I was invited to deliver the second Betty Pettit Oration at the St George Hospital on 6 October 1995 and chose to talk about social policy and disadvantage—a liberal conjunction that is often ignored by those of a more conservative bent.

The essence of the theme you have chosen for this conference concerns the people with whom we interact, their disadvantage, and the possibilities of their empowerment.

Such a theme is what traditional philosophical liberalism has always been about—the empowering of people and the taking of steps to make such empowerment possible. So philosophical liberals supported universal education, supported the extension of the franchise, supported the vote for women, supported income support for the elderly and for those in other need, supported decent industrial legislation, and supported equal employment opportunity for women. Philosophical liberals support anti-discrimination legislation and support the thrust of native title legislation.

I believe in those things still. That belief helped spell the end of my career in politics.

Social workers operate in that tradition. They care about people. They care about people independently of the diseases or problems with which those people present. They see the intrinsic value in people. They believe that the power and vitality of a society come from individual people. They work to empower many people to do things that will make their lives more satisfying. They do this either by helping people to develop latent skills and powers or they do it by placing people and community services in contact.
Almost 25 years ago I had a social worker working in my then private consulting practice. She took her own referrals and helped offer a range of continuing services and support that transformed that practice.

Betty Pettit was social worker in charge at this hospital until 1994. She was at St George Hospital as a social worker for 22 years, for most of that time as director of social work services. She was only the second person to hold this position—and her predecessor did not stay long. At the time of her retirement, she was also head of the division of allied health at St George Hospital. She saw the department move from one typical of a small district hospital to its current position as an important part of a major teaching hospital. During her time she also saw the move in social work from the old almoner to the modern social worker we know today.

She is described warmly by an associate as ‘a fantastic boss’, as a motivator and as someone remembered with affection as an inspirational colleague.

Though it may seem a digression, the training of our medical students in ethics today is based on many of the same principles. In my day, we were taught about relationships between care providers—how a letter was written, who preceded whom into a room, and how the expected courtesies and civilities between colleagues were carried out. But my profession was then quite paternalistic and authoritarian—as other professionals tell us now.

Today we teach a quite different kind of ethics. We teach young women and men about the ethical principles that should govern behaviour between care providers and care recipients. The relationships between care providers might be covered as a minor part in a more satisfying and more relevant course.

It is interesting that practitioners aged under about 45 take the newer view of ethics—that it is about relationships between people—while those over 60 are almost all ‘old fashioned’ and most are incapable of re-education. Older practitioners are likely to be more authoritarian, and more paternalistic. So those of you trying to get democratic messages across to care providers can be more persistent with younger people and with older people might just wait for them to fade away.

Today we believe in patient sovereignty and autonomy. So modern ethicists and teachers see experts as advisers—not as decision makers. Many older or more dogmatic colleagues do not wish to share decisions with their patients—well, maybe the development of case law will help solve that if nothing else does. Just yesterday my nephew phoned about whether or not he needed surgery. While I gave him advice, it was combined with the insistence that he owned the decisions, that he was ‘in the driving seat’. It seems clear to me that every major
treatment decision is owned by the person affected and that we specialists are
advisers to whom they may turn for accurate analysis of the problem and for
expert advice about the options for treatment.

But the decisions are, and remain, theirs.

Some colleagues do not agree. A cautionary tale was told to me by a friend
recently. She told of a person who was found to have glaucoma. That person
returned to her specialist with some questions she had written down following
a visit to the glaucoma association. ‘I ask the questions around here’, answered
the specialist. Today she has a new eye doctor who does answer her questions.

A surgeon told a group of our students two years ago that no woman with
a lump in the breast was in a fit state to make a decision for herself. So some
practitioners still do not accept patients as equal human beings—and they
should.

We also teach about confidentiality—something that was observed more in the
breach in my young days. It comes as a shock to some colleagues to be told that
no one, no-one at all, should know private details about anyone else, except
with explicit permission or for purposes of direct treatment. To test this, I asked
recently why a colleague was absent. Actually I did not care why he was away—
this was just an exercise to test the system. It will not surprise you to learn
that I was told his diagnosis—and all the gory details—when it had absolutely
nothing to do with me.

We teach about fairness, about beneficence, about non-maleficence and about
duty of care.

And we are aware that sometimes difficulties can arise when ethical principles
come into opposition. So I have some sympathy with those trying to balance
confidentiality with duty of care in the rare instances of a practitioner having
as patients two sexual partners one of whom has a sexually transmitted disease.
Does the practitioner observe confidentiality in which case a duty of care to the
unaffected partner might be breached, or does the practitioner tell the diagnosis
in which case the principle of confidentiality has been breached?

But we teach some other interesting things too. We teach that mortality is
universal, that life is a fatal sexually transmitted disease, that our task is to add
quality to whatever life people have, that death is part of life, that death does
not equal therapeutic failure, and that a lot of treatment should be directed to
situations in which cure is not an option. Our task is not made any easier by the
way large hospitals are structured or by the way they conceptualise themselves.
Hospitals today, especially large hospitals, are dedicated to diagnosis and cure—
and activities not directed to either of these aims are likely to be devalued
in large hospitals. They work to power and economic agendas that take too little account of the needs for care of the large populations of people in which they are located.

We emphasise the roles of care, symptom-relief, compassion, tenderness—especially where cure is not an option. We have to convince young men and women that these are important things when the young do not want to hear about physical imperfection or about mortality in general or about the inevitability of death and particularly about their own mortality and their own inevitable deaths. Any of you who have seen the reluctance of professionals even to talk to the dying will know what I mean.

Actually, the best students for this kind of teaching are those who are in their thirties and have some experience of life. Sadly, bright and attractive young 20-year-olds sometimes find our messages disturbing or irrelevant. And five years later these same people are running the hospitals and making critical decisions about care.

It follows that much of what we say and teach is not understood or appreciated by some in our faculty. But it is clearly important to do well what we do. The Australian Medical Council is demanding more of our kind of teaching, and in our groups dealing with communication skills, with general practice and with aged and extended care we have areas of medicine which are often consonant with our own views.

Social workers understand what we are saying, what we teach, and what we do. Our goals seem similar, our comprehension of human life and death is similar, we are both able to face our own mortality, our appreciation of human frailty is similar and our concept of what is possible is similar.

Incidentally, I teach students to be relaxed about alternative therapies. While public subsidy is a separate question—let us not deal with it today—the use of alternative therapy sometimes gives relief which has been denied with more conventional approaches. So it is that hypnotherapy is fine, chiropractic is fine, naturopathy is fine, megavitamin therapy is fine, and so on—provided that we have done what we do well, that we have excluded treatable disease, and that we have some arrangements for future review of the situation. Often patients need a telephone contact number as well. But back to the disadvantaged.

Dr Bob Gregory from the ANU has shown recently that the gap in Australia between haves and have-nots is widening. The rich are getting richer and the poor are getting poorer. More of the wealth of the nation is controlled by fewer people.
This means a lot for our clients—or customers—or patients. It seems beyond doubt that to be old in Australia is generally to be poor, to be powerless, and to be a non-person. To be an Aboriginal in Australia is to be poor, powerless, educationally disadvantaged, unemployed, and to have worse health and worse experience with police and the legal systems. To be a migrant in Australia is to be isolated by differences in language and culture, often to be ghettoised, to be foreign in a somewhat xenophobic country and to have to struggle for economic parity. Let us add another group—those with some disability. As a group (and actually there are many groups) they often are poor, powerless, ‘non-persons’, and in danger of being isolated from the rest of society.

The word power has come up several times in the paragraph above. Power over one’s own life, power over resources, power over where one lives, power over how one eats, power over recreation, these are the things that divide our society into two—those who have such power and those who lack it.

Is this the kind of society we want? Are these the features that we find desirable or acceptable? Is this the way we think things ought to be? Do we believe that poverty, or powerlessness, or lack of education, or unemployment, are in some way good for people? Is there a place for social Darwinism—does it serve some social good and should we be supporting it when we find it? Or might we say that it represents the message of a bygone era, that it is unfair, that it is not consonant with today’s beliefs and values, and that it should be rejected? Do we wish to have a society in which the only valid measure of success is economic? Or do we think that the costs of going down such a road are too high to bear?

It is my belief that values and attitudes are what we need to examine and the values and attitudes are what need to change if some of the groups with disadvantage are to receive a fair go.

One particularly bad thing about the 1980s in Australia was that selfishness was a dominant value. People actually admired those who became uselessly and excessively rich, admired those who paid too little tax, and responded to promises from politicians to reduce personal income tax.

There are costs as well as benefits to almost every action. So, the acquisition of great wealth may occur at the expense of others who become poor, the avoidance of income tax diminishes the public revenue that maintains services, and any reductions in income tax will diminish our capacity to meet our obligations to our fellows. In the same way there are costs to everything that hospitals do—shortened lengths of stay have costs as well as benefits, the failure to admit, or to delay admission has costs, the inability to offer care has costs, the closure of theatres over Christmas has costs, and so on. To argue that these things are cost-free is a convenient misrepresentation of fact.
Let us propose instead a different system of values. Let us espouse the value of mutuality, of caring for others, of being responsible for others, for paying our share of tax, and of rejecting as foolish any moves, by anyone, to reduce the tax base. Every person we treat, or with whom we consult, or whom we direct towards some service, could be us. It could be us from childhood if our parents had been unfortunate. It could be us from young adult life if we were black, or if we had an injury or incapacity, or if we could not speak the language or understand the culture. And it could be any of us tomorrow when we too are aged, demented and dependent.

We today have the capacity to influence those who represent us in the parliaments of the nation. What they need to hear from us are messages about values, about what we do support, about what we expect, and about what we reject as crass, crude, or unfair. Will you, remembering the service given by Betty Pettit, remembering her service, and her inspiration and her leadership, and determined now to do what you can, make known to all politicians the values that you hold to be important? They will listen, perhaps only over time, but they will listen.

Not only will I do this but as a philosophical liberal, will do all I can to empower more people and to prepare young professionals—doctors and social workers—who will work to empower people too. This may mean altering the dynamics of many interviews in the helping professions where we have presently a great disparity of power in favour of the provider. It will involve making people more aware of their rights and of their own capacity to have a role in all matters that involve them.

If we can succeed—even partially—then every caring professional will find new enrichment and new worth in what they do. They will feel better about their work and they will be better practitioners to know and to attend. It is a noble crusade. Will you be part of it with me?