

**Diamantina Health Care Museum Association Inc – Oral History Project**

***This transcript is a slightly edited version of the conversation on the tape.***

***Researchers interested in the fine detail and vocal nuances of the interview are encouraged to listen to the aural version.***

Place: Diamantina House

Interviewer: Sue Pechey (SP)

8<sup>th</sup> December 1999

Interviewee: Dr John Golledge (JG)

**SP** Let's talk about your childhood and education first please.

**JG** Well, strangely enough I was born in Torquay in England of Australian parents. My father had gone home to England, (what we used to call home then) to do surgical training and I arrived as a late entry into the family. It was about 6-8 months later when we landed in Fremantle and I lived most of my early life in Western Australia.

**SP** What brothers and sisters do you have?

**JG** I've got only one sister who is ten years older than I am and that's why the addition was a surprise. I went to secondary school on a government scholarship to Wesley College and I was school captain there in 1948 and from there I went to university to do geology in my first year. Midway through the first year I decided that I wanted to change to medicine and in those days it was flexible enough to change in first year and I ended up doing first year qualifying in Perth and then another five years in Adelaide, graduating in 1954.

**SP** Why did you move to Adelaide?

**JG** There was no medical school in Perth at that stage. You could only do the first year in Perth and then the rest meant coming over the eastern seaboard, or the southern seaboard in the case of Adelaide. From there I went back to WA and was a resident medical officer at the Royal Perth Hospital for two years and then I went into G.P. for eight years in a semi-rural practice at a place called Rockingham which is a sort of a seaside resort south of Perth but also has a farming community in the Hinterland. I really enjoyed that, then in 1964 Royal Perth created the first full time Director of an Accident Emergency Unit in the country and I was invited to apply for that post and I was appointed as full time Emergency Department Director.

**SP** Why were you asked to apply for it?

**JG** I had written something about a position in charge of Casualty when I was a resident there that someone had picked up on but I also I think established a fairly good reputation as a general practitioner also I used to look after the BHP rolling mills and their accident problems. The then superintendent contacted me to see whether I would apply. Then in 1968 I also became Deputy Superintendent of Royal Perth Hospital.

**SP** How old were you then?

**JG** I was thirty-eight and I stayed there as Deputy Superintendent and A & E Director until 1973 but while I was there I was lucky enough to be awarded a National Health and Medical Research Council Traveling Fellowship for a year and I took that year in Edinburgh and gained a Diploma of Social Medicine at Edinburgh University which was one of the two medical training places for hospital management existing in the world at that stage.

**SP** Is that was that year was, a year of study in hospital management?

**JG** Yes, hospital and, well I suppose, community health management as well. Business Management, Finance, Statistics, Epidemiology, those sorts of subjects, which gave me a fairly broad base for managing a healthcare institution. We had thirteen people doing the course and there were nine different countries represented including an Irish nun, a Japanese, a few Brits and a German and so on, so it was a fascinating year. I received a letter from Ross Patrick the Director General here in 1972 asking me if I would apply for this post and I said no four times but finally accepted because the offer was made very attractive. It was a number one post of course where I was number two at my existing hospital and the financial remuneration was significantly higher and they agreed after some negotiations to build me a five bedroom house in the suburbs which I could occupy rent free and they also agreed to a few things I demanded for the hospital like 400 new hospital beds as a condition for appointment and so then I arrived here in 1973.

**SP** Why did you ask for 400 new beds?

**JG** When I came here one of the worst things about hospital work was the poor state of cleanliness. Kicking through the cigarettes butts and dust in the entrance foyer and going into a ward full of rusty beds I found it quite a culture shock. Coming from a fairly well heeled hospital in Perth and the beds particularly I thought made it very hard for the staff to get enthusiastic about making the place look clean and tidy and so we replaced the worst 400 beds and that's how we kicked off the improvement. Then, of course, things like the general cleaning of the place we moved to make the wardsmen on the cleaning staff responsible for specific areas which tended to be, (particularly the public areas) falling between the slots a bit. So that was picked up fairly quickly and I think it's one of these things that unless you're coming new to a place you accept that that's the way it is.

**SP** You replaced Owen Powell?

**JG** I did and Owen had left us a terrific hospital staff who were very happy and proud of their hospital and made me feel very welcome. The cohesiveness of the staff in a place this size was quite remarkable. They had a very strong surgical side to the hospital then. People who were well known throughout Australia like Sam Mellick and Neville Davis and those sorts of people who were known to me even though I was across the other side of the country. They had some very good general physicians and a few good specialists but that specialty development in medicine needed a lot of gingering up and I guess I took that over as a next phase development for the hospital.

**SP** Who was the DON when you arrived?

**JG** That was Eleanor O'Connor. My wife Trish and I became very friendly with Eleanor and she actually spent our first Christmas over in the Medical Superintendent's house with us. We were living on site while our house was being built. We became very good friends but unfortunately not long after she developed cancer and died. We saw a lot of her in her last few days and that was rather a sad time.

**SP** There were a couple of nurses I talked to who nursed her through that period who were obviously very upset about the manner of her death.

**JG** We were almost the nearest she had as next to kin at the funeral which was also a source of sadness. She was a very brave woman at the end. Speaking of Eleanor, reminds me of the overcrowded wards, 6 beds in four bed bays and 8 beds in six bed bays.

**SP** Yes, beds down the middle.

**JG** Beds down the middle, nurses crawling under them to get to patients. As I walked around this I was astounded and I said to Eleanor "we are going to get rid of these beds" and in the space of about three months we pulled every one of those A and B beds out

and didn't replaced them unless there was an absolute crisis and we didn't reduce the number of patients being put through the hospital because I think, having got them out of the road, the efficiency of managing patients improved anyway and we got shorter length of stay.

**SP** It was about that time too that hospital stays were starting to be reduced due to very good medical reasons.

**JG** You really have to take the big bite and put people under pressure for them to move patients through their beds and that's what we did anyway.

**SP** Was that something you had to discuss with the Board before you did it?

**JG** I think I probably told the Chairman I was going to do it and I don't remember any objection to that at all. But basically Neil Wotley gave me a fairly free run in to do it. In fact, he was Chairman of the three boards at that stage and he virtually said after a month or two of getting to know me, "I'll leave you to run this place. I've got more problems than I can handle over at the other two". We communicated frequently and were good friends, went to each other's homes and that sort of thing but he didn't really interfere too much unless I sought advice. So anyway, we got rid of those and that was good. Then, Medical Records was shocking. Often people were kept waiting in Outpatients while their records were being found so we had to devote a fair bit of time to that. There was only a very token academic presence on site too. That was fairly quickly resolved. The university was keen to get some academics here and Professor of Medicine and Professor of Surgery were appointed within that first calendar year I think that I was here. That was a little bit under way before I arrived but we certainly struck up a good relationship with the Vice Chancellor and that worked well. There was very little in the way of research, there was Neville Davis' Melanoma Project, there was Gastro-

oesophageal and Colorectal Project and very little else in the way of research going on in the place and that was a big drawback. There was virtually no funding from the Health Department towards research and, in fact, even to this day there is not much that comes to a hospital like this for research.

**SP** And not a lot of funding for doctors to go and get expertise outside either.

**JG** No. There was already an association with the Lions Clubs and they were funding a fellow called John Healy doing kidney research and I had some discussions with Lions and the upshot of that was there was a Lions Research Foundation formed with a much wider view and I spent a lot of nights out at various Lions Clubs around the place and we got quite a bit of money for research projects and eventually a building, the Lions Research Building which was built in front of the hospital. We also had some extensions going up on the 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, and 8<sup>th</sup> floors, five floors going up on top of the Administration wing as it was then called, A wing, and the top floor of that I managed to carve a bit of space out for some research laboratories. Those two buildings allowed us to recruit two key people to the staff. One was Don Cameron in Endocrinology and he was a very good Endocrinologist from Melbourne and had been previously courted by Royal Brisbane but, because they couldn't give him any research place, he wouldn't come but I managed to give him a research place and he did come, so that was a win. The other was Ian Fraser into the Lions Research Building in Immunology and that was a big plus. So, I guess those were the sort of things that happened progressively early on and then when we gradually recruited more and more key subspecialty positions, Charles Mitchell, Ian Fraser as we have mentioned, Ralph Cobcroft in Pharmacology and quite a group of really bright, youngish physicians and that really bore fruit because in 1981 we had success with ten physician trainees, they all passed their FRACP in the one year and

that was the best result by any hospital in the country in the physician examinations. The same year we had five people pass their surgical exam too, obtaining their FRACS. So the training of the junior staff of the hospital went very well and just before that psychiatry had started off which had been a specialty missing from the place.

**SP** Not long after that you had transplants.

**JG** Well, renal transplants had been going on for some time and had been very successful but the 30<sup>th</sup> January 1985 was the coming of age of this hospital in my opinion when the first liver transplant was performed. Why the importance of liver transplants? Because it was probably the most technically difficult surgery you could attempt at that time and probably is still pretty close to being that. Also it lifts related specialties to a new level.

**SP** What did you do that day?

**JG** My wife Trish and Russell Strong's wife Judy knew it was going to happen and they drove up to the North Coast to a unit we had to spend the day together. I spent the day with Russell in the theatres coming and going and looking after him a bit when he came out tired. I was there to try to bat off the media because it had already got out very early on in the piece and we were trying to keep it quiet until it was over but somehow or other they had got hold of that so I was handling them.

**SP** Where were the media, physically? How far into the building did the media get?

**JG** There were phone calls. We could stop them outside. There's an interesting story about Russell Strong if we can go back a little because I think he probably, was the most pre-eminent doctor to ever have been recruited to the hospital and his standing on the world stage is of great renown. He has lectured as a guest in some 35 countries. Just after I got here the surgical directorship fell vacant and there were several applications in for it. I looked at the applications and there was this standout fellow who had done his training in

England and he started life as a dentist because he couldn't qualify for the medical course in Sydney. He took himself off to England and did his medical course while he did dentistry at night to pay for his course. Aubrey York-Mason, a very famous surgeon in England, and Neville Stredolph, also well known, both wrote references for him saying he was the best senior registrar they had ever had. I fought tooth and nail with the then Director General Ross Patrick who wanted a local person appointed. It even came to the stage where he was telling me before we went into the selection committee that he was going to veto Russell Strong's appointment that I could put him up but it was going to be embarrassing if he had to veto it. In any event, Eric Saint, the Dean for the Medical Faculty backed me to the hilt on the appointment at the meeting and Kurt Aaron who was the Consultant Physician on staff here also agreed and we ended up turning it around and the Director General recanted and he was appointed. So that was the interesting background to his arrival. But I think the thing about liver transplantation was that people didn't realise it was going to impact so much on the hospital. Everyone was worried about the financial implications of it including the Board who were fighting me tooth and nail not to do it and I even got accused of being disloyal to the hospital at one stage but the spin off benefits that we could see coming from it were not only liver transplantations but the lift it gave to the Intensive Care Unit, anaesthesia, biochemistry department, immunology. All these things get lifted to a much higher plain and that meant that anyone who was seriously ill in the hospital, whether it was from an accident or from another disease, was receiving better treatment at a much higher level. There was another spin off benefit, not for this hospital but for the Royal Children's Hospital, in as much as having negotiated with them to operate on children over there and we sent staff across. They also had to improve their Intensive Care Unit with their equipment and

staffing, so they profited from it. They also profited financially from it because a lot of Japanese children were coming across and they were being paid for at quite a high rate. It was in some of the national media that we were acting unethically doing this operation and members of the Ethics Committee at the Royal Brisbane said we were acting unethically.

**SP** Why?

**JG** Because they didn't think we were ready to do this level of surgery. Anyway, in a very short space of time we had reached a level equal or better than the most pre-eminent Liver Transplant Units in the world.

**SP** Was that a successful operation?

**JG** That patient actually died a month after because of a rejection problem and he was a very high risk patient which some of us thought shouldn't have been taken on as the first case but he was dying and he had been rejected by two overseas units as being too high a risk patient. That added considerably to the problem. He flew through the operation, if you could call someone having a seventeen-hour operation flying through, and was recovering quite well until rejection occurred. Anti-rejection drugs weren't as good then but they quickly improved and so that really led the hospital onto the international stage.

**SP** I am interested in your relationship with other people around the hospital, particularly say the Chairman of the Board, the DON, people like that. People you came into contact with fairly regularly.

**JG** Following Eleanor O'Connor, Shirley Kidd was appointed as Nursing Superintendent. Shirley had been working with Peter Nicol who is another part of the story on a management services study within the hospital to see about improving the way we did

things and I thought they both showed ability in management and so I was keen to have Shirley appointed as the new Nursing Superintendent and that transpired.

**SP** She told me she was fairly reluctant to apply.

**JG** Yes, we had to talk her into that and I think we got along very well together in our time here. We did have our differences of opinion but most of the time it was a very cooperative and certainly very happy relationship. The other one, Peter Nicol, I saw his potential in administration. He was a pathologist and I asked him to join me as Deputy following Kevin Murphy who was the previous Deputy Superintendent and was also carrying the title of Director of Medicine and I convinced Kevin that he would be better sticking with the Director of Medicine role rather than trying to do both and not doing each of them adequately because of the time consideration. So Peter came on as the Deputy then. Jack Richards was the Manager here when I arrived and we worked well together and there wasn't any problem on either side.

**SP** A very cheerful man, Jack Richards.

**JG** Yes, actually when we arrived from Perth there is a good story. I was sort of expecting a bit of a fanfare when we finally flew in and there was no one there to meet us at the airport. We didn't know quite where we were going to be staying and we had received a telegram about a hotel called The Ridge because they ran The Ridge together and we couldn't find the Ridge Hotel so I had to ring up Jack and he came out with a floral top over his pyjamas because it was fairly late at night. There we were with five kids and nowhere to go for a while but it all sorted itself out. We had a good time with Jack.

**SP** The Chairman of the Board?

**JG** The Chairman was Neil Wotley and we had a very very good relationship. I owe a lot to Neil for giving me a free rein and giving me a lot of support and a lot of financial advice and that sort of thing.

**SP** Was there much difference in management style when Bill Job replaced Neil Wotley?

**JG** Bill was a much more intrusive, let's say, Chairman of the Board and I found it a little bit difficult at times. He was very good on the works side of things but I think it was a case of two egos colliding a little bit from time to time.

**SP** Was it difficult having to explain the medical side of things all the time?

**JG** Not really, I think that's one of the things you learn after a while, being able to convert things in fairly lay terms. I think it's an important thing to be able to do. I don't think that was a difficulty. I guess some of our priorities were a bit different.

**SP** Can you remember specific instances?

**JG** Well, liver transplants were one.

**SP** It's also a period when the government is trying to take back control of hospitals too, isn't it? Towards the end of your period?

**JG** Yes, sure. I don't know whether he was actually underwriting instructions to try to cut me down to size being fairly high profile with the media for a while and at one stage he said I was getting more publicity than the Minister and that obviously wasn't the right thing to do. But we did have a very good public relations officer on the staff, Marilyn Bitomsky, and she did keep the hospital as pretty high profile. I think all superintendents have a bit of difficulty with chairmen. Bill and I play golf together occasionally now.

**SP** So you've settled all your differences?

**JG** Yes.

- SP** Were you there at the Board Meeting when he announced that everybody had to stop smoking?
- JG** I don't remember that.
- SP** Apparently he said that everybody had to stop smoking in the hospital. He was a smoker himself and he put out his cigarette in the middle of the Board Meeting and said "that's it".
- JG** Well I can remember him sending all the patients outside the various areas for "not smoking" but I can't remember what the birth of it was.
- SP** You weren't a smoker?
- JG** No, I wasn't. I think it had to be a smoke-free environment. I'm not too sure there wasn't a department directive on it at one stage.
- SP** Bill's memory of it is this was the first hospital in Australia where they banned it.
- JG** I can't recall that. I think if he had done something quite as dramatic as that I would have remembered it. Perhaps I wasn't here. There was one time I was in the Health Department for about nine months when they got me to chair a group to implement reorganization of the Health Department.
- SP** What year would that have been?
- JG** That would have been 1981-82. The other thing about Neil Wotley is that I had to sit for an accountancy exam as part of my Fellowship of the Royal Australian College of Medical Administrators and anyway I was finding this accountancy terrible. Neil had to hold my hand and tell me how to get debit and credit balances. That was a good education.
- SP** He was a confident accountant.

**JG** Yes, crossing T's and dotting I's. That's not a bad thing to have around the place, as the rest of us may be a bit laissez faire in that direction.

**SP** There are a couple of other things I am interested in and that's the more casual format of the hospital. For instance, nursing uniforms changed, the starch went, the ironing went, the very clear demarcation of what level of nurse you got in front of you seems to have gone a bit. Forms of address I think have changed. Can you comment on that?

**JG** I was fairly disappointed when the veils went because I thought they did mean a lot to patients being able to distinguish who the registered nurse was and the only compromise I got was that I suggested if they weren't going to wear something on their heads they had to wear something on their epaulettes to say who was the charge nurse and they finally agreed to that and it actually went on to being put in other hospitals. I don't think it really achieved the same aura that the veil used to have but I can understand they are not easy things to work in.

**SP** They are not particularly practical.

**JG** No I didn't think they were practical either.

**SP** In terms of laundering and ironing, it must have been a considerable saving when not only veils went but also the uniforms went from being starched to being drip dry.

**JG** The drip-dry bit I didn't mind at all. My wife is an ex-nurse and she didn't like the idea of the veils going. I guess that hasn't really been a tremendous worry but I think for a little while it made it a bit difficult for the patients to know who was who.

**SP** I think some of the nurses regretted the loss of formality in their dress. Some people commented to me that they find it difficult when they hear people calling each other by their given names, which would never have happened probably not up until the late 60's.

**JG** I guess that's pretty much a sign of the times isn't it.

**SP** I think it was happening everywhere. It certainly was happening in the university. I was there in the early 60's and with younger lecturers I wouldn't have called them Dr this or Mr that at all. It was all Christian name basis. You would be drinking with them down at the Regatta or the RE in the evenings so it it's a bit silly to be calling Mr somebody in class. So some people have spoken with regret about that.

**JG** I think it can be carried to extremes and I would have thought that probably the sister/student nurse relationships should have remained a little more formal.

**SP** What about the incursion of men into the nursing profession?

**JG** I found that a very good thing to be happening.

**SP** What was good about it? What change did it make?

**JG** I think it made it less of a sorority convent feel about. It was a fairly regimented life especially when they were all living over in the Nurses Quarters. I think a few of the boys coming in tended to break that a bit. I don't mean that they were involved with each other romantically or anything like that but I think it did broaden the horizons a little bit and almost made them feel a bit less isolated from the rest of the community.

**SP** What about patients?

**JG** Some of the female patients were a bit wary of male nurses, which is pretty peculiar because they had male doctors for a long while. I suppose it was much more a matter of getting used to something that was different. I think it still happens a bit.

**SP** What about men patients? Do they prefer male nurses or don't they care?

**JG** I think they prefer females but I don't quite know why. Having said that, I have never done a survey.

**SP** What about the change in nurse education? While you were here nursing education underwent big changes.

**JG** It went from hospital based to a university based. The difficulty was that the new graduate nurse from the university based program lacked a whole lot of practical skills particularly in the first 6-12 months on the staff and that caused a fair bit of work overload and a little bit of difficulty between the traditionally trained hospital based nurses that were already there and the new ones coming out from university. In the transition there were some significant difficulties. Having said that, I think if they moved into specialized units the university trained girls had greater potential to lift their sights higher in what they did and how they managed patients. I am not at all sure that in the general nursing on wards that the whole thing has been a success. Because I think the aspirations that are put into nurses in their academic training may be too high for some of the routine more menial jobs around the place. Even though we have domestics and ward clerks and those sorts of people there is still a certain amount of humdrum work that probably doesn't require a full-blown academic trained to do it. I often wonder whether we wouldn't be better going back a little bit into the nursing/assistant nurse/nurse aide type of training and having to two different levels, one where they can fulfil their aspirations etc that they have been trained for and one which is on a more practical individual personal caring base.

**SP** I was listening to the ABC the other day where they were saying that nurses are moving into areas which previously would only have been for doctors in terms of drug administration and even prescription and presumably as nurses are higher trained, that will happen.

**JG** I think that's been a gradual trend for some years. I think the difficulty is getting sufficient diagnostic training into it, which at the moment isn't really there. That probably is the main difference between the two professions I guess. Obviously people

in intensive care and operating theatres and coronary care units and specialized areas and gastroenterology etc. are doing much more than nurses ever did years ago and obviously things that doctors used to do.

**SP** Do you remember the day of the first heart transplant?

**JG** At Prince Charles?

**SP** Perhaps the cardiovascular surgery here, not heart transplants, the early work done by Sam Mellick would have been during your period?

**JG** Sam didn't really do any cardiac surgery, it was vascular surgery. That was already fairly well in when I got here and aortic aneurysms and things like that were done fairly frequently and I can't remember when they first started, probably in the 50's I should imagine, or the 60's. Sam was a very good vascular surgeon.

**SP** When deciding which hospital would take on which specializations in the major Brisbane hospitals. Bill talked a bit about the Chairman's involvement. Would that have been something that you had part of the decision making in?

**JG** It varied a bit over the years. When I first came there used to be regular monthly meetings between the Royal Brisbane and ourselves and the executives of those places and the joint Chairman and issues such as that used to be discussed fairly openly there. Now that doesn't mean to say there wasn't a fair bit of rivalry between the two hospitals about what we did or didn't do. But we used to at least air things and Alan Knivet and I had a fairly good agreement. The other thing was the Under Secretary and Director General used to meet with the two Superintendents of the two hospitals and discuss these sorts of issues in town also. That disappeared around about Llew Edwards' time and then there were various more formal mechanisms set up, surgical advisory committees and things like that and they were usually departmentally driven but over the years there

have been lots of discussions about who should do what things and we used to discuss those with the Director General.

**SP** Were there many times when there were great disagreements?

**JG** I think probably people wish to push on harder sometimes with some developments than others but really two hospitals this size have to virtually be able to do most of the specialties. There is very little that you can rationalize and this was a 1300 bed hospital when I came here. It was bigger than the Royal Brisbane and with that sort of size and dealing with the population base you've got there aren't too many things. We talked about not having Burns Units here and the staff here were very keen to retain their Burns Unit at that stage and we eventually agreed that we would but that the Royal Brisbane would be the major Burns Unit for the State and we scaled down a bit on our activities. Neurosurgery were feeling that that should only be provided as an outreach service here and we felt that we should have our own service, and with the Accident/Emergency Department and the population it services you have to have Neurosurgery, so that was a little bit of a battle for a while. RBH didn't really want to get into renal transplantation nor did they want to do spinal injuries, so that was rationalized again but I think they had more trouble about cardiac surgery and it going out to Prince Charles. Royal Brisbane was very keen to get back into cardiac surgery and that was a pretty vexed issue in later years but you know, on the whole it hasn't worked out too badly. With paediatrics and obstetrics there was a lying in area here for obstetrics at one stage earlier on which was a pretty funny sort of arrangement and there was a small maternity hospital in Corinda that came under the Board but they both went and the Mater took over the role from them.

**SP** What other specialist hospital was quite dear to Bill Job's' heart?

He wanted to build a specialist hospital attached to this one.

**JG** Private hospital?

**SP** I suppose so, yes. That was not something you and he ever discussed?

**JG** Oh we discussed it sure and we both wanted a private hospital on site and in the early days when Ramsays were first negotiating with Greenslopes we had almost reached an agreement with them to transfer over here. They were going to develop a private hospital here. I thought that that might happen more recently but obviously the co-location of the private hospital has fallen over again and, in any event, Ramsays is committed to keep Greenslopes on until sometime about, I think, 2005. I think they can't financially afford to put up the money for a second one.

**SP** Well they have a big commitment to hospital buildings at the moment, haven't they? Here and at the Royal Brisbane and in Townsville as well. How do you feel about the taking down of this one and its replacement with the new hospital?

**JG** I think that's probably the logical way to go. If you try to rebuild an existing hospital, if you gut it out and try to refit it out, it's going to cost you about 75% of it takes for a new hospital and then you still are stuck with difficult plans, difficult support areas etc and there were significant structural problems in the acute block.

**SP** What are those?

**JG** There is some concrete flooring that's giving some trouble in some of the lower areas of the building and I think there's still trouble with asbestos. We had a plan to gradually get all the asbestos lagging off the insulation etc. throughout the building and that's been progressively going on for years but it is very expensive to do and I suspect there is still some of it there. It would be a very difficult hospital to rebuild to modern standards and I think you are best to go for a green field site and say, okay, a hospital has a life of 25-30 years and this one has done more than that, and rebuild it.

**SP** Is that the current thinking, that a hospital has a life of 25-30 years?

**JG** Yes, I think so. Usually they are built with very large areas between them with demountable walls so that you can move walls around inside them but that wasn't the way that building was built. So is the Nurses Home of course.

**SP** I think Jack Richards told me there were six million bricks in that old hospital.

**JG** I don't think they will be doing a Canberra job on it.

**SP** No, it's not possible with that sort of construction.

**JG** I had a talk to the engineer that built it, who recently died, Sam Cambridge, and Sam was saying that this was the last one where everything was welded together and it would really take some knocking over. I think it will be good for the staff to have a new start. You can keep the hospital running while the other one is being built.

**SP** That must be a considerable advantage. Otherwise there would be big chunks of the hospital nonfunctioning for months or years.

**JG** We've done bits and pieces on it over the years. It's very difficult with dust getting around the place even though you do your best to contain it with plastic sheeting and all that sort of thing. While you've got work going on and patients being operated on it makes it very difficult.

**SP** Well, what have I missed that you would like to talk about?

**JG** I think we have probably covered most of the bits and pieces.

**SP** Is there anything you'd do differently if you had your time over again?

**JG** What, with regard to my career?

**SP** Yes.

**JG** No, I have enjoyed every bit of my career and I am enjoying my retirement at the moment with a couple of bits of interest. I'm still on the Council here and I attend a

Medical and Surgical Meeting once a month and there's the Anti-Cancer Council I have to go off to shortly and that's another interest and there was the Presidency of the Golf Club, but I am now out of that and flying into the golf.

**SP** There aren't any decisions you made here that you would reverse and think differently about?

**JG** I think we made a difficult decision at the time because we were keen to appoint a Professor of Geriatrics. That was one of the few appointments that didn't turn out to be a success and I think largely on interpersonal grounds and that was a disappointment to me. He came from Oxford and obviously was very bright, he just didn't seem to rub in well with the rest of the Geriatric staff and so that was a disappointment I was strongly opposed to the building of QEII at its present site and I felt they should have built that hospital in Beenleigh and subsequently of course they built it at Logan. I think that was the wrong decision but it was forced on State Government because of Federal Government intervention I gather at the time. I think they were talking about building a hospital to do with Griffith University and the State decided they had better get in and build one. The biggest draw back of QEII is it's proximity to the Princess Alexandra Hospital and the Mater. I think that was a bad choice but you can't win them all.

**SP** I'd like to thank you very much for your time and when you get the transcript if there is something we've missed you can have a second bite at the cherry.

**JG** Actually, we haven't talked about the hospital coming of age. The other thing I think is very important is that it received the inaugural award for surgical excellence from the Royal Australian College of Surgeons and that it was the first hospital in the country to ever be given that award was a tremendous achievement.

**SP** What year was that?

**JG** That was about 1992 when I was Regional Director.

**SP** Could we go on to talk a bit about being Regional Director, after you left here?

**JG** I tried to physically base us out at Mt Gravatt so that I wouldn't be treading on whoever came to replace me. We appointed Judith Robson as the Chief Executive Officer and I think she did a very good job here in trying to reorganize the medical and surgical divisions and set up a new structure. She was also very cooperative with endeavors that pertain to the community. I think she was very well attuned to what was needed at places like Inala, what was needed in community psychiatry. We actually with her blessing moved a bit of her budget into some of the community type activities. It was very difficult to do anything touching any money from the Mater. That of course is another story. When we got out there we were asked to review the role of QEII and I think Treasury at one stage were indicating that they might like to sell the hospital to a private company. Anyway, we reviewed that and I decided that I would ring up Pat Maguire, the Chief Executive Officer at the Mater, and bounce an idea off him. I rang him and said "Pat, what would you say if we suggested the Mater Children's Hospital move out to QEII. We have a very nicely built facility out there, it would bring you closer to where the kids are, there's always been this open ended talk about whether Brisbane needs two paediatric hospitals or only one and I think it would lock you into paediatrics coming up from the South Coast and from Logan where it's all developing." He said, "We would be quite interested in that, I'll sound people out". So we got the Department's blessing to push on with this project and we got the Mater to do a detailed study of what it would cost and eventually I convinced the Minister to give them everything they asked for and after nine months we got to the Minister's office and the Minister said "we are prepared to give you \$34 million" or whatever it was and Sister

Angela Mary said “we don’t want to go” but Pat said “but Sister Angela Mary, they’ve given us everything we’ve asked for” and she said “No, we’ve decided we don’t want it”. And so that was the end of that.

**SP** I wonder why they decided that?

**JG** I think there was an argument and you know, there is some basis to it, that they wanted the Neonatal ICU on site. They would have still had an Obstetric Unit at QEII, which is a good relationship. Of course, a lot of Paediatric Hospitals and most of them in this country stand-alone anyway. We were pretty miffed after we had done all this work. I guess if I had known what I know now I wouldn’t have started that.

**SP** As Regional Director what were your main tasks?

**JG** To try to coordinate the activities of all the hospital, there were nine hospitals in total. I broke it up into three regions, Judith Robson had PA and an area about that community health and then there was one at Logan and an area around there and one at Wynnum and Redlands. We had sector directors and it was a very amicable arrangement, particularly for the first year or two because the Health Department got themselves downsized and a bit disorganized and they didn’t worry us too much. Then, of course they wanted to centralize everything. It seems to go in waves of decentralization and centralization.

**SP** It all kinds of areas they didn’t really seem to make up their minds about where they’re sitting and perhaps it’s a matter of turning the dogs loose and letting them go and then realizing we’ve gone too far and we have to pull them back in.

**JG** I think the unfortunate part of that is that we recommended there should have been five regions and it could possibly have been reduced to three but politically they decided to make thirteen regions and then some of them were not small in area but small in population, fairly small in the hospital capacity they had. For regions to work properly

they need to be almost self-sufficient and that means that you have the bulk of the specialties available there and that sort of infrastructure and the thirteen regions became a bit of a nightmare and but anyway that was obviously what they thought was politically saleable because all the country seats were worried about being taken over by the metropolitan area.

**SP** They say that they were worried about the Charleville Hospital and how well it was staffed and the fact that if the slightest thing goes wrong you would get helicoptered out rather than keeping staff near on the ground. It is just a matter of money.

**JG** It's a difficult balance. The hospital is so important to the township for a variety of reasons, not least of all bringing salaried staff into the area and spending money and I think some people go off light heartedly and say oh well it would be cheaper if we could ship everybody out and I guess it's a balance between maintaining the hospital at a reasonably viable level and a cost-effective basis and not putting people at undue risk.

**SP** A sort of balance between the social role of the hospital in town and the medical role. A lot of those towns would fold up if you took the hospitals away.

**JG** I can remember, where were they, Ayr and Home Hill, those two hospitals kept on getting the question asked "why have two hospitals for such small areas?" The reason was that the bridge had gone under in 1956 or something or other. I think the real argument was that this brought a fair bit of life and social impact on the town.

**SP** The hospital keeps the businesses viable, keeps numbers up in the school. It's incredibly important, not only to people who happen to have an emergency or need a long stay in hospital.

**JG** I think they got around it there, they made one a nursing home and one the hospital which was probably a very clever way to handle it.

**SP** Well, thank you for your time.

**JG** I hope that's the sort of stuff you need.

**SP** It's exactly what I have been collecting more or less from different perspectives from other people. Thank You.

**Transcribed by Robyne Sherrington May 2000**

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**This transcript has been checked by Dr John Golledge**

**Signed: On hard copy**

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