

History of Occupational Medicine in Australia and Aotearoa New Zealand Project: Thematic Analysis of a Witness Seminar – ‘Occupational Medicine – Are we there yet?’

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Abstract

Background: A witness seminar was held as part of The History of Occupational Medicine Project - a collaboration between the Royal Australasian College of Physicians (RACP) Library, the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Australian and New Zealand Society of Occupational Medicine (ANZSOM). *Aims:* 1. To create a contextualised record of the recollections and reflections of key personnel involved in the development, establishment, and changes in the practice and scope of the specialty of Occupational Medicine in Australia and Aotearoa New Zealand. 2. To generate themes from the transcript and relevant archive material. *Methods:* The witness seminar followed the method of the Wellcome Trust History of Twentieth Century Medicine Group. Throughout transcript editing, themes were generated in a process of reflexive thematic analysis. *Results:* The transcript is extensively annotated for context. Five major themes were generated: 1. The complexity of becoming a specialty college; 2. The importance of collaboration; 3. The significance of government and economy influence; 4. The importance and value of occupational medicine; 5. Learning from the past. *Discussion/conclusion:* The witness seminar and edited transcript contribute to the professional heritage archive in the RACP Library. Themes generated from the discussion between key participants in the development of Occupational Medicine revealed difficulties and strengths that are coherent with previously documented information. The themes are relevant and actionable towards the promotion of the ongoing importance and relevance of this specialty. The methodology described in this report offers a model for future projects documenting the history of other specialties in the RACP.

Keywords: occupational medicine, history, witness seminar, thematic analysis

Introduction

The History of Occupational Medicine Project committee, jointly established by the Royal Australasian College of Physicians (RACP) Library, the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Australian and New Zealand Society of Occupational Medicine (ANZSOM), resolved to develop an archive within the RACP Library and facilitate historical research projects. The overall aims of this project are to:

- Prevent the loss of information held by occupational physicians (OPs) on the changing nature of industry, work and employment, work-related conditions of importance, and the organisation and management of workplace health and safety services in Australia and New Zealand.
- Promote the role and contribution of OPs to Australia and Aotearoa New Zealand.
- Demonstrate changes in the scope of practice over time.
- Provide a model for describing the heritage of the specialties in the RACP.

Historical research in health sciences has a long tradition (1,2) and proponents make compelling arguments for increasing its importance in medical university curricula (3–5). Studying the history of medicine provides us with more than just a chronological listing of facts. Insights can be developed regarding the relationships between people, events, time periods and places. Developing our understanding of these relationships helps inform current and future practices. This is relevant to both the practice of medicine and to developing the structure and advancement of a discipline. By examining the past, we can determine what went well, what practices should be preserved, and what mistakes we can learn from. Documenting the past serves also other important purposes including creating an informative archive, preserving professional heritage, and adding to the iterative process of historiography (6,7).

Occupational medicine (OM) is a relative newcomer to the stable of defined medical specialties (8,9), with the Australian College of Occupational Medicine (ACOM), the precursor to today's AFOEM, having formed in 1984. Physicians, however, have been interested in and practised OM since the early years of Australia's settlement (10), and, more broadly, since the days of Bernardo Ramazzini (1633-1714), an Italian physician acclaimed as the 'father of occupational medicine' (11).

There is published historical information regarding the practice of OM in Australia and Aotearoa New Zealand. In 1971 Professor Bryan Gandevia (1925-2006), a respiratory physician with an interest in occupational lung disease and a keen interest in medical history, published a history of occupational disease in Australia from 1788 to 1970 (10). Professor David Ferguson (1920-2002), regarded as one of the founding fathers of the modern specialty of OM in Australia, wrote a concise history of developments in occupational health and safety regulation, research and professional development, and service provision covering the period 1914 to 1994 (12). Professor Niki Ellis (13) and Professor Bill Glass (14) each published articles in the *Medical Journal of Australia* in 2014 with reflections and about the development of the specialty. In 2018, to commemorate the 50th anniversary of the foundation of ANZSOM, a document was published to collate recollections from past presidents and other prominent members (15). What has not yet been captured are the personal recollections of OPs about the formation of the specialty of OM and their experience of influencing factors that have shaped its development.

The study of recent history has challenges such as the subjective nature of memories, the absence of consolidated archival records, and the sensitivities and reticence that can arise when writing contemporary history about people who are still living. However, the benefits of capturing voices of living protagonists, gaining insights into recent events, and creating a comprehensive record outweigh these challenges (16).

A witness seminar is an oral history method which has been developed and extensively employed by the Wellcome Trust History of Twentieth Century Medicine Group to ‘promote the historical study of recent medicine and medical science’ since the 1990s (7). It has also been used in other fields of historical research including economics and social history (17,18). Discussion between key personnel involved in the event of interest is facilitated in a seminar environment, allowing reminiscences and memories to be stimulated, confirmed and challenged (7). The methodology does not aim to elucidate a unified, consensual truth. The goal of gathering oral history this way is to capture recollections and reflections from the key participants, to develop a more nuanced and comprehensive understanding of the subject beyond the ‘bare facts’ to be found in the written records (7). A witness seminar on the development and professionalisation of the specialty of OM is a novel activity in the documentation of its history.

Aims

The aims of the present project analysing the witness seminar are twofold:

1. Transcribe, edit, and annotate the recorded seminar to produce a document in the style of the Wellcome Trust History of Twentieth Century Medicine Group monographs (7,19,20), creating a contextualised record of the recollections and reflections of key personnel involved in the development, establishment, and changes in the practice and scope of the specialty of OM in Australia and Aotearoa New Zealand.
2. Generate themes from the witness seminar and associated archival materials to address the question “Are we there yet?” - a shorthand expression for examining how the practice of OM developed and changed, and considering whether the participants thought the specialty had achieved what it had intended at the outset and what the future directions might be.

Methods

The witness seminar was organised by the History of Occupational Medicine Committee. The planning process followed that of the Wellcome Group (Tansey 2006) as closely as practicable. Drawing on the Committee’s collective knowledge of key personnel involved in the development specialty of OM, relevant panel members were invited to attend. The 2-hour seminar was chaired by Professor Niki Ellis, the inaugural president of the Australasian Faculty of Occupational Medicine (AFOM), at the ANZSOM Annual Scientific Meeting (ASM) in March 2022.

Prior to the seminar, the overarching theme of the discussion – ‘Are we there yet?’ was developed. The seminar was divided into four principal topics (see Appendix 1). In addition to the chairperson, there were 9 panel members: one physician/medical historian, 4 senior OPs, one more recently credentialled occupational physician, two OP trainees, one physician who has held roles on the Council of RACP, and one senior occupational health nurse. Other contributors to the discussion in person or online included 9 OPs, and one senior occupational health nurse (listed in Appendix 1).

Panel members were invited to prepare material to open and stimulate the discussion of each topic. Other interested people who were attending the ASM were invited to attend. Participants

were informed that the seminar would be recorded and published on the ANZSOM website which is publicly accessible.

The entire witness seminar was recorded by video. Some invited participants and other interested attendees joined by video link. Attendees who were not part of the panel were able to submit comments via the webinar chat function of which a written record was kept. In total there were 40 in attendance in-person and 43 online.

I prepared a verbatim transcript of the video recording and edited it alongside repeated viewing of the video, to ensure meaning was captured correctly. The first edit was to improve comprehensibility as conversational speech does not always convert well to a readable text. I then sent this to participants for two purposes – to have their approval of the transcription of their words, seek minor corrections and amendments, ask for clarification on certain aspects, and invite contribution of additional comments or materials. The transcript and invitation to contribute was also sent to several absentees whose contribution was considered important to the discussion.

I completed the editing process by searching for sources with which to annotate the transcript for contextualising information. Sources included archive material from the RACP, published academic literature, news articles, websites of relevant medical and government organisations, and personal papers and correspondence provided to the archive, and from participants' correspondence to me. Critics of oral history as a historical research method emphasise the unreliability of memory and the subjective nature of personal testimony (7). The use of these sources therefore served a further purpose – to validate factual content within the seminar discussion.

Using the process of reflexive thematic analysis (RTA) based on the established qualitative research methodology (21,22) while reviewing and editing the transcript I was able to generate themes. The combination of oral history research and thematic analysis is well established in qualitative scientific research (23). Some authors of history have applied similar methodology to analysis of historical data (24,25). My RTA involved repeated watching and reading of the transcript, while comparing it with other source material. During this recursive and iterative process, preliminary themes were generated, then small extracts of the text were grouped and reviewed for their ability to support unifying concepts that developed into the major themes.

The themes are not presented as chronological narrative of topics, rather, this analysis focussed on elucidating the multifaceted themes surrounding the development of the specialty. The transcript (Appendix 1) is extensively annotated for contextual clarity.

Results

The edited and footnoted transcript is in Appendix 1. The video of the seminar is at: <https://www.anzsom.org.au/projects/history-of-occupational-medicine-project>.

From the analysis of the transcript and associated materials 5 major themes were generated (Table 1). In the following discussion, quotations from participants are italicised.

Table 1. Themes and Theme sub-components

Theme	Theme sub-component
1. The complexity of becoming a specialty college	1.1 Drivers
	1.2 Difficulties
2. The importance of collaboration	2.1 Internally within the specialty
	2.2 External (ANZSOM, RACP, government, allied professions, overseas)
3. The significance of government and economy influence	3.1 Economy and changes in industry
	3.2 Government involvement and regulation
4. The importance and value of occupational medicine	4.1 Recognition of importance
	4.2 Presenting a value proposition
5. Learning from the past	5.1 Influence of elders
	5.2 Learning from mistakes

Theme 1: The complexity of becoming a specialty college

1.1 Drivers

The discussion revealed an interplay of driving factors including the determination of certain proponents, collaboration between like-minded individuals, a desire for specialist recognition, and the establishment of an appropriately high standard of admission and practice. Other enabling factors included financial support from industry, and valued administrative support.

The principal objectives of ACOM when it was established in '82, were 'establishing and maintaining the highest standards of learning, skill, and conduct in the field of occupational medicine.'

Jim [Milne] had spent a year at IARC [International Agency for Research on Cancer] at or about that time, and came back, I think, with some enthusiasm for the idea of making ANZSOM more than it had been.

Going back to the formation [of ACOM], it was really around the Occupational Health Committee table [of the National Health and Medical Research Council (NHMRC)] that people had the opportunity to talk to more.

Participants recalled the importance of the contribution of committed administrative support in the early development of ACOM, and alluded to special efforts that had been required to secure funding for this.

'... Elaine [Siggins] made a huge contribution, as you know... it would've been around 1982 and I think it grew out of an ANZSOM conference in Melbourne that she organised. So, she came in at that stage and we scrimped and saved and scratched and did some dubious accounting within various oil companies to make sure that expenses generally were covered, including the salary for the first full-time administrator, which is what Elaine was.'

One participant noted in preparatory information sent to the Chair the following:

The real carrot for the College members was the eventual attainment of Specialist status under the National Professional Registration arrangements. Affiliation with the College of Physicians was a significant step along that path and without it, the College would have foundered in my opinion.

This was not discussed extensively but given the detail explicated in the AFOM President's address of 1998, it was included as part of this sub-theme as an important driver for formation of a recognised specialty. Specialist recognition was referred to by Dr Ian Gardner in this address as *'the Holy Grail'* (26).

1.2 Difficulties

Disagreements in the early stages of ACOM formation in the 1980s were multifaceted. Lack of unanimity on various fronts was a recurrent motif, highlighting the complexities of forming a new specialty college. There were tensions between groups of physicians in Victoria and New South Wales about the location of the College and an associated academic research base. Funding issues were also important – there was a balance to be struck between setting a high enough standard of entry to be taken seriously as a recognised specialty and admitting enough people to fellowship to fund operations with their subscriptions.

To put not too fine a point on it, the doctors didn't want to pay the money. Do they ever? And so, it had to come from somewhere to run, even the fledgling college. So, it was a matter of 'hand out' to industry for that.

There was also the divisive issue of the early ACOM executive pushing for ANZSOM to be merged into ACOM as the parent organisation 1980s. Participants alluded to the idea that the strong financial position of ANZSOM was a driver for this.

Lack of unanimity reappeared in later discussion about the period in the 1990s when preparations were made to join ACOM into the RACP and become AFOM.

The negotiations had all been done, and we thought that we had a deal and a handshake had been done...We'd done all the hard discussion, we'd reached an agreement, and then Ann [Long] and I were to go to the bigger executive meeting of the RACP to have the ceremonial

discussion. The work [had been] done beforehand and this was expected to go through smoothly. The day before or the weekend before, there was an uprising - the last-minute uprising by the people who didn't want this to happen. And in fact, the decision of the council [of ACOM] was that we couldn't go ahead with this. So, we had to go into this meeting where everything was expected to be done and dusted, and sort of recommence the negotiation. It was terribly embarrassing.

Control of funds was again a concern during this period:

The issues being discussed between the RACP and ACOM were mainly money. RACP were insisting all funds went into central pool and we were to be allocated a budget. Similarly, we were not to have dedicated staff, rather support would be provided by RACP. We also argued about identity and autonomy. All of those issues were prescient as they have been the sticking points in the relationship over the years.

Funding issues also affected the essential issue of academic research in the field:

I recall in the early days it was very hard to get an NHMRC grant because there was a feeling industry should be funding research.

Theme 2: Importance of collaboration

There was a recurring emphasis on collaboration, both internally within the specialty and externally with allied professions, overseas institutions, and other organisations including the RACP and ANZSOM.

2.1 Internally within the specialty

Internal collegiality between members of the specialty was seen as an important in maintaining social connections and networks, as well as professional development and even employment opportunities. ANZSOM was recognised as an important facilitator of collaboration through organisation of scientific meetings and later having been recognised as a specialty society by RACP.

I think it was at an ANZSOM meeting in Sydney that I spoke to Bob Wilson and said, "Hey Bob, you don't know of any good jobs going, do you?" And I ended up taking over from him, which just goes to show the value of a good meeting.

2.2 External

Engagement of the specialty with the RACP has seen significant development. Participants expressed surprise that the RACP had taken up the Hunter recommendations (27) and conducted a review of Occupational Health in Australia in 1955 (28), with a view to improving and developing OM education and practice in Australia. It appears that after this, while the RACP had physician members with an interest in occupational health as it related to their own subspecialty, it did not reconnect more formally with the specialty of occupational medicine until later, and for different reasons.

We felt that it would be a good thing to embrace as many bits of medicine as we could.

The elders of the ACOM recognised that being a very small independent College meant we would have very little influence in relation to policy relevant to our profession, including specialist recognition. They also recognised that there was an opportunity to become a part of the RACP under the visionary leadership of John Chalmers (President). He could see a splintered medical profession made it harder for governments and others to engage with the profession.

The discussion about the loss of multidisciplinary practice inside industry indicated participants regretted this loss and had valued working collaboratively:

There were also industrial hygienists and occupational health nurses and so on there. It was all very much a team, whereas now we tend to be much more in silos.

The benefit of overseas fellowships and collaboration was another recurrent idea. In the earlier years of the 20th century, both in Australia and Aotearoa New Zealand, visiting experts from the UK were invited by governments to advise on the development of industrial medicine practice. Later, Australian experts have become collaborators overseas. It was noted that now and in the future the specialty might benefit from developing overseas connections and taking

a leadership position helping other countries with less developed academic and regulatory structures.

We don't have much overseas presence in teaching in universities - we don't have that level of collaboration, and there's a lot of hunger [for that] out there overseas.

Theme 3: Significance of economy and government influence

3.1 Economy and changes in industry

Senior fellows had had opportunities to work inside industry organisations. This was viewed as good experience, and as a facilitator of comprehensive and expert OM practice. This has changed on the background of economic fluctuations, and the loss of manufacturing in Victoria was a particular example.

My last full-time job in industry was in Toyota, which wound up in the mid 1990s. And that was also a time when a lot of industry in Australia was winding down, stuff was moving offshore because it was cheaper. The economic rationalists had taken hold, I think, of industry. So, we gradually moved from being employed full-time or maybe part-time in an industry, but working at several [companies].

There was this general move to contracting out things which weren't "core business". Companies would say, "Well, look, you are not part of our core business."

Occupational health nursing had been similarly affected:

We wonder where all the other occ health nurses are – because many of their jobs have been replaced with exercise physiologists and safety people.

The discussion also highlighted recent regional differences in practice opportunities which related to the strength of the resources sector in Queensland and Western Australia where there was possibly more scope to work directly with industrial clients either in-house or as an external consultant.

3.2 Government involvement and regulation

Early development in Australia and Aotearoa New Zealand, as in the United Kingdom, was influenced by government ideas about regulation of work health and safety, and initiatives stimulated by concern regarding specific working groups (8,10,12). As already noted, in the early 20th century governments called on UK experts to assist.

Government regulation has also affected the nature of practice more recently, though perhaps more indirectly. It was noted that work health and safety regulation has been beneficial in terms of reducing injuries, but the involvement of OPs has also changed on this background. This may be due to the professionalisation of other groups such as health and safety (who are less costly to employ than doctors), and possibly a sense of complacency in society and industry that the hazards have been controlled and involvement of OPs in risk assessment and hazard management may not be required because there are codes of practice, or someone else 'knows how'.

But I think in the mid-eighties, there was a significant policy issue that drove it. I think the establishment of the National Occupational Health and Safety Commission was not good for professional bodies. There was the tripartite [of] government, and industry, and workers, but the people who knew anything about the science discipline were excluded from that process. And that was occupational medicine, occupational hygiene, the ergonomists and things. And I think that that change in policy has had a big influence on the practice of all of those disciplines.

I get disappointed now when companies come along and tell me what they want to do and then I've got to turn around and say, "Well no, you actually don't know what you're talking about." Because some ill-informed person within the organisation has read a WorkSafe New South Wales brochure and thinks they know all about it.

Theme 4: Importance and value of occupational medicine

Throughout the discussion there were references to the recognition of the importance of OM to healthcare, industry and the community – ways that it had been recognised, or conversely under-recognised.

4.1 Recognition of importance

The usefulness of OPs was demonstrated during the COVID-19 pandemic, in the response to the reappearance of coal worker's pneumoconiosis, and the silicosis epidemic in the stone benchtop industry. There was a sense that this was a return to the more collaborative and prominent scope of work for OP's that had been available in the past.

Now, one of the positive things out of COVID was that the Victorian Department of Health put on a panel of occupational physicians, of which I've been lucky enough to be one... All of that has just been, in a way, a bit of a rollback to the old days, but unfortunately, it's coming to an end.

4.2 Promoting a value proposition

The discussion also repeatedly turned to the importance of establishing and promoting OM's value proposition, both to industry and government as well as medical colleagues.

I think to some extent we probably undersold ourselves.

...the first question I get asked by physicians or GPs is, what is an occupational physician? Exactly what do you do? And the hard part is trying to convince or explain to them what we do, and I see a lot of my colleagues struggle as well.

I have not heard any mention yet of the importance of understanding how our activities help the customer. Every health practitioner should understand who their customer is and what they can do for them.

Theme 5: Learning from the past

5.1 Influence of elders

The influence of senior colleagues was recurrent in the discussion. Several participants referred to those who had inspired them to become involved in OM, or whose teaching and guidance they valued.

Well, Jim [Milne] was a really strong influence in my career when I did my two years of residency and took a year off to travel overseas and then came back and wondered what I was going to do with the rest of my life. He was quite supportive of me going into the area, not pushy, very supportive, and explained to me what occupational medicine was about.

5.2 Learning from mistakes

There was also reflection on the importance of learning from past mistakes and the discussion turned to missed opportunities to advocate for and protect the health of workers. There was emphasis on looking carefully at these failures and learning from them.

In 2015 OSHA put out a hazard alert about new silicosis in relation to engineered stone...It was at least two to three to four years after that that people really became interested in what's going on here. So, whilst we've been doing pretty good at playing catch up, I think it's disgraceful that a group like OSHA could be out issuing hazard alerts in 2015, and yet nothing seemed to have happened in Australia.

I think it was a large iatrogenic epidemic, RSI, as well as [being] associated with changes in technology. And a mistake has been made that we didn't learn [from] at that stage. Hopefully we are learning more now [that] the biopsychosocial approach to these conditions is important.

Discussion

So, 'are we there yet'? The discussion revealed that there is a strong foundation for the practice of OM in Australia and Aotearoa New Zealand. However, external influences have had a significant effect on the nature of employment for OPs across time and the vast geography of Australia and Aotearoa New Zealand.

The background of government influence and regulatory change upon which practice has changed have been documented previously (29–32). This discussion has now revealed personal recollections of how the specialty has been affected. As one participant put it neatly, OM is 'a

child of the economy' - because it predominantly serves industry clients, governments and insurers, it is inevitably affected by shifts in the economy.

The importance of making the case for cost effectiveness has long been known (30) and indeed key competencies in AFOEM training include understanding the nature of business organisations and marketing an occupational health service (33). Difficulty communicating the nature and relevance of this specialty to medical colleagues was a related concern which has previously been noted (15,34–36). The discussion revealed that OPs know that addressing these issues is crucial to maintaining the importance and relevance of the specialty in the wider medical and industrial landscape.

The analysis of the discussion highlighted the importance of looking to the past to inform the future - to learn from elders and their experiences, and critically review mistakes so as not to repeat them. The reappearance and 'rediscovery' of industrial diseases (silicosis being a current and prominent example) has been a problem through the ages (11), and the discussion indicated practice in Australia has not been spared. Analysis of accidents, errors or near misses is a well-established practice in occupational health and safety (37) which has also translated into clinical governance in medicine more generally (38). OPs are therefore well placed to look carefully at problems that have occurred in the past and implement systems to avoid repeating mistakes. Learning from past errors involves collaborative effort. Participants understood that there is strength in working together to solve problems and advocate to industries and governments.

This analysis, while it has been informative, is not without limitations. One limitation was the necessary constraint of panel and participant numbers due to logistics and time. Certain important voices may have been absent. This could be addressed in future historical investigations by conducting further interviews.

A long time period and multiple complex topics were covered, meaning that some finer detail inevitably could not be captured. Also, certain potentially important topics did not surface during the discussion. One was the nature of training for occupational physician registrars which, in contrast to other specialties within the RACP, occurs almost entirely in the private sector. Previous authors have noted this in Australia and overseas (34,35,39). Training issues may have exerted effects on the changing landscape of practice or conversely have been

affected. Another is the contribution of environmental medicine to the specialty and the omission in itself may have meaning. These issues could be explored in future investigations.

The degree of engagement from participants in reviewing the draft transcript was variable. Most commented briefly that they approved my editing of their own comments, several made extensive comments and provided further materials, and some did not respond at all. The variability in these responses could have been due to an extended period of time (around 18 months) between the witness seminar and distribution of the draft.

Conclusion

This project has addressed its dual aims of creating an edited, contextualised transcript of the witness seminar and using qualitative research methodology to generate themes from the oral history and associated archive materials. The themes are relevant and actionable towards the promotion of the ongoing importance and relevance of this specialty. The methodology described in this report offers a model for future projects documenting the history of other specialties in the RACP.

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Appendix 1:

The witness seminar transcript – attached separately