education programs. Courses to develop teacher awareness of the special problems of migrants and Aboriginals appear to be more freely available than do courses to develop awareness of the sociology of the education of women and girls.

20. There is a strong case for developing a comprehensive human sexuality strand in the core requirements of teacher education, and there is equally a need for specialists trained in the appropriate methodology and holding a degree or diploma in health education to work in the schools and to take over the function of the community education officer.[9]

21. We believe that teachers need post-graduate education of an interdisciplinary nature to help them to understand their own and others' sexual nature. The School of Social Biology at Melbourne University presently provides such interdisciplinary courses and may provide a model for other institutions.

Conclusions

22. We consider that tertiary education institutions should develop interdisciplinary courses in human sexuality covering the general topics already outlined in our report, and that such courses should be a prerequisite for the professional recognition of teachers, and be also recommended to social workers, welfare workers, nurses and health professionals. We also see degree and diploma courses in community health as necessary in tertiary educational institutions.

9. Submission 1244, Health Education Association of NSW.

8. Learning beyond formal education

Where does education end?

1. It is too readily assumed that education ends when a child leaves school, or a student leaves university or college. Education is often seen as being primarily concerned with professional and technical qualifications, whereas education should teach for the whole span of life and should cover leisure and the home. We have to decide in our leisure hours many things—whom we shall marry, how many children we shall have, how we shall rear our families, what political candidate we shall vote for, what games to play or TV programs to watch, what music to listen to, what plays and films to see. Recreational activities, sports and hobbies require skills which have to be learnt. Our academic education hardly touches the creative hours of every day and the whole of each weekend, and it only remotely shapes our relationships and our culture.

Education for living

2. Governments are now more aware of the need for education for leisure and the Commission notes with pleasure the help that has been given in recent years to adult education and the arts.

3. Our educational systems have been developed with the aim of producing adults with the knowledge and skills which would enable them to cope with the demands of our changing society, to earn a living, and generally to live happy lives. Schools and universities have succeeded to a limited extent. There is a demand for more widespread and less formalised education, which is less concerned with the training of the intellect or the development of practical skills; it needs to give greater opportunity to learn about human beings and human feelings and help everyone to appreciate what life is all about.

4. The Commission received submissions and evidence seeking new programs for adult education and also counselling and advice for those who have special needs—like engaged couples, parents facing their first child, mothers with unwanted pregnancies, estranged husbands and wives, and those who are lonely or feel discriminated against, like lone parents and homosexuals. There have been many pleas for counselling in specific situations: health, drug and alcohol problems; abortion; adoption and fostering; adolescents, pregnant girls, runaway young people; families in the country and in isolated communities; and new settlers in neighbourhoods.

5. Educational deprivation has several effects. Some young people successfully pass their examinations, but fail to mature emotionally; they find it hard to cope with such emotions as rage, aggression or humiliation. They cannot readily express warm affection; they have difficulty in communicating their feelings, desires and needs.

6. Others fail to fit in with the school system for a variety of reasons. Their academic achievement is negligible and their social skills limited. Their chances of obtaining cadetships or apprenticeships to improve their training are very slight; their chances on the labour market, especially in a period of economic recession, are small indeed. They are equally immature emotionally, sometimes through their family backgrounds, low intelligence or other handicap, sometimes because they are naturally shy and non-competitive.

7. The fact that many do succeed is not incompatible with the growing number of discontented young people who feel the school system has taught them that academic

'non-achievers' are undervalued and disregarded; hence they lack the confidence to apply efficiently for jobs, and are at risk for delinquency and deviant behaviour. Dr Robert Pigott, of the NSW Health Commission, wrote:

> At the moment our children are leaving school underequipped to appreciate, let alone meet, the complexities they will find. The time is surely overdue for asking just what 'basics' are in education for today's world.[1]

8. Further, there are particular groups, such as children in institutions, who have special needs which are not currently being met.[2]

9. A submission from the Religious Society of Friends brought to our attention conditions at a Queensland institution for children[3]; two members of the same organisation later gave evidence in Brisbane to the effect that children in the institution named lacked sufficient education from specialist therapists[4], although a different picture was given by the psychiatrist in charge. Mr W. H. Denney, a director of an organisation called 'Action for children', gave evidence in Sydney concerning the educational difficulties of state wards, and of how this handicaps their chances when they enter the labour market. He felt that such young people should be immediately eligible for vocational training under the NEAT scheme.[5]

10. The Mental Health branch of the ACT Health Services concluded in their submission that:

> . . . significant numbers of people are deprived of basic human nourishment—relationships that are warm, open and accepting, where self-expression is legitimate and valued.[6]

It must not be forgotten that these young people are going to become the citizens, the voters, the workers, the parents and the consumers of the future and that they are important to Australia politically, socially and economically. If it is believed that education enriches human life, then lack of education must impoverish life.[7] It is clear that many people experience a 'poverty of personal regard' which leaves them without the capacity to build and sustain rewarding human relationships.

11. Since education has been compulsory, there has been an accompanying tendency to regard it as something to be applied with or without a person's co-operation. Education is seen as having a definite beginning and an end, with its main objective that of preparing the child for employment.

12. Our evidence indicates that many people in the community feel that the government has a responsibility to deprived groups until our schools emphasise humanity and personal worth rather than capacities and intelligence.[8]

Adult education

13. There has been a gradual change in the meaning of this term during the past few years. Initially, adult education referred to a process whereby people who had a limited education could catch up in some way, or where some special interest could be

1. Submission 827, Dr Robert Pigott.
2. Submission 634, NSW Federation of Infants Schools Clubs.
3. Submission 295, Religious Society of Friends.
4. Evidence, pp. 1642–54, Ms Julie Gee, Mr Roger Sawkins.
5. Evidence, pp. 3189–94, Mr W. H. Denney.
6. Submission 927, Mental Health branch, ACT Health Services.
7. There is an extension of this argument in the *Report of the Central Advisory Council for Education* (HMSO, London, 1965).
8. L. F. Neal, 'State-controlled secondary education in Australia: a critical survey' in Donald MacLean (ed.) *It's people that matter* (Angus & Robertson, Sydney, 1969).

fostered. It was usually learning of a non-vocational kind. The change in meaning has swung closer to the notion of 'continuing education' in all kinds of fields including vocational training. It is in this sense that we use it in this report. In adult education, therefore, people no longer at school undertake organised activities to enhance their knowledge and skills. Adult education thus includes basic education, vocational and personal development, study of cultural and community affairs and, indeed, learning in any subject at all.

14. We have identified some continuing or projected programs of continuing education which seem best suited to 'assist the individual to progress toward the attainment of his full potential as a person and as a member of society'.[9]

15. Universities and colleges of advanced education provide courses which are open to adults. Some are designed to help people achieve literacy, or enable them to secure the requirements for matriculation, others stimulate interest groups in the creative arts or hobbies, still others help people to degree courses. By and large, these mature age students reach higher levels of achievement, in those courses where it can be measured, than younger students.

16. There are, however, many people in need of such courses who are unable to take advantage of them due to lack of child care facilities; many others are reluctant to enter the formal educational structure because of unhappy memories of their school days.

17. One submission, from a married woman in a Sydney suburb, sees the aim of adult education as enabling people to perceive more fully their own lives and the lives of others:

> . . . focusing on real life decision situations, the options available and the issues and consequences involved.[10]

18. The Adult Education Board of Tasmania made several recommendations representative of other evidence on this issue. They are:

(a) that adult education be seen as an element of community development and as part of the process of achieving satisfactory human relationships;

(b) that agencies be encouraged to promote activity designed to foster community interaction and enhanced personal relationships;

(c) that consideration be given to the proposal for a National Family Life Education Program.[11]

19. The 'learning exchange' seems to us a valuable means to help people continue to learn all through life. It has been defined as:

> . . . an attempt to develop the initial stages of a 'learning society' in which the direction of the learning process begins to come from an individual wanting to learn.[12]

Individuals in the community then co-operate in a sharing process. They share mutual concerns about wanting to know and they also share the pool of knowledge of the group. A group in Malvern, Victoria, has made considerable progress in this, as has the Canberra Learning Exchange. For example, one member offered a workshop and wanted to learn about ceramic casting and high-firing of clay bodies. Another offered the use of a potter's wheel. Someone else offered to share his musical skills; another wanted to learn about education and politics. A student offered to teach English and

9. Submission 634, NSW Fed. Infants Schools Clubs.
10. Submission 1081, name withheld.
11. Submission 843, Adult Education Board, Tas.
12. Commission consultation, John Burke, The Learning Exchange, East Malvern, Victoria.

another wanted to help someone to understand conversational Indonesian. Home nursing was offered in exchange for macrame work; bush carpentry, horticulture, light plane flying and mechanics were offered in exchange for more knowledge about chemistry, biology or geology. Organisations willingly came to help the Exchange. The Woden Valley Hospital offered its Diabetic Information Centre; the Adventurers Club offered to organise camping trips; the Music Club offered to compile registers of young musicians; the Humanist Society offered discussions on the Family Law Bill; the Nursing Mothers Association offered information and books.[13]

20. Women sometimes seem to be under special disadvantage in trying to resume education in adult life, and there appears to be a need for specialised counselling, orientation programs and courses to remedy past lack of education.

21. Ms Gwen Wesson, of the Department of Education in La Trobe University, testified to the special requirements of women re-entering education. She described an informal learning network 'Grapevine' which made creative use of people who volunteered skills, and others who learnt new skills and confidence, in informal learning situations. Ms Wesson remarked on the high rate of drop-out of women returning to education in the formal system and described a program developed to suit older women which also provided child care so that the participant could enjoy the courses without anxiety, including:

> . . . after-school activities for schoolchildren such as art, music, drama, plays. We provide a range of evening programs, some long term, some short term, and a number of things in the daytime from open drop-in discussion, coffee sessions which are really all the time, but we focus it on one day in the week where anybody can come in, bring friends and talk about anything . . . discussions about bringing up kids, budgeting, gardening . . . We have a whole set of alternative sixth form studies, some one term, some 6 months, some for a year. This year we had nineteen HSC classes as well. About 1000 people use the centre one way or another. We have one staff member and two part-time secretaries.[14]

Ms Wesson argued that the courses should be so designed that they succeed in rebuilding the confidence of the participants themselves, opening their minds to their potential and to the resources available.

22. We heard with interest of the success of orientation programs for women which were carried out in the Footscray Institute of Technology. Advertisements were placed in the press appealing for women who would like education that might lead to employment in technical trades and occupations. Those who applied were given a course to familiarise them with the terminology and scope of the various courses and taken to workshops to see the type of work to which the training available would lead them, so that an informed choice could be made.[15]

23. There are other agencies who run counselling services or make special arrangements for ongoing education in the case of disadvantaged groups. Thus both the Commonwealth Employment Service and the Vocational Guidance Bureau have specialist services for handicapped persons or retarded young people. An interesting experiment aimed at the migrant community has been the establishment by the West Sydney Technical College of an outreach program at Petersham. The college has made available a counselling service and uses part-time information officers who speak Italian. We had evidence of similar work amongst Greek communities, e.g. Dr George Kokoti who told of a successful home tutoring system, emphasising the social aspects of a knowledge of English rather than linguistic accuracy.[16] Courses are also

13. Submission 1084, Canberra Learning Exchange.
14. Evidence, pp. 2924–32, Ms Gwen Wesson.
15. K. S. Lenne, 'Women in engineering', *The Chartered Engineer*, June 1975.
16. Evidence, pp. 1457–67, Dr George Kokoti.

given on filling in taxation forms, and certain interpreting services. Dr Charles Price spoke of courses in Sydney and Melbourne which concentrated on teaching Greek or Italian to the Australian spouses.[17] Such centres do much to counteract the wastage caused in human lives by lack of education.

24. Disadvantaged groups in the community stand in special need of rehabilitation counselling, which provides assistance to persons found with problems due to disability or social disadvantage to enable them to fulfil a less dependent and more satisfying role in the community[18]—medical, psychological, vocational and economic advice may be variously organised. The Cumberland College of Health Sciences in Sydney offers a course with experts from many disciplines for those who wish to specialise in the provision of services to the handicapped.

25. Our terms of reference make us especially sensitive to the importance of sexual counselling since this is an area which may cause much distress. Our response is to encourage people 'to understand the problems they are likely to meet, to provide a basis for thoughtful, considered judgments and decisions, to have an understanding of their own reactions and those of others and to accept their sexuality with responsibility and realism'.[19] In other sections of our report, there is further discussion of how counselling can help in sex questions, e.g. homosexuals, methods of family planning or marital breakdown. West Australia has a telephone counselling service for people who are experiencing difficulties of a psychosexual nature.[20] Life Line similarly, as Dr Noller revealed in his evidence to us in Brisbane, makes a valuable contribution here.[21]

26. Alcoholics have their own problems, and so have their families; Alcoholics Anonymous, Al Anon and Alateen all run both counselling and education services, of which there is a further account in Part V.

27. The GROW organisation is a self-help, non-professional group which teaches interpersonal skills, aimed at developing maturity or sound mental health.[22] This springs from its original base as recovery groups for ex-psychiatric patients. GROW has expanded into a network of groups throughout Australia which are run by members with the co-operation of friendly local doctors, social workers, ministers and priests or other interested community members.

28. Certain specialist centres providing education for those at risk were brought to our attention. The Tavistock Institute of Human Relations in London adapted the sensitivity training which had proved successful for management personnel to training mental health professionals. The Cairnmillar Institute in Melbourne[23] is pioneering similar work in Australia as is also the Australian Institute of Human Relations in Sydney.[24] Both aim to break down the barriers which separate one person from another and so improve communications.

Conclusion

29. Our evidence leads us to believe that in Australia young people leave school with many educational deficits. Hence there is need for a variety of educational pro-

17. Evidence, pp. 1073–5, Dr Charles Price.
18. Dr Jeffrey Miller (paper delivered at first Joint International Seminar, Social and Vocational Commissions of Rehabilitation, Athens, June 1976).
19. Submission 591, ACOSS.
20. Submission 462, Ms Vivienne Cass.
21. Evidence, pp. 1481–7, Dr Charles Noller.
22. Commission correspondence, file 76/21.
23. Submission 116; Evidence, pp. 665–76, Dr Francis McNab.
24. Evidence, p. 3019, Prof. Dexter Dunphy.

grams which will make up these deficits: such programs should cover every age group, country dwellers as well as city; the disadvantaged and handicapped, as well as the normal and healthy. People need to make up the gaps in their training to prepare them adequately for the roles of later life, whether as spouse, parent or concerned member of a community. Every opportunity should be given to facilitate their continued growth as persons.

30. Community-based and voluntary organisations, in spite of some disadvantages, are better placed to provide continuing education and counselling services, which otherwise tend to be bureaucratic, and unavailable at weekends when crisis situations often develop. Our evidence suggests that people generally would prefer government assistance to be generously given to voluntary and community organisations to help them cope with their problems, rather than have other people's solutions imposed upon them.

Preparation for marriage

31. The trend to almost universal marriage in Australia, coupled with the rising divorce rate, has led to an increasing interest in courses preparing people for marriage and parenthood.

The need

32. Issues put to our Commission include whether such courses do, in fact, make for greater marital stability and happiness, whether they should be government funded, and whether they should be compulsory. We received many submissions in their favour and none in opposition. We feel we should preface this discussion with the observation, however, that many people have both happy and stable marriages without the benefit of pre-marital guidance.

33. Some people, like Dean Ian George of Brisbane, saw the need for advice as vital.[25] Others emphasised the 'preventive' contribution; these included the Family Life Movement of NSW,[26] the Victoria Park (WA) Counselling Centre[27] and the Baptist Union of NSW.[28] A married man with six children stressed the need to fill the vacuum caused by ignorance; he wrote that he did not:

> . . . believe two people are meant to live together for some 50 years under such pressures *unless* they are completely educated and prepared beforehand after a long engagement (2 years).[29]

The experience of the Catholic Family Welfare Bureau in Adelaide similarly indicated that:

> Unless couples are adequately prepared . . . varying degrees of marital instability will result.[30]

Government support for adequate preparation for marriage was evidenced by the Marriage Bill. This extends the length of notice for marriage from 7 days to a minimum period of 1 month for all persons. The Bill also requires minors seeking consent to marry to produce a certificate to the effect that they have had counselling, and provides for funding of voluntary organisations providing pre-marital education. The Bill was passed by Parliament and assented to in December 1976.

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25. Evidence, p. 1691, Dean Ian George; see also Submission 375, Mrs S. Cropley.
26. Evidence, p. 2699, Mr Stanley Johnson, co-ordinator of training, Family Life Movement.
27. Submission 471, Victoria Park Counselling Centre.
28. Submission 571, Baptist Union of NSW.
29. Submission 349, Mr Bob Gibson.
30. Submission 482, Catholic Family Welfare Bureau.

Who should provide education for marriage?

34. The voluntary organisations now providing pre-marriage education submitted that they need financial help from the government to supplement their present funds obtained from their own resources and from the fees of participants.[31] Some of the programs are specially designed for those of a particular faith. Others have a broader approach. In determining funding policies it is important to be aware of this distinction.

35. A Lutheran Church group in South Australia asked the Commonwealth government to 'establish and support family life education centres . . . for pre-marriage courses . . . for children and adults'. They thought that:

> In view of the important role the churches have in the realm of family life education, the government should encourage the churches to establish such centres and provide the churches with adequate financial resources for the implementation of approved applications.[32]

The use of voluntary organisations for this work was supported by the Centre of Personal Encounter in Adelaide, as:

> . . . it is to these voluntary agencies that people feel free to come for help before problems are so severe that expensive and professional help is needed.[33]

The Catholic Family Welfare Bureau drew a parallel:

> . . . the ambulance at the bottom of the cliff may be more dramatic than the fence at the top, but, in the long run, the fence may save more lives.[34]

A director of marriage preparation courses saw an:

> . . . appalling ignorance about the nature of marriage preparation at every level of the community, amongst the clergy, amongst educators, amongst the average man in the street; it cuts across class . . . religion and everything.

His idea was that 'marriage preparation begins at the moment of conception and it is continued until one partner dies'.[35] In parallel with this thought, the Family Life Movement believe that:

> . . . such preparation should be commenced during high school, but should be concentrated upon the adjustment period of engagement.[36]

36. Dr Clair Isbister,[37] a paediatrician, who has been involved with pre-marriage courses for some years, told us that people about to marry are not nearly as motivated towards receiving information and 'discovering themselves' as they are during adolescence or when they are about to have a child. She feels that young people in schools and people attending pre-natal classes are more receptive. She pointed out that just before people are married they are often in the full flush of sexual excitement and really are not interested in much else. Her experience is that young people in schools are willing to listen because adolescent development faces them with real personal problems. She also thinks that people expecting a child have a strong feeling of responsibility and are good subjects for education then.

31. These organisations include all those mentioned in this chapter; see also Submissions 262, Mrs M. Sands; 471, Mr H. Lucas.
32. Submission 158, Commission on Social Questions, Lutheran Church of Australia, North Adelaide.
33. Submission 144, COPE (a division of the Marriage Guidance Council of South Australia).
34. Submission 482, Catholic Family Welfare Bureau.
35. Evidence, p. 653, Father Don Burnard; see also Submission 117.
36. Submission 610, Family Life Movement of Australia.
37. Of the North Shore Medical Centre, Sydney, in verbal consultation.

37. The Family Life Movement considered:

> . . . that government funding should be available to develop and maintain marriage education programs and that such programs should be supported both by church and secular bodies.[38]

The Methodist Church noted that 79 per cent of all couples marrying in 1973 'chose to be married according to a religious ceremony', thus putting a minister of religion 'in a position to encourage them to attend a pre-marriage course'. The church therefore believed 'that direct financial assistance should be available to church organisations promoting marriage guidance courses'.[39] The proportion of couples marrying in church has reduced since 1973 but not to the extent of invalidating this argument for assistance to churches. A woman in Bassendean, WA, wished:

> . . . to see centres established with government aid, for training and preparing young people before marriage and every effort made to encourage young people to prepare themselves for this whole life commitment.[40]

38. The Australian Medical Association saw marriage counselling as being provided by a variety of groups of organisations and professionals, and including 'prophylactic measures by education in human relations and sexuality at secondary school level'.[41] The Family Life Movement provide 'courses for couples thinking of marriage', their slogan being, 'Let's make it together: share in courses for engaged or near-engaged couples'.[42] A group of women in Mackay, Queensland, wrote that:

> The need for preparation for marriage and parenthood should be shown as one of the most important areas of the subject of human relationships in schools.[43]

39. A different approach might be for marriage celebrants to hand out a brochure to prospective brides and bridegrooms. The Marriage (Amendment) Act provides for the marriage celebrant to give the parties a document in prescribed form outlining the obligations and consequences of marriage and indicating the availability of premarital education and counselling.[44] For the best impact such a brochure should be simple and helpful, and it should contain information about community resources. It would be a great advantage if this document or a companion brochure were available to set out information on property rights and law (including wills and passports) and contraception. Special brochures would be needed for people of overseas origin, giving advice on marriage law requirements and containing information in the main ethnic languages which would adequately reflect differing cultural backgrounds. Consultation with a range of opinions among the migrant community would be desirable.

40. In addition to set courses and brochures we believe that there is a role for more imaginative schemes for marriage education, schemes which would involve the media and reach out into the schools and into the workplace and wherever young people and young married people congregate. Marriage education is of course a natural extension of the programs in human relationships offered by schools, and should not be seen as something completely distinct. Just as sexual awareness and sexual behaviour develop in the growing adolescent and young adult so does the need for positive programs to help the growth of understanding in relationships. There is thus no cut-off point in the content of such programs, even though the target group changes from the school pupil to the young adult, young married couples and parents.

38. Submission 610, Family Life Movement of Australia.
39. Submission 1068, Dept of Education and Citizenship, Methodist Church.
40. Submission 262, Mrs M. Sands.
41. Submission 1101, AMA.
42. Submission 610, Family Life Movement of Australia.
43. Submission 709, Mrs Margaret Sheehy.
44. *Marriage Act* 1961-1976, section 42 (5) (a).

Who should attend?

41. The target group is primarily those intending to marry and those recently married; with advantage, young married couples and parents of new babies could be included. The problem is to identify those at greatest risk of marriage breakdown and to reach people who are not now being reached by programs. Often it is the young marrieds with young children who find it most difficult to attend classes, an argument for the provision of child care at marriage guidance centres.

42. Father Thomas Wright of Canberra told us that attendance at a prescribed marriage preparation course was:

> . . . not mandatory but . . . highly recommended . . . because each person does have a natural right to marry. That natural right would overrule any other right that another organisation or another person may have, although of course we as authorised marriage celebrants can refuse to marry a couple and in fact conscientiously we have to do that from time to time.[45]

The Lutheran Church in Adelaide would make it a necessary requirement for marriage celebrants to obtain from persons intending to be married a certificate showing that they had completed an approved family life education course.[46] The Community Education Committee of the Family Life Movement:

> . . . supports the introduction of mandatory pre-marriage counselling/education experiences for young people approaching marriage.[47]

43. The Marriage Act now makes it mandatory for young people seeking consent of the court to their marriage to produce a certificate from a marriage counsellor.

Goals

44. The content of programs would depend on the age of the participants and their marital situation. Like school programs for education in human relationships it needs to be geared to the people it serves. Some people told us that courses should be free from moral bias; others said that the courses should be based on ethics. There was no disagreement that there should be emphasis on communication.

45. A woman in Brisbane advocated:

> . . . classes in 'togetherness', in other words how to live amicably with another person in a close, intimate, harmonious relationship, where each contributes to the other's happiness and well-being, without intruding upon their personal privacy and individuality.[48]

A practising lawyer stressed the basic quality of companionship:

> . . . expressed in profound spititual, personal, emotional and sexual dimensions . . . [which] involves sharing and giving rather than taking.[49]

The Canberra Marriage Guidance Council believe:

> . . . that much can be done to learn and transmit the special qualities such as honesty, self-awareness and sensitivity which form the basis of effective communication, mutual acceptance, and co-operation in the continuous human interaction of living, in the family and in the community.[50]

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45. Evidence, p. 973, Administrator of St Patrick's Parish.
46. Submission 158, Commission on Social Questions, Lutheran Church of Australia, Adelaide.
47. Submission 610, Family Life Movement of Australia.
48. Submission 398, Mrs Frances Graham.
49. Submission 348, Mr A. J. Young.
50. Submission 949, Canberra Marriage Guidance Council.

A group of women in Mackay, Queensland, wrote that:

> . . . we seriously suggest that it should be part of the necessary requirements before a marriage be recognised by the society and the state.[51]

Our view is that it is desirable but cannot be made compulsory. An honorary director of research of the Marriage Guidance Council in Melbourne argued, in his evidence to the Commission, that in order to avoid the two major causes of marital conflict, namely 'lack of communication [and] lack of personal discussion . . . education for marriage at an early stage' was essential.[52]

46. Marriage preparation courses being conducted in Adelaide have a structure which:

> . . . is not so much information giving, but rather aims at helping each couple to look at themselves and each other, to look at their relationship and clarify their expectations of marriage and each other in that marriage.[53]

The Baptist Union of NSW wrote that:

> . . . instruction concerning moral and ethical issues must be dealt with positively and should always include all aspects of life. We recognise that the central problem is always the development of a philosophy of life and the creation of a set of socially meaningful and understandable values.

They commended the NSW Department of Education document *Personal development in secondary schools—the place of sex education* which they saw 'as an attempt to fill a need without abandoning traditional moral values'.[54] The Family Life Movement emphasised 'the value of relationship rather than reproduction as the basis for marriage'.[55]

47. Views expressed at a conference on 'Pre-marital education' in Sydney, in November 1976, were in favour of marriage education, not restricted to the period of pre-marriage. This view rejected 'pre-marital education' directed principally to engaged couples because education for marriage needs a far more comprehensive approach than can be provided in the short time between engagement and marriage.

Intercultural marriage

48. The special problems of intercultural marriage were brought out in a perceptive submission from the Catholic Family Welfare Bureau in Adelaide. The Bureau pointed out that differences in nationality and background affect something like 20 per cent of all marriages in Australia. The submission highlighted the differences that exist in attitudes to women, their status, their role within marriage, and the degree of restriction placed on them.[56] It is clear that counselling services should be sensitive to cultural differences. A doctor working with the Marriage Guidance Council in Melbourne added:

> . . . unfortunately Marriage Guidance Councils reach only a very small proportion of the population. It is still geared towards the English-speaking, Protestant and rather middle class people.[57]

One submission read:

> Cross-cultural marriages are fraught with communication problems over and beyond those normally encountered in developing a marital relationship[58]

51. Submission 709, Mrs M. Sheehy.
52. Evidence, pp. 826, 829, Dr J. Krupinski.
53. Submission 482, Catholic Family Welfare Bureau.
54. Submission 571, Baptist Union of NSW.
55. Submission 610, Family Life Movement of Australia.
56. Submission 482, Catholic Family Welfare Bureau.
57. Evidence, p. 827, Dr J. Krupinski.
58. Submission 1178, Mrs Y. Allen.

49. Another point to be considered here is that over-stressing differences and distinctions can detrimentally affect the special features of particular marriage customs. Care needs to be taken to ensure that guidance in the undoubted pitfalls of intercultural marriage does not spill over and unnecessarily dilute the richness that has come to the Australian community by way of marriage customs and practices through the immigration of people from other cultures.

How should it be taught?

50. We envisage that marriage education would be delivered in a variety of ways, including set courses delivered in an informal setting to enable discussion. Other ways appropriate to the needs of the persons concerned should also be tried. There was no disagreement among our submissions about the range of subjects to be covered, but there was a diversity in emphasis. Many preferred that education be given by voluntary organisations; we think there is a role for the media, too.

51. One area which particularly calls for assistance is the provision of co-ordinating facilities and the preparation and distribution of aids to education such as pamphlets, posters, discussion materials, video, films, film strips, voice tapes and so on. Another area is the training of course leaders. A third is the evaluation of existing programs. These needs were mentioned to us repeatedly. The National Marriage Guidance Council of Australia strongly favoured 'experiential learning' either in small groups or person-to-person experience rather than in purely didactic procedures, and they emphasised:

> . . . the necessity for improving standards and skills of all trained workers by continuing programs such as:
> (a) experimentation with methods of working;
> (b) advanced and refresher courses for people previously trained.[59]

Professional training

52. Our attention was invited to the need to introduce this pre-marital education to members of the helping professions. The Centre of Personal Encounter in Adelaide wrote of their:

> . . . increasing opportunities . . . to be involved in human relationships programs with nurses, medical students, teachers, and other professional people in training. It is our experience that these professional people are seeking this specialised knowledge of human relationships, found lacking in their previous training, to deal with the increased demands of their clients in all age ranges, occupations and socio-economic groups.[60]

Conclusions

53. We believe that in education for marriage there are three important factors to consider, viz.

(a) defining the objectives of the education;
(b) defining and reaching the target group;
(c) evaluating the program.

The objectives of the education could include helping those who are not yet ready for the responsibilities of marriage to defer their decision, as well as strengthening prospective and present partners in their ability to understand each other's role and needs in marriage. One factor in marriage breakdown is unreal expectations.[61] The

59. Submission 348, Mr A. J. Young, chairman, Legal Affairs Committee, National Marriage Guidance Council of Australia.
60. Submission 144, COPE.
61. See C. Gibbeson, Domestic violence, Commission research report, no. 11, 1977.

arrival of children is often a stress factor in marriage and many broken marriages involve very young children. This suggests that programs should have a broad approach and that they should be available at any time, e.g. to people who do not care to be involved before marriage.

54. Evaluation is difficult. Divorce figures are not necessarily reliable indicators of the number of broken marriages. Some work is being done in a longitudinal study under the auspices of the Family Life Movement in New South Wales to evaluate programs.

55. It might be a mistake to lay down rigid guidelines for programs. Preferably the government should attempt to monitor, provide resource information and encourage an outgoing program aimed at reaching those who would not otherwise receive this education. If voluntary associations are merely given funding to reach the same people who now receive education, then there will be little effect on the rate of marriage stability. The emphasis should be on innovation.

56. It seems to us that ideally the government should establish a resource centre with responsibility for gathering information about new publications, and new techniques in Australia and overseas, and for sponsoring the preparation of new educational material such as film and video-tapes for Australians. The Institute of Family Studies and the Curriculum Development Centre of the Department of Education could play a role in this. The Institute could also sponsor studies to evaluate programs and their effectiveness in reaching people as a basis for funding decisions. Training programs, which could cater for a number of voluntary organisations, could be organised by the resource centre.

57. One of the main target groups may well be the young couple in the lower socio-economic group, who have left school early. Existing programs run by voluntary organisations may not be able to reach this group effectively. They need to be found and to be offered help. An imaginative outreach program could include training young people from similar backgrounds and working through places where young people meet or work.

58. Since marriage education may not attract the group most in need, it is important to build up an image of a helping service, such as a survival skills course, which emphasises the benefits of the program in a manner appealing to the young. Straight lectures can be rejected as dull; films, video, discussions and outings may have more appeal. Continual experimentation and evaluation is needed and some of this should be done directly by the Institute or by specially sponsored pilot projects. Trade unions and employers may co-operate in providing workplace facilities for education programs.

59. To ensure that as many as possible know about education for marriage, and consider it useful, the media could be encouraged to convey information and even put over the educational message in an entertaining manner. The brochures to be handed out by marriage celebrants should have a style and content meaningful for the young.

60. Because of the difficulties in getting through to young people about to marry, efforts should also be made to offer programs to people before or on the arrival of the first baby. Hospital social workers could be involved at this point. Marriage, parenthood and family life programs could be combined to attract both parents. The Royal North Shore Hospital programs provide a model.

61. Another important matter is to ensure that people know where to turn at points of stress, e.g. to Family Court counsellors or marriage guidance counsellors. Information about existing community resources should be readily available. Unfortunately

there are not enough centres in the local community where people can turn for information and help. The Regional Councils for Social Development have done useful work and could be involved in this exercise.

62. We do not favour a move at present towards making it mandatory for couples to undertake a course before being married, but encouragement short of compulsion is clearly needed.

63. It is clear that many people believe that education for marriage is important and that present arrangements should be substantially developed with government assistance. We agree, and note that legislative provision has now been made for funding voluntary organisations. The problem is—how best to spend the money. The effectiveness of programs will vary and there should be no fixed views about the way to proceed. We see educational courses for marriage as one of the important and useful aids in the endeavour to ensure successful happy marriages and adequate parenthood. Education for marriage, then, is one of several aspects of education in human relationships and personal development which may affect marital stability. Equally important are personal development programs in schools and parent education.

Counselling

64. An article by George Gallup entitled 'What mankind thinks about itself' reviews the results of the first global public opinion poll; he remarks:

> The principal desire of people in all countries is to improve their standard of living. The hope for better health comes as a distant second and happiness for one's family and children third. The major worries expressed are fear of unemployment, deterioration of one's living standards and ill health.[62]

65. This picture of the hopes and fears of mankind is supported by the evidence that has come to us. The stresses and strains in human relationships emphasise the need for counselling services to help people to live. There are general complaints of not enough counsellors in our schools, and that training in counselling techniques is a gap in medical and paramedical education.

66. Counselling may come from those professionals whose main occupation lies in this field, e.g. psychologists, social workers and psychiatrists, but it is also an important part of the work of doctors, lawyers, ministers of religion and vocational guidance officers. Sometimes there is a simple need for factual information with an outline of the possible choices and their consequences. When the problem is more complicated, there must be a probing into the person's psychological and social background and only an expert can be trusted to handle the situation. Lay people have been used very successfully in some counselling situations. For example, Life Line uses lay people; so do some of the child abuse programs. Wherever lay people are involved it is essential that they receive training and have adequate back-up support from professionals. We see great value in this kind of community caring and involvement. Often here non-directive counselling is the best policy.

67. Another kind of counselling offers support and acceptance and expresses warmth and understanding to the person in trouble. The situation may range from having to make a difficult decision to having to come to terms with some painful reality such as disease, disablement or bereavement. These situations often occur at developmental life stages such as adolescence, career choice point, job seeking, marriage, family planning or retirement. Needs may arise at crisis points such as accident, sorrow, pregnancy, family breakdown, unemployment or irretrievable loss.

62. G. Gallup, 'What mankind thinks about itself', *The Readers Digest*, October 1976, p. 32.

School counselling

68. School counselling practices vary, but the pressure on family relationships is the same everywhere.

69. Education authorities are keen on the idea of preventive work but resources restrict them mostly to remedial work. For example, in NSW state schools the ratio of counsellors to students is 1:2500 though in the next 5 years the Department hopes to get this down to 1:1200. New ways may have to be found to meet these needs which may involve group counselling, and more widespread parent education.

70. Dr Don Edgar, Reader in Sociology of La Trobe University, told us of a research study done on 1214 adolescents in the 12–14 age bracket, rural as well as city, in Victoria, on self-esteem, sex roles and academic ability. This study indicates the need for better school counselling services if the stereotyping of roles is to be avoided, and the counselling of teachers, including principals, may be as necessary as that of pupils.

> I am particularly interested in looking at the way in which the school system is structured to the point where it denies the competence that many children believe they have because it rewards only certain aspects of competence . . .
>
> The difficulty is if the school continues to define as successful only those boys or girls who succeed at academic forms of competence, i.e. numerical skills, literary skills, in fact what the school is saying to a majority of children—you are a failure, you would not fit.[63]

Other counselling services

71. In connection with pregnancy, abortion and childbirth, the term counselling has different meanings for different groups of people. In the case of unwanted pregnancy, some believe that counselling means merely supporting the woman, to avoid abortion[64]; others interpret it as offering the woman a choice to help her make up her own mind.[65]

72. Our research has shown that expanded pregnancy support services are needed for mother and child. Counselling, a doctor argued, should be an integral part of all medical service to patients; the aim of abortion counselling should be supportive; it should help the woman to make her own decision, and then implement it; it should also assist her to control future fertility.[66]

73. There is general agreement about the value of marriage guidance, which provides pre-marriage counselling and also counselling when the marriage is threatened.[67] Some marriage guidance centres have been established by churches; others are voluntary bodies; they receive some government subsidy, but recent rises in costs have forced some curtailment of both counselling services and educational programs. There is a strong case here for increased subsidies.

74. Counselling is an important remedial function to help both the victims and the aggressors in family violence or child abuse.

63. Evidence, pp. 2769–80, Dr Don Edgar.
64. Submission 474, Co-ordinator, Womens Group, Gunnedah, NSW.
65. Submission 570, Preterm Foundation.
66. Submission 747, Dr Kelvin Churches.
67. Submissions 146, Mothers & Babies of Health Assoc., SA; 571, Baptist Union of NSW; 582, Miss Rhonda Farquhar; C688, Confidential; 691, NSW Council of Churches; 973, League of St Gerard Majella; 983, Mr John McGinley; 1156, Pastor John Whitbourn; 1163, ALP Womens branch, Launceston.

9. General conclusions

1. There is considerable public support for comprehensive education programs for both parents and their children, the programs being complementary to one another. The Commission supports the growth of greater interaction between schools and the community. However, the school's main responsibility is to the young. It is generally agreed that there is a real need in schools for broad and comprehensive human relationships education, giving sex information and an integrated program covering related social and psychological matters. The successful implementation of such programs could help in developing a community more open and tolerant in outlook, and better able to form meaningful relationships. As men and women grow in understanding of their respective roles and their responsibilities in relationships, the quality of marriage and family life could improve.

2. The Commission raises the question of how far the education system will respond to supply the need which we see. Education in the past has been a paternalistic field, with curriculum and programs reflecting what educators felt was 'good', 'valuable', 'educational' or 'useful for your future'. Young teachers were taught how to motivate their students to follow these programs. There is now a greater realisation that motivation comes from within the learner and that it is at its highest level when the program is seen as important to him or her.[1]

3. The evidence before the Commission advocates that both pupils and parents would welcome a more democratic relationship with teachers and schools. This would help the school to become a more meaningful institution, and make education in human relationships likely to succeed.

4. Education has been a prolific source of government reports in Australia and elsewhere for 100 years at least. They come, are news for a day and are absorbed by the system, apparently making little difference to what goes on in the schools. The Chairman of the Schools Commission, Dr K. R. McKinnon, spoke of the 'rigidity' and 'bureaucracy' and 'resistance to reform of Australian schools . . . by no means limited to high officials'.[2]

5. Professor Basil Hetzel of Monash University has written:

> The present educational system does not do enough to prepare the young adult for urban life with its tensions, competition and pace in which he has to establish himself in an occupation, in family life, and with a value system.[3]

6. This is a conclusion also to which our research has led us. The recommendations we have made aim to secure a wide awareness of the challenges to be met in our schools and to encourage governments to provide the resources to enable Australia to meet that challenge successfully and to provide happier and healthier citizens for the twenty-first century.

1. Sol Gordon, 'What place does sex education have in the schools?', *Journal of School Health* XLIV, 4 (1974).
2. 'Millions invested, but schools resist report—expert', *Sydney Morning Herald,* 18 October 1976, p. 3.
3. B. Hetzel, *Health and Australian society* (Penguin, Melbourne, 1974).

Recommendations

We recommend that:

1. The government should require the Department of Education to make a major effort to change the policies of all concerned with education so that these policies will be designed and directed to ensure the fullest possible development of the whole person, physically, emotionally, intellectually and socially. Within this fundamental policy, we make these further recommendations.

2. The Department of Education should initiate and carry through reforms to enable educational institutions to respond to the community's desires for better education for human relationships at all levels of the education system.

3. Education for human relationships should aim to be an integral part of education in all subjects at every stage and level.

4. Education in all fields and at all levels should provide opportunities for boys and girls to:

(a) develop a knowledge and understanding of the functions of emotion, feeling and caring in relationships;
(b) become aware of the varying attitudes to male and female roles in society and the ways in which these attitudes affect aspirations;
(c) discuss situations in their own lives and in society in which boys and girls, men and women are treated differently and to examine the origins of these differences and the reasons for their continuation;
(d) assess the effect of peer pressure;
(e) learn to appreciate the power of social forces and institutions (including the media) to influence the development of individual personality and choice of life style;
(f) develop skills in communication and interpersonal relationships, and for this purpose to
(g) acquire a correct vocabulary of sexuality.

5. Education departments should develop comprehensive human relationships education programs that:

(a) are appropriate to age and tolerant of differences in background and origins;
(b) begin in the primary school and are completed by school leaving age;
(c) are factual and frank;
(d) are comprehensive in the range of subject matters;
(e) are given by specially trained teachers in small groups of boys and girls;
(f) are constantly researched and evaluated.

6. At primary school level and below, parents should be able to withdraw children from classes of human relationships education.

7. Teacher education courses should look at women and men in their social and physical environment, at the human life cycle and at human sexuality.

8. A course in human relationships education, including ethics, should be a prerequisite in undergraduate training of teachers.

9. Information should be available to teachers about local community resources able to deal with family relationship and human relationship problems in specific areas.

10. Experienced teachers who are to work as specialists in the human relationships field should be selected according to the same criteria as guidance counsellors, i.e. after some years in the classroom and after further specific training.

11. Established teachers should be given opportunities to undertake retraining in communication skills including new approaches to the process of learning.

12. Research should be directed to:

(a) the issues of teacher education in matters related to human relationships;
(b) the evaluation of human relationships education programs and methods of delivering them;
(c) the effects on individual development of the characteristics, organisation and staff of schools.

13. Tertiary education institutions should develop interdisciplinary courses in human sexuality and such courses should be a prerequisite for the professional recognition of teachers, and should also be recommended to social workers, welfare workers, nurses and health professionals.

14. The government, in collaboration with education and broadcasting authorities, should explore ways of developing programs to support and supplement school human relationships and personal development programs.

15. The government should contribute to a professional education magazine which should especially draw attention to education in human relationships, and bring this to the classroom teacher throughout the nation with news and information on resource material.

16. Parent education programs should begin early in each school year and both parents should be encouraged to attend when their child enters infants school or pre-school, again on entry to primary school, and again at the age of puberty.

17. Each school district or local government area should employ a community education officer to work with the P & C, the school and the voluntary associations, to promote programs of parent education. The community education officer should be government funded.

18. The local primary school should be the focal point for involving parents in education for child rearing and indeed for other general community purposes.

19. Voluntary associations should be enlisted to evolve suitable programs of parent education, and some of these should be scheduled for Saturday afternoons, or times when child care facilities could be provided, and when both parents, and single parents who work, could attend.

20. Parent education programs should be funded in hospitals as part of pre- and post-natal classes and ways should be sought to increase parent education programs to people expecting the birth of a child.

21. Ways should be sought to enable secondary school students to have supervised experience of child rearing as part of their personal development course.

22. Educational aids, such as films, should be developed for use in state systems, and made available for the use of voluntary associations and the non-state systems.

23. The Departments of Education and Health should assist in funding the work of voluntary associations in education for human relationships, and schools should be funded to pay sessional fees for their services.

24. Voluntary associations should be assisted to develop as resource organisations for locally based programs of human relationships education for children involving both mothers and fathers and at times and circumstances which give most opportunity for both parents to attend.

25. The Schools Commission should seek educators and schools willing to undertake research on how to bring the school closer to the community.

26. Professionals who are involved in maternity hospitals and baby health clinics should direct the attention of parents to support services.

27. On preparation for marriage:

(a) the government should sponsor further research, including pilot programs, and evaluation of preparation for marriage courses;

(b) the government should extend its support of training programs and the preparation of resource material through additional funding;

(c) the government should publish and distribute pamphlets to marriage celebrants as a guide for those intending to marry; these should be in the main ethnic languages as well as in English;

(d) the government should extend financial support for the development of marriage education programs by approved voluntary agencies;

(e) ways should be sought of using all branches of the media as an effective part of marriage and parent education programs.

28. Schools and child care agencies should relinquish physical methods of punishment and, to assist this, educational authorities should research the best ways of handling the disruptive child, including the provision of alternative education.

29. Degree and diploma courses in community health with an interdisciplinary approach should be developed in tertiary educational institutions.

Annexe II.A

USSU, *Proposed guidelines for sex education in the Swedish school system* (Swedish State Commission on Sex Education, Stockholm, 1974)

The following are quotations from the publication.

1. Swedish sexual education
2. Aim of education in sexual and personal relationships
3. All essential facts to be imparted
4. Age level considerations
5. Early sexual relationships
6. Personal relationships
7. Marriage
8. Other subjects to contribute
9. Distribution over age groups
10. Instruction on values
11. Fundamental values
12. Controversial values
13. Early sexual relationships
14. Pornography
15. Contraceptives
16. Sexual roles
17. Counselling services
18. Collaboration between home and school
19. Migrants
20. Handicapped
21. Teaching aids
22. Teacher training

1. Swedish sexual education

Swedish sexual education has been criticised both within the country and abroad for being excessively 'biological', with insufficient emphasis on the importance of emotional factors . . . USSU's analysis of the sexual education actually provided showed that such criticism was exaggerated, but that it was to some extent justified. Another reason for according ample space to personal relationships is that these, in a structurally and ideologically rapidly changing society, have become increasingly problematical, presenting great difficulties for both the individual and society at large.

2. *Aim of education in sexual and personal relationships*

By his education in sexual and personal relationships, the pupil shall:

(a) acquire a knowledge of anatomy, physiology, psychology, ethics and social context that will equip him to experience sexual life as a source of happiness and joy in fellowship with another, and to strive for a relationship characterised by responsibility, consideration and concern;

(b) acquire an objective and all-round orientation of different values and philosophies that have a bearing on sexual life, both fundamental values that—by the terms of the aims and guidelines drawn up in the curriculum—are to be maintained and promoted, and controversial values that—by the general instructions given in the curriculum—are to be treated without any taking of sides by the school;

(c) develop a capacity to understand that sexuality is an integral part of a person's life, and is indissolubly connected with the development of personality, with relations of 'togetherness', and with the social structure;

(d) acquire greater awareness, and thus a greater opportunity to adopt a personal position at different levels of maturity and sexual experience.

If teaching is designed in accordance with these objectives and guidelines, it will cover three main fields:

(i) sexual anatomy and physiology;

(ii) sexual life in its various manifestations (e.g. intercourse, masturbation, disturbances in the sexual function, methods of birth control, abortion, variations in the direction of the sexual urge, venereal diseases);

(iii) questions arising in living together that have to do with emotions, human relations, values, moral standards and social conditions.

3. *All essential facts to be imparted*

Teaching should endeavour to combat prudery and secretiveness in the sexual field. Boys and girls should be instructed jointly. Sexual information should be provided as early as pre-school age. Children should be given honest answers to their questions.

4. *Age level considerations*

Certain phases of sexual teaching have been moved down from a higher to a lower age group, and the information given has been made more exhaustive at all stages. The motivation for this is (1) that the pupils have questions and thoughts in the areas concerned, and therefore need responsible teaching in them; (2) that these questions and thoughts—which occurred also in older times—have become even more common in our own age, as a result of increased sexual openness; (3) that a knowledge of sexual life cannot be regarded as problematical or injurious for any age; and (4) that young people need information and views on the subject before sexual and allied relationships are a matter of immediate concern to them.

5. *Early sexual relationships*

The excessively early sexual relationships that occur should be combated by other aspects of teaching than a general recommendation of restraint while one is young. No longer is the advice given to marry early, rather than enter a pre-marital relationship.

6. *Personal relationships*

Teaching in personal relationships, including preparation for family life, has been assigned much greater importance than previously.

7. *Marriage*

Panegyrics to marriage have been omitted, but the value of a lasting and intimate personal relationship between the man, woman and children is consistently emphasised.

8. *Other subjects to contribute*

The greater stress on personal relationships involves increased duties for the subjects of social studies, religious instruction, domestic science, child care and Swedish, within the framework of sexual education at the 9-year basic comprehensive school.

9. *Distribution over age groups*

Pre-school level (3–6 years)

The security and love that the child, at best, will experience during its first years of life will exercise the deepest of influence on its capacity for warm, human relationships, including those with the opposite sex. It is therefore important that the first information about 'where babies come from' is given at home in the pre-school years. The school can never replace the experiences of the child at that time. However, the pre-school, in close consultation with the parents, should take it as its guideline always to give children correct answers to their questions, in an atmosphere of warmth and intimacy.

Lower level (7–9 years)

The Commission proposes an increase in sexual education at the lower level. The main reason for this is that there is no longer the same anxiety at the idea of children knowing about sexual life; the amount of knowledge imparted can be adapted to their comprehension, and to their specific questions. Secondly, one must assume that lower level pupils today have a number of vague and, in part, erroneous ideas that must be corrected and put in order.

At a parents' meeting held in the autumn term of Grade 1, the teacher should inform parents regarding the sexual education provided in this grade, and listen to the view of parents and the information they provide.

Middle level (10–12 years)

In Grade 6, pupils are given the basic biological facts together with a preliminary run-through of the important questions concerning responsibility.

The aim of teaching at the middle level is that pupils should:

(a) acquire better orientation in reality;
(b) develop an understanding of the physical and mental changes that occur when puberty commences;
(c) develop an understanding that it is a worthwhile goal for the future to integrate sexuality in a personal relationship; and
(d) acquire a knowledge and understanding of the responsibility involved in a sexual relationship. In this way, pupils will prepare themselves for a decision concerning early sexual relationships, a decision that they will have to make in their teens.

Upper level (13–15 years)

The emphasis in sexual education at the upper level should be shifted from Grade 9 to Grade 8. At the upper level, the Commission proposes very extensive instruction in both sexual and personal relationships. For the first time, detailed proposals are now presented as to which phases of the course should be the duty of teachers in biology,

social studies, religious knowledge, domestic science and child care. Primarily, it is proposed that teaching be structured in one or more comprehensive 'fields of work', which incorporate matter from several different subjects and in which several teachers collaborate. Secondarily, the Commission proposes specific fields of work within a given subject. Great importance is assigned to the ethical, psychological and social aspects.

The comprehensive secondary school (16–18 years)

A survey among second year students of the 'gymnasium level' or secondary school showed that even today's young people consider themselves to be in great need of instruction in sexual and personal relationships at the school. Such instruction can be given partly in the freely disposable hours available in integrated classes, partly in smaller groups. Teaching in an integrated class can consist, for instance, of lectures and panel discussions, for the purpose of which there should be collaboration between the teachers, other school staff, outside experts in different fields and the students themselves. In the case of teaching about values, the same fundamental principles shall apply as in the basic school, but with even greater emphasis on the students adopting their own critical positions. Apart from this, teaching should both impart fresh knowledge and illustrate the extensive discussion of sexual and personal relationships in the community at large, from the ethical, psychological and social standpoints.

At all stages of the school, pupils should participate in the planning of the sex education.

10. Instruction on values

By the terms of the curriculum for the basic and the comprehensive school, instruction shall be given both on the fundamental values and on values which are in dispute, which are termed controversial values. In handling the fundamental values teaching should not be objective, but should take sides and aim to promote certain ideas. Examples of such values are the 'inherent value of man, the inviolability of human life and thus the right to personal integrity'. Examples of controversial values are the various fundamental political philosophies, and different attitudes to certain questions of sexual morality. In the case of controversial values teaching should be objective. The reason for this is that the public educational system should not be used as an instrument of indoctrination in favour of any one group of citizens vis-à-vis another group. Naturally, corresponding rules should apply to sex education.

11. Fundamental values

The fundamental values indicate that the following ethical guidelines, among others, should be maintained and promoted in the course of teaching:

(a) A worthwhile aim is to combine sexual life, togetherness and respect for the integrity of the other person. This, in the Commission's opinion, is a central value judgment that should set the tone of sex education as a whole.

(b) There apply to sexual relationships the same demands for consideration to others and responsibility for the consequences of action as held in other fields of life. This means, first and foremost, that no fellow being should be regarded exclusively as a means for the satisfaction of another's interests and needs. In the sexual as in other fields, any form of mental pressure or physical violence constitutes a violation of the other person's integrity.

(c) Teaching should support a standard that according to USSU's studies is embraced by the great majority of the Swedish population, namely the rejection of 'unfaithfulness'. By unfaithfulness should be meant in this context a disloyalty rather than a sexual act in itself.

(d) Teaching should reject the traditional double morality by which moral sentence is passed upon women for actions that a man can commit with impunity. The rejection of sexual double morality is one aspect of the function of teaching to combat prejudice regarding sexual roles.

(e) The demand for equal rights entails also that teaching should argue against racial discrimination in the sexual field. As immigration continues, this question can become increasingly topical.

(f) The condemnation of variations in the direction of people's sexual urge should be counteracted, and a considerate attitude to such phenomena promoted.

(g) Teaching should promote recognition of the right to a sexual life on the part of the physically and mentally handicapped, the mentally diseased, the inmates of prisons, and others tied to institutions. Prejudices against the sexual life of the elderly should be combated.

(h) Teaching should proclaim sexual tolerance in the sense of respecting the right of others to speak for, and live by, sexual standards that oneself rejects. Such tolerance, however, cannot apply to attitudes in the sexual field which are incompatible with the fundamental values which have to be promoted. Teaching, for instance, cannot take a tolerant view of racial discrimination in this field, or of double morality.

12. Controversial values

Among the controversial values the Commission lists the following, which should thus be treated without taking sides:

(a) Ethical attitudes to abortion. On this question, some groups consider that abortion should only occur on specific medical and other grounds, while others consider that the wishes of the woman should be paramount. The school cannot be involved in arguments in favour of either point of view. It is of the greatest importance, however, that the arguments of both groups be correctly reported.

(b) Pre-marital sexual relationships with the person one intends to marry or permanently live with are regarded as self-evidently acceptable by the great majority of the Swedish population. About half of those with a personal Christian faith, however, are convinced that sexual life together, in accordance with God's will, can take place only within marriage. Such parents and their children must be able to assume that their view will be presented in the schools in a proper and respectful manner. Teaching must not take sides against their view. It is another matter that teaching must devote considerable time to the questions of personal pre-marital relationships.

(c) There also exists a minority group, however small, which considers the use of contraceptives to be ethically and/or religiously reprehensible. In the considerably increased information about birth control methods recommended by the Commission, it must be made clear that there is no intention of trying to influence these pupils to change their views. On the contrary, it must be made clear to them that their right to have another view than what is common is respected.

13. *Early sexual relationships*

Many very early sexual relationships are started before the young people concerned can handle the situation emotionally, or cope with the responsibility, and this can have unfortunate consequences. Teaching in sexual and personal relationships should try to help reduce the number of such relationships, and mitigate their negative consequences. However, many teenage relationships are handled in a responsible and considerate manner, and the school should not cut itself off from the opportunity to provide assistance and advice for such young people. If the school were to declare that what they are doing is in all circumstances morally reprehensible (which is the import of a general recommendation of restraint), then these young people would feel they were being done an injustice in a matter vital to them. From such a premise, there would be no prospect of successful teaching in either sexual or personal relationships.

The objective of preventing excessively early sexual relationships, and mitigating their effects, should be pursued by other aspects of teaching. Teaching should point out the risks involved in excessively early sexual relationships, regardless of the standards one holds. These risks are as follows:

(a) that the relationship will be characterised by dissent, an incapacity for empathy, and thus little ability to show consideration and take responsibility;

(b) that one will find oneself entering a succession of short, impersonal relationships that were not intended, and which can create an unrealistically negative view of what a sexual relationship between a man and a woman has to offer;

(c) that the persons concerned, owing to their youth, will have insufficient experience and judgment to be able to prevent an unwanted pregnancy, or gonorrhoea.

Teaching should not adopt any general position on the question of sexual relationships among young people but it should actively try to combat excessively early relationships.

14. *Pornography*

Teaching, in the Commission's view, should systematically combat the picture of the relationship between man and woman promulgated by pornography and 'sexism'. The separation of sexuality and sexual life from the context of life at large, and, particularly, the presentation of woman purely as a sexual object, are incompatible with the objectives proposed for sexual education.

15. *Contraceptives*

It is desirable to establish in children from the beginning the attitude that it is their clear and bounden duty to themselves and their partner to use contraceptives if one does not want children.

The idea that teaching about contraceptives will be understood by students as a 'go-ahead' for sexual intercourse is unrealistic.

16. *Sexual roles*

Great emphasis should be given, in teaching about sexual and personal relationships, to the following passage from the curriculum under 'Aims and guidelines': 'The school should endeavour to promote equality between men and women—in the family, on the labour market, and in the life of the community at large. It should provide orientation on the question of sexual roles, and stimulate students to discuss and question the prevailing conditions.' The influence of the sexual roles, and of equality, on

the relationship between man and woman—including the sexual relationship—should be discussed on repeated occasions.

17. Counselling services

All students should be informed of the opportunities for individual counselling on sexual and personal relationships that exist locally, within and outside the school. Those in need of such counselling should not be in any doubt as to where it can be obtained.

18. Collaboration between home and school

Information on the content of teaching about sexual and personal relationships should be provided at a parents meeting at least once for every level of the basic school. Parents and teachers should have the opportunity at these meetings to exchange views on teaching. In view of the different beliefs held on the subject of sexual and personal relationships, it seems vital that the school should inform parents of the respect for different views on which sexual education is to be based. In presenting sexual education, it should also be stressed that the tasks of the home and the school to some extent differ, and that they can never take each other's place. The home, by its general influence, will provide the emotional development and the fundamental attitudes that are rooted in the personality. The school can impart factual knowledge, an insight into the consequences of different courses of action and a clearer view of different beliefs.

19. Migrants

The Commission has considered in detail the situation that occurs, with regard to views on sexual and family life, when immigrants arrive from countries with an essentially different approach to these questions than is common in western and northern Europe. In many cases there seems to exist a severe cultural conflict. On closer consideration, however, it becomes clear that the conflict arises essentially from the encounter with the new society as such, rather than by experience of sexual education in the schools. Factual information can correct misunderstandings and fill out gaps in knowledge which could otherwise easily prove fatal. For this reason, the Commission finds it right and necessary that teaching on sexual and personal relations should continue, as at present, to be compulsory also for immigrant pupils.

20. Handicapped

The Commission has tried to acquire a picture of the situation of different categories of handicapped as regards sexual and personal relationships, and of their requirements regarding information. In the Commission's opinion, there exist good manuals for providing sexual education for the mentally retarded both within the educational system and at institutions for adult retardates. One of the premises underlying these manuals is that this category of handicapped persons should have the right to a sexual relationship, which has in many cases proved to have a favourable influence on the retardate's life situation. The general sexual education given in the schools should counteract the prejudices existing in this field. However, a great deal remains to be done in respect of both the actual provision of sexual education, and the realisation of opportunities for intimate personal relationships.

Prejudices exist also as regards the needs and potentials of the physically handicapped for maintaining sexual relationships, and attempts should be made to counteract these in the schools. In so far as the handicapped are being integrated to an increasing extent in ordinary school classes, sexual education will for their part be

provided to the same extent and along the same principles as for the school as a whole. Obviously the same should apply also to those handicapped who cannot attend ordinary classes. At present their need of information is still often neglected.

21. Teaching aids

Teaching aids in local history and geography should be furnished with sufficiently ample sections designed for use in sexual education. It is desirable that the subject of Swedish should also be used for this purpose, at all levels. The stimulus reading of fiction that throws light on personal relationships with a sexual connotation is an indispensable contribution to a deeper understanding of this aspect of life.

Special, exhaustive 'extra reading' books in sexual and personal relationships should also be available in full class sets to permit a more thorough study of selected areas of the subject field. In this context, it is necessary to ensure that teaching as a whole complements and corrects any onesidedness, inadequacy or deviation from the fundamental guidelines laid down for sexual education on the part of these aids.

As regards illustrations in aids for sexual education, the Commission proposes that the following guidelines be applied. In the case of anatomical and physiological illustrations of the scientific type, no principles of selection need to be applied other than consideration to the pupil's capacity for comprehension and motivation at the level in question. No factual knowledge in these fields is unsuitable or injurious. In the case of illustrations presenting sexual relations between human beings, it should be ensured that they support the aims and basic values applied in teaching. Films of a psychologically and artistically high quality that contain scenes depicting intercourse can be useful in teaching. The Commission considers it suitable that the use of such films as a complementary aid be restricted for the present to the gymnasium-level school, where students attain the age (18) at which they have the legal right to decide for themselves to enter upon marriage. They cannot then be considered too young to see scenes of this kind presented, which are now a self-evident feature of many serious films.

Films, like other audio-visual aids (e.g. series of slides, and recorded radio and television programs) can never replace instruction by the teacher, only serve to complement it.

22. Teacher training

A representative sample of all categories of teachers who teach sexual education shows that the majority consider themselves to have received insufficient training in this field . . . the great majority say at the same time that they would have liked more instruction on both sexual and personal relationships. Improved training would probably better enable the teachers to provide good sexual teaching, not only from the standpoint of their knowledge but also in their attitudes.

The training future social studies teachers receive at university contains practically no matter related to sexual and personal relationships, in spite of the importance of these in society. In the Commission's opinion certain new elements should here be introduced, such as modern sexual sociology, sexual anthropology and family sociology.

Sexual and personal relationships have in recent years been accorded considerably greater space in the university training of future teachers of religious education, and the Commission notes this development with satisfaction.

The training of psychology teachers includes at one university extensive elements of sexual psychology, at other universities extremely little. If, following the Commission's proposals, great weight is to be assigned in sexual education to personal relationships, then it is desirable that all psychology teachers should have received a training that fits them to assist in this development at the gymnasium-level schools.

Annexe II.B

Statement to Royal Commission on Human Relationships on behalf of Canberra's School without walls

The nature of School without walls

The name 'School without walls' is, for us, a metaphor for change: we would like to see a society in which all people could communicate freely, in trust.

The need for change in the entire education system

We believe that open communication is a state which we can only dimly imagine because we are all so circumscribed by authoritarian structures, experts, role playing and fear (of being dumb, ignorant, failing, caught out, not included, misunderstood, powerless, ignored etc.).

We therefore believe that the most important 'learning' for everyone is the development of self-assurance and awareness of others. To this end:

anti-authoritarianism
real student participation
non-hierarchical systems
open-ended discussions
collectivity/communitarianism (group feeling)
non-sexist, non-racist attitudes
honesty
and caring (for other people)

are what we strive for. This seems to us to be the most effective means by which all of us may become autonomous, self-motivated, responsible, involved people. Such people are conspicuously able to determine what learning they want/need to be involved in and how they would like that learning to be organised or approached.

To this end, the role of the teacher is to 'be' a human being—one with his/her own experiences, enthusiasms, skills and expertise from which the students can draw. It is important that teachers be accessible to students not only as 'resources' in specific areas but as adult *persons*. Teachers, perhaps by definition, are interested in ideas and skills, and in communication, and are people with a respect for learning. That respect for learning should be as wide as possible. The teacher needs to strike a delicate balance between, on the one hand, encouraging people to discover and share their own interests, enthusiasms and skills, and, on the other, helping to create a genuinely free, non-coercive learning context in which individual students can develop their own autonomy and their own values, and determine the nature and direction of their own learning.

We believe a massive change in people (especially teachers) is necessary, so that the traditional hidden curriculum of anti-humane human relations in education can be eradicated from Australian society.

Elizabeth (Biff) Ward
Co-ordinator
School without walls

Annexe II.C

Examples of resource materials used in human relationships education

1. NSW has a series of booklets called 'Contact' each of which outlines an aspect of the program or a subtopic and gives a bibliography of relevant literature, films, etc. They are not prescriptive, but would be invaluable to the classroom teacher, particularly those in outer urban and rural areas away from other resource material.

2. South Australia has a similar guide which illustrates ways and means of introducing various subtopics and which invites teachers to use the document 'as written, or in ways that you feel are appropriate'.

3. The Tasmanian Curriculum Branch has a boxed kit called 'Decisions' which includes printed 'cues' on each topic, a cassette and colour slides, all of excellent quality.

4. All represent a considerable outlay on the part of respective departments and all would be equally valuable in their own way if they were available as resources to schools and teachers outside their systems and interstate.

Part III
HEALTH AND MEDICAL EDUCATION

1. Introduction

1. We were impressed with a statement by Professor Basil Hetzel that:

> The fact of the matter is that Australians can no longer take their health for granted in spite of the many natural advantages they enjoy. Australians do have some urgent health problems which require better understanding so that effective action can be taken . . . The maintenance of the health of a community is dependent upon a level of awareness and a decision to take some measure of individual and group responsibility for the quality of community life. There is a tendency for many of us to think that by paying our taxes we are absolved of all other responsibilities as citizens: such attitudes are not consistent with a high quality of community life and health.[1]

2. The truth of Professor Hetzel's statement became more apparent as we explored that section of our terms of reference which demanded that we should inquire into and report upon:

> . . . the extent of relevant existing programs in medical schools and their adequacy to provide comprehensive medical training in contraceptive techniques, in the physical, psychological and sexual problems experienced by women in adapting to marriage and before, during and after menstruation and in matters relating to pregnancy, fertility control, spontaneous and induced abortions and childbirth, and to encourage acceptance by the medical profession of its responsibilities in the field of contraceptive counselling.

3. Part of our evidence either concerned doctors or came from doctors; in addition we reviewed those courses in medical schools and post-graduate education which deal with questions of sexuality and human relations. Closely bound up with the training of the medical profession is the selection of medical students and the way they are prepared for involvement with people, whether patients, fellow practitioners or those providing other services, a process described as 'socialisation'.

4. Our investigations were welcomed by the medical schools and post-graduate colleges and by the Royal Colleges. With the technical assistance of the ANU, the Commission undertook a national survey of the training and practices of general medical practitioners. A copy of the questionnaire and the technical report from the ANU is at Annexe III.A.

5. In securing the high quality of community life and health of which Professor Hetzel speaks, we are mindful that paramedical as well as medical services are required: nurses, occupational therapists and physiotherapists, clinical psychologists, social workers, family planning and baby health nurses and health educators. We were not able to investigate these at depth, but we acknowledge their value and importance in maintaining a healthy community; government support is essential for paramedical services including health education. Mr James Carr, the executive officer of the Health Education Council of WA, told us in our hearings at Perth:

> When drug education money was made available, we were asked to put up programs. We submitted this social issues program as the only sensible way to tackle the drug issue—to begin to look across the board at issues in which the needs of people in society were really what was at stake rather than the effect of chemical substances. After some hassles the Commonwealth people accepted that and that has been our major program ever since.[2]

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1. B.S. Hetzel, *Health and Australian society* (Penguin, Melbourne, 1974), p. 14.
2. Evidence, p. 1973, James Carr; 'social issues program' refers to Exhibit 134.

6. We looked at the influence of the social environment and long-term health trends in order to identify some of the causes of stress and to make recommendations to alleviate them. We gave consideration to the needs of people with cultural differences like migrants and Aboriginals, and those with special problems like the poor, the handicapped and the aged.

7. Our investigations covered twelve main areas, or dimensions, namely human sexuality; patterns of illness in the community; normal development and behaviour; preventive medicine; womens health; fertility control; pregnancy and childbirth; social factors in health and disease; the role of the social service and community health programs; the role of the doctor; the needs of special groups as indicated in the previous paragraph, and finally training in the basic social sciences and the techniques of research and evaluation.

8. We were grateful for the help of a steering committee whom we invited to advise us. They must not, of course, be regarded as responsible for our conclusions. The members were:

Professor Kenneth Cox
Director of WHO Regional Teacher Training
Centre for Health Personnel
University of New South Wales

Ms Judy McLean
Director
Family Planning Association of NSW

Professor David Maddison
Dean, Faculty of Medicine
University of Newcastle

Dr John Powles
Department of Social and Preventive Medicine
and Department of Social Work
Monash University

Mr John Vinen
Chairman, Medical Education Committee
Australian Medical Students Association

Professor Carl Wood
Professor of Obstetrics and Gynaecology
Monash University

During the absence overseas of Professor Cox, Dr Arie Rotem, of the University of NSW Centre for Health Personnel, kindly assisted us.

9. Bearing in mind our concern with sexual relationships, family planning, pregnancies and abortion, we have emphasised the special problems of women in relation to the medical profession. A fuller treatment of family planning, pregnancy and abortion will be found in Part IV of our report, and for a full picture the two need to be read together.

10. We re-echo with approval the summary of a paper given by Dr Gillian Diamond, Education Consultant to the Family Medicine Program of Victoria, at the IWY conference on 'Womens health in a changing society', University of Queensland, August 1975:

> Sexuality is a part of us all and is an outward expression of each person's perception of him- or herself as a sexual being. If a doctor is unaware of his or her own sexual attitudes, these may intrude upon the doctor-patient relationship, especially in areas that are

specifically to do with sexual matters. The doctor's lack of understanding of different cultural and social norms may make him insensitive to the needs of his patients. A doctor who is rigid in what he believes to be right or wrong with regard to sexual behaviour may find great difficulty in helping a patient who does not conform to his standards . . . The patient's own view of her and her partner's sexuality will be of prime importance in any family planning or lack of it, and the doctor's awareness and acceptance of this will affect the way in which he is able to interact with the patient.[3]

11. Similarly Dr Norelle Lickiss, Professor of Community Health in the University of Tasmania, has written:

> Educational effort should be directed towards the acceptance of sexuality as part of the celebration of life . . . There is no place for sexual repression but there is need for human sexual response to be continually appropriate and authentic and never depersonalised . . . Education in sexuality must include not merely skilled communication of information concerning sexual life and conception control but also assistance in full personal development and growth in identity stability despite inevitable and continuing cultural change.[4]

12. As we shall see it is no longer possible, or indeed appropriate, that the medical practitioner should retain sole responsibility for the relationship problems of many of his patients. His willingness to refer and work closely with other health professionals, including psychologists and social workers, may be dependent very largely upon the breadth of his own education.

13. We are therefore in complete agreement with the Royal Commission on Medical Education in the UK (1965–68), which started from the premise that:

> . . . every doctor who wishes to exercise a substantial measure of independent clinical judgment will be required to have a substantial post-graduate professional training, and the aim of the undergraduate course should be to produce not a finished doctor but a broadly educated man who can become a doctor by further training.[5]

14. Attitudes towards health care and health services are undergoing remarkable changes. Responses to such changes need to be built into the curricula of our medical schools through the continuing analysis of social and health needs.

15. If the medical profession is to reflect social change, it needs to undergo change itself.

> In professional training much attention is paid to the socialisation of students into the existing norms of the professions concerned. Training programs are designed to ensure that the future doctor, lawyer, social worker or teacher fit into the established pattern. It is difficult to see, then, how the incoming generation of professional people—the people whom we expect to be concerned with social issues—can become agents of social change if we insist on creating them in our own image.[6]

16. It has been said that one area of social activity which shows little evidence of social change is the relationship between the established professions and the public. Whether or not we accept that our society is changing, action for social change is likely to generate conflict because of the persistence of norms, values and interests. The mass of experiences which have been passed on to us concerning the medical profession, and our observations of medical student dissatisfaction, suggest the need for

3. Dr Gillian Diamond, Sexuality and the doctor–patient relationship (paper delivered at IWY conference, 'Womens health in a changing society', University of Queensland, 25–29 August 1975).
4. Dr Norelle Lickiss (unpublished paper, Dept of Community Health, University of Tasmania, 1975).
5. *Report of the Royal Commission on Medical Education in the U.K. (1965–68)* (HMSO, London, 1968), p. 23.
6. A. Jamrozik, Social change (paper delivered at eighth national conference, ACOSS, Hobart, May 1974).

change. Controversial issues include medical priorities, the allocation of health service resources, the roles of various health professionals and voluntary helpers, as well as controlling the cost of care. 'Consumer participation' or 'community involvement' are active issues, with demands for closer partnership in health care services, and more knowledge about the influence over health resources. Some look to services such as faith healing and chiropractice; alternatively, the quack unfortunately still gathers his disciples. But the involvement of paramedical and allied health disciplines in more direct health care represents something of a revolution for traditional medicine, as well as realistic responses to changing social need.

17. 'While doctors are becoming more and more specialised, their patients are perversely becoming less so.' So wrote Dr M. Simpson of the McMaster University, Ontario; he criticises the failure of medical schools to reflect changing health needs:

> It has become a cliché that medical schools have a very important challenge to meet, but we cannot ignore the negligence of our previous techniques of dealing with it. We have taken the easy option throughout. It is easier when selecting students to choose replicas of ourselves than to develop better methods of choosing the sort of people we need. It is easier to train them in special hospitals, by hospital specialists, than in the community. It is easier to train them to want to be surgeons than anything else. It is easier, clinically and educationally, to investigate the irrelevant with superb methodology than to investigate the relevant with proper methods. We have generally chosen such highly motivated and accomplished students that they can hardly fail to become reasonably adequate doctors despite most things we do to them. To devise a system which will consistently and significantly enhance the student's learning and create the sort of doctors our community really needs—that is the real challenge we are only beginning to meet. Our system of values will need to change.[7]

18. The past 2 or 3 years have seen marked change within medical institutions, both undergraduate and post-graduate. Medical students have themselves been active in seeking reform. We believe we need to assess the effectiveness of such change by reference to the evidence we have received, as well as by an examination of trends within the medical profession itself. It is also important to refer to certain non-medical disciplines, such as sociology and psychology, which offer more specialised education in areas such as counselling and sometimes practical solutions to solve social problems.

19. While judgments about medical education as a whole may flow from some of our recommendations, this report concentrates upon certain perceived deficiencies of knowledge, attitudes and practice in human relationships in accordance with the evidence we have received. We recognise the effects of scientific advances, population changes, new ideas of health expectation and public demand for health care, greater specialisation, the development of technological advances and equipment, all of them increasing the tendency for health care to become more institutionalised and needing more manpower and consequently more finance. Governments are thus deeply involved in solving the issues we raise. The most important of these is how to ensure the welfare of the human person.

7. M. A. Simpson, 'A mythology of medical education', *Lancet* 1 (1974), pp. 399–401.

2. Australian health, health services and personnel

Introduction

1. The Royal College of Obstetricians and Gynaecologists stated in evidence to us:

> Breakdowns in human relationships, especially in families and between the sexes, frequently cause stresses which lead to psychosomatic and even organic illness, and pregnancies occur during the various stages of upset. Obstetricians and gynaecologists are therefore involved in the care of women during these stresses, as are family practitioners and psychiatrists. Members of the College are unanimous in their opinion that the morbidity resulting from upsets in human relationships is serious, and that appropriate measures should be taken that would reduce morbidity.[1]

2. Dr Lyn McKenzie of Melbourne spoke of her involvement with the Melbourne Womens Health Collective:

> In the future I would think that there may need to be streamlining of doctors into two main areas—those who are interested in technological advances and major illness treatment . . . but I would also see a role for a community medical person who may not necessarily be a doctor but someone who has skills to provide primary health care at a particular point in the community . . . so communities will motivate themselves to develop their own health care system and there may be a place for medical personnel there.[2]

3. These two quotations from evidence to us provide a starting point for our survey of Australian health, health services and personnel. We need in our contemporary situation, especially in the sprawl of our great cities, a variety of services if breakdown in human relationships is to be avoided. The great hospitals, the general practitioner with his close family links, the specialised family planning and baby health clinics all have their important roles, and, as the College of Obstetricians and Gynaecologists emphasise, have a real and deep concern in our field. But there is need for the more intimate care in community health services of various kinds where patients can more readily feel at home and where pressures of time are less acute. These services are provided in the community where people live, work and play, as distinct from those available in institutions.

4. This need was emphasised clearly by the Commission of Inquiry into Poverty in its third main report by the Reverend George Martin, in March 1976. This report on the social and medical aspects of poverty in Australia closely parallels the work of our Commission. For example we agree that the first principle is the right of the individual to total health care; the second, the importance of prevention of illness and the promotion of good health through control of the environment and community health education. The third principle is that health services should be accessible not only in geographic location but also in the range of services available and the personal qualities of the service delivered. The final accepted principle is that services should fit into a co-ordinated framework of community health care.[3]

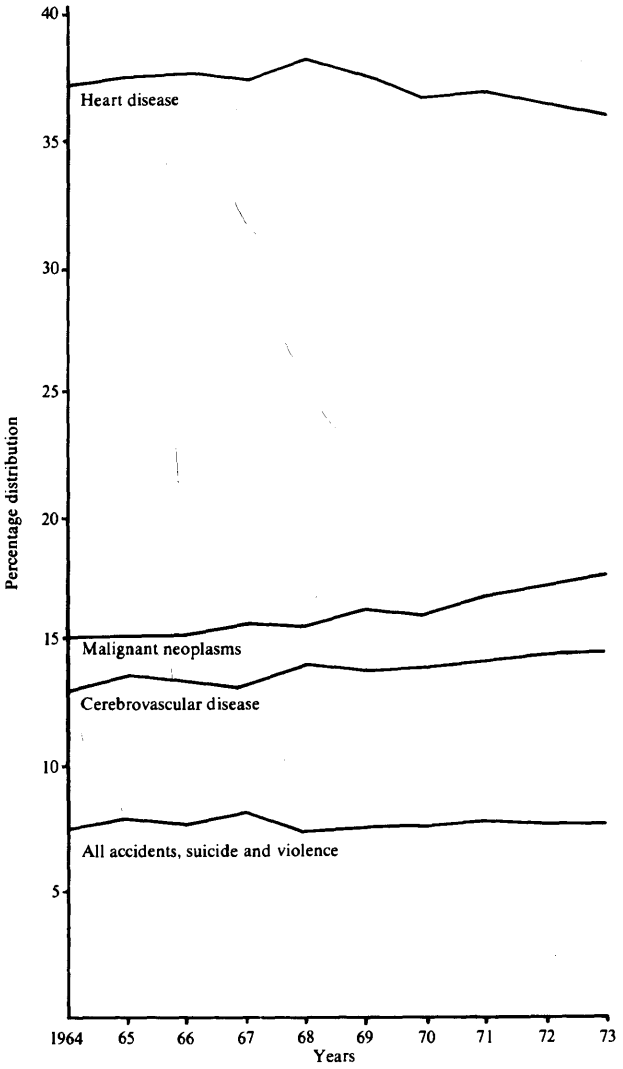
Measures of health and resulting patterns

5. Dramatic changes have occurred in the course of this century in the nature and treatment of disease. Instead of infectious disease causing 30–40 per cent of mortality

1. Submission 112, Royal College of Obstetricians and Gynaecologists (Australian Council).
2. Evidence, pp. 785–6, Dr Lyn McKenzie.
3. Aust. Govt Commission of Inquiry into Poverty, *Social/medical aspects of poverty in Australia* (AGPS, Canberra, 1976) pp. 6, 9.

as it did at the turn of the century, we now have the so-called diseases of civilisation, e.g. diseases of the circulatory system, bronchitis, cancer, as well as deaths from accidents, poisonings and violence. Between them they account for about four-fifths of all deaths in Australia.[4] Many of these deaths are contributed to by social and environmental factors such as alcohol, smoking and use of drugs.

Figure III.1 Percentage distribution of major causes of death, 1964–73[(a)]



(*a*) Causes accounting for 5 per cent or more of deaths in any year.

Source: Australian Department of Health, *Annual report of the Director-General of Health 1974–75,* p. 206.

Note: Time trends should be fitted to age-specific mortality rates for each cause of death, but these were not available. The percentage distribution of the major causes of death is an indication of how little change has occurred in the last 10 years.

4. B. Furnass in M. Diesendorf (ed.) *The magic bullet* (Society for Social Responsibility in Science, ACT, 1976), p. 7; see also Hetzel, pp. 112 ff.

6. Jim Carr of the WA Health Education Council said in evidence:

> Most people when they think of public health think in terms of immunisation, tuberculosis control and septic tanks. We began to talk about accidents as a health issue.[5]

7. While there is within the medical profession an increasing emphasis upon those degenerative diseases which prematurely shorten life, affecting the middle-aged rather than the aged, a more sophisticated approach than is commonly employed in medical education or medical care is required for their understanding and prevention.

8. Many people die too early of heart disease. Accidents and, to a much lesser extent, suicide represent the major causes of mortality for young people. Eighty-nine per cent of men and 93 per cent of women can however expect to survive until age 50.

Table III.1 Percentage distribution of major causes of death by age (over 5 years), 1973

Cause of death[(a)]	5–14	15–24	25–44	45–64	65+	Total[(b)]
Heart disease	1.3	1.5	17.4	38.4	40.5	35.9
Malignant neoplasms	16.6	6.5	18.7	25.6	15.8	17.5
Cerebrovascular disease	1.3	1.0	5.8	9.2	18.6	14.4
Motor vehicle accidents	30.8	54.3	15.6	2.6	0.7	3.5
All other accidents	16.1	11.3	8.9	2.1	1.7	2.7
Suicide	0.5	9.6	9.5	2.1	0.3	1.4
All other	33.4	15.8	25.1	20.0	22.4	24.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

(*a*) Where causes account for 5 per cent or more deaths in any one age group their percentage distribution has been included for all age groups (excluding congenital anomalies).
(*b*) All deaths including 0–4 years.
Source: Australian Department of Health, *Annual report of the Director-General of Health 1974–75*, p. 203 (abridged).

9. While life expectancy at birth for both men and women has increased by some 20 years since the 1880s, life expectancy at age 60 has increased in the same period by about 2 years in men and 4½ years in women. Sex differences and age factors in mortality statistics should be further investigated. Thus 61 116 men and 48 644 women died in 1972, representing 0.94 per cent and 0.75 per cent respectively of Australia's estimated mean population. More men than women died and men died sooner than women, giving credence to the belief that women more often than men have to face the social adjustments of widowhood. Between the ages of 45 and 49, four times more men than women died of ischaemic heart disease.[6]

10. The main changes in mortality rates from 1950 have taken place among those aged between 35 and 64 years, while under the age of 15 mortality has continued to decline. About five times the number of men die from cancer of the lung and bronchitis; there are about twice as many fatalities and suicides amongst men and about 50 per cent more heart attacks. The mortality rate for women in middle life has also improved due to the decline in maternal mortality.

5. Evidence, p. 1979, Jim Carr.
6. i.e. heart disease caused by bloodlessness through a contraction, spasm or blocking (by embolus or thrombosis) of the arteries, e.g. of the heart.

Table III.2 Percentage distribution of major causes of death by age and sex (children under 5 years), 1973

	0		1		2		3		4		Total under 5	
	M	F	M	F	M	F	M	F	M	F	M	F
No. of deaths	2356	1729	195	161	139	85	101	65	78	58	2869	2098
Cause of death[a] *Population '000*	128.8	122.7	135.9	130.6	134.1	128.8	126.8	121.2	126.7	121.8	652.2	625.1
Birth injury, difficult labour	16.0	12.6	na	na	na	na	na	na	na	na	13.3	10.4
Congenital anomalies	18.5	23.5	16.4	13.7	7.9	10.6	8.9	13.9	16.7	13.8	17.5	21.6
Other causes of perinatal mortality	37.6	38.1	na	na	na	na	na	na	na	na	30.9	31.4
Enteritis and diarrhoea	—	—	5.6	12.4	5.8	5.9	—	—	—	—	2.4	3.2
Respiratory causes	8.6	8.1	15.4	11.8	13.7	8.2	7.0	9.2	5.1	—	14.1	8.3
Motor vehicle accidents	—	—	8.2	8.7	10.1	20.0	23.8	24.6	12.8	19.0	2.4	3.2
Other accidents	—	—	31.3	28.0	40.0	27.1	27.7	21.5	20.5	15.5	7.6	6.7
Leukaemia	—	—	—	—	—	—	—	—	11.6	13.8	0.9	0.8
Other	19.3	17.7	23.1	25.4	26.6	28.2	42.6	30.8	33.3	37.9	18.9	14.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

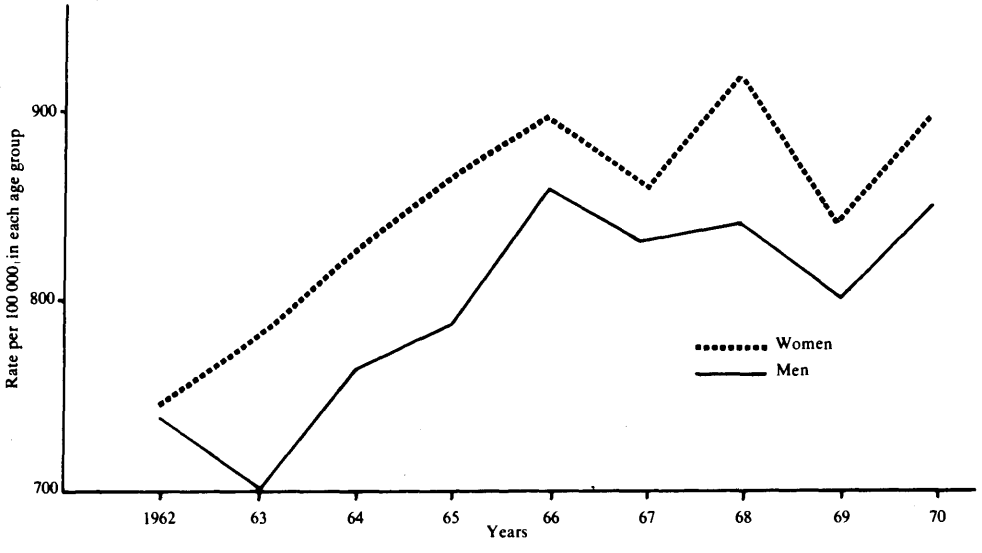
(*a*) Causes accounting for 5 per cent or more of deaths; '—' indicates fewer than 5 per cent; 'na' indicates not applicable in that age group.
Source: ABS, Causes of death, 1973 (unpublished).

11. Australia's mortality ranking is fifteenth, compared with similar developed countries.[7] Australia ranks tenth on infant mortality, thirteenth on mortality of men aged 35–44, sixteenth on men aged 45–54, seventeenth on women aged 35–44 and eighteenth on women aged 45–54. On this basis, Australian women do less well than women of most comparable developed countries even though the overall death rate for women is lower than for men.

> The altered patterns of death and disease in industrial countries, such as ours, have made a simple mechanistic model of dysfunction unrealistic. The diseases which eventually cause death are unlikely to be reversed, in spite of technological progress in medicine, and the causes of the diseases themselves are based on environmental and social 'life style' factors as well as on individuals' physiological dysfunctioning. In addition, increasing control of mortality has produced an increasing load on the community of morbidity and disability in those living longer. Diseases reflected in mortality statistics give no indication of the load of chronic morbidity and disability due to respiratory, arthritic, vascular and psychological causes. In addition, there are important sex differences in morbidity experience which differ from such experience with mortality.[8]

12. In contrast to their mortality rate, the hospital morbidity of women equals or exceeds that of men.[9] The growing number of patients in mental hospitals, especially of women, whether in- or outpatient, highlights the increasing load which psychological illness is placing on the health care system (see figure III.2). The relative responsibility which the medical profession and society at large should assume for such 'problems' is a basic issue.

Figure III.2 Persons treated in psychiatric institutions and outpatient units: Victoria 1962–70



Source: K. Benn, The psychiatric industry and womens health (paper delivered at IWY conference, 'Womens health in a changing society', Brisbane, August 1975).

13. In the report on a National Morbidity Survey, February 1962 to January 1963, G. C. Scott looked broadly at the general level of morbidity in the Australian population as measured by the frequency with which the GP will encounter a particular

7. R. Maxwell, *Health care: the growing dilemma* (McKinsey, New York, 1975).
8. Unpublished report of the Hospitals and Health Services Commission, 1976.
9. ABS, *Patients treated in hospitals, Queensland, 1973.*

episode. He concluded that there was a decline in infectious diseases and an increase in mental and psychoneurotic disorders and in accidents. He noted that the morbidity pattern of women reflected problems of the genito-urinary system.

14. Every fortnight the 'average' GP will encounter three new episodes of psychoneurosis in adult females and two in adult males. About every 8 weeks he will deal with the social and emotional problems of an adult male alcoholic and slightly more frequently he will attempt some readjustment in family relationships to relieve the emotional stresses and strains of a behaviour disorder in a child. About every fortnight he will encounter three episodes in a male patient and four in females where the prime complaint will be interpreted as a functional disorder of the heart, gastrointestinal tract or central nervous system.

15. Almost 8 per cent of all the episodes encountered by the practitioner were primarily mental, emotional or personality disorders, or conditions with a considerable emotional content. Women were affected more than twice as often as men, and most episodes concerned persons in young adulthood or early middle age.

> . . . 81 per cent of these episodes occurred in married people so that a considerable number of other persons—husbands, wives and children—would be affected to some extent by the patient's illness.[10]

16. On average, every 18 hours throughout the year the GP will encounter one episode of 'accident, poisoning or other trauma'. About 39 per cent of these episodes will be of a minor nature, but 18 per cent of them represent incapacitation for periods of 7 days or more, and just over one in 1000 were incapacitated permanently. Males were involved in this type of episode more than twice as often as females, reflecting the association with occupational risks. Accidents, poisonings and violence accounted for 11 per cent of all episodes recorded, and 28 per cent of these episodes concerned children under the age of 15 years (see table III.3).

17. The same survey indicated that women seek medical advice on a large number of occasions for gynaecological complaints as well as for pregnancy tests and the GP might expect one such episode every 3 days throughout the year. Disorders of menstruation headed the list, followed by cystitis, pyelitis and infective diseases of the uterus and vagina, with menopausal symptoms a close fifth. The episodes affecting the female genito-urinary tract represent a considerable degree of morbidity; most, in terms of danger to life, might be regarded as minor conditions but, in terms of the restriction of the woman's role in the family and in society, they assume a considerable degree of importance and should not be underestimated either in terms of their social effects or in terms of the need for adequate services.

18. In addition to these gynaecological episodes, this survey demonstrates that women in the age group 30–50 years contribute a greater proportion of visits to general practitioners than might be expected.

> Certain conditions such as benign melanoma (naevi), thyroid disease, diabetes mellitus, pernicious anaemia are known to affect females more frequently than males, but obesity is 5 times as frequent in females as males, the anaemias 6 times, and the psychoneuroses 2 to 3 times, gall bladder disease 4 times . . . This survey would indicate that some attention should be paid to the health of the Australian housewife.[11]

10. *Report on a National Morbidity Survey* (NH & MRC, Canberra, 1969), p. 116.
11. ibid., p. 117.

Table III.3 Age distribution of total accidents in males and females presenting to general practitioners and proportional morbidity rates for accidents in each age-sex group

Age group	Males		Females	
	Total accidents in males	Proportional morbidity rate	Total accidents in females	Proportional morbidity rate
	%	%	%	%
0–1	1	3	1	3
1–4	8	11	12	9
5–14	17	19	21	12
15–24	23	33	16	10
25–34	17	25	11	6
35–44	15	21	12	7
45–54	10	17	11	8
55–64	5	11	7	7
65–74	2	7	5	6
75+	1	7	3	7

Source: Report on a National Morbidity Survey (NH & MRC, Canberra, 1969).

Note: The proportional morbidity rate is the proportion that accidents comprise of the total morbidity for each age–sex group.

19. More visits are made to the doctor during an individual's first 5 years of life than at any other span of time. There is a slight rise in early adult life but, after that, the older men and women get the less they visit their GP (except for women during reproductive years). Older people up to the age of 75 have little more contact with their doctor than do schoolchildren. The GP sees more male than female patients up to the age of 15 years, and from then on the position is reversed (see tables III.4 and III.5).

20. There has been a dramatic increase of 69 per cent in the number of patients attending GPs for mental disorders in the 10-year period from 1962.[12] The increase is most noticeable in the psychoneurotic disorders and disorders of character, behaviour and intelligence. It is not certain whether this reflects a real increase in mental disorders or is due to better diagnosis and an increased readiness of disturbed patients to seek help.[13]

Table III.4 Importance of illness at various ages from point of view of the general practitioner

	0–4 years	5–14 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75+
Male episodes	28 645	23 867	18 697	18 888	18 490	14 992	10 719	7 479	4 219
Frequency /year of age	5 729	2 387	1 870	1 889	1 849	1 499	1 072	1 072	..
Female episodes	24 081	21 863	24 407	27 985	20 495	16 251	11 424	9 675	5 879
Frequency /year of age	4 816	2 186	2 441	2 599	2 049	1 625	1 142	968	..

Source: Report on a National Morbidity Survey (NH & MRC, Canberra, 1969).

12. Revealed by a comparison of the National Morbidity Survey (1962–63) and the Australian Morbidity Survey (commenced 1969).
13. Ian L. Rowe, 'The increase in mental disorders', *Australian Family Physician* 4 (1975), p. 53.

Table III.5 Comparison of relative numbers of episodes of illness at various ages —survey population

Age group	Population structure 1962		Episodes of illness weighted for sex		Episodes per year of age		Population adjusted relative values	
	M	F	M	F	M	F	M	F
0–4 yrs	578 186	552 315	28 645	25 208	5 729	5 042	5 067	4 460
5–14 yrs	1 064 307	1 014 730	23 867	22 930	2 387	2 293	1 148	1 103
15–24 yrs	819 929	776 984	18 870	25 757	1 870	2 257	1 171	1 613
25–34 yrs	722 155	666 747	18 888	28 144	1 889	2 814	1 360	2 206
35–44 yrs	752 737	717 568	18 490	21 499	1 849	2 150	1 257	1 462
45–54 yrs	635 154	607 811	14 992	16 982	1 499	1 698	1 206	1 366
55–64 yrs	441 177	444 390	10 719	11 342	1 072	1 134	1 210	1 280
65–74 yrs	266 767	337 095	7 479	7 656	748	766	1 238	1 268
75+	122 020	185 049	4 219	3 877	..	..	..	..

Source: Report on a National Morbidity Survey (NH & MRC, Canberra, 1969).

Note: Last column shows the relative numbers of episodes of illness experienced in one year by equal samples of men or women from each age group who attended the doctor during that year.

21. Another factor in the growth of mental disease is the effect of the pace of modern living upon some individuals. Social and environmental stresses are probably just as likely to cause emotional and 'mental' difficulties as other stresses if they are of sufficient intensity. Changes in the stresses that befall us in our community, economic and political life have not been measured and the reasons for such a large reported increase in mental disorders need further research.

22. Of more significance still is the form of medical response to emotional and mental disorder. Typically the response has been to prescribe drugs, thus placing the person with an emotional problem within the traditional role of a patient with a medical problem. Not only ought questions to be asked about the appropriateness of the drugs prescribed and the availability of alternative forms of help, but the entire process of treating many non-physical, emotional or relationship difficulties as objects of medical treatment needs further debate. One submission from a well-known general practitioner argued that our society has in fact 'medicalised' its social disorders:

> Work or study difficulties, anti-social, violent or criminal behaviour, sexual problems, drug or alcohol abuse, fears of possible anti-social behaviour, life crises, maturational difficulties, problems of sexual identity, social isolation, economic distress, bereavement, marital and family tensions all underlie a third to three-quarters of the GP's consultations. The GP is generally regarded as *the* person to whom one can turn with any or all of these problems, and from whom one can receive a sympathetic hearing and possibly some assistance, advice or direction.[14]

23. In response to concern expressed over recent years at the increasing use of prescribed drugs by the medical practitioner, the question was asked by a medical researcher: 'Do we prescribe too much?' Using the data gained from the Australian Morbidity Survey, he found the most common groups of drugs prescribed were: antibiotics 20 per cent, sedatives/hypnotics 8 per cent, psychotropic drugs 6 per cent, and the cardiovascular, antihistamine, analgesic, anti-arthritic and dermatological groups, in that order. Within the 'psychological diseases' category there was a much greater variety of drugs prescribed.

14. Submission 1251, Dr P. Arnold.

24. Dr Dunstone comments thus:

> This to me suggests that practitioners do spend more time counselling and advising these patients than is perhaps generally accepted, and certainly that patients are not getting drugs every time they walk through the door, and that they do, in fact, get a considerable number of consultations purely for advice and supervision, rather than a prescription.[15]

25. We note that some doctors are teaching relaxation techniques rather than resorting to the use of drugs.[16] This evidence makes the Commission realise, all the more, how important it is that medical education should include adequate training in counselling to those presenting with psychological problems. The kind of data arising from the Australian Morbidity Survey should provide medical teachers with a sense of proportion concerning diseases in general practice and the use of drugs for them.

> The data should lead to more understanding of the multiple factors concerned in each patient, especially the clinical assessment of the patient as a whole and not just the diagnosis, the wide use of psychotropic drugs for diseases other than mental disorders, and other factors influencing the prescribing, including cost.[17]

26. The social pressures need equal recognition alongside the psychological.

27. It is not sufficient to view the health of any community only in terms of medically recognisable disease or of death. Health is not a concept which is restricted to the medical perspective. In a national survey of chronic illnesses, injuries and impairments, in May 1974, it was reported that among the population who were not in institutions an estimated 701 800 persons (equal to a rate of 54 persons per 1000) were substantially handicapped in their social and recreational activities; 97 700 persons aged 5 years and over needed help from others in one or more of the acts of daily living (e.g. eating, bathing, dressing, getting into bed etc.); 190 900 persons aged 15 years and over were prevented from getting about alone (for shopping, visiting the doctor etc.); whilst it appears that 175 700 females aged 15 years and over were substantially handicapped in their ability to do housework.[18]

28. Recently the NSW Health Commission conducted a survey of health care in both the Gosford–Wyong and the Illawarra areas, some 80 kilometres north and south respectively of the city of Sydney. The survey was conducted by household interviews and its results are of great interest to our Commission.

29. Almost 1500 households covering some 3898 persons were visited in the Gosford–Wyong area, and 1600 households with 5236 persons in the Illawarra area. The response rates for each area were 92 per cent and 88 per cent respectively. Four dimensions of illness were assessed. First, respondents were questioned about common complaints experienced in the past 2 weeks and the conditions with which these complaints were associated. Secondly, respondents were asked about chronic illness. Thirdly came a set of questions about days spent in bed or lost from work. Fourthly, questions rated respondents for mental disturbance.

30. While the results in detail are yet to be fully analysed and interpreted, a number of significant factors relevant to our inquiry became evident. In regard to complaints, most of them fell into one of four broad categories:

(a) emotional (nervousness, anxiety, depression);

(b) acute upper respiratory tract infections;

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15. M. Dunstone, 'Do we prescribe too much?', *AFP* 2 (1973), p. 320.
16. See evidence, pp. 2701–4, Frank Pace.
17. I. Rowe, 'Prescription of psychotropic drugs by general practitioners: I. general', *Medical Journal of Australia* 1 (1973), pp. 589–93.
18. ABS, *Chronic illnesses, injuries and impairments*, May 1974.

(c) degenerative diseases of old age (joint pain, pain in legs, backache);

(d) non-specific complaints (dizziness, weakness, trouble sleeping, headache, overweight, loss of appetite).

31. A major conclusion is drawn by the NSW Health Commission surveyors:

> There are serious difficulties in using conditions as a measure of the incidence of illness in the community. In translating complaints into conditions, lay perceptions become entangled with medical diagnosis. Complaints are not necessarily due to illness. A headache can equally be a manifestation of worry about car payments or be due to viral influenza. The headache, in the first instance, is recorded as the condition 'headache' and, in the second instance, as the condition 'influenza'. Thus, a financial worry is made into a disease. Distortions of this type mean that conditions as coded according to the International Classification of Diseases, Injuries and Causes of Death (ICD) neither fully reflect self-perceptions of illness nor provide a precise description of medically defined disease in the community.[19]

32. Persons with chronic illness represent 52.2 per cent of the population of the Gosford–Wyong area and 34.6 per cent of the Illawarra area. This compares with a proportion of 27.9 per cent for NSW as measured by the Bureau of Statistics in 1974.

33. The increasing prominence of diseases which are not dangerous to life, but do prevent full functioning of the patient, and disorders which temporarily limit activity, produces a wide range of alternative health care:

> From family and informal care-givers . . . to voluntary agencies such as crisis centres, to alternative health professionals such as chiropractors and herbalists etc., and finally to a large number of formal professionals. It is no longer useful to look at doctor utilisation in isolation—only patterns of use of a range of health care alternatives will give an adequate and useful picture of how health care needs are met.[20]

Conclusions

34. Some distinct patterns are already evident. The first one is the relative increase in deaths from environmental and social causes and the corresponding decrease in deaths from diseases.

35. The second pattern concerns the earlier deaths of men over women, and the resulting social complications for women. There are distinctly different occupational patterns for men and women; the effects on men of retirement are greater since it is from a whole way of life and not just an occupation. These need research.

36. The third pattern is evident in the statistics of the major health problems of the day. Measured in terms of the causes of death, we obtain a very different perspective of the size of various problems and diseases. In fact, chronic morbidity and disability due to factors which will not normally cause death, but which cause much long-term personal anguish and social cost, are the major health problems of our community.

37. A fourth pattern emerges from the initial attempts at measuring the way in which the community uses its health service. There is a vast difference between a significant proportion of the GP's tasks and hospital care. The GP obviously deals with many people for whom hospital care will never be needed.

38. A fifth pattern reveals the rising proportion of health problems which have a psychological or social component. Better management might hinge upon either a decision to research the social causes of 'disease' and then act on the findings, or the provision of many more services to cope with their increasing incidence.

19. *Health care surveys in Gosford–Wyong and Illawarra areas of NSW, 1975* (Australian Bureau of Statistics and NSW Health Commission, Sydney, 1976), p. xviii.
20. ibid., p. xx.

39. A sixth pattern is the greater need of community and hospital health care services for women than for men, and this in contrast to the provision of resources for the alleviation of early death of men.

40. Yet a seventh pattern emerges in the need for services which may be more appropriately provided by those whose outlook is not disease oriented as has been characteristic of the medical practitioners since the 19th century. To see all problems as disease may perpetuate disorder and dependency rather than eradicate them.

41. The eighth pattern concerns the use of prescribed drugs as short-term solutions for problems focused around relationship and emotional disorder.

42. The final pattern concerns the presence in the community of health disorder and disability which is poorly served by our health care services. Lack of careful research and response to chronic disability is an indictment of our health care system.

Approaches to health care

43. People learn mostly from other people. To raise the quality of health behaviour in any community, health services should go to the people, live with them, start with what they have, build with what they know. In short, we must learn to use the community's own resources for spreading information.[21]

44. The health of a community depends both upon the public institutions and upon a community awareness of both problems and cures. An effective health care program must embrace hospital boardrooms, the GP's consulting room and the backyard fence where the families live. It should not therefore be assumed that all the disabled members of a community should receive formal health care. Health and illness lie on a continuum. They are not, as they may appear to the medical student, distinctly separate entities.

45. Good health means different things to different people; the perceptions of a patient, a health professional and a social scientist differ greatly. Many health professionals have in common the desire to restore their patients to their original condition. They tend to feel uncomfortable if they cannot do so. This is one sense in which the health care system 'creates' illness. For when a technical response is inappropriately given, the consequences may include unnecessary investigations, a fragmentation of health care services, and perhaps also use of specific drugs for non-specific purposes. The better response is surely to restore the patient to function again in the community as far as possible.

46. On the other hand, many of the disabled in the community do not receive adequate health or medical care. Morbidity studies have shown that people's expectations and perceptions of their health and needs vary with occupational and educational status, with the length and severity of the dysfunction, and also among people of different cultural groups. With higher levels of education people tend to have a concept of health closer to that held by health professionals.

47. The medical education system at present tends to produce a practitioner who comes from the higher socio-economic classes and perpetuates the present occupational and educational status of the professional.

48. It is no disparagement of the great hospitals and the normal professional work of general practitioners and specialists to emphasise the value of community health

21. Jim Carr (paper presented at IWY conference, 'Womens health in a changing society', University of Queensland, August 1975), p. 53.

centres in our large cities. As Dr Lyn McKenzie told us of the Melbourne Womens Health Collective:

> It was established because women felt they were angered by the non-informative approach by many doctors towards women particularly. They felt health care in medicine at the moment was becoming far too technological and complicated for women particularly as patients to comprehend. With this non-informative approach there seems to be no mechanism by which women could learn about their own bodies and their own health care.[22]

49. Such centres are even more important with mental health and health education services. We received testimony to this from Anne McNab, who is the co-ordinator of the Community Development Centre in Perth. She told us that the Community Development Centre was set up with a mandate to promote mental health in the community and, within this mandate, education and training in human relationships is a large part of the work. People who are in harmony with themselves, with other people and with their environment enjoy true mental health. In answer to a question whether patients who attend the centre come voluntarily or are referred, Miss McNab told us:

> They all come voluntarily whether they have been referred or not. This is one of the conditions—that people coming along want to come. They are referred by other government and non-government agencies, by GPs, self-referred, referred by the lady next door or what have you.[23]

50. Similarly Dr Ian Lewis, Professor of Child Health in Hobart, who had previously worked in Perth, emphasised the importance of health care and believed health education should be an independent body, under its own Act, as in Western Australia, rather than have to fight for its budget and existence between the departments of education and health. He believed there was a need for a top-level training centre in every State for training at the professional level, but also to take in all levels right down to grass roots voluntary training. All modern health problems, he believed, need a multidisciplinary approach and should no longer be the province of one particular person.[24]

51. There is a serious gap between clinicians and non-clinically-involved health personnel. This gap includes lack of communication, lack of knowledge and mutual lack of trust. It is vitally important to bridge this gulf.

52. We have heard with interest of consumer organisations in both Sydney and Melbourne concerning themselves, with the support of some doctors and paramedicals, in consumer health care, so that families can be advised how to get both the best value and the best advice for their members.

53. It is with much the same purpose that community health services in WA have developed a service model involving medical practitioners, various types of nurses, including Aboriginals, and some voluntary groups; it aims to undertake a total health audit.[25] We heartily support proposals of this kind.

Research and information

54. It is recognised by the Commonwealth and State governments that the haphazard collection of inadequate and inappropriate statistical information has impeded the development of responsible policies concerning health care.[26]

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22. Evidence, p. 783, Dr Lyn McKenzie.
23. Evidence, pp. 2032–4, Anne McNab.
24. Evidence, pp. 2304–9, 2314–17, Prof. Ian Lewis.
25. *Social/medical aspects of poverty in Australia,* pp. 232–3.
26. A plan for Australia: health and related welfare statistics (prepared by the H & HSC, August 1975).

55. Moves towards the establishment of a co-ordinated health statistics system are aimed at rationalising the collection, interpretation and use of statistical information. The development[27] of a comprehensive method of assessing the health needs of communities is an example of some early attempts to take into consideration a wide range of factors in the determination of service needs, including population characteristics and social problems.

56. However the current limitation of policy making to simple lists of specific medical diagnoses militates against concern for social and cultural factors. Groups which have special problems in using services are Aboriginals, the poor, especially in cities, migrants, especially of recent southern European origin, people living in remote and rural areas, and probably women. The third main report of the Poverty Commission has pinpointed the needs of these groups, and our own investigations would support their arguments and conclusions. The evidence of Dr Charles Price and Dr Helen Ware at our Canberra hearing and the submission of Dr Spiro Moraitis highlight the special health issues facing migrants.[28]

57. Women use more services and have special health needs related to childbearing and the genito-urinary system. They also use more prescribed psychoactive drugs though men make more use of alcohol. Women's use of family planning clinics and health centres reflects some dissatisfaction with usual health services, the orientation of which is almost always towards illness.

58. Few attempts are made to assess the effects of national economic and social policy on health. In a well-documented paper, an American biologist has noted significant effects upon his country's mortality rate as a result of stress arising from social organisation. He concludes:

> The irony of treating stress pathology by destroying the capacity of the organs to respond to the stress or removing them is lost on much of the medical profession, which sees only its duty to the individual. This is not surprising since the primary thrust of medical education is to identify the immediate cause of the pathology. This becomes the 'true' cause, and the search for understanding halts. The pattern of treatment follows directly, for if the cause of mental depression is a lack of brain nor-epinephrine, it makes sense to look for a drug that raises nor-epinephrine. If the cause of ulcers is excess acid secretion, it should be suppressed. And so on.[29]

59. Eyer states that there are at least four problems with this approach to medicine. One is that it is not 'cost effective'; another is that the medical cures evolved by modern technology will probably be ineffective in dealing with these problems; a third problem is that the technical approach contributes additionally and powerfully to the breakdown of community responsibility for the diseases in the first place; and, lastly, it seems inappropriate to view these diseases as mere technical defects in the body's machinery instead of dramatic evidence of the fear and pain pervading people's lives.[30]

60. There is obviously need for greater awareness and sympathy on the part of health care services for the unemployed and their families, and research in this field is still required.

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27. H. Gwynne (unpublished paper).
28. Evidence, pp. 1051-65, Dr Helen Ware; pp. 1064-75, Dr Charles Price; Submission 215, Dr Spiro Moraitis.
29. J. Eyer, Stress-related mortality and social organisation (unpublished paper, Philadelphia, USA, 1975), p. 35.
30. ibid., pp. 35-7.

61. Dr John Powles, lecturer in preventive medicine at Monash, told us that he believed it was necessary to have a closer relationship between the sociology and medical departments of a university if the doctor was to be helpful in this kind of problem.[31]

62. A closer look by governments and researchers at morbidity in relation to social and economic factors should afford an earlier opportunity to effect social change, as well as to reduce health care costs in the long term.

Support services in community health

63. We have stressed the importance of community care, partly because this kind of care is less expensive than that provided by the great hospitals and partly because it is more effective in promoting healthy family life. Preventive medicine is as important as curative, and health educators are reflecting a recognition by policy makers that health rather than 'ilth' (or illness-oriented help) should be the primary focus of our services. The extent to which they go in meeting the needs of the modern Australian community will continue to be the subject for debate and evaluation. One of the outstanding features of any health care service, however well organised, is the attitudes of its personnel. The point was excellently made by a psychologist, Garry Egger, at our Sydney hearings when he was discussing social planning:

> In fact, we have virtually won the battle against natural diseases. What is happening now is that the man-made type of diseases are taking over . . .
>
> The most important thing to remember here is that we have no known effective cure for those diseases—heart disease, lung cancer, hypertension, cirrhosis of the liver, chronic bronchitis, motor traffic accidents, things like this. I think the main thing is that they are man made. I think we should make the public aware it is quite possible we may never have a cure for cancer and, if that is the case, we have to take our emphasis off the engineering aspects of medicine, the medical model as such, and concentrate on the things that prevent these things from happening.[32]

64. Changes in society during recent decades were reported to have led to great demands on the health care system as a consequence of increasing concern about chronic disabilities, emotional disorders, including those due to alcohol and other drugs, and disabilities resulting from road accidents. In order to prevent and minimise the effects of these conditions, it was recommended that the nature of the health care task should be seen in a new light, with greater emphasis being given to the planning and financing of services for the prevention and early treatment of illness and effective rehabilitation.

> There is today a greater awareness of the personal, social and economic problems arising from hospitalisation, and the provision of health care in the community has become a major health issue in Australia.[33]

65. In the period of about 2½ years since the Community Health Program began, 727 projects have received Commonwealth financial support. Key concerns in the program are provision of services to promote 'health activity'; migrant health services designed especially for those whose concepts of health care differ from those of the rest of the community; rehabilitative services for the aged, the handicapped, alcoholics and drug-dependent persons; some specific Aboriginal health services; and some occupational health endeavours. We welcome the development of the Community Health Program (CHP), and see it as providing 'integrated primary care teamwork'—a concept in which medical, nursing, social work and related health and welfare personnel are jointly responsive to the wide range of community needs.

31. Evidence, pp. 742–50, Dr J. Powles.
32. Evidence, pp. 2458 ff., Garry Egger.
33. *Review of the CHP,* report from Hospitals & Health Services Commission (1976), p. 5.

66. Hitherto there has been confusing and inefficient fragmentation in the provision of health services. Preventive services have been introduced which often operate in comparative isolation from other clinical services: e.g. maternal and child health, child guidance, school health, venereal disease, industrial health and tuberculosis services. The average person, who is commonly seen by his general practitioner some forty times between birth and mature life, might enjoy a wider and more convenient range of counselling and other health services if each area had its community centre where all these services could be co-ordinated together. Under the CHP these centres have begun to come into being; they take various forms; their relation to the local GPs also varies from place to place.

67. The greatest problem confronting the CHP has been the need to change the attitudes of those concerned with health care delivery—doctors, nurses, health administrators and politicians. It was, and still is, necessary to convince them that new values in health care are emerging. Support has been given to training programs for health workers designed to expose trainees (especially undergraduates) to concepts of change and to influence their attitudes so that in time the attitudes of their professions might change.

68. In addition, courses have been provided to assist the reorientation of individuals seeking to enter new specialised areas of health care or to encourage qualified people to come back into active work in this field, e.g. the Queensland State Medical Womens Graduate Program for Family Medicine.[34] So far some thirty-seven health service training programs have been funded including:

(a) the Family Medicine Program of the Royal Australian College of General Practitioners;
(b) the establishment of teaching community health facilities associated with Chairs of Community Practice to stimulate non-institutionalised, multidisciplinary approaches;
(c) in-service training programs for community nurses;
(d) training courses for new categories of health workers, e.g. community practice nurses (NSW and SA) and multi-purpose aides (SA);
(e) experimental projects associated with multidisciplinary health care delivery teams involving graduate and student levels of health workers, e.g. Australasian Medical Students Association multidisciplinary team pilot study.

69. With a similar purpose a National Co-ordinator of Student Initiatives in Community Health set about, through questionnaires and consequent answers, arranging employment for medical students over the 1975–76 summer vacation, in many diverse areas of community health. Some sixty medical students in five States were employed in health centres, crisis centres, community paediatric units, alcohol and drug treatment centres. Others worked with GPs and in casualty departments.

70. An evaluation of the scheme by those who conducted it revealed how great was its value. Supervisors rated the students as 'extremely helpful and valuable', and unanimously agreed that the employment of a paid student was worthwhile and that they would take on a student again if the finance was available. Eighty per cent of the students would like to do the work again in vacation or elective periods, and they stressed the educational benefits of the scheme in that they 'were gaining a greater understanding of team work and community health care'.[35]

34. Evidence, pp. 1531–8, Dr Mary Mahoney; Submission 401, Dr Mary Rose Cooney.
35. J. O'Shea, An evaluation of the AMSA vacation elective employment scheme (unpublished, 1976).

Health services for women, infants, schoolchildren

71. The fragmented nature of health services can be seen clearly in the provisions made for mothers and their babies. Baby clinics, family planning centres and local medical centres are isolated from each other in administration and often in distance; there are no common registers or records. It seems essential that services for each person should be co-ordinated in such a way that health defects can be diagnosed early and remedies begun.

72. There is some controversy as to the relative roles of statutory and voluntary services in community health. The deplorable condition of the average Australian's teeth, in spite of education in dental care and the high quality of Australian dentists, illustrates the weakness of voluntary services; the almost complete eradication of TB and diphtheria, and the control of polio, illustrates the strength of the statutory services. No doubt some balance is needed. Infant welfare services are mostly backed by statutory authority, even though in a mild way, but, on the other hand, hearing or sight deficiencies in a young child are often not detected early enough and this points to the value of some statutory child health service which would screen the whole preschool population.

73. The ideal situation would be an integration of services and personnel for child health care. The relatively recent development of the Community Health Program has set out the guidelines for a better integration of such services within local areas.

74. The Commission notes with approval the establishment of the Early Childhood Development Complexes (ECDCs) in Victoria. These provide a fully integrated service for the guidance of parents from the woman's pregnancy to the end of the first 6 years of a child's life. Detection of any physical, emotional or social factor likely to impede a child's development will be noted. The development of infant welfare and mothercraft services are other attempts at meeting the need for the better health care of young children and their mothers. In South Australia the Mothers and Babies Health Association operates the maternal-infant health and welfare services. Every birth is notified to the Association and is followed up by visits and correspondence. They have mobile clinics and an interpreter service.[36]

75. The range of services proposed for ECDCs appears most comprehensive:

> . . . to undertake a study of the types of services in greatest demand and [to act] as a base for a child development officer, research workers, family day care programs and child minding; supervision of pre-school centres and toddler groups; special services for handicapped children; family planning; health supervision of pre-school and school-aged children; and a whole range of medical and paramedical personnel engaged in the program.[37]

76. However, the effectiveness of the proposed services may hinge upon the development of efficient interdisciplinary team work, and close links with the relevant general and specialist medical practitioners in private practice. Should this not occur, the suggested policy that all parents should have access to adequate facilities to care for their children up to the age of 3 years is unlikely to eventuate.[38]

77. A suitable network of relationships among those providing different aspects of the service needs to be developed. Cross-disciplinary understanding should be encouraged at the medical undergraduate levels.

36. Evidence, p. 1269, Dr H. G. Edhouse.
37. Submission 1130, Vic. Commission of Public Health.
38. Submission 886, Royal Aust. College of General Practitioners.

78. One area of significant mismanagement of children occurs where the child is abused by the parents either because the parents are under some stress or because the child is difficult or defective in some way, a problem fully dealt with under the chapter on child abuse in Part V of our report. Here is a problem in which the GP is but one member of a team which needs to work closely together. The provision of drugs for the mother may be a short-sighted approach which ignores the social and family setting in which the difficulties are perpetuated.

79. The learning of social adjustment for children for the first 5 years of their lives is almost completely in the hands of parents, but, after that, other influences impinge on their lives and supplement or contradict the training of parents.[39] Hence one submission suggests that there is often basic confusion between parental 'training' and school 'training', a subject which needs further research.

80. There are obviously other special groups who, for differing reasons, have not been fully integrated into a comprehensive and broadly based health care system. The Hospitals and Health Services Commission declared:

> As a general principle, the Commission wishes to encourage movement away from services catering for restricted groups towards provision of broadly based community health services. It has, nevertheless, supported the establishment of womens health centres in the belief that such action would help to influence the traditional health care system to cope more adequately and effectively with women's health problems. The Commission, therefore, sees womens health centres as a transitional step towards their close association with other health services.[40]

81. Thus the womens community health centres, such as those functioning at Leichhardt and Liverpool in NSW and at Perth, attempt to popularise health care for women and to make available a wider choice of health services; these include counselling, self-help groups and sex education as well as primary medical care. The extent to which medical care as distinct from broader health, welfare and education matters is emphasised varies from centre to centre.

82. Dr Rodney Shearman, Professor of Gynaecology at the University of Sydney, stressed the importance of family medicine programs in the medical curriculum.[41] Following the IWY conference on 'Womens health in a changing society', the *Medical Journal of Australia* concluded that there were two matters in particular which merited the serious concern of the medical profession:

> The first is the dissatisfaction expressed by a number of delegates with the treatment they had received from their own doctors . . . The vehement and outspoken accusations against the profession in general, whether or not they represent the views of the entire conference, and whether or not one questions their validity, cannot be ignored.
>
> Second, the fact that the Federal Government is supporting and that the public is utilising local health centres in which work such as counselling, teaching of self-examination of breast and vagina, giving contraceptive advice and treating vaginal infections is being done by people who have not been trained in any recognised educational institution to perform these tasks must create a dangerous precedent . . .
>
> The profession must look to itself for the causes of these ills. It must also look to itself for remedies. If, as we profess, we aim first to serve our patients, and our patients have so clearly demonstrated their dissatisfaction, then something has gone wrong either with our intent or with our practice. If with our practice, the remedy is easy to apply. If with our intent, the cause lies deeper, and the need for remedy is the more imperative.[42]

39. Submission 116, Cairnmillar Institute.
40. Policy statement, Hospitals & Health Services Commission, Canberra, March 1975.
41. Evidence, p. 3089, Prof. Rodney Shearman.
42. Leading article, *MJA* 2, 14 (1975), p. 540.

83. We look at these issues more closely in Part IV. Here we comment that until such time as these tensions are recognised and satisfactorily dealt with, the need for womens health centres will remain. In any case women should always be active participants as professionals and helpers.

Health care personnel

84. The World Health Organisation has emphasised the importance of a new look at the training and use of health educators and it notes that there has been a marked trend towards new careers in old disciplines and the emergence of new disciplines; the number of workers in health occupations has been growing at a rate much in excess of population growth; supply of professional health manpower cannot be changed quickly; manpower distribution may be poorly related to health service needs and is uneven; some categories of health manpower are in short supply; manpower use and productivity tend to be less than ideal and are not amenable to easy improvement.

85. In Australia this argument is reinforced by such factors as expenditure on health, both private and public, which was over $3000m in 1973–74, or more than 6 per cent of the gross domestic product. About three-quarters of this cost consists of salaries, including those receiving fees for service. The health services workforce is almost 300 000 persons. To provide new services, or to improve the delivery of existing services, a simple increase in manpower supply for existing occupational categories is not always appropriate.

86. The estimated number of medical practitioners active in Australia at 30 June 1972 was 18 000. This amounts to one doctor to 721 persons, a doctor–population ratio which is close to the corresponding ratios in similar countries. There is no statistical evidence of a shortage of doctors either in the present or the immediate future.

87. It was also found by the Committee on Medical Schools in its report to the Universities Commission that the improvement in the doctor–patient ratio in country areas may hide some deterioration in the smaller towns. The number of doctors in country areas where the towns have less than eleven doctors has not kept pace in general with the growth of population in those areas since 1961 (to 1971). The report notes that the doctor–patient ratio for GPs was one to 1750 for urban areas and one to 2000 for non-urban areas.[43]

88. Within urban areas the distribution is by no means even. For example in Sydney the north shore has a far higher ratio of doctors than the remote western suburbs. The same may be true for Melbourne and other large cities. In the country, too, the distribution is uneven, with the smaller places sometimes not able to secure one doctor.

89. In a discussion paper on the concept of university-based departments of community practice, the Hospitals & Health Services Commission considered that one of the central tasks of medicine is to help patients and families identify and manage many of their own health problems. It was stated that the maintenance of health does not rest solely or even mainly on the investigation, diagnosis and treatment of manifest illness. Social and environmental factors contribute to many of today's problems, which are often caused by domestic, social and occupational stresses and the harmful aspects of contemporary life such as smoking, pollution of the atmosphere, noise, chemical contamination, urban crowding and traffic hazards.

> Recognition of these facts by the community is essential if prevention is to be effective. Many other illnesses are genetically determined or associated with ageing and may not be

43. *Expansion of medical education,* report of the Committee on Medical Schools to Aust. Universities Commission (AGPS, Canberra, 1973), p. 29.

amenable to cure. All have a behavioral component. Other illnesses are of psychological origin. As a result of these observations, there is the view that medical students should be intimately involved in activities concerned with these perspectives of their future work.[44]

90. Government policies on health services are increasingly emphasising rehabilitation, support, prevention and community-based health care. This means that nursing, social work, physiotherapy and occupational therapy are being increasingly recognised as valuable partners for general medical practice. While some of these disciplines have existed for many years, their importance, as a point of first contact outside hospitals and nursing homes, may lead to their assumption of more direct responsibility and recognition. The same is true of the wide variety of nursing staff, including those concerned with mothercraft and infant welfare.

91. Education for doctors and nurses is currently under review perhaps because of the criticism that it is too academic and technical, and neglects the social and community problems of our time. Their lack of contact with patients as human beings in the early years, in the traditional courses, is thought by some to minimise concern for human factors and over-emphasise technical factors. But already in some medical schools the rigidity is disappearing. Hence most medical schools are now reviewing their curricula and initiating courses which are both more practical and more closely related to people. Departments of community medicine and practice are being established in the schools, in obvious recognition of modern patterns of disease and disability and the wisdom of a multidisciplinary response to many social and family problems.

92. The report of the Committee on Medical Schools, chaired by Professor P. Karmel, commended the type of academic development which would demonstrate the problems of community health care in practice, and would give those medical students destined to become specialists a greater appreciation of community problems and needs so that they could practise their own vocation with greater understanding.

> If such departments of community medicine embrace multiple responsibilities: general practice, epidemiology, preventive and occupational medicine, a comprehensive intellectual discipline can be established.[45]

93. Proposals were also received by the Australian Universities Commission from the National Advisory Council for the Handicapped calling for the expansion of the numbers of rehabilitation and related workers undertaking training at universities and colleges and the establishment of chairs of rehabilitation medicine in medical schools. Equally there is need for more work in the field of geriatrics; we are glad that Melbourne University has established a Chair of Gerontology but we still emphasise the importance of the broader concerns of rehabilitation, and their implementation in terms of appropriate training.

94. The effects on future medical practice of such actual and proposed innovations to medical school curricula will need to be assessed continuously, in relation to sound academic standards and changing needs.

Women in the health workforce

95. Much of our material has been concerned with relationships between the male doctor and women; consequently the proportion of women serving in the various

44. 'University Dept of Community Practice—a discussion paper', *MJA* 1 (1975), p. 278.
45. *Expansion of medical education*, p. 161, para. 9.14.

health services is of interest. At our Brisbane hearings Dr Mary Mahoney spoke of the importance of women for the success of family medicine programs. She said:

> One of the things about medical women, when they marry and have children, they find that when they come back to the workforce they have accumulated a large understanding and knowledge of human relationships by virtue of the fact that they have had children.
>
> We find that patients respond to us more than they do to men and whereas, a few years ago, a patient used to reject the idea of having a woman in casualty situations, now they say: 'I'm glad it is a woman; I am glad you are here.'[46]

96. In 1967 women constituted about 19 per cent of total new enrolments for the MB, BS degrees; by 1973 the proportion had reached 30.5 per cent. The variation between individual universities was reportedly wide, ranging from 36.6 per cent at the University of Tasmania to 21.7 per cent at the University of WA in 1973. By now, this proportion should be approaching 50 per cent (see tables III.6 and III.7). The proportion of women graduating had reached 19.1 per cent in 1972 and should be approaching 30 per cent by the end of the 1970s (see table III.8). The proportion of women in paramedical occupations is much higher than in medicine (see table III.9). There are, however, noticeable differences between medical and non-medical personnel in the health care field in terms of numbers of males and females.

> The health industry represents a model example of how women are clustered in the lower paid, lower status occupations and are underrepresented in top professional and managerial positions, as well as in the more skilled professions. This is despite the fact that women are numerically superior in the industry . . . of the 190 000 with health qualifications in the 1971 census, 78 per cent were females and 22 per cent males. Yet, for example, of the persons with post-graduate diploma levels in medicine and dentistry less than 11 per cent were females—and 89 per cent males—a total percentage reversal.[47]

97. With an increasing proportion of female medical students starting their courses, this should help to redress the imbalance in the areas of women's health generally, and also ensure that their voice is heard in determining future medical educational programs and in policy making generally.

98. It is often assumed that women have their own speical abilities in a helping situation, men being seen as more technical or matter-of-fact. In an age of great scientific advances our society has tended to endorse such assumptions, men assuming more of the specialised and policy-making positions. Such assumptions are beginning to cause concern for educationists. The womens movement has drawn attention to what it sees as the relative advantage men have over women in educational and work opportunities, and the assumption by society that child care and other domestic responsibilities must always be carried primarily by women. The recommendation of the Australian and NZ College of Psychiatrists, which relates to education generally, has no less relevance to medical education:

> 'Educational policy' should be to end the stereotyping of school subjects, activities, as 'male' or 'female' and the abolition of resource material such as books which promote as a desirable norm exploitative male-female relationships or which promote as socially desirable stereotyped roles for males and females, e.g. the male being depicted as predominantly involved in the outer world and the female being predominantly involved in the domestic world. The aim would be to promote the value for both sexes in participating in a balanced way in both worlds as well as the private creative world. It is perhaps as well also to recommend that the very important differences between sexes should not be neglected.[48]

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46. Evidence, p. 1537, Dr Mary Mahoney.
47. M. Reid, Women in health occupations (paper delivered at IWY conference, 'Womens health in a changing society', Brisbane, August 1975).
48. Submission 785, ANZ College of Psychiatrists.

Table III. 6 Annual rate of growth in total enrolments by sex, Australian medical schools, 1962–73

Year	Male enrolments	Female enrolments
	%	%
1962	0.4	0.5
1963	2.4	8.4
1964	2.6	10.2
1965	4.1	4.6
1966	0.2	4.0
1967	2.9	2.7
1968	5.0	7.8
1969	3.8	7.8
1970	0.2	11.0
1971	2.3	16.3
1972	2.7	10.0
1973	1.9	11.2

Source: Expansion of medical education, Report of the Committee on Medical Schools to AUC (AGPS, Canberra, 1973).

Table III.7 Female new enrolments as a proportion of total new enrolments Australian medical schools 1950–73

Year	Sydney	New South Wales	Melbourne	Monash	Queensland	Adelaide	Tasmania	Western Australia	Australia
	%	%	%	%	%	%	%	%	%
1950	16.7	..	12.0	..	10.8	12.6	..	5.0	13.7
1951	16.8	..	11.9	..	8.3	18.4	..	..	13.8
1952	17.3	..	13.1	..	20.6	11.3	..	17.6	15.9
1953	18.5	..	12.6	..	12.5	15.1	..	10.0	15.6
1954	24.8	..	11.6	..	11.4	10.5	..	..	15.6
1955	17.1	..	17.9	..	9.4	8.8	..	12.5	14.8
1956	19.3	..	12.2	..	11.6	21.5	..	9.8	16.1
1957	21.5	..	18.0	..	11.3	14.9	..	7.5	17.1
1958	20.3	..	14.3	..	16.8	19.8	..	8.5	17.5
1959	18.0	..	20.1	..	15.1	15.6	..	10.3	17.1
1960	18.5	..	14.8	..	13.3	20.8	..	8.5	16.1
1961	20.9	18.4	17.0	9.9	22.2	20.6	..	17.2	19.1
1962	23.0	11.8	21.3	10.8	21.3	17.1	..	17.1	19.1
1963	23.9	15.5	14.4	17.9	22.4	18.3	..	10.5	18.9
1964	26.7	18.4	18.3	11.0	25.2	15.7	..	22.4	20.9
1965	27.9	12.8	12.4	19.5	17.0	16.5	12.5	15.4	18.6
1966	24.1	19.5	21.7	15.6	18.1	13.7	20.0	24.6	19.8
1967	16.0	8.3	16.5	17.6	26.7	14.8	36.4	22.1	19.1
1968	24.5	12.2	23.6	15.4	25.1	24.2	40.9	21.9	20.7
1969	28.0	20.7	21.0	23.1	27.0	20.5	28.6	15.5	23.1
1970	29.4	30.9	25.6	19.9	26.9	19.6	23.7	24.2	25.6
1971	36.2	28.4	24.4	26.7	31.6	30.1	25.5	28.5	29.5
1972	34.0	31.8	22.0	22.8	30.1	25.8	19.0	24.7	27.6
1973	33.6	30.7	27.1	30.2	35.4	27.8	36.6	21.7	30.5

Source: Report of the Committee on Medical Schools to the AUC, 1973.

Table III.8 MB, BS degrees conferred on females as a proportion of total MB, BS degrees conferred Australian universities, 1939–72

Year	MB, BS degrees conferred	MB, BS degrees conferred on females	MB, BS degrees conferred on females as proportion of total MB, BS degrees conferred
			%
1939	318	41	12.9
1940	264	29	11.0
1941	328	35	10.7
1942	365	44	12.1
1943	291	40	13.7
1944	294	44	15.0
1945	280	39	13.9
1946	313	62	19.8
1947	350	53	15.1
1948	296	48	16.2
1949	229	35	15.3
1950	384	64	16.7
1951	563	61	10.8
1952	635	66	10.4
1953	610	76	12.5
1954	564	70	12.4
1955	478	65	13.6
1956	487	68	14.0
1957	440	60	13.6
1958	422	65	15.4
1959	394	60	15.2
1960	438	63	14.4
1961	286	37	12.9
1962	505	83	16.4
1963	563	70	12.4
1964	602	80	13.3
1965	640	94	14.7
1966	710	107	15.1
1967	744	123	16.5
1968	747	144	19.3
1969	842	166	19.7
1970	851	152	17.9
1971	893	155	17.4
1972	878	168	19.1

Source: Report of the Committee on Medical Schools to the AUC, 1973.

Table III.9 Percentage of women in labour force in specific health occupations Censuses of 1961, 1966 and 1971

	1961	1966	1971
	%	%	%
Medical practitioners	11.0	11.6	13.2
Dentists	5.0	5.3	6.1
Nurses	93.9	94.0	94.3
Pharmacists	18.4	21.4	25.2
Optometrists	3.9	2.7	7.5
Physiotherapists	81.5	85.9	86.3
Radiographers	42.5	46.4	55.1
Chiropodists	78.0	78.7	77.2
Dietitians	86.0		
Medical workers and technicians nec professional	57.4	67.3	70.2
Life science technicians	na	na	60.4
Pharmaceutical assistants technical	na	na	27.0

Source: Australian health manpower, Report of the Committee on Health Careers (AGPS, Canberra, 1975).
nec not elsewhere classified na not available

99. To improve this situation it has been suggested that there should be less emphasis on physical sciences in entrance requirements to medical schools and encouragement of movement from, say, nursing to medicine.

100. Clearly health professionals should be helped to recognise their own attitudes and practices towards both men and women, particularly where personal relationships are concerned. The recent encouragement of discussions between medical students of both sexes about their reactions to contentious sexual and social experiences should be welcomed. The evaluation of such teaching methods can only be made over a significant period of time.

101. It was stated in one submission[49] that , while hostility to women doctors within the medical profession used to be the rule, there seems now to be an increasing acceptance.

102. Dr Judith Lumley of Monash, in the same submission, notes that the Royal Commission into Medical Education in the UK (1968) made several points about the performance of women as medical students:

(a) the drop-out rate for male and female students during the course is the same;
(b) the proportion who fail to register as medical practitioners is the same for male and female;
(c) the work of female students is generally acknowledged to be better than that of male students.

103. The study by Ms Ione Fett of Australian medical graduates in 1972[50] showed that most women graduates marry within a few years of graduating and most have children. The requirements of the Royal Colleges for post-graduate qualifications make it difficult for women to achieve specialist status since a further 7 years after graduation must be spent studying. At least 3 of these years must be spent in specified

49. Submission 775, Dr J. Lumley.
50. I. Fett, 'Aust. medical graduates in 1972', *MJA* I (1974), pp. 689–98.

hospitals as resident medical officers. Relaxation of College attitudes would allow courses to be interrupted, part-time work to be accepted, and so enable women to combine parenthood with post-graduate training.

104. Fett's study also revealed that doctors' wives who are medically qualified worked less than medically qualified wives married to other professional men. With more than 50 per cent of women doctors married to doctors, their capacity to work outside the home is limited.

> Medicine is a good example of the two-person career in which the resources of both members of a marriage are put into the career of one of the partners.[51]

105. Recent government initiatives, in co-operation with the Royal Australian College of General Practitioners, have attempted to retrain women doctors in general practice. Dr Mary Cooney, the Women Graduates Co-ordinator (Qld) of the Family Medicine Program, made the following suggestions to us:

(a) That a different career structure must be available to take account of the lack of continuity during the child-bearing years by having access made available to part-time hospital training posts on the basis of two women sharing one full-time post; by having retraining facilities available for those who cease work altogether and wish later to return; and by filling public health positions in government with permanent employees on a part-time basis.

(b) That child care facilities, including for example care in the child's own home by one continuous mother-substitute, be made available on a subsidised basis to those wishing to use them and that the expense incurred in whatever form of child care be made tax deductible.[52]

106. Dr Mahoney told us the course in 1975 lasted 14 weeks, on 2 days each week from 9.30 a.m. to 2.0 p.m. Most of the training was in the form of lectures and discussion, though there was a little clinical work. In a later course, participants went, under supervision, into a general practice for a couple of days. The Family Medicine Program of the Community Health Program pays a subsidy to cover baby-sitting and other costs.

107. Dr Cooney argued in her submission for permanent part-time employment for medical women: she reported that in the UK there were schemes whereby two married women could share a hospital post, such as a surgical registrar or a paediatric registrar.

108. This is a proposal which the Commission recommends to the hospitals and medical profession. Government departments employing medical practitioners could set a lead, for example the Department of Veterans' Affairs.

109. A similar English experiment was discussed in the *Lancet,* 9 August 1975.[53]

110. The proportion of women who are doctors has increased in recent years (see tables III.8, III.10). It appears that the proportion of female doctors in general practice was almost the same as the proportion of male doctors but rather less in specialist work (table III.11). However, about half of the female GPs were in salaried practice situations.

111. The future age and sex distribution of doctors will affect their productivity. The results of a survey of medical graduates carried out by Ms Fett provide some indication of the relative working hours of male and female doctors, and the way in which the hours of work change with the age of the doctor (see table III.12).

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51. Submission 775, Dr J. Lumley.
52. Submission 401, Dr M. R. Cooney.
53. T. H. Bewley, 'Hospital doctors' career structure and misuse of medical womanpower', *Lancet,* 9 August 1975.

Table III.10 Female doctors as a proportion of all doctors, Australia, 1933–71

Year	Number	%
1933	300	6.2
1947	579	8.7
1954	880	9.6
1961	1309	11.0
1966	1488	10.9
1971	2104	13.1

1933–71, Census figures, unadjusted. Addition of the estimated number of female doctors aged 65 and over in 1966 would raise the number in that year to 1583 and the percentage to 11.5.
Source: Report of the Committee on Medical Schools to the AUC, 1973.

Table III. 11 Distribution of male and female doctors by type of work, Australia, June 1972

	Male doctors	Female doctors	All doctors
	%	%	%
General practitioners	40.2	37.8	39.8
Specialists:			
private practice	21.7	13.2	20.5
salaried	7.6	10.0	7.9
Other salaried	30.5	39.0	31.8
	100.0	100.0	100.0

Source: Report of the Committee on Medical Schools to the AUC, 1973.

112. The survey shows that female doctors appear to work longer hours on the average than is often supposed. The median weekly hours worked by female doctors in the survey were 39.9 hours, compared with 61.8 for male doctors. This is a ratio of 64.6 per cent. For each of the year-of-graduation groups, except the group who graduated in the 1920s, the median for female doctors was 38 hours or more, and in no case was it below 60 per cent of the median for males. For graduations before 1945 it was about 70 per cent of the median for males.

113. The proportion of women medical graduates no longer doing medical work at the time of the survey was 15.2 per cent, compared with 4.9 per cent for men graduates. For both women and men the proportion increased markedly for graduations earlier than 1930; for the men in this group there was also a marked increase in the proportion working less than 30 hours. The survey relates to graduates of Australian universities only, and is not confined to their medical work in Australia. The female graduates, as one might expect, had a higher proportion no longer in practice than the males; 25 per cent of women graduates could not be reached, but only 10 per cent of men could not be reached.

From these figures an attempt may be made to estimate the likely effect of the expected increase in the proportion of female doctors on the productivity of the medical workforce. If it is assumed that the proportion of females among new enrolments will continue to

Table III.12 Medical graduates of Australian universities, distributed by weekly hours of medical work, by year of graduation and sex, 1972[a]

Year of graduation	Weekly hours of medical work											Approx. median hours worked excluding nil hours
	Nil	1–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100 or more	Total	
	Males											
	%	%	%	%	%	%	%	%	%	%	%	hours
1920–29	26.3	21.6	11.1	15.2	8.2	9.4	2.3	0.6	1.8	3.5	100.0	41.7
1930–44	4.3	4.7	9.5	21.3	17.8	22.9	10.7	4.7	3.6	0.4	100.0	55.9
1945–54	1.0	1.0	3.2	12.0	23.5	27.2	16.6	10.3	5.4	..	100.0	62.7
1955–64	0.5	1.1	1.1	8.7	22.0	30.2	19.0	11.7	4.9	0.8	100.0	64.6
1965–69	3.0	1.0	1.9	8.1	19.6	25.9	14.4	12.6	13.3	..	100.0	65.9
All years	4.9	4.2	4.5	12.5	19.5	24.8	14.0	8.9	6.0	0.7	100.0	61.8

Year of graduation	Weekly hours of medical work											Approx. median hours worked excluding nil hours	As proportion of male median
	Nil	1–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100 or more	Total		
	Females												
	%	%	%	%	%	%	%	%	%	%	%	hours	%
1920–29	66.0	17.5	5.8	4.9	1.0	1.0	..	..	..	3.9	100.0	28.2	67.6
1930–44	17.3	25.9	13.2	17.3	8.6	7.0	4.9	0.8	2.5	2.5	100.0	40.3	72.1
1945–54	8.9	35.3	11.4	20.6	9.6	7.7	3.5	0.7	1.4	0.9	100.0	38.0	60.6
1955–64	11.9	31.5	12.8	17.5	10.6	7.9	2.5	2.5	2.2	0.7	100.0	38.8	60.0
1965–69	11.2	28.9	7.8	15.6	9.8	10.5	5.9	3.7	5.1	1.5	100.0	43.9	66.6
All years	15.2	30.1	10.8	17.0	9.2	7.9	3.8	1.9	2.6	1.4	100.0	39.9	64.6

(*a*) The survey was conducted in the last three months of 1971 and the first six months of 1972. Survey, Monash University, Department of Anthropology and Sociology.
Source: Report of the Committee on Medical Schools to the AUC, 1973.

increase in the proportion of female doctors on the productivity of the medical workforce. If it is assumed that the proportion of females among new enrolments will continue to increase, by 1991 about 22 per cent of all doctors might be females. If female doctors were to work on the average 64.6 per cent of the hours of male doctors (this being the ratio of the female to the male median hours worked in the Monash University survey) it can be calculated that the effect of this would be to make the productivity of the whole medical workforce about 3½ per cent lower than it would have been if the 1971 proportions had been maintained. However, as doctors are expected to work shorter hours in future, and it seems reasonable to expect the hours for males to be reduced more than those for females, this estimate should probably be taken as an upper limit for the effect of the change in sex distribution. The effect would also be reduced further, of course, by any improvements in the organisation of medical care which enabled female doctors services to be used more effectively.[54]

114. Dr Lumley affirmed in her submission:

> However, after graduation, women are much less visible in positions of power, authority and high status within the profession. Among university teachers of clinical subjects they are a very small proportion which decreases as one climbs the academic ladder. The following table was compiled from the Monash University Faculty of Medicine Handbook, 1974.

Proportion of women faculty members in clinical subjects

Title	Number of women	Number of men	Percentage of women
Professor	0	8	0
Associate professor	0	8	0
Reader	0		
Senior lecturer	*2	40	5
Lecturer	*4	11	27

* Five of the six hold part-time appointments.

> Neither Monash nor Melbourne Universities have any women faculty members in the departments of surgery, psychiatry or social and preventive medicine. This is not due to overt discrimination but to the absence of qualified female applicants. The lack of women teachers in medical school means that there are very few role models for female medical students.[55]

115. One reason for this may be that some women prefer the world of action where they may see more clearly the results of their efforts. Whatever the reason it looks as though better days are ahead for women in the medical school. Dr Lumley's appointment is noteworthy itself, and the Commission is pleased to note the appointment of Dr Norelle Lickiss as the first Professor of Community Health in the University of Tasmania.

54. *Expansion of medical education,* para. 5.42.
55. Submission 775, Dr J. Lumley.

3. Human relationships issues for medical practice

Introduction

1. It is not our purpose to write a complete report on the medical profession and training for it. The most important parts of the present chapter are those dealing with sexuality and medical practice, medical education and fertility control, which is covered on a much wider basis in Part IV, and medical attitudes to pregnancy and childbirth. The other material is an attempt to evaluate, from the evidence we have received, the capabilities of our health services to deal with these issues and services.

2. The survey of general practitioners to which we referred in our general introduction has supplied much of the material for this chapter.

3. Issues put to us referred especially to womens health problems. The value of health centres as well as hospitals and doctors surgeries was stressed, especially when emotional or psychological factors are involved, as in menstruation, menopause or vaginal disorders. A woman doctor told us about the endocrine research centre at Prince Henry's Hospital, Melbourne. There is evidence that only 15 to 20 per cent of women go through the menopause free of symptoms, and no original research has been done to remove the myths that persist in this area.

> Women felt they should put up with these symptoms because their mothers did. They have definite symptoms at this time and they did not know anything could be done about them and I really feel, because the women's life style has been different in the past, they have been able to absorb these symptoms and put up with them but in the future with changing life styles it is important they should do something about this state of affairs.[1]

4. James Ryan, Professor of Social and Preventive Medicine at the University of Queensland, emphasised the importance of teaching medical students the art of counselling.

> I cannot help feeling in the medical course too little time is given to training people in interview skills and counselling people, and in this respect I feel in the social workers course students are much more adequately prepared for this type of role.[2]

5. A medical student from the University of NSW complained that this was a weak point in the training he had received.

> There has been some introduction of counselling training in the new curriculum in the University of New South Wales but it really does not go into great depth . . .
>
> In human sexuality we are taught very well the physiology and anatomy, there is no doubt about that, this is sustained throughout the entire course, but as far as counselling people on sexual problems or in fact as far as any problem is concerned, we virtually have no training whatsoever and as medical practitioners, and indeed as medical students, we are expected to know how to interview people, we are exposed to it in our everyday lives and we are often found wanting because basically it relies on your own individual capacity rather than anything that has been developed in your undergraduate curriculum.[3]

6. We have also had to look at the special problems doctors and health services face in country areas, especially in the outback. Dr Keith Shaw of Kingaroy told of a scheme organised by the Family Medicine Program in Brisbane where older members went off to relieve younger members so that they could attend courses. He would

1. Evidence, p. 513, Dr Jean Hailes.
2. Evidence, p. 1812, Prof. James Ryan.
3. Evidence, p. 113, John Vinen.

like to see a physician, paediatrician and orthopaedic surgeon visiting some sector of Queensland every 2 months consulting and teaching under private and public conditions. He believed the RACGP should organise a pool willing to do 4-week locums to allow country doctors to come to the city and its resource centres.[4] The College could also involve teams of consultants in a permanent working/teaching role using light aircraft.

7. Against such a background of exciting change on the one hand and of dissatisfaction on the other, we proceeded to look more closely at human relationships issues for medical practice.

Problems in the doctor-patient relationship

8. While the need to understand human communications is beginning to receive some attention in educational courses for doctors, the development of a medical record system to cover the whole family has only recently been considered. Each practitioner has been left to his own devices to develop a medical record system which includes medical and psychological history, genetic, religious and ethnic factors, educational and intellectual status, and economic factors. The keeping of such information and using it regularly is vital in a program of family medicine. The RACGP is now developing and recommending a record system which may fill this gap. Another issue is the way in which the information is obtained; the patients must willingly be involved and their hopes and fears taken into account as well as mere information. Interview technique has only recently been included in medical education courses.

9. Women are usually most involved on behalf of the whole family with health services. The Australian Medical Association told us:

> . . . from the menarche to the menopause it is essential that women can be consulted with complete freedom from any embarrassment or loss of dignity.

and:

> Patients must know that their problems will be approached with sympathy and constructive analysis.[5]

10. Most families will be faced at times with the problems of coping with a sick, hospitalised or handicapped child. Frequently this is temporary and not serious. But a telephone counsellor for the Nursing Mothers Association in Victoria wrote:

> . . . the degree of trauma faced by the family does not necessarily correspond with the seriousness of the medical condition, but with the ability of the family to cope constructively with the situation.[6]

11. Therefore this submission calls for more effective communication between the various professionals, between professionals and parents, and parents with other parents who may be facing the same issue. Frequently the doctor is the only person with whom parents discuss their child.

> Parents have often complained to me of the seeming indifference and inability of the medical profession to provide sympathetic and constructive advice on coping with the day-to-day problems faced by the family. Specialists are usually busy men who perhaps spend less time with their families than the average father . . . Their degree of technical knowledge may make it difficult to explain even medical matters to lay people in terms they can understand.

4. See submission 401, Dr Mary Rose Cooney.
5. Submission 1101, AMA.
6. Submission 10, Mrs A. Hapke.

> Furthermore the feelings of anxiety experienced by even the most rational of parents often lead to a misunderstanding of what has been said. I have come across several instances where parents believed the doctor thought their child was likely to die or remain permanently handicapped even when such eventualities were unlikely.[7]

12. There is thus a need for reassurance and explanation. The requirement for medical practitioners is twofold: to be competent in technical skills and knowledge and to be equally skilful in communicating with patients, knowing when to refer or seek assistance.

13. Our evidence suggests an imbalance in the doctor's education in these areas. Knowledge of physical disorder or disease has been emphasised more than the development of skills in managing people with such disorders.

14. Similarly it was suggested that the patient should be more involved in making decisions about treatment.

> There is a need to change the situation where the doctor knows all the secrets of human physiology and health, while the patient is ignorant and must remain so. Far better doctor–patient relationships could be achieved if the patient could discuss and understand his state of health.[8]

15. We appreciate that many doctors do adopt the practice of informing patients and discussing their case; unfortunately we are more likely to hear complaints than praise. Nevertheless the practice is not universal—it should be extended and dealt with as part of medical education. While it was proposed that better publicity of public health education might be made through the media and our secondary and tertiary educational institutions, the issue of informing the patient looms large.

16. It was proposed that the government might establish diagnostic centres in each capital city[9] and that a committee should investigate cases of alleged mistreatment and neglect, collect relevant data and carry out research to make such centres more effective as well as preventing abuse in drug prescriptions. While such a proposal might well undermine the confidentiality of doctor–patient relationships and further complicate these relationships, the submissions indicate considerable discontent with present arrangements. It is not always easy or possible for patients to change their doctor. Much depends upon the willingness of the doctor to respond to his patients' concerns and to recognise his own competence and deficiencies.

17. The very nature of many of today's dominant illnesses and disabilities presupposes the existence of social and environmental causes, and invites the team work of doctors and other health agencies. The extent to which one person, and a medical person at that, can respond appropriately not only to physical presentations but also to inherent social and psychological factors is limited. Medical schools have for some years attempted to include the psychological factors, but the social factors have only recently been recognised as curriculum material.

18. Many medical practitioners are competent diagnosticians, but lack a capacity to provide emotional support and understanding. The closer relationship between these doctors and one professionally trained in a field such as counselling should complement the relationship—not fracture it. There is need, however, for government and professional bodies to co-operate more closely in this area.

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7. ibid.
8. Submission 96, Mrs N. Leggas.
9. ibid.

19. The doctor–patient relationship can sometimes come under threat when contentious issues are raised and the professional concerned becomes emotionally involved: for example, when questions arise about abortion, contraception, euthanasia, family violence, child abuse, homosexuality and artificial insemination.

20. The medical practitioner should respect the rights of individuals to make their own decisions, and recognise the emotive aspects of a particular subject, independently of whether he believes that the patient's decision was a good one. Ethical responses may depend largely upon the practitioner's awareness of social and legal attitudes concerning the issue, and upon his awareness of his own degree of involvement.

21. It is not always recognised by the medical profession that the same processes of communication, frequently depicted as unique to the doctor–patient relationship, also occur between other helping personnel and their clients and must be no less confidential and constructive. For this reason, counsellors, social workers, community workers and health aides are being employed to redress the imbalance in many health situations. Community nurses in contact with hospitals are often able to provide efficient continuity of care, if their potential is recognised and used by medical personnel.

Women

22. The term 'captive housewife' has been coined to describe the woman who is 'trapped' in the role of wife and mother perhaps in an isolated outer suburb in a large Australian city. This situation is not infrequently associated with nervous symptoms such as fatigue and insomnia, headaches and other pains as well as depression and anxiety and transient states of panic. It is probably a factor in the rising incidence of overdoses of drugs over the past 10 years.[10]

23. Many of the complaints made by women about their treatment by doctors may be the fault of male or female bias. However, in discussing the relationship between medical practitioners and patients, we are careful to remember that there are status differences between doctors and most of the patients they see, and that the difference is accentuated by the fact that the doctor is well and the patient is, or fears he may be, sick. Dr Lumley told us:

> Being sick often means being dependent, showing regression of behaviour, having one's personal identity threatened by not being able to work, as well as being in pain or distress. Moreover, the doctor is in a position of power because the patient wants something from him: a diagnosis, a statement that he is sick and can validly accept the role of patient, relief of symptoms.[11]

24. We also believe that the complaints made by some women about their treatment by doctors may be typical not so much of male–female bias as of the tensions that are often common between doctor and patient of either sex. Thus, the charge of sexism should be approached with caution.

25. The submission from Dr Lumley claims that sexism is frequently expressed in the fields of psychiatry and obstetrics and gynaecology. In the latter specialty it was alleged that there is a condescending attitude towards women; a lack of sympathy for minor female illnesses; an absence of effective treatment for female symptoms; a lack of awareness of sex role conditioning; misunderstanding generally of female sexuality; and restriction of access to contraception, abortion and sterilisation on grounds which are social rather than medical.[12]

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10. Hetzel, p. 93.
11. Submission 775, Dr J. Lumley.
12. ibid.; see also L. Johnson-Riordan, Medical advertising is ugly (paper presented at IWY conference, 'Womens health in a changing society', Brisbane, 1975).

26. If, as is argued, the doctor's lack of empathy for womens health experiences leads to his judgment of them as trivial or exaggerated, the increasing number of female medical graduates and the development of health services primarily for women should offer hope for change. Medical education must permit understanding of roles and relationships towards female patients. We were told in evidence that many gynaecology textbooks continued to reveal a persistent bias towards greater concern with the patient's husband than with the patient herself.

27. As Dr Lumley put it:

> Women are consistently described as anatomically destined to reproduce, nurture and keep their husbands happy. Traditional views of female sexuality (e.g. most women are frigid, vaginal orgasm is the mature response) were presented without reference to the factual studies of Kinsey, and Masters and Johnson.[13]

28. Conditions such as painful menstruation, nausea and vomiting in pregnancy, and pain in labour, although well documented as having organic aetiological factors, are still mentioned in the texts as being 'caused' by the patient's 'faulty outlook'.[14] The 1975 course for membership of the Royal College of Obstetricians and Gynaecologists did not mention the behavioural sciences. Normal female sexuality was not mentioned in the syllabus. Examination questions on contraception, sterilisation, emotional/psychiatric illness, pain relief in labour, and induced abortion totalled eleven out of 168 over a 6-year period. Female sexuality and social factors in illness rated no questions at all.[15]

29. Medical practitioners, who are respected as people with authority and trusted in personal and health matters, should certainly respect a wide range of attitudes and have a full understanding of roles and relationships in our society.

30. The NSW Association for Mental Health rightly told us:

> Little enough is generally understood of sexuality and so much of 'maleness' and 'femaleness' are inaccurately seen as exclusive of each other in any one person . . . Further examination of even apparently clear-cut physical sexual differences leads to a recognition that 'la difference' may be better understood as variation.[16]

31. The Australian Medical Association recognises that there are problems in doctor–patient relationships. Dissatisfaction with medical attitudes and unhelpful forms of assistance in sexuality and womens health issues has indicated the need for changes. Adjustments are now being made within medical schools and in practice so that family planning clinics enjoy closer co-operation with the practitioners, but there is room for further improvement.

32. The RACGP claimed that most family planning advice is currently provided by GPs and that this situation should continue since:

> The GP is in a unique position because of his detailed knowledge of the patient and family unit.

and:

> The GP, by virtue of his training and patient relationships, is best suited to communicate with the patient.[17]

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13. Submission 775, Dr J. Lumley.
14. K. J. Lennane & R. J. Lennane, 'Alleged psychogenic disorders in women—a possible manifestation of sexual prejudice', *N. Eng. J. Med.* 288, 8 February 1973.
15. Submission 775, Dr J. Lumley.
16. Submission 899, NSW Mental Health Assoc.
17. Submission 886, RACGP.

33. We agree that the GP is in a unique position, being commonly regarded as the primary source of general health care. But, as we have seen, the training of the GP has left much to be desired in terms of the development of the ability to communicate with patients. A diversity of services and facilities may be needed (see Part IV).

Cultural differences

34. Culture conflict is unfortunately a pervasive problem and may be traced in part to a widespread belief in the virtues of a homogeneous Australian society. The third main report of the Poverty Commission covers, in a detail we had not the resources to pursue, the relation of poverty and health amongst migrants, Aboriginal and Island groups.

35. Our concern, however, lies especially in the problem that faces the doctor when confronted with migrant or Aboriginal patients; his training has given him little opportunity for successful communication either in language or grasp of different backgrounds and manners. Health centres which often exist near areas where migrant groups predominate must equally take into account the social and religious customs of alternative cultures.

Migrants

36. The use and availability of interpreters presents problems. One submission suggests that:

> . . . doctors, all health staff, legal officers and their staff and other welfare staff should be trained in the use of interpreters.[18]

37. Professor Shearman in evidence in Sydney told us:

> Neither the Health Commission nor the federal government will provide us with interpreters. In obstetric units in this country it is an incredible situation. It would be like you or me being sick in Teheran and not speaking Iranian. The Social Services and Charities Commission in Melbourne in the Royal Womens Hospital have about twelve interpreters, but in King George V, which is now the biggest obstetric unit in Sydney, we have one interpreter who is employed part time to speak Yugoslav and English. There is nobody who can speak Greek, Italian, Turkish, Lebanese.[19]

38. Dr Spiro Moraitis of Melbourne wrote:

> Lack of Greek-speaking welfare workers, psychologists and psychiatrists is a tremendous problem. There is also a lack of sufficient professional people working with Greek immigrants. For example, in Melbourne there is only one Greek-speaking dentist, one social welfare officer and six doctors for an immigrant Greek population of approximately 108 000.[20] [The figures are for 1971.]

39. The large Italian and Greek population in Sydney and Melbourne and the Aboriginal groups in Redfern and South Brisbane therefore tend to bring their problems to the local health services.

40. We need to remind ourselves that it is the interpreter who will largely determine the extent to which a problem is physiological or psychosocial. Embarrassment and confidentiality are also relevant. Wider use should be made of medical practitioners who have a ready knowledge of the language and traditions of migrant or other groups representing alternative cultures.

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18. Submission 591, ACOSS.
19. Evidence, p. 3099, Prof. Rodney Shearman.
20. Submission 215, Dr Spiro Moraitis.

41. In our survey of GPs we inquired what proportion of patients were migrants whose basic language was other than English. Of the metropolitan GPs, the following results were obtained:

	Female GPs	Male GPs
	%	%
Less than 10 per cent	54.1	58.3
Up to 25 per cent	27.5	25.9
Up to 50 per cent	11.9	10.1
More than 50 per cent	4.6	5.4
[Not answered]	[1.8]	[0.2]

Of the country GPs, the following results were obtained:

	Female GPs	Male GPs
	%	%
Less than 10 per cent	75.9	81.3
Up to 25 per cent	20.7	12.6
Up to 50 per cent	1.7	3.6
More than 50 per cent	1.7	1.5
[Not answered]		[1.0]

42. A further question asked whether the respondent could take a patient's history in a language other than English. Of the metropolitan GPs who could do this (38 per cent females, 36 per cent males), the following table emerged:

	Female GPs	Male GPs
	%	%
W. European	18.3	17.2
E. European	14.7	7.4
Italian	10.1	9.1
Other (including Asian languages)	4.6	6.2
Chinese	2.7	4.5
Greek	0.9	2.2
Middle East	0.0	1.6
Yugoslav/Croatian	0.0	0.7
Turkish	0.0	0.0

Thus western European, eastern European and Italian were the languages which predominated. Of particular note is the relatively large proportion of the female GPs who had access to eastern European language, and the lack of GPs who had access to Greek, Yugoslav/Croatian and Turkish languages.

43. Of the country GPs who could take a history in an alternative language (28 per cent females, 25 per cent males), the pattern was much the same. Thus GPs who could speak alternative languages had oriented more towards metropolitan practice.

44. An analysis of country of birth of the sample revealed a relatively high proportion of non-Australian-born GPs. Of particular interest were:

(a) in the metropolitan area there was a higher proportion of female GPs who had come from the UK than of males;

(b) the relatively high proportion of male GPs from Asia who practised in the metropolitan areas by comparison with their female counterparts in the same areas;

(c) in the metropolitan sample only 55 per cent female and 59 per cent male GPs were Australian and in the country sample 53 per cent female and 60 per cent male GPs were Australian born.

Aboriginals

45. Aboriginals are an important instance of an alternative culture with its own special health care needs. Two major Australian health problems are created by the high infant death rate and prevalence of alcoholism amongst these people. While the infant death rate since 1966 has been halved, it nevertheless remains 79.7 per 1000 live births compared with 16.5 for Australia as a whole (see table III.13). The Commonwealth Department of Health in conjunction with the Department of Aboriginal Affairs is stimulating research in these problems, but the GP needs to have sympathy and be helpful when confronted with them.[21]

Table III.13 Infant mortality rates [(a)]–Northern Territory Aboriginals and Australia, 1966–73

Year	Northern Territory Aboriginals	Australia[(b)]
1966	147.3	18.7
1967	100.0	18.3
1968	80.9	17.8
1969	94.8	17.9
1970	115.1	17.9
1971	142.9	17.3
1972	87.0	16.7
1973	79.7	16.5

(*a*) Number of deaths of liveborn children within one year of birth, per 1000 live births.
(*b*) Rate for Australia includes Aboriginals.

Source: Australian Department of Health, Submission to the House of Representatives Standing Committee on Aboriginal Affairs, p. 19; *Annual report of the Director-General of Health, 1974–75*, p. 194.

46. The annual report of the Director-General of Health, 1975, draws attention to the need for active participation and involvement of motivated Aboriginals to help other Aboriginals suffering from alcohol abuse and generally enhance their dignity and independence. He reported that lack of success was:

> . . . due largely to the reluctance by Aboriginals to participate because of shyness, a feeling of not identifying, not relating, not being understood and even of not being wanted.[22]

In the same way, at the invitation of Associate Professor J. Cawte of NSW University, a small group of Aboriginals and Islanders has undergone training as behavioural health workers in Townsville, Queensland, with the object of trying to identify some of the causes of excessive drinking and associated behaviour patterns. This training is

21. See the studies by Martin in *Social/medical aspects of poverty in Australia.*
22. *Annual report of the Director-General of Health, 1975–76* (AGPS, Canberra, 1976).

seen by the Department of Health as the forerunner for similar courses for trainees from other Aboriginal communities.

47. Poor access to health services was claimed to be the reason for the establishment of the Aboriginal Medical Service in Sydney. Lack of suitable response to the special needs of Aboriginals by hospitals and health personnel generally may be a reason for poor health service usage by Aboriginals. Thus, of the remote Kimberley region of WA, Dr R. M. Spargo claimed:

> The Aboriginal patient was continually faced with doctors and nurses unfamiliar with the problems of Aboriginal health and totally unequipped to deal with Aboriginal patients. The irony is that the Aboriginal patient was probably never aware of this failing in the system.[23]

Some of the health problems of Aboriginals were identified by Dr Spargo as: difficulties in retrieval of past medical records; cultural, linguistic and educational difficulties in eliciting an adequate history; a tendency for the physical examination to be superficial; difficulties in explaining rectal and vaginal examination procedures to Aboriginals.

48. The development of primary health care for the Aboriginal community is needed with teams to consist of a field nurse as the key person, a nursing aide and a camp nurse who should be an established member of each particular community. Special requirements for such health care personnel are seen as gentleness and patience, as well as gaining the support of the tribal elders in any decision making, and being aware of protocol in an attitude of mutual learning.[24]

The doctor's role in human relationships

49. Here we are concerned mainly with the doctor's role in marital, family and parent–child relationships and with the social institutions which bear upon them.

50. A submission from the AMA emphasised the importance of parent–child relationships:

> Sibling and other child contact relationships must be considered constructively by the parents and professional advice sought where aberrations in behaviour indicate.[25]

51. The Commission survey found that over 90 per cent of GPs felt that the task of counselling parents who have problems with child management was a doctor's responsibility. However, this contrasted with answers to a further question about the difficulties of child management in practice. In fact, GPs preferred to refer patients with difficulties in this area to the various support or rehabilitation services. There appears to be some discrepancy between GP attitudes and practices. Most GPs obtained their degree with little teaching in counselling techniques; 'counselling' may well be interpreted as advice provided after the normal diagnostic processes. Their practice is to refer—and this is considered the appropriate action where they think support and further rehabilitation services are necessary. The task of basic medical education courses should therefore be to encourage awareness of situations in which patients could benefit from a referral to counselling, and the possible alternative sites to which they can be referred.

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23. R. M. Spargo, 'Aboriginal communities in remote Australia, health care delivery—a doctor's role', *MJA*, Spec. Suppl. 1 (1975) pp. 1–3.
24. ibid.
25. Submission 1101, AMA.

52. It was recognised by the AMA that under conditions of stress any parents may have difficulty in looking after their children:

> Any factors which distort these relationships e.g. parental absence, bereavement, marital discord, mental illness, physical injury or disability, must be recognised and appropriate counselling or compensation attempted.[26]

53. Hence medical course curricula should cover the normal aspects of parenthood, the needs and expectations of offspring, and the gradual lessening of the parental role as the children grow up.

54. It was further submitted[27] that more advice and help should be given to the whole family in its child-rearing role rather than to the mother alone, and services should become less 'mother oriented'.

55. It was claimed the medical profession was indifferent to or unable to provide advice on coping with day-to-day problems faced by the family.[28]

56. Parents often have irrational feelings toward their children. These may be based upon ignorance of childhood development, and this is an area where the GP can help. He should be able to recognise the difficulties and ensure that parents receive appropriate counselling and support.

57. Not only doctors, but teachers and nurses could be taught more about child development.

> An educational program would have to consider the individual's expectations of himself as a carer, of his self-concept and ability to form relationships, his educational background, his abilities, his health and the social and economic pressures upon him.[29]

58. Curricula often give little awareness of normal child development and the psychological needs of young children. While there is inadequate child health care generally in the community, the greatest deficiencies are in hospitals.

> Hospitals, for various reasons often beyond their control, are often badly organised and inefficiently run, leading to dissatisfaction and apathy among staff—this has an adverse effect on all patients, particularly children.[30]

59. Hence the Commonwealth Government has lent its support to the Association for the Welfare of Children in Hospital (AWCH).

60. A submission urged that those involved in child care should be chosen for their personal attributes such as perception, sensitivity and compassion for young children.[31]

61. The basis on which medical students are selected often means they are chosen for their academic record, and come from predominantly higher socio-economic classes; this makes it more difficult for them to appreciate a broad range of cultural attitudes toward child rearing.

62. Similarly, medical practitioners realise how little they have been prepared for marriage problems in their medical schools. Our survey of GPs revealed that marital counselling was regarded as falling within their area of responsibility (metropolitan 81.8 per cent, country 82 per cent). When asked how often patients were referred to

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26. ibid.
27. Submission 899, NSW Mental Health Assoc.
28. Submission 10, Mrs A. Hapke.
29. Submission 620, Future Lobby.
30. Submission 1100, Assoc. for Welfare of Children in Hospital.
31. ibid.

marriage guidance services, 7.9 per cent metropolitan and 6.2 per cent country GPs did this 'often'; 75.8 per cent metropolitan and 71.3 per cent country GPs 'sometimes'; and 15.6 per cent metropolitan and 19.3 per cent country GPs 'never'.

63. When asked, however, whether the GP referred patients with marital problems, 78.3 per cent of metropolitan and 76 per cent of country GPs did so. The question remains: what happens to patients who are not referred?

64. When asked if they considered counselling techniques were adequately covered at undergraduate training level, 92.3 per cent metropolitan and 90.0 per cent country doctors in the sample indicated they were not. Since no more than about 40 per cent of GPs received formal post-graduate education, the deficiency in this area is a matter of concern to us.

65. It is significant that people who are married show a lower death rate than those unmarried; this was revealed in a recent paper by one of our witnesses, Dr John Powles.[32] A supportive relationship may be a factor in this; it is clearly important for the doctor to refer people to support services where there is a threat of the breakdown of male-female relations. De facto relationships or other forms of relationship may require similar treatment. A moralising or judgmental approach to such relationships may well increase the chances of poor health occurring in those involved. The doctor's attitude to marriage is important to his patients and may colour his approach to them.

66. The importance of learning about marriage is further emphasised by the fact that, in a conflict-ridden marriage, violence, physical and psychological, is often a component. 'A characteristic of such marriages is that the principal issues are never solved or settled.'[33] The general practitioner is likely to be the first to identify a marital conflict and must recognise that one of his tasks is to prevent violence which causes bodily harm or mental distress. Just what he then does about it, how he initiates preventive action and how he evaluates injuries inflicted will depend largely upon the doctor's education and general sensitivity.

67. Other issues which involve the medical practitioner in the marital setting are contraception, abortion and sterilisation.

68. It was submitted that intending marriage partners should receive appropriate preparation before marriage; Dr J. McFarlane, Director of Maternal Welfare in Queensland, told us:

> The problems of today can only be resolved if people understand what marriage is about, what having a family is all about, what responsibility is all about and what is give and take.[34]

69. Medical participation may be merely to conduct a health check before marriage. In France this is compulsory, with tests also for TB, cancer and VD, and with fertility control literature being supplied.[35] Compulsion seems unnecessary here, but we support the concept of adequate preparation for marriage, including a thorough health check; again awareness of when counselling is needed is valuable.

70. In a wider field, the medical practitioner has an obvious involvement in any physical problem which besets the individual. But his willingness to be involved in

32. Dr John Powles, Socio-economic health determinants on working age males (paper delivered at conference, 'The impact of environment and life style on human health', ANU, September 1976).
33. Submission 116, Cairnmillar Institute.
34. Submission 440, Dr J. McFarlane.
35. Submission 619, Abortion Law Repeal Assoc.

family problems—as teacher and counsellor—may well depend on the individual.[36] The doctor is seen as being the important first point of contact for most ills, be they physical or otherwise.

71. Thus his effectiveness as teacher and counsellor will depend largely upon his understanding of family behaviour and of methods of family therapy. A submission from the Cairnmillar Institute in Melbourne stated:

> Our experience has shown the need for human relations training in the professional training for doctors, teachers, clergy, social workers, psychologists, dentists, lawyers, bankers, nurses and, indeed, all the helping and personal relationship professions. Present training shows a lack, in that while these professions are directed towards dealing with people, they have no training in human relationships.[37]

72. The massive changes affecting the family in western society should be reflected in medical educational material.

73. The medical profession, and in particular general practitioners, are becoming more and more aware of the importance of early childhood in the formation of healthy attitudes and practices for the future. It is essential to recognise how important is the child's family setting in instilling such attitudes and practices. Traditionally the profession has concentrated on the individual in isolation rather than the social environment in which each person lives and works. But the GP is now beginning to realise his role in this regard.

74. In accepting the place of the family, in both preventive health measures and appropriate treatment, the medical practitioner should do two things:

(a) question the role of the family while supporting it; at the same time he should respect alternative groupings and attempt to meet the needs of all ages;

(b) recognise the possibility that the individual's apparent problem may be a symptom or reflection of a disturbance in family or group relationships.[38]

75. The mental health field in this country now recognises such factors as being important to the more effective treatment of psychiatric and related social disorder. An obvious extension of this approach is into the general health field where the establishment of a logical connection between stress and physical and psychosomatic problems is becoming clearer. This recognition may lead to easier referral between differing disciplines at the general health care level. It may also modify the GP's response to such presentations by reducing present dependence upon drugs. It may be there will be greater use of the personal qualities and attributes of individual health care personnel, whether medical practitioner, community nurse, social worker, counsellor or volunteer.

Violence in relationships: the doctor's role

76. Violence in human relationships is commonly the concern of the medical practitioner. However ill equipped the family doctor may be to cope with it, physical and emotional damage are often brought to the GP as the first point of contact. Sometimes the true situation is hidden. The victim (or the parent in cases of child abuse) may approach the hospital to escape embarrassment or personal confrontation with the GP. False reasons for the damage are often given to hide the real cause.

36. Submission 1146, Dr J. J. Billings.
37. Submission 116, Cairnmillar Institute.
38. Submission 899, NSW Mental Health Assoc.

77. It is necessary to show that violence is an unacceptable behaviour pattern, and to help develop a more satisfactory means of coping with the situations which provoke it. This requires more than just the treatment of a wound—it requires careful interviewing and a sensitive approach. Recurrent violence must be recognised and preventive action taken with the participation of both parties, probably over a period of time. Whether the doctor undertakes the therapy himself or refers for more specialised help will depend largely upon his own abilities, and the availability of other effective sources of help.

78. Family violence often follows excessive drinking by one spouse. The attitude of an empathetic doctor will open the way for the doctor to discuss the problems of the patient and his family relationship, and lead to specific preventive action. The doctor is in a position to take direct action to eradicate the basic problem, but failure at this point often occurs as a result of the doctor's lack of education in the problems of alcoholism.

79. Child abuse is another aspect of family violence which doctors may encounter. It is essential that they are educated not only to identify child abuse cases and children at risk, but also to have a full understanding of the complex nature of the problem. Many doctors are oblivious of the widespread nature of child abuse. We were told that doctors will go to great lengths to deny the possibility of physical abuse of a child by its parents.

80. One difficulty of identification is that the children concerned are often moved from doctor to doctor and hospital to hospital. Some may appear well dressed and well looked after. Others may be brought to a hospital suffering from some apparently trivial injury, yet this represents the parents' call for help. A bruise on a child's arm may be the visual representation of a family in deep conflict; it is important that the doctor look beyond clinical evidence.

81. It is unlikely that a situation will correct itself by the sole action of drug prescription, which merely provides a respite from anxiety for a time, especially when the violence occurs repeatedly. The medical profession is too often subject to the argument of drug agencies, and of advertisements in widely read journals, which portray solutions to stress through the use of their particular drugs.

82. If community and professional attitudes toward child abuse are to be changed, obviously medical education at all levels should consider how to recognise and manage the problem; here the work of Professor Henry Kempe of the USA gives us valuable guidelines. There is much discussion these days of imposing an obligation on doctors and others to report suspected cases of violence. The medical profession should join in these discussions in a constructive way, recognise their duty to the victim of violence and help to find solutions which do not require punitive measures.

83. Rape is another instance of violence in human relationships, and it is essential that appropriate emotional counselling should accompany medical care. Consideration of rape and its consequences is now being introduced into some medical undergraduate education and some post-graduate courses.

84. Few GPs will have had opportunity to deal with the emotional and social problems resulting from rape; special procedures have been developed in some capital cities whereby womens health centres or their equivalent have evolved close working relationships with hospitals and police.

Sexuality and medical practice

85. In evidence to the Commission in Melbourne in June 1975, Dr Carl Wood, Professor of Obstetrics and Gynaecology at Monash, said:

> One of the difficulties has been the developing of education in human sexuality; if you make it too oriented to sexuality alone people criticise you because they say you are taking it out of context of all human behaviour. We believe sexuality is just one aspect of human behaviour. In the past psychologists and psychiatrists have dealt with human behaviour but they have left out sexuality. Obviously when you are changing something you have to overemphasise it to get it firmly put into the course.

In answer to a question concerning general practitioners, he went on to say:

> There are two or three small groups of general practitioners who have asked some of the experts to conduct seminars for them on an informal basis, with people who are specialists in sexuality. They have discussed patients within this area who have come to them. They are beginning to learn how to counsel without the advantage of teaching at an undergraduate level. It is hard for the older doctor to move back into this area of counselling. In days gone by many of us were very anxious about our own sexuality let alone trying to talk to someone else about their sexuality. It is the younger general practitioners who have tried to instigate post-graduate education in this area.[39]

86. The community at large would most often approach the GP, the obstetrician and gynaecologist or the psychiatrist if they wished advice on a matter of sexuality. The AMA informed us:

> It is likely that most women now consider their local doctor the appropriate person to approach, and probably the only person with whom they could discuss such problems.[40]

87. However, no single group can assume sole responsibility for the discussion of sexual problems, if only because many of the facets are of a non-medical nature for which many medical practitioners are unprepared. If doctors are to remain as the first contact they must be adequately educated and prepared for such contacts, and willing to refer women elsewhere when problems arise beyond their competence. The alternatives, consultant psychologists and other professionals (e.g. social workers), need to be considered as well as services in clinics and health centres. There is a strong case to be made for the provision of sexual advice and counselling by people other than medical practitioners.

88. In commenting on the terms of reference of this Commission, Dr Peter Arnold asked the following questions:

> Does this work need the services and skills of medically qualified people? Is it economic to utilise the services of the highly paid medical professionals when it appears that less expensive personnel can do the job? Is this sort of work really the domain of doctors at all?[41]

He went on to point out that our terms of reference are a response to the widely held assumption that the medical practitioner should provide all the solutions to every social disorder if it has any physiological component to it. GPs should not be regarded as 'social therapists': because, he said, first the medical profession may gradually lose its primary talent, that of detecting and treating personal bodily dysfunction; secondly, doctors are amongst our most expensively produced service personnel, and should be used mainly in those areas where they have special skills.

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39. Evidence, pp. 542–3, Prof. Carl Wood.
40. Submission 1101, AMA.
41. P. Arnold, 'Doctors and sex', *Quadrant*, October 1976, p. 8.

89. At the present time we are seeing the development of appropriate services for help with sexuality through the avenues of family planning clinics, sex clinics and community health services in which a wider, and more appropriate, range of personnel are being made available.

90. Dr Arnold sums up his view by saying:

> If people wish for counselling to handle social problems, then let this responsibility lie where it belongs, with the social workers, the psychologists, the marriage guidance counsellors and others. Let us not so dilute our medical personnel with the disorders of society that they become blind to the bodily ills of the individual.

91. Professor Ryan of Brisbane warned us that this is a specialist field and there are dangers if GPs treat problems of sexuality without adequate knowledge.

> I think the general practitioner or the family physician should realise his limitations in this field . . . in dealing with . . . problems of some magnitude, I really think in general practice they should be referred on because . . . most of the problems that present themselves stem more from anxiety and ignorance . . . Since the work of Masters and Johnson, there are techniques that can be used to deal with a number of common sexual problems. I see no reason why these techniques cannot be taught to the general practitioner, and patients told about them, and with co-operative people there is no reason why they cannot solve their problems at that level.
>
> One of the reasons why I feel it is very important that this sort of work be done on a proper basis is that, according to Professor Renshaw, there are 3000 sex clinics in the United States and an estimated one in eighty of these is reliable, and I think there is a very big danger that if this sort of thing happens in this country people are probably not going to be getting very good treatment; so for this reason alone I think it really is important for universities and the medical profession especially to become interested in this field because it could lead to charlatan practice.[42]

92. It is the hope of this Commission that, with the encouragement of the medical faculties and post-graduate colleges, there may be frequent and thorough consultation between doctors and community services so that the right treatment may be given to those suffering sexual anxieties, whose family relationships may be at risk. Women doctors and workers are important here; it is significant that many women approach family planning clinics for this very reason. Female GPs in the local area are often disregarded, for, as the AMA remarked, 'patients are also inhibited by erroneous ideas of the attitude of their family doctor or gynaecologist in this area'.[43]

93. The AMA in their submission claimed that women fail to seek treatment because of embarrassment.

> Over the past few years factors such as open discussion of sexual problems by the media have led to many more women presenting with a direct request for treatment of a sexual problem.[44]

94. The NSW Association for Mental Health[45] saw sex education as a last priority in medical curricula yet of highest priority in terms of the social need of those presenting to the practitioner.

95. Further, it was emphasised that the fragmentary approach of the undergraduate medical education system did not permit the students to be confronted on their own sexuality. The student is left to integrate the material for himself.[46]

42. Evidence. p. 1819, Prof. James Ryan.
43. Submission 1101, AMA.
44. ibid.
45. Submission 899, NSW Mental Health Assoc.
46. Submission 253, FPA, WA.

96. We should be prepared now to agree that sexuality properly has its place in medical school curricula; at present we are conscious of fragmentation and confusion as to whether the subject should be taught as a separate subject[47] or as a part of an existing group of subjects.[48] The subject now is split up between the various departments of obstetrics and gynaecology, psychiatry or behavioural sciences, anatomy and the new community medicine departments. However the degree to which the subject is taught leaves much to be desired. We agree with a Launceston health educator:

> . . . 'sex education' standing just alone should be avoided and should always be in the context of a program of interpersonal relationships.[49]

A further question surrounds the placement of the subject within the courses: should it be in one segment over the 5-6 year course, or continuously throughout the complete course and beyond? One submission urged that it should be taught by all departments and in every year of the course.[50] But the need for full integration of the subject, and co-ordination by one authority within each school, was also seen to be essential. A further issue is the methodology of education in this subject. If medical students are to become aware of what their own attitudes are towards sexuality, they should learn less through formal lectures and much more from small group discussions. We were specially interested in what was being achieved by Dr R. Montgomery, psychologist at La Trobe University.[51]

97. Dr Jules Black stated:

> First, the way the doctor behaves and what he says to the patient can affect him/her adversely. I have had patients who have been to GPs and specialist gynaecologists alike, and when they complained of a sexual problem, the doctor dismissed the patients with phrases like, 'take up tennis', 'you're too old for that sort of thing', 'you ought to be ashamed of yourself' or 'don't worry about it'. Doctors have sexual hangups too, they are only human, but why inflict them upon patients so that they go away confused, disappointed and bitter? The patients are crying for help and they are not getting it.[52]

98. Another issue surrounds the capacity of many academics to teach sexuality. Their research background does not encourage the use of sophisticated educational methods.

99. Moral issues also need to be a subject of discussion in medical schools. One submission put it:

> The doctor needs to develop a sane and healthy philosophy in regard to sexuality, a clear concept of his role and his responsibilities.[53]

100. The emphasis within traditional medical schools has been upon technical aspects as distinct from the humane and emotional aspects. One submission comes out strongly in favour of relating the emotional and physical aspects of sex:

> The medical profession has an inescapable involvement in any problem which besets the family, as a teacher and as a counsellor in the therapy of physical and psychological disorders which occur as a result.[54]

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47. ibid.
48. Submission 529, Miss M. Campbell-Smith.
49. ibid.
50. Submission 1101, AMA.
51. Submission 1054, Dr R. Montgomery.
52. Submission 29, Dr Jules Black.
53. Submission 1146, Dr J. J. Billings.
54. ibid.

The deficiency of teaching in this subject will not be overcome unless the medical aspects are considered with full recognition of their social, emotional and behavioural contexts. Often our submissions sought to ensure that human relationships were dealt with at the same time as sexuality and with this the Commission is in emphatic agreement.

101. We are glad to see that medical education in sexuality is now spreading beyond the medical schools to lectures at graduate meetings[55] and courses within the family medicine and related programs of the RACGP. Much yet remains fragmentary, and the graduate schools have to make up for deficiencies in undergraduate training.

102. In our survey GPs were asked whether the counselling of patients with sexual problems fell within their responsibility; 88.8 per cent of females and 93.4 per cent of males said 'yes'. Yet when asked if they considered their undergraduate training covered the areas of 'sexual behaviour' and 'counselling techniques' adequately, approximately 90 per cent of GPs said 'no'.

103. Based on her survey in 1968 of American physicians, Professor I. B. Pauly concluded:

> Physicians in practice estimate that at least 10 per cent of their patients have significant sexual problems. In addition, physicians acknowledge in themselves personally and attribute to their professional colleagues considerable inadequacy in treating patients with sexual problems.[56]

104. It was further stated that doctors should be able to recognise that patients often do not know what questions to ask and what terms to use in discussing a sexual problem.[57]

105. One submission from a gynaecologist observed that doctors may give advice which has confused and worried patients unnecessarily.

> An example is the finding of a retroverted uterus, a *normal* anatomical variant in 20 per cent of women. These women are told, 'you have a twisted womb', 'your womb is inside out', 'your womb is back to front', 'your womb has fallen over' or 'your womb is facing the wrong way'. These remarks are taken very seriously by the patients and they go away thinking they are truly abnormal and distorted and this influences their sexuality.[58]

Conclusion

106. If the medical practitioner is to accept the task of counselling in sexual problems, he has to recognise the signs of embarrassment in his patients and learn to overcome them. Adequate interview techniques need to be developed in medical schools as in other health-related schools. The problems are many; terminology concerning the sexual anatomy may well vary from person to person, and may require responses in like fashion; patients may need an excuse to 'validate' their visits to the doctor, and on the way out state: 'Oh, by the way, doctor . . .'

107. Over the last few years womens health centres and family planning clinics have developed rapidly and are generally meeting a strong demand. Women predominate in such services and form multidisciplinary teams which include paramedical and voluntary personnel. While the involvement of the medical profession in this field is

55. Submission 29, Dr Jules Black.
56. I. B. Pauly, 'Human sexuality in medical education and practice', *Aust. N.Z. Journal of Psychiatry* 5 (1971), p. 206.
57. Submission 454, Ms G. Pack.
58. Submission 29, Dr Jules Black.

necessary, other disciplines and persons can provide educational, supportive and therapeutic services. The involvement of women in these processes is essential.

108. Though the medical profession, through the AMA, may officially claim that students are competent in this field and that the medical practitioner is the person of first contact[59] another submission can, with some justification, say:

> Before the medical profession can be encouraged to accept responsibility for the problems encountered by people in evaluating and understanding their own sexuality, medical students need to be taught an appreciation of normal sexuality and its possible aberrations.[60]

109. In any event, graduates of all but the most recent years certainly require updating in knowledge and attitude.

110. An important consideration for this Commission, therefore, is how best to ensure an appropriate level of understanding by the medical profession of the problems too long left unmet, misunderstood or inappropriately managed. We are certain the medical profession and the GP in particular will remain a primary source of contact in human relationships issues for many years to come, and it is to the GP and the medical student that programs on sexuality must be mainly directed.

Medical education and fertility control

111. The AMA submitted that the medical profession accepts responsibility to see that every member of the community receives adequate advice in family planning; their view was that in this area the majority of Australian women prefer to consult a doctor of their own choice in a private capacity.

112. While the medical profession may claim that the ideal provider of family planning advice is the family doctor[61], the Family Planning Associations of each State have, over the past few years, established specialist clinics. These are meeting needs in which so many changes have occurred and for which the medical profession was not suitably prepared. We received submissions and evidence from Family Planning Associations in Canberra and every State. We were impressed with the breadth of their work, and their educational programs, often on very small budgets. Usually the FPA has warm support from doctors, but in some places we heard a different story; from Victoria we heard a complaint that:

> . . . doctors in the community took vastly different ethical, moral and religious stands on issues related to abortion and sex, and that all doctors could not be relied upon to discuss their patients problems with the sympathy and objectivity we thought the patient had a right to expect.[62]

113. The need for such clinics arose in part because existing hospital staff required retraining programs and prejudice could be strong in hospitals.

114. It was recognised by some[63] that the title 'family planning clinic' deters some women from seeking advice. Clearly, alternative titles and methods of advice should be considered.

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59. Submission 1101, AMA.
60. Submission 253, FPA, WA.
61. Submission 1101, AMA.
62. Submission 535, Miss Yvonne Foster.
63. Submission 556, F. Beighton & J. B. Cole.

> Innovative delivery systems, particularly in relation to special groups such as young people, rural residents and those who have completed their families, should be tested. Likewise alternative methods of delivery such as through the private physician should be assessed.[64]

115. In effect, family planning should be accepted as an integral part of the family life cycle. There should be progressive family life education, freely available contraceptive advice and counselling and ready access to contraceptives. The AMA supported such a proposal[65] and the Commission fully agrees.

116. Family planning should be available to everybody within the mainstream of services and education programs.[66] Some consider the GP is ideally placed to initiate action, since he is accessible and naturally concerned with the well-being of families.

117. The medical educational curriculum for family planning should, it was submitted, follow the guidelines of the World Health Organisation.[67] Until recently the curricula of medical schools lacked any consideration for family planning. But the efforts of medical students, some faculty members and society at large (especially through the Family Planning Association) have resulted in important modifications to the curriculum. The changes vary from school to school and there is debate as to whether the course should be a single 'block' course or a continuous course.

118. Apart from the guidelines set by the WHO, the Australian Federation of Family Planning Associations claims that such a course should include the concepts of family planning, the operational and administrative mechanisms of the family planning program and the specific functions appropriate to various roles, implying the involvement of categories of personnel in addition to medical personnel.

> There should be optimum utilisation of all existing categories of personnel. In particular, paraprofessional and paramedical personnel should be trained to undertake more medical/non-medical tasks, leaving physicians and nurses free to perform the functions for which they are specifically qualified.[68]

119. The Family Planning Association of the ACT suggested to us that nurses could assess the family planning needs of families, that it should be an integral part of the general nurses training and that social workers and other community workers should have a working knowledge of modern contraceptive practice.[69]

120. In our survey of GPs we sought to discover how often general practitioners themselves initiated the subject of family planning during consultations. Eight situations were presented to the responding doctors and, with regard to each, they were asked to indicate whether they routinely raised the subject of family planning. The percentages of responses to this question are shown in table III.14.

121. It is significant that some 60 per cent of metropolitan GPs and 73.5 per cent of country GPs said they did not refer their patients to other services for this kind of advice. Of those who did, reference was mainly to the gynaecologist, or for sterilisation to the urologist. The next largest point of referral was to family planning clinics, especially in the country. Beighton and Cole after their survey of Melbourne university students urged:

64. Submission 612, Aust. Federation of FPAs.
65. Submission 1101, AMA.
66. Submission 899, NSW Mental Health Assoc.
67. Submission 253, FPA, WA.
68. Submission 612, AFFPA.
69. Submission 198, FPA, ACT.

. . . students enrolled in courses which may ultimately put them in the position of motivating others on contraception, medicine and education should receive lectures on human reproduction and contraception early in the course.[70]

Table III.14 Percentage distribution of responses to the question: 'Do you raise the subject of family planning as a matter of routine in any of the following situations?'

Situation	Area of practice	Yes	No	No consultations on this matter
At 6-week post-partum check up	metropolitan	72	7	16
	country	84	9	6
At a pre-marriage consultation	metropolitan	84	6	6
	country	82	8	6
At a first gynaecological consultation	metropolitan	61	28	4
	country	58	32	3
As a normal part of history taking	metropolitan	53	37	1
	country	52	40	1
At a rubella vaccination	metropolitan	65	21	6
	country	61	26	7
At a request for abortion	metropolitan	86	6	3
	country	82	10	4
At discussion of sexual/marital problems	metropolitan	90	6	1
	country	90	5	2
At discussions concerning venereal or vaginal disease	metropolitan	66	27	2
	country	67	25	3

Percentages do not sum to 100 owing to rounding and a small number of responses not identifiable by area.

122. In the difficult field of abortion the doctor's role as counsellor is important. Whatever his own attitudes and moral position, if he is truly responsive to the needs of his patient, as should be the case with every good counsellor, he should be able to refer to appropriate services. Medical courses should take account of womens needs and rights just as they should reflect the need for counsellor training, with the necessary factual information and advice for the doctor to pass on.

123. We agree with the third Poverty Commission report[71] which has an admirable treatment of family planning and abortion. We believe that family planning should be seen as both a health and a welfare measure, involving doctors and other personnel.

Pregnancy and childbirth: medical attitudes

124. It was proposed to us that training in obstetrics should recognise the emotional impact of pregnancy and childbirth on family life, including the anxiety and depression which may occur as a result of an unplanned pregnancy.

70. Submission 556, F. Beighton & J. B. Cole.
71. *Social/medical aspects of poverty in Australia*, p. 159.

> The woman may fear deformity to her own body, deformity of the baby at birth, or she may feel that she will be unable to cope with the baby after birth. Fear of the birth itself . . . commonly causes a woman to feel anxious.[72]

125. The changes in sexual relations that are likely to happen in a woman's relation to her husband in pregnancy should have a place in discussion.

> During the first and third trimesters, the woman commonly experiences a loss of libido which may be exaggerated by complications of pregnancy such as nausea, tiredness, varicose veins. General attitudes in society tend to isolate the male from pregnancy—women talk about the subject, but men do not.[73]

126. Doctors and nurses should therefore discuss general topics of importance to the pregnant woman such as nutrition, home and personal management, the rights of the father, the child, and possibly the grandparents.[74]

127. The extent to which the medical profession views pregnant women in terms of physical illness needs to be assessed. It has been said that doctors are trained mainly to care about the 'interesting' cases. We were told that other personnel could provide a better service in some areas and that they should assume part of the responsibility for care in pregnancy.

> . . . the major part of medical training in obstetrics concentrates on the 5 per cent of births which are abnormal or difficult.[75]

128. Another submission[76] spoke of the difficulties of the single pregnant woman in her contact with her doctor and his staff. Such women were sometimes subject to gossip in the doctor's surgery and moral lecturing by the doctor. This did nothing to alleviate the anxiety arising out of the psychobiological changes occurring.

129. If 95 per cent of all births are normal, medical education should reflect this. It was claimed that many doctors and nurses tend to regard pregnancy and childbirth as a series of symptoms to be scientifically dealt with:

> . . . e.g. the condition of the uterus, the blood pressure, the contractions of labour. The mother is regarded as a body to be manipulated through a series of procedures and to conform to hospital routines and efficiency.[77]

130. But a woman's feelings about childbirth affect her attitude toward her child, her partner and her family, and have a great influence on how quickly she recovers. With proper preparation the mother's labour time may be shorter, there is a decreased need for drugs and there is less likelihood of surgical intervention.[78]

131. Hospitals should orient their activities towards support of the family in childbirth and place less emphasis on established routine. The problems faced by one mother in a country hospital maternity ward give credence to this problem.

> I would say that about 75 per cent of the mothers in the unit were upset by the following daily occurrences:
>
> Crying babies in the nursery, which was in the middle of the unit. Each mother thought it was her own but could not find out because it was sacrosanct and questions along those lines asked of a busy staff naturally meet with disapproval.

72. Submission 998, Childbirth Education Assoc.
73. ibid.
74. Submission 179, St Patricks Parish Council.
75. Submission 998, CEA.
76. Submission 535, Miss Yvonne Foster.
77. Submission 998, CEA.
78. ibid.

> When a feed was not a good one, babies were often returned briskly for the rest and mothers usually invited not to play with it. There was a distinct attitude of guilt thrust upon the mothers.
>
> Nursing one's child at any time but the all too brief feeding time was forbidden. A ludicrous situation regardless of any routines, staff or time shortages . . . no problem can be great enough to forbid the nursing of a baby.[79]

132. Many witnesses argued it was wrong if women are persuaded to have births induced purely for the convenience of the obstetrician.[80] In modern hospital design there are sometimes more 'induction rooms' than 'delivery rooms', a fact which, if correct, reinforces the view expressed above concerning the very impersonal approach taken to the procedure of childbirth.

133. It was further claimed that epidural anaesthesia is often forced on women who are mystified, have no idea they have any choice or what exactly their choice is. The obstetrician and anaesthetist have made little attempt, often, to understand the individual feelings of the woman concerned. We believe therefore that more attention should be given to psychological and emotional factors in courses in obstetrics.

The doctor and sexual variations

134. In this section of the report we are concerned with the attitudes of the health professionals to homosexuality, in particular, and to deviant behaviour.

135. If homosexuality is not regarded as an alternative life style within a pluralist society, then it is perceived as a disorder or a disease. The medical profession on the whole has followed traditional belief that homosexuality is unacceptable. Often it has sought to alleviate this 'disease' by the use of psychiatric and psychological techniques. Although there have been significant moves away from such a perspective on the part of psychiatrists (e.g. the statement made by the Australian and New Zealand College of Psychiatrists in 1973) evidence we received indicates that discriminatory attitudes still exist toward the homosexual.

136. One statement claimed that most doctors were ignorant of sexuality, in particular homosexuality. Many psychiatrists were reported to be 'clearly hostile' to homosexuals, suggesting they are sick, neurotic and paranoid. 'They have used aversion therapy to experiment with homosexuals'.[81] While psychiatry has normally dealt with the homosexual 'problem' for the profession, the general practitioner cannot escape his role as the professional of first contact. It has been claimed that the local GP, who sees almost all homosexual adolescents and their parents when homosexuality is suspected, gives a response which is typically 'less than informed'.[82] The 'don't worry, he'll grow out of it' answer is 'common'.

> The family doctor is traditionally one of the first to whom those in trouble have gone for help. The general ignorance of doctors about homosexuality and, indeed, about sexuality in general means that this avenue is closed to most.[83]

137. Once referred to the psychiatric specialist, the homosexual has been frequently 'diagnosed' homosexual and some form of treatment entered into to modify or reverse what is thought aberrant behaviour. Although the psychiatric and psychological professions have, in recent years, issued policy statements which reflect a new attitude toward homosexuality, many GPs and sections of the professional specialities have retained perspectives not in accord with 'official' policy.

79. Submission C874, confidential.
80. Submission 422, Margaret Coombs.
81. Submission 1026, Mr B. Lindberg.
82. Submission 430, Campus CAMP, Qld.
83. Submission 558, CAMP, NSW.

138. A particular aversion therapy program was considered inhumane by one of the submissions presented to us.

> The aversion therapy work . . . is largely a development of experiments carried out overseas, mainly in Britain and the United States . . .
>
> It is based on the use of punishment, usually by electric shock or the administration of emetic drugs, to try to prevent the patient from responding to homosexual stimuli. These courses of treatment can be quite rigorous.[84]

139. Other forms of treatment commonly used to treat homosexuality are psychotherapy, psychosurgery and chemical castration. Chemical castration through drugs developed allegedly to cure homosexuals usually has severe side effects and is still in the experimental stage. A submission reads:

> Because homosexuals, along with several other groups, are one down in the society we are particularly subject to pressure from the relatively incautious medico or drug company seeking experimental patients for their new ideas. The state should actively intervene to stop this unprincipled exploitation of the weak by a very strong section of the community.[85]

140. Although the homosexual community within a reasonably sized city has generally learnt of the whereabouts of a homosexual doctor, and has thereby received help with medical problems in a relaxed and accepting atmosphere, significant difficulties remain for the rural or isolated homosexual, the adolescent who has not yet fully identified his potential sexuality, and the transvestite and transsexual, each of whom must still be prepared to face the reaction of his own doctor.[86] The general practitioner has usually referred these cases on to the specialist, most often the psychiatrist, and sometimes the psychologist or social worker. The impression given is that the homosexual is by his very nature sick and disordered, the GP responding more to the homosexuality of the patient than to the specific problem with which he presents.

141. There are homosexuals who, like heterosexuals, suffer from a wide variety of personality disorders and mental illnesses. It is claimed, however:

> . . . that there are homosexuals . . . who are happy with their lives and have made a constructive and realistic adaptation to being members of a minority group in our society.[87]

142. One submission put the view that the types of illnesses from which homosexuals suffer may well require particular kinds of treatments, patients being permitted to choose the direction of the treatments.[88]

Conclusion

143. The causes of homosexuality, whatever they are, require a great deal more research. Forms of treatment for homosexuals should be as diverse as forms of treatment for heterosexuals; the assumption that the sexual identification requires changing need not be relevant at all. In other words, the person should receive treatment for diseases and mental illnesses irrespective of his sexual identity.

Mental illness and community health

144. Professor Issy Pilowsky, of the Department of Psychiatry at Adelaide University, told us of the new attitude to mental health.

> I am talking of people who are really rather ill, and in the past what would they have done? They would not have wanted to go to a mental hospital—an asylum as we use the

84. Submission 430, Campus CAMP, Qld.
85. Submission 1128, Mr Lex Watson.
86. Submission 462, Ms V. Cass.
87. Submission 447, Mr R. P. Critchlow.
88. Submission 995, Congregational Union of Aust.

word today. 'Asylum' is a beautiful word, and, as the church well knows, people were given asylum and were not persecuted and killed, but this picture of asylum changed tremendously and it has become a frightening word. People do not want to go there, and there were not many psychiatrists around at all in the early days. In the last 20 years the situation has changed. We are very proud of our post-graduate training program in South Australia, and we are training more psychiatrists. So from that point of view the situation is improving, and even country areas can now count on having a visiting psychiatrist at least once or twice a week.[89]

145. The attitudes of the community towards the mentally ill have been modified over the years from one of rejection, by isolation and committal to institutions, to guarded acceptance of such people within community settings in which health services maintain continuous support and therapy.

146. A greater awareness of the effects of unsatisfactory environments and excessive stresses upon people is growing. The establishment of crisis centres is one manifestation of this. One recommendaton made to the Commission was to encourage the departments of community medicine to investigate, assess and treat all aspects of general community mental health.[90] The development of community health services which provide rehabilitative, social and psychological aids, to complement the medical services already available, is a further attempt to manage the problems of mental health outside institutions and within the settings to which the ill person may eventually return anyway.

147. In response to the recognition that 'professionals' gradually become less effective with all levels of the community in terms of their direct clinical contact, some State and Territory mental health services have employed mental health visitors from a wide range of ages and life styles. Such people can more effectively identify with a variety of people in need, including migrants and Aboriginals. Any lack of professional education and knowledge is compensated for by their close relationship with health professionals.

148. A psychologist wrote:

> The role of the psychologist could be likewise non-attached community based. This would inevitably force the psychologist away from clinical description and toward social action on behalf of the so-called misfit (rather than on behalf of the dominant economic group).[91]

149. At present, mental hospitals often lack comfortable facilities for counselling. A number of submissions mention the discrimination which exists against the mentally ill. Patients who have been in psychiatric institutions are left in a state of poverty through a combination of stigmatisation and reduced capacity to work effectively. Schizophrenia is a long-term illness which leads to frequent job losses, a factor which is not helped by the lack of consideration by employers.

> A survey of personnel officers in local industries and business houses showed that if profitability was likely to be affected these people would not be considered for employment.[92]

150. It was submitted that social security benefits for people with physical or emotional disabilities discourage rehabilitation and make such persons dependent on pensions. Small earnings are deducted from sickness benefits, and thus the client is

89. Evidence, pp. 1174 ff, Prof. Issy Pilowsky.
90. Submission 52, Dr M. Harris.
91. Submission 1102, P. J. Fox.
92. Submission 1002, Mrs Clarice O'Meara.

often worse off, and life is robbed of purpose, dignity and equality.[93] If the spouse of a person receiving an invalid pension goes to work the pension may be reduced—this is harmful to relationships.

151. It was submitted that in at least one State (NSW) in 1975 discrimination against psychiatric patients was evident by the health funds, including Medibank.[94] Charges to psychiatric patients were haphazard, leading to the suggestions that either such patients should be covered by a medical benefits scheme or charging should be abandoned.

152. It was elsewhere suggested that officers of those agencies dealing directly with people who are mentally ill need specific training in human relationships.[95] Examples were given of the poor control of the officers' own feelings and reactions. The referral of clients from office to office and statements that late cheques were in the mail or delayed, when in fact they were available but not readily at hand, were said to be examples of officers' passive aggression toward clients. This reinforces our belief that all hospitals need some sort of ombudsman to whom can be referred such cases of neglect, or lack of co-operative service.

153. We were told of a mentally ill wife who could not work and required the support of her husband in order to remain reasonably well. Her husband lost his job and this led to their separation in hostels in order to obtain maximum benefits, a situation demoralising to the rehabilitation of the ill person.

154. Instances were provided of psychiatric patients having to live on invalid pensions, and only being able to afford shared accommodation which impinged on their privacy.[96]

155. The way in which services are attempting to rehabilitate mentally ill patients is not matched by other services. There is a lack of co-ordinated effort and relationship support sometimes coupled with inflexible and restrictive legislation. Appropriate care should be matched with financial support if the mentally ill are to be happy within a community setting.

Conclusion

156. The issue of the effectiveness of mental health services in ensuring the well-being of the families—in particular the wives of mentally ill men—is recognised. The rights of the individual who may be mentally ill must be balanced against the rights of those who suffer under the continued lack of control and treatment of that individual. Physical and psychological abuse of women by disturbed husbands should be thwarted by appropriate protective mental health legislation and effective health services.

157. To quote Professor Pilowsky again, on dangerous insanity:

> I think we have to differentiate between people's diagnoses, if you like, and their behaviour. If someone does something which is dangerous to other people, and criminal in that sense, if it contravenes the law, then society has to decide how it is going to handle that behaviour, and it may well be that society decides it will handle that behaviour in a prison. But where it feels that that behaviour is determined to some considerable extent by psychological disturbance, it will arrange to have an area of the prison set aside to offer therapy.[97]

93. Submission 1099, Doctor—name withheld.
94. Submission 899, NSW Mental Health Assoc.
95. Submission 1099, Doctor—name withheld.
96. ibid.
97. Evidence, p. 1177, Prof. Issy Pilowsky.

158. However, many mentally ill people need to be cared for and treated within the community before their illness becomes severe. It is important to recognise and sometimes intervene in the social, environmental contexts of the ill person.

Medical practice and drug dependency

159. The major drug dependency problem in our community today is alcohol abuse. The report on alcohol of the National Health and Medical Research Council reflects an increasing awareness of the problem by health authorities. Under the *Mental Health and Related Services Assistance Act* 1973 funds were concentrated on services for alcoholics and drug-dependent persons (amongst others). The major focus of the community health program is to control and prevent such problems within the community, i.e. before institutionalisation becomes necessary.

160. A National Alcohol and Drug Dependence Multidisciplinary Institute (NADMI) was set up in 1975, to facilitate the education of all personnel involved in the more effective management of the problem. Doctors should be well informed about the social and medical issues of alcohol and drug dependence and about community resources in this area.

161. Our own survey revealed that a high proportion of GPs in this country considered that detection and treatment of alcohol and drug dependence fell within their responsibility. Many GPs distinguished between detection and treatment and were of the opinion that treatment was less their responsibility than detection. This was reflected in the very high proportion of GPs who referred patients with alcohol and drug dependence problems to support and rehabilitation services.

162. The general practitioner is in a position to recognise the early signs of alcohol dependence. It is the GP who must certify as 'sick' the worker who suffers from excessive drinking and wishes to claim sick leave. The GP can detect other signs of physiological and psychological deterioration commonly seen in alcohol abusers, and often has contact with members of the alcoholic's family when they complain of abuse or relationship problems.

163. The drug dependence issue looms large in the area of prescriptive drugs. It is claimed that doctors readily resort to prescribing drugs to deal with stress of various kinds within the community. The possibility of remedying the social setting in which the stress originated is often left to chance. The drugs may provide no more than a period of tranquillity.

164. Much is now being said about stress as a cause of physiological disorder and disease. The modern diseases of hypertension, ulcer, heart failure and mental illness may all be stress related. The causes may include environmental, social and economic factors.

165. The relationship in Australia between unemployment and increased disease and mortality needs investigation. The epidemiology of socially related illness should be discussed in medical education. Sources of stress such as divorce, bereavement, migration, unemployment, isolation, industrialisation and change should be recognised.

166. If the primary thrust of medical education is to identify the immediate cause of pathology rather than search for real understanding, it may be facilitating modern disease patterns. It is therefore most important to review medical curricula to determine whether they convey a real appreciation of environmental factors.

167. The question of over-prescribing drugs is the subject of a paper based on the Australian Morbidity Survey. After comparing prescribing rates over 2 years (1970-71) and showing the proportions of various prescriptions provided for particular groups of diseases and disorders, the writer states that not only do 33 per cent of all patient-doctor contacts not result in any prescription, but when a prescription is written, in the areas discussed, doctors do show a great deal of thought as to what they write.[98]

168. One submission claims categorically that the practising doctor is only too ready to prescribe drugs as defence against other forms of involvement and to save time.[99]

169. Much of this assumes there are alternative forms of treatment or action which can prove more effective in the long run. One submission[100] called for more study in medical schools in the wider field of drug therapy while another[101] called for greater control by the public sector of such prescribing. It was recommended that the patient be given, in legible writing, the name of the drug, its chemical composition and the specific purpose for which it has been prescribed. As an alternative source of information, it was further recommended that the government set up drug diagnosis and advisory centres in each capital city where a patient can receive as much information as he requires about the drug. Such a series of recommendations clearly points to the need for public and patient awareness of, and responsibility for, the drugs prescribed. Far more community involvement in health care is required as a measure of prevention.

Conclusion

170. We believe that national trends in life styles and living conditions may need modification if many of the causes of stress are to be reduced. We also believe that much more thought needs to be given to the phenomenon of the environmental influences upon disease, and the recognition of alternative or supplementary actions (besides drug prescription) by medical practitioners. This is fundamental to a consideration of present day medical education. A great deal remains to be done with medical school curricula which are only beginning to reflect current concern about drug prescription as a lone source of treatment.

The health care of the handicapped

171. The diagnosis and care of the mentally handicapped requires a multiple service approach. Thus the NSW Association for Mental Health submitted:

> Within the health services—especially in psychiatry—it becomes increasingly apparent to many professionals that an identified 'sickness'—'physical' or 'emotional'—in an individual frequently represents disturbance in the family/group relationships and requires a family/group approach for effective therapy. We submit that this orientation is needed within the training of professionals (legal, teaching, health) and in the policies of programs of care (health services, courts, schools).[102]

Parents and families of handicapped people play a much more significant helping role than in other areas in which health professionals are involved.

98. Dunstone, p. 320.
99. Submission 899, NSW Mental Health Assoc.
100. Submission 155, Miss D. O'Halloran.
101. Submission 96, Mrs N. Leggas.
102. Submission 899, NSW Mental Health Assoc.

172. The doctor becomes involved at the time of diagnosis rather than later when education and rehabilitation is necessary. Submissions concerning the inaccessibility of diagnostic services were received. A father of an autistic child told the Commission:

> The first hurdle to overcome was the most difficult one of diagnosis. We did the rounds . . . and the further we went the more confused we became.[103]

173. Parents are often left to cope on their own with their handicapped child's special needs. They find out by chance rather than by referral about self-help and parent support organisations.

174. There is a need therefore to assess the degree to which the medical profession learns about the need for diagnostic and supplementary services for the mentally handicapped. Although these services are predominantly government sponsored, the professionals in them were said in one submission to have enormous power which was not always seen to be used in the most humane ways.

175. The need for a multidisciplinary approach is acknowledged but not always followed; co-ordination of services was seen as essential. Families become 'the meat in the sandwich of professional in-fighting for authority'.[104] The professional must put his own house in order first by accepting that he is a member of a team, co-operating with other professions and with non-professional workers; he must fully utilise facilities and staff; he must maintain and improve quality of services; he must seek to improve community understanding of the mentally handicapped.

176. While there is general sympathy on the part of GPs before specialised diagnosis takes place, the profession was said to show at times a surprising lack of sensitivity.[105] For example, the doctor claims the mother is over-anxious and prescribes drugs for her or for the child; it is said that the child is slow and that he or she will eventually catch up; parents do the rounds of GPs searching for a solution. In some places, once specialised help is contacted, a 3-month wait is inevitable, a fact which is intolerable from the parents' point of view, and damaging to the child for whom early special education is imperative.

177. One mother writes:

> I blame the stress in my marriage on the lack of ability to diagnose these cases, or even to get some medication, which in the end was the only thing which helped our son to be at all livable. The three GPs at our local clinic in Melbourne refused to see that there was anything wrong with X that a bit of discipline would not cure. This with the lack of understanding from my husband, who was assured by these doctors that X was normal, made me think that I was mental, and the frustration was at times unbearable. A relieving doctor did give X a liquid barbiturate, which was so vile tasting that he would not swallow it. It is necessary for the child, and the health of those he lives with, that GPs should be encouraged not to diagnose themselves, but get expert help.[106]

178. GPs in our survey indicated that they did refer such patients to support and rehabilitation services, but the referral would take place only when the decision had been made that such action was required.

179. We believe that diagnosis, support and care for the handicapped is inadequate in Australia. One of the major areas of concern is the need for closer working relations and understanding between private practitioners and government services.

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103. Submission 163, Dr Vern-Barnett.
104. ibid.
105. Submissions 468, Mrs Helen Lilly; 1058, name withheld.
106. Submission 468, Mrs Helen Lilly.

180. The basic ingredients for effective care of the handicapped include interviewing, assessing social backgrounds, observing the problems of people within their own homes and maintaining contact with parents and support services. Undergraduates need to be taught appropriate diagnostic procedures and to understand the difficulties faced by parents in accepting that their child is handicapped.

181. The need for screening procedures in maternity hospitals of infants born with any impairments was called for:

> The success of such a program depends heavily upon the co-operation of attending obstetricians.[107]

Conclusion

182. The handicapped need a fuller place in the curriculum of the medical school and in the training of other health professionals. Both the need for early diagnosis as well as the long-term nature of handicaps should be recognised, and the role of the doctor in relation to specialists, psychologists, social workers, counsellors and particularly parents should be fully explored.

Children in hospital

183. We have already seen that hospitalisation is not always the best course of treatment, especially for children, and have therefore stressed the value of community health services.

184. The Association for the Welfare of Children in Hospitals (AWCH) has, in the past few years, received Commonwealth support in improving attitudes and conditions for children who are hospitalised. The trauma of finding themselves in an institutional setting, without the basic social relationships of home and family, as well as the rigid systems of hospital life are the concern of this Association which seeks to minimise physical and emotional distress to children and their families whether inpatients, outpatients or in some other form of community health care.[108] It also recommends that the child should be kept in touch with his parents, and that mothers might be encouraged to stay with their child when in hospital.

185. Children should only go to hospital if there are clear needs for this. The duration of the stay, particularly for the young child, should be as brief as possible. There is ample evidence available which shows how detrimental institutional care can be to the emotional and physical well-being of young children.

186. The medical profession should welcome the establishment of more community-based health care services and acknowledge that to send children to hospital does not necessarily make for good health.

187. Separating child from mother and family has many implications. The medical practitioner has to assess whether the emotional and psychological upset for the child sent to hospital is relatively less important than the correction of a medical problem for which there is no alternative source of treatment. The behaviour of young children observed in hospitals is different and somewhat disturbing. Long-term effects are not easy to assess, but short-term effects reveal trauma due to separation.[109]

Institutional care

188. Much is being attempted now by health authorities to reduce the unnecessary stay in institutions by patients. More attention is being given to the extension of preventive health services, and services based on the philosophy that the ill person who

107. Submission 1120, Mrs L. Healy.
108. Submission 1100, AWCH.
109. G. Caplan, *An approach to community mental health* (Grune and Stratton, NY, 1961), chapter 4.

can live at home with medical care and support should do so. Hence the work of the GP needs to be complemented by the provision of community-based paramedicals as well as community nurses and support personnel, who can visit the homes of patients regularly and report to their doctors.

189. In considering the welfare of the patient, consideration must also be given to the family or others who provide home care, particularly in the case of mental illness. It was submitted that the general medical practitioner may not be sufficiently experienced and trained to make judgments concerning the committal to hospital of mentally ill people.[110] Decisions to hospitalise are generally made by the members of the medical profession or by the judiciary upon medical advice. In the ACT, there has been debate concerning a proposed Ordinance on mental health, and the proposal to authorise a multidisciplinary professional group to make a decision as to whether admission is in the patient's interests. The definition of mental illness now focuses on psychiatric classifications whereas the opinion of paramedicals could be of value. There is, however, no agreement as yet upon any radical alterations to the tradition that the psychiatrist makes the decision.

190. A submission on mental hospitals[111] proposed to us that the federal government should legislate for mental hospitals, and recommended the issue of a statement of patients rights sanctioned by government authority.

191. Such a submission ignores the nature of most serious mental illness, in which the formal procedures proposed above may complicate the illness further. The procedures may come too late to remedy the problems they are set up to avoid.

192. This is not to deny that society has a definite role to play in ensuring the rights of individuals who may be defined by a profession as mentally ill and in need of hospitalisation, or the need to provide safeguards for the review of cases of involuntary hospitalisation through tribunals which are independent of government influence; patients should be allowed legal counsel.[112]

Conclusion

193. We believe that the various Mental Health Acts need urgent revision.

194. We urge that the medical education system should pay greater attention to mental health and mental disorders.

195. For the less disordered patients, community-based facilities and services, supported by the *Mental Health and Related Services Assistance Act* 1973 and the community health program, should be extended and encouraged. They have set the pattern for self-help. Counselling and social network interventions are being offered alongside traditional forms of care for emotional and psychological disorder. Such multifaceted approaches to this grey area of health care reflect more truly the nature of their causes. We also support a submission[113] urging that institutions should not be at a distance from centres of population so that patients are isolated from families, and that when possible their size should be reduced to make them more homelike.

The medical profession and death

196. Death is a subject to which insufficient attention seems to be paid, either in medical schools or in discussions amongst doctors. One of the saddest and often most appreciated roles of doctors is the way that they look after the dying patient, and

110. Submission C1082, confidential.
111. Submission 96, Mrs N. Leggas; also ibid.
112. Submission C1082, confidential.
113. Submission 864, Mr J. L. Sinclair.

effective teaching needs to be provided to help them to be competent in this area. Doctors should consult with social workers, psychologists, nurses and, in many cases, clergy who could give the benefit of their knowledge and experience.

197. A number of submissions referred to euthanasia. Although the Commission has had no opportunity to discuss the issue fully, it is of some relevance to our inquiry because of the way it has been linked by some to the abortion debate and because of the difficult problems of family relationships often involved.

198. The term euthanasia applies to two basic situations, summed up in the rhyme:

> Thou shalt not kill but needst not strive
> officiously to keep alive.

199. The first situation is that in which the doctor must decide whether to cease a form of treatment which though prolonging life causes pain and suffering to the patient and anguish to the family. In some cases the amount of a drug needed to relieve pain may be a fatal dose. These are decisions which primarily rest with the doctor and his own conscience. The community owes a debt to doctors for the way in which they accept responsibility in such situations—a responsibility which they often have to carry alone, though some doctors are able to discuss openly with the patient and share the decision to withhold treatment which could prolong life. It would be intolerable in our view that responsible medical decisions of this kind should bring the doctor into conflict with the law. On the contrary we believe that the community should openly acknowledge these issues and give its support to the profession. Medical education too should face these issues.

200. The problem was perhaps well summarised in a submission by a West Australian woman who told us[114] that, though she was opposed to euthanasia, she saw no need for the unnecessary prolonging of life for a sufferer.

201. A different situation arises under submissions put to us by Voluntary Euthanasia Societies[115] and in evidence at our Sydney hearings in November 1975.

> I think there is no area of human life and relationship that has not been subject to pressure towards evolution, and among them there are movements which have wanted to look more carefully at the actual condition of human beings at all stages of their lives. The terminal stage comes into it . . . I think a person in possession of his faculties should be able to make a declaration that if the time should come when that person is in thus and thus kind of situation, carefully spelt out, it is his wish that all of those who are concerned with his condition and well-being should allow him to die with euthanasia, an easy death, and if necessary take steps to effect this.[116]

202. In effect, what is being sought here is that a patient should be able to request that his life be brought to an end—not only at the time of illness but by an earlier declaration. Has a patient old and tired, or suffering from an incurable disease, the right to ask a doctor to end quietly an existence which no longer seems to be real living? It has been suggested that this is an extension of the argument for or against abortion.

203. The view against euthanasia was forcibly put by the South Australian Right to Life Association:

> The clamour for 'easy' abortion and for 'euthanasia' comes at a time when there has never been less need for either. We have at our disposal an array of potent pharmacological agents and surgical procedures which enable the pain of dying to be adequately relieved.

114. Submission 252, name withheld.
115. Submissions 26, VES, Vic.; 157, VES, SA; 453, VES, NSW; 994, Human Life Research; C1222, confidential.
116. Evidence, p. 2676, Mr William Coughlan.

> The real suffering of death stems from the fear that support and relief may be withheld. We must give psychological support and strong reassurance that loving help will be freely given when the time comes.
>
> A coherent defence against 'euthanasia' requires a strong offensive against abortions for reasons other than the preservation of the life of the mother. Both abortions and euthanasia subordinate the right to live to lesser needs of others or to the social design of the state. Once the validity of either is acknowledged, then our objections to Auschwitz and Buchenwald will be reduced to the functional and to the sentimental.[117]

This view would be supported by other submissions and evidence. We reached no final conclusion on this issue except to state that we do not see any necessary connection between euthanasia and abortion, for reasons spelt out in Part IV.

204. Another aspect of euthanasia arises in relation to the handicapped child. Many would feel justified in avoiding extraordinary means to sustain or prolong life in a mentally handicapped child whilst others would seek to justify active intervention to ensure early death.

117. Submission 131, Right to Life Assoc. SA branch.

4. Undergraduate medical education

Human sexuality

1. Dr Carl Wood, Professor of Obstetrics and Gynaecology at Monash, in the course of our hearings at Melbourne in June 1975, told us:

> The medical student is a particular person. I do not say particularly important, but he is particularly different because he is a highly successful matriculant... he works very hard... he may not have the same experience of life as people doing other courses in the university... I think any interdisciplinary involvement is a good one.

He went on to say:

> If you make education in human sexuality too orientated to sexuality alone people criticise you because they say you are taking it out of context of all human behaviour. We believe sexuality is just one aspect of human behaviour. In the past psychologists and psychiatrists have dealt with human behaviour but they have left out sexuality.[1]

2. This evidence is a good starting point for our review of the education given to undergraduates in Australian medical schools; our concern is not with medical education in general, but how effectively the themes of sexuality and human relations are covered in the syllabus at present; we have tried to find out what the students themselves feel they need in this field, and what changes in the curriculum are already being made. It has been suggested to us that medical students graduate knowing less about sex than the average man and woman. Our concern is not just with sex but with whole relationships including the sexual relationship.

3. Similarly Dr Dudgeon, a gynaecologist from Hobart, asked us to consider:

> The doctor seems to be the person most commonly turned to by people in emotional and relationship difficulties, but, at the present stage of medical education, there is little or no training to equip graduates to either feel comfortable with such requests, or to be able to embark on any really helpful course of action...
> The two areas where work is most likely to bring long-term social benefit are:
> (a) in sexual and relational counselling of young married couples when the problems first arise, and
> (b) in adequately caring for, and following up, young girls who are forced to seek help because of unwanted pregnancies.
>
> I see the personnel required for this service being best provided by the training of medical students and later general practitioners, who would work in conjunction with social workers and other trained counsellors, perhaps in special clinics specially for the purpose, though I must express the view that this area of work is best served by the personal one-to-one approach.[2]

4. It is difficult to assess exactly what an ideal course should comprise for Australian medical students; a paper emanating from the World Health Organisation offers some guidelines:

> The syllabus should state clearly the aim of each course, its justification, and the abilities the student is expected to acquire by following it. The general aim may be defined as the acquisition of the knowledge, skills and attitudinal changes required to help individuals and social groups to manage their sexual and reproductive lives successfully.[3]

1. Evidence, pp. 538–58, Professor Carl Wood.
2. Submission 105, Dr Graeme Dudgeon.
3. WHO, *Chronicle* 29 (1975), pp. 49–54.

5. Evidence suggests that in the early days of study the student is primarily interested in the development of his own sexual adjustment. Increasing knowledge, diagnosis and treatment will follow in that order over the years of the course as a whole.

6. One form of organisation of the curriculum is for specific areas of sexual knowledge to be assigned to the larger departments of the school (e.g. gynaecology or psychiatry) leaving the student to integrate the material for himself. The other form is for the teaching of human sexuality to be co-ordinated in one unified course and either offered at a given time or else spaced as units over the entire training period. The teachers, representing all the relevant disciplines and working together as a team, would present material drawn from many sources coherently and intelligibly in the context of a broad philosophy of human sexuality.

7. Teaching should be conducted by men and women who have a thorough knowledge of educational methodology and who inspire confidence and are able to deal with all the types of questions raised by the subject. Evaluation should be based on the stated objectives of the course.

8. The use of audio-visual aids is of special importance, particularly when they are locally produced and reflect local interests and culture.

9. In 1971 the Medical University of South Carolina began offering a specific elective entitled human sexual behaviour taught by a male and female team. The course deliberately introduced anxiety-provoking subjects in ascending order of provocation. The following topics were covered in the course: masturbation, heterosexuality, pregnancy, birth control, abortion, homosexuality, perversion, censorship and pornography, how to take a sexual history and pre-marital counselling. Those responsible for the course believed the students experienced little anxiety or discomfort because:

(a) the course deliberately aimed to develop tolerance toward others' behaviour; the primary goal was not to change the students' personal attitudes and beliefs but to teach them to tolerate those of others;
(b) working in groups helped the learning process because an appreciation of the different attitudes of others assisted in the development of tolerance toward them;
(c) the control of anxiety was aided by the gradual introduction of anxiety-laden topics.[4]

10. One important method is discussion in small groups. Another American course consisted of medical students, some faculty and other community leaders, their spouses and fiancés. The sponsors reported:

> We first concentrate on the individual's right to know the range of human sexual behaviour. Audio-visual materials depict a wide variety of masturbation, homosexuality, heterosexuality, mixed sex, bestiality, and sadomasochistic behaviour and fantasy. Sensory saturation is intended and is usually reached. The program then changes and students are presented with critically accented movies indicating the beauty and care that can occur in a love relationship where there is a feeling of affection and responsibility. A variety of individual patterns of love making are depicted and the program ends with movies teaching therapeutic techniques of body massage for increasing sensuality. Throughout the 2

4. D. B. Marcotte, 'Sex education and the medical student', *Journal of Medical Education* 48 (1973), pp. 285–6.

days the leaders of the large group discussion sessions introduce the films to be shown and provide historical and epidemiological data on sexual behaviour in the present American scene.[5]

11. With a similar purpose, an experimental course was conducted at La Trobe University in Victoria in 1973; it established two hypotheses:

(i) participation in the course increases a student's knowledge of human sexual behaviour and sexual counselling;

(ii) participation in the course reduces a student's difficulty in discussing sexual behaviour and problems.

A questionnaire was designed to be self-administered by the students immediately before and after the experiment; the course 'appears to have been generally successful in achieving its original aims'.[6] The twenty-five items of the questionnaire were divided into sections, six of them describing situations involving encounters with persons of both sexes, with varying degrees of clinical involvement, bluntness of expression and seriousness of sexual difficulty. The students were asked to estimate their degree of emotional discomfort, anxiety or embarrassment in such a situation. Fifteen items presented these six situations, in all possible pair combinations, with the students' task being to choose which one of the pair of situations would be more emotionally uncomfortable. In the four final items responses to a clinical situation were requested.

12. The use in the USA of a Sex Knowledge and Attitude Test (SKAT), the Adjective Checklist and Attitude Rating Scale provides a standardised basis on which to assess sexual knowledge. A survey of sex education in United States medical schools, in 1973, found that 62 per cent of the schools had a specific sex education course; 30 per cent taught human sexuality as part of a general course; 8 per cent taught sex education both as a specific course and as part of a general course. Medical schools in Australia, especially those more recently established, are experimenting with courses in sexuality. Evaluation, which is so important, is in its early stages and there is still debate on its value.

13. Matters investigated include the departments involved in teaching sexuality, number of teachers in the programs, whether offered as core or elective curriculum, hours assigned, teaching methods and aids used, content of courses, needs of medical students, problems of establishment and maintenance of courses and evaluation methods.

14. The Standing Committee on Medical Education of the Australasian Medical Students Association conducted its own curriculum survey, in April 1976, using the WHO survey format and comparison. All Australian medical schools were approached and all responded although questionnaires were not treated in quite the same way.

15. It was found with regard to the sexuality courses that all but two formed part of more general courses and were not specifically concerned with sexuality. Persons primarily responsible for the courses varied from full professors in two universities to 'others' in three universities. The departments or disciplines represented by the instructors were predominantly drawn from the departments of obstetrics and gynaecology and psychiatry with family medicine, psychology and sociology as the next

5. P. Rosenberg and R. Chilgren, 'Sex education discussion groups in a medical setting', *International Journal Group Psychotherapy* 23, 1 (1973), pp. 23–41.

6. R. B. Montgomery and G. Singer, 'An experimental brief course in sexual behaviour and counselling', *Medical Journal of Australia* 2 (1975), p. 529.

most common. The years in which the course was taught differed at every medical school. Sexuality was covered in every year at one school, in 1 year only at two others. The remainder varied from 2 to 4 years not necessarily consecutively, or early in the course. Comprehensiveness of coverage also varied but, in every school, the subject was part of the core curriculum ensuring full student-body participation in the subject.

16. Six of the eight respondents to the question on academic credit indicated that credit was given for satisfactory achievement in the subject. From 10 to 70 hours were devoted to the subject. Six schools indicated they examined students in this area.

17. Course preparations were carried out predominantly through discussion in both faculty committees and student–faculty groups, while in two schools the course instructor did his own preparations. The more popular teaching techniques were seminars and small group discussions, as well as lectures. Case demonstrations, supervised treatment of patients and community field experiences were used in some schools. Films were the most widely used teaching aid, followed by audio-tapes and reading. Some used guest lecturers. Most audio-visual aids used were reported to be both topical and erotic.

18. Most schools considered that every aspect of the subject should be included in the course. The acquisition of knowledge and modification of attitudes were the greatest need in the experience of the respondents.

19. In most schools, it was claimed that faculty members had initiated the courses, while in two schools both faculty and students were involved. Two schools indicated that the dean's office had initiated such courses in response to the students' requests. The departments which had been most significant in the planning of such courses were obstetrics and gynaecology, primary care and community medicine.

20. A direct comparison of the Australian courses in medical schools for sex education with the American courses is not possible due to the much larger number of courses and schools which can be assessed in America. However, the Australian schools have clearly lagged behind their American counterparts, both in time and in the priority given to the courses.

21. The Australasian Medical Students Association (AMSA) has been in the forefront of activity to obtain inclusion of courses on sexuality in the medical school curricula. A survey of 631 medical students from first to fifth year at Monash, in 1971, showed their knowledge of sexual facts as well as ability in sexual counselling to be inadequate. One-third of the students admitted that they '. . . didn't know what normal sexual behaviour is, much less how to recognise and deal with the abnormal'.[7]

22. To assess current undergraduate education in human sexuality, the Medical Education Committee of AMSA conducted a survey of all fourth, fifth and sixth year medical students at the eight medical schools then existing in Australia. A response rate of 41 per cent was obtained from 3171 students in the sample. Results indicated that:

(a) 78 per cent of the students who responded considered that human sexuality deserved a specific course of instruction, 14 per cent did not, and 8 per cent were uncertain;

(b) of those who wanted a specific course of instruction, 22 per cent wanted it dealt with in a 'block' course, 47 per cent in an extended course, 23 per cent in both forms, and 8 per cent were uncertain;

7. O'Shea et al., 'The teaching of human sexuality in the undergraduate medical curriculum', *Medical Journal of Australia,* May 1974.

(c) in an analysis of the responses of the sixth year students of all schools, table III.15 gives their majority opinions in regard to the importance of each topic, and the adequacy of cover by each school;

(d) the majority of medical students who responded considered that the subject of human sexuality was not covered adequately in their courses.

Table III.15 Survey of 6th year medical students from eight medical schools, 1973

	Importance			Inadequately covered							
Topic	essential	useful	not useful	Monash	WA	Adelaide	Melbourne	Tasmania	Sydney	NSW	Queensland
Physiology of human sexual behaviour	*						50/50			*50/50	50/50
Psychology of human sexual behaviour	*			*	*	*	*	*	*	*	*
Physiology of reproduction and contraception	*										
A discussion of mature sexuality and common sexual problems	*			*	*	*	*	*	*	*	*
Sexual behaviour in middle and later years and associated problems	*			*	*	*	*	*	*	*	*
Social group differences in sexual attitudes and behaviour		*		*	*	*	*	*	*	*	*
Concepts of normal and abnormal sexual behaviour	*			*	*	*50/50		*	*	*50/50	
Moral and ethical aspects of human sexuality: sexuality and religion		*		*	*	*	*	*	*	*	*
Legal aspects of human sexuality: deviancy, rape, abortion etc.		*		*	*	*	*	*	*	*	*
Family planning	*			50/50				*50/50		*	
Clinical aspects of abortion	*							*		*	
Social and psychological aspects of abortion	*			*	*50/50		*	*	*	*	*
VD	*						50/50	50/50			
Sex education by doctors	*			*	*	*	*	*	*	*	*
Management of sex problems by doctors	*			*	*	*	*	*	*	*	*
Counselling methods	*			*	*	*	*	*	*	*	*

23. John Vinen, a student of the University of NSW, gave evidence in Sydney as a representative of the AMSA and stated that the courses were too scientifically oriented in the first years of the course and neglected consideration of patients as people; little attention was given to counselling beyond an introduction. He told us of a survey done by the AMSA, in 1973, which showed that medical practitioners were definitely not being prepared adequately in the area of counselling in sexuality. Mr Vinen said he would like to:

> . . . introduce communication techniques, self-awareness, sensitivity training and different types of counselling, and using it in situations such as techniques of role playing, group dynamics, perhaps some type of drama.[8]

24. The Adelaide University medical undergraduates gave similar evidence in their submission:

> Student opinion is that the human sexuality course is seriously deficient both in terms of quality and quantity. The psychology and sociology of sexuality, counselling and management techniques are considered to be especially poorly covered: there is a place for a less sterile stereotyped teacher/learning approach, and small group structures could be more beneficial than the lecture-seminar format. We feel also there is a place for non-medical personnel participating in the course.[9]

25. As we stated at the beginning of this part we examined the courses offered at the various medical schools, the time allotted to them, and their effectiveness in the eyes of those taking part in them (see Annexe III.B).

26. Courses vary widely in comprehensiveness of content and in integration into medical curricula. The Family Planning Associations in the various States are involved in most cases.

27. Professor Ian Lewis, University of Tasmania, told us:

> Our own university medical school . . . has just started . . . a new curriculum. The students will complete their theoretical work at the end of 5 years and the sixth year will be entirely clinical . . . young students coming into the medical schools . . . are given the chance of discovering themselves early in the course, how they tick and how they function; in the first year, they explain themselves to themselves early in the course. In the first 2 years, they can get the science of health, growth and development structure before they then hit the abnormal side of life . . . in the clinical study . . . The knowledge of the sexuality part of the course will increase. We have done more in the time it has been going possibly than any other medical school in Australia.[10]

Fertility control

28. We have particularly looked at teaching given in medical schools on family planning and the termination of pregnancy.

29. In an analysis of the Australian general practice morbidity and prescribing survey conducted by the Royal Australian College of General Practitioners, Professors C. Wood and W. Walters of Monash University noted the frequency of all visits for various obstetric and gynaecological conditions. Their findings are shown in table III.16.

30. A comparison of the frequency of obstetric and gynaecological diagnoses with that of other common diagnoses (first visits) is shown in table III.17.

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8. Evidence, pp. 112-17, Mr John Vinen.
9. Submission 343, Adelaide University Medical Faculty, Undergraduate Members.
10. Evidence, pp. 2295-317, Professor Ian Lewis.

Table III.16 Frequency of visits for obstetric and gynaecological conditions

	Per cent	Number
Normal pregnancy and puerperium	32	4740
Contraception	26	3855
Vulvovaginitis	14	2112
Menstrual disorders	6	899
Papanicolaou smears	6	846
Complications of pregnancy	6	840
Menopause	4	539
Infertility	2	229
Salpingitis	1	191
Marital counselling	1	171
Cervical disease	1	120
Venereal disease	1	97
Prolapse	1	85

Table III.17 A comparison of the frequency of obstetric and gynaecological diagnoses with that of other common diagnoses (first visits)

Obstetric and gynaecological diagnoses		Other common diagnoses	
Condition	Number of visits	Condition	Number of visits
Vulvovaginitis	1143	Common cold	1757
Pregnancy diagnosis and normal care	1130	Anxiety	911
Contraception	930	Depression	596
Menstrual disorders	459	Hypertensive disease	554
Menopause	459	Appendicitis	107
Complications of pregnancy	383	Hernia (external)	104
Salpingitis	81	Ischaemic heart disease	86
Prolapse	30	Breast condition	79

Source: C. Wood & W. Walters, 'The relevance of a GP health survey to the teaching of obstetrics and gynaecology' *Medical Journal of Australia* 2 (1975), p. 551.

31. We were interested to see how visits to obstetricians and gynaecologists predominate in the survey information. The authors qualified the usefulness of the results in determining what should be taught in the medical school. Doctors, for example, may only diagnose conditions which they have been previously taught to recognise. Thus the diagnoses may reflect only previous learning experience, and the absence of a significant number of sexual difficulties or marital problems may indicate an area of diagnostic weakness amongst the practitioners. They wrote:

> Our own opinion is that, while medical bias may exist in determining the diagnoses, the data are still relevant, particularly in those areas in which diagnosis is commonly agreed upon, for example pregnancy and contraception.[11]

32. A further possible objection to these data is that the frequency of diseases does not necessarily determine their importance. A mistaken diagnosis of vaginal discharge may not be as serious as one of carcinoma of the cervix. However:

11. C. Wood and W. Walters, 'The relevance of a GP health survey to the teaching of obstetrics and gynaecology', *Medical Journal of Australia* 2 (1975).

> Many patients consider that doctors are much too concerned with life and death and that they should devote more time to helping people cope with physical and emotional problems that are not directly threatening their lives. After all, the patient is interested in the quality of life as well as its existence.[12]

33. Wood and Walters go on to note that the three most common conditions for which patients see the general practitioner are those where patients often complain about inadequate medical care; the frequency with which the general practitioner advises patients about contraception and vulvovaginitis (28 per cent and 14 per cent respectively) emphasises their importance in the teaching of medical students; although the survey found a low frequency of consultations about marital and sexual counselling, a recent study[13] suggests that 30–50 per cent of women have sexual or marital problems and most of them would welcome medical counselling.

> More likely explanations of the survey findings are that the patient may not complain directly of marital or sexual problems or that doctors may not recognise their existence. Furthermore, general practitioners may not have sufficient time to counsel about such matters. The roles of the general practitioner, psychologist and marriage guidance counsellor in these areas are still evolving.[14]

34. The undergraduate courses need to cover counselling in contraception as well as normal pregnancy; our survey confirmed that many GPs consider their family planning and counselling training inadequate at this level. While the curricula today are different, the question of their adequacy is subject to much the same reasoning as that relating to sexuality. Obstetric and gynaecology departments are significantly involved in most sexuality courses in Australian medical schools. Professor E. Symonds, then of the University of Adelaide, wrote:

> My contention is that, in fact, there has been a tendency to separate sex and reproduction as if they were two different subjects. The difficult and emotive areas of sexual counselling and sex education have fallen into a limbo somewhere between psychiatry, obstetrics and gynaecology, physiology and anatomy, whereas in fact they should be the subject of integrated teaching by all these groups within the medical school.[15]

35. Hence the need for courses concerned with fertility control. They should conform with the broader issue of sexuality and both come within a wider field of community health. Since many of this Commission's issues focus on a lack of adequate training in specific forms of contraceptive help and pregnancy termination, the content of courses at present dealing with these matters must be considered.

36. In a letter to the deans of all medical schools, early in 1975, the Director-General of Health wrote:

> It is generally considered that, in the past, there has been some degree of variation in the quantity and quality of family planning advice given to patients by their medical practitioners, although the latter have constituted the main source of such information. Part of the reason for variation of approach may well have been feelings of diffidence in an area uncomfortable for both doctor and patient, as well as differing backgrounds in the medical education of doctors.[16]

It was recognised that a special role is played by voluntary Family Planning Associations in providing a contraceptive service, but that this type of advice and practice

12. ibid.
13. Levis and Wood (1973), ibid.
14. ibid.
15. E. Symonds, 'Medical responsibilities in the teaching of human reproduction', *Medical Journal of Australia* 1 (1973), p. 39.
16. Correspondence, Department of Health, January 1975.

should be provided within the field of medicine as a part of total health care. The letter said:

> . . . the Government is interested in developing and expanding training programs for medical personnel at both the post-graduate and undergraduate levels.[17]

37. A new curriculum in obstetrics and gynaecology was introduced at the University of NSW in September 1972. This was based on stated objectives with the probable student outcomes and the learning strategies clearly expressed.

38. The course is a model of its kind. Current changes to the medical courses in terms of both sexuality and fertility control teaching, however, make it difficult yet to assess the present course structures and their conceptual framework.

39. Much of the training required for practical work in the field is given at the graduate and post-graduate stages. It is difficult to determine the extent of family planning training at the graduate level, and considering the institutional basis and the pressure of time, it is probable little experience is obtained in this area. Recognising the limited place for practical experience and development of skills in undergraduate training, concern must be expressed about the ability of the GP in family planning. Our survey showed that a large proportion of GPs have no post-graduate degree or diploma, and many do not take any kind of additional education course; hence their abilities in family planning are largely subject to learning on the job.

40. Family Planning Associations co-operate with the medical schools but, as the following reply to our inquiry shows, this too is all too limited:

> Our small program for fifth year Monash University medical students started following a lecture on 'Contraception' given by Professor J. Leeton. Each Thursday two students attend for an hour of instruction and discussion, mainly on diaphragms, condoms, spermicides and IUDs. Following this each student sits in with a doctor for a clinical session of 3 hours, where the contraceptive method most commonly presented is the pill. About fourteen students will have attended by mid June.[18]

41. The foregoing descriptions of family planning training imply almost complete concentration on contraception. In putting a case for conception as well as contraception within family planning, Dr Jules Black says:

> Family planning refers to the control of fertility. This in turn means that an individual woman or couple can decide to have or not have children . . . it is peculiar to think that, to date, family planning has mainly involved stopping the unwanted side effects of a pleasurable act between two people, namely pregnancy. The act itself has been ignored, but those days are over.[19]

42. In emphasising the need for conception control, the doctor all too readily assumes the patient already possesses knowledge about sexual anatomy and aspects of sexual intercourse. This is often not the case. Further, the methods of male and female sterilisation require consideration for family planning training. Hence the need for fully integrated courses in sexuality.

Community and social health

43. The Commission has an interest in community and social health since this is a field where human relations are closely involved.

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17. ibid.
18. Commission correspondence, file S216, FPA Vic, June 1976.
19. J. Black, 'Psychosexual counselling in family planning practice', *Australian Family Physician* 5 (1976), p. 463.

44. While one would expect the subjects of human sexuality, fertility control, pregnancy and childbirth, and to some extent womens health, to be included primarily in the departments of obstetrics and gynaecology, the wide range of subjects which need to be covered in a program of health and human relations could be expected to be the primary concern of most of the other departments in the medical school. We identify as community and social health issues topics like the following: womens health, preventive medicine, patterns of illness in the community, normal development and behaviour, social factors in health and disease, community medical and social services, occupational health needs of special groups, socialisation processes and the role of the doctor, as well as basic social science and research techniques for the evaluation of medical research.

45. The nature of the subjects of necessity involve the overlap of departments in the medical school. We consider the present fragmentary treatment of such courses in specific departments, without due care for their integration within the course as a whole, to be detrimental to those who must absorb their implications for later application in their own practices. In a working paper on community medicine for the new Faculty of Medicine of the University of Newcastle, Professor Maddison writes:

> It will be essential to ensure that the appointment of a Professor in Community Medicine is not seen as a justification for all other members of the faculty to turn their backs on community involvement, a tendency which may have to be continually resisted. Certainly all professors should see themselves as having some responsibility to the community, of a kind and to an extent appropriate for their discipline.[20]

46. The curricula of these new departments on the whole reflect that discipline's major concern for the subjects we have listed above. Community medicine has only begun to emerge as an academic discipline, and as a specialty within the practice of medicine. There are diverse and developing ideas about its aims, method and content. One approach is to see as its concern the identification and resolution of the total health needs of a defined population[21], rather than the management of separate episodes of illness in individuals. In this view both quality and continuity of care for each individual are the important factors, seen to include not only technical skills of a high order, but humanity and compassion. Hence there is a need for a substantial component of health care research, including the study of health manpower needs, as well as an active involvement in prevention:

> While it is clear that some of the best GPs and GP organisations accept this as a significant component of the GPs task, the organisation of medical care in this country, and in particular the existence of a health insurance scheme centred on fee for service, means that private care in the community will tend inevitably to be slanted towards the treatment of episodes of illness, rather than the maintenance of health.[22]

47. The recent introduction of community medicine departments has recognised in principle the need for students to be involved in community health at an early stage. At NSW University, for example, the school has four components: formal lectures, tutorials, preceptorships and visits. Lectures by a panel cover communities at risk; health services, medical law and ethics; general practice, family medicine and primary care; and epidemiology and preventive medicine. Panel members are drawn from people working in fields being discussed, e.g. the very poor, the aged, migrant health, the road toll and Aboriginal health.

48. Epidemiology and preventive medicine are taught in tutorial form, while experience of general practice is obtained by students being attached to doctors in the

20. D. Maddison, Working paper 4, University of Newcastle, p. 7.
21. ibid, p. 2.
22. ibid, p. 4.

metropolitan area. Each student spends six sessions with his preceptor in the surgery, on home visits or on other professional activities. Thus students experience other aspects of medicine than those of a general hospital including the patient's first approach to the doctor, the preventive measures taken, family medicine and continuing patient care.

49. Health resources visits are arranged with many community agencies. Groups consisting of ten people are involved in services provided for families, handicapped children, geriatric patients, alcohol- and drug-dependent persons, migrants and other groups receiving community aid services. In addition, students may undertake with supervision 'experiments in living', learning of unfamiliar situations such as a weekend as a prison inmate. The reports by these groups have been published and reveal the 'breadth of the students' explorations and the depth of their discoveries'.

50. Thus the group which studied 'women and health' reported their impressions with a group of young single males and females on the subject of sexuality and the associated change in sex roles. The problems of housebound mothers, women and drugs and the issue of segregated health care for women and men were discussed. Concern arose about the difficulty of communication between general practitioners and their patients; also isolation of doctors from patients; moral views affecting the doctor's dispensation of treatment; the fact that general practitioners often fail to make the patient feel comfortable, or appear unwilling to discuss problems and treatment procedures adequately with a patient, or finally make an insufficient and inaccurate diagnosis without considering the social consequences.

> It is hoped that courses such as introductory clinical studies and human behaviour (University of NSW medical course) will help doctors of the future overcome some of the above communication problems.[23]

51. The students gained some insight into the work of the Leichhardt Womens Community Health Centre; they interviewed a number of people there, respected the work done but were worried by negative responses in their survey. On returning 'to find out the causes for such dissatisfaction', the students were told that they were a 'lost cause' and would most certainly fall into the trap of becoming typical unethical general practitioners.

> This resulted in the group rejecting the attitudes of these women when perhaps something worthwhile was hidden in the tirade of bitter accusations. This issue remains unresolved for both parties.[24]

52. Other groups looked into such subjects as divorce and separation, doctor–patient relationships, reaction of women to pregnancy, attitudes to rape, abortion and venereal disease. In his notes for an orientation lecture on 'Towards community medicine', Professor Ian Webster said:

> In making a clinical decision the doctor weighs up the gains and losses for his patient of particular courses of action. In managing the patient's problems more information is presented to the doctor than ever before; the accessible data base has expanded with a bewildering mass of inconsequential and important measurements and observations. In the one patient there are many problems with different priorities and little of this fits into conventional diagnostic categories. The fact that the patient is old, lives alone and has impaired vision may be more important than the diagnosis of ischaemic heart disease and cardiac failure.[25]

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23. *The students group projects, introductory clinical studies* (Faculty of Medicine, Uni. of NSW, 1976).
24. ibid., p. 4.
25. I. Webster, Towards community medicine: notes in orientation (Uni. of NSW).

53. In 1971–72, fourteen medical students spent between 2 and 5 weeks attached to the Arid Zone Project, an Aboriginal community health research project at Bourke, NSW.

> All the students spent some time observing the work of the community health, infant welfare and bush nursing sisters. They went on trips with the health inspector and members of the St John Ambulance Service. Each student visited the experimental pre-school kindergarten, and also participated in at least one function of a service organisation in the town. Some students also had the opportunity to descend into a copper mine and to work with the first aid officers employed by the mining company. The students assisted the general practitioners in the hospital and some also sat in on their private surgery consultations. Those students who requested it undertook the day-to-day management of Aboriginal patients in the hospital under the supervision of the writer. They all accompanied the writer on field trips and attended clinics run by him on the Aboriginal reserve. All the students were asked to observe the inner organisation of the hospital by spending time with the chief executive officer, the matron and the pathology technician. Apart from being asked to write a life history of a selected Aboriginal person, the remainder of the student's time was left as free as possible.[26]

54. Nearly all students found it difficult to relate to the Aboriginal people, but, by the end of the elective term, they had at least the beginning of an understanding of how a group's culture and norms can affect its way of life. One student saw two Aboriginal children who had just returned from medical care in Sydney, and expressed 'almost total incredulity' that their state of health was so bad one week after specialist medical attention.

> This one experience showed him that the large hospital has but a small part to play in alleviating the poor state of health of most Aboriginal people.[27]

55. The evaluator of the course commented with satisfaction on the whole range of reports.

> All students expressed an awareness of the lack of perspective about medical practice which their traditional hospital-based medical training had given them. They knew they had been fed a rarefied diet and felt a craving for the bread and butter of medicine.[28]

Other medical schools are also conducting valuable experiments in community health teaching, especially Monash and Tasmania. We believe these innovations are worthwhile.

56. The orientation of the new schools of community medicine towards GP preceptorship schemes and placements of students in community health centres under the guidance of medical officers and experienced GPs are valuable. The GPs benefit from contact with medical students. Many GPs are the subject of such early training and enjoy gaining a broader perspective themselves.

57. Our investigations reveal:

(a) The Royal Australian College of General Practitioners runs an annual seminar lasting 3 days for fifty students from both Melbourne and Monash Universities, usually at the end of fourth or fifth year. Some students from St Vincents Hospital, Melbourne, and from Monash University have informal associations with general practitioners and visit them at intervals. The Royal Melbourne Hospital has a counselling scheme arranged by the College in fourth year. Some students take the opportunity to arrange clinical attachments with general practitioners through the College.

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26. M. Kamien, 'Education in community medicine with the emphasis on the health of an Aboriginal community: a pilot project', *Medical Journal of Australia* 2 (1975), pp. 509–13.
27. ibid., p. 512.
28. ibid., p. 512.

(b) The College runs live-in seminars at Busselton, WA, of 3 days' duration, three or four times a year. Fifth and sixth year students attend voluntarily. Facilities are available for students to arrange extra contacts with general practitioners.

(c) At Adelaide University, the new general practice course is being modified each year as a result of suggestions made by students.

(d) At Melbourne University, under the new course, the formal time spent with general practitioners will be eliminated, and there will be a period of 16 weeks in which students may undertake any option they wish. A hope is expressed that some may undertake a study of general practice. Students commented that few are likely to do so; other (paid) work is more attractive.

(e) The new course at Sydney University will expose students to community medicine and to psychiatry, each for half of the time in an 8-week course in the new fourth or fifth year. Students commented that the present course is bad, and will persist until the present second year students graduate in 5 more years. At the University of New South Wales, in the fourth year of the new course 'for some of the time [students] may be based in community health centres or general practices'.

(f) In Western Australia students commented that they generally enjoyed the attachment period, considering it both worthwhile and adequate. It should be noted that in Western Australia those students who wish may be employed in hospitals as junior resident medical officers.[29]

58. While community medicine departments seem to redress the imbalance which has existed for so long against general practice, there is obviously much more to community health than learning to be traditional GPs. The new Newcastle medical course proposes to include clinical epidemiology, community child care with particular reference to the disadvantaged child, community facilities for the mentally ill, problems in the environment, occupational and industrial health, rehabilitation units, community care for geriatric patients, health education and the gathering of statistics in community health.

59. Departments of community medicine are still new and experimenting with curricula. Our inquiry did not specifically call for a detailed analysis; we presumed all would cover sexuality, fertility control and womens health. Yet the more one seeks to place the issues of sexuality into a suitable context (one which will enable a proper perspective of society and its relationships) the more the philosophies of community medicine seemed to fill that gap.

Conclusion

60. Medical school handbooks present the intending student with a bewildering array of departments, courses and electives, many of which do not seem to tie together. There are serious gaps in areas of social concern (e.g. child abuse, womens health or rape) and in giving the student experience of the normal and healthy side of our society. Courses provided by departments of community medicine, obstetrics and gynaecology and behavioural science need to be integrated. The principal gains from current modifications to curricula will depend upon the teaching methods used, and the emphasis which examination questions give. The ways in which all this is integrated into student assessments and course work will be measures of the adequacy of medical schools in the field of human relationships. The different approaches being

29. J. A. Dickinson, 'Undergraduate GP teaching in Australian medical schools: the student viewpoint', *Medical Journal of Australia* 2 (1975), p. 519.

taken by some schools of community medicine are not everywhere understood and accepted by members of some of the more traditional schools. We are conscious that these often will exercise more control and power in university politics.

61. Valuable changes are taking place in medical schools, and there is growing awareness that the medical profession is concerned with people both as individuals and as part of various community groups. There is increasing acknowledgment that behind many apparent physical disorders and psychological stresses lie problems of human relationships.

62. Schools of community health are growing and these departments are relating students to practice and issues outside the universities. This interchange of experience between academic training and the work of the doctor and paramedicals in the field is a significant advance. It has been suggested to us that medical students, like architects or engineers, might do a year of apprenticeship in the field and then return to the final clinical year. The gain in knowledge of people as people would be immense. Professor Malcolm Whyte, of the Australian National University, spoke of a possible undergraduate course in which students would progress by dealing with patients' problems and chasing solutions; it would start with the health needs of the patient and move into the expansion of services. Students would fulfil needs as part of the course. The paramedical professions would also be brought into the training scheme. The main issues of the course would be self-directed training, orientation toward needs, and the production of aware, sensitive and skilled people who encouraged the resourcefulness of their patients and of the community at large.

5. Post-graduate and continuing medical education

Introduction

1. Professor E. G. Saint of the University of Queensland has said:

> First class training can be given only in institutions maintained and supported at the highest level of morale and intellectual stature . . . Government, acting in this regard as custodian of the public interest, must ensure that training for general practice, internal medicine, and so on, is of an acceptable quality: this involves government ineluctably in an educational and financial commitment that extends beyond the undergraduate years.[1]

As we have seen, undergraduate medical training produces but an embryo doctor: it is his time in a hospital and his later experience and studies that turn him into a true professional. The education of doctors is never finished until they retire.

2. The Royal Australian College of General Practitioners proposes training courses for those GPs who feel lacking in knowledge of human relationships.[2] Such training would need to include counselling on human relationships; education about human relationships and sexuality; updating existing knowledge, e.g. about contraception, contraceptive techniques, abortion and counselling techniques used in dealing with difficulties of relationships and matters other than sexual ones.

3. The need for continuing education is obvious in the medical as in other professions. We propose to examine programs provided by the Royal Colleges, then certain interdisciplinary experiments, and finally short courses in local areas often under the auspices of the Royal Australian College of General Practitioners.

4. In 1974, the Hospitals and Health Services Commission recommended:

> That a formally organised and adequately funded system of continuing education for medical practitioners be established to ensure high standards of medical care. It should aim to ensure the availability and utilisation of appropriate services and be linked with the health service delivery system.
>
> That the system of continuing education for medical practitioners be organised and funded through the joint efforts of the profession and the Australian Government.
>
> That area committees of continuing education coinciding where possible with health service regions be established, each with a medical director who should develop links with a clinical medical school; the committees to be responsible for identifying local needs and co-ordinating the systematic delivery of continuing education at local level.
>
> That the Australian Government establish an Australian committee on continuing medical education to be responsible to the Minister through the Hospitals and Health Services Commission for planning and allocating finance for a formal system of continuing medical education.[3]

5. Post-graduate education has tended to be fragmentary and sporadic. Schemes have often lacked structure, clear objectives, sound methodology or sufficient discussion with members of other disciplines.

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1. E. G. Saint, 'Politics, universities and teaching hospitals', *Medical Journal of Australia* 1 (1970), pp. 1027–8.
2. Submission 886, RACGP.
3. *Continuing medical education,* report of the Hospitals and Health Services Commission (1974).

Post-graduate medical education

6. A report to the Minister for Health from the Hospitals and Health Services Commission in August 1974, entitled *Continuing medical education*, criticised continuing education as inadequate for five main reasons:

(i) Utilisation is low. This was reflected in our recent survey of GPs (see chapter 3) and is not surprising when we take into account such factors as the lack of encouragement in present conditions of practice, the personal costs involved and the geographic isolation of many in Australia.

(ii) The design and provision of programs are unstructured, lacking objectives.

(iii) The budgets and resources of the post-graduate committees and medical colleges are insufficient to provide continuing education programs adequately, even for their members.

(iv) Specialisation and the interdependence of health professionals are not catered for.

(v) Technical problems, e.g. education methodology, receive inadequate attention.

7. That report set, as the overall objective for a continuing education progam, the development and maintenance of a high level of professional competence amongst medical practitioners. This was regarded as essential to ensure the highest possible standard of health care for all Australians.[4] The first report of the Hospitals and Health Services Commission, *A community health program for Australia*, had called for:

> . . . major attention to education and continuing education of doctors, nurses, social workers and allied personnel. Indeed, the successful implementation of a major community health program could be jeopardised without the development of appropriate education. Such training should be neither considered nor conducted in isolation from the delivery of services, and integrated interdisciplinary (or shared) courses should be encouraged. Shared education is of value in the promotion of team work.[5]

The Colleges and post-graduate education

8. In Australia, post-graduate education has been the responsibility of the post-graduate committees in each medical school, financed partly by the profession, partly by university and government grants, and by the various Royal Colleges. These are the Royal Australian College of Physicians, the Royal College of Surgeons, the Royal College of Obstetricians and Gynaecologists (Australian Council), the Royal Australian College of General Practitioners and the Australian and New Zealand College of Psychiatrists. They offer both continuing and vocational forms of post-graduate education. In some cases this can lead to a fellowship, membership or to a diploma. The membership of the Royal College of Obstetricians and Gynaecologists, for instance, requires a minimum period of post-registration training of 3 years, 2 of which must be devoted to clinical obstetrics and gynaecology; the third offers a variety of choices. Specialist status does not automatically follow upon the passing of membership examinations. Often a further period of advanced training is required, but a doctor cannot claim specialist status without fulfilling an approved form of training.

9. The Royal Australian College of Physicians recently received a grant from the Kellogg Foundation of almost half a million dollars to assist in the establishment of a centre for continuing medical education for physicians in Australia, New Zealand and

4. ibid., p. 10.
5. ibid., p. 10.

South-East Asia. The Royal Australian College of Physicians has determined a policy for continuing medical education to ensure that the practising physician will have available through the College a system of organised medical education which is in accordance with the assessed needs of doctors and the community they serve.

10. The challenge to the College is a real one, because physicians in Australia and New Zealand have a significantly different role from that of their colleagues in South-East Asia. The principle cited by Kelloggs that 'good health is a prerequisite to human well-being' will be before the College and its members at all times, but its application will vary according to the needs of the local community.

11. It is the immediate intention of the College to appoint a Director of Continuing Medical Education who will have an academic status equivalent to that of a Professor of Medicine. The Centre for Continuing Medical Education will be equipped with audio-visual aids and provision will be made for educational units of the College in the individual States of Australia, in New Zealand and in a selected centre in South-East Asia. Modern methods of education will be incorporated in the ongoing training of specialist physicians.

12. The Royal Australian College of General Practitioners has laid down requirements for admission to membership which follow a similar pattern to those of the other Colleges. This College expects trainees in their senior residency period to cover appointments in medicine, paediatrics, psychological medicine and geriatrics as well as a period spent in general practice. The advanced training phase will extend over a further 2 years and will normally be spent as an associate or registrar in an accredited practice, at the end of which there will be an examination for membership of the College. Membership of the Royal Australian College of General Practitioners remains voluntary; unlike the other specialist colleges in medicine, GPs are not required to become RACGP members in order to practise.

13. There is increasing recognition that the training of which Professor Saint spoke must be given in institutions of the highest intellectual standards, but also that such education will only be of an acceptable quality if it is taken up wholeheartedly and responsibly by both university medical schools and the Royal Colleges.

14. The Royal Australian College of General Practitioners has also instituted a Family Medicine Program which may lead to a fellowship of the College. The FMP is funded under the Community Health Program. Examinations are not an essential part of it, but opportunities are offered to those who complete their FMP training to sit for the examinations of the Royal Australian College of General Practitioners and secure a fellowship.

15. The policy of the FMP course is to educate the trainee in such a way that he is able:

(a) To demonstrate an understanding of family dynamics.
(b) To adjust his approach to history taking and diagnosis according to the age, sex and social background of each patient.
(c) To understand the way in which interpersonal relationships within the family can cause illness or alter its presentation, course and management.
(d) To be aware of the effect of the doctor on the patient and the patient on the doctor.
(e) To demonstrate an understanding of the impact of physical, social, ethnic, educational, environmental, occupational and economic factors on the patient, his illness and the family and how they may be dealt with.

(f) To define problems and make diagnoses about patients which are expressed simultaneously in physical, psychological and social terms.

(g) To understand the management of personal, family and social disorders and to be able to employ personal skills and the resources of the community.

(h) To acquire that discernment which allows the most effective use of time and enables the doctor to make his decisions with confidence.

16. It is of particular interest to us that this course gives special emphasis to the psychological and social aspects of clinical medicine, the College expecting that trainees will be already conversant with the physical aspects of medicine.

17. The Family Medicine Program's focus is upon the new and recent graduate; it begins after the doctor has completed 1 or 2 years as an intern in a hospital and lasts for 4 years. On 30 September 1976 there were 1223 trainees, of whom 418 (34 per cent) were women.

18. The FMP has been thoroughly organised. A system of local area committees (at present there are seventy-five) was recommended to make contact with as many practitioners as possible all over the country and carry on educational programs at the level warranted by the circumstances. The program tries to relate to activities of other health organisations, and has appointed a national co-ordinator of family planning education as well as a co-ordinator in human relationships. In the RACGP submission to us, the policy was stated:

> The College proposes to try to establish suitable training courses for those members who feel lacking in knowledge of human relationships, remembering that such courses have existed in medical schools for only a few years. Such training would need to include:
>
> (a) training in allocating consulting time for counselling on human relationships;
>
> (b) education about human relationships and sexuality, as distinct from sex education;
>
> (c) updating existing knowledge, e.g. about contraception, contraceptive techniques, abortion;
>
> (d) counselling techniques used in dealing with difficulties of relationships and matters other than sexual ones.[6]

19. We shall return to the other aspects of the Family Medicine Program when we look at local short courses, with which it is also concerned. The evidence of Dr Stephania Siedlecky, of the Department of Health, describes still other aspects in detail.[7]

Interdisciplinary post-graduate education

20. We have noted earlier in this part of our report the importance of co-operation between the medical practitioner and the various paramedical and health professionals. This co-operation is just as important in post-graduate education, especially when the course of study is concerned with sexuality and human relationships.

21. Of special note is the work of the Social Biology Resources Centre at Melbourne University. Mrs Delys Sargeant has virtually pioneered interprofessional seminars on human sexuality, beginning in 1970. The seminars cater for some 180 people a year including doctors, nurses, social workers, teachers, publishers, journalists and policemen. They last 2 hours a week for 8 weeks. New and changing learning techniques and resources are employed. Students of the course are self-selected, work at

6. Submissions 886, RACGP.
7. Evidence, pp. 1112–26, Dr Stephania Siedlecky.

their own pace and use video-tape for self-evaluation of their work in groups. The aim is to break down insularity between professions and help people come to terms with their attitudes to a given body of knowledge: in this case, sexuality.

22. Although Mrs Sargeant considers these seminars are very successful in what they set out to achieve, she is currently evaluating their professional value by conducting personal interviews 2 years after the respective courses. The Centre overlaps many disciplines at undergraduate and post-graduate levels, with sexuality as a basic topic and improved human relationships as the objective.

23. In her evidence Mrs Sargeant told us of her Centre:

> At the present time it is the only organisation which is formally providing continuing education in interdisciplinary education about sexuality. We try to maintain a proportional representation of professions in our 5-month courses limited to forty people in each. In the current two courses of that number we have a majority, as a professional group, of secondary school teachers. We have one in each course from primary education; a principal of a Catholic primary school in the country and a primary teacher from the special services division concerned with teaching deaf and other handicapped children . . . [there are also] social workers, nurses, medical practitioners from a variety of specialist areas, teachers of police cadets, and legal officers.

Later she added:

> Specific aspects of sexual dysfunction and professional practice relating to human sexuality should be included in continuing educational post-graduate studies for the medical person. A person who is responsible within the medical undergraduate course should have an opportunity to undertake specialist tertiary level educational experience.[8]

24. Following a meeting, in December 1974, between many relevant post-graduate medical, health and welfare authorities the need for family planning education at all levels was discussed. Subsequently in each State a Co-ordinating Committee for Family Planning Education was established to plan a program for that State. Each organisation was represented at the State level and the activities have been organised through the post-graduate committees, the Family Medicine Program and the Family Planning Associations.

Short courses in post-graduate education

25. Our survey of general practitioners revealed that more than one-third of GPs had never undertaken a course related to their professional work which did not lead to some formal qualification. A significant proportion of GPs had not attended a conference or seminar other than for a degree. Table III.18 indicates the courses attended in both country and city areas.

26. Of the GPs we surveyed, 23.1 per cent females and 37.2 per cent males in the metropolitan areas, 30.5 per cent females and 40.5 per cent males in the country areas had undertaken post-graduate medical or non-medical degrees or diplomas. Of the total sample the proportions of men and women who had formal post-graduate qualifications in a course concerned with sexuality were 9.2 per cent and 3.6 per cent respectively. These courses were Obstetrics and Gynaecology Diplomas, or other obstetrics or gynaecology qualifications.

27. Short courses are therefore a necessity, especially when arranged in local areas. Motivating practitioners has up to now presented a major problem. An evaluation of continuing education in family planning after 8 years' operation in New York discovered that physicians declared they had been unable to attend because of lack of

8. Evidence, pp. 2756–68, Mrs Delys Sargeant.

Table III.18 Courses not leading to formal qualification undertaken by GPs (percentages)

Course	Metropolitan			Country		
	F	M	Total	F	M	Total
Family Medicine Program	18.6	4.0	6.5	13.6	5.4	6.1
Medical refresher courses (in obstet. & gynaec. and/or paediat.)	8.4	6.8	6.8	10.2	13.0	12.9
Medical refresher courses (in psych./hypnoth.)	4.7	3.6	3.9	1.7	1.7	1.5
Medical refresher courses (other or non-specific)	16.7	25.1	24.2	17.0	35.3	32.2
Family Planning Assoc. Cert.	22.2	4.2	7.4	10.2	2.2	2.8
Conferences/Seminars	1.9	11.2	9.0	6.8	9.2	9.8
Clinical meetings/post-graduate lectures	2.8	7.9	6.8	3.4	8.3	8.1
RACGP courses	16.7	15.0	15.4	13.6	12.0	11.9
Fringe refresher courses/others	4.6	5.6	5.3	5.1	5.4	5.5

time, their inability to leave their practices for a course of any length, and concern about acquiring credit or loss of finance. In a similar survey by the Californian Medical Association, there seemed to be agreement that courses lasting only 2 or 3 days would be most convenient. Here again it was found that many practitioners were preoccupied by their own local problems. They were disinterested in social and psychological aspects of family planning; others declared, especially if they were in a sole practice, that absence on courses meant loss of income, and hence they requested financial compensation. The American Medical Association has found it wise to give credits or awards to motivate practitioners, but believes the custom in some European countries of enforcing post-graduate education by government mandate is undesirable.[9]

28. The experience in Australia would be similar but awards and credits do not seem to be much of a motivation to encourage doctors to attend short courses. Distance and the cost of travel and accommodation are also important factors in this country.

29. In Australia, continuing education in the medical field is certainly uncoordinated, sporadic and lacking in clear objectives. It would appear that, when an interesting speaker visits an area, he may be asked to give a talk in his specialty. It may depend upon who knows him, and the primary interest of medical specialists or practitioners who are already aware of his specialty. Certainly in relatively novel or unpopular fields, such as sexuality and psychosocial topics, the impetus is lacking to initiate courses within the present network of medical contacts. This is quite apart from the organisation of courses for those who would not normally attend intermittent educational sessions through their work commitments or lack of contact with educationally oriented doctors.

30. It is significant that the Family Medicine Program has concerned itself with the organisation of short courses as well as the longer and more specialised programs to which we have already referred. It is now possible for the bulk to be paid whilst taking the course; the trainee is given some say in planning his or her own course and encouraged to develop some specialist interest.

9. L. S. Wan et al., 'Continuing education in family planning for practising physicians', *American Journal of Public Health* 64, 1 (1974), p. 35.

31. The FMP can have special value for outback areas. An interesting submission contained a letter from Dr Keith Shaw of Kingaroy outlining proposals put up by him to the Minister for Health in Queensland and the Queensland branch of the Royal Australian College of General Practitioners.

Reasons

(a) If we can support the practitioners at present in remote areas, they may well stay. Surely this is a desirable accompaniment to the family medicine plan, to encourage and train more doctors in general practice–some of whom we hope will choose to serve in remote areas.

(b) If, in this process, we can produce an interchange of ideas and a mutual understanding of problems we will make all personnel involved more complete doctors, and bring more people in contact with the west and its problems and rewards.

Ways

(a) Back the Family Medicine Program's efforts in this field by providing relief while remote doctors attend:
  (i) weekend courses in western centres;
  (ii) week-long courses in the city;
  (iii) longer periods of combined education for the doctor and relaxation for his family.

(b) By doing all we can to encourage other members and members of other Colleges to join *teams* to provide such relief, contact, encouragement and education.

(c) By encouraging regular visits by the *same teams* to the same area and thus perhaps involving consultants in working sessions at chosen centres, thus making the provision of more equipment practicable. This could introduce a concept of bringing the facilities out to the country instead of *always* the patient to the city, and incidentally provide great moral backing for the remote doctor.

Results

Hopefully a closer liaison with the nursing profession and the production of a course for those members so inclined to learn skills which would suit them to be an important support (and to some extent substitution) for the currently sparse, overworked medical population.

It is interesting to record that during the work and discussion involved in some feasibility surveying, we have already had *offers* from active practitioners to involve themselves in all the levels of the relieving work mentioned above.[10]

32. Of special interest is the reorientation program for practitioners who have been out of practice for some time. These have been attended by eighty-eight practitioners, seventy-nine being women. FMP is currently giving consideration to a 'retrainer' training system as distinct from the 'retraining' program. This they see as a more positive and constructive way to maintain practitioners as well as to facilitate continued interest in the practice of choice. As it now exists, however, there are two choices for those who wish to undertake the retraining program: a 2-week intensive course or a 6-month extended course.

33. The objective of FMP is to emphasise the psychological and social aspects of clinical practice, with a special interest in human relationships training, revealed by the employment of a director of human relationship studies, Dr Gillian Diamond. In co-operation with State offices and the area co-ordinators, Dr Diamond conducts discussions, workshops and seminars which are part of the vocational training course syllabus, on issues such as communication, sociology, developmental patterns, preventive medicine, marriage and obstetrics: indeed topics cover the whole life cycle from birth to old age. A library of resource material is available including films,

10. Submission 401, Dr Mary Rose Cooney.

audio-cassettes and video-cassettes. No less than twenty-five items deal specifically with sexuality in its broader sense, and many more with interpersonal relationships, doctor–patient relationship, interviewing and counselling.

34. Dr Mary Cooney gave evidence to us in Brisbane about the Queensland experience of putting the retraining scheme for general practice into effect, under the aegis of the Family Medicine Program.[11] Although the courses are open to both male and female graduates, the majority of the participants are women who have had to drop out of medicine through family commitments. A typical course runs for about 14 weeks on 2 days a week during school hours. At the end of the course the participants ideally spend fifty sessions working in a training practice, where supervision and help is readily available and for which the practice receives a subsidy. They are also encouraged to attend an ongoing course which consists of a lecture and discussion every fortnight.

> It cannot be stressed too strongly that in any retraining scheme for women, a woman must be part of the administrative framework of such a scheme; too often the very factors that have prevented a woman working in the past [e.g. child care, increased tax, household chores] are overlooked by those setting up retraining facilities . . . there are some positions in all Australian States available to medical graduates as permanent part-time employees, e.g. consultant staff at public hospitals, but these are very limited and usually restricted to those with a post-graduate qualification. There are many positions within both the Australian and the State governments which could be filled by permanent employees on a part-time basis and which could provide a proper career structure for the employee concerned. Such a position would be ideally suited to a married professional woman providing both job satisfaction and job security.[12]

We commend both these schemes.

11. ibid., Evidence, pp. 1531–4.
12. ibid., Submission 401.

6. Medical students

1. An article in the *Medical Journal of Australia* said:

> It may be that the whole system of admissions needs changing . . . Should we perhaps start from first principle, as has happened in China? The barefoot doctor is perhaps hardly a starting point, but the policy of recruiting to the medical course only after the applicants have shown by their performance in the community and in the health field that they are strongly motivated might be, even if a little disturbing to traditional ways here, finally rewarding.[1]

2. The question of the selection of medical students is a controversial one. Professor Blunt of the Department of Anatomy, University of Sydney, wrote:

> Present medical students in NSW are, in my experience, as thoughtful, courteous and pleasant as one might hope for. Many of them are highly idealistic. However, the degree to which they, as a group, possess the humanistic qualities which most people would consider important in the practice of most kinds of medicine is determined in a purely accidental way.
>
> Certainly there is no necessary correlation between intellectual aptitude and a capacity for caring and compassion. Nor is the converse true. There is, however, evidence that selection procedures based on school achievement are predictive of nothing more than the capacity to pass examinations which themselves have poor predictive value in relation to either post-graduate academic performance or the practice of medicine.
>
> There are also some disadvantages. The system favours the sort of thinking that is good at finding answers but not asking questions, consequently excluding from medical courses some potentially creative thinkers. It favours urban rather than rural applicants, which is important when the needs of country practice should be considered.[2]

3. Traditional methods of selecting medical students place a heavy burden on university faculties to instil certain attitudes and understanding in people who are already well disposed. The methods used imply that the role of the medical practitioner should remain one of providing technical expertise; however he needs to learn to relate more closely with other health care workers. This is, in fact, what is proposed in such policies as the Community Health Program and the Family Planning Association policy. Hence, it is suggested, selection should be modified to effect attitude changes and reflect a broader range of community life styles.

4. An examination of the role of doctors, and the structures and methods of medical schools, raises the following propositions.

(a) Medical education has tended to pay little or no attention to '. . . the self-learning process which ultimately must become a leading objective of any educational program'.[3]

(b) The basic science education provided in the traditional medical school destroys the motivation and the idealism of many students, while still leaving most of them with an inadequate preparation for their clinical education and for their practice as a clinician.[4]

(c) Integration and the provision of a great deal more 'topic teaching' must go ahead despite the pleas by traditional departments for 'unintegrated hours'.[5]

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1. R. R. Andrew, 'Admission policies to Australian medical schools', *Medical Journal of Australia* 1 (1974), pp. 781–5.
2. Letter, *Sydney Morning Herald,* 27 January 1977.
3. M. Prywes, 'A look at the future', *World Medical Journal* 20 (1973), p. 37.
4. D. Maddison, What's wrong with medical education? (A.W.T. Edwards Memorial Oration, Australian Society for Medical Research, December 1975), p. 5.
5. ibid., p. 9.

(d) The administrative structure of the traditional faculty makes for inflexibility; it is difficult to adapt policy and programs to a rapidly changing world.[6]

(e) Those sciences concerned with man, society and culture should form a significant part of the medical curriculum; each graduate should be provided with skills in interviewing and in communication generally.[7]

(f) Medical educators need to be more interested in the attitudes toward medicine which students bring with them to medical school, and in their development during undergraduate life.[8]

(g) The quality of medical care may depend on the social distance which seems to exist between the professional and the patient, persons of lower status receiving inferior care, those of higher status too much attention. Whether or not this is due to cultural or to status factors, it is the case that there is an imbalance between low status areas and high status areas.[9]

(h) Although the public prefer the doctor to be one who is their friend and adviser, the complexity of medical education and its cost means that practitioners are too highly trained, and in societal terms too expensive, to be used mainly for relationship therapy even if they could handle the cultural barrier.[10]

(i) Medical schools should enrol more mature students who have already been involved in community health service, and there should be a core course of knowledge which all students should do for 3 years; after this time, streaming or partial specialisation should occur for 2–3 years before final graduation.[11]

5. One of the most thorough examinations into selection procedures was made by Professor R. R. Andrew, Dean of Monash Medical School; he writes:

> Admission policies rank equally with curriculum and evaluation as controversial issues facing most medical schools . . . In general there is increasing discontent, intramural and extramural, with the dominance of the time-honoured system of admission using academic merit, not easily defined and increasingly challenged, as the sole arbiter for selection.[12]

The summary of admission policies to Australian medical schools in table III.19 is taken from his paper.

The following factors emerged from Professor Andrew's examination of admission policies to Australian medical schools.

(a) Only the University of Melbourne, Monash University and the University of Queensland require English for admission; other universities have various formulae, but all lean towards maths and the physical sciences.

(b) All schools have quotas (see table III.20), even though these may be for first or second university years; three schools, the Universities of Queensland, WA and Tasmania, select into the medical course proper on the results of the first year at the university in a science year or its equivalent. The other six universities admit directly to the medical course in the first year.

(c) There is no policy of sex discrimination.

6. ibid., p. 10.
7. ibid., p. 12.
8. ibid., p. 15.
9. G. Andrews, 'The role of the doctor in society', *New Doctor* 1 (1976), p. 10.
10. ibid., p. 10.
11. B. Wren, 'Medical education: which way ahead?' *Tharunka,* 4 June 1975.
12. Andrew, 1974, pp. 781–5.

Table III.19 Summary of admission policies to Australian medical schools

University	Quotas: 1st year	Quotas: 2nd year *ad eundem statum*	Quotas: Overseas	Prerequisites	Selection	Remarks
Sydney	250 (1972)	Up to 20	Six South-East Asians; others in competition	Nil	Aggregate best five subjects in matriculation examination	Quota fixed by Senate each year. Five-year course from 1974. 330 2nd year 1978 (b)
New South Wales	235 (1972)	About 10	No quota; admitted in competition	Science, Mathematics (HSC) (1974)	Aggregate best five subjects in matriculation examination	
Melbourne	220 (1972) 230 (1974)	About 20	A few (up to 10)	English, Chemistry and one of Physics, Biology or Mathematics (1974)	Aggregate best four subjects, including prerequisites; 10% bonus extra subjects; 10% debit for repeated subjects	240 2nd year 1977 (b)
Monash	160 (1973)	5-10	15% until 1973; 10% 1974; sponsored only 1975	English, Chemistry and two of Physics, Biology, Mathematics and a fourth subject other than Mathematics (1974)	Aggregate best four subjects including prerequisites; 10% bonus extra subjects; 10% debit for repeated subjects	*Ad eundem statum*—3rd year a few and 4th year a few. Interviews for last 10%. 200 2nd year 1979 (b)
Adelaide	135 (1972)	Small number	Six Asians	Nil	Aggregate best five subjects at matriculation	Prerequisites—nil formal Adequate standard in Science and Mathematics. 150 2nd year 1979 (b)
Flinders	64 (a) (1974)	1975 Small number	A few	Nil	Aggregate best five subjects at matriculation	80 2nd year mid 80s (b)

Queensland	..	230 (including 12 outside Faculty)	Seven Asians	English, Mathematics I, Chemistry and a second Science subject out of five taken at Senior Examination	1st year—nil; 2nd year performance in Chemistry, Physics, Cellular Biology and a fourth optional	About 300 sit 1st year, of whom 230 selected, including repeats and *ad eundem statum* students
Western Australia	190 (1973)	90 (including 10 outside Faculty)	Six South-East Asians in 1st year	1st year—nil; 2nd year—Biology, Chemistry and Human Biology and a fourth subject	1st year—nil; 2nd year performance in Biology, Chemistry and Human Biology	Possible change to 90 in 1st year and all who pass proceeding to 2nd year. 120 2nd year 1977 (b); 150 2nd year 1983 (b)
Tasmania	Open (1974) 48 (1975)	48 48 (including outside Faculty)	Up to four sponsored students (1st year) Up to four sponsored students (1st year)	1st year Mathematics and Chemistry 1st year Biology, Chemistry, Physics and Mathematics	1st year HSC; 2nd year performance in 1st year. 1st year aggregate four at HSC with bonuses; 2nd year performance in Chemistry, Physics, Biology or Zoology	Selection to 2nd year on basis of 1st year results. Interviews may be used

(a) First entry year.
(b) Recommended by Karmel Committee (1973).

Source: R. R. Andrew, 'Admission policies to Australian medical schools', *Medical Journal of Australia* 1, 18 May 1974, pp. 781–5.

Table III.20 Enrolment quotas Australian medical schools, 1973

University	Year a quota first imposed	Current quota: First year	Current quota: Second year	Comments
Sydney	1962	250	..	
New South Wales	1961	235	..	
Melbourne	1952	220	..	
Monash	1963	160	..	
Adelaide	1962	135	..	
Flinders	..	64 (b)	..	
Queensland	1972	..	185	Not including repeats and later year entrants
Western Australia	1958	190	90	72 reserved for students entering from 1st year
Tasmania	1968 (a)	..	48	Not including repeats

(*a*) A second year quota has been imposed only in 1969 and 1972.
(*b*) 1974.

Limitations (quotas) on the number of enrolments are applied in all Australian medical schools at either the first or second year level of the course. The years in which quotas were first imposed and their current level are shown.

Source: Report of the Committee on Medical Schools to the AUC, 1973.

(d) The aggregate mark of three, four or five subjects (either the best or from the prerequisite subjects) constitutes the sole criterion for selection for the Universities of Sydney, NSW, Melbourne, Adelaide, Tasmania and Flinders. A system of debits and credits accrues at Melbourne and Monash Universities where subjects may have been taken for a second time or for subjects beyond the required number.

(e) Medical schools do not always use interviews or school reports for selection. Monash University and the University of WA do give interviews to determine the last 5–10 per cent admitted and the Universities of Melbourne, Adelaide and NSW retain the right to interview.

6. If, as many believe, the medical practitioner must primarily be technically competent, then clearly the student's previous experience and academic career are relevant. If, as many GPs believe (see our survey results), medical practice requires a doctor to be humane, compassionate and emotionally responsive, the selection process should also give some weight to these factors.

7. There seem to be three criteria by which, therefore, students could be admitted to medical schools: first, purely on intellectual achievement, mainly measured by public examinations in secondary school or other assessment. This tends to give advantage to students from city schools as opposed to rural schools, and from independent and selective high schools rather than those of the lower socio-economic suburbs. The second method would combine the intellectual method with random selection of others to secure greater diversity. The third method would be based on interviews, either solely or in conjunction with school results. Here the interviewer could look for qualities of humane outlook and sensitivity to people's needs, though, as Professor Blunt pointed out in his letter, experience has shown that reliance on interview techniques has resulted in inequities and unpredictable bias. More diversity is certainly desirable. To quote Professor Andrew again:

> There can be no doubt that the selection processes of Australian schools with their bias towards the numerate and the problem solvers are likely to disadvantage, if not exclude, many of those which fit into the Hudson (1966) classification, the divergers (about 30 per cent) who are the 'higher creative', as opposed to the 30 per cent 'higher IQ' convergers, with 40 per cent 'all rounders'. Of course, there is a network of connections between the two extremes. However, is there not a need for all kinds in a profession which covers such an extraordinarily wide range of aptitudes and callings?[13]

8. Only two schools, and then only for some 5–10 per cent of possible students, conduct interviews for selection. Professor Andrew points out that there is insufficient time for interviewing all prospective students in the time available and within the system as it now functions. Professor Maddison has stated that, from his experience and observations, there is no doubt about the extent to which bias, acknowledged or unacknowledged, can influence the evaluation of interview data.[14] Professor Andrew observed that in 1972, at Monash, 52.7 per cent of all admissions came from independent schools, although they provide places for only 12 per cent of all pupils in the State.

9. If the medical practitioner is to be more than the provider of technical medical services and is to understand the range of life styles across the whole of Australian society, he should be selected from an equally wide range. Clearly there are disadvantages in relying on teacher reports which can so easily be subjective. But there are also difficulties in basing selection judgments upon traditional intelligence measures.

10. Indeed, we agree with Professor Andrew in his conclusion that alternative measures to determine entry are often socially unacceptable and there is as much reason to research new methods as there is to retain the measurement of intelligence. We would agree that intelligence involves much more than verbal and cognitive proficiency, and includes elements of affective or emotional capacity. Yet the emphases given to traditional measures of intelligence do not give sufficient weight to the more emotional/affective traits essential for relating with people. Nor do they permit recognition of social characteristics representative of our society.

11. In reply to a paper on the selection of medical students[15] in which alternative suggestions were put for measuring the desired attributes of potential doctors, Professor Andrew wrote:

> In our complex and ever-changing society one attribute stands unchallenged and unalterable and that is intelligence. Not only can it be defined, it can be measured, and from generation to generation is distributed in a complex genetic pattern, which is none the less predictable. Insights, compassion and motivation are all desirable qualities but cannot be defined with acceptability to all, nor measured.[16]

12. Even if this is true it does not follow that intelligence, so measured, implies ability to cope with social and psychological processes. Efforts should be made to establish a broader basis of selection than is currently used. Even if it is not possible yet to define exactly how this is to be measured, there must be some consideration of other factors constituting our society like cultural differences and psychosocial aspects of health.

13. If the selection procedures for entry to medical faculties are based solely upon success at school, or upon scoring superior academic ratings, then one must ask

13. ibid., p. 783.
14. D. Maddison, *Medical education in Australia* (Australian Association for Medical Education, Sydney, 1972).
15. Campbell et al., 'Selection of medical students—a burning question', *Medical Journal of Australia* 1 (1974), pp. 785–8.
16. R. R. Andrew, Correspondence, *Medical Journal of Australia* 1 (1974), p. 1045.

whether the courses reflect community health needs. With the recent addition of new courses, such as behavioural sciences and community medicine, changes are being made. Yet the sheer weight of extra courses in addition to pre-existing courses might be an argument for retention of students high in academic prowess. The concept of undergraduate 'streaming' may accommodate both the newly expressed community health needs and the wider cross-section of selections for the study of medicine.

14. The medical profession and government should create more opportunities for people from a wide range of social contexts. A study in Britain showed that pupils from lower socio-economic groups are widely inhibited from applying for medicine. Hence not all the blame for social discrimination in selection can be laid at the door of the selectors. The study compared the social characteristics and academic achievement of medical students and unsuccessful medical school applicants, and concluded that of those pupils who do apply the ones admitted are representative of the total, in respect of social class, but are highly atypical in respect of other social parameters, in that those with medical fathers and those educated outside the state system are grossly over-represented.[17]

15. It seems to us appropriate that selection of medical students should rest upon a combination of intellectual proficiency and proofs of emotional maturity and sensitivity to people's needs, these proofs being afforded through interviews or reliable referees.

Characteristics of medical students: social background and some attitudes

16. In a survey carried out in Sydney, in 1969[18], 253 fifth year medical students from Sydney and NSW Universities were interviewed. The following facts emerged:

(a) There was a great preponderance of sons and daughters of professional men. Forty-nine per cent of students had fathers in the category of professional, executive or related workers, and 16.7 per cent had fathers who were doctors. By comparison, 6.6 per cent of males at the 1961 census were in this category, and medical practitioners of both sexes accounted for 0.11 per cent of the population and 0.26 per cent of the workforce.

(b) At the University of Sydney, 55 per cent of the sample attended public schools whereas 45 per cent attended private schools. Amongst the males, the proportion of students attending public and private schools was practically equal. However, for the girls, the differences between the numbers attending private or public schools were much larger. Of the girls, 73 per cent had attended public schools, whilst 27 per cent had attended private schools. Of those who had attended private schools, only 17 per cent had attended Catholic schools.

(c) There was a clear trend away from a desire for general practice, there being little difference in the students' preference for hospital or specialist practice at the two universities, and in both cases it was higher than the aggregate preference for general practice.

(d) Within general practice preferences, there was a strong preference for group practice.

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17. M. L. Johnson, 'A comparison of the social characteristics and academic achievement of medical students and unsuccessful medical school applicants', *British Journal of Medical Education* 5 (1971), pp. 260–3.

18. S. Encel & H. E. Resler, 'Medical students—a collective portrait', *Medical Journal of Australia* 1 (1971), pp. 698–703.

(e) The studies quoted in the paper suggest that there are wide gaps between the structure of medical education, the structure of medical practice, and the needs and interests of students.

(f) The trend towards specialisation and away from solo general practice underlines the fact that many of the values inculcated in medical faculties need reshaping.

17. We have considered another study conducted in Adelaide in March 1974.[19] This found no significant differences between the proportion of migrants in the community and their relative proportion in the medical school. There was, however, a disproportionate 53 per cent of medical students that had attended non-government schools. This compared with 45 per cent in Sydney[20] and 52 per cent average in Monash between 1971 and 1974—nearly ten times the expected frequency.

18. 'Idealism' was seen to decrease significantly when students reached the clinical years of the course, just when their ability to help people was beginning to be developed. However, the study concluded that new students had 'unreal' ideas about medical practice, a judgment which may just as easily imply that the student's attitudes were changed during the course by the course, or that the type of medical practice into which he was being channelled was not the most desirable type of practice from the point of view of the community as well as the student.

Attitude changes during medical school

19. We have dealt with the admission of students to the medical schools: it is now necessary to examine their reactions and attitudes once they have started the course. The selection, education and evaluation of medical students are closely intertwined, and the needs of the community in terms of its health care should provide the primary goals of the whole process.

20. In a review of the written research concerning attitude changes, Professor A. Rezler concluded that medical school contributes to the development of cynicism in students.

> There is evidence, however, that attitudes do change after medical school; as physicians begin to practice in 'high interaction' specialties, cynicism subsides.[21]

21. Upon asking the question 'Are special teaching programs capable of changing students in a specified direction?', Professor Rezler's review concluded that:

(a) Positive orientation toward treating patients with social and emotional problems, even if evident during participation in comprehensive teaching programs, was short-lived after students returned to the regular medical school environment.

(b) Once students had developed a preference for treating physically ill patients, neither instruction in family medicine nor psychiatry succeeded in getting them to widen their interests.

(c) Medical histories recorded by students in family health care programs paid no more attention to social histories than those of regular programs.

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19. I. O. W. Leitch & J. Ludbrook, Some characteristics of medical students at the University of Adelaide (unpublished paper, 1974).
20. Encel & Resler.
21. A. C. Rezler, 'Attitude changes during medical school: review of the literature', *Journal of Medical Education* 49 (1974), p. 1025.

(d) Favourable attitudes toward other members of the health team increased when the student was exposed to comprehensive programs, but students failed to find allied health professionals of comparable usefulness to the medical specialist.

22. It is clear that a person's attitudes are strongly influenced by the groups to which he belongs, and a person is rewarded for conforming to the standards of the group and punished for deviating from them.[22] Consequently, as long as the peer group and the faculty hold and reward certain attitudes (e.g. preference for treating patients with organic problems), special programs designed to inculcate different attitudes, such as concern for the social and psychological aspects of patient care, have little chance for success. Newly acquired attitudes in special programs will fade and eventually disappear when students return to the regular program.

23. It becomes more important to select students who already possess certain attitudes rather than attempt to modify them after entrance.

24. But attitude assessment as a technique for such selections is not acceptably developed for the majority of medical schools. The newer programs, e.g. of family and community medicine, being introduced to medical schools may fail if the context into which they have been introduced remains basically unchanged.

25. Nevertheless, the issue of sexuality and its adequate teaching in medical schools has caused something of a mild revolution in a number of medical departments, new and old. Departments of each school have met to apportion time and energy to the establishment, integration and co-ordination of the subject. Within a traditional medical school structure, the gaps between departments can be very wide, hindering reasonable communication in areas of essential overlap. The students have been those who have rebelled against the fragmentary approach to topics like sexuality and have conducted surveys and taken action to initiate change. The question remains as to the lasting effect of such changes as have occurred.

26. The understanding and management of sexuality by the medical practitioner is a socially important topic which has revealed the inadequacy of medical school structures to cope with teaching issues which do not fit neatly into traditional departments. There are others, not the least of which is community health, which are quite properly the joint responsibility of many departments. If sexuality and other relevant social concerns and issues are to be channelled into a single existing departmental structure, it is unlikely they will be recognisable over a period of time.

27. The need for different teaching methods in the fields of human relationships and sexuality was considered most important. Margaret MacNamara, of the Adelaide University, asked:

> How can students acquire ease in talking with patients and relatives in such a way that they both obtain and impart meaningful information? It is simple enough to tell a student what attitude he should adopt to the patient and relatives, but the didactic approach does not necessarily help him to function in a satisfactory manner in a social situation . . . Other methods such as role playing, simulation, student-organised clinico-pathological conferences, and student-centred techniques in general, do in fact approach this problem of the transfer of information into practical utilisation.[23]

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22. P. Zunbardo & E. B. Ebberson, *Influencing attitudes and changing behaviour* (Addison-Wesley, Reading, Mass., 1970).
23. M. MacNamara, 'Talking with patients: some problems met by medical students', *British Journal of Medical Education* 8, 1 (1974), pp. 17–23.

28. The use of video-tape and discussion techniques have been considered effective in developing the skills essential in doctor–patient relationships and in understanding the dynamics of group communication.[24] Nevertheless, there is little trend towards the use of such techniques, and this itself reflects the low priority of relationship issues in the medical curricula. The failure to use techniques of these kinds in teaching about human relationships behaviour and sexuality reflects a lack of understanding of the subject matter, and there may be a continuing over-emphasis on knowledge to the detriment of attaining skills and appropriate attitudes.

29. One other issue is the debate about the traditional medical course distinctions between pre-clinical, para-clinical and clinical stages. The pre-clinical phase has normally meant the complete lack of student contact with patients. This can go on for 2 to 3 years. Only then, with the basic academic study completed, do students have the opportunity to meet patients. The effect of this is to reduce both the motivation and the enthusiasm of students in the more humane aspects of their training and to underline the technical aspects. Various measures are now being taken, and more are suggested, to modify the dampening effects of the pre-clinical phase.

30. In a lecture entitled 'Humane medical education: some problems and possibilities', Dr H. Jason, of Michigan State University, claimed that present methods of training health care personnel were inhumane. Speaking on a visit to the NSW Medical Faculty in 1976, Dr Jason claimed that the main cause for this lay in the recruitment for the most part of researchers as medical educators. As a result of their research backgrounds and lack of teaching skills, they failed often to give the right perspective but fell back on tradition; did not recognise the interpersonal demands of teaching; and were frequently intuitive and assertive in presentation, giving students little opportunity to develop inquiring minds and problem-solving techniques. The situation he described in America may apply in Australia as well.

31. The processes involved in the production of a medical practitioner have been shown to be complex. The medical student also learns to rely basically upon his own abilities and those of a few other trusted medical practitioners. With the advent of a philosophy of team work in health care, the medical practitioner will also learn to relate with other health personnel.

32. Furthermore, as a result of policy trends toward community rather than institutional care, many people must now live with physical and mental disability. They and their relatives need support. Some psychological and social stresses are not grounded in a medical condition, but arise from difficulties of relationship—at home, work or school.

> To the GP who is committed to meeting these needs in his practice, close collaboration with a social worker offers an opportunity to develop his own counselling and team work skills.[25]

33. Such a suggestion cuts right across traditional early socialisation processes for the medical practitioner. His schooling has taught him independence or, at most, intra-professional referral. Now, however, other disciplines are also important.

Conclusion

34. The medical practitioner of the future should learn in his undergraduate course about working relationships with others who have a different philosophical approach to health care.

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24. A. Werner & J. M. Schneider, 'Teaching medical students interactional skills', *New England Journal of Medicine* 290, 22 (1974), p. 1232.
25. J. Huntington, 'Social work and general practice: a review article' *Medical Journal of Australia* 1 (1976), pp. 661–3.

Recommendations

We recommend that:

1. Undergraduate medical education should give more attention to human relationships and their effects upon illness and health care.

2. Sexuality should be regarded as a proper subject for medical study; those selected to teach it should be properly trained, preferably with interdisciplinary experience.

3. Medical textbooks, especially in obstetrics and gynaecology, should be assessed to ensure that sexist attitudes are not perpetuated.

4. Family planning and fertility control measures, including conception, should be included in a human sexuality course in medical schools.

5. Universities and colleges of advanced education should co-ordinate courses for medical and paramedical students.

6. Courses should be designed to cover problems faced by Aboriginals and migrants of a lower socio-economic status.

7. In support of the recommendation of the Poverty Commission, places should be reserved in medical and paramedical quotas for qualified migrants and Aboriginals.

8. Child care and development should be a positive feature in undergraduate courses.

9. Medical education, both undergraduate and post-graduate, should ensure that adequate information is given on alternatives to drug prescription, in cases of emotional stress and neurosis, and that students receive instruction and experience in the resources available in the community, and counselling techniques.

10. The government should be more generous in the recognition of professional and technical qualifications of migrants.

11. The Royal College of Obstetricians and Gynaecologists should offer more courses for women for specialist or refresher training.

12. The Family Medicine Program of the RACGP should expand retraining programs for women who have given up practice for a time.

13. Hospitals should institute part-time work and job sharing for women doctors, especially as registrars.

14. The government should encourage schemes to break down divisions between city and country and enable outback doctors to attend refresher courses.

15. Universities and government health authorities should undertake job analyses of tasks which can be done by paramedical and allied health workers.

16. The medical profession, as a result of such analyses, should delegate some of their tasks to obstetric nurses or qualified family planning nurses.

17. State and Commonwealth government authorities, especially those responsible for the community health program, should examine the training and use of health educators and health visitors;

(a) to establish liaison with education programs in schools;
(b) to meet the special health needs of Aboriginals, migrants and at-risk sections of all Australian communities.

18. A universal pre-school health scheme should be implemented by State health authorities to screen all pre-school children for physical, psychological and social dysfunctions or disorders, with the health visitor as the first and continuing contact person in such work; and such a scheme should work in close collaboration with broadly based community health and welfare services to ensure proper long-term care.

19. The health professions should develop a comprehensive and easily communicable health record system, where possible, between hospitals and community-based services and GPs.

20. Patients should be afforded sufficient information concerning their health problems, and the drugs prescribed with their side effects, to enable the patient to have some share in making decisions, and there should be no reflection on a doctor when asked to refer the patient.

21. Every patient, if it be her wish, should receive adequate advice on fertility control methods, including pregnancy termination, and if such procedures are unacceptable to the patient's own doctor, she should receive such advice by referral.

22. The patient's wishes should be respected, as far as is possible, in childbirth with regard to anaesthesia, induction and presence of husband.

23. Government health services should give full encouragement, through the community health program, to support of the handicapped and the mentally sick.

24. Mental Health Acts should be reviewed with a view to consulting a wider range of health personnel before certification of patients to institutions.

25. Research should be promoted to facilitate the maintenance and improvement of community health programs in both country and city areas.

26. Research should be funded to inquire into community perspectives of health, the socio-economic causes of stress and the range of services that need to be provided to relieve it.

27. An ombudsman should be part of the staff of every large hospital, especially mental institutions, to receive complaints of poor care or neglect from patients or their relatives and friends and to advise on services available.

28. Interpreters should be available in all large hospitals, especially in gynaecological or womens wards, to encourage understanding between migrants, doctors and nurses.

29. The Department of Health should analyse and evaluate the full results of our survey of GPs.

Annexe III.A

Commission research report, no. 1

Royal Commission on Human Relationships
100 William Street, Sydney

Strictly confidential

National Survey of Medical Practitioners

Dear Doctor,

I would like to request your assistance in completing this questionnaire.

The Royal Commission on Human Relationships has been directed to inquire into and report upon certain aspects of medical training and practice in Australia. In the absence of reliable information, the Commission has decided that it needs to seek the professional opinion of doctors on certain matters related to these issues.

Given the public concern about these matters, I feel sure the Commission can rely on the support of medical practitioners in obtaining this information.

All information which is supplied will, of course, be treated in the *strictest confidence* and will not be available to anyone outside this Commission in any form that will allow the identification of any individual doctor supplying information.

Thank you for your assistance.

Yours sincerely,

Elizabeth Evatt
Chairman

Strictly confidential

National Survey of Medical Practitioners

How to complete this questionnaire

Please read each question carefully. Please answer *all* questions by *placing a tick* in the appropriate brackets, or *writing in* an answer where requested.

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1. At which medical school did your obtain your *first medical* qualification? (If the school was outside Australia, please state in which country).
   . . . . . .
2. *When* did you obtain your *first* medical qualification? . . . . . .
3. Please indicate any other *medical or non-medical degrees* or *diplomas* you hold
   . . . . . .
   . . . . . .
4. In the last five years have you undertaken any course(s) related to your professional work, but which *did not lead* to a formal qualification?
   Yes . . . . . ( ) (Please give brief details)
   . . . . . .
   . . . . . .
   No . . . . . ( )
5. Which category below most accurately describes your type of practice?
   Private General Practice on my own . . . . . ( )
   Private General Practice in a group of two or more . . . . . ( )
   Solo or Group Private Practice including paramedical staff . . . . . ( )
   Salaried Practice with paramedical staff . . . . . ( )
   Other (Please give details) . . . . . .
   . . . . . .
6. In the main, which of these descriptions best fits your *patients*?
   Generally speaking, more patients from the middle or upper socio-economic classes (e.g. white collar or professional workers) . . . . . ( )
   Generally speaking, more patients from the lower socio-economic classes (e.g. blue collar or manual workers) . . . . . ( )
   Generally very evenly divided: a wide cross-section . . . . . ( )
7. About what percentage of your patients are aged from 15 to 45 years?
   Less than 25% . . . . . ( )
   25% to 50% . . . . . ( )
   More than 50% . . . . . ( )
8. In a typical week, what percentage of your patients would consult you on issues of *family planning*?
   Less than 5% . . . . . ( )
   Up to 25% . . . . . ( )
   Up to 50% . . . . . ( )
   More than 50% . . . . . ( )

9. Do you raise the subject of *family planning* as a matter of *routine* in any of the following situations?

	Yes	*No*	*No consultation*
At a 6-week post-partum checkup	( )	( )	( )
At a pre-marriage consultation	( )	( )	( )
At a first gynaecological consultation	( )	( )	( )
As a normal part of history taking	( )	( )	( )
At a rubella vaccination	( )	( )	( )
At a request for an abortion	( )	( )	( )
At discussions of sexual/marital problems	( )	( )	( )
At consultations concerning venereal or vaginal disease	( )	( )	( )

10. Do you *refer* patients to other services for *family planning advice*?
Yes . . . . . ( ) (Please give details of the type of service)
. . . . . .
. . . . . .
No . . . . . ( )

11. Have you recommended the following *family planning methods* in the past 12 months?

	Yes	*No*
Oral contraceptives	( )	( )
The intra-uterine device	( )	( )
Condoms	( )	( )
Spermicidal foams, jellies etc.	( )	( )
The diaphragm	( )	( )
The 'rhythm' or 'temperature' method	( )	( )
The ovulation method	( )	( )
Coitus interruptus ('withdrawal')	( )	( )
Abortion	( )	( )
Male sterilisation	( )	( )
Female sterilisation	( )	( )
Abstinence	( )	( )

12. Under what circumstances do you recommend women patients for sterilisation?
For family planning reasons . . . . . ( )
When the patient requests it for family planning reasons, but only where there is a clear medical contraindication to pregnancy . . . . . ( )
On my own recommendation only, where there are medical contraindications . ( )
Under no circumstances . . . . . ( )

13. Do you recommend *vasectomy* to male patients?
Yes . . . . . ( )
Yes, but for medical reasons only (male and female) . . . . . ( )
No . . . . . ( )

14. Would it be helpful in your practice to be able to delegate the following tasks to appropriately trained nurses and/or paramedicals?

	Yes	*No*
Repeat oral contraceptive prescriptions	( )	( )
Intra-uterine device insertion	( )	( )
Diaphragm insertion	( )	( )

Pap smear	( )	( )
Bi-manual pelvic examination	( )	( )
Breast check	( )	( )
General family planning advice	( )	( )
Instructions in sexual anatomy and hygiene	( )	( )

15. About how many women patients have consulted you seeking an *abortion* in the last 6 months? . . . . . ( )

16. To your knowledge, about how many of these women who consulted you seeking an abortion had their pregnancies *terminated*? . . . . . ( )

17. Do you *refer* women patients seeking abortions to other *specialised services or agencies*?
    Yes . . . . . ( ) (Please indicate which service you refer to)
    - Services which support pregnancy . . . . ( )
    - Services for the termination of pregnancy . . ( )
    - Both, according to circumstances . . . . . ( )
    - Other . . . . . ( )

    No . . . . . ( )

18. If you refer women patients seeking abortions to a *pregnancy termination service*, please indicate *all* of the following services to which you refer.

	Refer	*Do not refer*
A hospital (public or private) in this State	( )	( )
A hospital (public or private) in another State	( )	( )
A private clinic in this State	( )	( )
A private clinic in another State	( )	( )
A private doctor in this State	( )	( )
A private doctor in another State	( )	( )
Not applicable to my practice as I do not refer		( )

19. In your professional opinion, do the following tasks fall within the responsibility of the general practitioner?

	Yes	*No*	*Do not know*
Counselling parents who have problems with child management	( )	( )	( )
Referral to the appropriate support services for the parties involved in a disturbed parent-infant relationship	( )	( )	( )
The guidance of school age children in issues of sexuality	( )	( )	( )
Counselling patients with sexual problems	( )	( )	( )
Ensuring that patients receive adequate family planning advice	( )	( )	( )
Detecting and treating alcohol and drug dependence	( )	( )	( )
Counselling people in cases of bereavement or loss	( )	( )	( )
Detecting disturbances in a child's emotional development	( )	( )	( )
Marital counselling	( )	( )	( )

20. About what *percentage* of your professional time is taken up by consultations of the following kinds?

Consultations based on physical symptoms but which have personal or emotional problems associated . . . . . (%)

Consultations of patients without physical pathology but who require counselling for personal or emotional problems . . . . . (%)

21. In your professional opinion, are the following types of information of relevance to a doctor in *history taking and diagnosis*?

	Yes	*No*	*Do not know*
The general social, financial and occupational circumstances of the patient	( )	( )	( )
Any family and/or marital problems of the patient .	( )	( )	( )

22. About what proportion of your patients are migrants whose basic language is *other than English*?

Less than 10% . . . . . ( )
Up to 25% . . . . . ( )
Up to 50% . . . . . ( )
More than 50% . . . . . ( )

23. Can you take a history in a language other than English?

Yes . . . . . ( ) (Please state which language)

. . . . . .

. . . . . .

No . . . . . ( )

24. Do you refer to the following journals regularly?

	Yes	*No*
Medical Journal of Australia	( )	( )
Australian Family Physician	( )	( )
Modern Medicine of Australia	( )	( )
British Medical Journal	( )	( )
The Lancet	( )	( )
Current Therapeutics	( )	( )

25. How *useful* have *each* of the following factors been to you in your professional practice when dealing with such matters as family planning, sexual dysfunction, abortion and other interpersonal and emotional problems?

	Very useful	*Fairly useful*	*Not useful*
Your undergraduate training	( )	( )	( )
Your professional library	( )	( )	( )
Professional post-graduate training	( )	( )	( )
Contact with other doctors	( )	( )	( )
Liaison with paramedicals, and health and welfare professionals	( )	( )	( )
Drug company literature	( )	( )	( )
Medical journals	( )	( )	( )
Practical experience	( )	( )	( )
Non-medical or paramedical journals and literature	( )	( )	( )
Local community contact	( )	( )	( )
Discussions with patients	( )	( )	( )

26. How *often* are you consulted about the following matters?

	Often	*Sometimes*	*Never*
Premature ejaculation	( )	( )	( )
Impotence	( )	( )	( )
Frigidity	( )	( )	( )
Failure of a woman to obtain orgasm	( )	( )	( )
Homosexuality (male)	( )	( )	( )
Homosexuality (female)	( )	( )	( )
Masturbation	( )	( )	( )
Venereal disease	( )	( )	( )
Infertility	( )	( )	( )
Incest	( )	( )	( )
Rape	( )	( )	( )

27. Do you consider that your *undergraduate* training covered the following areas adequately?

	Yes	*No*
Family planning	( )	( )
Sexual behaviour	( )	( )
Counselling techniques	( )	( )

28. How *often* do you *refer* patients to the following kinds of services?

	Often	*Sometimes*	*Never*
Marriage guidance	( )	( )	( )
Psychiatrists	( )	( )	( )
Psychologists	( )	( )	( )
Family planning clinics	( )	( )	( )
VD clinics	( )	( )	( )
Gynaecologists	( )	( )	( )
Urologists	( )	( )	( )
Members of the clergy	( )	( )	( )
Social workers	( )	( )	( )
Community services	( )	( )	( )
Books and other literature	( )	( )	( )

29. Do you *refer* patients who present to you with the following problems to *support* or *rehabilitation services*?

	Yes	*No*
Mental retardation	( )	( )
Family violence/child abuse	( )	( )
Alcohol/drug dependence	( )	( )
Marital problems	( )	( )
Rape	( )	( )
Child management difficulties	( )	( )
Delinquency of adolescents	( )	( )
Mental breakdown	( )	( )

Personal background data

30. What was your age last birthday? ( )
31. What is your sex? ( )
32. What country were you born in? ( )

33. What religion (if any) do you practise? . . . . ( )

34. What is your present marital status?

Never married . . . . . ( )
Married . . . . . ( )
Divorced or separated . . . . . ( )
Widow/widower . . . . . ( )
Other stable relationship . . . . . ( )

PLEASE RETURN THIS QUESTIONNAIRE IN THE STAMPED ADDRESSED ENVELOPE PROVIDED. THANK YOU.

ANU Survey Research Centre

Technical report on the National Survey of Medical Practitioners carried out for the Royal Commission on Human Relationships

Introduction

The ANU Survey Research Centre was retained by the RCHR for consultation and to assist with a National Survey of Medical Practitioners. The following report documents the work carried out on the Survey by the SRC on behalf of the Commission.

Sample selection

The research staff of the Commission decided that the Survey should be directed to first contact doctors, that is GPs, for reasons related to the subject matter of the inquiry proposed. It had also been decided that the Survey should be conducted by mail, i.e. the questionnaire sent out by post for self-completion by the respondent, who subsequently returns it also through the mail, as this method is generally cheaper and somewhat easier to organise.

Even after extensive Survey we could not find a comprehensive and definitive national listing of GPs and their addresses which was available to us to use as a sample frame. The State Medical Register listings do not necessarily distinguish GPs, and moreover some doctors may be registered in more than one State and thus appear in more than one listing. The Medical Directory is currently 2 to 3 years old and by no means complete.

We decided therefore to use the Permail commercial mail listing as a sample frame. This is kept up to date, provides mailing addresses, and identifies doctors by type of practice (e.g. general, hospital, specialist etc.) and also by area of practice—metropolitan and country.

It was decided that a sample of about 1500 should be approached. We asked Permail to provide a listing of addresses, selecting every fourth doctor in their country practice list and every fifth doctor in their metropolitan list. By using a systematic fixed interval selection procedure, the States were automatically represented proportional to size of GP population. Permail provided 1681 names and addresses covering all States and Territories. This list was later manually updated by Permail, to identify any address changes. As a result of this procedure, twenty-eight names were removed from the original listing, these being doctors who had left their listed address and for whom no other address was recorded, or who had died or gone overseas. The final sample size was 1653. The names and addresses of the selected doctors were punched on to computer cards, and used to produce three duplicate address labels and one control card—with name and address printed on for each doctor.

Dispatch of questionnaires

All stationery used in the Survey was identified as Royal Commission material, i.e. letters were headed as RCHR and return address on envelopes gave the RCHR postal address. All postal material was franked and sent out from RCHR in Sydney; completed questionnaires were returned to RCHR likewise, in the first instance.

Wave 1: Dispatch date 9.8.76. The first approach to the doctors consisted of an introductory letter, a copy of the questionnaire and a stamped return addressed envelope for reply.

Wave 2: Dispatch date 23.8.76. A short reminder letter was sent out to all doctors who had not returned a questionnaire. This letter incorporated thanks for any questionnaire which might currently be in the post.

Wave 3: Dispatch date 6.9.76. A reassuring letter, a copy of the questionnaire (numbered as on Wave 1) and a stamped return addressed envelope were sent to all doctors not recorded as having returned their questionnaire by that date.

Unfortunately a postal dispute in Sydney disrupted the receipt and dispatch of material during much of September.

Wave 4: Was therefore dispatched a few days later than the printed date (16.9.76). This consisted of a letter only, again asking for co-operation.

As we wanted to identify the doctors who replied (so that superfluous reminders were not sent out) we devised a numbering system which linked numbered questionnaires with names and addresses. On the control card for a given doctor, a unique identification number was stamped; the same number was stamped on the questionnaire which was dispatched to that doctor. When the questionnaire was returned, the corresponding numbered card was moved to the RETURNED category. It was thus very difficult to link any particular doctor with their questionnaire; the card listing was under the direct control of the Research Officer only, and was locked away when not in use.

The card control system worked reasonably well; due partly to postal difficulties beyond our control, however, we obviously sent out some reminders unnecessarily. This resulted in our receiving some complaints about short time for reply and non-receipt of earlier material, and also in our receiving some duplicate questionnaires; five duplicates unfortunately were included in the analysis. The numbering system on the questionnaires incorporated information as to State and area of practice. Since eighteen respondents detached these numbers in the interests of their confidentiality, they were allotted a separate series of numbers. We could not therefore include these respondents in any analysis by area of practice.

Coding and editing of questionnaires

For many questions the answer could be indicated by ticking in the appropriate brackets. Other questions needed some kind of written reply, as we could not provide all the possible alternative answers. In consultation with the RCHR research staff, a coding frame was devised for classifying these written replies (see attachment). Otherwise we checked that ticks were placed unambiguously. As a general rule, any item left blank was taken to read zero by the data processing unit; this was translated into a missing data code during computer processing.

The coded responses were transferred to magnetic tape by the Data Processing Unit at the ANU.

Analysis of data

We decided to use the Princeton package PSTAT for the machine editing and analysis of the data. This package has excellent edit-checking and data transformation facilities; moreover two of the Centre staff have had considerable experience in using it. Any errors thrown up during the edit procedure were checked on the original questionnaires, and the master data tape corrected accordingly.

The correct master data file was then used for marginal tabulations and cross-tabulations as specified by the RCHR research staff. All tabulations were controlled by the variable metropolitan/country practice, because of the varying sampling fraction for the two strata.

Response rates and other information about the sample

As described in the main report, the sample was stratified according to Permail's definition of area of practice—metropolitan or country. The table below shows usable response rates for each stratum.

Area	Number dispatched	Number usable responses	Per cent response rate
Metropolitan	988	659	67
Country	665	469	71
No ID number*	..	17	1
Total	1653	1145	69

* Information as to area of practice was included in the ID number stamped on the questionnaire. If a respondent removed this number before returning the questionnaire, area of practice was not therefore known.

We received also questionnaires or written information from doctors who should not have been included in the sample, i.e. they were not practising as GPs or they were retired from practice. The table below shows the proportions of such ineligibles, for each stratum.

Area	Number	Per-centage
Metropolitan	41	4
Country	21	3
Total	62	4

Some of the sample could not be contacted for various reasons; they were ill, away overseas, or had left the address supplied. Non-contact proportions are shown below.

Area	Number	Per-centage
Metropolitan	29	3
Country	13	2
Total	42	3

Some doctors wrote back indicating that they were not prepared to co-operate in the survey, for reasons that they wished to make clear to the Commission. The remaining doctors did not respond in any way. The non-response rates are presented below.

Area	Number	Per-centage
Metropolitan–		
known refusals	20	2
overall non-response*	259	26
Country–		
known refusals	14	2
overall non-response*	162	24
Total–		
known refusals	34	2
overall non-response*	421	25

* Overall non-response includes refusals, and doctors not replying who were not identified as non-contactable or ineligible.

Information available about non-responding doctors

We decided to compare the groups of responding and non-responding doctors with reference to various personal characteristics, in an effort to check the representative nature of the response.

The major sources of information about doctors are the State Medical Registers and the Medical Directory, a commercial publication. There were three items of information uniformly available from either source: sex (with a few estimates on foreign names), date of obtaining first medical qualification and the medical school at which the qualification was obtained.

We looked at the possibility of identifying retired or specialist practitioners—that is, the ineligible component of the non-response. However, information on specialism is not uniformly available, and the absence of a doctor from a register listing does not necessarily indicate retirement, as the available State registers varied in date of compilation, and some recent graduates or removals to a State may not be listed either.

The tables following list the information as available for respondents and non-respondents practising in metropolitan areas. No information was available for 6 per cent of non-respondents i.e. they could not be traced in either listing, and this 6 per cent should be added on to the figures listed to complete the non-response. Percentages may not add up exactly due to rounding.

(a) Sex

	% non-respondents	% sample
Female	13	16
Male	78	84
Not known	4	..
Total number	259	988

(b) Date of obtaining first medical qualification

	% non-respondents	% sample
Up to and including 1945	15	14
1946–54	21	28
1955–59	12	10
1960–64	15	12
1965–69	21	20
1970–74	10	16
Total number	259	988

(c) Medical school for first qualification

Melbourne	20	21
Sydney	30	24
Adelaide	9	13
Queensland	11	8
Western Australia	2	2
Monash	1	5
New South Wales	2	1
United Kingdom	10	11
Other European	5	5
USA/Canada	0	*
Pacific area	0	1
Asia	3	7
Other	1	1
Tasmania	*	*
Total number	259	988

* less than 0.5%

The tables following list the information as available for respondents and non-respondents practising in country areas. No information was available for 6 per cent of these non-respondents.

(a) Sex

	% non-respondents	% sample
Female	11	12
Male	83	88
Total number	162	665

(b) Date of obtaining first medical qualification

Up to and including 1945	18	13
1946–54	31	24
1955–59	12	12
1960–64	10	16
1965–69	14	22
1970–74	10	12
Not known	..	1
Total number	162	665

(c) Medical school for first qualification

	% non-respondents	% sample
Melbourne	17	14
Sydney	26	27
Adelaide	5	7
Queensland	12	15
Western Australia	1	1
Monash	2	2
New South Wales	2	1
United Kingdom	18	18
Other European	1	3
USA/Canada	2	*
Pacific area	2	1
Asia	7	7
Other	1	2
Tasmania	0	0
Not known	..	1
Total number	162	665

* less than 0.5%

Coding frame for National Survey of Medical Practitioners

Card I

Identification number — Cols 1–4
Card No. 1 Col. 5

Digit one identifies State.

Within each State 001–499 are allotted to metropolitan doctors: 501–999 are allocated to country doctors (*except in Tasmania*).

0001–0499 = New South Wales metropolitan
0501–0999 = New South Wales country
1001–1499 = Victoria metropolitan
1501–1999 = Victoria country
2001–2499 = Queensland metropolitan
2501–2999 = Queensland country
3001–3499 = South Australia metropolitan
3501–3999 = South Australia country
4001–4499 = West Australia metropolitan
4501–4999 = West Australia country
5001–5499 = Tasmania *country*
5501–5999 = Tasmania *metropolitan*
6001 + = Questionnaires with original identification number missing.

New identification variables for State and area were subsequently derived from the identification numbers during the computer analysis.

Question 1. Medical school where *first medical qualification* obtained. Cols 6–7

Not stated	00
Melbourne	01
Sydney	02
Adelaide	03
Queensland	04
WA	05
Monash	06
NSW	07
Any United Kingdom (incl. Dublin)	08
Other European	09
USA/Canada	10
Pacific Region	11
Asia	12
Other—(incl. Middle East, Egypt, South Africa)	13
Tasmania	14

Question 2. Date of obtaining first medical qualification. Col. 8

Not stated	0
Up to and including 1945	1
1946–54	2
1955–59	3
1960–64	4
1965–69	5
1970–74	6
1975 and after	7

Question 3. Other medical or non-medical *degrees* or *diplomas.* Col. 9

FRACGP *only*	1
FRACGP *plus* obs. and gynae. diploma	2
FRACGP *plus* other medical qualification	3
FRACGP *plus* non-medical qualification	4
Dip. RCOG or other obs/gynae. qualification *only*	5
Dip. obs./gynae. *plus* other medical qualification	6
Other medical qualifications (e.g. LRCP/MRCS, Dip. Med. Cairo) *only*	7
Non-medical qualifications (Dip. and Degree only)	8
Combination of FRACGP, obs./gynae. diploma, and other medical qualification	9
None/no degree or diploma/not stated	0

Question 4. Courses related to professional work but not leading to a formal qualification. Cols 10–11

This question gave some problems for interpretation. Respondents varied considerably in the detail they provided and in the terminology used to describe possibly identical courses. For example, some respondents included conferences and seminars in their listings; some other doctors might have decided that these were not strictly courses, and omitted to mention them. We decided therefore to use very general coding categories, which accounted for the majority of replies, and to record the first two activities mentioned. By adopting this approach we of course lost some detailed information; in our judgment the results give a more reliable overall picture.

Two coding positions were allocated, for recording up to two courses per respondent. If 'no' had been ticked, or 'none' written in, or the question had been left blank, two zeros were coded. If only one course was mentioned, the second coding position was coded zero. Because the categories were so general in their scope, particularly 'other medical refresher courses', the same code could appear in both coding positions, e.g. if a doctor reported attending refresher courses in anaesthetics and dermatology, then the coding record would read (4 4).

Family Medicine Program	1
Refresher course—obstetrics/gynaecology/paediatrics	2
Refresher course—psychiatry/hypnotherapy	3
Refresher course—other medical fields *or* non-specific	4
FPA certificate/psychosexual counselling/other human relations	5
Conferences/seminars	6
Clinical meetings/post-graduate lectures	7
RACGP courses (specified as such)	8
Other medical lectures/courses—(e.g. acupuncture, diving medicine)	9

Question 5. Type of practice. Col. 12

Private general practice—solo	1
Private general practice in group	2
Solo or group private practice including paramedical staff	3
Salaried practice with paramedical staff	4
Locum/part-time in general practice only	5
Other (e.g. part-time salaried clinic, Flying Doctor Service)	6
Specialist/GP clinic grouping	7

Question 6. Socio-economic status of patients. Col. 13

Generally more from middle or upper groups	1
Generally more from lower groups (blue collar or manual)	2
Evenly divided, a wide cross-section	3

Question 7. Percentage of patients aged 15–45 years. Col. 14

Less than 25%	1
25%–50%	2
More than 50%	3

Question 8. Percentage of patients consulting on family planning issues, in a typical week. Col. 15

Less than 5%	1
Up to 25%	2
Up to 50%	3
More than 50%	4

Question 9. Routine discussion of family planning matters. Cols 16–23

The eight sections of this question were punched directly from the answer recorded on the questionnaire. Each section was treated separately.

'Yes' ticked 1
'No' ticked 2
'No consultation' ticked 3

Question 10. Referral to other services for family planning advice. Cols 24–25

Two coding positions were allocated, allowing for the recording of up to two referral services per respondent. If 'no' was ticked, this was coded as two zeros. If only one service was mentioned, the second position was coded zero.

Specialist/gynaecologist/obstetrician/for sterilisation/urologist 1
Hospital clinic/other *public* clinics 2
FPA and similar specialist clinics (e.g. Children by Choice, Brotherhood of St Laurence) 3
Catholic Family Welfare Bureau/instruction in ovulation method 4
Counselling groups/marriage guidance 5
Other (e.g. other GPs) 6

Question 11. Recommendation of family planning methods in past 12 months. Cols 26–37

For each method listed,
'Yes' ticked 1
'No' ticked 2
Item left blank 0

Question 12. Recommendation of women for sterilisation. Cols 38–41

The alternatives presented in this question were intended to be mutually exclusive and ranked in order of precedence. However, a substantial minority of doctors indicated that they recognised more than one circumstance for recommending sterilisation, and so each section was coded independently.

Section ticked 1
Section blank 0

Question 13. Recommendation of vasectomy. Col. 42

Yes 1
Yes, but for medical reasons only 2
No 3

Question 14. Delegation of tasks to trained nurses and paramedicals. Each task was coded separately. Cols 43–50

'Yes' ticked 1
'No' ticked 2
Section blank 0

Question 15. Number of women consulting in last 6 months for seeking an abortion. Cols 51–52

Up to 98 consultations were allowed for in direct coding, i.e. the number as given was recorded (with leading zero for right justification, if required, e.g. 4 was recorded as 04).

Many/98 and over 98
Don't know 88
Item left blank 77

Question 16. Number of those consulting who actually had their pregnancy terminated. Cols 53–54

Number as given was recorded. Any answer in percentage form was converted back to a number. As in Q.15 above, 98 and over were coded as 98.

Left blank	77
Not known	88
Not applicable (i.e. no consultations recorded in Question 15)	99

Question 17. Referral of abortion consultations to specialised services or agencies. Col. 55

'No' ticked	1
'Yes' ticked—also ticked:	
Services which support pregnancy	2
Services for termination of pregnancy	3
Both, according to circumstances	4
Other (e.g. gynaecologist)	5

Question 18. Referral to pregnancy termination services. Cols 56–61
Each section was coded separately.

'Refer' ticked	1
'Do not refer' ticked	2
Left blank	0

If the respondent recorded the 'not applicable to my practice' option, *or* had indicated in Question 17 that he did not refer, any ticks were deleted, and all the services sections were coded 3 (not applicable). In the computer analysis, this was transformed to missing data code.

Question 19. Tasks falling within the responsibility of the general practitioner. Cols 62–70
Each section was coded separately.

'Yes' ticked	1
'No' ticked	2
'Do not know' ticked	3
Left blank	0

Question 20. Percentage of professional time spent on consultations based on physical symptoms but with personal or emotional problems associated. Cols 71–72

The number as recorded was coded, allowing up to 98%.
Unknown, not stated was coded 99.

Percentage of professional time spent on consultations for counselling only. Cols 73–74

The number as recorded was coded, allowing up to 98%.
Unknown, not stated was coded 99.

It is probable that a number of responses to the two sections of this question add up to more than 100% of the respondent's professional time. This was not checked systematically at the coding stage, and no editing rules were implemented, as it seemed more appropriate to undertake this task using computer editing and checking facilities.

Question 21. Relevance of information for history taking and diagnosis. Cols 75–76

Each section was coded separately.

'Yes' ticked	1
'No' ticked	2
'Do not know' ticked	3
Left blank	0

Question 22. Proportion of migrant patients with basic language other than English. Col. 77

Less than 10%	1
Up to 25%	2
Up to 50%	3
More than 50%	4
Left blank	0

Question 23. History taking in language other than English. Cols 78–79

Coding positions were allocated to record up to two languages per respondent. If 'no' was ticked, two zeros were recorded.

Italian	1
Greek	2
Yugoslav/Croatian	3
Turkish	4
Chinese	5
West European (German, French, Dutch, Spanish)	6
East European (Polish, Czech, Hungarian, Russian)	7
Middle East (Arabic, Armenian, Lebanese)	8
Others (mainly Hindi & other Indian languages, Indonesian, Pidgin)	9

For the grouping codes 6–9, if a respondent spoke more than one language from within the group, then that code would be recorded for each position. For example, possible combinations might be Polish and Russian, or Hindi and Urdu. These would be recorded as 77 and 99 respectively.

At this point on the questionnaire, the identification number was written in, followed by the digit 2, to indicate the beginning of the second card image relating to the one questionnaire. Card II Cols 1–5

Question 24. Regular referral to journals. Cols 6–11
Each section was coded separately.

'Yes' ticked	1
'No' ticked	2

Question 25. Usefulness of various factors in dealing with family planning, sexual dysfunction, abortion and other interpersonal and emotional problems. Cols 12–22
Each section was coded separately.

'Very useful' ticked	1
'Fairly useful' ticked	2
'Not useful' ticked	3

Question 26. Frequency of consultation about various matters. Cols 23–33

Each section was coded separately.

'Often' ticked 1
'Sometimes' ticked 2
'Never' ticked 3

Question 27. Adequacy of undergraduate training in certain areas. Cols 34–36

Each section was coded separately.

'Yes' ticked 1
'No' ticked 2

Question 28. Referral of patients to other services. Cols 37–47

Each section was coded separately.

'Often' ticked 1
'Sometimes' ticked 2
'Never' ticked 3

If 'service not available' was written in, or otherwise indicated (as could happen for country doctors), section was coded 4

If 'not applicable' was indicated in some way (e.g. 'don't get these cases') section was coded 5

Question 29. Referral of patients to support or rehabilitation services. Cols 48–55

Each section was coded separately.

'Yes' ticked 1
'No' ticked 2
'Not applicable', 'No such cases' 3
Referral service not available 4

Personal background data

Question 30. Age last birthday. Cols 56–57

Number as given was recorded.

In the computer analysis 'age' was regrouped as follows:

Up to 29 1
30–34 2
35–39 3
40–44 4
45–49 5
50–54 6
55–59 7
60 and over 8

(Note: This transformation is *not* effected on the master data file, nor on the questionnaires.)

Question 31. Sex of respondent. Col. 58

Female 1
Male 2

Question 32. Country of birth. Col. 59

Australia 1
United Kingdom 2

W. Europe (including Malta, Greece) 3
E. Europe 4
USA/Canada 5
Asia (including SE Asia) 6
Pacific Region (including NZ) 7
Others (mainly Middle East) 8
Africa 9

Question 33. Religion practised (if any). Col. 60

None 1
C of E/Anglican 2
Roman Catholic 3
Other Protestant 4
Other Christian/'Christian' only 5
Jewish 6
Non-Christian 7
Not stated/refused 8

Question 34. Present marital status. Col. 61

Never married 1
Married 2
Divorced or separated 3
Widow/widower 4
Other stable relationship 5

For reference,

(a) four digit postcode of respondent's address was written in Cols 62–65

(b) three digit (2/1) date of return of questionnaire written in Cols 66–68

2 digit actual date

1 digit month — Aug. 8
Sept. 9
Oct. 1

Annexe III.B

Summary of courses in sexuality in Australian medical schools

Sydney University, Faculty of Medicine

1. Sydney University students now undertake a 5-year course. The 1976 handbook indicates that human sexuality is covered in the department of behavioural sciences in medicine over the first 2 years. The subjects cover selected basic psychological and sociological concepts, the human through his lifespan, the skills of communication and interviewing, illness behaviour and the doctor–patient relationship, medicine in a changing society and human sexuality. In third and fourth years the clinical science strand offers some practical experience in the area of sexuality in the departments of behavioural sciences in medicine, child health, psychiatry, preventive and social medicine, obstetrics and gynaecology and general and special medicine.

2. Concern was expressed as to whether, as a result of changes in curricula, students were becoming any more enlightened about human sexuality and relationships in general. We were told that promising innovations were negatived by the extent of the institutional teaching in clinical medicine and surgery, and by an authoritarian approach to special areas (e.g. paediatrics). There was criticism that the course might introduce some rudiments of knowledge and skills but would do nothing to assist the students to develop useful attitudes.[1]

3. We heard later from the University of a 2-week course on human reproduction and human sexuality, with such objectives as:

(a) To enable students to acquire a knowledge of human sexuality so that they may come to terms with their own attitudes and prejudices to sexuality.

(b) To introduce to students counselling skills and to increase their ability to communicate, without embarrassment and with open-mindedness and understanding, particularly to patients with sexual problems.[2]

NSW University, Faculty of Medicine

4. The subject of human sexuality as such is not raised in this faculty's handbook. However, the structure and goals of the entire medical course appear to facilitate understanding of human relationships and sexuality in its broadest sense:

> The general goal of the Faculty of Medicine is to produce a graduate who is competent to undertake the care of patients, under supervision, at the level of a provisionally registered medical officer and who is adequately prepared at the time of full registration to undertake further education in any field of medicine.[3]

5. Within this framework, some more specific goals are sought by the time of graduation, viz. a capability to:

(a) Institute emergency care in life-threatening situations.

(b) Manage without supervision patients with common minor conditions.

(c) Manage under supervision, and at the level of a provisionally registered medical officer, patients with serious conditions.

(d) Recognise psychosocial problems encountered by the patient and family, and be an effective counsellor.

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1. Commission correspondence, file S216.
2. Commission correspondence, file 75/1570.
3. Uni. of NSW, Medical Faculty, Handbook, 1976.

(e) Recognise those clinical problems where his personal resources are inadequate and in such cases to seek appropriate help.

(f) Use appropriate clinical and community resources for the prevention of disease.

(g) Communicate effectively with colleagues, including teachers, with other health professionals and with relatives and patients.

(h) Understand the role of the student, the doctor and other health care professionals in the health care team.

(i) Demonstrate ability to work as an effective member of a group.

(j) Appreciate his personal assets, potential, limitations and emotional reactions.

(k) Learn, independently, useful skills and relevant knowledge in any field of medicine, given adequate resources and facilities.

(l) Recognise the need to continue his education by his own efforts.

(m) Judge, from evidence presented, the degree of certainty with which a proposition may be held.

(n) Examine data critically and reach logical conclusions (including novel conclusions).

(o) Accept legal, ethical and moral responsibilities associated with the practice of medicine.

6. At the NSW University the human behaviour school sets behaviour objectives before the courses commence. General objectives of behaviour are reduced to specific objectives as required, and both the designing of a course and the communication of its goals to students, instructors and evaluators is made clear. In effect, some aspects of human sexuality, sexual problems and human reproduction are covered in most of the subjects taught.

7. A specific sexuality course has begun under the guidance of a committee covering all relevant departments. Didactic presentations of material on normal male and female sexual responses, and resultant common problems, are systematically followed by group discussions of equal time. Physiological and emotional aspects of pregnancy, sex differentiation, contraception, venereal diseases and homosexuality are also covered. The latter two subjects are afforded 3 hours of curriculum time including group discussion. The course occurs in second year.

8. Group discussion leaders from various fields of practice assist in facilitating discussion and learning.

9. Within the school of community medicine, human sexuality is considered within a number of teaching projects. The formal lectures deal briefly with 'sexual problems and counselling' in the first year. Family planning is considered within the context of epidemiology and preventive medicine tutorials, while general practice preceptorships and health resources visits provide opportunities for direct observation of problems of sexuality in the community.

Melbourne University, Faculty of Medicine

10. The Melbourne 1976 handbook has no mention of sexuality. Information from the faculty indicates that there was no formal course for the teaching of 'medical sexology'. There were, however, discussions between the various departments in 1973 and it was agreed to place more emphasis on this subject under a heading 'human sexuality'. Topics suggested by the students were then incorporated into the existing course. The faculty said:

It was considered that the topics as suggested in the student report could be incorporated into the existing course structure. While aware of the student preference for seminar-type teaching in this area it was noted that many of the topics would be difficult to teach in this way. As the topics would need to be included in the existing course structure without incurring any additional financial costs to Faculty the method of teaching would need to be tailored to existing teaching programs and facilities within departments which would undertake the topics suggested.[4]

A graduate needs knowledge matched with appropriate attitudes towards people. The present course does not augur well for its success in terms of its influence on graduates in respect of their attitudes toward their patients.

Monash University, Faculty of Medicine

11. The Monash 1976 handbook mentions sexuality in the department of obstetrics and gynaecology as a third year course. The syllabus emphasises fundamental reproductive physiology, human sexuality, family planning, normal pregnancy and parturition, psychological and social aspects of obstetrics and gynaecology and the recognition of common abnormalities of pregnancy and diseases of women.

12. A small program for fifth year Monash medical students is offered by the Family Planning Association of Victoria. A lecture on 'contraception' is given; each week two students attend for an hour of instruction and discussion and, following this, each student sits in with a doctor for a clinical session of 3 hours, where the contraceptive method most commonly presented is the pill.

13. A 2-day training course has, until recently, been provided in sexual counselling for fifth year Monash medical students by the Sexual Difficulties Clinic of La Trobe University's school of behavioural sciences.

14. However, recent efforts to develop an integrated program in human sexuality and sex counselling in the whole of the medical course has led to the production of a report entitled 'Teaching in human sexuality' by a subcommittee of the faculty of medicine. The report recognised that 'a considerable amount of teaching in human sexuality already occurred' but the proposed course was designed to improve the teaching of human sexuality.

15. A set of objectives was established and they relate to three basic areas—obtaining the factual information, an appreciation of both the student's and the patient's sexuality, and the acquisition of counselling skills:

(a) to provide the student with orientation and information in the area of human relationships, sexuality, marriage and the family in order that he may recognise the relevance of these subjects not only for medical practice but also in personal life;

(b) to help him communicate effectively and comfortably with patients, especially in the area of sexuality. This goal will be facilitated by an understanding of his own sexuality; adequate knowledge and understanding of the anatomical, physiological and psychological aspects of sexuality; an ability to integrate these aspects in order to understand the person as a whole; and acquisition of therapeutic skills;

(c) to help the student become aware of his own liabilities and limitations in the counselling area, and equally aware of the special strengths and weaknesses of referral sources available within the community.

4. Commission correspondence, file S216.

16. Important considerations in setting the context for this teaching were as follows:

(a) Material to include selections from courses covering human relationships, marriage, the family, child development and human sexuality which are relevant to the practice of medicine, and to the life of the medical student.

(b) Emphasis on integration, over the 6 years in which it is taught, between the departments involved in the presentation of the course.

(c) Material presented in a progression from the socially acceptable, personal and immediately relevant, to the abnormal and pathological.

(i) Material of personal value to the student presented before material of clinical interest. This order is consistent with the principle that the student is able to learn and integrate material more effectively after his own emotional reactions have been resolved.

(ii) An understanding of the development of human emotions, e.g. anger, fear and love, before the presentations on interpersonal relationships and sex role learning.

(d) Sexual behaviour viewed in terms of interpersonal relationships without classifying sexual behaviour into the dichotomies of male and female.

(e) The physician to encourage his patient to consider sexual functions as natural processes. Consideration for biological processes enters into such behaviour as resumption of intercourse after surgery, when to intervene in childbirth, feeding of infants etc.

(f) Those people whose profession brings them into a therapeutic relationship with others to be capable of recognising each individual's rights to choose his or her sexual expression. The therapist to be aware of his responsibility to himself and the community.

Queensland University, Faculty of Medicine

17. The 1976 Queensland medical school handbook has a reference to sexual function and reproduction, and their social implications as a matter of importance, but details are not given. More information came from the Dean in a submission.

> Briefly, instruction on sexual matters takes several forms in this faculty:
>
> (a) Our medical sociologist, Dr Najman, discusses the psychology and sociology of the sexual role as part of the course in medical sociology in the second year (about 2 hours).
>
> (b) In the third year our child psychiatrist, Dr Helen Connel, discusses the intellectual and emotional growth of children and adolescents.
>
> (c) Various aspects of the psychopathology of sexuality are discussed in the fifth year program in social and preventive medicine—sexual delinquency and venereal disease etc.
>
> (d) The psychiatric aspects of abnormal sexual behaviour feature in the department of psychiatry's program in fifth year.
>
> (e) The general principles of family planning are featured prominently in Professor Mackay's teaching program in the final year of obstetrics.
>
> In addition, other less formal seminars are held from time to time. For the past 3 years the Student Health Service has had a 2-day seminar, directed more to students' personal sexual problems than to those of other people, and I believe that the College of General Practitioners are also mounting a seminar in the near future.
>
> With the appointment of Professor Ryan as head of a new department in community practice, I have no doubt that he will be playing a very active part in seminar tutorial teaching in this subject.[5]

5. Submission 1101, AMA.

18. We refer again to Professor Ryan's evidence to us.[6] He believed that at the moment sexual problems receive insufficient attention and thought students at the undergraduate level should be able to discuss their problems frankly, and give and receive advice in a non-directive way.

19. The Medical Education Committee representative forwarded a copy of the Queensland course curriculum on human sexuality. He claimed that, although the total time devoted to this aspect of teaching was in excess of 80 hours, the course is ineffective because it is uncoordinated.

20. The Committee aimed to introduce a co-ordinated course on human sexuality into the fourth year curriculum consisting of approximately twenty lectures supplemented by films and with small group discussions following the lectures. The course was to be introduced in 1977 and hoped to pay specific attention to counselling techniques.[7]

21. Reflecting this concern for a more integrated course, Dr Najman, of the Department of Social and Preventive Medicine at the Queensland University, agreed with the general consensus that in the past teaching in this field has been inadequate both at schools and at universities. Thus in 1975 a range of departments were offering snippets. The teaching lacked co-ordination and perhaps technique but certainly not time in the curriculum.

22. Dr Najman's own courses included a number of lectures and seminar groups (about 6 hours total) where the following subjects were looked at:

(a) 'normal' and 'abnormal' sexual behaviour;
(b) sexual problems presented to doctors;
(c) the role of morality and personal ethics in the treatment of sexual difficulties (both the doctor's and the patient's morality);
(d) marriage in society and sex in marriage.

Dr Najman found that the most satisfactory form of communication for a topic as sensitive as this one was small group teaching with audio-visual aids.

Adelaide University, Faculty of Medicine

23. While the more technical aspects of human development and functioning are covered by various parts of the medical course, formal education in 'sexuality' is described in the 1976 calendar as taking place within obstetrics and gynaecology in fifth year. Seminars are conducted in which 'social, psychological and psychosomatic aspects of human reproduction and sexuality' are discussed. Within psychiatry the course is:

> . . . designed to help the student acquire the knowledge and skills necessary for the evaluation of psychological and sociological factors and the integration of these with biological factors in all forms of illness.[8]

Disease is clearly the major preoccupation, and experience gained will be limited to psychiatric units within hospitals in fifth year. Community medicine offers some contact with general practice settings, and preventive and epidemiological aspects of disease, but needs to be more flexible.

24. In a submission to this Commission, the Adelaide University's Faculty of Medicine claimed that:

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6. Evidence, pp. 1810–29, Prof. James Ryan.
7. Commission correspondence, file S216, June 1976.
8. Adelaide University, Calendar, 1976.

> . . . no modern medical curriculum therefore can be regarded as complete without some additional discussions of methods of providing sex education, and also of individual counselling methods . . . Most must obtain their practical skills after graduation.[9]

25. The submission recommends that education programs in human reproduction and sexuality should be introduced in universities and colleges of advanced education, both for medical students and for arts and science students who are destined for teaching. It also recommends that, when a suitable corps of teachers is trained, courses in human relationships should be a normal part of school work, from an early age. It recommends that additional funding should be made available for fundamental research in reproduction, and for applied sociomedical research in sexuality, including abortion.

26. The students of this faculty in a submission said research had already shown that the community's faith in the doctor's competence in all areas of sexuality is often misplaced. They felt that since sexuality was so important, it should be given more time than is now the case.[10]

Flinders University, Faculty of Medicine

27. The 1976 handbook places human sexuality in the human behaviour course in third year: this consists of a discussion of developmental psychology and human sexuality. Developmental psychology covers the nature and development of personality and behavioural characteristics from infancy to old age. Sexuality covers attitudes to sexuality, development of human sexuality and sexual roles, including sociological considerations, the physiology and psychology of human sexual responses, sexual abnormalities and problems in men and women, birth control and family planning.

28. In correspondence from Flinders, it was stated by the Professor of Obstetrics and Gynaecology that:

> My understanding of the philosophy of this school is that we are and will continue to view sexuality, family planning and other related matters in the total context of human relationships. This has already been reflected in our interim curriculum where the students have been given introductory material on the psychology and physiology of the sexual response in the reproductive system course in term 7 (year 3). This course also included material on the biological basis of fertility control. Pregnancy and childbirth were dealt with in an integrated way, not only with regard to the morphology and physiology, but also to their behavioural aspects.[11]

29. Professor Jones stated that the third year students take a course on 'human relationships' which spans all aspects of human behaviour and development from infancy to old age. Some 15 hours of this course are concerned with sexuality, family planning, abortion and other related matters.

30. The middle week of a 13-week block devoted to paediatrics, obstetrics and gynaecology in the fifth year will concern itself with behavioural problems in the family, and include childhood and sexual problems; emphasis will be placed here on the acquisition and development of counselling skills. A specific opportunity will be given to discuss sexual difficulties and alternative sexual life styles.

31. In addition, during the obstetrics and gynaecology block in the fifth year, significant recognition will be given to the altered emphasis in this discipline from mechanical and surgical aspects to more medically and behaviourally oriented aspects.

9. Submission 74, Prof. L. W. Cox.
10. Submission 343, Adelaide Uni. Medical Faculty, Undergraduate Members.
11. Commission correspondence, file S216.

WA University, Faculty of Medicine

32. Sexuality as such is not mentioned in the 1976 handbook of this faculty. However the teaching of human sexuality is spread throughout the 6 undergraduate years in the form of several separate segments, each taught by a different department. There is no distinct curriculum, as such, each segment being a small part of an overall course taught by each particular department. There is no apparent continuation or correlation between the segments, specific areas of teaching being scattered at random throughout the medical course.[12]

33. In criticism of the present course, the WA Medical Students Society cited the following content areas as being inadequately covered: psychology of human sexual behaviour; discussion of mature sexuality and common sexual problems; sexual behaviour in middle and later years and associated problems; sex education by doctors; management of sexual problems; counselling methods. They preferred open discussion rather than didactic lectures and they thought that courses should be mostly in the form of small group discussions, tutorials and panel discussions. They proposed that one co-ordinating body should be given the task of controlling the whole course, with objectives along the lines of those set by the students at the University of Sydney.

34. Finally, the students considered that discussions and teaching on human sexuality should continue throughout the 6 years. They felt there was a need for discussions of attitudes to begin in the first year of medicine alongside the teaching of factual material.

35. In a paper by John O'Shea, President of the WA Medical Students Society in February 1975, two suggestions were made to improve course deficiencies. He suggested:

(a) an increase in curriculum content of family planning–human sexuality;
(b) more efficient use of the many learning situations currently available for the teaching of these subjects.

He claimed:

> It is important to stress here that discussions of family planning be integrated as much as possible with human sexuality and all its aspects. Perhaps the most important aspects of these fields are discussions of attitudes, beliefs, hang-ups etc. about this area of medicine. For there is a great variety of attitudes among undergraduate and graduate medicos, and it is these which seem to determine their approach to this subject. Hence, while a full knowledge of different contraceptive methods and human sexuality problems is needed, the attitudes towards these things are more important in the long term.

As regards the use of available facilities, O'Shea illustrated what he meant with the following examples:

(a) use the family planning clinic, at King Edward Memorial Hospital, on Monday and Thursday evenings for teaching purposes;
(b) encourage medical students to accompany the community health sisters who follow up 'high risk' cases from the King Edward Memorial Hospital family planning clinic;
(c) have medical students attend the training courses run by the Family Planning Association, and then work in family planning clinics as junior assistants;
(d) have students accompany a general practitioner, or other person, on a country tour of general practices (such as those run by the RACGP);

12. Lalor & Lord, A report on education in human sexuality for medical students (W.A. Medical Students Society, Medical Education Committee, 1975).

(e) have some weekend seminars on the subject of family planning and human sexuality.[13]

36. It is evident that the WA Medical Faculty is attempting to integrate discussions of sexuality into the existing school structure while relying heavily on current staff to lead such discussions.

Tasmania University, Faculty of Medicine

37. The first woman Professor of Community Medicine, Dr Norelle Lickiss, told us about the course informally:

> For several years introduction to human sexuality was offered in the first year course entitled previously 'introduction to behavioural sciences' and entitled now 'medical sciences (man and society)'. This has been under the supervision hitherto of the Department of Anatomy. Further opportunities for general discussion were offered in Med. III with the stress continuing to be on those aspects of human sexuality which would assist personal growth and self-understanding, together with some discussion of family planning. Biological aspects of sexuality, of course, come into courses in physiology and anatomy.[14]

38. The main formal teaching in human sexuality has been during fifth year with a block of three successive Fridays, lasting for most of the day. Methods of learning have varied over the last 3 or 4 years since this program was introduced. Initially very explicit teaching was needed (e.g. Masters and Johnson-type films) and welcomed, but the need for this 'seems less apparent now, though an occasional student very much welcomes clarification'. In general, the course commonly uses some input in the form of a brief talk, by a good resource person, film (e.g. *Sexuality and communication, Who killed Jenny Langby?),* followed by discussion. One much appreciated session on homosexuality has taken the form of two homosexual men—one around 50, the other around 20—who discussed anything the students wished to discuss from 4 to 6 p.m. in the students common room. It was not possible to find a homosexual woman prepared to meet the students.

> This year, instead of the previously small number of students (20–25) we had more than forty, and obviously we need more small group discussion and intend to change procedures next year with the assistance of some very helpful students. It is hoped that some sessions can include senior nursing students next year; hitherto we have done this in teaching on the care of dying people and in discussions on drug abuse, with real success, and the potential of interdisciplinary learning is, I think, very real, with obvious long-term benefits. More formal instruction in gynaecological aspects of fertility control is offered in the course in obstetrics and gynaecology. Students' research projects and dissertations frequently relate to human sexuality, e.g. students have explored, in group projects, topics such as knowledge of sexuality among university students; patterns of incidence of venereal disease; unmarried mothers. The projects are not very sophisticated but are a valuable learning experience.[15]

Conclusions

39. Following a number of experimental courses on human sexuality (e.g. Smith and Macourt in NSW, Montgomery and Singer in Victoria)[16], and the widespread interest of medical students, every medical school now includes more teaching on sexuality. Some faculties appear merely to have added lectures to an already overcrowded curriculum with the expectation that the subject will be effectively

13. J. O'Shea, Sexuality in WA medical course curriculum (unpublished, 1975).
14. Commission correspondence, file S216.
15. ibid.
16. *Medical Journal of Australia,* 27 September 1975.

managed in just the same fashion as, say, anatomy. This is unrealistic and more likely to produce the kind of practitioner described by Professor Ryan of Queensland as 'a positive menace in practice especially if he is judgmental and authoritative'.[17]

40. Other faculties have grappled seriously both with the subject and the broader issues which flow from it. These include the role of the medical practitioner as counsellor, and his awareness of social factors in the management of medical problems. The issue of sexuality as a valid and major part of the medical student's education has begun to revolutionise the medical schools. Courses in human relationships have equally been a concern of paramedical personnel.

41. In Australia, the complaint about lack of sexuality education in medical schools has not yet led to the esablishment of separate intra-faculty departments of sexuality or sex education. The philosophy is to perceive sexuality as a part of relationship-oriented courses, as is reflected in the recent establishment of departments of community medicine or practice. Most such departments do see sexuality as an important element although they recognise the overlap which exists with such long-existing departments as obstetrics and gynaecology and psychiatry (and more recently with behavioural sciences). The recognition, however, that priority will only be given to this subject if it is fully integrated demands co-ordinating authorities within each faculty. Whether these are to be committees or specified individuals with significant authority is yet to be determined. In some faculties at this stage, however, the subject of sexuality is beginning to break down barriers between separate departments—something which has been necessary for some time.

42. It is difficult to determine whether sexuality is now being taught in medical schools as a positive aspect of human personality and behaviour bringing pleasure and enhancing a relationship as well as for the purposes of reproduction. Normal sexuality was sometimes included as a part of the curriculum. However, the fundamental and traditional role of the medical practitioner in respect of illness or disease has continued to be reflected in his education. The question of the medical practitioner's role as counsellor therefore remains one of conjecture. Given that he does have an advisory, responsive and supportive role to play, when confronted with emotional problems in a patient, to this extent he provides counsel. But the many techniques, skills and impartial attitudes required of the good counsellor may not be achievable in every medical practitioner. There are doctors who will counsel well, and those who will not.

43. The Australian medical schools have, by and large, chosen the easier method for making changes to existing courses. The appointment of sufficient staff to facilitate the work of interdepartmental committees on this subject seems essential. It would be a pity if the complementary nature of such interdepartmental committees were to be replaced by separate, new departments and we do not recommend it.

44. There is still an over-emphasis on aberrant sexuality, and too little on the broad range of normal sexual modes. More cross-disciplinary education, with involvement of students and staff of the less medically oriented, more behaviourally oriented professions, is needed.

17. Commission correspondence, file S216.

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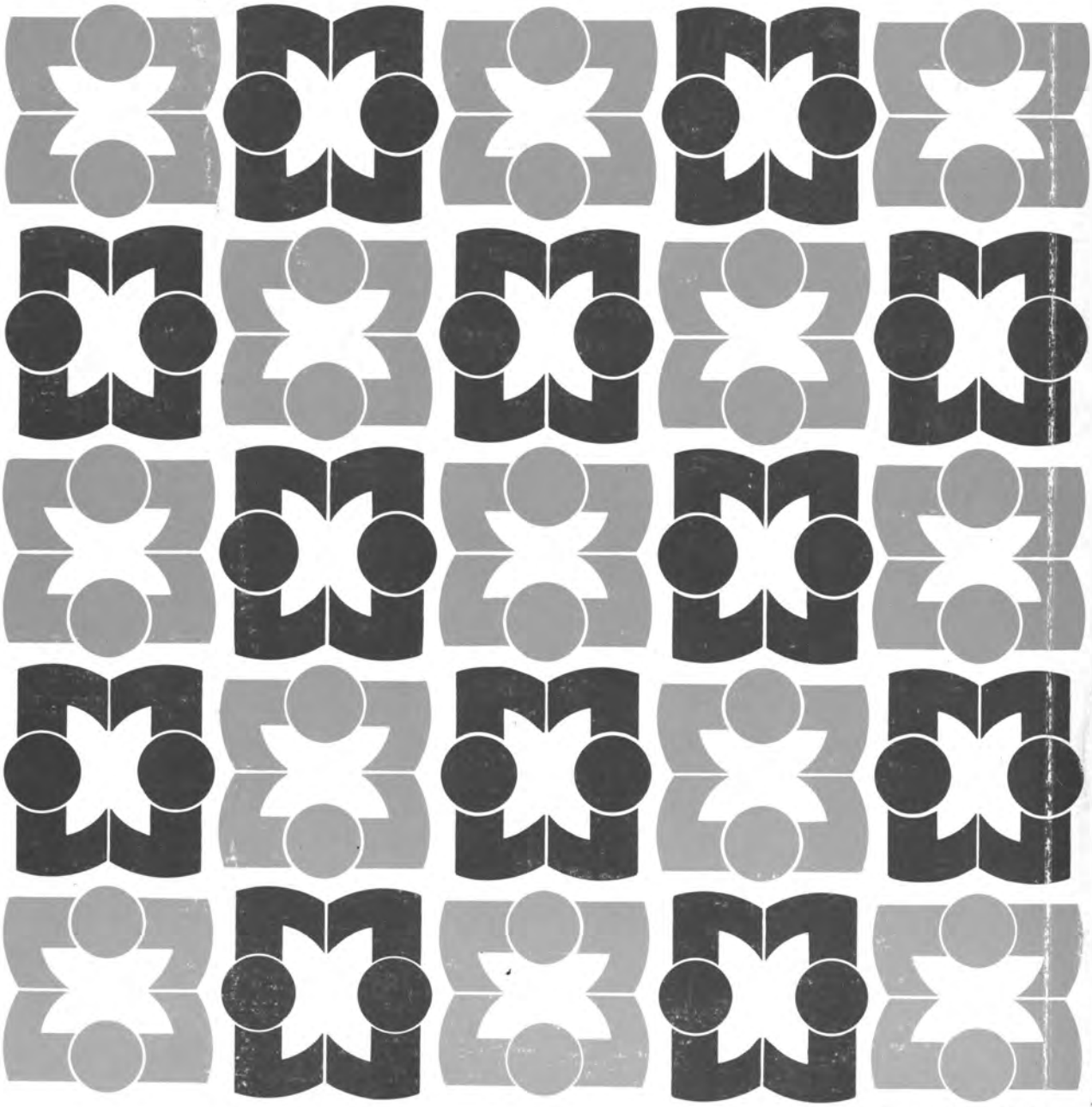

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