Practising Surgery

A history of surgical training in Australia, 1927-1974

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Abstract

This thesis set out to examine the extraordinary degree of control that Australian surgeons have over their own training process and to ask how and why this has arisen. The Royal Australasian College of Surgeons was founded in 1927 and from an early date concerned itself with teaching and training as well as accrediting surgeons. Over the next forty years, a number of different models of surgical education were trialled, often closely following British ideas, but none had more than limited success. The model of training that finally found favour with trainee surgeons and public hospitals in the early 1970s owed much to the "long residency" pattern of training that was proving successful in the United States. However, in Australia, in contrast to the situation in the United States and Britain, the training agenda has been set almost exclusively by the body representing surgeons.

Between 1927 and 1975, relatively little attention was given to teaching the manual skills involved in operating. Greater importance was attached to teaching and examining in the "science" of surgery and to the acquisition of "clinical judgment". Training in surgery involved what was generally described as an "apprenticeship", practising surgery on public hospital patients. The reasons why surgery was not practised on private patients (or cadavers, or animals) lay in the deep-seated cultural attitudes to public hospital patients within the moral economy of the hospital.

When the College managed to set up a coherent training program in the early 1970s, it was allowed to control this training—by governments, hospitals, the universities and surgeons—partly because it was the only body that had shown sustained interest in the issue in the past, and partly because it had succeeded in capturing and holding the moral high ground in Australian surgery. It achieved this largely through its use of the moral economy of the gift. Most surgical training took place in public hospitals, where it relied on the gift by the patients who allowed themselves to be practised upon, and the gift by surgeons, who were
not paid to teach. The only other organisations that were involved in providing any surgical education—the universities and State postgraduate committees—could not match the College's ability to mobilise surgeons and persuade them to form the unpaid workforce for its training program.

However, as the thesis progressed, the unacknowledged role of the patient in training came to seem increasingly important. Consequently, it is suggested that in future the role of patients in the gift exchanges surrounding training should be explicitly recognised. It is proposed that surgeons should acknowledge that they need patients for their training, that they should invite both public and private patients to participate, and that they should thank them for doing so.

Declaration

This is to certify that
(i) the thesis comprises only my original work, except where indicated in the preface
(ii) due acknowledgement has been made in the text to all other material used
(iii) the thesis is less than 100,000 words in length, exclusive of tables, bibliographies and appendices

[Signature]

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Preface

In 1999, Bruce Barraclough, President of the Royal Australasian College of Surgeons at the time, was kind enough to give permission for open access to the Archives of the College. This is a rich and so far little used source of information on the history of surgery in Australia and New Zealand. The main records used for this study were the Minutes and Agenda Papers for Council and the Executive which are held in the College Archives in Melbourne, plus the Register of Fellows and personal papers of individual surgeons. Use was also made of material in the Archives of the Queensland State Branch of the College in Brisbane. In addition, chapter six relies heavily on the surgical travel diaries of Malcolm Earlam and John Laidley. Strictly speaking, these form part of the Archives of the Urological Society of Australasia, but they are held in the Archives of the Royal Australasian College of Surgeons in Melbourne. Permission to use them was kindly given by the Society’s Honorary Archivist, Peter Lawson. Use was also made of material in the Archives of the Royal Melbourne Hospital and of the Mater Misericordiae Hospitals in Brisbane.

The other major primary source of information for this study was a range of oral history interviews with eighteen surgeons who trained during the 1950s and 1960s. Half of them were associated with the Royal Melbourne Hospital and half were associated with the Princess Alexandra Hospital in Brisbane. For Melbourne, an approach was made to all those surgeons who could be traced from the Medical Register and whose names appeared in training positions at various levels of seniority in the Royal Melbourne Hospital Annual Report for 1967. There were twenty-two of them and nine of these subsequently agreed to be interviewed. Details of the University of Melbourne’s Ethics Committee requirements, and copies of the plain language statement and consent form used, are in appendix 1. For Brisbane, seven surgeons known to have been interested in training were approached and six agreed to be interviewed. The same plain language statement and consent form was used as for the Melbourne group. In addition, three Brisbane surgeons (from three different specialties) have given advice throughout the course of the research, and interviews were conducted with them on a less formal and more frequent basis. All eighteen surgeons were invited to choose their own pseudonym for the purposes of this thesis, but some preferred to be referred to by their own name. Copies of the sections of the thesis where they are cited
were sent to them for checking, and any corrections or changes were incorporated in the
final draft.

This thesis also draws on an earlier study of the history of the Urological Society of
Australasia, and in particular on the material on their training obtained from interviews with
approximately eighty Australasian urologists.¹ This information provided the background
context within which the smaller group of interviews for this thesis were conducted.

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Thanks are due to the archivists at the Royal Australasian College of Surgeons in Melbourne,
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Hospital, Gabriele Haveaux was unfailingly helpful, and at the Mater Misericordiae Hospitals
in Brisbane, the hospitality offered by the archivist, Sister Josephine, was in a class by itself.
Thanks are also due to Warwick Anderson, Janet McCalman and Sarah Ferber for their
expert supervision and inspiration. In addition, this thesis owes a particular debt to the
surgeons who have patiently answered my peculiar questions over the last three years. Don
Moss, in his role as associate supervisor, plus Lawrence Hirst, Chris Elmes and especially
Geof Hirst have provided the necessary surgical "reality check" on what follows. None of
them should be held responsible for any errors that remain and neither should it be assumed
that any of them agree with the conclusions reached or the views expressed in this thesis.

A number of sections of this thesis have formed the subject of conference papers and I
would like to thank the many people who contributed their ideas in response to those
papers, including Warwick Anderson, Janet McCalman, Randall Albury, Ian Anderson, Wyn
Beasley, Sue Forsyth, James Gillespie, Marilyns Gillemin, Jennifer Rabach and Michael
Tyquin. There were also many helpful comments from people whose names I unfortunately
do not know.

The papers were:


2001: "In 1946, the Australian Labor Party gave doctors constitutional protection from nationalised health. Why?" Biennial Meeting, Australian Society for the History of Medicine, Adelaide. (Also published in electronic format as a part of the conference proceedings).

2001: "Informed consent and the surgical training paradigm", Australian Association for the History, Philosophy and Social Studies of Science, Melbourne. (Also given as a seminar paper to the Centre for the Study of Health and Society).


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Practising Surgery: A history of surgical training in Australia,²

Introduction

This study draws on a long tradition of using the benefits of a stranger's point of view. The outside observer may see something different and distinctive, where insiders see merely the mundane and the everyday.³ Since the 1970s, it has become commonplace to apply this ethnographic approach to strangers in time as well as in space, and the interdisciplinary exchanges between anthropology and history have been enormously fruitful.⁴ For an Australian, surgeons in twentieth century Australia are not very far away in either time or space, but they provide an example of a very distinctive culture, as exotic in its own way as that of any remote group of "natives". This has not escaped the attention of sociologists, who have been studying the culture of surgeons, especially in the United States, since at least the 1950s.⁵

² This study pays particular attention to developments in Victoria and Queensland, but there are frequent references to patterns in the other Australian States and New Zealand. The principal body representing surgeons, the Royal Australasian College of Surgeons, covers both Australia and New Zealand, and surgeons in the two countries have much in common, including their training system.  
³ A major inspiration for cultural historians is Clifford Geertz, The Interpretation of Cultures—Selected Essays (New York: Basic Books, 1973), especially chapter 1: "Thick Description: Toward an Interpretive Theory of Culture".  
The major borrowing from anthropology in this study is a group of ideas associated with the concept of "the gift." This thesis examines how Australian surgeons were trained, and argues that their training relied upon a set of gift relationships within Australia's public hospitals. However, it should not be assumed that these gift relationships were necessarily altruistic. Relationships between surgeons and patients were inherently inequitable, and inequalities in status, power and autonomy were reproduced through gift exchange within the moral economy of the public hospital. This moral economy was characterised by a set of expectations of mutual rights and obligations under given circumstances. Surgeons relied financially on fees from private patients, but for most of the period covered by this study, many of them treated public hospital patients for free. In return, they expected that only those patients who could not afford to pay for their medical care would attend public hospitals.


A number of the most influential writers on the gift have emphasised that gift relationships are not necessarily mutually beneficial. They have tended to see human motivation as largely economic, and to regard gifts as an alternative (and possibly archaic) way of achieving broadly economic aims and/or as being about the pursuit of power and status. See, for instance: Mauss, The Gift, The form and reason for exchange in archaic societies; Bourdieu, Outline of a Theory of Practice; Godelier, The Enigma of the Gift; Marshall Sahlins, Stone Age Economics (London: Tavistock Publications, 1974). In contrast, some writers have taken a more positive view of the gift, emphasising moral and spiritual considerations. This view is well represented among those writing about the gift in twentieth century western society. Family life and interpersonal relations are seen as lying within a gift economy. For example: James G. Carrier, Gifts and Commodities, Exchange and Western Capitalism since 1700, (London: Routledge, 1995); Jacques T. Godbout, The World of the Gift, trans. by Donald Winkler 1998 ed. (Montreal: McGill University Press, 1992); Helmut Berking, Sociology of Giving, Patrick Camiller trans., 1999 ed. (London: Sage Publications, 1999); David Cheal, The Gift Economy (London: Routledge, 1988); Lewis Hyde, The Gift, Imagination and the Erotic Life of Property, 1983 ed. (New York: Vintage Books, 1979). Alan Schrift has edited a collection of essays that includes pieces by representatives from both camps, although his subtitle perhaps indicates his own position: Alan D. Schrift, ed., The Logic of the Gift, Toward an Ethic of Generosity (New York: Routledge, 1997).


Financial considerations are not the only motivation for human behaviour and there is now a considerable body of research illuminating work of various kinds that falls outside the market economy.\textsuperscript{10} Robert Putnam's work, for instance, and the concept of social capital, linked the rate of participation in voluntary organisations to participation in the democratic political process.\textsuperscript{11} A rather different body of scholarship initiated, according to Estelle James, by John D. Rockefeller III in 1977, describes the workings of the "third sector", that part of the economy which is not run by governments and which is not for profit.\textsuperscript{12} There is no doubt that most of Australia's public hospitals are still banks of social capital, where many individuals and organisations have invested huge amounts of time and effort on a voluntary basis, and there is also no doubt that not-for-profit private hospitals form an important component of Australia's third sector.\textsuperscript{13} But in examining the motivations of surgeons working on an honorary basis in public hospitals, and their relationship with public hospital patients who have allowed themselves to be practised upon by junior doctors of various kinds, the concept of the gift has proved particularly illuminating.\textsuperscript{14} This exchange of gifts was about honour, but it was also very much about power and status.\textsuperscript{15}


\textsuperscript{13} Mark Lyons, \textit{Third Sector, The contribution of nonprofit and cooperative enterprise in Australia} (Crows Nest: Allen & Unwin, 2001).

The principal question that this study sets out to answer concerns the reasons why Australian surgeons enjoy such an enormous degree of professional autonomy in regard to training. From the 1930s, the Royal Australasian College of Surgeons (RACS) constructed surgical training as an apprenticeship process. Although it was some years before the College worked through the implications of this idea, it followed that the best (if not the only) person to train an apprentice surgeon was a master surgeon. At the end of the year 2000, the RACS applied to the Australian Competition and Consumer Commission (ACCC) for exemption from some sections of the Trade Practices Act. This was because by then the College had such a high degree of control over the training of surgeons in Australia (and New Zealand), that it was at risk of being in contravention of some sections of the Act.

In Australasia at the end of the twentieth century surgeons chose their successors, trained their successors, accredited their successors, reaccredited themselves and largely controlled


15 For this view of the gift, see particularly: Bourdieu, Outline of a Theory of Practice, especially the sections of chapter 4, pp.171-197, on "Symbolic capital" and "Modes of domination".


the number of their successors. Through a complex process of accrediting training posts in the various surgical specialties, a large number of surgeons were involved in decisions over adding to or reducing the number of places for surgical trainees. This took place through committees of the Royal Australasian College of Surgeons representing the various surgical specialties. Members of these committees liaised with individual hospitals and accredited and re-accredited hospital training posts for surgical registrars across all Australian States. The Federal and State governments were not directly involved in the decision making.\(^{19}\)

Besides controlling (in consultation with the hospitals) the number, location and distribution by specialty of surgical trainees, the RACS provided virtually the only route through which registrars could be accredited for independent practice.\(^{20}\) Its sophisticated two-part examinations were conducted by Fellows of the RACS. The content of the examinations was determined by the Boards of Surgery of the College in the various specialties, and members of these Boards also supervised the training process and the rotation of registrars through a sequence of accredited training posts.\(^{21}\) In summary, virtually all key decisions affecting training were made by surgeons. The level of professional control that Australian surgeons have over their training is especially remarkable when compared with the patterns

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\(^{19}\) There is a Federal Government body—the Australian Medical Workforce Advisory Committee (AMWAC)—which is responsible for surgical workforce projections. The RACS co-operates closely with AMWAC and in 2000, for instance, met AMWAC targets for the number of surgical trainees in all specialties except ear, nose and throat surgeons. But neither AMWAC nor State or Federal Governments have any direct control over the number of surgical trainees. Peter Baume, *A Cutting Edge: Australia’s Surgical Workforce, Report of an Inquiry into the Supply of and Requirements for, Medical Specialist Services in Australia*, (Canberra: Australian Federal Government, 1994); B. P. Morgan and R. A. Chapman, “Recent History of the College,” in *Royal Australasian College of Surgeons and Faculty of Anaesthetists, Handbook* (Melbourne: RACS, 1988).

\(^{20}\) The Federal Government limits the rights to practice medicine in Australia. Doctors are registered with the State medical boards and since 1969, there have been guidelines for recognising specialists, including surgeons, and paying them more than general practitioners. For many years, British surgical qualifications were recognised, as well as the Fellowship of the RACS. Surgeons with other qualifications have faced a variety of restrictions, including (since 1978) a national examination system. There has also been close scrutiny of the processes by which medical specialists are selected onto training programs: Peter J. Brennan, *Trainee Selection in Australian Medical Colleges*, (Canberra: Medical Training Review Panel, Health Workforce Section, 1998).

which have developed elsewhere. Surgeons in Britain and the United States, for instance, do not enjoy anything like the same degree of autonomy.22

How have surgeons in Australia obtained and retained such control over the training of surgeons? Is this control, as the RACS argues, the best way of maintaining high clinical standards? Is the training pattern at the beginning of the twenty-first century the result of a conscious policy program by surgeons, or is it the result of historical accident, conflicting agendas and compromise? At a more basic level, why is undergraduate medical education provided by the universities, with Federal Government funding and control, while specialist postgraduate medical education has developed in a completely different way, substantially outside the university system, with virtually no specific funding and under the aegis of independent clinical colleges?

In order to answer these questions it is necessary to establish not only what is special about surgeons in general, but also what is special about surgeons in Australia in particular. Surgeons in Australia have been allowed, by successive governments and the public, to establish and maintain control over their own training. Whether or not the pattern of training has been the result of a conscious plan of action by surgeons, governments have either been unwilling, or unable to curtail the autonomy of surgeons in this regard.23 Federal governments have attempted to regulate the supply of doctors, through their control of university funding, and hence medical school funding.24 They have succeeded in regulating


23 This may or may not be about to change. In 2000, the RACS had the (guarded) support of the then Federal Minister of Health in its application for exemption from some of the provisions of the Trade Practices Act: "College to test Trade Practices Act," RACS Surgical News 1 (2000): 6; Messenger, "Competing interests:," 10-11. In February 2003, the RACS was still awaiting the view of the Australian Competition and Consumer Commission on its training programs.

24 R. L. Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce, (Canberra: Department of
the supply of general practitioners, by first funding the Royal Australian College of General Practitioners' training program, and subsequently making such training a necessary prerequisite for independent general practice. But no Australian government has (so far) succeeded in having more than a minor impact on the supply of surgeons, despite concerns about insufficient numbers in some of the surgical specialties. It could be argued that this is because no government has tried very hard to influence surgical training, and the question then becomes, why not? Why, until the end of the twentieth century, have governments been happy to allow surgeons to make decisions not only about standards of training, but also about the number of surgeons trained?

Evan Willis has argued that medical dominance generally is made possible by state support and that this support is forthcoming because medicine helps reproduce and maintain the dominant class structure. But this does not explain why in the twentieth century surgeons enjoyed more autonomy in Australia than elsewhere. Willis also argues that the claim to possess scientific knowledge helped legitimate medical dominance, but that the class

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26 Baume, the Baume report. It should be noted that many doctors firmly believe that an increased supply of doctors directly increases the costs to the health care system, and there is some support for this view from economists. See: J. R. Richardson, "The Inducement Hypothesis: that doctors generate demand for their services," in Health Economics: Australian readings, ed. J. R. G. Butler and D. P. Doessal (Sydney: Australian Professional Publications, 1989). Many doctors also believe, however, that an increased supply of doctors leads to a potentially reduced income for individual doctors in the same specialty in the same area.


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relations within medicine predate the rise of "scientific" medicine.28 T. S. Pensabene in his study of the rise of the general practitioner in Victoria, and Milton Lewis and Roy MacLeod in their study of the medical profession in New South Wales, have also emphasised the importance of science.29 Lewis and MacLeod argue that only at the end of the nineteenth century when science and therapeutically effective medicine were linked did the profession receive government support.30 Pensabene emphasised the importance of doctors' control over a body of scientific knowledge.31 While not in any way challenging the importance of the idea of science in supporting the status of surgery, this thesis highlights the assumption, rather than proof, of the therapeutic effectiveness of surgery. In 1972, Archie Cochrane pointed out the absence of good scientific evidence for much of medical practice.32 There were no randomised controlled trials for drugs before 1948 and scientific trials of surgical procedures were later still.33 The ideas of Cochrane and of Thomas McKeown, who pointed out that "scientific medicine" could not take the credit for the decline in mortality at the end of the nineteenth century, were published at about the same time as the RACS was implementing a nationwide training program in surgery.34 Together these ideas challenged medicine's claims to therapeutic efficacy. However, the impact of these ideas on Australian surgical training in the 1970s was minimal, and Cochrane and McKeown do not appear to

28 Evan Willis, Medical Dominance, The division of labour in Australian health care, especially chapter 4, pp. 61-91.
30 Lewis and MacLeod, "Medical Politics and the Professionalisation of Medicine in New South Wales, 1850-1901," 69-82, pp. 80-81.
31 Pensabene, The Rise of the Medical Practitioner in Victoria, for example p. 159.
have had any impact on the willingness of other bodies to allow surgeons in Australia virtually totally autonomous control over their own training.

Pensabene, Lewis and MacLeod and Willis all emphasise the importance of the British Medical Association as a union representing doctors, and other scholars, notably Thelma Hunter, James Gillespie, Amy McGrath and Diane Mackay, have made a particular study of the role of the BMA and its successor, the Australian Medical Association, in the development of the Australian health care system. There is some consensus that it has been an enormously effective trade union, despite the fact that doctors have seldom been united in their views. However, relations between surgeons and the BMA were sometimes problematic, and this is discussed further in chapter one. While the BMA/AMA has played an important role in setting the medico-political context within which Australian surgeons have worked, neither organisation has made any significant contribution to surgical autonomy with respect to training. On the contrary, through the various State postgraduate committees in medicine, the BMA/AMA has been involved in providing education that was sometimes in competition with that provided by the RACS. This issue is discussed further in chapters five and nine.

Health policy specialists and economists have also made an important contribution to the understanding of Australia’s hospitals, and the context within which training has taken place, although none have specifically been interested in surgical training. There have, however,

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been a number of studies of medical education, including specialist medical education.\(^{37}\) The focus of all of these studies is mainly on the numbers of doctors trained. Both Peter Baume and R. L. Doherty, for instance, were interested in the control that surgeons have over their own training, but principally in the context of control over the numbers trained. Neither was specifically concerned with the cultural context or content of training.\(^{38}\)

There have also been a number of studies of the history of the RACS, and the most recent by Wyn Beasley was published while this thesis was being written.\(^{39}\) But all of these studies are concerned with the development of the RACS as an institution, and apart from Colin Smith's important examination of the relative importance of British and American influences, (a theme also taken up by Lewis and MacLeod) there are few attempts to place the history of the college within a wider context.\(^{40}\)

All of these ways of looking at Australian doctors and Australian hospitals have proved fruitful and this study owes much to the work of these scholars, but none of them have made a systematic study of anything other than a few institutional aspects of the history of Australian surgical training. The approach in what follows is rather different. Using concepts borrowed from anthropology and cultural history, this study is a cultural history of surgical

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\(^{37}\) Baume, the Baume report; Doherty, *Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce; Karmel, Expansion of Medical Education; Report of the Committee on Medical Schools to the Australian Universities Commission; Sheldrake et al., *Medical Education in Australia: present trends and future prospects in Australian medical schools.*

\(^{38}\) Baume, "the Baume report"; Doherty, "Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce."


\(^{40}\) Lewis and MacLeod, "Medical Politics and the Professionalisation of Medicine in New South Wales, 1850-1901": 69-82.
training in Australia. It sets out to examine how that culture has been produced and reproduced, and details some of the ways in which surgeons used gifts to obtain and retain the moral high ground, and hence professional autonomy, within the moral economy of the hospital. This is an important theme of chapters one, two, four, eight and nine. The focus is on the status of surgeons and the tradition of honorary (unpaid) work in public hospitals, which continued in some Australian States until 1975. This thesis also examines the content of Australian surgical training and the context in which it was conducted and this is discussed in some detail in chapters three, five and six, as well as in the last three chapters.

It is hoped that this perspective will help illuminate not only the professional autonomy of surgeons, but also the broader culture of doctor-patient relations in Australian hospitals. The relative power of the patient and the surgeon in their clinical encounter depends upon the context of the moral economy of their gift relationship. There is currently something of a crisis in Australian medicine, as patients sue their doctors in increasing numbers, and surgeons in some specialties are finding the cost of insuring themselves prohibitive. Understanding the clinical encounter as an exchange of gifts, expectations and obligations within a moral framework, rather than an exchange of clinical expertise for money, might assist those who are trying to find a way through the current crisis.
PART I

Setting the Scene for the Training of Surgeons in Australasia

1: The consecration of the Royal Australasian College of Surgeons

2: Surgeons and their classrooms

3: Accrediting Surgeons: international qualifications
A snapshot of Public Gifts and the Inaugural Ceremonies of the Royal Australasian College of Surgeons from the Fifth Annual General Meeting, Melbourne, 1932
Presentation of the Great Mace, 
Wednesday February 17, 1932, 8.15 p.m., 
Wilson Hall of the University of Melbourne

"Evening and, if possible, academic dress will be worn at this meeting... Cards of admission for Fellows, their wives and daughters are available at the College office and must be presented at the door of Wilson Hall."

1: The consecration of the Royal Australasian College of Surgeons

On a hot summer evening in Melbourne, a gathering of hundreds of surgeons, some accompanied by their wives in evening gowns, met to watch the presentation to their five-year old college of a "Great Mace". Besides the surgeons, there were hundreds of other guests, and most of the men were university graduates. The usual estimate of the number present that evening is 2000, all crowded into the mock gothic splendour of Wilson Hall at the University of Melbourne in their wing collars and white ties, wearing academic robes with the white lined hoods of law and the blue lined hoods of arts, to add to the scarlet of medicine and the pink of surgery. The mace was presented by C. H. Fagge, who was

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1 RACS Archives Melbourne: Royal Australasian College of Surgeons, Fifth Annual General Meeting 1932 (Programme), Se 73. In 1932, and for many years afterwards, College practice was to presume surgeons were men. This was not always the case—only almost always. Five of the 484 Fellows admitted before February 1932 were women, including Lilian Cooper, a general surgeon from Brisbane and Constance D'Arcy, a gynaecologist from Sydney. RACS Archives Melbourne: Register of Fellows of the Royal Australasian College of Surgeons, Se 21, 25 September 1926-. In this study, reference to the sex of surgeons attempts to reflect the reality at the time, rather than any normative position.


3 Royal Australasian College of Surgeons, "Proceedings of the Annual Meeting," Australian and New Zealand Journal of Surgery 1 (1932): 443-448. The ceremony was given substantial coverage in the Melbourne papers, including the Age, the Argus and the Herald. For academic dress, see: Melbourne University Calendar, 1932. In this era, students and graduates were supposed to wear academic dress
representing the Royal College of Surgeons of England. Fagge then delivered the first Syme Oration. Sir George Syme, who died in 1929, was the inaugural president of what was initially called the College of Surgeons of Australasia. Syme argued that:

The aim of the College may be summed up as an endeavour "to promote the art and science of surgery", to use the words of the Charter of the Royal College of Surgeons of England, and in so doing to enable the public to get better surgical service. The College proposes to carry out these aims by arranging for special post-graduate training in surgery and by establishing standards of surgical competence and surgical ethics.¹

According to Leo Kenny, the first secretary of the College:

The College was created because leading Surgeons in Australasia were satisfied that major surgery was being attempted by numbers of legally qualified medical practitioners who were deficient in technical skill, and that many unnecessary operations were being performed because of deficient surgical judgment and, in some cases, for the sake of the operating fee.²

In other words, the College was formed to try and stop general practitioners performing major surgery. Initially, the College adopted a group of aims closely modeled on those of the American College of Surgeons. These were set out in the Exordium, which means, according to the Shorter Oxford Dictionary, "the beginning of anything, especially the introductory part of a discourse or treatise."

² RACS Archives Melbourne: Minutes and Council Papers, Sc 7, 16 February 1932, p. 32.
EXORDIUM.¹

Whereas it is advisable, in the interests both of the peoples of Australia and New Zealand, and of those who practise the profession of Surgery in these countries, that

1. the high traditions of that profession should be upheld and developed,
2. the intensive study of the science and art of Surgery, and the extension of surgical knowledge by means of research should be promoted,
3. facilities should be provided for the higher education and advanced technical training of surgeons and surgical specialists,
4. a high standard of moral conduct should be demanded from all who accept the responsibilities of a surgeon, in their relations with patients and members of the medical profession,
5. the public should be educated to recognise that the practice of Surgery demands adequate and special training,
6. the standards of surgical practice in hospitals should be elevated.

Now, we, the undersigned, of our own free will, bind ourselves together for the fulfilment of the aforesaid objects, and hereby form ourselves into the College of Surgeons of Australasia; and we pledge ourselves to obey all such by-laws, regulations and ordinances as may be adopted from time to time by the College, or by its governing body or duly delegated authority, and we will submit to any penalties, including that of expulsion from the College, that may be imposed by the College, or by the governing body, for violation of any of the said by-laws, regulations or ordinances.

Clause 5 of the Exordium proposed that "the public should be educated to recognise that the practice of Surgery demands adequate and special training."² This turned out to be a

¹ RACS Archives Melbourne: Handbooks and By-Laws, Se 29, The College of Surgeons of Australasia (which includes New Zealand) By-Laws (Dunedin: College of Surgeons of Australasia, 1927), p. 3.
The consecration of the Australasian college

highly controversial clause, which provoked anger from many general practitioners. The GPs regarded it as the result of American influence (which it was), and argued that it called for advertising. Advertising was strictly against the code of ethical practices for doctors, as laid down by the British Medical Association (BMA) and its Australian and New Zealand branches. But the main point of the clause was that it assumed that the standard medical degree of Bachelor of Medicine and Bachelor of Surgery (MBBS) did not qualify a doctor to perform surgery. Legally, as Kenny pointed out, general practitioners could operate, but technically, it was argued, they might be deficient in skill, and they might also be deficient in surgical judgment.

Clause 5 of the Exordium became the focus of the row between GPs and surgeons over the need for and role of a college of surgeons.¹ The clause was eventually dropped, and Pensabene (and after him Willis) have argued that this represented a victory for the GPs and/or the BMA.² The College of Surgeons agreed that the BMA should represent the profession as a whole over questions of medical politics. But this was a hollow victory for the GPs, in that it made it easier for the College to take the high moral ground and appear to be above politics and acting in the public interest. This helped the College achieve its primary aim of stopping GPs performing major surgery. The College appeared to lose the battle over the Exordium, but in fact it was more of a strategic retreat, and eventually, the College won the war.

By 1932, the new generation of medical students was already taking it for granted that becoming a surgeon required both a specialist qualification and specialist experience. The Australian Medical Association (which replaced the Australian branch of the BMA from 1962) did not formally acknowledge that surgery required specialist qualification until 1965, but by then most general practitioners performed only minor surgical procedures, except under special circumstances—in emergencies or in remote areas, for instance. As early as 1936, the Charities Board in the State of Victoria required that all surgeons appointed to public hospitals in country areas have a specialist surgical qualification. Despite the fact that general practitioners continued to perform some surgery, especially in country areas, for many years, by the end of the 1930s, the trend was clearly towards full time surgeons (as opposed to part-time surgeon/general practitioners). Although the clause of the Exordium on the need to educate the public was dropped, effectively the public (and the medical profession) did come to recognise that "the practice of Surgery demands adequate and special training," and that not all doctors were equal. In the process, the College of Surgeons pulled off a public relations triumph, whereby it came to be seen as representing high surgical standards, rather than the selfish interests of surgeons. This was the real struggle within the profession, and within a decade of the formation of the College, the surgeons had won.

This triumph was achieved, at least partly, through public ceremonies and an emphasis on the links with British traditions. In 1931, following determined lobbying, the King was "graciously pleased to approve the prefix Royal to the title of the College," and the College of Heralds approved a grant of arms. The College of Surgeons of Australasia became the Royal Australasian College of Surgeons (RACS). In later notes on the history of the College, Hugh Devine wrote:

THE RITUAL OF THE ANNUAL MEETING OF THE COLLEGE [and]
OF THE SYME ORATION

Dignity, colour, full evening and academic dress, the most formal ritual woven around and into the Syme Memorial lecture. The design was Alan Newton's who was a past master in this art.

On the first occasion when he brought this into being, he surprised University academic circles. A precisely organised procession to the dais in the beautiful Gothic Wilson Hall. Primeval colours, university and college gowns; a measured processional march—not a step out of place, and then a most distinguished overseas lecturer and a subject so natural, so broad, so satisfying.

After this, the Syme Memorial lectures were the highlights of the College year. In most cases these orations had a social side. They brought not only the Fellows but also their wives from all over Australia and New Zealand...

After the lecture everybody met everybody and their (sic) was much private entertaining and fire side talks, old friends met and much swapping of surgical experience, often more illuminating and entertaining than the formal meetings and lectures...

These meetings raised the prestige of the profession, kept the lay world generally aware of what was going on in the College for their benefit...

As Devine clearly understood, all the "dignity, colour... and most formal ritual" of the annual meetings helped raise "the prestige of the profession." Among other things, the meetings helped shift the balance of reporting in the newspapers. Splendid ceremonies

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1 RACS Archives Melbourne: Sir Hugh Berchmans Devine, SB 28/7, Memoirs.
2 Other members of Council were also quite explicit about the value of ceremonial. In 1937, for instance, "H. B. Wade stated that it was desirable to hold an impressive, dignified Inaugural Meeting in a large hall in New South Wales. He thought that the resultant publicity greatly helped in enhancing the prestige of the College in New South Wales..." RACS Archives Melbourne: Minutes and Council Papers, Se 7, 31 August 1937.
3 Pensabene has shown the importance of newspapers in both reflecting and helping form public perceptions of doctors. Pensabene, The Rise of the Medical Practitioner in Victoria. This section is based on the press cuttings held in the Archives of the Royal Australasian College of Surgeons: RACS Archives Melbourne: Press Cuttings, Se 216, 1926. The cuttings are mainly from metropolitan newspapers in Melbourne, Sydney and Auckland. There are a limited number of cuttings from Adelaide, Hobart and Launceston, and the coverage of New Zealand is not limited to Auckland. Western Australia, Queensland and rural Australia are not represented. The cuttings are pasted into a book in date order. While by no means comprehensive, there is no reason to doubt that the cuttings are broadly representative of metropolitan press reporting of the College in its early years.
were given wide coverage. While articles critical of surgeons and surgery were not uncommon in the 1920s, in the 1930s they were significantly outnumbered by generally positive articles reporting on the meetings of the RACS. In particular, the inaugural ceremonies at the beginning of each meeting and the Syme Oration were regularly given substantial coverage, while the associated garden parties and functions featuring the wives of Fellows were reported in the social pages. Effectively, the press obligingly took on the role of educating the public to associate the practice of surgery with the Royal Australasian College of Surgeons, while giving both surgery and surgeons a positive image.

Rituals and the Public Image of Surgeons

Immediately after the first annual meeting of the College in Canberra, the headline in the *Sunday Times* (Canberra) on 22 April 1928 was "Surgeons and their still-born College". "Farcical attempt to Corner Sawbones Market" it continued, "Catholic Physicians' Monopoly in Melbourne; Protestant Doctors in Control in Sydney, B. M. A. Beams on Questionable Practices."

The second annual meeting in Sydney also attracted adverse publicity: "Surgeons met in secret to discuss shearing the lambs; Splitting fees" ran the headline in the *Daily Guardian*, Sydney, in March 1929. "In profound secrecy the Australian College of Surgeons is sitting 'somewhere in Sydney' to discuss appendix-snooping, snaring the tonsil, dissection of the pay-roll, and other subjects dear to the top-notch sawbones." While the influence of these newspapers in Canberra and Sydney respectively may have been limited, the anti-surgeon attitudes are quite striking.

Fee splitting (where a GP referred a patient to a specialist and they divided the fee between them) was strongly opposed as unethical by the College of Surgeons, but the issue had the effect of bringing doctors as a whole into disrepute. Missing the nuances of exactly who was opposing what, some newspapers simply focused on unethical behaviour by doctors.

"It is not overstating the case to say that certain physicians are sharing a patient's tonsils with a friendly surgeon" and "unnecessary operations are advised... This transfusion of cash revives a sick bank account..." ran an article in the *Melbourne Herald* on 23 March 1930.
The consecration of the Australasian college

The public brawling between surgeons and general practitioners in this period has been described by Bryan Egan. GPs objected to the formation of the College on the grounds that the degree of Bachelor of Medicine and Bachelor of Surgery entitled all doctors to perform surgery. The resulting row did not provide the infant College with a good press. Bryan Egan has described the debate in the Sydney press and the issue also gave the College unfavorable publicity in Melbourne. "Surgeons' College criticized, General Practitioners Bitter, Boosting and Superiority Complex..." ran a headline in the Melbourne Herald on 28 March 1930.

But by the early 1930s, press reports on "unnecessary surgery" and "appendix-snooping" by "sawbones" were far outnumbered by headlines such as "College of Surgeons—Gratifying Progress", "Achievements in Surgery", "Art of the Surgeon" and "The Skill of Surgery". On 16 February 1932, the Melbourne Herald ran a small item headed "Surgeons Arrive for Conference—Important Meeting, Presentation of Mace Chief Ceremony." There was a photograph of Sir Henry Newland and reference to a "distinguished group of men." "They are members" wrote the Herald's reporter, "of a profession which avoids self-advertisement, and so they will slip as quietly as possible into the city's stream." Yet for the next week, various aspects of the fifth annual meeting of the College were reported every day, often at some length and accompanied by large photographs, in every major Melbourne newspaper. The 1932 College meeting represented a triumph of public relations.

Criticism of surgeons and surgery may not have disappeared totally after 1932, but it certainly faded into the background. Year after year, the image of surgeons presented through the annual meetings was of restrained and dignified ritual. But despite this, surgeons could maintain that they were above "self-advertisement". The ceremonies were seen as uncontroversial, and nothing to do with politics. In a sense, the newspaper reporters seem to have taken a certain pride in the "Colorful Scene at Wilson Hall" and the overseas visitors paying tribute to Australasian surgeons. The model for these highly successful ceremonies, in tone, rather than in specific content, seems to have been the contemporary flowering of newly invented ritual traditions associated with the British monarchy.

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2 Evening Post, 6 April 1933; the Age, 1 March 1934; New Zealand Herald, 19 January 1937.
David Cannadine has highlighted the importance of British royal pageantry in this era. In the period 1914 to 1953, the traditions invented between 1870 and 1914 were given new meaning as an "expression of continuity in a period of unprecedented change." Queen Victoria had refused to take part in public ceremonies in the early years of her reign, but was won over by the end of the nineteenth century. Her son, Edward VII, favoured both public grandeur and high living. Then George V (1910-36) managed to combine a respectable private life, comparable to that of his grandmother, with his father's fondness for attention to detail in public ceremonies. Cannadine describes him as "obsessed with matters such as the correct dress and manner of wearing decorations. But at the same time, his private life combined the unpretentiousness of the country gentleman with the respectability of the middle class." The result was truly popular. The monarchy came to appear as above politics and, eventually, above reproach. Cannadine argues that "the restrained, anachronistic, ceremonial grandeur" of the British monarchy in this period contributed much to its popularity and air of unassailable stability. But the press also played an important role. Cannadine describes the response of the media as "sustained obsequiousness", reporting "the great ceremonies of state in an awed and hushed manner."

"Restrained, anachronistic, ceremonial grandeur" was precisely the tone set by the rituals devised for the RACS by Alan Newton and although the response of the press was hardly obsequious, it was generally respectful. While surgery was going through a period of dramatic change and an enormously rapid increase in the number and range of operations performed, the newly invented ritual traditions gave the infant College an air of dignified stability. This was reinforced at the annual meetings, by repeated public display of the links with Britain. At the twelfth annual meeting, for instance, in 1939, the principal guest was Sir Alfred Webb-Johnson, surgeon to Queen Mary. He read a message of good wishes from the Queen, and the President and Fellows of the RACS promptly cabled a reply to the effect that "the Queens' message would inspire them and their successors to strive in collaboration with

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1 A survey of the Herald, the Sun and the Age revealed items in each paper every day between 16 and 20 February 1932. Not one piece was even remotely critical.
3 Ibid., p. 223.
4 Ibid., p. 224.
their brethren in the Mother country to advance the knowledge of the science and art of surgery.  

The RACS, by association, borrowed the past of the British colleges of surgeons, with all that entailed. In the process, the RACS succeeded in borrowing much of the mantle of confidence in surgery that went with the myths and traditions surrounding Harley Street surgeons. The first formal ceremonial occasion which pulled off this borrowing of British history was the presentation of the Great Mace in 1932.

The Gift of the Great Mace

The RACS was not the only college of surgeons to be presented with a ceremonial mace by British surgeons. The American College of Surgeons was presented with a ceremonial mace in 1920. No mention was made of this in the speeches in 1932, but many of the Fellows of the RACS would have been aware of the precedent. Sir Louis Barnett, for instance, ended his talk to the first annual meeting of the Australasian College in 1928 with the following:

In 1920 the American College of Surgeons was presented with the Great Mace, a massive and beautiful emblem of international goodwill which now figures prominently at every convocation. It was a gift from the Consulting Surgeons of the British Army to the American College of Surgeons in memory of mutual work and good fellowship in the great war 1914 to 1918. In his graceful presentation of the Mace, Sir Berkeley Moynihan said: "We pray, God may regard it as a symbol of our union in the harsh days of trial, as a pledge of unaltering and unchanging hope that the members of our profession in the two lands shall be joined in brotherhood for ever in the service of mankind."  

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1 For other examples of the invention of tradition see: Hobsbawm and Ranger, The Invention of Tradition.  
2 The Sun 16 March 1939; Webb-Johnson also presented a Rudyard Kipling manuscript to Australia, handing it over to Mr Lyons at a ceremony in Canberra. Argus, 19 March 1939.  
Receiving "public" gifts is a characteristic of high status institutions that participate in gift exchange as well as operating in a market economy.¹ They receive gifts designed to be put on display. Monarchies are an obvious example, and Buckingham Palace and Windsor Castle contain rooms full of gifts from heads of state and other dignitaries; so does the White House. Such gifts are typically presented during ceremonies associated with official visits and they serve as a symbol of a continuing relationship after the visitor has gone.

A local and less grand example of an institution in receipt of gifts of this kind is the Melbourne Club. Lord Somers, for instance, who was Governor of Victoria from 1926-31, presented the Club with a silver cigar box before he left for England.² Gift giving of this kind is about honour and status. The prominence with which such gifts are displayed relates not to the nature of the object but to the status of the donor. Ostentatious gifts from low status donors can be an embarrassment, relegated to dark corridors or obscure corners. High status donors can confer honour by recognising a person or organisation with their gift. The Mace was a gift of this kind.

The headquarters of the Royal Australasian College of Surgeons on Spring Street in Melbourne is now full of public gifts, including a large number of portraits, but the Mace was one of the earliest and is among the most significant.³ It is inscribed "from brothers to brothers" and represents a formal acceptance of the Australasian college into what might be called the "club" of English-speaking colleges of surgeons. This "consecration" of the

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² Ernest Scott, *Historical Memoir of the Melbourne Club* (Melbourne: Specialty Press, 1936), p. 77. The section of the history which describes gifts given to the Club is headed 'Lares et Penates', i.e. household gods.

³ Not all the portraits were gifts. The College commissioned a number of portraits of Presidents: A. W. Beasley, *Portraits at the Royal Australasian College of Surgeons* (Melbourne: RACS, 1993). The RACS building in Melbourne acts as a means of displaying gifts to the College, including the site itself (a gift at a peppercorn rental from the Victorian Government), the portico at the front and the elaborate fountain at the back. The portico, interestingly, was the gift of a physician, A.E. Rowden White. He and Devine were friends and played tennis together every Wednesday afternoon. RACS Archives Melbourne: A E Rowden White, SB 28, *Recollections of the early development of the Royal Australasian College of Surgeons* (1960).
College, to use Bourdieu's term, was carried out by the senior college of surgeons. The Royal College of Surgeons of England was not the oldest English-speaking college, but its senior position was quite clear. If the 1932 meeting of the RACS had featured a gift from the Royal College of Surgeons of Edinburgh, for instance, this would have been very welcome, but it would not have carried the same significance as marking acceptance of the standing of the Australasian college.

A simple illustration of the perceived seniority of the various colleges is the order in which papers on their respective histories were read at the first annual meeting of the College of Surgeons of Australasia (not yet Royal) in Canberra in 1928. Hamilton Russell's paper on the Royal College of Surgeons of England was first, followed by Scott-Skirving's on the history of the Royal College of Surgeons of Edinburgh, Leslie Cowlishaw's paper on the Royal College of Surgeons in Ireland and Sir Louis Barnett on the American College of Surgeons. This very clearly represented the orbit within which the Australasian college saw itself as operating. In this celebration of what might be called founding myths, there was no mention of French or Spanish colleges of surgeons, for instance.

It was Moynihan who presented a ceremonial mace to the American College of Surgeons in 1920 and it was Moynihan, as President of the Royal College of Surgeons of England, who first suggested the presentation of a ceremonial mace to the Australasian college. Both echoed the presentation of a mace to the RCS of England, as recently as 1822, by King George IV, which in turn followed a lengthy tradition of presenting maces to various organisations as a symbol of their links with/loyalty to the crown. Some ceremonies are not

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1 Bourdieu, *The Field of Cultural Production*.
3 Peter G. Jones, "The Arms of the Colleges of Surgeons I: The Arms and Mace of the Royal Australasian College of Surgeons," *Australian and New Zealand Journal of Surgery* 40 (1970): 105-110. The Mace was a gift from the Members of Council of the Royal College of Surgeons of England, and made by London silversmith Omar Ramsden in silver gilt. The grant of the prefix "Royal" came when the mace was nearly finished, and "Royal" was therefore added in front of "College of Surgeons of Australasia".
4 C. H. Pagge described the tradition of the mace as follows: "A mace was in early days a weapon of offence, but in the 12th century ceremonial maces, originally for the protection of the King's person, came into use. At first the flanged end of a mace—that is, the head of a war mace—was borne uppermost, and the small button bearing the Royal Arms in the base; but by the fifteenth century the position was reversed.
as old as they seem, but they may draw much of their power to reinforce the status of those involved precisely from an evocation of venerable traditions and links to a mythologised past.¹

The idea of the gift of the Australasian mace, however, was not a spontaneous act of recognition by the RCS of England. The English college was repeatedly lobbied by key players in the founding of the Australasian College, to persuade it to acknowledge the RACS. Hamilton Russell was the first emissary. He went to London in 1927 to attend the Lister celebrations (he had been a house surgeon under Lord Lister), and tried to establish the credentials of the Australasian college. Sir George Syme was next, and he went to London just before his death in 1929. Success in recognizing the Australasian college was finally achieved by Hugh Devine, who was in London in 1930.²

News of the granting of the prefix "Royal" and the gift of the mace reached Australia more or less at the same time, and the Australian press seized upon the story, some collapsing the two events into a single (metaphorically true) recognition of the Australasian college by the British:

The King has conferred upon the College of Surgeons the prefix "Royal" and the president of the British (sic) Royal College, Lord Moynihan, will visit Australia in 1932 to present the mace.³ Lord Moynihan is one of England's greatest surgeons, and a brilliant orator.⁴

Papers as diverse as the Launceston Examiner and the Melbourne Age carried stories about the mace at the beginning of 1931, and there was a detailed description and photograph in The

owing to the greater importance of the end which bore the Royal Arms. Gradually this end of the mace has completely eclipsed the 'heel' as the beauty and elaboration of its decoration has increased. In the year 1822 a mace was granted to our college by the munificence of our most august Sovereign King George IV."


¹ Hobsbawm and Ranger, The Invention of Tradition.
³ The original plan was that Moynihan would present the mace, but his wife was taken ill and Fagge travelled to Australia to present it in his stead.
⁴ Daily Guardian, Sydney, 6 January 1931.
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Times (of London). In a sense, the gift of the mace was received with pride by "the public" of Australia (and New Zealand) as well as by Australasian surgeons. "Lord Moynihan to visit us" ran a headline in the Daily Guardian in 1931, striking a completely different note from the "appendix snooping sawbones" in the same paper two years earlier. By the time the mace was presented in Wilson Hall in February 1932, and C. H. Fagge (literally) bade it farewell, it had been the subject of hundreds of column inches of "news". After it was presented, the "public" wanted to see it, and it went on ceremonial display in art galleries in Victoria, New South Wales and New Zealand.

The Role of America in the Founding of the RACS

Fellows of the Australasian college were not content to tell stories of the founding of other colleges. From an early date, they also told stories of the founding of their own. The 1931 Handbook of the Royal Australasian College of Surgeons begins with an eight page "Historical Summary" of its founding and an expanded version of the story has pride of place in the 1935 Handbook. Julian Ormond Smith, who played a role in the story as a young surgeon, expanded on this founding myth in the early 1970s. Colin Smith, who was the College Archivist in the 1990s, has written a rather different sort of history. But all the versions of the founding of the RACS agree on the main outlines of the story.

There is no doubt that the founding of the American college in 1913 and the 1924 visit of Franklin Martin and William Mayo to Australia and New Zealand were vitally important influences in the founding of the RACS. However, it is misleading to see, as Colin Smith

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1 In the event, Lord Moynihan was unable to travel to Australia to present the mace, because his wife was ill. C. H. Fagge presented the mace in his stead. Fagge is reported as saying: "And now companion of my waking thoughts for many months, farewell. You have I watched from earliest hours when, a plate of virgin silver, you gave yourself to be fashioned by the craftsman’s skill. Your every spray of wattle, every frond of fern, have come to life within my ken, and gradually, once a thing inanimate, your spirit has entwined itself around mine. Today we part, but it is my hope that your new friends will ever hold you in their hearts, not only as a kingly emblem, richly wrought, but as a spirit of affection which has passed from Mother Country to her sons.": "College of Surgeons, Brilliant ceremony, Great Mace presented," The Argus, Thursday 18 February 1932 1932, 2.
3 Sometimes known as Julian Smith junior, because his father, Julian Augustus Romain Smith was an honorary surgeon at St Vincent's hospital, Melbourne
The consecration of the Australasian college does, the founders of the Australasian College as initially copying an American model instead of a British one. The founders copied an American model which had, in turn, drawn inspiration from the British pattern. As Franklin Martin, founder of the American College of Surgeons, put it: "gradually the vision of a college or a guild of surgeons had been crystallizing; some organization that would correspond to the Royal College of Surgeons of England, Scotland and Ireland."

Sir George Syme's view was that: "It was felt that if something was not done to establish an Australasian College, the American College would acquire a footing in Australasia and carry out what we were failing to do." In this era, America had many of the characteristics of an exotic and unknown place, while Britain was "home" even for Australians and New Zealanders who had never been there. Australasian surgeons might admire American surgery, and surgeons, (especially those who had been to America to see for themselves) but the allegiance to Britain was never in question. Hamilton Russell, in his address to the first Annual Meeting of the College in Canberra in 1928 noted: "This great adventure of ours is the first of its kind to be embarked upon by members of the British family who have left the household of the Motherland to make their homes in the distant places of the earth." R. Scot Skirving ended his address to the same meeting with the couplet: "Changed are the skies, not so the British name, or mind or heart, which still remain the same!

The other constant element in the founding stories concerns the roles played by the various Australian States and New Zealand. The seminal idea for an organisation of Australasian surgeons came from a New Zealander, Sir Louis Barnett, and the idea was floated by a Victorian, Hamilton Russell, under the umbrella of a conference of the British Medical Association meeting in Brisbane in 1920. Robert Gordon Craig from Sydney and Sir George Syme from Melbourne opposed the idea at the time. However, after the visit of Mayo and Martin in 1924, Hugh Devine, a Melbourne surgeon of a somewhat younger generation,

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2 In his recent history of the College, Wyn Beasley argues that "From its beginnings, the American College was in the same stable as its English exemplar" Ibid., p. 40.
3 Barnett, "History of the American College of Surgeons,": 26-33, p. 27.
became enthusiastic about the idea. He then managed to persuade Syme to change his mind. As Syme put it in 1928, one of the reasons why:

... those who opposed the independent formation of the College in 1920, changed their minds was that they had become more and more convinced of the harm that was being done by the extensive performance of operations by insufficiently trained operators [with] disastrous results...²

Together with Hamilton Russell, in 1925 Devine and Syme (all three of them Victorians) set about getting support for a college. The Sydney surgeons, including Robert Gordon Craig and Professor Sandes, then moved things along and in 1926 proposed a set of aims closely modelled on those of the American College of Surgeons. These were set out in the Exordium. In 1927, piggy backing on the BMA conference in Dunedin, a disappointingly small group from among the forty one surgeons who had agreed to be Founders met and elected their first Council and Executive.³

During this process, leaders of the infant Australasian college were trying to work out what the qualifications for fellowship of their college should be. Was the American model of practical experience appropriate, or the British model of an examination? Or should they try to devise something distinctively Australasian? For the first five years, the College followed an admissions policy very similar to that of the American college. Essentially, it recognised and admitted to Fellowship the existing body of full time practising surgeons. This was a pragmatic decision, and admission was supposedly based on peer recognition of technical competence. However, this method admitted surgeons to the Fellowship of the Royal Australasian College of Surgeons (FRACS) who had no academic training in the science of surgery. The Fellowship of the Royal College of Surgeons of England (FRCSEng), in contrast, required Fellows to pass a stiff Primary examination in the surgical sciences and a second Final examination in clinical surgery, but required little evidence of surgical competence or even of practical surgical experience. After 1932, the RACS opted for more

¹ Skirving, "The Story of the Royal College of Surgeons of Edinburgh,": 10-20.
² Syme, "The Aims and Objects of the College of Surgeons of Australasia,": 488-491.
stringent requirements for the FRACS, requiring evidence of both surgical experience and success in a two part surgical examination similar to the FRCSEng.¹ (See below, chapter 3).

While there was considerable input from Sydney and New Zealand before 1927, after that date, the College was essentially shaped by a small coterie of Melbourne men. In inventing the tone of the Royal Australasian College of Surgeons between 1927 and 1935, whether accidentally or on purpose, they formed an institution that seemed appropriate and even natural to their colleagues. In the process, they transformed an institution with American inspiration and an American set of objectives into something thoroughly British (and colonial) in style.²

"Two Very Strong Characters"³

In the register of Fellows of the RACS, the first name is that of Hugh Berchmans Devine. Devine noted that "This was a specific direction of Sir George Syme."⁴ It recognises Devine as the driving force behind the founding of the College. He was a Catholic, with an honorary appointment at St Vincent's Hospital, Melbourne, so that, despite the expectations of many, including the Catholic press, the College was never an organisation run exclusively by and for WASPS. In an era that Janet McCalman has described as the most sectarian in Australia's history, this was significant.⁵ The first Secretary of the College was another Catholic, Leo Kenny, an Ophthalmologist, who also had an appointment at St Vincent's.

Devine was in his forties at the time of the founding of the College. The front men in the founding story—Sir George Syme, (President), Sir Louis Barnett and Sir Alexander MacCormick, (Vice-Presidents), Leo Kenny, Hamilton Russell, Sir Henry Newland and Robert Gordon Craig—were all significantly older. This meant, in the rigid hierarchy of

² For a discussion of the colonial relationship between the RACS and England, see below, chapter 7.
³ RACS Archives Melbourne: Sir Hugh Berchmans Devine, SB 28/7, Memoirs.
Australasian surgery, that they were senior to Devine. (Devine joined the ranks of the surgical knights, but not until 1936.)

The forty Founders were deliberately chosen as the most senior surgeons in Australasia, ten each from New South Wales and Victoria, six from New Zealand, five each from South Australia and Queensland and two each from Western Australia and Tasmania. Many of the Founders were already retired or semi-retired and "consultants to their respective hospitals." Few had the energy to do much work for the College, but they gave it an unmistakable stamp of authority and respectability, if only because they were too old to "consider personal advantage." The 165 foundation fellows subsequently chosen cemented that respectability. They consisted of the in-patient surgeons of every teaching hospital in Australia and New Zealand, plus "prominent senior surgeons who worked in well-known non-teaching hospitals," which effectively meant in the major public hospitals of those States which did not have medical schools (or, therefore, teaching hospitals.) They came from a world in which each knew their exact position in the hierarchy, and that position mattered. For instance, in his history of the College, Julian Smith notes that Victor Hurley and W. G. D. Upjohn were appointed to a committee, while Alan Newton was not, although "he was senior to both Hurley and Upjohn at the Melbourne Hospital". This is a good example of the fine gradations of seniority. Newton, Hurley and Upjohn went through medical school together and they were all appointed RMOs at the Melbourne Hospital on 15 February 1910. Following closely parallel, but not identical, careers, they were all appointed Surgeon to In-patients in 1927, but not on the same day. Alan Newton was appointed first, on 18 January, Victor Hurley on 12 July and W. G. D. Upjohn on 19 July. Newton was therefore senior to the other two in the Melbourne Hospital hierarchy by six months, but this was enough to draw comment from someone who was a junior member of the same hierarchy at the same hospital at the time.

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1 Smith, The History of the Royal Australasian College of Surgeons from 1920 to 1935.
2 Ibid.
3 In 1927, there were medical schools in Adelaide, Dunedin, Melbourne and Sydney.
In 1929, Alan Newton joined Hugh Devine to form a team which decisively shaped the character of the RACS. Newton was, as Devine noted, the junior member of the partnership:

As students we had been friends. I had been senior to him [at the Melbourne Medical School]. I came to be his tutor when I was a resident and he was a student. He paid me thirty shillings. He always said my fee was the only thirty shillings he had ever mis-spent…

It was 1929. Sir George Syme was going to England. Dr Leo Kenny had given up the Secretaryship. It was too much for him. Sir Louis Barnett was in New Zealand. He was temporarily president while Sir George Syme was overseas. Sir George had given me a completely free hand to appoint a secretary in place of Dr. Kenny. Dr. Hamilton Russell and I were alone on the Executive.

Having a lonely and unhappy drink in the lounge of the Wentworth Hotel in Sydney, where the second Annual Meeting of our College of Surgeons was being held, I was full of my troubles, which by the way were not slight at the time, when who should walk in but Alan Newton. My sad story I could not repress. When I had finished, he surprised me by saying: "Would I do for Secretary?" Of course he would.¹

After Syme’s death, Sir Henry Newland became President, but he was from Adelaide. Consequently, the "two very strong characters" of Newton and Devine invented the College, including its ceremonies, the requirements for fellowship and the first attempts at a training system for surgeons, from Melbourne.² Together, they ran the RACS through what Devine described as "twenty delectable years."³

They were complementary characters, [wrote Douglas Miller], Devine, the tactician, the negotiator, the friendly envoy; Newton the aloof ruler, the elder statesman; the one brimful of ideas often struggling for expression, and the other articulate and pedantic to the last syllable. The one had a whimsical gaiety, the other was authoritarian and uncompromising.⁴

¹ RACS Archives Melbourne: Sir Alan Newton, SB 44, Alan Newton Becomes Secretary of the College, (1929).
³ RACS Archives Melbourne: Sir Hugh Berchmans Devine, SB 28/7, Memoirs.
⁴ Miller, "The History of the Royal Australasian College of Surgeons from 1935 to 1960,": 302-311.
In 1932, Julian Smith Junior was appointed Honorary Assistant Secretary to Alan Newton, and he has left us a first hand account of meetings of the Executive on Collins Street. Following periods in Devine’s and Kenny’s rooms, the College rented a single small room that opened directly onto Collins Street. It contained a fireplace, a typewriter table for Miss Oldham, two filing cabinets, an office table and five chairs.

On top of one of the filing cabinets was an alarm clock... the executive committee met every Wednesday at 12.45 p.m. Hamilton Russell, then an old man, crippled with arthritis, would take the chair. Alan Newton would wind up and set the alarm clock. He would then take a seat in company with A. L. Kenny and Hugh Devine. The writer was in attendance in a junior capacity as Honorary Secretary of the College. The meeting would begin. Hamilton Russell would shortly fall asleep, and Miss Oldham would take down the proceedings in shorthand. At 2.00 p.m. the alarm clock would explode and the meeting would adjourn.

We may suspect that both Julian Smith and Hugh Devine (who has described the same scene) were amused by the alarm clock, but that Alan Newton was not. In a personal tribute to Newton, Charles Mackay wrote: "He possessed a watch of fine workmanship which was an accurate time keeper. It was both his mechanical servant and his master, it ruled the minutes of his working life." Mackay described Newton as "more dignified than dignity itself," with a "love for ceremonial and... respect for tradition and sound lineage." This was the man who was master of ceremonies for the presentation of the Great Mace. Newton produced a ceremony that conferred precisely those attributes of dignity, respect for tradition and sound lineage on the infant Royal Australasian College of Surgeons.

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1 Smith’s memory is misleading him a little. While Russell was alive, he was Honorary Assistant Secretary. He became Honorary Secretary following Hamilton Russell’s death in 1933, when Newton became Censor-in-Chief. The new member of the group as Honorary Assistant Secretary was G. R. A. Syme, son of Sir George Syme, the first President of the College.
3 RACS Archives Melbourne: Sir Alan Newton, SB 44/18, Alan Newton, A personal tribute.
4 Ibid.
Thursday, February 18, 9 a.m.
Operative Demonstrations at the Melbourne Hospital
Alan Newton: Cholecystectomy (Second Theatre)
Victor Hurley: Goitre (Top Theatre)
W. G. D. Upjohn: Hydatid Disease (Third Theatre)
W. A. Hailes: Glands of the Neck (Summer Theatre)

2: Surgeons and their classrooms

In Melbourne in 1932 at the fifth annual meeting of the Royal Australasian College of Surgeons, there were operative demonstrations at the Melbourne, St Vincent’s, the Alfred, the Women’s, the Children’s and the Eye and Ear hospitals. All of these were public hospitals. They were supported by a combination of charitable donations, government subsidy, contributions from those patients who could afford to pay something towards the cost of their treatment and various other (often ad hoc) fund raising activities. All these hospitals had some full time medical staff, but the senior medical staff essentially worked part time, for free, under the honorary system. At the 1932 meeting, the College did not organise a single operative demonstration at any of the 207 private hospitals in Melbourne, where patients paid the hospital the full cost for their care and also (separately) paid their doctor.

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1 RACS Archives Melbourne: Royal Australasian College of Surgeons, Fifth Annual General Meeting 1932 (Programme), Se 73, p. 9.
2 Ibid., pp. 9-14.
There are many possible explanations for this, including the generally smaller size and poorer facilities of private hospitals in this era. But the straightforward reason is that private hospitals were not used for teaching.4 Medical students did not follow surgeons or physicians through the wards and cluster round beds to hear their verdicts on diagnosis and prognosis. An aspiring surgeon did not make his (very rarely her) first attempt at finding and removing an appendix or a gall bladder in the operating theatre of a private hospital. Private hospitals were private.

In Australasia, as in Britain, (but not in the United States) the undergraduate teaching hospitals were all public hospitals.5 The postgraduate education of surgeons also relied increasingly on public hospitals. In the 1930s, two very different models of an apprenticeship in surgery were beginning to emerge in Australia. The "old-style" apprenticeship was based on a one to one relationship with a master surgeon.6 The apprentice would typically observe and assist him in his work with private patients, for which he might receive an assist fee. This was often combined with an unpaid position at a public hospital, providing operating rights, and/or with some paid work as an anatomy demonstrator for the medical school. This was the model of training in favour in Melbourne and Adelaide and there were also Sydney examples of this pattern of training.7 However, in the 1930s an alternative model was evolving in Sydney at hospitals such as the Royal Prince Alfred.8 This bore a closer

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6 Douglas Miller, one of Australia's first specialist neurosurgeons and President of the RACS 1957-59, wrote an account of his apprenticeship to Sir Alexander MacCormick in Sydney in the 1920s. Such arrangements were largely informal and depended on the personal relationship between the senior surgeon and the "apprentice". Douglas Miller, A Surgeon's Story (Sydney: John Ferguson, 1985), especially chapters 3 and 5.

7 RACS Archives Melbourne: Minutes and Council Papers, Se 7, Minutes of Council of the Royal Australasian College of Surgeons, 18 March 1936.

8 Minutes and Council Papers, Se 7, Report of a conference held between representatives of the Royal Australasian College of Surgeons and of the University of Sydney Post-graduate Committee in Medicine,
resemblance to the American residency model of training and by the late 1960s it had become the norm in Australia. However, in the 1930s it was still novel and, like the old-style apprenticeship arrangements, uncommon. Trainee surgeons were appointed to paid positions at public hospitals, which were specifically designed to have a training content. (See below chapter five). Under both models, trainee surgeons spent most of their time observing their seniors and gained little practical hands-on operative experience, but what experience they did get was generally on public hospital patients, especially in emergencies and after hours. It therefore seemed natural to Alan Newton and Hugh Devine, when organising the program for the 1932 meeting, that all operative demonstrations would be at public hospitals. They were accustomed to performing public surgery, that is to say, performing in front of an audience of medical students and other doctors, on (poor) public patients in public hospitals.

Surgeons were identified by their public hospital appointments. A recent ten-page article on Hugh Devine, for instance, has two separate sections devoted to his role at St Vincent's Hospital, but does not once mention a single private hospital (in Australia) where he worked. This is not a failing of the article. It simply reflects the fact that surgeons were not identified by their private hospitals. Devine lived in Toorak, he sent his three children to elite private schools and he and his family made multiple trips to America, Britain and Europe. On one trip to Europe he had an audience with the Pope and on a subsequent trip to England, his daughters were presented at Court. Yet Devine did not make any of the money to pay for all this at St Vincent's. His work there was part time and unpaid. Neither did he come from a wealthy background. He made a substantial income in the time left over from his very public work at St Vincent's through his private practice.

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12 June 1946: The Post-graduate Committee in Medicine in the University of Sydney, Training Appointments, New South Wales Metropolitan Hospitals, Royal Prince Alfred Hospital.

8 In 1927, following two years' postgraduate experience as a demonstrator in anatomy and "student-apprentice" to Sir Alexander MacCormack, Douglas Miller went to England to study for the FRCS. Despite the fact that he had "witnessed and assisted at a vast number of operations" he got his first personal operating experience on poor law patients at the Hackney Hospital in the East End of London: Miller, A Surgeon's Story, p. 53.

10 Vellar does mention his work as a visiting surgeon at private clinics overseas, such as the Mayo: Ivo D. Vellar, "Hugh Berchmans Devine: Surgical Visionary and Great Australian," Australian and New Zealand Journal of Surgery 70 (2000): 801-812. Vellar also mentions Devine's private consulting rooms.

11 RACS Archives Melbourne: Sir Hugh Berchmans Devine, SB 28, SB 36, SB 106-107, Se 177, papers and press cuttings.
Public hospitals depended on private hospitals. The one could not exist without the other. This was not because of direct cross subsidy (although this was an important component in the financing of Catholic health care). It was because surgeons (and physicians) worked for free in the public hospitals. They therefore had to make a living somewhere else. The result was a symbiotic relationship between two interlocked economies, one driven by market forces, and the other by the logic of a gift relationship.

Public Hospitals and the Gift Economy

In the first half of the twentieth century, the annual reports of Australia's public hospitals were a part of the cycle of exchange in a gift economy. Essentially, they were documents designed to publicly acknowledge gifts and to tell the donors what had been done with their time or money or gifts in kind. The Melbourne Hospital reports, for instance, began with a statistical summary of the number of doctors, nurses, patients, beds and operations performed (page 1) and then provided a tear out form for subscribers to fill in, either making a donation or leaving a legacy (page 2) before the title page: "Melbourne Hospital Report of

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the Committee of Management with Statement of Accounts Lists of Subscribers and Donors and Statistical Returns for the Year Ended 30th June.\textsuperscript{13}

The Annual Reports of the Mater Misericordiae Public Hospitals in Brisbane generally began with a straight-forward statement of purpose. For instance: "The Sisters of Mercy have much pleasure in presenting to benefactors and subscribers the First Annual Report of the Mater Children's Public Hospital."\textsuperscript{14} The Mater Annual Reports listed gifts in kind as well as in cash, so that we learn that in 1932 (mainly for Christmas) fifty named individuals and ten organisations made gifts of food or clothing. These included pumpkins, donated by Mrs. A. Bulgar, turkeys from Mr. Hickey, pillow slips from Mr. Laird and pyjamas, dressing gowns and face washers from the All Hallows Needlework Guild.\textsuperscript{15} Catholic hospitals relied particularly upon gifts from members of the wider Catholic community. Partly because it was smaller, and partly because of the special links with Brisbane's Catholics, the Mater enjoyed a rather more intimate relationship with its donors than the Melbourne Hospital.\textsuperscript{16}

While few Catholic doctors worked at the Melbourne Hospital, many doctors who were not Catholics worked in Catholic hospitals and the records of Australia's Catholic hospitals are full of the names of Jewish doctors, for instance. But overall, it appears that both the Melbourne Hospital and the Mater in Brisbane had broadly similar relationships with their medical staff. Prominently placed in their reports was a general acknowledgment of the work of the honorary medical staff and a listing of their names, qualifications and precise honorary positions. Honorary medical staff were literally honored by the hospitals for the gift of their time and expertise. The Melbourne Hospital Reports, for instance, feature the dates of graduation and appointment through the successive ranks of the hospital hierarchy for each "Honorary Medical and Surgical Officer". The exact sequence of appointments varied a little but the basic pattern began with an appointment as resident medical officer (RMO), possibly

\textsuperscript{13} For example: Melbourne Hospital, \textit{Eighty-fifth Annual Report of the Committee of Management with Statement of Accounts, Lists of Subscribers and Donors and Statistical Returns}, 1932. Copies of the annual reports are held in the Royal Melbourne Hospital Archives.


followed by a period as Registrar, and/or Medical Superintendent. None of these were specialist surgical or medical positions, and they were all paid. Those who wished to specialise as surgeons at the Melbourne might spend a period as Surgical Clinical Assistant. Then came the great divide between the paid and honorary positions. Honorary staff typically spent a period as Surgeon (or Physician) to Out-patients, before the ultimate achievement of a position as Surgeon (or Physician) to In-patients. After retirement, some were honoured with an appointment as Honorary Consulting Surgeon (or Physician).

The Melbourne Hospital more or less exclusively appointed its own men, who had worked their way through that hierarchy, attracting the favourable notice of the right people from their days as medical students at the University of Melbourne. Once they had achieved an honorary appointment, their careers were publicly laid out for all to see in the Annual Reports. The nurses, however, were not listed by name and were relegated to a brief joint entry at the end of the report. If the doctors of this era were almost always men, the nurses were almost always women (although some hospitals employed male wardsmen for tasks such as inserting catheters in male patients).

16 For the varying nuances of religious culture and community in this era see: Janet McCalman, Journeyings, The Biography of a Middle-Class Generation 1920-1990 (Melbourne: Melbourne University Press, 1993).
18 For example: “Alan Newton, M.B., M.S., Melb.; F.R.C.S., Eng. Resident Medical Officer, 15th Feb., 1910. Registrar, 14th Feb., 1911. Resigned 30th Sept., 1911. Surgical Clinical Assistant, 23rd April, 1912. Surgeon to Out-patients, 18th Nov., 1913 (vice Dr. T. H. Boyd). Surgeon to In-patients, 18th Jan., 1927 (vice Dr. F. H. Langlands, deceased).” Ibid., p. 8. Newton resigned from the (paid) position as registrar in order to take up a role as apprentice to a senior Melbourne surgeon, assisting him in his private work. The appointment as Surgical Clinical Assistant allowed him access to operating experience in the Melbourne Hospital.
19 In 1933, the only surgeon, whether general or specialist, at the Melbourne Hospital whose original medical degree was not from the University of Melbourne, or who had not served as an RMO at the Melbourne Hospital, was Charles Littlejohn, who graduated from Oxford. Ibid., p.11.
The Annual Reports of the Mater Misericordiae Public Hospitals Brisbane, also began with a listing of honorary staff, but in far less detail.21 However, written thanks to the honorary staff were, if anything, more profuse: "the Sisters return thanks in the first place to the 'Giver of all good gifts', and after Him to the Honorary Staff. The debt due to these devoted friends the Sisters cannot repay," was the entry for 1922.22 "The success of the work is due, under Providence, in very great measure to our honorary staff of Physicians and Surgeons, and we desire to express to them our sincere gratitude," was the entry for 1929.23

Public hospitals were places where gifts were given, received and acknowledged. But they were also places for teaching and learning and had been since long before there were any hospitals in Australia or New Zealand. Education was a part of the moral economy of gift exchange within the public or charitable hospital.24 The wards and operating theatres were also classrooms, not only for doctors, but also for nurses. As Robert Gordon Craig put it in 1928:

From the beginning of time man has had a right to his health and for hundreds of years it has been an accepted fact that if he could not afford to pay for medical attention, it must be given him without payment; and so hospitals have been established to which he could come for advice and treatment and be nursed back to health, whether he could afford to pay for it or not. This has always been the main function of hospitals and many of them do nothing more than this; but those with which we are concerned—the great teaching hospitals—should also provide for: (i) The training of nurses, (ii) the teaching of undergraduates, (iii) the teaching of graduates, (iv) medical research.25

21 1932 was the first year in which Fellowships of the Royal Australasian College of Surgeons were included among the qualifications listed at the Mater, although some of the surgeons, including Lilian Cooper, had been entitled to the honour for several years. Mater Misericordiae Public Hospitals Brisbane, Twentieth Annual Report, 1st July, 1931 to 30th June, 1932, pp. 2-3.
23 Ibid., 1929, p.5.
Surgeons were identified with their honorary appointments at "the great teaching hospitals". Much of the kudos of these appointments was precisely because they were at teaching hospitals. Large public hospitals in cities without medical schools—in Brisbane before 1936, for instance—did not enjoy quite the same status as those in Adelaide, Melbourne and Sydney. Robert Gordon Craig was familiar with the system in the United States where teaching and research were not confined to public hospitals set up for what he called "the sick poor or hospital class". But in Australia and New Zealand, as in Britain, teaching and research took place at public hospitals, where doctors made the gift of their time and expertise.

Relations between Australian medical schools and their chosen teaching hospitals were frequently strained, especially in the late nineteenth century. The Melbourne Medical School, for instance, had begun with a difficult relationship with the Melbourne Hospital. Before 1910, honorary medical officers were chosen by subscribers to the hospital in hotly contested elections. Doctors often had to resort to open electioneering in order to get elected or re-elected and there was no guarantee of overlap, let alone coincidence, between those chosen by the subscribers and those with appointments as lecturers in the Medical School.

The pressures which eventually led to a change in the appointment system at both the Melbourne and Alfred Hospitals came from doctors. They wanted the appointment of honorary medical staff to be based on recommendations from doctors, preferably representatives of the existing honorary staff. They were able to use the new appointment system at St Vincent's Hospital as leverage. That system, in turn, was a part of a package of measures put in place at St Vincent's to meet the requirements of the University of Melbourne for its inclusion as a teaching hospital. Mother Mary Berchmans Daly (very reluctantly) agreed to take advice over future appointments not only from representatives of St Vincent's honorary staff but also from representatives of the University. In order to be

27 Inglis, Hospital and Community, A History of the Royal Melbourne Hospital; Russell, The Melbourne Medical School 1862-1962.
28 This was, of course, of importance for the achievement of professional autonomy; Evan Willis, Medical Dominance, The division of labour in Australian health care (Sydney: Allen & Unwin, 1989).
accepted as a teaching hospital, St Vincent's also went to the expense of increasing the number of beds and providing a pathology building.29

Public hospitals wanted the kudos of becoming teaching hospitals, and once they were teaching hospitals, this could have a considerable impact on how they were organised. In 1933, for instance, the timetables of the Melbourne Hospital went through a major reorganisation in order to accommodate changes to the curriculum of the medical school. Members of the Faculty of the Medical School decided that "routine work on the wards" was more important to the training of medical students than "listening to honoraries on their visiting days".30 Clinical teaching was timetabled for the afternoons instead of the mornings and as a result, the whole timetable of the hospital, including outpatient clinics and visiting hours, was changed "to fit in with the University curriculum."31

The way that hospitals looked was also influenced by the fact that they were sites for the training of nurses and doctors. Quite apart from the nurses' home, a major physical presence in public hospitals of this era, there were all the uniforms. At the Mater Hospitals in Brisbane, no medical students were trained until 1949, but nurses were trained there from 1912. About that time, the nuns changed from black to white habits and the nurses also wore long white dresses. Distinctions between nursing nuns and lay nurses and between the different grades of student nurse were displayed through variations in the style of headdress and veil—and it was not just the nuns who wore veils.32

At St Vincent's Hospital in Melbourne, student nurses wore blue belts on their uniform dresses in the first year, striped belts in second year and white belts after that. The medical students all wore short white coats, proudly swapped for long white coats once they qualified as doctors.33 Spotting the honorary medical staff could be rather more difficult, especially

29 Egan, Ways of a Hospital. St Vincent's Hospital Melbourne, 1890s-1990s.
30 Royal Melbourne Hospital Archives: Honorary Medical Staff Minutes, Vol 7, pp. 57-87, Medical Curriculum, Report of Sub-Dean, Henry Searby, August 1931.
32 H. J. Summers, They Crossed the River. The Founding of the Mater Misericordiae Hospital, Brisbane, by the Sisters of Mercy (Brisbane: University of Queensland Press, 1979).
33 Egan, Ways of a Hospital. St Vincent's Hospital Melbourne, 1890s-1990s.
for patients. The following is an extract from *The Speculum*, journal of the Melbourne Medical Students' Society, for May 1932:

The primary shock of seeing blood and operations for the first time has now fully passed, as also have the warm blushes that rise to the face of the fourth year student when the first few patients call him doctor. This doctor and student question must offer considerable difficulties to the patient, but as an honorary laid out a plan the other day, all doubt as to who's who should be removed. He said: "if he looks like a doctor, he is a student, and vice versa, but if he looks like an outpatient looking for the Cas. desk he's certain to be an honorary."

Apparently nurses were also sometimes confused by the fact that honorary medical staff did not wear "uniforms". There are tales from the history of the Alfred Hospital of more than one senior surgeon being mistaken for a patient, going along with the joke, and allowing himself to be "put back to bed". Not all surgeons were as conscious of their dignity as Alan Newton.

The position of honorary surgeon to in-patients at a major teaching hospital had many advantages, not the least of which was that there was virtually no one in a position to tell the incumbent what to do. Many were highly conscientious about their visiting times and their teaching responsibilities, but the stories about those who were not, are sufficiently common to make the point that honoraries did not have to come and go at set times. The jokes in the Melbourne medical students' magazine about surgeons rushing out of the operating theatre to go and play golf are just one example. Honorary surgeons could play golf or tennis on week days if they chose, or they could work 14 hours a day, seven days a week. They were the aristocrats of the hospital world, their own masters (or mistresses), free to come and go as they pleased. For while the public hospitals gave them thanks second only to God, the

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private hospitals were even more concerned to keep their good opinion—and the business they brought with them.

Private Practice and the Market Economy

As has already been noted, surgeons were identified by their public hospital appointments. This marked their status as specialist surgeons, as opposed to general practitioners who sometimes performed operations. The other marker of their status was the address of their consulting rooms. In their private practice they were identified not by the private hospital where they operated but by the street on which they worked. Some particularly independent minded individualists did not conform, but generally specialist surgeons (and physicians) clustered together in clearly defined locations.\(^{37}\) In Sydney, this was on Macquarie Street. In Melbourne it was on Collins Street and the phrase "Collins Street surgeon" clearly marked a doctor out as being what Christopher Lawrence has called a "medical aristocrat", a specialist rather than a general practitioner.\(^{38}\) Similarly, in Adelaide specialists had their rooms on North Terrace; in Brisbane it was Wickham Terrace; in Wellington it was Willis Street or The Terrace and in Perth it was St. George's Terrace.

It was their consulting rooms, rather than any particular hospital, that formed the public, and possibly also mental, focus of their private practice. Private hospitals have almost a ghostly quality in the surviving records, compared to the less numerous, but generally much bigger and longer lived public hospitals. Even the long lived Catholic private hospitals seem to have existed in the shadow of their more prominent public counterparts. The Sisters of Charity in Melbourne, for instance, built St Vincent's Hospital (public) and Mount St Evin's (private) side by side. The hospitals grew together, but St Vincent's was the well known institution, in the news whether for fund raising or fetes or medical breakthroughs.\(^{39}\) Similarly, in Brisbane the Sisters of Mercy built the Mater Misericordiae Private Hospital first, to help fund the opening of the Mater Public Hospital. The Mater private hospitals

\(^{37}\) The model for this behaviour was in London. See: R. Pound, Harley Street (London, 1967).


\(^{39}\) Egan, Ways of a Hospital. St Vincent's Hospital Melbourne, 1890s-1990s; Tyquin, A Place on the Hill, The History of St Vincent's Private Hospitals in Melbourne 1906-93.
grew in size and multiplied in numbers, but it was the Mater public hospitals (for adults, children and women) on the same site, south of the Brisbane River, which drew most of the media attention and loomed largest in the public consciousness.\textsuperscript{40}

While doctors competed for positions as honorary consultants at the major public hospitals, private hospitals wooed the doctors to bring them their patients. Public patients chose their hospital. That is where they went, and they were treated by which ever student or junior doctor happened to be on duty at the time. Private patients chose their doctor. The doctor then generally made the decision as to where the patient would be treated. Private hospitals therefore depended on doctors to bring them business. It did not often walk in off the street in the same way as patients flooded into the public hospitals. The relationship is illustrated by this story from the founding of the Mater Private Hospital in Brisbane in 1906:

Now one patient was Mrs. Thomas, Sister Mary Consilio’s mother. She was a patient of Dr. Lilian Cooper, the first and only lady doctor in Brisbane at the time. When Mrs. Thomas mentioned the Mater Hospital to Dr. Cooper, she said "I don’t know anything about them and they may be very kind. But they have no trained nurses, and I would not like to risk you over there." Mrs. Thomas said "Well I’m prepared to take the risk if you are prepared to attend me there." So she followed her over to North Quay and Dr. Lilian Cooper became the greatest benefactor really that we had among the doctors, right through to her death…

By degrees several of the doctors came, Dr. Byrne, Dr. Wilson, Dr. Page who was rather friendly right from the beginning; Dr. Glynn Connolly, who was not very friendly at first but became very attached to the hospital; and they all looked to Sister M. Antonio [who was an experienced nurse before she became a nun]. As soon as they appeared they wanted her; we had to disappear because we knew so little.\textsuperscript{41}

\textsuperscript{40} Summers, They Crossed the River. The Founding of the Mater Misericordiae Hospital, Brisbane, by the Sisters of Mercy.

\textsuperscript{41} Quotes from an interview with Sister Mary Dominica in Ibid., p. 26. In 1910, the private hospital moved from North Quay to the 'Mater Hill', south of the Brisbane River.
The Catholic private hospitals were on the whole larger and longer lived than most private hospitals. In Melbourne, Mount St Evin's, for instance, was a fifty-bed hospital founded in 1906 and closed in 1967, although it was succeeded by St Vincent's Private. In Brisbane, the Mater Private opened in 1906 and was still going strong at the turn of the next century. But private hospitals of the 1920s and 1930s were generally small, often set up by a nurse in a converted private house, and most only survived for a few years. With its fifty beds, grand lobby, five floors and two up-to-date operating theatres, Mount St Evin's was considered by some to be the best private hospital in Melbourne. It was also probably the largest. In 1926, there were 480 private hospitals in Victoria, but they had only 3,701 beds between them or an average of fewer than eight each. Compared with this, the public hospitals were giants. The Melbourne Hospital was particularly large, with a normal capacity of 378 beds, but the average size of the 57 public hospitals in Victoria in 1926 was 40 beds, and this figure includes the 29, generally small, country base hospitals. There were four intermediate hospitals at the time and they, too, were far larger than the average private hospital, with 250 beds between them.

Another important feature of private hospitals was that they offered open access to doctors. Access to beds in public hospitals was only available to doctors who held an appointment at that particular hospital. Access to private hospitals was available to all registered medical practitioners (subject to the availability of beds). By the 1930s, honorary appointments at the major metropolitan public hospitals were more or less restricted to full time specialists. Some country GPs had access to public hospital beds, and some GPs also had appointments at a limited number of city public hospitals, but by the end of the 1930s, this was coming to be seen as anachronistic. Increasingly, if a general practitioner, especially in any of the

43 Hurley, "An outline of a suggested policy for the College of Surgeons of Australasia for the improvement of hospitals," 43-52. See also Victorian Year Books for hospital statistics in this period.
44 In this respect, Australia was like Britain, where the voluntary hospitals were "closed", although there was open access to some cottage hospitals. In the United States, however, a system of open access hospitals came to predominate. For the significance of this for the status of general practitioners and specialists, see: Frank Honigsbaum, *The Division in British Medicine, A History of the separation of general practice from hospital care 1911-1968* (London: Kogan Page, 1979).
45 Yule, *The Royal Children's Hospital: a history of faith, science and love.*
major cities, wanted to perform surgery, he or she had to do so in a private hospital or in the patient's home. This was the area of greatest concern to surgeons like Sir George Syme:

It is... common knowledge that in all the States many serious and difficult major operations, both in general and special surgery, are performed not as emergency, but habitually, by practitioners who do not possess the requisite qualifications and experience, and often in hospitals inadequately equipped. The public has no means whereby it can discriminate as to who are adequately qualified and experienced surgeons, or between hospitals that are perfectly satisfactory from a surgical point of view, and those that are not.

Private surgical practice was an essential part of the dual medical economy. It was where surgeons made their living. At one end of the scale, it was associated with luxurious accommodation and elite surgeons. But it was also associated with small hospitals, makeshift private arrangements and general practitioners operating on a part time basis.

Pressures for Change

The hospitalisation of surgery and the surgicalisation of hospitals

In the nineteenth century, it was customary for doctors to talk about their "hospital practice" and their "private practice". They treated public patients (for free) in hospitals and private patients (for a fee) in their homes. But by the 1930s, even private patients were going to hospital if they required surgery. Archibald Watson's diaries provide direct evidence of some of the reasons why this was so. Watson was the first Professor of Anatomy at the University of Adelaide and throughout his long career he kept a series of diaries. Some are

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47 However, in the 1980s GPs could still access to Melbourne's outer suburban hospitals. Warwick Anderson, personal communication.
48 Quoted by Devine: RACS Archives Melbourne: Sir Hugh Berchmans Devine, SB 28/7, Memoirs.
50 RACS Archives Melbourne: Archibald Watson, Box 64, P1, and following folders, Diaries 1895-1915.
surgical and they provide a record of many hundreds of operations. Sometimes he was an observer, sometimes he assisted and sometimes he performed the surgery himself.

In 1897, Watson assisted at an operation on a woman with multiple ovarian cysts. From the beginning there were problems. The operation took place on the patient's kitchen table and despite putting blocks under the table legs, the patient was still not in the best position to provide the surgeons with good access. The room was small with "terribly bad light", so that in addition, it was difficult for them to see what they were doing. There was no electricity in the house and they were: "Afraid to use a candle on acct. of ether." In addition, the silk they were using for sutures kept breaking, and it was difficult to achieve haemostasis. The overall result was a disaster. "Will be careful in future not to allow (if I can prevent it) an operation of such a serious nature being undertaken in a room with bad light and rotten silk." The patient died three days later.\(^5^1\)

Basic items of equipment such as adjustable operating tables, good light and access to supplies of suture material were regularly available in hospitals, but were not regularly available in private homes. Hospitals also provided round the clock nursing care. But lights and operating tables were among the less expensive items in the inter-war hospital. The public hospitals were equipped "at great expense to the community with all the latest appliances that science can offer."\(^5^2\)

Much of the more expensive equipment was diagnostic such as X-ray machines, for instance, and laboratories for the pathologists to do their work with slides and microscopes and reagents. This equipment could not just be purchased once; it had to be kept up to date. It cost £1,112.14.10 to run the Mater Public Hospital, Brisbane, in 1911, its first year of operation. In 1932, the maintenance account of the hospital had risen to the grand total of £17,741.10.0. This sixteen-fold increase over twenty years was only the beginning of the never ending fund raising struggles of the Sisters of Mercy. The other side of the story was the enormous capital expenditure. Over the 20 year period, more beds were added, taking the theoretical total from 70 to 140, (although extra patients were often put up on verandahs

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\(^{51}\) RACS Archives Melbourne: Archibald Watson, Box 64, P1/2/5 Aug 27- Nov 11 1897.
and in corridors), but the Mater did not only face capital expenditure on space for more beds. New operating rooms for ophthalmology and the ENT surgeons, and a new, bigger, well lit casualty area were added in 1921, then in 1923, there was a new electrical lift to transport patients from the operating theatres to the wards. But the major recurring capital expense seems to have been on X-ray equipment. The plant installed in 1921 was replaced by a new machine in 1928, and in 1929, with the assistance of the Cancer Trust, a new "Deep X-ray machine" was installed and the federal government provided "Half a grammie of Radium".

Private hospitals simply could not afford either to buy this sort of equipment in the first place, or keep it up to date, mainly because most of them were simply too small. A ten or even a twenty bed hospital could not afford to buy an X-ray machine and leave it unused for most of the time, whereas public hospitals, most with 100 or more beds, could reap the benefits of economies of scale. As Victor Hurley noted in 1928:

The fact is that there is a steadily increasing drift towards general dependence on free medical treatment and for this several factors are responsible. Amongst them are:
1. The formidable increase in the cost of diagnosis alone in recent years—X-ray, biochemical, pathological and other investigations being frequently necessary, as well as the opinions of other specialists.
2. The public knows that these are available at public hospitals.
3. Similar facilities are not available for private and intermediate patients and these must be provided.
4. The altered attitude of the public towards public hospitals is that the latter are regarded more as public utilities than public charities.

One response to this trend was fewer, larger private hospitals. In Victoria, for instance, there were only 266 by 1947, compared to 476 in 1921, and the average size had doubled to

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53 Craig, "Improvements of Hospitals." 39-43. For the history of technology in the hospital in this period see: Howell, Technology in the Hospital, Transforming Patient Care in the Early Twentieth Century.
about 16 beds each.\textsuperscript{55} But the main response of patients to what might be described as the "hospitalisation of surgery" or perhaps the "surgicalisation of hospitals" was to go to one of the major public hospitals. As Victor Hurley complained in an address to the Victorian branch of the BMA (he was the retiring President) in 1932, between 1902 and 1926, the population of Victoria increased by 21.4 per cent, while the number of public hospital in-patients increased by 112.6 per cent and the number of out-patients by 160.9 per cent.\textsuperscript{56} Most of the increasing number of patients were going to hospital for surgery. In 1931-32, for instance, 8,451 in-patients were treated at the Melbourne Hospital and 10,593 "Main Operations" were performed.\textsuperscript{57}

In Brisbane, figures for the Mater Misericordiae Public Hospital provide confirmation that this trend was not confined to Victoria. In its first full year of operation in 1912, the Mater admitted 941 patients and 210 operations were performed (excluding what were described as minor operations in the "out-door department").\textsuperscript{58} In 1932, the Mater admitted 3,026 patients and the number of operations (again, excluding minor out-patient procedures) had risen to 2,645.\textsuperscript{59} Not only had the number of patients more than tripled but the proportion of patients admitted for surgery had risen from less than one in four to more than two out of three. Indeed, in 1931, the number of operations pretty much equalled the number of patients (2,728 patients, 2,722 operations).\textsuperscript{60} Even allowing for patients who had more than one operation during their stay, the surgicalisation of the Mater between 1912 and 1932 is very clear.

By 1932, public hospitals had become places where patients, by no means all of them poor, went for surgery, and in the inter-war years, surgery was a major growth industry. Appendicectomies, cholecystectomies and tonsillectomies were only the most numerous of a

\textsuperscript{55} Government of Victoria, \textit{Victorian Year Book} (Melbourne, 1964), pp. 269, 271.
\textsuperscript{58} Mater Misericordiae Public Hospitals Brisbane, \textit{Annual Report}, 1912, p. 4.
\textsuperscript{59} Mater Misericordiae Public Hospitals Brisbane, \textit{Twentieth Annual Report, 1st July, 1931 to 30th June, 1932}, p. 5.
\textsuperscript{60} Mater Misericordiae Public Hospitals Brisbane, \textit{Annual Report}, 1931, p. 5.
whole range of operations that were virtually unheard of half a century before. In 1930, a senior English surgeon argued that: "Since 1900 operative surgery has advanced with such strides that text-books of surgery have become, like railway time-tables, useful only for a season." While amputations, the mainstay of the nineteenth-century surgeon, had come to be considered relatively minor procedures, surgeons were performing increasing numbers of thyroidectomies, prostatectomies and hysterectomies. But the increasing range of surgical procedures that were being devised for conditions not previously considered suitable or safe for surgery was not the only cause of the increase in surgical cases.

During the past few years, [wrote the Medical Superintendent of the Melbourne Hospital in 1933], the demand for surgical treatment has steadily increased. Consequently, more and more medical beds have been taken over by the surgical side of the hospital, and sick patients are often forced to attend the Out-patient Department, because there is no in-patient accommodation available for them... One of the reasons for the great demand on the services of the surgical side of the hospital is the large number of accident cases which have been treated. This burden is becoming heavier each year, and is shown by the fact that 701 fracture cases were treated as in-patients during the year.

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63 For changes in gynaecology and obstetrics in this era see: McCalman, _Sex and Suffering, Women's Health and a Women's Hospital_, especially pp. 223-252. For changing fashions in the treatment of prostatic obstruction, see chapter 6 below. For an example of a surgical procedure that was rapidly discredited see: John P. Royle, "A history of sympathectomy," _Australian and New Zealand Journal of Surgery_ 69 (1999): 302-307.
The motor car and the motor bike were beginning to have their impact on the distinctive mortality and morbidity patterns of the twentieth century.

This growth in demand for surgery is the context for the formation of the Australasian college of surgeons. Senior surgeons at the major public hospitals, like Sir George Syme and Hamilton Russell, had seen an enormous expansion of their profession during their lifetimes. Many of their colleagues had been able to turn themselves from general practitioners into full-time surgeons because of the increase in the sheer volume of work for surgeons. More and more new surgeons were needed, and people like Syme and Gordon Craig and Newton and Devine wanted them to be better trained than the old guard, many of whom were self-taught. In particular, they wanted new surgeons to be trained in big hospitals, where they could be watched, and could learn from, more experienced surgeons. As J. S. Elliott put it for New Zealand:

We require a type of surgeon that knows without any rules, dear to the official mind, when further advice and help is necessary and the best form of consultation is available only in the large and fully equipped hospitals, where automatically patients come under the observation of various departments. Thus commonly a patient with a gastric condition has the benefit of a physician, a radiologist, a laboratory worker and, if necessary, a surgeon. A young surgeon needs to serve an apprenticeship as an assistant and, instead of working independently, to gain by observation of the technique and opinions of more senior men. In the one-man or even two-man hospitals of New Zealand the surgeon is likely to continue the same methods year after year and to make the same mistakes, because he has not others to learn of or emulate and has not the stimulation of friendly competition.65

64 "Report of the Medical Superintendent" in: Melbourne Hospital, Eighty-sixth Annual Report, 1933, p. 29.
65 By 1928, New Zealand hospitals were municipally run and funded and the system of honorary appointments was limited to a small number of positions in the largest hospitals. J. S. Elliott, "The Hospitals of New Zealand and the Promotion of the Practice of Surgery," Journal of the College of Surgeons of Australasia 1 (1928): 34-38.
At its first meeting in 1928, the College resolved that surgeons were best trained in hospitals with 100 or more beds, which effectively meant in the larger public hospitals. Like their patients, surgeons recognised that the major public hospitals were able to provide not only better facilities, but often also better surgery than small private hospitals. This growth in the stature of the public hospitals put the dual economy of hospital practice and private practice under enormous strain.

The solution advocated by many, including Hugh Devine in Victoria and Robert Gordon Craig in New South Wales, was the conversion of public hospitals to community hospitals on the American pattern, with a mix of private, intermediate and public beds. Surgeons were quite happy to continue treating poor patients for free, but they wanted to be able to offer their private patients all the benefits of the latest diagnostic technology, generally only available in the public hospitals. Interestingly, Robert Gordon Craig chose a shipping analogy to describe the system he had in mind:

Take, for instance, the ocean liner from England to America: the passenger can pay £200 for his passage or £20 or anything in between these two amounts, according to the amount he is able or chooses to pay. The shipping company is as willing to take the small fare as the large. The skill of the navigator, the watchfulness of the engineers, the safety insured by the wireless, the care exercised in the food service are all his whether he pays £20 or £200, the difference lies wholly in the accommodation and luxuries he is able or chooses to enjoy... The safety of the transport is the same for every one. And after all what is a hospital but the means of transport between sickness and health? Let there be one hospital and the same facilities in medical treatment for everybody, but let those who can, pay for any luxuries they choose; let those who can pay the whole of the doctor's fee and let those who cannot pay the whole of it pay what they can.

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Meanwhile, governments had begun to supplement charitable fundraising to help pay for the enormous increase in the workload of public hospitals.\textsuperscript{68} The depression of the early 1930s adversely affected the level of charitable donations and the ability of patients to pay the full price for private care.\textsuperscript{69} This may have accelerated the tendency for patients to treat public hospitals as theirs to use when they needed them, and to make a contribution to the cost of their care. The combination of increasing government subsidy for public hospitals and increasing contributions from the patients themselves helped shape the public perception that public hospitals were not just the last resort of the indigent poor with nowhere else to go. In 1931, for instance, traditional sources of charitable fundraising provided only 33 per cent of the revenue of Victoria's public hospitals. Government and municipal subsidies provided nearly 20 per cent and patients' contributions provided another 25 per cent.\textsuperscript{70}

When surgeons spoke about the problems in the hospital system at the first meeting of the Australasian college in 1928, they were defending the dual system of public and private practice. In particular, they were defending "their" public hospitals, the "great teaching hospitals" where they worked for free, against the combined onslaught of public hospital patients who could afford to pay (and should therefore be private, not public patients) and government interference in health care.\textsuperscript{71} Their honorary positions as unpaid surgeons to public hospitals became the symbol of the kind of hospital system that they favored, but the gift of their time was conditional. As Robert Gordon Craig put it:

\begin{quotation}
\textit{Every profession has its own private charities; but in none is charity so taken for granted as it is in medicine. We are not grumbling at this, provided that the right person gets the charity; and at present we feel that this is not always the case. We ask}
\end{quotation}

\textsuperscript{68} For an overall view of the politics of health funding see: James A. Gillespie, \textit{The Price of Health: Australian Governments and Medical Politics 1910-1960} (Melbourne: Cambridge University Press, 1991). For a medical perspective on overall changes in hospitals in this era see: Brown, "The Development of Australian Hospitals in the last Fifty Years,"; 40-45.


\textsuperscript{70} Hurley, "An outline of a suggested policy for the College of Surgeons of Australasia for the improvement of hospitals,"; 43-52.

for no remuneration for the time and skill given week after week, year after year, to the public hospitals; but perhaps it would not be asking too much to suggest that some recognition be made of our services by the Taxation Department when the estimate of our income tax is being made up, by placing these services on the same footing as other contributions to charity and allowing us so much exemption for them.\textsuperscript{72}

Robert Gordon Craig was not objecting to the concept of a gift economy. On the contrary, as will become clear below, he himself engaged in public gift giving on a huge scale. But the gifts he gave had to be fully acknowledged and used in ways that he considered appropriate. He had a strong personal sense of what was due to him in return for his gifts. The gift of his time and skill as a surgeon was, to use Thomas' concept, "entangled", or to use a common phrase, it had "strings attached".\textsuperscript{73}

The Art and Science (and Craft) of Surgery

In 1928, Sir George Syme addressed a hostile meeting of the Victorian branch of the BMA on the aims and objects of the College of Surgeons of Australasia. Many general practitioners were opposed to the formation of a college of surgeons, which they saw, correctly, as part of a move to restrict the performance of operations to full-time surgeons. Syme chose to end his address as follows:

The ideal of the College of Surgeons of Australasia is to make more perfect the art of surgery and to free it from all commercialism, so that all who practice it shall give the best and most perfect service to the public. The College holds with Sir Berkeley Moynihan that: "Of all the temples in the world none is more sacred than the operation theatre, that nothing base should dwell in such a temple, and as this temple waxes, the inward service of the mind and soul grows wide withal."\textsuperscript{74}

\textsuperscript{72} Craig, "Improvements of Hospitals": 39-43, p. 40.
Surgeons and their classrooms

Lord Moynihan is not alone in describing operating theatres as sacred or ritual spaces.\textsuperscript{75} But operating theatres are also mundane spaces for those who work there every day, sites for the normal workplace jokes and gossip, once the patient is unconscious. Even so, they are often places of raised tension, where surgeons show stress by throwing things, or shouting.\textsuperscript{76} They are very frequently performance spaces of heightened experience, aptly called theatres. But they are not the only places where surgery is learned, and since 1928 there have been a number of shifts in the emphasis that the RACS has placed on the importance of the various elements that combine to make a competent surgeon.

The inclusion of operative demonstrations in the Annual Meetings of the RACS followed the example set in America, where Franklin Martin began organising operative demonstrations in 1910. Martin's idea was that "show me is more convincing than tell me", and was an attempt to supplement reading about new surgical procedures in the journal he founded: \textit{Surgery, Gynecology and Obstetrics}.\textsuperscript{77} Like Martin's enormously popular "wet clinics", the RACS meetings provided the opportunity for mature Australasian surgeons to watch each other work, and (hopefully) to learn something, if only about the differences between the major public hospitals. The Annual Meetings provided an opportunity for the leading surgeons in the host city to show off the latest techniques, and they provided an opportunity for surgeons from elsewhere to observe operations they had not seen before. But the emphasis was on observing, not doing. In 1932, the RACS made no attempt to grapple with the problems of how to teach, let alone examine, the manual skills involved in surgery.\textsuperscript{78} On the contrary, in the requirements for the FRACS, the College was about to move away from peer reports on surgical competence towards an emphasis on examining in the surgical sciences. Future Fellows of the College were to be rigorously examined on their knowledge.

\textsuperscript{78} In the inter-war years, the Royal College of Surgeons of England did attempt to examine in operative surgery and candidates for the Final conducted surgical procedures on cadavers. Douglas Miller described his own experience of this in 1928: Miller, \textit{A Surgeon's Story}, p. 68.
of anatomy, but hardly at all on their skill with the scalpel. They were also supposed to serve a lengthy surgical apprenticeship, although what this meant in practice varied enormously and seldom, in Australia, involved much practical hands-on surgical experience. (See below, especially chapter eight). However, an important component of the apprenticeship ideal was the acquisition of surgical judgment—deciding when, and most importantly, when not to operate, and which operation to perform.79

In this thesis, the art and science of surgery is regarded as having three, not two, components. Theoretically, at least, since 1932 qualification for the FRACS has required passing a two-part examination in the science of surgery. It has also required a period of surgical apprenticeship considered adequate to acquire the beginnings of the art of surgical judgment. But the third component, the manual art or craft of surgery, has not been formally assessed for the FRACS, and it was not consistently taught in Australia until the 1970s. (See below chapters eight and nine).

This relative neglect of the manual craft of surgery strikes the lay observer as odd. It goes with the sentiment that "you can teach a monkey to operate", and with an emphasis on the importance of what goes on outside the operating theatre, including diagnosis, clinical decision-making and pre- and post-operative care of the patient. It is also particularly associated with general surgeons and with an emphasis on the lengthy experience needed to acquire sound clinical judgment. (See below chapter five.) It may be that an emphasis on the art of surgery in this sense, as well as on the importance of surgical science, served surgeons well in their efforts to both raise surgical standards and persuade general practitioners to leave surgery to the experts. The message was that manual dexterity alone might make an "operator", but it did not make a "surgeon".

However, surgeons as a group were not united. Already by 1932 a number of surgical specialties had emerged with different interests from the general surgeons.80 In many ways,

the story of the RACS is the story of the management of a persistent tendency for the profession of surgery to fragment. Obstetricians and gynaecologists were the first to go their own way with their own college, followed by the ophthalmologists. In the 1930s, orthopaedic surgeons and urologists were already setting up their own professional associations, and although they have remained under the umbrella of the RACS, this has not been without considerable tension. Overlapping with the struggle of the general surgeons to persuade general practitioners to leave appendicectomies and hernia repair to them was a struggle by the orthopaedic surgeons to persuade general surgeons to stop treating compound fractures and by urologists to persuade general surgeons to stop performing prostatectomies. In the process, members of the surgical specialties seem to have been less inclined to downplay the importance of manual skills, and more inclined to argue that practice makes perfect. They argued that a surgeon who performed a procedure once a week was likely to get better results than a surgeon who performed it once a year. (For the example of urology in the 1930s, see chapter 6.) However, in 1932 (and for many years afterwards) the RACS saw the world through general surgical spectacles.

Thursday February 18, 2.45 p.m.
"The University of Melbourne will hold a Special Conferring in Wilson Hall, at which a degree by special grace will be conferred on C. H. Fogge Esq., F.R.C.S., to which the University cordially invites all Fellows and their wives... Cards of invitation can be obtained at the College office."

3: Accrediting surgeons: international qualifications

From the late 1940s, the RACS held its own examinations and came to regard University qualifications in surgery as having limited practical usefulness. Effectively, Australia and New Zealand followed the British pattern of accreditation by the various Royal Colleges, where bodies representing surgeons as an organised profession provided the major recognised qualifications in surgery. This was different from the American pattern of accreditation, which had developed in the 1920s and 1930s, where members of each surgical specialty (ophthalmology, orthopaedics, urology etc) could apply for accreditation by a dedicated specialty board. The specialty boards typically included representatives from a range of bodies, not just the American College of Surgeons.

1 RACS Archives Melbourne: Royal Australasian College of Surgeons, Fifth Annual General Meeting 1932 (Programme), Se 73, p. 10.
3 Although there were a number of specialist diplomas and degrees, most awarded by universities, their status was always problematic and the FRCS remained the bench mark qualification for a surgeon. John Blandy and John S. P. Lumley, eds., The Royal College of Surgeons of England 200 Years of History at the Millennium (London: The Royal College of Surgeons of England and Blackwell Science, 2000); John Lister, Postgraduate Medical Education (London: The Nuffield Provincial Hospitals trust, 1993); Rosemary Stevens, Medical Practice in Modern England and the Impact of Specialization and State Medicine (New Haven: Yale University Press, 1966).
However, it was not until more than twenty years after its founding that the RACS began to hold its own examinations. Indeed, in the first few years, members of Council do not seem to have envisaged that the College would ever become an examining body along the lines of the British colleges. Instead, they looked to the Australian and New Zealand university medical schools. They headed the column for qualifications in their Register of Fellows "Degrees", they held their early annual meetings on university premises, and they set themselves the task of persuading the universities to all offer degrees of master of surgery of a comparable (high) standard. It was therefore considered right and proper that the conferring of an honorary degree on Fagge form part of their 1932 annual meeting.

Initially, the College saw itself as co-operating with, rather than in competition with, the universities. According to Sir Henry Newland, President of the College 1929-35: "The academic side of surgical training in Australia has necessarily to be arranged in co-operation with the universities..." The College took on the task of trying to influence the universities, and believed that the universities had a role to play in providing both surgical qualifications, and surgical training. As Victor Hurley put it in 1928: "The most pronounced gap in our present system is that no really effective facilities exist for post-graduate training. The College can effect much improvement by influencing universities and hospitals to make adequate arrangements to meet this need..." In 1931, Sir Henry Newland reported that:

With the object of basing the science and art of surgery on a sound foundation of anatomy and physiology, representatives of the Royal Australasian College of Surgeons conferred in Melbourne two years ago with representatives of the Universities of Adelaide, Melbourne and Sydney. As a result of the conference the examination for the degree of master of surgery in the three universities in future will be divided into

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5 Fifth Annual General Meeting 1932 (Programme), p. 8.


two parts. The first part of the examination will consist of anatomy and physiology.
The final examination will be in surgery in its various aspects.  

In 1932, the qualifications held by surgeons in Australasia were many and varied, including  
the old style basic British medical qualification of Licentiate of the Royal College of  
Physicians and Member of the Royal College of Surgeons, with or without a fellowship of  
one of the British royal colleges of surgeons.¹⁰ None of these qualifications were degrees, nor  
did they require study at a university. However, most of the younger surgeons did have an  
undergraduate medical degree, whether Australasian or British. In addition, many had post-  
graduate medical degrees, including MSs and MDs (Australasian or British), or specialist  
medical diplomas of various kinds from a range of British bodies, few of which were  
universities. Some of these were considered more prestigious than others, and the perceived  
hierarchy is set down very clearly in the report drawn up by Hugh Devine and Alan Newton  
and presented to Council on 16 February 1932.¹¹ The preferred senior surgical qualifications  
were a "F.R.C.S. England and/or M.S. Adelaide or Melbourne".¹² In 1932, 131 Fellows or  
26.55 per cent held one or other of these qualifications. Second preference was for a Sydney  
University MD (held by 11 Fellows). Last on the list was a Fellowship from either the Royal  
College of Surgeons of Edinburgh, or the Royal College of Surgeons in Ireland (held by 88  
Fellows in 1932, according to Newton and Devine's report).

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¹⁰ In the nineteenth century, most British doctors trained at one of London's hospital-based medical schools. These were not, originally, attached to a university, (although by the end of the century a number had a relationship with the University of London), nor did they offer degrees or diplomas. Aspiring doctors were accredited by the Royal College of Physicians and the Royal College of Surgeons (and less and less frequently by the Society of Apothecaries). For a history of nineteenth century British medical qualifications and the emergence of the general practitioner from the separate professions of physicians, surgeons and apothecaries see: M. Jeanne Peterson, The Medical Profession in Mid-Victorian London (Berkeley: University of California Press, 1978); Noel Parry and Jose Parry, The rise of the medical profession, a study of collective social mobility (London: Croom Helm, 1976). For British training of Australian doctors in the nineteenth century see: Laurence M. Geary, "The Scottish-Australian Connection 1850-1900," in The History of Medical Education in Britain, ed. Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995); Donald Simpson, "The Adelaide Medical School 1885-1914, A study of Anglo-Australian Synergies in Medical Education" (MD, University of Adelaide, 2000).
¹¹ RACS Archives Melbourne: Minutes and Council Papers, Se 7, Hugh Berchmans Devine and Hibbert Alan Stephen Newton, Policy in regard to the future admission of Fellows, 16 February, 1932.
¹² Ibid.
A number of things are significant about this list. The degree of ChM from Sydney is missing, even though it was held by more than 80 Fellows. Until 1922, it was available on request to recent graduates of the medical school and it was not, therefore, a "real" senior surgical qualification (ssq). The Sydney MD was allowed as a surrogate ssq, but although MDs abounded among the qualifications held by Fellows, it is clear that only the Sydney MD counted as an ssq. In contrast to the Sydney ChM, the degrees of MS from Adelaide and Melbourne were both relatively rare and highly prestigious. Only 18 from Melbourne and 6 from Adelaide were awarded in the ten years before 1932. Finally, the Edinburgh Fellowship did not rank as highly as the English Fellowship or an MS from Adelaide or Melbourne. This was because in 1932 the Edinburgh fellowship was not obtained through a two-part examination.

1932 marks the dividing point between the College recognising who surgeons actually were (and admitting them to Fellowship) and deciding what the future qualifications of surgeons ought to be. From 1932, all new Fellows had to have a senior surgical qualification, defined as obtained through "a primary examination in Anatomy and Physiology and a final examination in Surgery, Surgical Anatomy and Surgical Pathology." This essentially meant that new Fellows had to have one of the three recently standardised degrees of Master of Surgery from Adelaide, Melbourne or Sydney, or an FRCS Eng. The Edinburgh Fellowship would no longer do (although after World War II it became a two-part examination that met the Australasian criteria), and neither would the Otago MS (although the rules were later bent to accept this rather uncommon degree). An important feature of the College's conception of a two part ssq was that the two examinations did not have to be passed in the same university or college of surgeons. In February 1932, the Universities of Adelaide and Melbourne, for instance, had already agreed that passing the Primary examination for an FRCS Eng exempted candidates from Part 1 of their own MS. Sydney University, however, was still refusing to come into line with the wishes of the RACS.

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13 Register of Fellows.
15 Devine and Newton, Policy in regard to the future admission of Fellows, p. 27
16 RACS Archives Melbourne: Minutes of the Fifth Annual General Meeting of the Royal Australasian College of Surgeons, Se 45, held at Menzies Hotel Bourke St Melbourne on Thursday February 18, 1932 at 6.30 p.m., p. 9.
17 Ibid.
18 Minutes and Council Papers, Se 7, 16 February 1932, p. 10.
As a part of this reciprocity, the College negotiated with the Royal College of Surgeons of England to hold examinations for their Primary in Australasia. The first was in August 1931, and the Australasian and English colleges agreed to share the costs. There was a precedent in that English Primaries had already been held in Toronto in 1929 and Montreal in 1930. In 1931, Professors William Wright and E. A. Buckmaster did a round the world trip, holding primaries in Melbourne and Toronto. Of the twenty candidates examined in the Arts building of the University of Melbourne on Tuesday 11 August, ten passed, seven from Melbourne, two from Sydney and one from Otago.19 Given that the normal pass rate for the primary was 30 per cent, this was considered a very good result.20

The Fellows in 193221

The College admitted 484 Fellows before February 1932. Of these, 207 were the Founders and Founding Fellows, chosen on the basis of seniority in 1926 and 1927.22 The rest were admitted under rules comparable to those of the American College of Surgeons:

...a candidate must be nominated by three Fellows and must give the names of five other medical practitioners, three of whom must be surgeons, as references. The five referees are then asked to fill in a confidential report concerning the surgical judgement and ability of the candidate and his moral and ethical standing. The candidate must also, in his application form, furnish details of his undergraduate and post-graduate education. The application, together with the reports of the referees, is

19 Minutes and Council Papers, Se 7, 7 September 1931.
20 William Wright, "The Fellowship of the Royal College of Surgeons of England," The Speculum 130 (1932): 5-7. The visit by Professor W. Wright and Professor G. A. Buckmaster was reported in the Age, the Argus and the Herald, complete with photographs, a summary of their careers (Buckmaster, Australians were told, was the brother of Lord Buckmaster) and a full itinerary for the visiting professors, who stayed at the Melbourne Club.
then considered by the State/Dominion censors who report to the Council of the College, which then decides whether to admit, reject or defer the application.23

In the period 1927-32, only 27 applications were rejected and 125 surgeons without an ssq were admitted as Fellows.24 A further 62 were admitted with the FRCS Edinburgh and one with the FRCS Ireland, and eleven were admitted with specialist surgical diplomas.25 Given that one of the main aims of the College was to raise the standard of surgery, particularly through training, it is not surprising that less than half of Australasian surgeons in 1932 could meet the level of qualifications they set for the next generation. What is, perhaps, surprising is that those surgeons who had set out to specifically obtain post-graduate qualifications in surgery had gone to enormous trouble and expense to do so.

Of the Fellows admitted before 1932, 188 had taken a fellowship of a British college. This meant travelling to Britain and spending time there studying. But this is only the tip of the iceberg. Many more surgeons had spent time studying surgery overseas without necessarily taking a British fellowship, and many made multiple study trips overseas. Brisbane surgeon Lilian Cooper made two extended study trips to Britain and America, without taking a British fellowship.26 She also had a prolonged opportunity to study overseas surgery, serving in the middle east during World War I. Robert Gordon Craig never took a British fellowship, but he made overseas study trips every five years, including multiple visits to the Mayo Clinic.27 Wyn Beasley has pointed out that fewer of the Sydney Founders had overseas qualifications than their Melbourne counterparts, and Douglas Miller argued that in the 1920s Sydney surgeons travelled less than those from Melbourne.28

24 Devine and Newton, Policy in regard to the future admission of Fellows, p. 22.
25 Register of Fellows.
<table>
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<tr>
<th></th>
<th>Melbourne MS</th>
<th>Adelaide MS</th>
<th>Total</th>
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<tbody>
<tr>
<td>1.1: Fellows with Australasian qualifications only</td>
<td>10</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>Sydney MS</td>
<td>1</td>
<td>Total</td>
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<th></th>
<th>FRCS England</th>
<th>FRCS Edinburgh</th>
<th>Total</th>
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<tr>
<td>1.2 Fellows with overseas qualifications only</td>
<td>20</td>
<td>5</td>
<td>54</td>
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<tr>
<td></td>
<td>CM Edinburgh</td>
<td>FRCS Ireland</td>
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<td></td>
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<th>FRCS England</th>
<th>FRCS Edinburgh</th>
<th>Total</th>
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<tr>
<td>1.3 Fellows with overseas qualifications and an Australasian medical degree</td>
<td>32</td>
<td>15</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>CM Edinburgh</td>
<td>FRCS Ireland</td>
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This table represents the older group of Australasian surgeons. Those with no Australasian qualifications (Table 1.2) broadly represent the migrants, whilst among the rest, more than half had travelled to add overseas qualifications to their Australasian medical degrees. A total of 90 (46 per cent) had no senior surgical qualification. Among the rest, the FRCS Eng predominated (52 or 27 per cent) compared with only 20 holding the FRCS Ed and only 12 holding an Australian Master of Surgery. Ten of the Fellows included in Table 1.3 held more than one senior surgical qualification. Source: RACS Archives Melbourne: Register of Fellows of the Royal Australasian College of Surgeons, Se 21, 1926-.

Although surgeons from Sydney may have travelled less than those from Melbourne, it appears that overall the Founders and Founding Fellows were a well-travelled group. Partly this was because the Founders and Founding Fellows were more likely to be migrants than those Fellows admitted after 1927. A rough indication of this is the proportion who held no Australasian qualifications: 28 per cent of the Founders and Founding Fellows and only 14...
per cent of the Fellows admitted between 1927 and 1931. But the migrants did not all just qualify overseas, come to Australia or New Zealand and then stay here. Many returned for further study. The Australasians, too, did not just make one trip to Britain for post-graduate qualifications, and then come home for good. Many, particularly those who achieved

| TABLE 2: QUALIFICATIONS OF THE 277 FELLOWS OF THE RACS ADMITTED 1927-31 |
| In six cases, the place where qualifications were awarded is unknown |

2.1: Fellows with Australasian qualifications only

| Melbourne MS | 13 | Adelaide MS | 2 | No sen. surg. qual. 106 |
| Sydney MS | 5 | Total | 126 |

2.2: Fellows with overseas qualifications only

| FRCS England | 9 | FRCS Edinburgh | 13 | No sen. surg. qual. 13 |
| FRCS Ireland | 1 | CM Edinburgh | 1 | Other 1 |
| Total | 38 |

2.3: Fellows with overseas qualifications and an Australasian medical degree

| FRCS England | 38 | FRCS Edinburgh | 52 | No sen. surg. qual. 6 |
| Other | 11 | Total | 107 |

Table 2 represents the younger generation of surgeons who applied for, and were granted, Fellowships between 1927 and 1931. Fewer of them were overseas born than the Founders and Founding Fellows, but about the same proportion as the older group held no senior surgical qualification (125, or 46 per cent). Interestingly, the FRCS Ed was more common than the FRCS Eng (65 Edinburgh c.f. 47 England). Six Fellows held both diplomas and five of the Fellows included in table 2.3 held an Australasian MS (four Adelaide, one Otago) in addition to a British fellowship. Source: RACS Archives Melbourne: Register of Fellows of the Royal Australasian College of Surgeons, Se 21, 1926.

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29 Register of Fellows.
prominence in the profession, continued to travel.\textsuperscript{31} Tables 1 and 2 give an indication of the
diversity of qualifications from both sides of the world held by more than a third of
Australasian surgeons. That this underestimates the amount of travelling which they undertook
in order to learn their craft is clear, but the exact amount of travelling involved is hard to
estimate. It does seem that the more prominent surgeons, the ones for whom there are
press cuttings and biographies, travelled more than those whose careers did not include
major teaching hospital appointments and knighthoods.

The only group for which information on study trips is available on a fairly consistent basis
is the Founders. In 1984, Sir Patrick Kenny (who was President of the College 1969-71)
persuaded senior colleagues in the various States and New Zealand to write a few paragraphs
on the Founders from their respective regions.\textsuperscript{32} Of the 34 Australian Founders, only eight
held a fellowship of one of the colleges of surgeons and fourteen of them had become
surgeons after a period as a general practitioner. However, this gives a rather misleading
impression of their range of surgical experience. Several of them, including Cyril Corlette,
Robert Gordon Craig and Francis Pockley from Sydney, Leo Kenny and David Morton
from Melbourne, William Anstey Giles from Adelaide and John Lockhart Gibson from
Brisbane, made surgical study trips to Britain or Europe or America, but had no formal
senior surgical qualification.\textsuperscript{33} In some cases, overseas study was a prelude to taking up
surgery on a full time basis. Andrew Brady, for instance, travelled to Vienna and spent a
period working in Politzer’s ear nose and throat clinic before returning to practice ENT
surgery in Sydney.\textsuperscript{34} David Lines made two trips to Europe to study general surgery and later
spent six months at the Eye and Ear Hospital in Melbourne before specialising in
ophthalmology and ENT surgery in Hobart.\textsuperscript{35} In fact, only five of the Founders are not
known to have had any overseas postgraduate surgical experience and of these only three

\textsuperscript{30} Simpson, “The Adelaide Medical School”.
\textsuperscript{31} Register of Fellows.
\textsuperscript{32} Sir Patrick Kenny, ed., The Founders of the Royal Australasian College of Surgeons (Melbourne: RACS,
1984). Kenny himself and Sir Douglas Miller came up with the brief biographies for New South Wales, R.
N. Howard provided the information for Victoria, Wyn Beasley for New Zealand, A. C. McEachern for
South Australia, Sir Clarence Leggett for Queensland, P. Braithwaite for Tasmania and a team of three
came up with information on the two Western Australian Founders.
\textsuperscript{33} Cyril Corlette was originally a reserve, but signed the Exordium as a Founder because Thomas Fiaschi
died in April 1927, before he could sign the Exordium. Smith, The History of the Royal Australasian
College of Surgeons from 1920 to 1935, p. 18.
\textsuperscript{34} Kenny, ed., The Founders of the Royal Australasian College of Surgeons, p. 4.
\textsuperscript{35} Ibid., p. 71.

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(Francis Percival Sandes from Sydney, Alexander Morgan from Adelaide and Ernest Sandford Jackson from Brisbane) are not known to have had any overseas surgical experience at all.

Fourteen of the 35 Australian Founders were migrants. A smaller proportion of the later generation of surgeons were overseas born, but they seem to have been no less inclined to travel to learn their surgery. Many more of them held fellowships of British colleges than held the degree of MS from the Australasian universities where they had first graduated in medicine. (See Table 2) Where we have biographical details, it is clear that at least some surgeons travelled overseas to improve their surgical knowledge, without taking any further qualifications. This may only be the case for the more prominent surgeons, rather than being representative of Australasian surgeons as a whole, but it is still hard to avoid the conclusion that as a group, surgeons were extraordinarily well travelled. Well over half of them, it seems, had practical exposure to the way surgery was performed outside Australia and New Zealand.

Policy in Regard to the Future Admission of Fellows

The principal function of the RACS was to act as a gatekeeper to the practice of surgery. The idea was to identify those doctors who were both technically competent and ethically fit to be surgeons. Once they were issued with a "hall-mark", the Fellowship of the RACS, the public would be able to tell who was a certified surgeon and who was not, and choose accordingly. But there were other hall-marks available to surgeons—the degree of Master of

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Surgery, at least until the 1950s, and the fellowships of the British colleges. If they held one of these, why would surgeons also seek a fellowship of the Australasian college? The RACS was to struggle with this issue throughout the 1950s and 1960s, and it was only really resolved in the 1970s when the RACS began to offer effective training, as well as accreditation. (See below chapters 7-9). However, in 1932 Alan Newton and Hugh Devine believed surgeons would only bother to take the FRACS if it was more difficult to obtain than the qualification they already held.

There is no doubt—such is human nature—that the "hall-mark" is not valued unless it is difficult to obtain. If the "hall-mark" is not valued, few will be inclined to increase their surgical efficiency in order to obtain it.38

In 1932, two out of three of those surgeons who had been granted a FRACS had no senior surgical qualification.

It seems reasonable to suggest, therefore, that admission to the College, under the present system, does not indicate that a high standard of surgical proficiency has necessarily been attained and we feel that, in consequence, Fellowship of the College does not, at present, enjoy the prestige that we desire.39

Newton and Devine wanted the RACS to hold its own examinations. However, Council rejected the idea until after World War II. The first Australasian Final was held in 1946 and the first Australasian Primary in 1950.40 These examinations were very much modelled on the format devised by the Royal College of Surgeons England. However, in 1932, Newton and Devine seem to have been proposing a rather different type of examination that tested not only the science of surgery and the art of diagnosis and clinical judgment, but also practical surgical skills.

38 Devine and Newton, Policy in regard to the future admission of Fellows, p. 28.
39 Ibid., p.22.
1. The only surgical "hall-marks" which are valued are those obtained by examination. If our "hall-mark" is granted after such a test, an increasing number of Surgeons will endeavor to attain to the required level of efficiency and, in consequence the general level of surgical capacity in Australasia will be raised.

2. With the exception of the American College, which gives a qualification of rapidly decreasing prestige, all Surgical Colleges, including that recently constituted in Canada, demand an entrance examination.\textsuperscript{41}

Newton and Devine did not advocate an examination that would be equivalent to the existing MS degrees, with their emphasis on the surgical sciences of anatomy, physiology and pathology. The FRCS Eng was also criticised as too academic, although it did in that era include a limited test of surgery on the cadaver. Instead, Newton and Devine wanted an examination in the "practical application of surgical principles" which would overcome the criticism that the current senior surgical qualifications were all academic and "a successful candidate may, despite the fact, be a bad Surgeon."\textsuperscript{42} Perhaps the difficulties of devising such a practical examination contributed to rejection of the idea by Council. Instead, the RACS fell back on the model of a two-part examination provided by other bodies, particularly the Royal College of Surgeons England.

In 1932, the Fellowship of the Royal College of Surgeons of England was widely regarded as the premier senior surgical qualification. It was difficult to obtain, and many aspiring surgeons sat for it several times. The Old Boys' column of the Melbourne Medical Student's Society magazine made this quite plain. "Research at the College of Surgeons. Regular attendant at Primary exams. Always hopeful." Was one entry. "Only one of Melbourne bunch to pass December Primary," noted another.\textsuperscript{43} Despite this, it was generally accepted that it was possible to hold the FRCS Eng with out much practical experience as a surgeon. "Fellowship first go" was the triumphant entry from one Melbourne graduate, "Now learning to be a surgeon at the Royal Northern."\textsuperscript{44} The English fellowship was widely regarded among surgeons as a qualification for entry to the training process rather than a mark of completion of training.

\textsuperscript{41} Devine and Newton, Policy in regard to the future admission of Fellows, pp. 28-9.
\textsuperscript{42} Ibid.
\textsuperscript{43} "Old Boy's Column," The Speculum 129 (1932): 66-67.
In contrast, the Fellowship of the American College of Surgeons marked a certain level of competence among practicing surgeons.\textsuperscript{44} It certainly did not mark any level of academic attainment. Before 1932, the FRACS was comparable to the FACS. But after 1932 the FRACS became something very different. In future, it was to be awarded only after considerable supervised experience, and passing a two-part academic examination (conducted by one of the bodies recognized by the RACS), and passing a viva voce examination.\textsuperscript{46} In other words, unlike the FRCS Eng, it was to be an "exit" qualification at the end of training.\textsuperscript{47} From 1933, new Fellows of the College supposedly had to produce evidence of an apprenticeship in surgery, and they had to appear before the Board of Censors for a final viva voce examination. However, in practice, "apprenticeship" became simply a period of work in a hospital post accredited by the RACS, and no systematic attention was paid to the training content—if any—of such posts until the 1970s. (See below chapters 7-9.)

One of the arguments that Newton and Devine used to support their case for higher standards concerned Robert Gordon Craig. Gordon Craig died in September 1931 and, after making allowance for members of his family, he left the balance of his estate to the College. Initially, the amount was estimated at £40,000, but by 1932, this had been revised to £50,000 and in the end, the College received £60,000.\textsuperscript{48} This was a considerable sum of money at the time, enough to run the Mater Hospital in Brisbane for three or four years, for instance, or the Melbourne Hospital for seven or eight months. Gordon Craig left the money "for the education of Surgeons and the promotion of research."\textsuperscript{49} Newton and Devine argued that:

\textsuperscript{44} Ibid.
\textsuperscript{47} For many years after the College began to hold its own academic examinations in 1946, candidates who had passed the Part 1 of one of the British colleges of surgeons were exempted from sitting for the Part 1 of the RACS exam. See below, chapter 7.
\textsuperscript{48} Details of the exact amount of the bequest emerged over a lengthy period of time in the 1930s, as Robert Gordon Craig's estate was wound up and the various assets sold. Updates on this process were presented at most Council meetings between 1932 and 1936: RACS Archives Melbourne, "Minutes and Council Papers, Se 7, Vol 1, 1926-36", passim. See also: A. W. Beasley, \textit{Portraits at the Royal Australasian College of Surgeons} (Melbourne: RACS, 1993); Earlam, "Robert Gordon Craig,"
\textsuperscript{49} Devine and Newton, Policy in regard to the future admission of Fellows. This was not Robert Gordon Craig's only contribution to the education of surgeons. Before his death, he left £20,000 to the Royal
The College cannot faithfully discharge the former of these obligations unless it combines, with a system of surgical education, a test in the form of a modern surgical examination, which is necessary in order to find out if the surgical education is effective and, also, to set a standard for the young Surgeon to attain. Without some form of scrutiny, a great deal of this money will be wasted in diffuse, unguided and objectless efforts.\textsuperscript{50}

It is not clear whether Gordon Craig's bequest was really the critical factor which persuaded Newton and Devine to push for a College examination, but they certainly implied that it was. Gordon Craig's gift received far less publicity than the gift of the Great Mace. But if it influenced Newton and Devine (and eventually Council) to see the future of the College as an examining body, then it was truly a transforming gift.\textsuperscript{51} At the fifth Annual General Meeting of the College, at the Menzies Hotel on February 18, 1932, Fellows were officially informed of Gordon Craig's death, and of his "munificent bequest". The College suddenly had not only a Great Mace, but also a significant amount of money. Fellows accepted Newton and Devine's report on higher standards for future admission to Fellowship, and went on to a celebratory dinner with Fagge.\textsuperscript{52}

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\textsuperscript{50} Minutes and Council Papers, Se 7, 16 February 1932, p. 30.

\textsuperscript{51} RACS Archives Melbourne: Papers for Executive, Se 61, Hibbert Alan Stephen Newton, Report on the use of the Gordon Craig bequest, 1937. The money was used to fund scholarships for trainee surgeons and a number of overseas study trips in the late 1940s were funded in this way. In addition, some of the money was used to purchase the journals that formed the core of the Gordon Craig Library at the RACS.

\textsuperscript{52} RACS Archives Melbourne: Minutes of the Fifth Annual General Meeting of the Royal Australasian College of Surgeons, Se 45, held at Menzies Hotel Bourke St Melbourne on Thursday February 18, 1932 at 6.30 p.m.
Surgeons did not just travel to learn. They travelled for pleasure. Successful surgeons belonged to the upper middle class and in the inter-war years, this was associated with a very specific lifestyle. Women of this class seldom worked for money, although there were a few doctors and other professionals. More often they worked for free. It was expected that they would spend several days a week working for charity. Even those women who had professional careers were expected to work for charity in their spare time. For instance, under the heading "The Woman's World", the Melbourne Herald ran the following item:

Among interstate delegates who have come to Melbourne to attend the Royal Australian [sic] College of Surgeons fifth annual conference, which will open this evening, is a woman surgeon, Dr. Connie D'Arcy of Sydney. She has been here for a week staying at the Quamby Club. Although her profession comes first, Dr. D'Arcy manages to find time to participate in a number of welfare movements for the betterment of women and children..."56

Upper-middle-class women sat on committees and organised small armies of women who ran fetes and stalls and flag days for the Red Cross, or the Society for the Prevention of Cruelty to Children, or the hospitals. It was not only surgeons who were involved in the moral economy of gift exchange. So were many of their wives. They were members of what Kerreen Reiger has called the upper-middle-class charity network. Whether they were

53 The title is taken from an article by Pang, in which he discusses traveling by British gentlemen scientists to observe eclipses of the sun: Alex Soojung-Kim Pang, "The Social Event of the Season, Solar Eclipse Expeditions and Victorian Culture," Isis 84 (1993): 252-277.
54 Fifth Annual General Meeting 1932 (Programme), p. 10.
56 Herald, 17 February 1932.
57 Shirlee Swain, "The Victorian Charity Network in the 1890s" (PhD, University of Melbourne, 1976), especially pp. 285-295.
raising money for worthy causes or simply enjoying themselves, the activities of members of this group were regularly reported in the social pages of the newspapers. Such "news" items were intensely formulaic. The reporter noted what the hostess was wearing and the flower arrangements, mentioned the venue and the occasion, and then listed the guests, beginning with the most famous, and/or those perceived to have the highest social status. The following extract from the *Canberra Times* is a typical example:

Gowned in a plum coloured georgette frock, trimmed with fine lace, and a black hat relieved with the same colour, Mrs. Earle Page was hostess at an afternoon tea given in the drawing room of the Hotel Canberra in honour of the wives and visiting doctors… Lord Stonehaven, the Governor-General was present, and before tea Mrs. Earle Page presented the ladies to his Excellency. Among those present were… Mrs. Gordon Craig (Sydney), Mrs. Sandes… Dr. Lilian Cooper….

This report concerns a function held in association with the first Annual Meeting of the College of Surgeons of Australasia in Canberra in 1928.

For members of the upper middle class, there was a distinct rhythm to the cycle of the year. While the opening of the duck shooting season (in 1932, it was on the weekend before the RACS meeting in Melbourne) did not have the same social cache as the opening of the grouse shooting season in Scotland, the autumn horse racing carnival was the focus of a significant round of social events, and the spring racing carnival, especially the Melbourne Cup on the first Tuesday in November, was as much an elite social event as any horse race in England. Some women made a trip to London every few years, had their frocks and gowns made in Paris and returned to Australia in time for Cup Week. Select Melbourne and Sydney dressmakers also made the pilgrimage to Paris, and returned to make copies of the latest fashions for those who could not afford to travel to France to buy the originals. Young women still "came out" and their mothers arranged balls for the purpose. A select few enjoyed "the season" in London and were presented at Court.

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59 *Canberra Times*, 2 April 1928.
This class was no more immune from the effects of the depression than any other. Between 1929 and 1932, the big private balls more or less came to a halt.\textsuperscript{62} However, charity balls continued. In some instances, these were effectively more or less private parties, where most of the guests knew each other. The difference was that they had all paid for their tickets, with any money left over after the cost of the function going to a worthy cause such as the Children's Hospital.\textsuperscript{63} Private parties were hard to afford in the depression, but they were possibly also considered in rather poor taste. In retrospect, the worst of the depression may have been over by 1932, but it certainly did not seem that way at the time. In February, for instance, Scott's Hotel on Collins Street announced that it was reducing its tariff "To meet the reduced spending power of the travelling community".\textsuperscript{64} By no means all surgeons were wealthy and the depression badly affected many who had once been quite financially comfortable. A letter from an Auckland surgeon in 1932, for instance, concerns his inability to pay the fees of the College. Before 1914, he was prosperous, but:

Five years of active service not only ruined my practice, but the consequent depression has robbed me of my possessions... I have been hoping all along that I should be able to scrape up enough to send along for the subscription, but, so far, have found it very difficult to buy food and clothing. Had I been able to forsee what would have happened, I should have declined the honor of having been elected a Fellow, but the depression came gradually and my assets melted away little by little.\textsuperscript{65}

While there were parties associated with the First Annual Meeting of the College in Canberra in 1928, the next few meetings were more austere. At the third meeting, in Melbourne in 1930, for instance, the motto of the conference was "strictly business" and there were "no

\textsuperscript{62} Miller, \textit{A Surgeon's Story}.
\textsuperscript{64} \textit{Argus}, 19 February 1932. Scotts was one of four hotels especially marked on the map included in the program for the 1932 meeting of the College. The others were the Oriental (also on Collins Street), the Windsor and the Menzies. Fifth Annual General Meeting 1932 (Programme), pp. 3-4.
\textsuperscript{65} Minutes and Council Papers, Se 7, A. C. Purchas, letter to The Honorary Secretary, 16 November 1931, in Council Papers, 16 February 1932, p. 41.
entertainments". The garden party at the University in 1932 was something of a half way house, before the full flowering of the social program in the later 1930s.

The opening of the College headquarters on Spring Street, Melbourne, in March 1935 provided a particularly good excuse for a major round of social events. Originally, Sir George Syme had planned that the headquarters of the College would be in Canberra, and the Federal Government allocated a site for the purpose, but as Sir Hugh Devine put it "early it became obvious that Canberra as a site for a National College was impractical."  

The Executive began looking for suitable land in Melbourne and various options were considered. In 1932, the island site in Spring Street became vacant. It had been occupied since 1854 by the Melbourne National Model and Training School and its successor, the Continuation School. According to Devine, the Spring Street site was first proposed by the Labor Premier of Victoria, Hogan, following an approach by Devine. They were already on friendly terms and had worked together on the proposal for building a new Melbourne Hospital adjacent to the University. (In 1932, the hospital was still on the corner of Lonsdale and Swanston Streets). Shortly afterwards, the Hogan Government was defeated at the polls, but the new Premier was Sir Stanley Argyle, "also" wrote Devine, "a friend of mine." "Sir Stanley said: If the College would put its headquarters in the middle of the site, the government would plant the whole site, make paths and gardens and roads." So the College headquarters was built in the middle of what is essentially a park, maintained by the Melbourne City Council. Even after extensions in 1965, it remained relatively modest in scale, with two storeys and a basement. This left plenty of room on the site for substantial trees and lawns, and for many years the building embodied dignity, restraint and privilege. The address of the College is "College of Surgeons Gardens, Spring Street" and visually it formed a link between Carlton Gardens and the gardens of Parliament House. While

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66 Partly, this was to counter criticism from GPs of "American style boosting" rather than the result of a shortage of funds.
67 Sir Hugh Berchmans Devine, SB 28/7, Memoirs. On 14 April 1932, the College was granted a fifty-year lease, renewable for a further fifty years, on the "Old Melbourne High School Site". The rental was £1 a year. RACS Archives Melbourne: Lease of the Old Melbourne High School Site, 1932 SB 38; Smith, The History of the Royal Australasian College of Surgeons from 1920 to 1933, pp. 24-25.
69 Sir Hugh Berchmans Devine, SB 28/7, Memoirs.
gleaning office towers, occupying every square centimetre of their enormously valuable sites, went up around it, the College remained aloof amidst its shady lawns.

Sir Holbutt Waring, President of the Royal College of Surgeons of England, opened the building on 4 March 1935. The College invited surgeons from all over the English speaking world, and many accepted the invitation. The opening was timed to coincide with the autumn racing carnival, and the meeting was incorporated into the celebrations surrounding the centenary of the City of Melbourne.  

Melbourne has been very gay during last week and many overseas and interstate visitors have been in town to attend the races, watch the progress of the polo tournaments, and take part in the varied festivities associated with the coming of the autumn season. A number of distinguished visitors came for the congress of the Royal Australasian College of Surgeons, and on Sunday afternoon Mrs. Hugh B. Devine (whose husband is vice-president of the College) gave a delightfully planned party at their home in Woorigoleen road, Toorak, at which the special guests of honour were the president of the Royal College of Surgeons of England (Sir Holbutt Waring), the president of the Royal Australasian College of Surgeons (Sir Henry Newland) and Lady Newland, the president of the American College of Surgeons (Dr. Donald C. Balfour) and Mrs. Balfour, Sir D'Arcy Power (London) and Miss Angela Power...  

That week Mrs. Alan Newton, Lady Newland, Mrs. B. T. Zwar and Mrs. Victor Hutley all gave parties for the surgeons and their wives, including visitors from England, Scotland, Canada, South Africa and the United States. All were reported in the papers, and the Melbourne public was also well informed about what Miss Angela Power and Mrs. Balfour (described as distinguished overseas visitors) wore to the races. The comings and goings of members of this class were regularly noted in the social pages, as they got on and off ships. Successful surgeons and their wives and families were integrated into a moral economy of working for charity, but they were also members of the travelling classes. Repeated study trips abroad fitted seamlessly into this way of life.

71 Smith, The History of the Royal Australasian College of Surgeons from 1920 to 1935, p. 27.
72 Australasian, 6 March 1935.
PART II

Surgical Training in the 1930s and 1940s—was there any?

4: The politics of a gift economy

5: Apprenticed to incommunicable knowledge

6: Travelling to acquire transferable skills
Introduction

Before the formation of the RACS, there was virtually no systematic surgical training in Australia. Generally speaking, aspiring surgeons worked out their own training programs involving some combination of public hospital experience, a period assisting a senior surgeon in his private practice, overseas travel and learning through trial and error while treating patients. In that context, the various attempts by the RACS to set up apprenticeship training posts in conjunction with hospitals were not innovative. They simply drew on these existing patterns of behaviour. However, the RACS initially had only limited success in persuading hospitals to set up apprenticeship positions. In the 1930s, the RACS also attempted to provide systematic teaching in surgery in both Sydney and Melbourne, but with even less success. These failed attempts to devise a workable training system are described in chapter five.

However, it is also illuminating to highlight what the RACS did not attempt to do in this era. The RACS did not incorporate private hospitals into any of its training schemes. Although assistance in private practice was an implicit component of the Melbourne view of apprenticeship, the actual apprenticeship posts were all at public hospitals. The political attitudes behind this difference in approach to public and private patients are discussed in chapter four.

In addition, so far as is known there were no attempts to teach basic surgical skills on animals, in imitation of the work of Harvey Cushing at the Johns Hopkins Hospital, for

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instance. This seems to have been because work on animals was associated with research rather than practical surgery. Sometimes established surgeons used animals when they were trying out new techniques but generally animal laboratories, where they existed, were used for research, not training. This clinical/research divide was reinforced by a separation between the universities, clinical surgery and surgical training. The University of Melbourne's Medical School, for instance, had no Professor of Surgery until the 1950s. This is in marked contrast to the attitudes to clinical research which were developing in the United States in the inter-war years, and this issue is discussed further in chapter four.

As has already been noted, in the early 1930s the RACS showed no particular antipathy to the universities and seems to have had a working model in mind, whereby the universities would provide surgical training and the RACS would provide accreditation. But by the mid-1940s it was clear that apart from the University of Sydney, none of the universities was willing or able to provide much in the way of surgical education, with the possible exception of teaching in anatomy. However, they were offering accreditation in surgery. In 1946, the RACS began conducting its own examinations and in 1948 Council of the RACS changed its attitude to the degree of master of surgery. Henceforth, this was to be regarded as a research, rather than a clinical, qualification. In the late 1940s, most aspiring surgeons were in any case travelling to England to take the FRCS, and a university degree ceased to be a recognised qualification for surgical practice in Australia. This issue is discussed further in chapter five.

In this context, the training paradigm envisaged by Robert Gordon Craig is particularly interesting. He was much influenced by American ideas and in 1926 he funded a training position in urology that involved cooperation between the University of Sydney and the...

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5 RACS Archives Melbourne: Minutes and Council Papers, Se 7, 24 June 1948.
Royal Prince Alfred Hospital, and that incorporated research into the training provided. The work of two of the Gordon Craig Fellows in Urology is discussed further in chapter six. In particular, the issue of how surgical techniques were learned is considered in some detail.

In this era, new surgical procedures were adopted without any formal training or accreditation in the new techniques, and neither was there any process of testing the usefulness or safety of new surgical procedures. What were the attitudes at the time to the long learning curves and associated high morbidity and mortality? In chapter six it is shown how in an attempt to improve results, many surgeons made their own modifications to procedures and to the instruments they used. From some perspectives, this approach to learning might be considered as experimentation, but at the time it was a routine and accepted feature of the practice/practise of surgery. Through a process of adaptation and innovation, in an attempt to solve practical surgical problems, many surgeons contributed to the rapid rate of change in surgery in the 1930s. Only a small proportion of these innovations was ever widely adopted by other surgeons for any length of time, but chapter six provides a glimpse of what learning (and practising) surgery involved during this period of rapid growth in the profession of surgery.


4: The politics of a gift economy

Public hospitals and private patients

The 1930s and 1940s were marked by an international ferment in discussions over health policy. This is a much studied period, and the events leading to the introduction of the National Health Service in Britain, to constitutional change in Australia and to a voluntary insurance based system in the United States have inspired an enormous volume of historical research. In particular, there have been a number of productive international comparisons, examining the relative strengths of interest groups in Britain and the United States. In Britain, the National Health Service both reflected and reinforced the division in the medical profession between general practitioners and hospital based specialists. In the United States, this era saw an acceleration of the trend towards specialisation and "open" hospital systems. There, patients consulted specialists directly without seeing a GP first, and both the number of GPs and the range of problems they dealt with consequently declined. Australia, which shared the British tradition of specialists seeing patients referred to them by GPs, retained a strong tradition of general practice.

Much of the literature on medical politics emphasizes the role of pressure groups, and there has been a tendency to look at the political process as a struggle between interest groups, with outcomes depending on some combination of the relative strengths of such groups.

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their organisation, and the role of individual actors. The literature on the sociology of the professions has also tended to take a generalised view of interest groups in medicine, and the forces acting to produce medical dominance. This chapter examines the role of the RACS in a number of areas of medical politics in the 1930s and 1940s. The paradox emerges that although it is remarkable how often the RACS got what it wanted, this seems to have been the result of accidental and exogenous forces as much as it was the result of conscious lobbying, at least at the national level.

After 1942, the RACS as a body consciously stayed out of any overt involvement in the political process, although individual Members of Council remained very active within the BMA. By 1942, the RACS had also more or less abandoned its brief war-time attempt to promote itself through the Conjoint Committee on Public Relations. This was set up by the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians

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12 Surgeons may have been more effective in local struggles, with individual hospital boards, for instance.

13 Sir Henry Newland was President of the Federal Council of the BMA from 1933 to 1949 and a member of the Council of the RACS from 1927 to 1946. He was also President of the RACS from 1929-35 and thus actually President of both bodies simultaneously for two years: Kenny, ed., The Founders of the Royal Australasian College of Surgeons; David E. Theile, P. H. Carter, and Colin Smith, eds., Royal Australasian College of Surgeons Handbook (Melbourne: 1995). Sir Victor Hurley succeeded him as President of the Federal Council of the BMA and was on the Executive of the RACS from 1937 to 1953: John Victor Hurley, Sir Victor Hurley KBE, CB, CMG, MD, MS, FRCS, FRACS, Surgeon, Soldier and Administrator 1888-1938 (Hawthorn, 1989). Newland and Hurley were following in the tradition set by Sir George Syme, the first President of the RACS, who was President of the Federal Committee (which preceded the Federal Council) of the BMA in Australia at the time of the formation of the RACS: Ernest Muirhead Little, History of the British Medical Association 1832-1932 (London, 1933).

14 The Conjoint Committee met on 6 April and 1 August 1940: RACS Archives Melbourne: Minutes and Council Papers, Se 7, C. G. McDonald, Report of Conjoint Committee on Public Relations, Royal Australasian College of Physicians and Royal Australasian College of Surgeons, 1940. The final meeting seems to have been on 15 July 1941: RACS Archives Melbourne: Minutes and Council Papers, Se 7, A.H.
in 1940 to improve "the public relations of the two Colleges". The aims were: "the assumption by the two Colleges of a position in the public life of the community consistent with their ever-growing importance and second, the necessity to use all ethical means to guide and instruct people in matters of medical and surgical interest." But in August 1941, a meeting of the Public Relations Sub-Committee of the Colleges, which was attempting to set up a 'Bureau of Medical Information' "decided to recommend that the details of the proposal be postponed until a more favourable time." Many surgeons and physicians were away on active military service and many more were "preoccupied" with "war efforts." The sub-committee does not seem to have reconvened.

The hospital system within which the RACS operated throughout the 1950s and 1960s bore a distinct resemblance to the community hospital system it had publicly espoused in the 1930s and early 1940s. A number of major public hospitals, especially in New South Wales and Victoria, introduced a range of intermediate and private beds for patients who paid fees to their medical practitioners. But as will be shown below, it is not clear that the RACS can claim any direct responsibility whatever for this outcome.

Between the 1930s and the 1950s, there were also a number of changes to overall hospital funding, but despite significant increases in State and Federal government funding of public hospitals, surgeons continued to treat public hospital patients one way and private patients another. Specifically, while they gave their private patients their personal attention, increasingly over this period, public hospital patients were dealt with on a day to day basis by junior doctors. In addition, public hospitals were frequently used for training doctors and

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17 This is not in any way to imply that public patients received inferior clinical care, but there were deep-seated attitudinal differences to patients who were paying for their care, as opposed to patients who were not. Robert Gordon Craig, for instance, talked about the "sick poor or hospital class", by which he meant public hospital patients before World War I. He argued that standards of living had increased since then and "...the wage earner who really has no claim to be called a poor man, still expects his old privilege and the hospital beds are filled with men and women from this class... Is this fair to the other classes of the community?" Robert Gordon Craig, "Improvements of Hospitals," *Journal of the College of Surgeons of Australasia* 1 (1928): 39-43, p. 39.
nurses. In the 1930s, the idea of postgraduate medical training was still somewhat novel in Australasia, but it seemed natural to the Fellows of the RACS that it should take place largely in public hospitals. Private patients were not used as "teaching material" in the same way.

During the 1930s, the RACS was beginning what was to be a long struggle to develop a viable model for Australasian surgical training. Most of the ideas centred around some form of apprenticeship, although there was considerable variation in what this actually meant in practice. However, some apprentices, usually called associate assistants, assisted their masters in private practice, and therefore gained experience in diagnosis, clinical judgment and patient management in private hospitals, but they did not operate on their master's private patients. Detailed evidence for this period is not available, but on balance it does not appear that much major elective surgery in Australia's public hospitals was ever performed by trainees. However minor surgery, and especially minor emergency surgery at night and on weekends in public hospitals was often performed by junior staff. By the

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18 Robert Gordon Craig argued that the five functions of public hospitals were: to treat the sick; to train nurses; to teach undergraduate medical students; to teach postgraduates; and medical research: Ibid., p.39.
19 In 1933, Sir Louis Barnett wrote: "It is generally recognized that hospitals are necessary for the training of nurses, medical students and house surgeons, but it is not equally recognized that they are essential for the further education of practitioners, particularly surgeons in a later stage of their career." Sir Louis E. Barnett, "Post-graduate education as a function of hospitals," Australian and New Zealand Journal of Surgery 3 (1933): 95-96, p. 95.
20 In 1929, Melbourne surgeon C. H. Kellaway suggested that young surgeons should make use of public hospital patients to practice operative technique, and for research: "During the early years, before the claims of [private] practice fill his whole time, he can with benefit not only widen his experience and improve his operative technique by hospital practice, but he may with enormous advantage to himself devote a fixed portion of his time in the investigation of some problem by experimental or other methods." C. H. Kellaway, "The value of research in the training of a surgeon," Journal of the College of Surgeons of Australasia 2 (1929): 263-264, p. 264.
22 Miller, A Surgeon's Story, chapters 3 and 5.
23 The view of Council in 1932 was that Surgical Assistants "shall receive instruction in major operative surgery by acting as Assistants at operations of this nature performed by the Indoor Surgeons." RACS Archives Melbourne: Minutes and Council Papers, Se 7, 16 February 1932, p. 9. There was no mention of them actually performing major operations. However, in practice the experience provided to trainees varied from hospital to hospital and from master surgeon to master surgeon. The problem of insufficient experience of performing major operations was a repeated complaint from those who trained in the 1950s and 1960s. See below chapter 8.
24 At the Alfred Hospital in Melbourne, "Emergency Surgical Officers" were not supposed to perform "routine operations", but their duties did include operating where necessary in emergency, and in cases not requiring major surgery. At the same hospital, the duties of "Clinical Assistants to Indoor Surgeons" included assisting at, but not performing, surgery. "Post-Graduate Work and Hospital Practice - The Training of Surgeons," Journal of the College of Surgeons of Australasia 1 (1928/29): 444. See also Peter
1950s, an arrangement that had grown up as a part of a tacit gift exchange—free treatment for the poor, in return for their co-operation in medical training—remained in place, even though hospitals were increasingly funded by taxpayers' money and occupied by those same taxpayers as patients. The gift economies within hospitals were changing, but the moral economy within which training took place did not keep pace with that change.

Ideas for an Australian Hospital System in the 1930s

By the 1930s, each State had developed its own distinct pattern of hospital provision. Victoria had a system of independent public hospitals and Catholic hospitals, each run by its own board. Funding came mainly from charitable donations, patient contributions and the State Government. State Government contributions were coordinated by the Charities Board of Victoria. The depression and decline in both charitable donations and public ability to pay for treatment led to pressure for further increases in government funding, and by the mid 1930s the Charities Board was effectively making policy for country hospitals. In 1948, it was replaced by the Hospitals and Charities Commission, with the task of coordinating hospital policy for the State. However, as Arthur Brown put it in 1951, the "pleasant fiction" was "still fostered that the hospitals still belong[ed] to their subscribers". New South Wales had a similar system with a Hospitals Commission coordinating State Government funding (and policy) for hospitals. However, there was rather greater political intervention than in Victoria and although there were attempts to maintain at least nominal independence for the hospital boards, by the 1940s there had been several episodes of intervention in hospital administration by New South Wales governments. South Australia had a mixed system. Some hospitals were State owned, but most were not and local authorities contributed to funding through a special rate. Although most hospitals were managed by their own local

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Yule, *The Royal Children's Hospital: a history of faith, science and love* (Rushcutters Bay: Halestead Press, 1999), pp. 235-6, for an account of tonsillectomies performed by medical students.


26 Brown, "The Development of Australian Hospitals in the last Fifty Years," 40-45, p. 41.

committees, by 1950 it was harder to maintain the fiction of independent charitable status that was so influential in Victoria and New South Wales.  

The other three States basically had Government-run hospital systems by World War II. In Western Australia, there was a system of State and municipal hospitals, supplemented by voluntary subscriptions. Each hospital, however, continued to be run by a notionally independent committee. In Tasmania, hospitals were State owned and run, and access was not means-tested, despite objections from the honorary staff. In Queensland, hospitals were also State owned and run and the honorary system of staffing came to an end in 1938. Only the Catholic public hospitals remained independent, but their running costs were also substantially underwritten by the State Government. Queensland hospitals became free to patients after 1946, following the introduction of Federal contributions to funding. The Northern Territory also had a Government-run hospital service, administered directly from Canberra.

Within the College until well into the 1950s, senior surgeons, and particularly members of the Executive of the RACS, (which consisted of those members of Council who were based in Melbourne), continued to talk about hospitals as if independent charitable hospitals remained the norm. But by the 1950s, although each State was different, four effectively had State Government-run hospitals and the other two effectively had State and Federal Government-funded hospitals. However, with the exception of Queensland, the tradition of a senior medical staff composed mainly of part-time honorary surgeons and physicians remained until the early 1970s.

Throughout the 1930s and 1940s, a series of Federal Governments of various political complexions tried to increase the role of the Federal Government in the provision of health care. But the constitution of 1901 allowed for a very limited Federal Government role in this

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28 Brown, “The Development of Australian Hospitals in the last Fifty Years,”: 40-45.
31 Brown, “The Development of Australian Hospitals in the last Fifty Years,”: 40-45, p. 42.
field. The provision of health services, so far as it was envisaged as an area of government activity at all, was seen to be largely the responsibility of the States. J. H. L. Cumpston, as Director General of Health from 1921, had a limited role in areas pertaining to quarantine and public health.\(^{32}\)

However, the Constitution did make provision for Federal Government involvement in national insurance, and a series of conservative governments attempted to devise some sort of national insurance scheme to provide for members of the workforce who got sick.\(^{33}\) In 1928 Earle Page, Founding Fellow of the RACS and Treasurer in the Bruce-Page Ministry, introduced a National Insurance Bill, proposing employer and employee contributions.\(^{34}\) But the Bill failed to become law and in any case, it did not include provision for a national health service.\(^{35}\) In this context, in the interwar years the RACS more or less had the field to itself in attempting to consider Australian hospital services from a national perspective.\(^{36}\)

At its first annual meeting in Canberra in 1928 (attended by Federal Treasurer Earle Page and Minister for Home and Territories and for the Health of the Commonwealth, Sir Neville Howse—both Founding Fellows of the RACS) the College agreed to a set of resolutions on training and hospitals.\(^{37}\) There was some disagreement on the exact system favoured. Members of the Council of the RACS were heavily influenced by conditions in their own

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\(^{33}\) Sax, A Strife of Interests: Politics and Policies in Australian health services, pp. 31-42.

\(^{34}\) Before he entered politics, Page was a classic example of the rural general practitioner/surgeon: Sir Earle Page, Truant Surgeon (Sydney: Angus and Robertson, 1963).


\(^{36}\) Gillespie describes the Federal Health Council as an ineffective body. The NHMRC was not operational until 1936, the Royal Australasian College of Physicians was not formed from the Australasian Association of Physicians until 1938 and the Australian Hospital Association was not formed until 1946. Mary Dickenson and Catherine Mason, Hospitals and Politics, The Australian Hospital Association 1946-1986 (Canberra: Australian Hospital Association, 1986). Josephine C. Wiseman, ed., To Follow Knowledge, a history of the examinations, continuing education and specialist affiliations of the Royal Australasian College of Physicians. (Sydney: Royal Australasian College of Physicians, 1988).

States and members of the Executive were all (by definition) from Melbourne, but the "College view", so far as there was such a thing, also strongly represented the views of Sydney surgeons. It was summarised as follows:

Patients who are not in a position to pay anything toward the cost of their hospital maintenance and treatment should have first claim on the public hospitals. Patients who are able to pay either in whole or in part should not be excluded from the facilities obtainable in properly equipped modern hospitals. To meet the needs of these the community hospital system under which all classes of patients are received—non-paying, intermediate and paying—is the ideal to be aimed at and should replace the present unsatisfactory system of small private hospitals. The payment of surgical fees from intermediate and private patients is to be a matter of choice, that is, the patient should have free choice of a medical practitioner and the paying and intermediate wards of the hospitals open to any medical practitioner.38

Honorary surgeons (and physicians) worked within a moral framework that included the assumption that those patients who could afford to pay for treatment should do so. Those who could not afford to pay would be treated for free. Unfortunately, the way that surgeons understood their rights and obligations in public hospitals, and the corresponding rights and obligations of patients, conflicted with a view of public hospitals that was increasingly prevalent in the wider community. Many people were coming to regard public hospitals as public utilities, available to all. This basic disagreement about the nature of the moral obligations that applied to doctors and patients in public hospitals underlies most of the debates about hospital policy, at least until the 1970s. In the 1930s, many surgeons saw community hospitals as offering an alternative to the existing public hospitals. The main spokesman for this view was Robert Gordon Craig. Although he emphasised that he did not speak for New South Wales as a whole, community hospitals were essentially the hospital system supported by Sydney surgeons and implemented in Sydney over the next decade or

38 College of Surgeons of Australasia, "Proceedings": 147-170, p. 160. The emphasis on "free choice of medical practitioner" was important because it encapsulated the essence of the difference between public and private patients. Public patients were generally treated by whichever surgical "firm" was receiving patients on the day they entered hospital. The senior surgeon would then allocate their case to a member of his firm. Private patients chose their surgeon.
so. The idea of community hospitals, with public and private patients in the same institution, was popular in America, and it has been argued that it was introduced to Australia and New Zealand during the visit of Franklin Martin and William Mayo in 1924.\(^9\) However, although American hospitals were not as well known in Australia as those in Britain, the Mayo Clinic, for instance, was already well known in Australian medical circles long before 1924.\(^{40}\) By 1928, the Royal Prince Alfred Hospital already had plans for building 100 private and intermediate beds.\(^{41}\)

At the first Annual Meeting of the RACS in 1928 Victor Hunley, representing the Victorian view, did not specifically advocate community hospitals. He was more in favour of persuading religious groups or other organisations to build large private hospitals and come to some financial arrangement with the existing public hospitals for using their diagnostic and other facilities.\(^{42}\) Hurley dismissed the idea of hospitals managed and funded by the government, "as advocated by the Labour Party in England... "It will, I think, be generally admitted that from our knowledge of State conducted public hospitals the system cannot be expected to prove in any way satisfactory either to the public or the profession."\(^{43}\)

Hurley probably had in mind the mental and infectious diseases hospitals. Both were statutory State Government responsibilities. Hurley did, however, see a role for the States in the coordination of hospital services. He was in favour of some form of "State sickness

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\(^{41}\) College of Surgeons of Australasia, "Proceedings," 147-170, p. 159. The Alfred Hospital in Melbourne opened a private wing on a similar basis: Hamilton Russell House.

\(^{42}\) Ibid.; Victor Hurley, "An outline of a suggested policy for the College of Surgeons of Australasia for postgraduate training," *Journal of the College of Surgeons of Australasia* 1 (1928): 56-61; Hurley, "An outline of a suggested policy for the College of Surgeons of Australasia for the improvement of hospitals,:" 43-52. Hurley probably had in mind the kind of arrangement that existed between St Vincents Hospital (public) and Mount St Evans Hospital (private) in Melbourne. They were on adjacent sites and both were managed by the Sisters of Charity: Bryan Egan, *Ways of a Hospital. St Vincent's Hospital Melbourne, 1890s-1990s* (St Leonards: Allen and Unwin, 1993); Michael Tyquin, *A Place on the Hill, The History of St Vincent's Private Hospitals in Melbourne 1906-93* (Melbourne: Hargreen Publishing Company, 1997).

\(^{43}\) Hurley, "An outline of a suggested policy for the College of Surgeons of Australasia for the improvement of hospitals,:" 43-52, p. 46.
insurance organisation" to help intermediate and private patients pay for their care, and he was in favour of State coordination of hospital provision.\textsuperscript{44} This idea was modeled on the Charities Board of Victoria, which had been set up in 1923.\textsuperscript{45} There was broad support for this sort of role for the States, and the College agreed to the resolution that:

In order to prevent the multiplication of unnecessary hospitals and to correlate and coordinate the hospitals of various grades according to accepted standards, it is recommended that a central hospital board with executive powers be established in each State and Dominion. Adequate medical representation on such a board is essential. The Council of the College shall decide what is adequate medical representation.\textsuperscript{46}

In 1942, the College again advocated the provision of private and intermediate beds in public hospitals.\textsuperscript{47} By the 1950s, this had become the accepted pattern in Sydney and, to a lesser extent, in Melbourne, but there is no evidence that the College as a body lobbied hospital boards to provide such beds. Rather, the provision of private beds suited the funding needs and ideological viewpoints of the boards of many of the major public hospitals, as well as the private practice requirements of honorary physicians and surgeons. Similarly, by the 1950s each State had set up some sort of body, as advocated by Hurley, to co-ordinate hospital provision within its borders, but not as the direct result of any organized pressure from surgeons.\textsuperscript{48}

Surgeons and Attitudes to Research Funding

James Gillespie has emphasised the major divisions within the medical profession, but one area where there was some measure of agreement, at least some of the time, was over

\textsuperscript{44} Ibid., pp. 49-50.
\textsuperscript{45} For a general discussion of ideas for hospitals in this era see: Inglis, \textit{Hospital and Community, A History of the Royal Melbourne Hospital}, especially pp. 180-181.
\textsuperscript{46} College of Surgeons of Australasia, "Proceedings," 147-170, p. 160. The Charities Board of Victoria had a Medical Advisory Committee which included both Hugh Devine and Alan Newton as representatives of the RACS: Minutes and Council Papers, Se 7, 22 August 1936.
\textsuperscript{47} Ibid., 17 April 1943.
\textsuperscript{48} Brown, "The Development of Australian Hospitals in the last Fifty Years," 40-45, pp. 41-43.
resistance to salaried employment, and in particular to salaried government employment.\textsuperscript{49} Certainly this was a clear theme in policy statements by the RACS. The Executive of the College was not against "the possibility of whole-time salaried officers being provided in remote areas", but was otherwise opposed to full-time salaried employment for surgeons. Preference for a health service "divorced from governmental and political control" was particularly strongly emphasized.\textsuperscript{50}

This resistance to salaried employment is interesting, because the objections seem to have applied to clinical practice, but not to medical research.\textsuperscript{51} Gillespie's work has highlighted the dangers of generalising about doctors' political views and motivations, but there do seem to have been views shared by doctors in a number of countries. Australian surgeons do not appear to have eschewed research because it was salaried or government funded, but rather because the salaries looked like a pittance compared to what they could earn in private practice.

In the United States, where the financial and other resources for research were greater, there was a greater commitment to salaried research. In the interwar years there was a small group of American surgeons who were engaged in salaried practice.\textsuperscript{52} Most were employed by the

\textsuperscript{49} For Australia, Gillespie has emphasised the weakness of the state, rather than the strength of the medical profession. He rejects Marmor's proposal that doctors consistently resisted attempts to change their accustomed mode of remuneration and points to the deep divisions within the BMA in the early 1940s over the favoured method of paying doctors. Never-the-less, by the late 1940s the BMA in Australia had achieved something approaching a consensus over a preference for fee for service or sessional payment, rather than salary or a panel system of capitation payments. Gillespie, \textit{The Price of Health: Australian Governments and Medical Politics 1910-1960.}, especially chapter 7, "Pay the Doctor: the BMA Caught Between Salaried Medicine and Fee-for-Service"; T. R. Marmor, ed., \textit{Political Analysis and Health Care} (Cambridge: 1983).

\textsuperscript{50} Minutes and Council Papers, Se 7, 17 April 1943.

\textsuperscript{51} Perkins has placed the debate over salaried employment versus private practice in the context of the debate over an "industrial model" of medicine, versus medicine as a "cottage industry". She points out that the "industrial model" was implemented as long ago as the beginning of the twentieth century in the large American academic medical centers such as the Johns Hopkins: Barbara Bridgman Perkins, "Shaping Institution-Based Specialism: Early Twentieth-Century Economic Organization of Medicine," \textit{Social History of Medicine} 10 (1997): 419-435.

\textsuperscript{52} Examples include the Peter Bent Brigham Hospital, where the directors of the surgical and medical clinics spent most (but not all) of their time in the hospital and the University of Michigan Medical School, Ann Arbor, where the University paid the professors. However, in Ann Arbor there were major problems of clinical staff resigning in the 1920s because salaries were too low, and the surgical staff became part time in the 1930s: Peter McL. Black, Mathew R. Moore, and Eugene Rossitch, \textit{Harvey Cushing at the Brigham} (Park Ridge: American Association of Neurological Surgeons, 1993); Horace Davenport, \textit{Not Just
high profile teaching hospitals for some combination of teaching and research. This was referred to as the "full-time system" and it was not achieved without considerable opposition, even at the Johns Hopkins University School of Medicine, which became a prime example of this system of staffing. Full-time clinical professorships were introduced at the Johns Hopkins in order to facilitate research, but there was considerable resistance to the idea until the Rockefeller Foundation began to promote it after the release of the Flexner Report in 1910. However, resistance continued for the next forty years or so, and the full-time system was implemented department by department, depending on the availability of funds and the objections of individual personalities. In particular, many of the chiefs of the various divisions of surgery at the Johns Hopkins were averse to giving up their rights to private practice, and remained part-time. However, by 1953 even the Divisions of Urology and Orthopedic Surgery had full-time chiefs. Research flourished under this system, not only at the Johns Hopkins but also at other American universities that had adopted the principle of full-time clinical professors. These were not obscure figures in remote areas but on the contrary included members of the American surgical elite. Australian Urologist, Malcolm Earlam, visited one of them in 1948:

Huggins is a full-time man at the Univ. of Chicago with no right of private practice. Research is a sine qua non at this institution and Huggins' time is divided between research, clinical urology and teaching. He has 15-20 beds and three residents (1st, 2nd and 3rd year) all of whom must do research also. He therefore researches about half the time, possibly more. Subject of the research is malignancy in general, of prostate in particular, from biochemical and therapeutic aspects.

In 1941, Charles Huggins and C. V. Hodges published on the effect of castration on metastatic prostate cancer. In 1948, Huggins was experimenting on the respective merits of

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57 Ibid., pp. 207-212.
stilboestrol and bilateral orchidectomy. He was awarded a Nobel prize for this work in 1966.\textsuperscript{57}

As the example of Huggins at the University of Chicago makes clear, American surgeons working within this particular set of economies had access to the same sort of honour and status as scientists.\textsuperscript{58} Surgeons with full-time posts at the Johns Hopkins were in a similar position. Visiting professorships, international research reputations and Nobel prizes were the rewards for this group. As anatomist A. A. Abbie quoted in 1951: "What is the true mark of academic distinction... the Nobel Prize on the one hand or two Cadillacs in the garage on the other?"\textsuperscript{59}

The American Medical Association accommodated the view of this elite group of doctors who built careers in research, sometimes alone, and sometimes combined with clinical practice. The AMA had no objection to government funding of medical schools for research, but remained resolutely opposed to government funding of medical schools for clinical teaching.\textsuperscript{60} From the late 1940s, government funding for medical research in the United States grew very rapidly, with money disbursed through the National Institutes of Health.\textsuperscript{61} As grants flowed through to the medical schools, they became major research institutions. Doctors in the United States seem to have had no ideological problems with indirect government funding of medical research and salaried medical scientists, while continuing to resist government-funded clinical teaching and medical practice.\textsuperscript{62}

\textsuperscript{56} Archives of the Urological Society of Australasia: M S S Earlam and J W S laidley, Item 78, Surgical diaries 1936-7, 1938 and 1948, held in the RACS Archives Melbourne, Earlam, 6 October 1948.
\textsuperscript{59} A. A. Abbie, "Medical Education in the United States, with some reflexions on the future in Australia," \textit{Medical Journal of Australia} I (1951). Abbie noted that "now the rewards of medical practice are so great universities [in Australia] can no longer depend upon the altruistic devotion of their teachers to relieve their economic problems", but he thought that salaries in British medical schools were competitive. (p. 77)
\textsuperscript{60} Stevens, \textit{American Medicine and the Public Interest}. especially chapter 16: "Professionalism and the medical school".
\textsuperscript{61} Victoria A. Harden, A Short History of the National Institutes of Health (National Institutes of Health, 2001); available from www.nih.gov/od/museum/exhibits/history/full-text.html.
In Australia, the BMA similarly seems to have had no problem with government intervention in medical research. Early in 1935, when he was acting Prime Minister, Earle Page requested the Federal Council of the BMA to discuss "the subject of medical research at Canberra" with Dr Cumpston (Commonwealth Director-General of Health). In his autobiography, Page recalls that this was prompted by a visit from the President of the British Medical Association. The (Australian) BMA reported back to Earle Page later in the year, recommending that the Federal Government set up a Medical Research Council on a similar basis to the Medical Research Council, England. Both the BMA in Britain and the BMA in Australia, it seems, were in favour of government sponsored medical research. At the Seventh Australian Cancer Conference in Melbourne in May 1936, Sir Henry Newland proposed setting up a National Medical Research Council and Sir Hugh Devine seconded his motion. In other words, the RACS supported the BMA's call for federal government funding of medical research.

The government subsequently agreed to set up the National Health and Medical Research Council (NHMRC). This had a wider role than just overseeing medical research. Its functions were "to advise Commonwealth and State Governments on all matters of public health legislation and administration, on matters concerning the health of the public and on medical research." Cumpston chaired the NHMRC and its brief at least partly reflected his interests as Commonwealth Director-General of Health. Council of the RACS was never happy with this wider role, but it appointed Harold Dew (Professor of Surgery at the University of Sydney) as its representative, specifically in his capacity as a "research worker".

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62 See also Kenneth M. Ludmerer, *Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999), especially chapter 8, "The Ascendancy of Research".
64 RACS Archives Melbourne: Papers for the Executive, Se 61, October 1943, Letter from Federal Council of the BMA, 4 April 1935, to Dr. The Honourable Earle Page, M.P, Acting Prime Minister.
67 Papers for the Executive, Se 61, October 1943, Letter from J. H. L. Cumpston, Chairman, National Health and Medical Research Council, 11 August 1943, to Professor Dew.
69 Papers for the Executive, Se 61, October 1943, Letter from the President of the RACS, Sir Alan Newton, September 1943, to Professor Dew.
However, there were to be no prestigious research positions for Australian surgeons analogous to those in the United States. At this time there was only one professorship in surgery (Dew's position in Sydney) and this did not carry even remotely equivalent funding or status to the research and teaching positions in Chicago or Baltimore. As has been argued in chapter 2, elite Australian surgeons depended for their honour and status on the dual economy of honorary positions at the major teaching hospitals plus private practice. The ultimate honours were knighthoods rather than Nobel prizes and it is tempting to speculate that the structure of this system meant that surgeons were inherently likely to be politically conservative.

This contrasts with the position of scientists. Like surgeons, the honour and status of scientists were linked to a gift economy. They published scientific papers for no immediate financial gain and were engaged in the exchange of the fruits of their labours in other ways. Robert Kohler, for instance, has described the exchange of Drosophila fly stocks in the interwar years between scientists working on genetic structure, and Warwick Anderson has described "how suffering was once—and perhaps still is—circulated as science" as a part of a gift exchange.

The day to day income of scientists typically depended on salaried employment in research institutions of various kinds. It made little practical difference whether the funding for such institutions came from governments, business or philanthropic donations. Professional scientific autonomy was possibly more likely under some funding arrangements than others.

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but there was certainly no group tendency for scientists to prefer business over government funding for their research. Scientists' honour and status and career-building came through the gift economy of published scientific papers, presentations at conferences and the exchange of research material. For the rare few, there were also honours such as Nobel prizes. This economy worked in parallel with the economic systems which provided scientists with their financial rewards.

In the 1930s, much medical scientific research in the United States and Britain was funded by the philanthropy of individuals such as Carnegie or Nuffield. In Australia, the principal centres for medical research before 1950, the Walter and Eliza Hall Institute, the Baker Institute, the Kolling Institute and the Kanematsu Institute, were all also set up with philanthropic funding. The NHMRC also began with the help of funding from Lord Nuffield. But it mattered little to the scientists engaged in the work whether their university or research institute was funded by Lord Nuffield or their government. Business funding, by the pharmaceutical industry, for instance, might if anything be seen as less desirable, if it restricted their professional autonomy. The economies of science, therefore, although enmeshed with the economies of gift exchange, had no particular structural tendency to make scientists averse to government funding or salaried employment.

For surgeons, however, the gift economy which provided them with honour and status was structurally intertwined with a health care system based on charity for the poor and private practice for the rest. Surgeons could see how voluntary health insurance could be integrated into that system without undermining either their status or their private practice, but government funding and salaried practice were perceived as far more threatening. The only experience most surgeons had of salaried practice was as lowly junior doctors in public hospitals, working long hours for low pay and very little status.

Although there were a number of exceptions, for instance in Newcastle where Jack Smyth and others struggled to set up full-time hospital practice on the Johns Hopkins model, the tendency of surgeons in Australia was to resist both government intervention and salaried

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practice. For instance, cardio-thoracic surgeon Rowan Nicks recorded strong opposition to salaried practice at the Royal Prince Alfred Hospital in Sydney, when he moved to a full-time appointment there in 1956.

Instead of a warm welcome at the Royal Prince Alfred Hospital in 1956 I found coldness and veiled hostility from the senior staff. The Medical Board had not been consulted about my appointment and was divided on the issue of appointing a salaried surgeon to head a clinical department… The establishment regarded me with indifference or with the coldness of entrenched self-interest… The hospital was dominated by the honorary system and private enterprise.

Ideas for an Australian Health System in the 1940s

In 1938, the conservative Lyons Federal Government introduced a National Health and Pensions Bill. Initially, the Federal Council of the BMA, led by Sir Henry Newland, (recent past President of the RACS) negotiated with the Government over the details of the Bill, but rank and file GP members objected and the Federal Council had to make an embarrassing backdown. As Attorney General in the Lyons Government, Robert Menzies was a supporter of the controversial Act, but it was never implemented, despite the fact that Menzies became Prime Minister in 1939.

75 Nicks, The Dance of Life. The Life and Times of an Antipodean Surgeon, pp. 75-78.
76 Ibid., pp. 75-76.
77 For a detailed discussion of the splits within the BMA see: Gillespie, The Price of Health: Australian Governments and Medical Politics 1910-1960. The health provisions of the Act related mainly to general practice, proposing an insurance funded panel system, similar to that in operation in Britain. Some of the papers and minutes of the Executive and Council of the RACS for this period are missing and no trace of any RACS interest in the heated debates over the Act has so far been found. See also: Sax, A Strife of Interests, Politics and Policies in Australian health services, pp. 40-42; Dewdney, Australian Health Services; Diane Mackay, "Politics of reaction: the Australian Medical Association as a pressure group," in The Politics of Health; the Australian experience, ed. Heather Gardner (Melbourne: Churchill Livingstone, 1989); Diane Mary Mackay, "Politics of reaction—The Australian Medical Association as a Pressure Group" (La Trobe, 1985); Sir Robert Gordon Menzies, The Measure of the Years (London: Cassell, 1970); Page, Truant Surgeon.
However, before he lost the 1941 election, Menzies introduced child endowment (with Labor support) to supplement the basic wage and he also appointed a Joint Parliamentary Committee on Social Security to look at national policy on health, among other issues, for after the war. In other words, even the conservative parties were beginning to accept that welfare policy might be an appropriate area for at least some government intervention. The Joint Parliamentary Committee on Social Security continued to meet after Curtin replaced Menzies as Prime Minister, in October 1941. It produced nine reports, four of them relating to health.

The Labor Government wanted a "free" national health service, but this idea was strongly opposed by many within the medical profession. However, there was agreement that change was needed, and during the war the BMA and the National Health and Medical Research Council—among others—worked on the details of policy for setting up and running a coordinated health service. In both the United States and Britain there had been considerable debate on health policy during the 1930s and in both countries pressures for change increased during the war. Although the United States, Britain and Australia each ended up with very different health systems by the 1950s, they shared the policy ferment of the war and immediate post-war years. Australian doctors were particularly well informed about BMA views of developments in Britain, because these were regularly given prominence in the *Medical Journal of Australia*.

The Joint Parliamentary Committee on Social Security favoured a scheme involving salaried doctors and so did both J. H. L. Cumpston and Raphael Cilento. Cilento had been junior to Cumpston at the Commonwealth Department of Health, before he was appointed Director-

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71 Menzies, *The Measure of the Years*.
75 However, many Australian doctors were also well informed on developments in the United States and Earle Page in particular was influenced by events there: Page, *Truant Surgeon*.
General of Health for Queensland, and he was the Queensland representative on the NHMRC. Like Cumpston, he was an outspoken and influential figure in debates over public health and together they played a key role in developing the NHMRC scheme, which included proposals for a salaried national medical service. The NHMRC scheme was heavily influenced by Cilento's views and the Queensland experience, and work on it began in 1941 before Menzies lost the election in October. It was drafted by a sub-committee consisting of J. H. L. Cumpston, Raphael Cilento, Harold Dew and Newman Morris (the BMA representative).

This proposal for a salaried national medical service was embarrassing for the RACS because of the involvement of its representative (Dew) in the production of the NHMRC plan. In 1943, Council re-appointed Professor Dew as its representative, with the proviso that he only spoke for surgeons as a whole on questions relating to medical research. On all other matters, his views were his own. In other words, the College distanced itself from Dew's support for a salaried service.

Meanwhile, this involvement had forced the College to reconsider its position on medical politics. Its tax-free status in Victoria had depended on staying out of medical politics. With the move of income tax to the Federal arena in 1942, the College found itself faced with a tax bill. It engaged Robert Menzies to appeal its case, but meanwhile had to decide whether the BMA adequately represented its interests in the current debates over a national medical service. Both the BMA and the RACS seem to have taken it for granted that there would be such a national service. The question was exactly what form it would take.

Gillespie has described the division within the BMA between the patrician view that the way to proceed was to become involved in policy making and actively take part in shaping a health system that would be acceptable, and the rank and file attitude of boycotts and non-

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86 Ibid., 15 March 1939. Council rebuked New Zealand fellows for publicly supporting the BMA in its opposition to the National Health Insurance Scheme. All policy announcements were to be made through Council. Newton also strongly made the point that the College was an educational body. The BMA was the appropriate political body to speak for the profession.
cooperation. The members of the Executive of the RACS were naturally inclined towards the former position. They favoured what Gillespie called, "the confident tactics of a group of men used to ruling." However, the publication of the NHMRC proposals did not immediately prompt action, because the new Labor Minister of Health had given Sir Henry Newland an undertaking that no national health service would be introduced during the war:

The Secretary [of the RACS] stressed that the Executive Committee had not decided the principle as to whether the College should take part in any representations made to the Government concerning [a National Health and Medical Service] either directly or indirectly, but that a decision had been left to the Council. As the President of the Federal Council of the British Medical Association had been assured by the Minister for Health that no further action would be taken to implement the scheme until after the war and until the medical profession had been consulted, the College had not done anything further in the matter.89

By the spring of 1942, this position appeared to have changed. There was a heated exchange of letters between Dr Cumpston and Sir Henry Newland and there was also considerable correspondence, including urgent telegrams, between Newland, Sir Alan Newton, Sir Hugh Devine, Denis Ahern (President of the College at the time, and a Queenslander), Hugh Poate, who was one of the two Vice-Presidents, George Syme (junior) who was Secretary to the Executive, and Professor Dew. It seems that the Parliamentary Committee had asked the NHMRC to consider "the introduction of the salaried service in whole or in part during the war."90

At the Executive meeting of the College on 2 December, Newland was present at Devine's invitation.91 Following a discussion on "the proposed National Health and Medical Service"

87 Ibid., Report from Executive, 17 April 1943.
89 Minutes of the Executive, Se 1, 15 April 1942.
90 RACS Archives Melbourne: Sir Henry Newland, SB 7, draft of a letter from Newland to Cumpston, 1 December 1942, Newland to Cumpston 20 November 1942, Cumpston to Newland 24 November 1942; Papers for the Executive, Se 61, 2 December 1942.
91 The executive of the RACS consisted of those members of Council who were based in Melbourne. As a member of Council of the RACS, but based in Adelaide, Newland was entitled to attend Executive meetings, but, like other members of Council who were not from Melbourne, he rarely did so. However, he
the Executive set up a sub-committee of Hurley, Newland, Dew, Devine and Syme. It also sent a letter to the Federal Council of the BMA, with copies to Dew and the Secretaries of the NHMRC and the Joint Parliamentary Committee on Social Security. This letter noted:

The Executive Committee would like the Federal Council to know:

1. That the scheme for a National Medical Service, which was formulated by the National Health and Medical Research Council and submitted to the Government, was never considered by the Council of the Royal Australasian College of Surgeons although its representative was one of the sub-committee which drew it up.

2. … the College does not feel that it is in any way committed to this plan…

3. That as the Royal Australasian College of Surgeons is an educational body, the Executive Committee thinks that the Federal Council of the British Medical Association is the proper body to represent the views of the whole profession in regard to National Service.

4. That the Royal Australasian College of Surgeons, representing as it does most Australian surgeons, and having as one of its ideals that the surgeon should be so circumscribed in any medical service that he can give the best surgical service to the public, will naturally have an important point of view in regard to National Medical Service.

5. That the Executive Committee is sure that (a) the Council of the College would welcome the opportunity to collaborate with the Federal Council of the British Medical Association in regard to any point of view the Council of the College might have, so that the Federal Council might use this view to mould a concerted opinion from the profession in regard to National Medical Service; and that (b) the point of view of the College, emanating from an educational body, would give strength to any opinion voiced by the British Medical Association... 

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did keep members of the Executive very fully briefed on events within the BMA and the minutes and papers of the Executive from this era are liberally sprinkled with references to information provided by Newland. There is a sense in which Newland behaved as an ex officio member of the Executive, with a special brief on matters of medical politics.

92 Minutes and Council Papers, Se 7, Report from Executive to Council, 17 April 1943.
The Executive's sub-committee proceeded to formulate a "College view" on a national health service. The members of the sub-committee were, as has already been noted, precisely "a group of men used to ruling". The inclusion of the current President of the Federal Council of the BMA (Newland), the future President (Hurley) and a member of the select group which had drafted the NHMRC proposal (Dew) indicates how very easily the RACS could have become an inside player in medical politics, had it so wished.

The College sub-committee reported rapidly and its recommendations were considered by the Executive on 11 March 1943. They were subjected to minor modifications and then adopted. Devine then met with the Federal Council of the BMA on 16 March and Sir Trent de Crespigny was also present, representing the Royal Australasian College of Physicians. As Devine reported to Council on 17 April, the Federal Council of the BMA essentially adopted the views of the Colleges and incorporated them into its own proposals. This timetable meant that neither Council of the RACS nor the majority of Fellows were given the opportunity to comment before the "College view" was put to the BMA. Interestingly, the RACS Executive did not assume in advance that the College and BMA views would coincide:

4. It is conceivable that, after deliberations of the College with the Federal Council, it may be obvious that the views of the Federal Council in regard to surgical and surgical specialist service in a National Health Service may be unacceptable to the College. In this case, it would not then be possible for the Federal Council to represent its views as those of the WHOLE profession.

5. In the event of this happening, it will be necessary for the Council of the College (at its forthcoming meeting) to consider whether it should separately represent the College views to the Government in regard to surgeon and surgeon specialist service in any National Medical Scheme....

6. On the other hand it is not unlikely that... the Government may ask the College to appoint a representative who would present the opinions of the College... the sub-
committee recommends that the Council… should decide whether it should be represented in such a conference…

The sub-committee of the Executive produced a list of six "Essential principles in any National Medical Service in which a sound surgical and surgical specialist service is to be included" and four "Essential principles in Specialist Surgical Service." In the event, the BMA seems to have had no objection to any of them. The six general principles were: universal coverage (which had not been provided for under the 1938 Act); free choice of doctor; a service "divorced from governmental and political control"; cash benefits that could be used to pay for treatment outside the scheme; no whole-time salaried service; but the Executive was not against "the possibility of whole-time salaried officers being provided in remote areas." The principle of "free choice of doctor" is significant in the context of postgraduate medical training. If implemented (and it was not), it would have severely limited the postgraduate training of doctors in general and surgeons in particular in public hospitals. Public hospital patients did not choose their surgeon, and the training system that was evolving in Australia depended on this fundamental characteristic of public hospitals. Although the importance of the one to one relationship between doctor and patient was repeatedly emphasised by surgeons as well as by other doctors, the implications for training never seem to have been addressed.

The four surgical principles were: surgeons must have approved qualifications; an adequate supply of properly trained surgeons and an organised scheme of post-graduate training, plus "special financial arrangements would have to be made to provide surgeons and surgeon specialists in the sparsely populated districts"; all public hospitals to become community hospitals (i.e. with intermediate and private beds); surgeons in such hospitals to be part-time (allowing for private practice) and paid, and surgeons to be responsible for undergraduate and postgraduate training in the teaching hospitals.

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94 RACS Archives Melbourne: Minutes and Council Papers, Se 7, 1926-, 17 April 1943.
96 Minutes and Council Papers, Se 7, 17 April 1943.
The result of this burst of activity in late 1942 and early 1943 was that overall, the surgeons remained happy to let the BMA deal with medical politics. Partly this was because their schemes were not incompatible, but partly this was simply because in this era the Federal Council of the BMA had significant overlap with the Council of the RACS. As has already been noted, key players throughout these debates effectively wore "two hats". Most obviously, Sir Henry Newland was a member of Council of the RACS and President of the Federal Council of the BMA throughout the 1940s. 97 Victor Hurley was also active at the highest levels in both the BMA and the RACS. He was the RACS representative at the June 1944 conference between members of the medical profession, the Minister for Health and the Federal Treasurer. He was a member of Council of the RACS from 1937 to 1953 and as a Melbourne member of Council, also on the Executive for the same period. He was Vice-President of the College for a record period from 1945 to 1951 and President 1951-3. 98 But in June 1948 he resigned his position as Chairman of Council of the RACS (but not any of his other RACS positions) owing to the pressure of his work as Vice-President of the Federal Council of the BMA. 99 In other words, he was Vice-President of both bodies simultaneously. In 1949, Hurley succeeded Newland as President of the political body. 100 Overall it is quite clear that in this era the Executive of the College could be confident that surgical interests were adequately represented at the highest levels in the BMA. The other important factor that kept the RACS out of any overt involvement in medical politics was its tax free status. This depended on the RACS being an educational and not a political institution.

After the events of 1942-3, when the BMA formally took on board the College view of a national health service, the greatest test case of the College commitment to stay out of politics came in 1945. That was when the Federal Government began to subsidize public hospital beds. These grants to the States were made on the condition that the beds concerned were available free to the patient. 101 This abandonment of means testing might

98 Ibid.
99 Minutes and Council Papers, Se 7, June 1948.
100 Hurley, Sir Victor Hurley KBE, CB, CMG, MD, MS, FRCS, FRACS, Surgeon, Soldier and Administrator 1888-1958.
have been expected to meet with resistance from the BMA and/or the RACS and the RACP. After all, it threatened the charitable basis of the major public hospitals in Victoria and New South Wales, and the honorary system that went with this. But the BMA was deeply divided over the issue and unable to come up with a united policy. Some senior consultants at the major teaching hospitals defended the honorary system, while some junior hospital doctors and those outside Sydney and Melbourne were more kindly disposed towards the idea of paid hospital practice. After all, the system of sessional payments seemed to be working quite well in Queensland, without significant loss of status.\(^{102}\)

Gillespie has argued that the government was anxious not to disrupt the existing pattern of hospital provision. It did not want to offend the Catholic hospitals (or Catholic voters) and it feared the additional costs of ending the honorary system. It simply wanted wider access to the public wards and an end to the stigma of means-tested admissions. In the event, the bed subsidies did not lead to a revolt by honorary staff calling for payment, although there were those, including Earle Page, who claimed that the level of charitable donations fell further because of Federal funding.\(^ {103}\)

This is the point at which it might have been expected that the RACS would break its silence and enter the political arena, but this did not happen. No evidence has been found in the minutes and papers of the Executive and Council that the matter was even debated officially within the College. Possibly there was an awareness that, like the members of the BMA, Fellows of the College might be divided on the issue. It should be noted that no commitment either to means-tested access to free hospital care or the honorary system was included in the RACS "Essential principles in any National Medical Service" or "Essential principles in Specialist Surgical Service".\(^ {104}\) Silence from the senior figures at the Royal Melbourne Hospital, whilst continuing in their honorary positions, helped maintain the status quo. Federal bed subsidies and a (temporary) end to means testing produced no concerted opposition from the medical profession and no dramatic changes in the way the gift economy operated within hospitals.


\(^{104}\) Minutes and Council Papers, Se 7, 17 April 1943.
The Pharmaceutical Benefits Act and the 1946 Referendum

Possibly the most well known instance of intervention by doctors in Australian politics concerns section 51 (xxiiiA) of the Australian constitution. This allows the Federal Government to make provision for: "maternity allowances, widow’s pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental service (but not so as to authorize any form of civil conscription), benefits to students and family allowances." This placitum entered the constitution following a rare successful referendum in 1946, but this was not the original wording. When it first appeared before the House of Representatives as the Constitution Alteration (Social Services) Bill in March 1946, both the word "pharmaceutical" and the phrase "but not so as to authorize any form of civil conscription" were missing. The absence of the word pharmaceutical was simply a mistake, and the Attorney-General, Dr Evatt, added it in in Committee on 9 April. The phrase "but not so as to authorize any form of civil conscription" was an amendment proposed by the leader of the opposition, Robert Menzies, and accepted by the Attorney-General. 105

So how has it come about that doctors and dentists have this particular constitutional protection in Australia, and not anybody else? The simple answer has nothing to do with medicine. It is because the Labor Government lost the so-called fourteen powers referendum in 1944 in the face of an organised campaign suggesting that a yes vote would be a vote for industrial conscription. 106 Sir Henry Newland claimed that he was responsible for the "no civil conscription" amendment and that it was the best service he ever did the BMA. 107 But when Menzies was still Attorney-General in 1939, he introduced the phrase "Nothing in this section shall authorize…. any form of industrial conscription" in the National Security Bill. 108 The clause appears to have been influenced by the failure of two military conscription referenda during World War I, and it was supported by the Labor

105 "Constitution Alteration (Social services) Bill 1946," in House of Representatives, Debates (Canberra, 1946); Menzies, The Measure of the Years; Kylie Tennant, Evatt: Politics and Justice (Sydney: Angus and Robertson, 1970).
106 "Constitution Alteration (Social services) Bill 1946," in House of Representatives, Debates (Canberra, 1946). 9 April, Mr. Riordan, p. 1176; Mr. Haylen, p. 1183.
Party. So the concept of legislative protection from non-military conscription was originally sponsored by Menzies in 1939, with Labor Party support.

In 1944 Evatt introduced his "fourteen powers" referendum, designed to increase Federal power during the war and for five years afterwards. Conservative opponents of the referendum conducted a campaign against the increased powers on the grounds that they would enable the Government to introduce "industrial conscription", and the referendum failed. Labor politicians subsequently argued that people were "stampeded by the cry of industrial conscription" and this campaign "wrecked the referendum".

In April 1944, the Government also passed the Pharmaceutical Benefits Act, which subsidized a limited range of drugs. The medical profession reacted very strongly and in June 1944, the Federal Council of the BMA resolved not to be a party to the Act, effectively ushering in a boycott of the Act by doctors. The story of opposition to the Act has been ably told at some length elsewhere. But to summarise, doctors from both the left and the right of the political spectrum opposed the Pharmaceutical Benefits Act, but for different reasons. However, they were unable to challenge the Act directly, because it did not directly affect them. Eventually, the Victorian State Attorney-General was persuaded to challenge the validity of the Act in the High Court. The challenge succeeded and the Pharmaceutical Benefits Act was declared unconstitutional.

This High Court decision threw into doubt not only the Pharmaceutical Benefits Act but also a range of older legislation, including a number of measures passed by conservative governments. Evatt, therefore, set to work to draft another amendment to the Constitution and in 1946 he put forward legislation to increase federal power in a number of areas, including the power to legislate for terms and conditions of employment and the power to

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109 Ibid., 3 April, Mr. Menzies, p. 906; Dr Evatt, p. 906.
110 Ibid., 9 April, Mr Riordan, p. 1176, Mr Haylen, p. 1183.

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make provision for a health service. He introduced three separate Bills, so that if one
failed the referendum, it would not bring down the others, but they were all debated
simultaneously in the House of Representatives in April 1946. Bearing in mind the defeat of
his "fourteen powers" referendum two years earlier, the proposed amendment on industrial
powers read: [power to regulate] "Terms and conditions of employment in industry, but not
so as to authorize any form of industrial conscription".113

As has already been noted, the Social Services Bill was designed to amend the Constitution
to allow the Federal Government to make provision for "maternity allowances, widow's
pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits,
medical and dental services, benefits to students and family allowances." Despite speaking
against various features of the three Bills and debating them over several days, the
opposition voted with the Government and passed the Bills. Menzies then proposed his
famous amendment, to be inserted after the word "services": "but not so as to authorize any
form of civil conscription."

It was the wee small hours of the morning and the House had been sitting all night. Evatt
wanted the referendum to pass and he had had the recent experience of seeing a referendum
fail in the face of an organised campaign to suggest that it might result in industrial
conscription. Dr Evatt stood up and spoke in favour of the amendment:

It is perfectly true, as the right honorable gentleman said, that he has borrowed
certain words from the bill dealing with industrial matters, but the Government
had previously borrowed the same set of words from the National Security Bill
introduced by the right honorable gentleman when he was Attorney-General. I
believe that one good turn deserves another, and that if industrial workers are
entitled to be protected against conscription members of the medical and dental
profession are entitled to similar protection.114

112 "Constitution Alteration (Social services) Bill 1946," in House of Representatives, Debates (Canberra,
1946), 3 April, Dr Evatt, p. 906.
113 Ibid., 3 April, Mr Menzies, p. 904.
114 Ibid., 10 April, Dr Evatt, p. 1215.
In the event, the voters of Australia passed the referendum to give the Government power to introduce "pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription)", but they did not pass the other two referenda. Clearly, it had been Evatt's intention that workers in industry should have constitutional protection from civilian conscription, but the voters of Australia produced an unexpected outcome. Doctors and dentists ended up with constitutional protection from civil conscription, and other Australians did not. The irony is that the voters almost certainly believed they were voting for a national health service, or at least voting to give the government power to provide them with a national health service. This constitutional protection for doctors was tested in the High Court in 1949 and the Court ruled that such an apparently trivial matter as requiring doctors to write prescriptions only on Government forms constituted civil conscription.\textsuperscript{115} The interesting question remains as to why the High Court in 1949 took such a very wide view of civil conscription.\textsuperscript{116} Presumably Evatt, an ex-member of the High Court himself, had no inkling that they would. It would seem that this has to be added to the list of accidental conjunctions of circumstances.

Overall, it seems clear that this amendment to the constitution was not the result of careful planning by the BMA and neither does it reflect the power of organised medicine acting through its trade union, the BMA, to defeat the wishes of the Labor Government. The BMA can claim responsibility for the defeat of the first Pharmaceutical Benefits Act, but neither the BMA nor Newland can claim responsibility for the "no civil conscription" clause that was subsequently added to the constitution. The phrase was Menzies' own and it was added to the wording of the referendum because of events associated with the defeat of an earlier referendum that had nothing to do with medicine. Protection from civil conscription for doctors and dentists was the result of a chain of events, most of which weren't related to medicine at all, a chain of events which could be characterised as bad luck for the Labor


\textsuperscript{116} In his biography of Victor Hurley, John Hurley suggests that Sir Victor had considerable sympathy for the Minister of Health (McKenna) but was obliged to support the Federal Council of the BMA in their appeal against the Act. He argues that Sir Victor found the whole thing "somewhat distasteful" and as a result, was all too happy to step down from the leadership of the BMA. He then became President of the RACS. "President of the College of Surgeons was a much more pleasant and less onerous position than
Party and serendipity for those members of the medical profession who didn't want a national health service.

This accidental victory for the profession profoundly affected relations between governments and doctors for many years to come. In November 1948, the Labor Government passed the National Health Service Act. This provided no detail on any future health service, but set up the legal framework within which changes could be introduced by regulation. However, Gillespie argues that by then the Labor Government had tacitly accepted that it could not introduce anything which went against the BMA's wish for fee-for-service and co-payment.\(^{117}\)

The Menzies/Page Health System

At the end of 1949, Menzies became Prime Minister again and he appointed Earle Page as Minister for Health. Over the next four years, a series of regulations and Acts produced what Labor had failed to achieve—Federal intervention in health care delivery by both general practitioners and specialists.\(^{118}\) The BMA had a major impact on the form that this intervention took, not by offering positive policies, but rather by successfully resisting any proposals that were unpalatable to the Federal Council or any of the State Branches.

The Menzies Government also intervened in hospital funding. Page continued the bed subsidy introduced in 1945, but changed the basis of funding. Instead of being dependent on free access to the beds, Federal subsidies were tied to means tested public hospital access. There was also a sliding scale of further grants for patients with private insurance cover. The greater the level of insurance cover, the greater the Government subsidy. Effectively, the Federal Government was providing financial support for the Victorian and New South Wales systems of private and intermediate beds within public hospitals. The system devised by Page required State Government support, and some States were slower than others in

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falling into line. Queensland in particular remained committed to a public hospital system which was not means tested. On the whole, surgeons there (and physicians) seem to have adapted quite comfortably to paid sessional attendance at public hospitals. Elsewhere, the return of means testing under the Earle Page system helped maintain different attitudes to different classes of patients within the hospital.
In his presidential address to the American Surgical Association in 1935, Edward Archibald compared the training of surgeons in Britain, his native Canada, the United States, Australia, Germany and France. He described the fellowships of the various British colleges of surgeons as setting high academic standards, but providing no evidence of operative competence. He considered the standard set by the American College of Surgeons to be too low, although he was in favour of the emphasis on character and operative experience. He considered the French qualification too exclusive and although he was impressed with the German qualification, his clear preference was for the Australian system:

I feel that it is legitimate to express a personal opinion quite frankly—and that opinion is in favour of the Australian system because it alone satisfies my possibly old-fashioned ideals. A good practical knowledge of the basic sciences, including surgical pathology, and a relatively long apprenticeship under the direct supervision of a surgeon of unquestioned authority ought to constitute the essentials of the training of a real surgeon. The other systems lack one or both of those requirements.

This address is significant because it has been identified by some scholars as setting in motion the events leading to the founding of the American Board of Surgery two years

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later. At the time that he made it, Professor Archibald and his wife had just returned from attending the opening of the new Royal Australasian College of Surgeons building on Spring Street in Melbourne on 4 March 1935. While there, Professor and Mrs Archibald had been among a select group of guests at a round of parties hosted by Mrs Hugh Devine, Mrs Alan Newton, Lady Newland, Mrs Victor Hurley and Mrs Bernard Zwar. Their fellow guests included Sir Holburt Waring (President of the RCS of England), Dr Donald Balfour (President of the American College of Surgeons) and his wife and professors of surgery from Edinburgh and South Africa. In this typical mix of the professional and the social, Archibald was well placed to inform himself on what the elites of surgery in the English speaking world thought about surgical training. In particular, it is to be expected that Archibald was well informed on what the members of the Executive of the RACS thought training ought to be in 1935. Whether he was equally up to date with what training was actually taking place in Australia was another matter.

This chapter examines the debates within the RACS during the 1930s and 1940s over what form training ought to take in Australia, and it also attempts to throw some light on what sort of training actually took place. There was general agreement that training ought to include an apprenticeship, but there was considerable disagreement over what, exactly, an apprenticeship should entail. By the 1950s, a pattern of training analogous to the American long residency was beginning to emerge as the dominant model, but in the 1930s it was by no means obvious that this would be the case. In a very real sense, in this era the RACS was trying to invent a workable model for Australian surgical training. This turned out to be a long and difficult process and much of this chapter is about false starts and failed attempts at devising models for teaching the science of surgery and for training surgeons in the art of clinical judgment. Training in the manual skills of surgery is the subject of chapter 6.

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5 See above, chapter 3.
In the 1930s, there was no clear consensus over who should accredit surgeons and what form that accreditation should take and the RACS faced difficulties in attracting surgeons to its ranks. Under the system of qualification for Fellowship in place between 1934 and 1946, the number of new Australasian Fellows barely kept ahead of deaths. Candidates for the Fellowship of the RACS had to have a Master of Surgery from an Australasian university or the FRCS Eng, five years' post graduate experience, including a period of apprenticeship in a recognised institution, and they had to submit themselves to an interview by the Board of Censors of the College. This system produced very slow growth in numbers. There were 600 Fellows in 1936 and only 630 in 1945. Partly this is because so few Fellows were admitted during the war (a total of only 86 between 1939 and 1945). But admissions were almost equally low during the 1930s, an average of fewer than 20 a year between 1933 and 1938. It is not clear whether this reflected the difficulties of qualifying for Fellowship or indicates that surgeons did not find a FRACS necessary in order to pursue their careers.

Recognising that the FRACS represented a tough hurdle, the College bent the rules to admit a small number of well-established surgeons. Between 1934 and 1945, twenty two were admitted with the FRCS Ed, even though it was not a two part examination, and six were admitted with no senior surgical qualification whatever. The vast majority of new Fellows (95) were admitted with a FRCS Eng. Nine had the MS from Sydney, two the MS from Adelaide and two in 1940 the MS from the new medical school in Queensland. But perhaps the most interesting feature of qualifications in the 1930s is that the second most

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8 Register of Fellows.
9 Not all surgeons with senior surgical qualifications took the FRACS. At Sydney Hospital, for instance, Howard Bullock had an appointment as surgeon to in-patients from 1913 to 1945. He had a FRCS Eng, but no FRACS. Specialist surgeons often took a specialist qualification, but no FRACS. Many ophthalmologists, for instance, favoured the DOMS, London. At Sydney Hospital, for example, L. H. Stanton Cook, 1927–1951, Darcy Williams, 1930–1935, F. J. Jensen, 1937–1941, E. V. Waddy Pockley, 1938–1942 all held the DOMS, London, but did not take a FRACS. Orthopaedic surgeons might take the M.Ch.Orth, Liverpool, and not the FRACS, and so on. The examples could be multiplied from any of the teaching hospitals.
10 Register of Fellows.
common route to a FRACS, an MS from Melbourne, was often combined with an FRCS Eng. The Primary only had to be taken once, and sixteen of the thirty-three men who took the MS in this era went on to take the FRCS Eng. Examinations for the Primary examination for the FRCS Eng were held in Australasia in 1931, 1934, 1937 and 1946. The three Fellows with the New Zealand MCh all also had FRCS Eng, for the same reason. It is thus clear that even before the RACS began conducting its own examinations from 1946, a fellowship of a College of Surgeons was a far more popular route to qualification as a surgeon than a higher degree from a university. In practice, therefore, in the 1930s and 1940s most Australasian surgeons in search of qualifications continued to travel to England to take the final examination for the FRCS Eng, and then set about gaining surgical experience.

In his history of American medical education, Ludmerer has described how the university medical schools lost control of postgraduate education in this era, and he argues that "the transfer of control of graduate medical education from universities to the profession occurred by default rather than by design." In Australia throughout the 1930s and 1940s there was disagreement over the respective roles of the universities and the College in training and accrediting surgeons. However, by the 1950s, the degree of MS had become an academic research qualification, while a fellowship of one of the Royal Colleges of Surgeons had become the accepted qualification for clinical practice as a surgeon. By the 1970s, the profession in Australia had gained even greater control of graduate medical education than in America. How and why this pattern began to be set in place in the 1930s and 1940s is one of the questions examined in this chapter.

12 For instance Melbourne surgeons Sir Benjamin Rank, Sir Edward Dunlop and John Hayward all took their MS in this era, before travelling to England to take the FRCS: Margaret Geddes, Remembering Weezy (Ringwood: Viking, 1996), pp. 48-50.
13 Register of Fellows.
Apprenticed to Incommunicable Knowledge

In the 1930s senior surgeons in Australasia (and Britain) described surgery as an art and a science, and in their plans for accrediting new surgeons they set out to measure both these components of surgery.¹⁶

It must be recognised that the surgeon of today is not a mere craftsman. He ought to be a scientist, versed in physiology and biochemistry, pathology and bacteriology, as well as anatomy. He ought to possess judgement, derived from experience, as well as technical skill.¹⁷

The emphasis on science was embraced by the infant RACS, when it insisted on a two-part examination, the first part to cover the science of surgery, specifically anatomy and physiology, and the second part to cover surgery and surgical pathology. The art of surgery, which included the skills involved in diagnosis and patient management, plus that vital but hard to define ingredient—clinical judgment—was supposedly learned through apprenticeship. There was also a third component of surgery—technical skill, the manual skills involved in performing competent operations—and this seems to have been what was meant when surgeons talked about the craft of surgery.¹⁸ Both the art of clinical judgment and the manual skills involved in surgery included an important component of tacit knowledge—knowledge that could not be specified in writing, but that could be acquired

¹⁶ Both Christopher Lawrence and Judy Sadler have discussed the tensions between conceptions of "science" and "art" in medicine, with particular reference to elite British physicians. For the inter-war years see: Lawrence, "Still Incommunicable: Clinical Holists and Medical Knowledge in Interwar Britain,". Lawrence also discussed similar issues for an earlier period: Christopher Lawrence, "Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914," Journal of Contemporary History 20 (1985): 503-520.. Sadler covers a broader time period and also discusses the class relations between physicians, surgeons and apothecaries: Judy Sadler, "Ideologies of 'Art' and 'Science' in Medicine: The transition from Medical Care to the Application of Technique in the British Medical Profession," in The Dynamics of Science and Technology, ed. Wolfgang Krohn, Edwin T. Layton Jr, and Peter Weingart (Dordrecht: D. Reidel Publishing Company, 1978).


¹⁸ "...a sound knowledge of anatomy [is]... essential for the practice of surgery, which after all is a craft as well as a science." Sir George A. Syme, "Discussion on senior surgical qualifications," Journal of the College of Surgeons of Australasia 1 (1928): 409-413, p. 410.
with experience. In particular, the acquisition of clinical judgment was considered to require lengthy experience. However, as will be argued below in chapter 6, young surgeons could and did take steps to learn the manual skills involved in new surgical procedures relatively rapidly. In the 1930s, few senior surgeons emphasised the importance of their manual skills. On the contrary, it was common for general surgeons in particular to point out that operative competence alone did not make a good surgeon:

The training of the young surgeon should be on two main lines. First, and most important, is that of clinical experience, clinical observation and deduction, observation of post-operative results and the correlation of the whole in one setting. The other side—that of the operation itself—though important, should be looked upon only as an incident in the whole course of the case, and should not be the climax often staged to be a striking spectacle to the uncritical.

Despite the various routes to accreditation as a surgeon, in the 1930s many Australasians held the position of honorary surgeon to inpatients at a public hospital simply because they had worked there for many years and waited in line. Many aspiring surgeons climbed the ladder of hospital positions and then spent years as honorary surgeon to outpatients, waiting for someone to retire or die so that they could step into the position of honorary surgeon to inpatients. They might hold some other qualification, but they might not, especially at the less prestigious hospitals and in cities without a medical school. What they did have was experience, and this in itself was highly regarded. Frequently, this accumulation of experience was likened to a period of apprenticeship, especially where there had been some form of mentoring by a particular senior surgeon. As one New Zealand surgeon put it in 1928: "A young surgeon needs to serve an apprenticeship as an assistant and, instead of working

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20 Lord Moynihan was something of an exception. Although he emphasised the other attributes of his conception of an ideal surgeon, he devoted much attention to description of the "wonderful craft" of surgery: Sir Berkeley G. A. Moynihan, "The Ritual of a Surgical Operation," British Journal of Surgery 8 (1920): 27-35.
independently, to gain by observation of the technique and opinions of more senior men."  

Apprenticeship in this sense was an individual matter and how much, if any, specific training was involved no doubt varied considerably, but the essence of this conception of apprenticeship was lengthy experience of observing and assisting senior surgeons treat a great many patients. The method could perhaps be characterised as learning by osmosis. By the 1930s, it was considered that the best place to do this was in a large, busy public hospital. As Sir Louis Barnett put it to a gathering of hospital administrators in New Zealand in March 1937:

Supposing one of you or one of those near and dear to you was stricken by illness or injury necessitating surgical treatment for its relief or cure... You may be told of a clever young man with a good pair of hands and plenty of so called "nerve" who has jumped into a busy Surgical practice without going through the mill of long hospital service, but you would be unwise to select him.

Barnett emphasised the importance of "sound and cautious judgement" and long experience so that the surgeon was able to decide whether to operate as well as how to operate:

You ought to realise that the man without adequate hospital training is not likely to be a good surgeon in the proper sense of the term. The only reliable pathway to true surgical efficiency goes through the large and busy hospital... So if you are wise you will pick for your surgeon a man who has had a good long course of postgraduate training in a large hospital. It is not essential that he should be a Fellow of the College for there are competent Surgeons who are not Fellows but what is essential is that he should have gone through his surgical apprenticeship.

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23 RACS Archives Melbourne: Papers for Executive, Se 61, Sir Louis E. Barnett, Address to Conference of Hospital Boards, April 1937.
24 Ibid.
Christopher Lawrence has used the concept of "incommunicable knowledge" in describing the attitudes of elite London physicians.\textsuperscript{25} This knowledge is only obtainable as the result of long experience as a practicing clinician, and was privileged above the results of scientific tests. Lawrence argues that in the 1930s, the patrician elites of London were not opposed to medical science, but they were opposed to the ideas of "division of labor, specialism, and scientific management," that they associated with the laboratory. "To be a gentleman, a status they were instrumental in recasting in professional terms, was central to their ethos. By the interwar years, elite physicians added denunciation of mechanisation and standardisation to their holistic repertoire."\textsuperscript{26}

The full range of attitudes that Lawrence attributes to elite London physicians before World War II may have been confined to that group, but elements of the concept of "incommunicable knowledge" were more widely espoused. Charles Bosk, for instance, found a related group of views among elite American surgeons in the 1970s. They taught trainee surgeons that when their own clinical experience conflicted with published reports, they should trust their own clinical experience.\textsuperscript{27} As Bosk points out, this attitude served to reinforce the authority of senior surgeons in relation to trainees, because of their inherently greater clinical experience. Kathleen Knafl and Gary Burkett found closely related attitudes in their 1970s study of trainee orthopaedic surgeons in the United States. They argue that an important feature of the medical sub-culture "is the comparatively greater value placed on clinical as opposed to academic learning and knowledge," and that trainee orthopaedic surgeons stressed that the "development of sound orthopedic judgment is more important than the mastery of specific technical skills."\textsuperscript{28} They found that "a central function of the [four-year] residency is to provide the prospective orthopedic surgeon with adequate time and opportunity to cultivate the judgment needed to make successful decisions."\textsuperscript{29}

\textsuperscript{25} Lawrence, "Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914," 503-520; Lawrence, "Still Incommunicable: Clinical Holists and Medical Knowledge in Interwar Britain."
\textsuperscript{26} Ibid.
Apprenticed to incommunicable knowledge

As has already been shown, the leaders of the RACS were great admirers of things British, and it is easy to find similarities in attitude between elite surgeons from Melbourne and Adelaide and those in London. Both Sir George Syme and Sir Henry Newland, for instance, were fond of quoting Lord Moynihan, whom Lawrence sees as a patrician President of the Royal College of Surgeons of England. For these men, the idea of apprenticeship, with its individualistic ethos and the possibility of directly handing over the wisdom of long experience from one generation to the next, had considerable appeal. As Lawrence put it: "in many of their formulations the patricians claimed laboratory work generated factual knowledge, almost mechanistically as it were, whereas years of clinical experience produced wisdom." There is a further element in Australasian (and English) views of the ideal surgeon, and this is the concept of the operating physician. "Surgeons ought to be physicians and physicians first" according to Sir George Syme. In his biography of his father, John Hurley wrote: "His ideal of a surgeon was not one who indulged in dramatic feats of technical dexterity or who was merely a skilled pair of hands to carry out the decisions of a physician, no matter how eminent. He believed that a surgeon should be a physician who operates."

This view was associated with an identification with the culture and social class associated with physicians. "We wish to see the community supplied with an adequate number of men fitted by culture, training and experience for the highly responsible duties of a surgeon," wrote Sir Louis Barnett.

28 Ibid., p. 400
30 Lawrence, "Still Incommunicable: Clinical Holists and Medical Knowledge in Interwar Britain."
31 Syme, "Discussion on senior surgical qualifications."
Never the less, in Australia the main characteristic favoured by senior surgeons seems to have been seniority. They distrusted "clever young men" with "good hands" and surgical nerve and placed their faith in the kind of wisdom that could not be gained from books and for which there were no short cuts. Almost by definition, this kind of tacit knowledge was not encountered among young surgeons and there is a hint of a generational struggle here. In the climate of the 1930s, with rapid change in medicine in general and surgery in particular, young men could travel overseas and come back with ideas their elders had never encountered. The apprenticeship model offered a way of controlling and moulding the "clever young men". As Professor Archibald put it, in order that a young surgeon "should not gain experience at the expense of the patient, he must be taught by one of the elders and guided."

Members of the Executive of the RACS seem to have had a conception of a surgical apprenticeship based partly on their own experience and partly on ideas associated with apprentice undergraduate surgeons in England a century or more earlier. Following a description of the apprenticeship of English surgeon Sir James Paget in the 1830s, Sir Henry Newland wrote: "...the recent appointment of surgical assistants at the Melbourne Hospital, in pursuance of the policy of the Royal Australasian College of Surgeons, revives in a different form the old custom of apprenticeship as a way to a knowledge of the craft."

As Newland made clear, Paget was apprenticed to a small-town surgeon-apothecary for more than four years, before he moved to London to work in a major hospital. There were few resemblances between an apprenticeship of this kind, complete with articles and a fee.

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35 This view was particularly clearly expressed by Sir Louis Barnett during a row over honorary surgical appointments at the Auckland Hospital: RACS Archives Melbourne: Papers for Executive, Se 61, Sir Louis E. Barnett, Letter to the Executive re appointments to the staff of the Auckland Hospital, June 1936.
37 Sir Alan Newton, for instance, resigned his position as registrar at the Melbourne Hospital in September 1911 to work in an apprentice-type relationship with F. D. Bird, one of the older generation of Melbourne surgeons, who died in 1918. It should be noted that apprenticeship was an even more important model in nineteenth-century American medical training than it was in England. This is because there was so much less hospital based training in America. J. A. Curran, "Internships and Residencies, Historical backgrounds and Current Trends," Journal of Medical Education 34 (1959): 873-884; Edward C. Atwater, "Making Fewer Mistakes: a history of students and patients." Bulletin of the History of Medicine 57 (1983): 165-187.
paid to the master, and the kind of postgraduate hospital-based apprenticeship envisaged by
the RACS. Mentoring and private practice were key elements that the College wished to
retain, (plus, it should be noted, the lack of any direct relationship with a university) as it set
about inventing an apprenticeship system that accepted the realities of the 1930s.  

By 1932, members of the Executive of the RACS almost exclusively carried out their surgery
in hospitals rather than private homes, whether or not they were paid for their work by their
patient. All the members of the Executive were honorary surgeons to inpatients at major
teaching hospitals in Melbourne, and this was where they tried out their ideas for formalising
apprenticeship training in surgery. They set about trying to persuade the major Melbourne
teaching hospitals to make apprenticeship posts available, and the Alfred Hospital
cooperated with this scheme from as early as 1929. St Vincent's also set up apprenticeship
posts, and the Melbourne Hospital appointed its first three "Assistants to Indoor Surgeons"
on 31 April 1932. The number was increased to six the following year and the name was
changed to Associate Assistants, and then to Surgical Associates. It should be noted that
these were part-time unpaid posts, and that there were similar posts for Associate Assistant
Physicians. The apprentices were effectively the most junior members of the honorary
staff. As they were appointed on the recommendation of the RACS (generally from among
the existing surgical clinical assistants at the hospital), this contributed to the relatively high
proportion of new Fellows of the RACS who were from Melbourne. By 1936, thirty men
had served an apprenticeship of this kind, generally for two years, thirteen of them at the

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39 Use of the term apprenticeship served some of the same functions as the RACS use of ceremony, in that
it made use of a borrowed English surgical past. E. J. Hobsbawm and T. Ranger, The Invention of Tradition
(Cambridge: Cambridge University Press, 1983). However, there were also apprentice surgeons in
nineteenth-century Australia: W. E. L. H. Crowther, "A Background to Medical Practice and the Training
of Surgical Apprentices and Pupils in Van Dieman's Land," Australian and New Zealand Journal of
40 "Post-Graduate Work and Hospital Practice—The Training of Surgeons," Journal of the College of
Surgeons of Australasia 1 (1928/29): 444.
41 RACS Archives Melbourne: Minutes and Council Papers, Se 7, Report on surgical assistants, 16
February 1932, p. 9.
42 Melbourne Hospital, Eighty-fifth Annual Report of the Committee of Management with Statement of
Accounts, Lists of Subscribers and Donors and Statistical Returns (Melbourne: Spectator Publishing Co.
Pty. Ltd., 1932); Minutes and Council Papers, Se 7, Report of the Censor-in-Chief to Council, 18 March
1936, p. 13b.
43 Melbourne Hospital, Eighty-sixth Annual Report of the Committee of Management with Statement of
Accounts, Lists of Subscribers and Donors and Statistical Returns (Melbourne: Spectator Publishing Co.
Royal Melbourne Hospital, twelve at the Alfred Hospital and five at St. Vincent's Hospital, Melbourne. In 1936, Sir Alan Newton described the duties of the surgical associates at the Royal Melbourne Hospital:

The surgical associate... acts as first assistant to the senior surgeon at all difficult operations, assists the outdoor surgeon in the out-patient department, advises the resident officer and helps in teaching students. He is given operative work of suitable types and, when he is thought to be qualified, does some of the immediate operations... the appointee must be approved by the surgeon to whom he is to be allotted.\textsuperscript{45}

A notable feature of this list of duties is that it does not include any suggestion that the senior surgeon was expected to assist the associate to perform any difficult operations himself. This was despite the fact that the associates all appear to have been at a fairly advanced stage of their training. They all had to have a senior surgical qualification and twenty-one of the thirty who had served a two-year apprenticeship of this type by 1936 had already been to England and taken the FRCS before they began. However, even such prestigious apprenticeships did not necessarily lead straight to full-time surgical practice, and twelve of these men went into general practice, at least for a while.\textsuperscript{46} Alan Newton's report incidentally throws some light on what was expected at an earlier stage of surgical training.

The work of the surgical associate does not interfere with that done by the house surgeon, who receives an adequate training in the surgical technique of conditions such as acute appendicitis or inguinal hernia. During the first month of each house surgeon's appointment, he is not allowed to operate and operations of the type specified above are done by the associate. For the remaining months of each house surgeon's appointment, he is allowed to do operations of this nature under supervision. He is told that, if he wishes to be a surgeon, he must get a senior degree

\textsuperscript{44} Minutes and Council Papers, Se 7, Report of the Censor-in-Chief to Council, 18 March 1936, p.13.
\textsuperscript{46} Ibid, p. 13c.
and become an associate and that he is merely being taught enough to fit him to cope
with surgical emergencies.\textsuperscript{47}

Hospitals and young doctors all over the country were discovering that the staffing needs of
the former and the experience requirements of the latter might be met simultaneously in
paid positions as resident medical officers. At the Melbourne Hospital in 1933, there were
eighteen junior resident medical officers and eight senior residents.\textsuperscript{48} At the same time, there
were more than thirty unpaid surgical clinical assistants of various kinds, and an equivalent
number of medical clinical assistants, in addition to all the more senior outpatient and
inpatient honorary staff.\textsuperscript{49} The resident staff was relatively small and the honorary staff was
relatively large. The honorary system continued for another forty years, but over that period,
there was a consistent trend towards an increase in the number and proportion of paid
clinical staff. Until the 1970s, the RACS showed little interest in junior hospital staff, but in
fact it was the pattern of hospitals employing increasing numbers of residents for longer
periods of time that became the framework within which surgical (and medical) training took
place.

In the early 1930s, a similar scheme of clinical assistants to those in Melbourne was set up at
the Adelaide Hospital (again for both physicians and surgeons). There were five general
surgical units, and by 1936 each had two clinical assistants. Sir Henry Newland argued that
they had "ample opportunities for a sound surgical training" but he was concerned that there
might be insufficient supervision by the senior surgeons.\textsuperscript{50} Sir Alan Newton expressed no
similar concerns about the system in Melbourne.

The Melbourne and Adelaide schemes were initiated by high profile members of the
honorary staffs of the hospitals concerned, but they depended for their success on the
cooperation of the relevant hospitals. The Sydney hospitals do not seem to have been so

\textsuperscript{47} Ibid, p. 13b.
\textsuperscript{48} Melbourne Hospital, \textit{Eighty-sixth Annual Report of the Committee of Management with Statement of
Accounts, Lists of Subscribers and Donors and Statistical Returns}. p. 20.
\textsuperscript{49} Ibid., pp. 13-19.
\textsuperscript{50} Minutes and Council Papers, Se 7, Comments by Sir Henry Newland on the report by the Censor-in-
Chief, 18 March 1936, p. 15.
ready to cooperate in setting up apprenticeship positions for surgeons. It appears that the resistance to the ideas put forward by the RACS sometimes came from surgeons, sometimes from hospital administrations, and sometimes from both. Some of the reasons for resistance where the clinical staff did not substantially control surgical appointments are clear from this complaint from New Zealand surgeons:

As the appointments are politically controlled, senior surgeons are loath to train their juniors. Cases have been known where junior men having political influence have, after receiving their training, received the appointments of their tutors. One senior surgeon said that they were quite frankly afraid of training traitors.\(^{51}\)

But for at least some Sydney hospitals there is another explanation. A number of Sydney surgeons seem to have held a different view of the appropriate model for training surgeons. For some Sydney surgeons, American ideas were influential and in particular, there were those who advocated paying trainee surgeons, rather than adding them to the honorary staff of a hospital, in other words effectively lengthening the period of residency experience from one or two years to three or four.\(^{52}\) Certainly this was a more practical option for young surgeons. Under the Melbourne model of apprenticeship, they struggled financially unless their chief paid them to assist him in his private practice, or they got other part-time paid work, as a general practitioner for instance, or a university anatomy demonstrator.

Individual surgeons in Melbourne and Sydney held a range of views, and there is absolutely no suggestion that all surgeons in Melbourne wanted the RACS to control training, while all surgeons in Sydney wanted the university to control training. But the traditional Sydney/Melbourne rivalry, combined with the fact that Sydney had a professor of surgery while Melbourne did not, produced a distinct difference in emphasis and style between the two cities. While Melbourne surgeons were more British and patrician in outlook, and saw a

\(^{51}\) RACS Archives Melbourne: Minutes of the Executive, Se 1, 2 March 1937.

leading role for the RACS in the provision of training, Sydney surgeons tended to look to America rather more often, and a number of key figures thought surgical training should be under the aegis of the universities.

During the 1930s and 1940s, there was a very significant degree of overlap between Honorary (general) surgeons to inpatients at the Royal Melbourne Hospital and the Executive of the RACS. Sir Alan Newton, Sir Victor Hurley and W. G. D. Upjohn were followed as inpatient surgeons by Allan Hailes, Henry Searby, A. E. Coates and Julian Ormond Smith. Of this group, only Upjohn and Coates were never members of the Executive of the RACS. Newton, Hailes, Searby and Julian Ormond Smith were successively Censors-in-Chief of the College from 1933 to 1961, emphasising further the dominance of the view from general surgery at the Royal Melbourne Hospital in College thinking on training and examinations. But while the views of these men were highly influential in Melbourne, elsewhere they had only limited success in achieving their objectives. This is particularly clear in the case of apprenticeship posts.

Brigadier W. A. Hailes succeeded Sir Alan Newton as Censor-in-Chief in 1943, when Newton became President. There followed an intensive period of debate in the Executive on the requirements for Fellowship. What emerged from the lengthy discussions and multiple papers to the Executive and to Council was a renewed commitment to the principles of apprenticeship plus a senior surgical qualification obtained via a two-part examination. The main change was that for the first time, the RACS was proposing to conduct its own examinations. This led to renewed attempts by the Executive to persuade

53 In 1935, the membership of the Executive was increased to include all members of Council resident in Victoria: Minutes and Council Papers, Se 7, 9 September 1935.
54 Both the Royal Australasian College of Physicians and the RACS followed their British counterparts in setting up the position of censor-in-chief. Incumbents were responsible for the overall setting of content and standards for examinations. Sir Benjamin Rank succeeded Orm Smith in the role in 1961, a break with tradition only in so far as he was a plastic surgeon rather than a general surgeon at the Royal Melbourne Hospital. Tradition was restored when Sir Edward Hughes became Censor-in-Chief in 1969.
55 Minutes of the Executive, Se 1.: Report of Censor-in-Chief, 7 July 1943; Report of Censor-in-Chief embodying draft curriculum for candidates for Fellowship of the Royal Australasian College of Surgeons 12 July 1944; Censor-in-Chief's Report on Admission of Specialists to the College 30 August 1944; Post-Graduate Education in Surgery, 7 December 1944; Report from Hugh Poate to Alan Newton, 20 February 1945 on facilities for training at the Sydney Hospitals; Consideration of list of Examiners, 19 December 1945; Report from the Censor-in-Chief on Apprenticeship Training, 3 April 1946; Minutes and Council Papers, Se 7: Report of a Conference held between representatives of the Royal Australasian College of
Sydney hospitals to set up apprenticeship posts. The Executive did not approach Sydney hospitals directly, but did so through Hugh Poate. Poate was on the honorary surgical staff of the Royal Prince Alfred Hospital in Sydney and in 1944 he was Vice-President of the RACS. In July 1944, Sir Alan Newton asked him to approach the New South Wales State Committee of the RACS. A letter was also sent to the chairman of the board or mother superior of the Royal Prince Alfred Hospital, the Sydney Hospital, the Royal North Shore Hospital, the Prince Henry Hospital, St Vincent’s Hospital and Lewisham Hospital. Herbert Schlank, Chairman of the Directors of the Royal Prince Alfred, was an influential figure in hospital management and the driving force behind the formation of the Australian Hospital Association in 1946. His reply is therefore particularly interesting:

I am interested to learn that the R.A.C.S. proposes to modify the condition of admission to its Fellowship and to assume the functions of a surgical examining body which will insist on a period of apprenticeship to Senior Surgeons on the staffs of hospitals approved by the College.

While I am in sympathy with any effort to improve the standard of surgical practice, I have some doubt as to whether the time is ripe for such an attempt to obtain a more or less rigid formalism in P.G. surgical instruction throughout Australasia.

I suspect that Universities, Boards of Management of Hospitals, and their Honorary Medical Staffs might possibly resent interference with the existing order by outside agencies, even if they are purely professional and act with the best intentions.

Only Lewisham Hospital was unequivocally prepared to cooperate with the RACS in setting up apprenticeship posts. The University of Sydney Post-Graduate Committee and its Secretary, Mr Coppleson, were (rightly) concerned that the change in the RACS entrance

Surgeons and of the University of Sydney Post-Graduate Committee in Medicine held in Sydney, 12 June 1946; Reports to Council by Executive 2 October 1943 on postgraduate education, on postgraduate examinations in surgery, including examination for entrance to the Royal Australasian College of Surgeons, appointment of surgical associate assistants, regulations relating to the Examinations for the Diploma of Fellow; Report from executive to Council 1944 on Suggested Curriculum for those Graduates Desirous of Qualifying for the Fellowship of the Royal Australasian College of Surgeons;


77 RACS Archives Melbourne: Papers for the Executive, Se 61, Dr Schlank to Mr Poate, 9 October 1944, quoted in Hugh Poate to Sir Alan Newton, 20 February 1945.
requirements put the College examination in direct competition with the MS from the University of Sydney. The RACS proposal also met opposition from some individual surgeons at the Sydney Hospital. Poate advised Newton that future approaches should be through the University of Sydney Post-Graduate Committee, and Newton wrote directly asking for its cooperation. But despite considerable efforts, especially by Poate and Professor Dew, and many meetings over three years, by the end of 1946 there were only five (unpaid) apprenticeship posts in Sydney. 58

In the 1930s, the College began to follow the example of the Royal College of Surgeons of England in accrediting hospitals. The RACS set up a Hospitals Sub-committee, chaired by the Censor-in-Chief. In order to qualify for the fellowship of either college, surgeons had to work for a specified period of time (much longer for the Australian than the English college) in a hospital accredited by one of the colleges. Thus periods spent in accredited English hospitals could be counted towards the requirements for the FRACS and periods spent in accredited Australian hospitals could be counted towards the requirements for the FRCS Eng. 59 In contrast to the official "Associate Assistants", which the RACS was proposing as part time unpaid apprenticeship posts, the accreditation of a wider range of hospitals for surgical experience helped those aspiring surgeons who wished to work full time in paid positions as some form of senior resident medical officer or "registrar", as the more senior positions of this kind were increasingly frequently called.

This process of accreditation turned out to give the College some influence over hospital boards, and not only in Victoria. By the 1970s, accreditation had emerged as the major route through which the RACS influenced the number and distribution of training positions. Generally, hospitals wanted the kudos of being accredited, especially as this made it easier to attract good junior medical staff. The way the system worked in the 1930s and 1940s, the teaching hospitals got first pick of residents and non-teaching hospitals got the rest. 60 Both

58 Minutes of the Executive, Se 1, 31 July 1946. Minutes and Council Papers, Se 7, 10 June 1946.
59 Ibid., 19 January, 15 March, 18 March, 1939. Six months consecutive surgical experience was required for the FRCS Eng.
60 There are close parallels between the emerging Australian pattern of residents and registrars and the way the system of interns and residents was evolving over the same period in the United States. See Ludmerer, Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care., especially chapter 4.

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the English and Australasian colleges only wanted to accredit hospitals where the honorary surgical staff held senior surgical qualifications, especially their own. They also only wanted to accredit hospitals where the senior medical staff had a major say in appointments to the honorary staff. In the late 1930s and 1940s, the Hobart Hospital, the Launceston Hospital, the Brisbane Mater Misericordiae Hospitals, and the Newcastle Hospital all applied for accreditation. The Royal Hobart Hospital succeeded in persuading the RACS that it had made sufficient changes to meet their criteria, but the others did not. The Mater was advised to reapply in 1951, when new staff were to be appointed, "and the Committee expressed appreciation of the fact that efforts were being made by members of the staff to obtain senior surgical degrees."  

Apprenticeship training in a busy hospital, under the supervision of surgeons with senior surgical qualifications, was supposed to lay the foundation for clinical experience. But there is also a phrase which sums up the kind of new addition to the surgical ranks that was favoured by senior surgeons. During a row over appointments to the Auckland Hospital, Sir Louis Barnett talked about "a good type of man."  

Adelaide surgeon L. C. E. Lindon (a future President of the RACS) wrote to Council in support of a colleague who wished to be awarded a FRACS, but could not meet the technical requirements, noting that: "He is quite a good type of chap…."  

This idea of the "good type of man" or "chap" does not seem to have been confined to Australia. In the United States, Boston surgeon David Cheever, specifically in the context of training, referred to the "splendid type of man" produced by the internship system at the Massachusetts General Hospital.  

There is an implication that the "good type of man" represents more than simply the technical content of training. Shared values are implied, and for the RACS, the viva voce examinations provided the Censor-in-Chief and the examiners with the opportunity to make judgments as to who was a "good type" and who was not.

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61 Minutes of the Executive, Se 1, 24 June 1948.
62 Papers for Executive, Se 61, Sir Louis E. Barnett, Address to Conference of Hospital Boards, April 1937.
63 Minutes and Council Papers, Se 7, 18 March 1939.
Teaching Surgeons to Pass Exams

Besides apprenticeship, the other key requirement for a Fellowship of the RACS was a senior surgical qualification, resulting from a two-part examination. Initially, as has already been noted, it was envisaged that this would be the degree of Master of Surgery from one of the four Australasian medical schools, or the FRCS Eng. However, the University of Melbourne with no professor of surgery did not make any real provision for teaching candidates for the Master of Surgery. It simply conducted the examinations. The situation was rather different in Sydney where in 1935 the NSW Post-Graduate Committee in Medicine (begun by the BMA in 1929) became a committee of the University of Sydney. In 1936, the Coast Infectious Diseases Hospital, renamed Prince Henry Hospital, officially became a post graduate school of medicine of the University of Sydney. With the aid of £5,000 p.a. from the New South Wales Government, Directors of Post-Graduate Medicine and Surgery were appointed early in 1938, including Hugh Poate as Director of Post-Graduate Surgical Studies. However, this was not the beginning of an unqualified success story in surgical education. Postgraduate training at the Prince Henry Hospital was abandoned during the war and had still not recommenced by 1951.

In Melbourne, there was an experiment in using what had been the Homeopathic Hospital for postgraduate surgical education, but under the aegis of the RACS rather than the University of Melbourne. By the early 1930s, the Homeopathic Hospital was in serious trouble. Even before the depression, it was in danger of bankruptcy, then in the early 1930s income from patients fell sharply as unemployment rose and wages were cut. The Homeopathic was a marginal hospital, with its medical staff banned from membership of the BMA. However, for many years, most of the members of the medical staff had been practising conventional medicine and in the late 1920s Sir George Syme was among those

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66 Minutes and Council Papers, Se 7, 23 March 1938.
67 McIntosh, "The Development of Post-graduate Training in Medicine in Australia."
arguing that they should be allowed back into the BMA. As he pointed out, the Homeopathic Hospital was essentially operating as an orthodox hospital, but with one or two prominent members of staff particularly Bouton, homeopathic surgeon and Chairman of the Board of Governors, remaining committed to homeopathy. Welcoming the staff back into the fold, argued Syme, would also bring the hospital under the mantle of orthodox medicine. But even after the BMA ban was lifted, the hospital was the last choice for young doctors looking for a position as resident medical officer. In her history of the hospital, Jacqueline Templeton describes the whole institution as decrepit by the early 1930s.\(^a\)

This was the position in 1933 when the honorary medical staff came up with a proposal to transform the Homeopathic into an orthodox postgraduate training hospital for surgeons. The scheme involved the cooperation of the Victorian Charities’ Board and the RACS. The Homeopathic was to be completely rebuilt and revitalised with funding from the Charities’ Board, and in September 1934 the name was changed to Prince Henry’s Hospital.\(^b\) On 31 August 1937, Professor G. Grey Turner from the British Postgraduate Medical School of the University of London officially opened a postgraduate training school for surgery at Prince Henry's.\(^c\) The choice of George Grey Turner (Professor of Surgery) to open the school gives a strong hint that the British Postgraduate Medical School, based at the Hammersmith Hospital, was the model that Newton and Devine had in mind in setting up the Melbourne school. The British institution was opened two years earlier with government funding and the task of providing postgraduate education for GPs, plus specialist training and clinical research.\(^d\) The Melbourne school had a much narrower focus, with no university affiliation, no research and, despite approaches to the Royal Australasian College of Physicians, it was only ever involved in the teaching of surgeons.\(^e\) In addition, the official opening in 1937

\(^{a}\) Ibid.
\(^{b}\) Papers for the Executive, Se 61, 2 March, 5 May, 7 April 28 July, 18 August 1937.
\(^{c}\) The Herald, 18 August 1937, 16 September 1937; The Age 19 July 1937, 1 September 1937; The Argus 1 September 1937.
\(^{e}\) The Royal Australasian College of Physicians held its first examinations in 1938. However, it had very little involvement in training before the late 1960s and aspiring physicians, like aspiring surgeons, put together their own training programs: Ronald Winton, Why the Pomegranate? (Sydney: Royal Australasian College of Physicians, 1988); Josephine C. Wiseman, ed., To Follow Knowledge, a history of the examinations, continuing education and specialist affiliations of the Royal Australasian College of Physicians. (Sydney: Royal Australasian College of Physicians, 1988).
proved to be something of a false start. Nothing much happened, pending the construction of new buildings and the scheme remained in abeyance during the war.\textsuperscript{74}

In 1946, in the light of the new examination structure and the requirements of returned service men and women with medical degrees, the RACS began running a series of thirteen week courses, two per year, at Prince Henry's, Melbourne.\textsuperscript{75} The curriculum for the Final Examination specified an intensive course of instruction conducted over at least three months and covering revision of surgical anatomy, plus surgical pathology and clinical demonstrations.\textsuperscript{76} It may be assumed that the course at Prince Henry's was of this kind, and designed to prepare candidates for the Final. Alan Newton also tried to interest the RACP in training physicians at Prince Henry's. At a joint meeting between the Colleges in Melbourne in July 1944, there was agreement in principle, but nothing seems to have come of the proposal.\textsuperscript{77} The honorary lecturers in surgery were supposed to be appointed by the College and there were some overseas luminaries who gave a few clinical demonstrations whilst on a visit to Melbourne for other reasons. However, Alan Newton, Hugh Devine and other senior local surgeons also gave lectures, and there is an air of improvisation in reports of the courses. Importantly, Prince Henry's remained a low status hospital, and despite backing from Melbourne's surgical elites, the College struggled to attract sufficient (paying) students to make the courses viable. For instance, two months before the second course was due to start in September 1946, the College had had only five tentative inquiries. In the end, only two students took the full course, but four others took parts of it.\textsuperscript{78} Initially, the College had hoped for as many as twenty students on each course.\textsuperscript{79} Meanwhile, there was huge demand to sit for the English Primary in 1946, with 63 candidates in Melbourne, 29 in Sydney and 36 in Dunedin. Presumably the failure of the courses at Prince Henry's is a direct reflection of the small numbers who sat for the Final Examination of the FRACS. Only seven candidates

\textsuperscript{74} Drawings of the proposed new buildings were published in 1937: "Post-Graduate School at Prince Henry's Hospital Melbourne," \textit{Australian and New Zealand Journal of Surgery} 7 (1937): 91-93.
\textsuperscript{75} Minutes and Council Papers, Se 7, 4 March 1946. Minutes of the Executive, Se 1, 5 September 1945.
\textsuperscript{76} Minutes and Council Papers, Se 7, Curriculum for course of study for the Final Examination, 7 October 1944, p. 11.
\textsuperscript{77} Ibid., July 1944.
\textsuperscript{78} Minutes of the Executive, Se 1, 26 June 1946, 18 December 1946, 5 February 1947; Minutes and Council Papers, Se 7, 10 January 1947.
\textsuperscript{79} Minutes of the Executive, Se 1, 26 June 1946; Minutes and Council Papers, Se 7. 10 June 1946, 10 January 1947.
sat for the first Australasian Final in June 1946 and another nine sat for the exam in December. The contrast with the numbers taking the Primary is striking. Most aspiring surgeons continued to take the Primary examination in Australasia and then travel to England to sit for the Final. By 1952, when Prince Henry's became an undergraduate teaching hospital, the postgraduate scheme had effectively fizzled out for lack of student demand. From December 1951, postgraduate training courses were no longer conducted by the RACS at Prince Henry's.

**Melbourne and the RACS vs Sydney and the Universities**

During the late 1930s and 1940s, there were at least two schools of thought within the College on the most appropriate way to provide training, and both had failed by the early 1950s. The Melbourne view, represented most strongly by Sir Alan Newton, was that the College should play a leading role in training surgeons, including running courses for candidates for the Final. It was also Newton who was largely responsible for deciding that a substantial proportion of the Gordon Craig bequest should be used to provide scholarships for surgeons studying for the Fellowship of the College. The Sydney view, represented particularly by Hugh Poate, was that the universities, in conjunction with the postgraduate training committees, were the appropriate bodies to provide training.

Initially, each view more or less prevailed in its home State. Poate was in charge of postgraduate surgical education at the Prince Henry Hospital, Sydney, which was funded by the State Government and run by a postgraduate committee, under the aegis of the University of Sydney. Newton, meanwhile, played a leading role in attempting to transform Prince Henry’s Hospital, Melbourne, into a postgraduate teaching hospital, directly under the

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80 Ibid., 10 June 1946, p. 6; 10 January 1947, p. 4.
81 Minutes of the Executive, Se 1, Report from Executive to Council, 24 June 1949.
82 Minutes and Council Papers, Se 7, Report to Council by Sir Alan Newton, 9 September 1939, on the role of the colleges in postgraduate education.
83 Minutes of the Executive, Se 1, Report to the Executive by Sir Alan Newton, 22 December 1937, on the disposal of the income from the bequest of the late Gordon Craig. Council had already decided that £1,000 p.a. of the income from the bequest should go towards the Gordon Craig Library at the College in Melbourne. This left an income of £1,800 p.a. for scholarships.
84 Minutes and Council Papers, Se 7, Comments on the report by Sir Alan Newton on the role of the Colleges in Post-Graduate Education by Hugh Poate, 9 September 1939.
aegis of the RACS. Overall, official College policy was heavily influenced by the Melbourne perspective.

For a period after the war, however, the Sydney model began to achieve greater prominence, even though the Prince Henry Hospital did not recommence training surgeons. The Commonwealth Reconstruction Training Scheme, as it applied to medical personnel returning from the forces, was administered through the postgraduate committees. They enjoyed a consequent mushroom growth in the late 1940s, culminating in the formation of the Commonwealth Post-Graduate Federation in Medicine in 1948.85 But the mushrooms shrivelled as fast as they had grown, once Commonwealth funding came to an end. The principal focus had been on postgraduate courses for general practitioners, as had been the case with the original postgraduate committees set up by the BMA after World War I.86

Another important influence on training in the immediate post-war era was the scholarships for international travel provided by the Nuffield Foundation, the Rockefeller Foundation, the Carnegie Corporation, the Commonwealth Foundation and the Australian Red Cross Society. Gordon Craig Fellowships aided a modest number of aspiring surgeons to this flood of Australian doctors, once more travelling to learn.87 The Commonwealth Post-Graduate Federation in Medicine coordinated ships' surgeons posts for the travellers and arrangements began to be made for their accommodation, particularly in London. The College played its part, arranging with the Royal College of Surgeons of England for a residential hostel for aspiring Australasian surgeons in London.88

This postwar ferment in postgraduate medical education had the effect of putting College efforts in the shade. The RACS was no longer more or less the lone player in providing ideas on postgraduate medical education (at least in Melbourne). Government, the

85 McIntosh, "The Development of Post-Graduate Training in Medicine in Australia."
86 The first "Permanent Post-Graduate Committee" was set up in Melbourne in 1920. The South Australian Branch of the BMA set up a similar committee in 1928 and New South Wales followed in 1929. Both the South Australian and New South Wales committees subsequently came under university administration.
87 Of the 42 Gordon Craig Fellowships awarded between 1946 and 1952, 30 were for overseas study. All Gordon Craig Fellows had to be candidates for Fellowship of the RACS. Smith, "The Shaping of the RACS 1920-1960," 13-54.
universities, the postgraduate committees and above all hundreds and hundreds of individual young doctors were contemplating the problem. This relative eclipse of the College, and particularly of the Melbourne point of view, was accelerated by a change in key personnel on the Executive and Council. Sir Henry Newland retired from Council in 1946; Sir Alan Newton retired in 1947 and died in 1950; Sir Hugh Devine and Hugh Poate resigned in 1949 (although Devine continued to be influential behind the scenes for some years); and in 1949 Brigadier Hailes died and was succeeded as Censor-in-Chief by Henry Scarby. The Melbourne/Sydney rivalry continued in the 1950s, particularly through the personal rivalry between Henry Scarby and Sir Douglas Miller.98 Colin Smith has argued that Scarby's style made him enemies, so much so that Devine gave his backing to Miller and it was Miller who defeated Scarby in a vote for the presidency in 1957.99 Whatever the details of College politics, it is clear that by the late 1940s a new era had arrived and from the 1950s, the RACS was no longer dominated by Melbourne general surgeons. Groups of Fellows from Sydney, including Douglas Miller, began to question College policy and challenge the oligarchy of Council. The Executive responded by beginning to have its minutes, and sometimes those of Council, stamped "confidential". When a meeting of Fellows in Sydney sent the Executive a list of complaints, the response was denial that any change was needed.91 But significantly, in 1948 the Executive did begin to send a quarterly newsletter to Fellows.92 The size of Council was increased and the cosy system of Council making its own appointments to fill casual vacancies ceased to be the routine way of perpetuating the oligarchy.93

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98 Minutes and Council Papers, Se 7, Report from Council to Fellows, 1950. By 1950, not only were the primary examinations of the RACS and the RCS Eng reciprocal, but so were examiners.
91 In 1947, a number of Sydney Fellows, including Douglas Miller, began calling for reforms, including more frequent Council Meetings and an enlarged New South Wales State Committee. In June 1948 they were joined by some Fellows from Perth and Brisbane, and the demands were broadened to include a more accommodating attitude to the surgical specialties. There was a special meeting of Fellows in Sydney on 25 June 1948, which came up with a list of requests to Council. Council then referred the issue to the Executive for consideration and the Executive essentially produced arguments against all of the requests, but it did send a letter containing those arguments to all Fellows. See: Minutes of the Executive, Se 1, especially 5 December 1948.
92 Previously, there had been one annual report to Fellows at the time of the Annual Scientific Meeting.
Meanwhile, both the Sydney and Melbourne attempts to provide formal postgraduate courses in surgery had come to nothing. It seems clear that the failure of university sponsored postgraduate training for surgeons in Sydney was not the result of a triumph of the College agenda, but rather the result of multiple individual decisions by hospitals and by young surgeons trying to build careers. Ludmerer has shown for the United States that by the late 1930s, what was called the "long residency" of three or more years had become the sole accepted route to specialisation. 94 This change was cemented in place by the various American specialty boards set up during the 1930s, most of which required precisely such training. The pattern of training that emerged in Australia in the 1950s and 1960s was similar in some respects, and could perhaps be called the "long registrarship". However, it involved fewer links to the universities, and the role of certifying competence, which in America was performed by the specialty boards, in Australia (and Britain) was taken by the Royal Colleges.

94 Ludmerer, Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care, p. 87.
6: Travelling to acquire transferable skills

The viewpoint of aspiring urologists

In Australia at least until the 1960s, general surgeons and members of the various surgical specialties were in competition with each other for patients. This was also the case in England, where control over hospital admissions was usually divided up between the various general surgical "firms". However, this does not appear to have been the pattern in the United States where a far larger proportion of doctors had access to hospital beds.¹

Much depended on the procedures for admission to each individual hospital. Where admissions came under the control of general surgeons, there was always the potential for friction. At the Melbourne Hospital, for instance, the way that the relationship between surgical beds and admissions was organised reinforced the power of the general surgeons. Following a reorganisation in 1933, the six "Surgeons Attending In-patients" at the Melbourne Hospital were strengthened in their positions as feudal barons of semi-independent fiefdoms within the hospital.² Each headed a unit consisting of himself, one of the Surgeons Attending Out-patients, an Associate Assistant and a Ward Resident Medical Officer. "Receiving days" were introduced for the wards. This meant that on any one day, all surgical admissions would go to a specified ward, under the control of one of these six men.

At the time there were six specialist surgeons at the hospital (each also with assistants and ward residents): an ophthalmologist, two ear, nose and throat surgeons, a gynaecologist, a urologist and an orthopaedist. They all had to rely on "crumbs" from the general surgical "table". They were allocated patients only as and when the general surgeons saw fit, and this could lead to conflict, as is well illustrated by the example of Charles Littlejohn (Honorary Orthopaedist). In 1935 he wrote:

The out-patient figures show a considerable decrease on those of last year. This is due to the restriction of new cases allotted to Specialist Clinics. In addition, the type of new case sent to the clinic is lacking in interest and variety. It will be difficult to interest assistants and house surgeons if this is to continue.\(^2\)

This seems to have had the desired effect. The following year he wrote:

The work of the Orthopaedic Department has been more satisfactory during the past twelve months. Arrangements have been made for the supply of more suitable material, and co-operation with the other members of the staff has been established.\(^4\)

In Australia, wherever this system existed of admitting patients to the care of general surgeons first, the development of the surgical specialties was restricted by the reluctance of general surgeons to refer patients on to them. Only when general surgeons acknowledged that the specialists had particular expertise that they lacked were public hospital patients passed on. This sort of battle for patients between general surgeons and the rest, and the subsequent tension between them, was to continue for many years.\(^5\) The attitudes of general

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\(^4\) Royal Melbourne Hospital, *Report of the Committee of Management with Statement of Accounts Lists of Subscribers and Donors and Statistical returns for the Year Ended 30th June* (Melbourne: RMH, 1936), p. 37. Note that patients are referred to as "more suitable material".

surgeons to specialists have been discussed at length elsewhere, but in what follows the emphasis is on the viewpoint of the specialists, specifically urologists, and on their training in the 1930s and 1940s. The emphasis is on the practical business of acquiring manual skills in surgery. The picture that emerges is nothing like the apprenticeship view of handing over an established body of knowledge from master to apprentice. On the contrary, learning to be a urologist in the 1930s was about enthusiasm, trial and error, and sustained efforts to overcome practical surgical problems through a process of innovation and adaptation of surgical techniques. In the 1930s Australian urologists received very little training. Mainly, they taught themselves.

This chapter examines in some detail the process of learning the specific manual skills necessary for the performance of one particular urological procedure: transurethral resection of the prostate. This throws some light on how specialist surgical skills were acquired, as well as on variations in the popularity of the procedure (and the specialty of urology) from surgeon to surgeon and from country to country. The procedure of transurethral resection never entered the repertoire of the general surgeon.

Urology in Australia in the 1930s

In the 1930s, the main centre for urology in Australia was the Royal Prince Alfred Hospital in Sydney. In 1926, Robert Gordon Craig gave the University of Sydney £20,000 to fund research and training in urology and Dr Adolph Bolliger, a biochemist from Chicago, was appointed as Director of Research. Fellows in Urology were to be appointed for three years, working as Registrars to the Royal Prince Alfred Hospital Department of Urology, with its twelve male and six females beds, as well as conducting research under the direction of Adolph Bolliger and Harold Dew (Professor of Surgery at the University of Sydney).

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Gordon Craig’s gift thus funded a formal training post in urology, so far as is known, the first such postgraduate training position for a surgeon in Australia.

As has already been noted, Robert Gordon Craig was a frequent traveller and seems to have made his first study tour to England and the United States in 1908. He was particularly impressed by the Mayo Clinic and made repeated return visits. Gordon Craig seems to have been particularly influenced by American ideas on training, and in contrast to the model advocated by Melbourne general surgeons, his Fellows were paid. The Gordon Craig Fellowship post was set up before the founding of the RACS, and under the aegis of the University of Sydney, with a specific research component. It was used to train urologists for the next sixty years.

The first two Gordon Craig Fellows in Urology were John Laidley and Malcolm Earlam. In the 1930s and 1940s they each made study trips to Britain and North America and they kept diaries of their travels, largely it seems, for the benefit of each other. These diaries throw some light on what could be learned by travelling to watch overseas surgeons at work and in particular, they help illuminate the process of learning the very difficult manual skills involved in the new procedure of transurethral resection of the prostate. Laidley and Earlam were interested in the full range of urological procedures, but they were especially keen to learn more about transurethral resection. This highlights one of the key problems with any apprenticeship-type model of training in a period of rapid change.

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10 Gordon Craig’s money and Chairman of the Board Herbert Schlink’s ambitions for the Royal Prince Alfred Hospital set in motion the development of a range of training posts there, all for specialists. By 1946, besides the Gordon Craig Fellowship in Urology, the Royal Prince Alfred Hospital had two Fellowships in Obstetrics and Diseases of Women, endowed by the King George V and Queen Mary Maternal and Infant Welfare Foundation, a Fellow in Ophthalmology, a Fellow in Ear Nose and Throat, a Liston Wilson Fellowship in Neuro-Surgery and three Fellows in Pathology. All of these (paid) training posts were full time, with board and residence provided by the hospital, and they all came under the umbrella of the University of Sydney: RACS Archives Melbourne: Minutes and Council Papers, Se 7, 1926-1946."The Post-graduate Committee in Medicine in the University of Sydney, Training Appointments, New South Wales Metropolitan Hospitals, Royal Prince Alfred Hospital" in "Report of a conference held between representatives of the Royal Australasian College of Surgeons and of the University of Sydney Postgraduate Committee in Medicine held in Sydney on Wednesday 12th June 1946."
11 Archives of the Urological Society of Australasia: M S S Earlam and J W S Laidley, Item 78, Surgical diaries 1936-7, 1938 and 1948, held in the RACS Archives Melbourne.
The ideal of an apprenticeship was one to one instruction as the master progressively gave the apprentice more and more freedom to exercise his (rarely her) judgement in dealing with patients, deciding on treatment, performing surgery and providing post operative care. But this assumed an established body of knowledge that could be passed from master to apprentice. However, the 1930s was a time of enormously rapid change in surgery, as in other areas of medicine. What happened when the master lacked experience of the latest instruments and the latest operations? In the 1930s, virtually no training in resection was available in Australia. John Laidley and Malcolm Earlam as the first two Gordon Craig Fellows in Urology, were specifically trained in urology at the Royal Prince Alfred Hospital in Sydney. Their mentor Gordon Craig made multiple study trips overseas, especially to the Mayo Clinic, and returned with the latest instruments and the latest techniques, but he retired the year before the first practical resectoscope appeared and died shortly afterwards. He may have taught Laidley and Earlam how to use the Braasch-Bumpus punch, which was developed at the Mayo Clinic, but Laidley and Earlam had to teach themselves how to use resectoscopes. They could read about the new techniques, and then try them out on animals and/or on patients, and they could travel overseas to find out what other urologists were doing, buy the latest instruments and refine their skills. Laidley and Earlam’s diaries make it possible to understand something of how new surgical techniques were learned in the 1930s, and it becomes clear that there was often very little formal training or teaching involved. Laidley and Earlam learned their urology by following their interest in the subject.

Unusually for an Australian surgeon, Robert Gordon Craig encouraged research, but even without that support for intellectual curiosity, it is clear that learning to be urologist in the 1930s was not about acquiring a finite body of knowledge and skills within a fixed period of time. On the contrary, it was about what in a later period was called "self-directed learning." To a great extent, Earlam and Laidley taught themselves, particularly when it came to manual skills. The art of clinical judgment might be learned over time by watching and assisting a senior surgeon, despite rapid changes in the range of operations that he was performing. But this did not apply to the manual craft when new techniques were involved. Generally speaking, new procedures seem to have been learned by a combination of trial and error, and by travelling to learn directly from those who were developing the new techniques.
Many, if not most, of Australasia's specialists of the 1930s and 1940s seem to have spent some time learning their craft overseas. Neurosurgeon Sir Douglas Miller, cardio-thoracic surgeon Rowan Nicks and orthopaedic surgeon McKellar Hall are just three examples.\(^\text{12}\) Besides John Laidley and Malcolm Eadie, a number of the early Australian urologists also seem to have been both prepared to travel and very willing to learn from urologists in Britain and America. In particular, Keith Kirkland from Sydney and Henry Mortensen from Melbourne were famous for the frequency with which they travelled to overseas surgical meetings.\(^\text{13}\) Those who travelled could see for themselves what was possible with the new techniques.\(^\text{14}\) Poor results when operating "from the book" could be understood as the fault of the surgeon, not the new procedure, and practice could be followed by better results.

The Context for the Development of Transurethral Resection of the Prostate

For most of the twentieth century, it was assumed that the enlargement of the prostate with age had a direct causal relationship with a range of lower urinary tract symptoms, which men commonly experience as they become older.\(^\text{15}\) Symptoms sometimes include the inability to

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\(^{15}\) The case of benign prostatic hyperplasia (BPH) illustrates that the construction of a group of symptoms as a disease and the construction of a disease as surgical are not events but processes, and both may be reversed. In the 1930s, there was no debate as to whether urinary symptoms in men resulted from adenomatous prostates, and there was little debate as to whether this "disease" should be treated surgically. The debates centred around which operation to perform, not whether or not to operate at all. But in the 1980s and 1990s proponents of evidence based medicine pointed out that there was no direct correlation between urinary symptoms in men and the size of the prostate, or with relief of symptoms following surgery. BPH came to be regarded as a natural bodily phenomenon rather than a disease, and urinary symptoms came to be regarded as appropriately managed by a range of treatments, not just surgery. National Health and Medical Research Council, "Clinical Practice Guidelines: The Management of Uncomplicated Lower Urinary Tract Symptoms in Men," (Canberra: Commonwealth of Australia,
urinate at all (urinary retention) which could be fatal if untreated. One of the earliest treatments for this potentially lethal condition was the insertion of a catheter, either permanently or on an intermittent basis. While this procedure, offering the patient what was known as "catheter life" could relieve the retention, it was also associated with ubiquitous urinary tract infections and with very high mortality rates. Cystotomy was sometimes performed, providing an opening from the bladder through the abdominal wall, but this, too, carried high mortality rates. For instance, in 1936 Harry Rolnick and Lester Riskind reported a mortality rate of 28.6 per cent for cystotomy on patients in the Cook County Hospital in Chicago, although mortality was significantly lower for the same procedure in their private practice. Rolnick and Riskind discuss at some length the reasons for this very high mortality in the County Hospital. Patients suffering from "prostatic obstruction" were often sick old men with impaired renal function, severely infected bladders and significant co-morbidities. Further, in the early 1930s, County Hospital patients were poor sick old men. As American urologist James Sargent put it in 1933: "If one is to hope to avoid mortality, he will have to avoid the responsibility of operating upon the physical derelicts that abound in the wards of public institutions." Nearly a decade later Hamilton Stewart, a urologist in Bradford, England, reported a mortality rate of 11.7 per cent for suprapubic cystotomy. Neither "catheter life" nor cystotomy actually cured the patient and so more drastic procedures were developed to remove the enlarged part of the prostate and hence, it was assumed, relieve the symptoms.

The prostate lies just below the bladder and like a tiny fist or doughnut it surrounds the upper part of the urethra, which carries urine from the bladder and down through the penis. From a surgical point of view, there are several possible ways of gaining access to the gland. At the end of the nineteenth century, perineal prostatectomy (approaching the prostate from below, behind the scrotum and in front of the rectum) was popularised by Hugh Young at


the Johns Hopkins Hospital and it remained the favoured method in America until the 1930s. However, this procedure carried a high risk of damage to the rectum, and the complications of faecal incontinence, or faecal fistulae, or both. In 1938, John Laidley watched Fred Foley at work in Minneapolis and noted that he was conducting the operation with an illuminated bulb in the rectum, to help him avoid cutting the external sphincter (leading to incontinence) or entering the rectum (leading to a recto-vesical fistula), thus protecting "the patient from the surgeon in two ways." In New York, Laidley was told that if a surgeon had never entered the rectum by mistake, he had not performed many perineal prostatectomies.

An alternative operation to perineal prostatectomy was suprapubic prostatectomy, approaching the prostate from above, through the lower abdomen and down through the bladder. This procedure was particularly associated with St Peter's Hospital for Stone in London. In 1930, John Thomson-Walker reported a mortality rate of 6.1 per cent for the procedure in his private practice, 9.9 per cent on public hospital patients at St Peter's Hospital for Stone and 19.5 per cent in hospitals where the operation was largely performed by general surgeons. In Australia during the 1920s and early 1930s the operation was also widely performed by general surgeons, with very high mortality. At the Melbourne Hospital, for instance, 25 per cent of the 124 prostatectomy patients operated on in the eighteen months up to June 1933 died, but it should be noted that the mortality rate for those with "symptoms of prostatic enlargement" who did not undergo surgery was even higher at 54 per cent (15 out of 28 patients). At St Vincent's Hospital in Melbourne, the death rate from suprapubic cystotomy alone in 1933 was 14 out of 24 cases, or 67 per cent.

23 As in other reports of mortality rates in the 1930s, the period after the procedure is not specified, but the clear implication is that the patient did not leave hospital alive. B. T. Zwar, "The Mortality in Prostatic Obstruction," *Medical Journal of Australia* I (1934): 301-3, p. 302. It is worth emphasising the point made earlier. In public hospitals in the 1930s, the problems of many patients were compounded by poverty, or in the words of the Melbourne Hospital's Annual Report for 1933: "...patients whose real need
Some Australian and New Zealand surgeons preferred the modified version of the operation for suprapubic prostatectomy that was developed by Sydney urologist Harry Harris and first reported in 1928. Harris emphasised that the two essential points in his operation were "the complete control of haemorrhage by suture and the reformation of the prostatic urethra." The Harris procedure was not an instant success, but by about 1935 it had been widely adopted in Sydney, Melbourne, Adelaide and Auckland. Harry Harris himself reported a very low mortality of 2.8 per cent for this procedure but others had less success, especially outside Australia and New Zealand. Harry Harris' reported results were so good that many surgeons simply did not believe them, despite the fact that he travelled to Britain and Europe in 1935/6 to demonstrate his procedure. Harry Harris died at the end of 1936.

It has been argued that the Harris operation met with little acceptance outside Australia and New Zealand and it does, indeed, seem to have been ignored in North America. But in the late 1930s and early 1940s it was popular with a number of British surgeons, including Clifford Morson at St Peter's Hospital for Stone, Terence Millin at All Saints Hospital and Eric Riches at the Middlesex, all in London. Elsewhere in England it was performed by C. Alexander Wells and J. Cosbie Ross in Liverpool, Walter Galbraith in Glasgow and...
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Hamilton Stewart in Bradford. Generally, British urologists modified the Harris procedure but few seem to have achieved the good results claimed by Harris himself.

In summary, "prostatic obstruction" was a common and frequently fatal condition, and all the treatments in use before the 1930s carried very high mortality. Most surgeons who treated the condition on more than an occasional basis developed their own modifications of the principal instruments and procedures, and there was a widespread and sustained, if totally unsystematic, search for better methods of treatment.

The Search for Improved Methods of Prostatectomy

The Annual Reports of the Mater Misericordiae Hospital in Brisbane allow us to note changes in the method of prostatectomy and variations in mortality rates over time. In 1915, the Mater reported two prostatectomies and two deaths, an awful statistic out of the 620 operations and twenty-two deaths for the hospital as a whole that year. This began to change when Arthur Stanley Roe was appointed as urologist to the Mater in 1919. His was only the third Australian hospital appointment in urology, after Harry Harris at the Lewisham Hospital in 1914 and Robert Gordon Craig at the Royal Alexandra Hospital for Children in 1918, both in Sydney.

In Roe’s first year, there were five prostatectomies and one death, but after that things improved. Throughout the 1920s he performed five to ten prostatectomies a year with a mortality rate of about 10 per cent. In 1926, however, he began to perform "Young's punch operation." This was a procedure devised in 1909 by Hugh Young at the Johns Hopkins Hospital in Baltimore. An instrument was inserted in the urethra and bits of the prostate were sliced away. The Mater Annual Reports record no deaths from this procedure, but numbers remained small, presumably because it was so difficult to cut tissue and control

bleeding by this method, which was performed by "feel". The urologist could not see what he was doing. By the early 1930s, Roe had been joined by Alex Inglis and the urology department at the Mater was performing ten to twenty prostatectomies with one or two deaths and a handful of Young's punch operations every year. But then in 1935, there was a revolution in the treatment of prostatic enlargement at the Mater hospital. The Annual Report records forty-three "Resectoscopic Resection Prostatic Bar" and only one death. The staff of the urology unit at the Mater Hospital in Brisbane had begun to employ the technique of transurethral resection of the prostate.

Although urologists devised a range of "open" surgical procedures, the growth of the specialty was particularly associated with endoscopic procedures, using instruments that could be inserted into the urethra, bladder and even ureters without making an incision in the skin. The earliest of these procedures, such as passing a sound to guide the scalpel while cutting for bladder stones, depended on "feel", but subsequent developments allowed the urologist to also "see".

By the beginning of the twentieth century there was a range of instruments known as cystoscopes, which could be used to see inside the bladder and which were used as an aid to diagnosis. In addition, as has already been noted, early in the century Hugh Young developed a punch operation which used an endoscopic instrument to cut away pieces of the prostate by "feel". These two separate endoscopic activities—"feeling" and "seeing" inside the body—were put together by many urologists in conjunction with instrument makers, in attempts to both cut and see at the same time. In the 1920s and 1930s urologists and instrument makers, particularly in North America, had many of the characteristics of what Weber Bijker, a sociologist of science, has described as a social group working within a

32 Mater Misericordiae Public Hospitals Brisbane, Annual Reports, 1935.
technological frame. Their agreed goal was to develop a viable means of removing all or part of the enlarged portions of the prostate endoscopically. One of the key problems was haemostasis and machines were devised to use electric current to both cut and coagulate. These diathermy machines, as they were called, worked in the same frequency range as radio.

An instrument which combined the ability to see and also enabled cutting and coagulating with electric current using a loop of tungsten, the resectoscope, was invented by Maximilian Stern in America in 1926. Stern referred to the resection of obstruction at the bladder neck as "minor surgery" and "a mere cystoscopic procedure", and initially, those who read his article assumed that his instrument was not difficult to use. This was far from being the case. The tungsten loops on these early resectoscopes kept breaking and the diathermy machines of 1926 did not produce a current that would effectively cut tissue under water. In 1931, however, American urologist T. M. Davis reported 230 cases of resection, with no deaths, using a more robust cutting loop and a more powerful cutting current. Davis also gave the impression that his instrument was easy to use, claiming that resection was "a minor surgical operation". Also in America in 1931, the Stern-McCarthy resectoscope emerged from the combined efforts of instrument maker Frederick Wappler and urologist Joseph McCarthy. It used the Wappler/McCarthy panendoscopy and its foroblique lens system for vision, (which provided a 30 degree forward view), in conjunction with the bakelite sheath developed by Kenneth Walker in London and the cutting loop developed by T. M. Davis.

38 Ibid., p. 1726; Nesbit, Transurethral Prostatectomy, p. 135.
39 Ibid., p. 134.
41 Ibid., p. 1674; Crowell and Davis, "Motion Picture Demonstration of Prostate Resection," 629-638, p. 638.
43 Murphy, The History of Urology, p. 428.
The Stern-McCarthy resectoscope included provision for coagulating as well as cutting, plus vision, and was essentially the instrument which first made the operation of transurethral resection of the prostate feasible on any scale. Surgeons rushed to buy resectoscopes and diathermy machines in numbers which Reed Nesbit described twelve years later as having attained "panic proportions". By the end of 1936, 2,500 Stern-McCarthy resectoscopes had been sold, more than double the membership of the American Urological Association. As James Sargent put it in 1933: "Almost overnight men everywhere bought their machines and started whistling." In North America, these developments sparked an upsurge of interest in urology, leading to the formation of the Board of Urology in 1934, three years before the American Board of Surgery.

Problems with Transurethral Resection

In 2002, transurethral resection of the prostate, using an instrument which would be recognisable to Stern, Davis and McCarthy, was the gold standard for all but the largest prostates, where surgical intervention was indicated for the treatment of lower urinary tract symptoms in men. But in the 1930s it was by no means obvious that transurethral resection would become the procedure of choice for so many urologists in so many cases. On the contrary, the procedure was widely attempted in 1931 and 1932, by general surgeons as well as urologists, and then almost as widely rejected as impossible to perform successfully. Surgeons took Stern and Davis' remarks at face value, that transurethral resection was a "minor surgical operation." When they found for themselves that it was nothing of the sort, they put their brand new resectoscopes away to gather dust and returned to the open operations for "prostatic obstruction", dismissing the published results of resection as suspect, if not positively dishonest. Subsequent acceptance of the procedure depended on enthusiasts who persevered and went on to publish good results, train young urologists in resection, and convince their colleagues that their results were as good as they said they were.

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47 Nesbit, *Transurethral Prostatectomy*. 167
As Irish urologists Canny Ryall and Terence Millin wrote in 1932: "The technique [of resection] is not simple nor is the method one for the occasional cystoscopist." 48

Throughout the 1930s, the merits of the operation were hotly debated on both sides of the Atlantic, and much of the debate centred around the undeniable difficulty of mastering the manual skills involved in the procedure. 49 Were poor results an inherent feature of the technique, or did they reflect the fact that the urologist concerned had not yet developed the requisite manual skills? As an American urologist put it in 1937:

...too enthusiastic resectionists may overstate the mortality and incidence of poor after results of total prostatectomy, whereas some prostatectomists who have not trained themselves sufficiently in transurethral resection to relieve obstruction adequately by this means, unqualifiedly condemn the procedure in everyone's hands. 50

In the terms of the twenty-first century, transurethral resection of the prostate had a very long learning curve. 51 As American urologist Robert Day put it in 1932:

...how does one get to be an expert, and how much bungling is inevitable in the process of becoming one?...Let no one, no matter how experienced and skilled in other cystourethroscopic procedures, delude himself into believing that he will not do

49 The literature on the topic is enormous and there is hardly an issue of the Journal of Urology in this era which does not feature articles on the topic. For instance: Abeshouse, "A comparison of results in the treatment of prostatic obstruction by transurethral resection and prostatectomy," J 1101-1122. And the discussion of the paper on pp. 1123-1129. In Britain, the issue was debated more in the pages of the Lancet and the British Medical Journal than in the pages of the British Journal of Urology. See also: Hugh Lott, "The Treatment of Prostatic Obstruction Other than by Enucleation," British Journal of Surgery 25 (1937): 191-203.
considerable bungling during his apprenticeship, and that many of his results will not be deficient.\textsuperscript{52}

Resection built on the specialist skills that urologists developed whilst performing cystoscopies, and cystoscopy itself was a difficult skill to master. Vision was limited and contrast poor and in addition the "bijou" lamps used as a light source in this era frequently burned out. The instrument then had to be removed to change the lamp and the patient might receive a mild electric shock. English urologist John Blandy noted that "Cystoscopy was generally performed under local urethral anaesthesia and took skill and confidence on the part of the surgeon and fortitude on the part of the patient."\textsuperscript{53} In explaining why not all Americans were in favour of transurethral resection in 1936, Californian urologist Irving Wills told Malcolm Earlam that: "The men who condemn it are very largely members of the older generation, who have never acquired a completely efficient cystoscopic technique…"\textsuperscript{54} Malcolm Earlam and John Laidley published their own early results from resection in 1936 and noted:

\ldots transurethral surgery of the adenomatous prostate is\ldots far from being the simple matter that one might imagine it to be from a perusal of some of the published reports\ldots the actual removal of obstructing tissue may often be much more easily contemplated than carried out. At first the cutting loop, instead of biting deeply into the prostatic tissue, merely slides over its surface, and the experience of a good number of resections is necessary before the operator acquires the knack of automatically placing the loop and adjusting the axis of the resectoscope in that position which by repeated trial and error has been found to afford him optimum mechanical advantage.\textsuperscript{55}

\textsuperscript{54} Archives of the Urological Society of Australasia, "M S Earlam and J W S laidley, Item 78, Surgical diaries 1936-7, 1938 and 1948.," Earlam, 2 November 1936.
However, the difficulties of the procedure did not lead Earlam and Laidley to reject it as a method. On the contrary, they wrote that: "We find it difficult to conceive that any better method for the surgical treatment of median bar could possibly be evolved." They went on to say that "We... regard our modified successes and our failures as due to our own shortcomings in technique, and not to the type of operation performed."

Although later modifications of the Stern-McCarty came thick and fast and many urologists had their own personal variation, the resectoscope remained inherently difficult to use. In America, Joseph McCarthy argued that the use of his instrument was technically difficult and required "self education" and a "personal apprenticeship." Louis M. Orr Jr argued that "In all urologic surgery I do not believe there is anything quite as difficult as a resection on a highly vascular gland which bleeds freely at each excursion of the loop." In England, Kenneth Walker argued that: "Even to the experienced urologist a perurethral resection often proves to be a difficult operation. In the hands of the inexpert the resectoscope can be an instrument that is more deadly than the knife. Years of practice are necessary in order to become master of it." There was a serious risk of removing too much tissue and/or cutting in unintended areas. In Australia, R. I. Campbell complained that:

The endoscopic resection instruments are exceedingly difficult to use and it is only after considerable experience that one can hope to become reasonably proficient. Unless enough prostatic tissue is removed, the operation is completely useless; and then with the McCarthy resectoscope there is always the fear of removing too much, as the coagulation extends a variable distance below the cut surface. It is this coagulated tissue which is the source of the almost inevitable infection.

56 Ibid., p. 83.
57 Ibid., p. 88.
Acquiring the skill necessary to accurately and expeditiously remove tissue took a lot of practice. When John Laidley visited Reed Nesbit in May 1938, the series of resections at the Ann Arbor clinic already exceeded 3000. The urologists at the Mayo Clinic also had plenty of opportunity for practice, using punch type instruments, rather than versions of the Stern-McCarthy resectoscope, and they performed about 700 resections in 1936. Gershom Thompson was considered particularly fast and Malcolm Earlam noted that he removed fifteen grams (a small prostate) in fifteen minutes. John Laidley observed the work of one New York urologist and noted that although he had performed more than 500 resections, John Laidley thought both Malcolm Earlam and himself were technically better.

Urologists, of course, argued that resection should be left to them. Hugh Lett, President of the Section of Urology of the Royal Society of Medicine argued as early as 1933 that: "these operations were not for every surgeon to undertake. The results varied directly with the experience of the operator in urethral instrumentation."62 The operation offers numerous advantages" wrote J. Cosbie Ross of Liverpool in 1936, "but at the same time presents many technical difficulties and dangers which render it inadvisable for the occasional cystoscopist."63 By the mid-1930s even some general surgeons were agreeing that they should leave transurethral resection to the urologists. In 1936, Melbourne general surgeon Albert Coates noted: "...much of this prostatic surgery was better left in the hands of the genito-urinary surgeon."64

Clearly, transurethral resection was a highly specialist skill. Even urologists who were already skilled at cystoscopy, the art of just looking down a telescope into the bladder, might have to perform hundreds of resections before they were sufficiently skilled to remove prostatic tissue accurately and expeditiously. Because of the difficulties in learning and performing the procedure, transurethral resection did not become a part of the repertoire of the general

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63 Ross, "Prostatic obstruction and the indications for the various methods of treatment." 1297-1300, p. 1299.
surgeons. A competent transurethral resectionist almost by definition had to be a urological specialist.\footnote{Surgeons were using instruments based on the same principles as cystoscopes to investigate the body through other orifices. By 1950, for instance, the catalogue of American Cystoscope Makers Incorporated included a small range of "Rectal, Abdominal and Pelvic Instruments" and there was also a section for "Thoracic Equipment." But there was no move to develop endoscopy as a specialty, using the related skills and instruments to operate on several areas of the body.}

Learning Transurethral Resection of the Prostate "from the book"

Despite the difficulties of learning transurethral resection, it would appear that in the 1930s at least some surgeons did this by simply reading about a procedure and then trying it out. In 1933, for instance, John Everidge, senior urologist at King's College Hospital, London, wrote an article on "trans-urethral technique" for the Medical Journal of Australia. "The details of technique of individual operations," he wrote, "can be best studied from monographs by Caulk, Davis, McCarthy, Stern, Ryall and others; it is not intended to extend the scope of this brief survey to include them."\footnote{John Everidge, "A brief survey of trans-urethral technique for bladder neck obstruction in the prostatic subject," Medical Journal of Australia II (1933): 579-81, p. 580.} But Everidge appears to have expected his article to be used by the novice not only in resection but also in cystoscopy:

> For those commencing this work and who are not too familiar with visualization of the bladder neck, bladder base and posterior urethra, the coagulation by transfusion of intravesical projecting lobes affected with electrodes passed through a Wolf's cystourethroscope, or one of similar design, is recommended as being the safest introduction to the method of per-urethral technique... When acquaintance with common appearances and a degree of confidence have been gained, careful attempts may be made in the use of the McCarthy resectome.\footnote{Ibid., 580. Everidge added the difficulty of understanding his text to the difficulty of the procedure he described.}

That reading about a procedure and then giving it a try was standard practice for at least some surgeons is also clearly assumed by the anonymous 1944 reviewer of Reed Nesbit's monograph Transurethral Resection.
There is no operation in surgery the success of which is more determined by the skill and the experience of the operator than that of transurethral prostatectomy. Formerly there were few reliable descriptions in urological literature of the technique to be employed in carrying out this difficult procedure, and the beginner was compelled to acquire his own technique by the painful process of trial and error. Fortunately this defect is now being remedied, and the operator with little experience of transurethral resection is able to obtain guidance from those who are experts. Dr. Nesbit gives a detailed and very clear description of the particular technique which he employs in the Michigan School of Urology. 68

It would appear that at least some surgeons in the 1930s and 1940s believed that they could learn the manual skills needed to perform a procedure which was acknowledged to be particularly technically difficult "from the book", by reading about it, obtaining an instrument, and then trying it for themselves.

The manual skill involved in surgery is only one component of the surgeon's craft and, as has already been noted, in Australia and New Zealand in the 1930s, it was fashionable to downplay either its difficulty, or its importance, or both. In a 1937 article entitled "The complete surgeon", New Zealand surgeon James Elliott reported John Hunter as saying that a good carpenter could be taught to operate. 69 The author went on to argue that acquiring the other (non-manual) surgical skills of diagnosis, patient management and clinical judgment was more complex and required "a wide and general culture." 70 Sir Hugh Devine argued that: "In a surgeon there is no quality of mind more to be desired than that of judgement. Judgement is the product of a mind cultured by a liberal and professional education and matured by experience. It is judgement even more than skill that makes a truly successful surgeon." 71 Full time Australian surgeons were keen to downplay the

69 James Elliott, "The Complete Surgeon," Australian and New Zealand Journal of Surgery 7 (1937): 177-180, p. 177. Much more recently, in the preface to a book on teaching surgery, members of the surgical faculty of the University of Michigan wrote: "Although it may appear paradoxical to the lay person, the teaching of operative techniques is the easiest job of the surgical educator." p. vii.
70 Ibid., p. 180.
importance of operative competence alone, in order to distance themselves from those
general practitioners who also performed surgery.

For North America, Peter Olch has argued that in the early years of the twentieth century
surgical technique was stressed at the expense of surgical judgment and that dexterity and
speed were highly valued. Olch goes on to argue that the founding of the American College
of Surgeons in 1913 did relatively little to change this because the requirements for
Fellowship stressed operative competence rather than medical knowledge or surgical
judgement. Over the next two decades, criticism of the American College of Surgeons
grew, particularly from the elite interests represented by the American Surgical Association
and from academic surgeons more broadly. These surgeons accused the American College of
Surgeons of accrediting mere "operators". Evarts A Graham, Professor of Surgery at
Washington University, St. Louis, (and later President of the Board of Regents of the
American College of Surgeons) strongly criticized the overemphasis on operative skills.
Evarts Graham and Canadian surgeon Edward Archibald (president of the American
Surgical Association) were among those instrumental in the founding of the American Board
of Surgery in 1937. As has already been noted, Archibald argued that the Australasian system
of accredititation of surgeons through both a stiff two part examination, (including a
substantial component of anatomy, physiology and pathology), and a period of surgical
apprenticeship, was the ideal model. From 1937, this was broadly what certification by the
American Board of Surgery required. In other words, the science of surgery was stressed, not
just the operative competence required for Fellowship of the American College of Surgeons.
In Britain, too, it was argued that a "first class operator" was not the same as a "first class
surgeon". In reference to Harry Harris, London general surgeon Sir William Wheeler wrote:

From Harris's insistence upon scientific treatment before and after operation and the
necessity for care and judgement in the general management of the case we may infer
that he was one of those who considered the term "operating surgeon" as obnoxious.

72 Peter D. Olch, "Evarts A. Graham, The American College of Surgeons, and the American Board of
73 Ibid., 250.
74 Ibid.
and that he realized the fundamental distinction which often exists between first-class operators and first-class surgeons. Harris was by no means a mere technician; he was what Wilkie alludes to as an "operating physician", a term which accurately signifies the modern line of thought.\textsuperscript{76}

It seems that in the 1930s, whether in Britain, North America or Australasia, good surgeons were not just clever with their hands.\textsuperscript{77} Surgeons of this era appear to have valued surgical judgment, pre-and post-operative care and the science associated with their surgery. They argued that doctors should not take up surgery without special training and experience in these areas, as well as in the manual skills involved.

But did those who held this group of ideas and who sneered at "operating surgeons" assume that once duly accredited and experienced, "first-class" surgeons could tackle any surgical procedure without necessarily having to undergo further training? The position of the various colleges of surgeons was that surgery required special training and experience and that their several diplomas of fellowship were the hallmark of a qualified surgeon. Once so qualified, by implication the surgeon was in a position to perform any surgery. This was especially the case in Britain, where the general surgeons continued to hold sway and there were no calls for special training in new procedures.\textsuperscript{78} In the United States, however, the 1920s and 1930s saw the beginnings of moves to accredit surgeons by specialty, rather than in surgery as a whole.\textsuperscript{79} But even in the United States there was no suggestion that once accredited by the Board of Urology, a urologist needed any further special training or

\textsuperscript{77} However, having good hands remained a compliment to a surgeon. Sir Alexander McCormack, for instance, was described admiringly in 1937 as having "had hands of God". RACS Archives Melbourne, "Papers for Executive, Se 61, Bruce T. Mayes, Letter to the Secretary," (1937).
\textsuperscript{78} "I have no apology to offer" wrote London general surgeon W. Sampson-Handley in 1941, "for my intrusion upon the urological domain. It is in my opinion essential for the future of surgery that general surgeons shall maintain their right of entry to the common lands which, with such success and advantage have been fenced and cultivated by the various specialties." W. Sampson-Handley, "Hemiprostatectomy for unilateral adenomatous enlargement," \textit{British Medical Journal} II (1941): 681-685, p. 681.
accreditation before he (rarely she) could tackle (or indeed develop himself) any new urological procedure.

The operative component of the art of surgery was about tacit or embodied knowledge, about manual dexterity and hand/eye co-ordination. Hands had to be taught as well as heads when learning surgery and, John Hunter notwithstanding, as has been shown for transurethral resection, some procedures were technically difficult to master. As might be expected, results varied as surgeons struggled with the long learning curve. Some surgeons saw this as a problem. In a thoughtful 1938 paper on prostatic obstruction, provincial Australian urologist G. M. Davidson noted that in the case of transurethral resection: "...the mortality figures for the first 50 to 100 patients are usually considerably higher than those operated on subsequently. It is indeed disturbing to contemplate that efficiency is gained at such a cost." Interestingly, Davidson went on to argue that: "I am certain... that the surgeon who spends much time in thinking about his patient before and after operation will in the long run obtain better results than he who is satisfied mainly with brilliant surgical technique." It is almost as if surgeons of this era were prejudiced against attaching too much importance to technique. However, not all surgeons learned new techniques mainly "from the book". In the early years of the 20th century there were already those who were arguing that it was at least preferable to watch a new procedure performed before attempting it oneself. This often involved travelling, sometimes a very long way.

Travelling to Learn

80 For a recent example of learning curves in new urological techniques see: Cuschieri, "Whither minimal access surgery? Tribulations and expectations.," 9-19; de Costa, "Teaching gall bladder surgery: remembrance of things past, or defensive cholecystectomy revisited," 834-836; Hasan, Pozzi, and Hamilton, "New surgical procedures: can we minimise the learning curve?," 171-3.
82 Ibid., p. 619.
83 including Davidson, who acknowledged assistance from three Sydney urologists, Harry Harris, his brother Richard Harris and Bobby Silverton "all of whom were unsparing in their efforts to help me." Ibid., p. 619.
As Harry Collins and other sociologists of science have pointed out for scientific experiments, they are very hard, if not impossible, to replicate for those who just read written information about the experiment.\(^5\) Collins highlights the importance of detailed first hand knowledge of an experiment in order to successfully replicate it elsewhere. This would seem intuitively to be equally true for surgery, and it is therefore perhaps more surprising that procedures were attempted "from the book" than that surgeons travelled to learn. New surgical procedures are hard to learn by just reading published descriptions, especially when the procedure is in any way conceptually novel. The runaway success of Franklin Martin's "wet clinics", where he provided the opportunity to watch surgery performed, set in train the formation of the American College of Surgeons.\(^6\) By then, Harvey Cushing, William Mayo, George Crile and other elite American surgeons had already organised a surgical travelling club to watch surgeons at work around America, and subsequently also around Britain and Europe.\(^7\) The idea became popular and other surgical travelling clubs were formed in North America and Britain.\(^8\)

Travelling to learn was associated with a clear appreciation that not everything necessary for the successful performance of a procedure could be specified in a written text.\(^9\) As historian of science Mario Biagioli puts it: "the knowledge necessary for the successful replication travels with bodies and not only with texts."\(^9^0\) Similarly, David Turnbull argues that "a vital component of local knowledge is moved by people in their heads and hands."\(^9^1\) There was also a strong element of scepticism. Surgeons were disinclined to believe published results if

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they conflicted with their own experience.\textsuperscript{92} It may be suspected that some surgeons who had poor results from transurethral resection did not believe that it was possible to get good results from resection. Importantly, this may have contributed to their failure. To quote Biagioli again: "... it is not simply that an experiment is 'right' because it can be replicated, but it also becomes replicated by being accepted as 'right'... in a sense, one has to accept an experiment before one can reproduce it."\textsuperscript{93}

For urologists to persevere with the hard work of practising many hundreds of resections, they had to believe that their results would improve and that good results were attainable. Seeing is believing and in 1937 Melbourne urologist Henry Mortensen criticised a colleague who argued that transurethral resection produced bad results, because the colleague in question had only seen British and not American results:

I feel sorry that Dr. Campbell, whilst returning from his recent stay abroad, did not take the opportunity of obtaining first-hand information on this important subject by visiting the principal American urological centres, where resection is practised. There he would have had demonstrated to him more cases in one week than it was his privilege to see in his twelve months period at Saint Peter's. Then I am sure he would have refrained from suggesting that practically all urines sterile prior to resection become infected subsequently.\textsuperscript{94}

Similarly, in 1937 British urologist Walter Galbraith criticised a colleague who thought that the Harris prostatectomy produced poor results:

If your readers have not had an opportunity of seeing a plastic operation (Harris) performed by a surgeon experienced in the correct Harris technique and of noting the

\textsuperscript{92} Good published results were thus inherently suspect, while bad published results were not. In 1932, American urologist N. G. Alcock made public his poor results from early attempts at resection, and described the learning curve that he encountered. He described his first fifty resections as "extremely trying and somewhat discouraging," and his paper was subsequently much admired and cited by other urologists: N. G. Alcock, "Ten months experience with transurethral prostatic resection," Journal of Urology 28 (1932): 545-559.

\textsuperscript{93} Biagioli, "Tacit Knowledge, Courtliness, and the Scientist's Body.\textsuperscript{94} 69-81, p. 71. See also Steven Shapin, A Social History of Truth (Chicago: University of Chicago Press, 1994).

amazing wellbeing of the patient immediately following the operation and the smooth, comfortable, and speedy convalescence, then I ask them to take the earliest opportunity of doing so, and meantime I ask them to reserve judgement on Mr. Irwin’s statements.\textsuperscript{95}

Watching a procedure performed by others, especially if a significant amount of travelling was involved, took time and money, and there is an air of superiority in the statements of those who had done so, compared to those who had stayed home. In 1945 British urologist A. M. McMaster wrote:

\begin{quote}
To me the different approach to the perurethral method in this country and in America is most striking, for they are almost diametrically opposite. In the States very many surgeons, both experienced and inexperienced, are using the method… whereas in this country the surgeons using the method are few and far between… this is the more surprising when one has seen the excellent post-operative condition of the patient after the perurethral operation… also one cannot fail to be impressed by the vast improvement from the patient’s point of view in the freedom from pain…\textsuperscript{96}
\end{quote}

Both the quote from Mortensen and that from McMaster clearly imply that in order to see good results from resection, it was necessary to go to America, and the question therefore arises as to why British urologists were not getting good results. In 1940, American urologist Fred Foley argued that any general appraisal of such a technically difficult procedure as transurethral resection was impossible. Success varied with the "skill, ability and experience of the operators."\textsuperscript{97} He went on to outline the factors that he considered governed the development of the resectionist and determined his skill. "In the first place," he argued, "a liking for the procedure is essential. Without this the status of a resectionist will be about the same as the status of a musician who dislikes music."\textsuperscript{98} Foley argued that the main variable in the indications for transurethral resection was the skill of the resectionist. For the

\textsuperscript{95} Galbraith, "Prostatectomy by the Two-stage Method,": 472-3.
\textsuperscript{96} A. M. McMaster, "Prostatic Obstruction," \textit{British Medical Journal} II (1945): 864.
\textsuperscript{98} Ibid., p. 567.
competent, the operation was indicated in 80 to 95 per cent of cases of obstruction, whereas the incompetent should not perform the operation at all. He did not say how the requisite skill was to be acquired, although he did point out that in the past, the development of transurethral resection produced "poor results and a mortality that now seem shocking." Clearly, the procedure was developed (and improved) by many urologists practising on many patients.

Malcolm Earlam was in America in 1936 and went on to England early in 1937. In America, he found that transurethral resection was generally more popular among the younger urologists, and that it was more frequently adopted as a technique when the prostate was relatively small. For instance he noted that Frank Hinman "does not like the transurethral operation for large prostates but does quite a number for the smaller varieties," and that Fred Foley "says most of the opposition to resection comes from the older men. With every practicing urologist below the age of 45, there is absolutely no question of its wide application, value and permanency." 

In 1936, Louis M. Orr Jr. conducted a survey of selected members of the American Urological Association, chosen to represent all areas of the country. He found that they were performing nearly three times as many resections as open prostatectomies and that those who were performing the largest number of resections were the ones who were also getting the best results. However, more than half of those surveyed only advocated resection for small prostates. A number of urologists in both Britain and America also emphasised the advantages of transurethral resection during the depression. Mainly because of shorter stays in hospital, it was cheaper for the patient.

99 Ibid., p. 570.
100 M S S Earlam and J W S Laidley, Surgical diaries. Earlam, 5 November 1936.
101 Ibid., Earlam, 16 November 1936.
102 Orr, "Discussion,": 28-31.
In England, many surgeons tried the technique in the 1930s, but few remained enthusiastic for long. English urologist John Blandy opened his 1971 monograph on transurethral resection with a brief history of the technique. He notes that London urologists Canny Ryall, Terence Millin, Kenneth Walker and Ogier Ward all tried the technique but had been forced to more or less abandon it by the World War II. John Blandy, on the basis of information supplied by Terence Millin, places much of the blame on the unreliability of the diathermy equipment used in Britain. However, the views published by these urologists at the time give a rather different picture. Terence Millin at All Saints' Hospital, Kenneth Walker at St Paul's, Ogier Ward at St. Peter's and Eric Riches at the Middlesex Hospital all had lengthy experience of resection. The first three worked at the most influential urological centres in Britain, and St Peter's Hospital for Stone was especially important in its role of teaching future generations of urologists. What happened at these hospitals had a very important impact on the British view of resection.

Eric Riches was still advocating resection in 1941: "endoscopic resection undoubtedly has an important place in prostatic surgery..." In 1938, Ogier Ward also seems to have remained keen on the technique and published his own modification. However, the technique seems to have seldom been used at St. Peter's before then. Melbourne urologist Henry Mortensen, who had spent time training in both England and the United States, pointed out that St Peter's Hospital for Stone reported only eleven resections in 1936. Early in 1937, Malcolm Earlam noted that at St Peter's Hospital for Stone "The R.S.O. has not seen a single good result following resection!"

Kenneth Walker at St Paul's Hospital and Terence Millin at All Saints' had been among the pioneers of transurethral resection in Britain, but by 1937, both were tending to reduce the

105 Ibid., p. 8.
108 Ward, "Subvesical diathermy prostatectomy:" 175-76.
110 M S S Earlam and J W S Laidley, Surgical diaries. Earlam, February 1937
proportion of cases of prostatic obstruction where they thought it appropriate. Millin estimated that he was resecting about 32 per cent of his cases, and Walker was restricting the procedure to about 20 per cent of cases, mainly for small prostates and men who were otherwise poor operative risks. Neither mentioned any problems with their diathermy machines when explaining their change in attitude to resection. According to Millin:

I introduced the modern transurethral... prostatic resection operation into this country in September, 1930, and after an experience of more than 400 cases (largely municipal hospital patients) am satisfied that the functional results are not so satisfactory as enucleation for general enlargement of the gland...in 1932-3 I employed the endoscopic technique in approximately 90% of prostatic obstructions in hospital practice, but after careful follow-up of many cases have reached the above conclusion. The brilliant work, moreover, of the late S. Harry Harris has given urological surgeons a more exact method of securing haemostasis in the open surgery of the prostate....

Note the emphasis on the use of the procedure in hospital (as opposed to private) practice. Kenneth Walker made it plain that he was not opposed to transurethral resection, but he emphasised the common problems of haemorrhage and sepsis. He argued that in England the majority of urologists "have accepted perurethral resection as a valuable addition to our methods of treating the obstructing prostate", but that they used the technique in moderation - by which he meant in about one in five cases. In 1937, F. McG. Loughnane of All Saints' was advocating resection in 96 per cent of cases. Like Fred Foley, Loughnane strongly associated poor results with the skill of the individual urologist:

The operation... is not devoid of danger, and with increasing reports of catastrophes some of the early enthusiasm has waned. The catastrophes have been chiefly due to surgeons unskilled in cystoscopic and urethrosopic manipulations attempting the

112 Millin, "Treatment of Prostatic Obstruction,:" 243.
113 Walker, "Transurethral Resection of the Prostate, a Review of Fourteen Years' Work,:" 901-3, p. 903.
resection operation. Either they have resected too much and made an opening in the rectum, or too little, with the result that the complete operation has had to be done later. The operation is not one for the general surgeon unless he has special knowledge and practice... Injury to the bladder wall is due to lack of experience...\textsuperscript{115}

By the late 1930s, few English urologists (or general surgeons) shared Loughnane's enthusiasm for resection. As John Laidley noted in 1938: "Millin... does larger prostates by SP [suprapubic] method... Millin says that in London the resectoscope is being used by all and sundry & its reputation is not too good."\textsuperscript{116} The techniques of resection were never discussed in the pages of the \textit{British Journal of Urology} with anything even remotely approaching the frequency and enthusiasm of the debates in the \textit{Journal of Urology} and overall, by the late 1930s, few British urologists met Fred Foley's first prerequisite for success. They did not like the procedure of transurethral resection. In particular, there was no enthusiastic supporter of the technique at St Peter's Hospital for Stone in London. As this was the principal centre for training new young urologists from all over the Commonwealth, the absence of training in resection at St Peter's had a significant impact.

However, in Australia at least some urologists did like resection. In Melbourne, Henry Mortensen from St Vincent's Hospital is reputed to have "caught the next boat" when he heard of the good results being achieved at Ann Arbor, Michigan. Mortensen did his original training in urology at St Paul's in London, but he learned to resect from Reed Nesbit in Ann Arbor.\textsuperscript{117} In 1935 when members of the Sydney Urological Association entertained Clifford Morson, from St Peter's Hospital for Stone, at the Australia Club, they engaged in a lively discussion on the topic. The Minutes of the meeting note that:

\textsuperscript{115} Loughnane, "Endoscopic resection for enlarged prostate,": 244-254, p. 249.
\textsuperscript{116} M S S Earlam and J W S Laidley, Surgical diaries. Laidley 21 March 1938.
\textsuperscript{117} Wilde, \textit{Joined Across the Water, A History of the Urological Society of Australasia}, p. 37.
Transurethral resection of the prostate whether it be for adenomatous, fibrous or neoplastic types appears to be accepted as a justifiable and useful measure by most if not all of the Sydney urologists, yet Mr. Morson's views were otherwise.\textsuperscript{118}

Clearly most of the Australians did not share Morson's reservations about the value of transurethral resection, despite the fact that several of them had trained under Morson at St Peter's Hospital for Stone.\textsuperscript{119} Two years later, the same group of Sydney urologists founded the Urological Society of Australasia, a decade before any similar body was founded in Britain.\textsuperscript{120}

Those who "liked" the procedure of transurethral resection were the ones who practised it and if, like Earlam and Laidley, they were prepared to expend an enormous amount of time, money and effort, they could become experts in the technique. Travelling to learn could be an intense and exciting experience, and a great deal of unpublished and unpublishable information about surgery could be acquired. Quite early in his trip to the United States in 1936, Earlam called on C. D. Creevy, Professor of Surgery at the University of Minnesota. Earlam noted that Creevy spent only nine months of the year on urology and three months on general surgery.

He learnt cystoscopy at the Mayo and uses the Braasch... he does 90% of obstructions transurethrally. He thinks he may be doing too many, but is still carrying on. Has a 3-4% mortality, and has very poor material to work on. I believe this—I did a ward round with him and never saw such a collection of human wreckage in my life—he has done over 600 [transurethral resections], a good number of those twice... He uses his own instrument, really a McCarthy... He seemed to have no trouble in removing just what tissue he wanted to. Technically he is way ahead of you and me...Like Hinman and Foley he uses the retrograde telescope routinely and considers it indispensable. It does give a very nice view... At the end of the operation the

\textsuperscript{118} The phrase "if not all" is neatly crossed out in the original document. Archives of the Urological Society of Australasia: Minutes of a Meeting of the Sydney Urological Association at the Australian Club on Friday 6 September 1935, Held in the RACS Archives Melbourne.

\textsuperscript{119} Wilde, Joined Across the Water, A History of the Urological Society of Australasia.
irrigation was clear, absolutely, and he had a prostatic urethra like nothing I have ever produced in an adenomatous prostate... the entire circumference of the bladder neck and prostatic urethra was concave...\textsuperscript{121}

It is clear from Earlam's notes that Creevy allowed him to look through the telescope both before and after the operation and that some very effective teaching was going on. Earlam drew diagrams in his diary of the view of the urethra and bladder neck before and after the operation and appears to have raised his own expectations as to what it was possible to achieve. However, Earlam was not always impressed by what he saw. For instance, he seems to have had grave reservations about H. L. Kretschmer in Chicago, particularly about his clinical judgment. His comment for Laidley in the case of an operation on tuberculosis in the epididymis was "You or I would have left [the patient] severely alone." In a case of surgery for bladder cancer, Earlam noted:

After palpating the interior and incidentally smearing carcinomatous debris all over the wound, and possibly the peritoneal cavity which had been incidentally opened, Kretschmer debated for a while whether to do a total cystectomy or not\textsuperscript{122}

The overall impression from Earlam's diaries is of boundless enthusiasm for urology and a willingness to learn. "In times of change" quoted neurosurgeon J. C. Rich, "learners inherit the earth; while the learned find themselves beautifully equipped to deal with a world that no longer exists."\textsuperscript{123} On his travels, Earlam learned much about urology in general and transurethral resection in particular because he was prepared to go to a great deal of trouble to do so. He took a considerable amount of time away from his practice and spent a significant amount of money travelling to learn from British and American urologists. Although he was by no means uncritical of what he saw and heard, he was generally

\textsuperscript{121} M S S Earlam and J W S Laidley, Surgical diaries., Earlam, 17 November 1936.  
\textsuperscript{122} Ibid., Earlam, 24 November 1936.  
receptive to new ideas, particularly about technique. While he was less fond of multiple
exclamation marks, Laidley, too, clearly loved his work and was keen to learn.

It was Terence Millin in his Harley Street rooms who first told Laidley to go and see Reed
Nesbit in Ann Arbor. Reed Nesbit and Friedrich Wappler had come up with a modified
resectoscope with a trigger grip, which could be operated one handed. Meanwhile, John
Laidley was also working with Wappler, but on a child’s cystoscope. When in New York in
April 1938, he visited Wappler and they discussed the latest developments. Wappler told
him that a “visit to Reed Nesbit at Ann Arbor was absolutely necessary.” Two weeks later,
Laidley was in Ann Arbor.

After basing much on the hopes of enlightenment at Ann Arbor, my spirits became
lower as I approached the holy spot. Perhaps this was at least in part due to the fact
that we missed the railway connection in Detroit & spent from 8.30 a.m. to 12.32 p.m.
at a temperature of 90 in the shade, in the Pennsylvanian railway station whose
magnificence did not recompense me for the absence of my entire baggage, which
though checked through had missed the connection by more than I had. However the
darkest hour proverbially comes before the dawn, and I am now in the midst of a
clinic who have forgotten more about resection than we ever knew.

Laidley watched Nesbit operate, talked to him and to the other staff at the unit and made
notes on post operative care. For the benefit of Earlam back in Australia, Laidley described
the anaesthetic that Nesbit used, the position of the patient on the operating table and the
operation itself. The operating theatre does not seem to have been crowded, and Nesbit
appears to have allowed Laidley to get a close look at what was going on, besides discussing
what he was doing while he was doing it. Laidley would not actually have been able to see
what was happening at the cutting end of the resectoscope, but Nesbit allowed him to put
his finger in the rectum before and after the procedure, to feel the prostate. The great
advantage of the new resectoscope devised by Nesbit was that it could be worked with one
hand, allowing the urologist to put a finger in the rectum and push the prostate up towards

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124 M S S Earlam and J W S Laidley, Surgical diaries. Laidley, 21 March 1938.
125 Ibid., Laidley, 3 May 1938.
the cutting loop. "Full marks for every advance in technique", wrote Laidley. "The finger in the rectum is so obviously a help it is a wonder we have not tried it..."  

Laidley was also enthusiastic about the post-operative care. "The regular use of the Foley catheter and also of a combined irrigation drainage apparatus will do wonders for our cases. It takes the work away immediately from the wardsman... & puts it in the hands of a nurse who if even moderately intelligent can do far better with it than [the wardsman at the RPAH] or a resident could do the old way..." Laidley was able to watch Nesbit operate and talk to him at length, and he came away from Ann Arbor full of enthusiasm for the modified resection technique. He noted that "Nesbit gave me a copy of an article which has not yet been published. It puts all I have told you in a nutshell & it should be our bible. He has set my aims for resection on a far higher plane. So frequently in the past we have been satisfied with a measure of relief. Now he wants cure and so should we." Seeing was believing for those who were prepared to travel to learn.

Earlam and Laidley were not just interested in acquiring the technical details of new procedures. They were also very keen observers of the clinical judgment of British and American urologists, and the grounds on which they made the decision whether to operate and which operation to perform. Their notes allow glimpses of Earlam and Laidley's own values and how they assessed the men (they visited no female urologists in Britain or America) they observed. It emerges that they placed a higher value on character and clinical judgment than on technical skill, and in addition they valued enthusiasm and those urologists who were continually looking for ways to improve their results. The diaries also record problems encountered by urologists during one procedure, while commenting on technical skill from the same urologist during a different procedure. For instance, Laidley watched Reed Nesbit remove a stone from a ureter and noted: "He dug for some time into a deep dark hole and produced the ureter eventually - not impressive... He is apparently the

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126 Ibid., Laidley, 4 May 1938.
127 In the 1930s, inserting catheters for male patients was not considered suitable work for female nurses. Bedpans, catheters, etc. on the male wards were the responsibility of male wardsmen.
128 M S S Earlam and J W S Laidley, Surgical diaries., Laidley, 5 May 1938.
instrumentalist rather than the surgeon...” But clearly Laidley was enormously impressed with Nesbit's skills as a resectionist: "If Foley is considered a good resection merchant, then we are too. Actually none of us have even touched the fringe of good resection as demonstrated by Reed Nesbit.”

Fred Foley is another example of a urologist for whom both Earlam and Laidley clearly had a warm regard that had nothing to do with his level of technical competence. It seems rather to have been Foley's boundless enthusiasm for continually coming up with new procedures and new instruments to try and do things better that was so impressive. Earlam was also impressed with Vincent O'Conor in Chicago, praising his careful consideration of cases and conservative approach, but his comments on O'Connor's surgery produce a picture that is at first somewhat disconcerting to the lay reader. "He has had the same experience as we have, viz. Some of the resections he has been most pleased with have been followed by the world's worst results... while others that looked like the dog's dinner have turned out 100%."

It is clear from this and other entries in the diaries that the surgery that Earlam was watching was not about technically competent urologists producing reliable outcomes. On the contrary, it was about uncertainty and trial and error. The urologists that he admired seem to have been the ones who were always trying to do better (the learners), rather than the ones who thought they had the answers (the learned). Many of the operating theatres he visited seem to have been "messy worksites" where new knowledge was being produced; laboratories rather than workshops turning out standard products.

Overall, it is very clear that learning urology was a continuing process, rather than an event that ended with the granting of some certificate of competence, whether the FRACS or the FRCS or certification by the Board of Urology. Not all urologists were continually modifying their techniques in the light of results, but most were. Importantly, however, they were modifying their technique in the light of their own results, not in the light of results.

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130 M S S Earlam and J W S Laidley, Surgical diaries., Laidley, 4 May 1938.
131 Ibid., Laidley, 15 May 1938.
published by others. As has been shown above for Terence Millin and Kenneth Walker, new
techniques were tried and accepted or rejected on the basis of their own experience.
Christopher Lawrence and Judy Sadler have noted that physicians tended to privilege their
own clinical experience over scientific evidence, but for surgeons adopting new procedures,
there was no scientific evidence.134 There were no randomised controlled trials to assess
outcomes from surgery. Indeed, randomised trials on the efficacy of drugs did not begin
until the antibiotic revolution after World War II.135 Trials to provide evidence for the
efficacy or otherwise of surgical procedures have been much slower to develop and it is only
really since the work of Archie Cochrane and his supporters that there have been any
systematic efforts to collect statistical evidence for the practice of medicine.136 In that
context, in the 1930s surgeons could choose between believing the published results of
others, or believing their own results. Many chose the latter option.

This can be seen in the case of the major debate between urologists in the 1930s: which
operation to perform in cases of "prostatic obstruction". As has been shown above, in the

133 Turnbull's concept of the contingent assemblage of knowledge seems to fit what Earlam was seeing.
1930s the likelihood that a patient with "prostatic obstruction" would receive a transurethral resection varied with where he lived, the size of his prostate and the age of his urologist. At the time, both Fred Foley and Robert Day specifically argued that there were no absolute grounds for deciding which operation to use. On the contrary, a urologist should perform the operation that he was best at, or in the words of the 1930s, the operation which produced the best results "in his hands". If a patient received one of the open operations, which one varied according to rather different factors. Urologists seem to have harboured a preference for the procedure that they were taught in their initial training, thus "Johns Hopkins men" had a preference for perineal prostatectomy whilst those who trained at St Peter's Hospital for Stone were far more likely to prefer suprapubic prostatectomy, and Australians and New Zealanders favoured the Harris operation. Preference also varied, however, with results and Earlam and Laidley quote a number of instances where urologists changed their preference from one operation to another, based on personal experience of outcomes.

But if the patient with "prostatic obstruction" attended a teaching hospital, the operation he received might also be influenced by the senior urologist's views on training. In Montreal, for instance, David McKenzie had been trained in perineal prostatectomy, but changed to the suprapubic operation. However, Earlam noted that "He still does a few perineal prostatectomies for the edification of the student staff." McKenzie also seems to have sometimes gone against his own clinical judgment in the best management of prostate cancer. "He is not enamoured of Young's radical operation for Ca Prostate, but provided that he strikes a reasonably favourable case, does about one annually, again mostly for the benefit of the residents." Earlam noted a similar attitude from Edgar Burns in New Orleans: "On the public side he does perineals as well, partly to train the resident staff, and

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137 Day, "Endoscopic resection of the prostate, an analytical study,": 569-579; Foley, "The present status of transurethral resectionists, competent and otherwise,": 565-571.
138 Robert Day quoted Hugh Young as saying that "for the surgical relief of prostatic obstructions, each individual should employ that particular method which in his own hands gives the most satisfactory results." Day, "Endoscopic resection of the prostate, an analytical study,": 569-579, p. 571.
139 M S S Earlam and J W S Laidley, Surgical diaries., Earlam, 30 November 1936.
partly to maintain the facility in perineal surgery which is essential if one is going to do radical prostatectomy on the early malignancies, which he does.\textsuperscript{140}

There is no suggestion that Earlam was uncomfortable with the idea of a urologist performing an operation he considered to be sub-optimal on a public patient, in order to keep his hand in.

The Benefits of Passing on Transferable Skills

A surgeon whose name was attached to an instrument in widespread use achieved a certain immortality. The example of the Stern-McCarthy resectoscope illustrates how several people might be involved in the development without sharing the glory. But not all eponymous instruments were widely used or widely known. Laidley's child's cystoscope, for instance, did not become a Hoover or a Biro. However, his American contemporary Fred Foley invented a catheter with an inflatable balloon tip to keep it "indwelling" that made his name an everyday word in hospitals all over the globe. Many surgeons devised instruments and operations. It was good for their status and future careers if other people used their instruments and performed their operations. The most straightforward way to increase their circle of influence was through the training process, teaching registrars their way of doing things. If established surgeons wanted to come and watch them work, so much the better. They were likely to be both flattered and hospitable. In November 1937, for instance, Earlam called on Fred Foley without a letter of introduction:

Thinking it would be nice to watch him work on a Monday morning (if this were on) I phoned him from Minneapolis one Sunday. He said: "Sure, but why don't you come over for afternoon tea with myself and my wife." So I did, to find that "afternoon tea" was a combination of Scotch, rye and martinis. I tried to escape after this, but no, I must stay for supper. I tried again, but no, some friends were coming in for a rubber

\textsuperscript{140} Ibid., Earlam, 30 November 1948.
or two of bridge... Again I tried to escape, but no, I must stay the night. And so it came to pass. I saw him at work the next day, after which he released me, after taking me to lunch at his club.\textsuperscript{141}

Laidley and Earlam and many other Australasian urologists shared the culture of the growing specialty of urology with their counterparts in Britain and the United States and Canada. Whatever their differences, they spoke more or less the same language, had a comparable basic medical training, came from comparable social backgrounds, fought on the same side in two world wars, read many of the same journals, especially the \textit{Journal of Urology}, and shared a broad understanding of what a specialist urologist was, defining themselves against the general surgeons who should, it was agreed, leave surgery of the genitourinary system, especially in men, to them. They shared comparable standards of asepsis in their operating theatres and they generally used similar, or even identical, instruments and drugs to treat more or less the same range of conditions. Within this framework, developments in the field of urology could be adapted for use in places outside the locality where they originated.\textsuperscript{142} Urological knowledge was readily transportable from Britain and America to Australia within the shared culture of urology. This was the real context for Australasian surgical training in the 1930s. Little training was available in Australia or New Zealand, so young surgeons worked out their own training programs, often travelling to Britain and/or the United States to acquire the skills they could not learn at home.\textsuperscript{143}

\textsuperscript{141} Malcolm Earlam, letter to Dick Craven, 25.9.80. filed with Ibid.
\textsuperscript{142} For the concept of local knowledge and the conditions under which it may or may not be transportable, see Turnbull, \textit{Masons, Tricksters and Cartographers}, \textit{Comparative Studies in the Sociology of Scientific and Indigenous Knowledge}.
PART III

1949-1974: The Colonial Phase of Training Gives Way to an Independent National Training Program

7: Attracting surgeons to the FRACS

8: "I don't think you should do this operation until you've done ten of them"

9: Gifts and time
Introduction

In May 1968, a Joint Conference of Surgical Colleges was held in Melbourne.¹ The Joint Conference of the English, Edinburgh, Glasgow, Irish, Australasian, Canadian and South African colleges of surgeons first met in 1955. It was set up to discuss reciprocity in the Primary examinations for fellowship of the various colleges, but it normally met in Britain and the 1968 meeting was its first in Australia.² The system of examination for Fellowship of the RACS, and particularly the Primary, had been under review for some years, and the Joint Conference in Melbourne was preceded by a flurry of reports, as Council struggled to have an agreed policy on changes to the Primary in place before May 1968.³ In addition, in July 1969, members of the Neurosurgical Society of Australasia convened a seminar on specialist surgical training and accreditation, which was attended by representatives of the RACS and the various surgical specialties.⁴ This seminar was the tip of an iceberg of pressure from the various specialties for changes to the system of examination and training in the specialties. It followed a series of changes in English specialist surgical training and accreditation.⁵

These events were associated with an intense period of review of the whole process by which Australian surgeons were trained and accredited. Council of the RACS had already set up a subcommittee to collect comparative information on surgical training in Australasia and other English speaking areas of the world, and it was becoming apparent that there were a

¹ RACS Archives Melbourne: Minutes and Council Papers, Se 7, June 1968, Minutes of the Joint Conference of Surgical Colleges at the Royal Australasian College of Surgeons in Melbourne on 17th May, 1968.
² Minutes and Council Papers, History and Development of the Joint Conference, October 1967.
³ Minutes of the Executive and Council of the RACS in 1967 and 1968 are dominated by these issues. See, for example: Minutes and Council Papers. Primary Examination, February 1968.
⁴ Minutes and Council Papers, October 1969, Minutes of Seminar on Specialist Surgical Training and Accreditation 13 July 1969.
number of influential surgeons who wanted to see a greater role for the College in training, as well as accrediting, surgeons. As early as February 1968, Council passed a resolution advising the setting up of "organised training programmes in the hospitals of Australasia." In May of the same year it was noted that "there was general agreement with regard to training and the Final Examination that there could well be a gradual trend towards the North American system. The concept of 'training programmes' in the hospitals was strongly supported...". E. S. R. Hughes became Censor-in-Chief of the RACS and held the position until 1974. During that period, the College essentially reframed its role from acting principally as an examining body, (which also provided some teaching) to taking overall responsibility for coordinating Australasian surgical training. The College was also involved in joint discussions with the Royal Australasian College of Physicians, the Royal College of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners. Through the deliberations of the ad-hoc Combined Education Committee, they were able to present hospitals and governments with a united front on specialist medical training.

Since 1962, the RACS had been involved in running some courses offering teaching in the surgical sciences. These were short courses of didactic lectures, mainly run in the evenings, designed to help candidates prepare themselves for the Primary examinations of the College. But the lengthy business of acquiring practical hands-on experience in all aspects of surgery, including operative experience, had been left up to the individual trainees to sort out for themselves. During the 1950s and 1960s there was much talk of surgical apprenticeships, although, just as in the 1930s, what exactly that meant seems to have varied considerably by State and by hospital and will be discussed in more detail in chapter 8. However, in so far as

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9 Ad hoc Combined Education Committee, "Postgraduate Medical Training in Australia," Medical Journal of Australia 1 (1972): 534-538. This Committee was chaired by E. S. R. Hughes.
the phrase implies a direct one to one relationship between a master and an apprentice, with
the former taking responsibility for training the latter, surgical apprenticeship is a profoundly
misleading way of describing the process of acquiring surgical experience in Australia in the
1950s and 1960s. As had been the case in the 1930s and 1940s, with a few exceptions
aspiring surgeons were, as one put it, very much more like surgical journeymen, picking up
their tools and travelling from one master to another, gaining experience (and if they were
lucky, training) wherever they could.12

The reasons why this ad hoc training pattern came to an end are complex, and include
international as well as local factors. In addition, the first examinations under the new
system in March 1973 did not mark the end of a period of change, but the beginning. Since
then, the RACS has been involved in developing successively more structured training
programs, offering ever more detailed guidance to trainees.13 But during the period 1969-73,
the RACS effectively reinvented itself as a training, as well as an examining, body.
Importantly, it succeeded in obtaining cooperation from hospitals and governments, State
and Federal, while it put together the first generation of Australian surgical training
programs.14 There seems to have been virtually no resistance at the time, organised or
otherwise, to the RACS taking on this extraordinary degree of control over the production
of future Australian surgeons.15 The College was aware of potential for resistance from
hospital boards, and there were signs that some might be unhappy about outside
intervention in their rights to fill posts for junior medical staff as they saw fit. Consequently
the RACS, through the Ad hoc Combined Education Committee, set out to allay any such
fears. The 1972 report of the Committee noted: "The individual Colleges represented in this
report do not influence, nor have they sought to influence, hospital authorities in their

11 Committee, "Postgraduate Medical Training in Australia", p. 536.
12 Interview with Jeff Watson, 4 April 2002.
13 For the position at the beginning of the twenty-first century see: Richard West, "Building on Excellence,
15 On the contrary, in 1977, an editorial in the Medical Journal of Australia seemed almost to be lamenting
the fact that the RACS did not have even greater control over the number of surgeons in training: Editorial,
"Surgical manpower and the Royal Australasian College of Surgeons," Medical Journal of Australia 1
(1977): 727-728. For a clear outline of the role of the various clinical colleges in influencing medical
manpower see: R. L. Doherty, "Australian Medical Education and Workforce into the 21st Century: Report
of the Committee of Inquiry into Medical Education and Medical Workforce," (Canberra: Department of
appointment of particular individuals to their house staff". But in the event, in contrast to the position in the 1940s, cooperation from hospitals seems to have been fairly general, and the College and the various surgical specialty organisations did come to have a considerable influence over appointments to training posts. Hospitals which set up accredited training posts enjoyed a certain kudos and had the benefit of high-quality applicants.

The following three chapters examine the last two decades of ad hoc surgical training and experience in Australia. Hopefully, they throw some light on the circumstances surrounding the emergence of structured surgical training. Chapter 7 looks at the 1950s and 1960s from the perspective of the RACS. It highlights some of the ways in which Australasian surgeons followed the lead of their colleagues in England, including in the pattern of changes introduced in the early 1970s. Chapter 8 looks at the period from the registrars' point of view and examines when, where, how and under what circumstances surgical experience was acquired. Some of the dynamics of change in relationships between junior and senior hospital staff are outlined, in the context of wider changes in the nature of established authority in society as a whole. Chapter 9 examines the 1950s and 1960s from the point of view of the hospital. The changing nature of relationships between hospitals and their senior clinical staff is examined, and the shifts in thinking associated with the demise of the honorary system. The evolving interaction between hospitals, surgeons, patients and surgical training is also discussed, in the light of the concept of the gift.

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16 Committee, "Postgraduate Medical Training in Australia,": 534-538, p. 536.
7: Attracting surgeons to the FRACS

During the 1950s and 1960s, the RACS had considerable trouble persuading young surgeons in Australia (and New Zealand) to take its Fellowship.\(^\text{18}\) Most travelled to Britain and took the FRCS Eng, (or the FRCS Ed), and only a fraction of them then bothered to take the FRACS as well.\(^\text{19}\) This was particularly true outside the southern States. In 1963, only one Victorian surgeon in eight who had a senior surgical qualification did not have a FRACS (whether alone, or in conjunction with a British fellowship).\(^\text{20}\) But in New South Wales, Queensland and Western Australia more than one in three surgeons who held a senior surgical qualification did not have the FRACS, and most of those who had joined the Australasian College were in the older age groups. In 1955 it was noted that in Queensland, while 38 surgeons under the age of 50 had an FRCS Eng, only 17 had the FRACS.\(^\text{21}\) This chapter examines the struggles of the RACS to overcome this problem and argues that by and large it did so not by rejecting the Royal College of Surgeons of England, but by imitating it.


\(^{19}\) RACS Archives Melbourne: Minutes and Council Papers, Se 7, March 1964, List of Fellows of the Royal College of Surgeons resident in New South Wales but not Fellows of the Royal Australasian College of Surgeons; Reciprocal Fellows not being Fellows of Australasian College, Queensland; List of Adelaide graduates who hold an Overseas Fellowship only and who now reside in Australia; Western Australia Fellows of Other Colleges; Victoria - Royal College of Surgeons of England, Royal College of Surgeons, Edinburgh, Royal Faculty of Physicians and Surgeons of Glasgow, Royal College of Surgeons in Ireland; Reciprocal Fellows not being Fellows of Australasian College, Tasmania, 1963.

\(^{20}\) RACS Archives Melbourne: Register of Fellows of the Royal Australasian College of Surgeons, Se 21, 25 September 1926.-

Imitation is the Sincerest Form of Flattery

In 1967 in a much-cited article, George Basalla set up a three-phase model to describe the spread of western science around the world.22 In Basalla's phase 1, the non-western society or nation provides a resource for European science. Banks, for instance, collecting his specimens for return to Britain, is an example of this phase in Australia.23 Phase 2 encompasses "colonial science", a dependent science which looks elsewhere, particularly to the metropolis, for training, validation and assistance. Phase 3 marks the emergence of an independent scientific tradition or culture where scientists undertake most of their training at home and look to colleagues in their own country for validation of their work.

This model has been much criticised as simplistic and overgeneralised and in practice no country has been found to pass through Basalla's stages.24 For most countries as Rod Home and Sally Kohlstedt put it: "The converse of dependence has proved to be not independence but interdependence, not national science, but international science."25 Never the less, the model has proved fruitful in providing a framework for debate about the practice of Western European science outside of Western Europe.26

In this context, the broad concepts of dependent colonial science and independent national science are worth considering in relation to the development of surgical training in Australia. From 1946, Australian and New Zealand surgeons could sit for an examination in Australasia to qualify for the FRACS, but for many years most of them continued to travel to Britain to train and to take one of the British fellowships. In Basalla's terms, Australasian surgical training before the 1970s was "colonial" and heavily dependent on Britain. The Minutes of Council of the RACS for the period 1946 to 1973 are full of evidence of the close links between the Australasian College and the Royal College of Surgeons of England. For instance, a report from the Executive to Council in 1948 argued:

The possession of the English Fellowship by approximately two hundred Australian and New Zealand Surgeons constitutes a strong bond between England and these Dominions at a time when the Executive considers that it is vitally important that all such bonds should be preserved and, if possible, strengthened.

The following year, the president of the Royal College of Surgeons of England, Lord Webb-Johnson, suggested that "Australian surgeons visiting this country could sometimes be made members of the Court of Examiners during their stay over here." As Censor-in-Chief of the RACS, Henry Searby was keen to agree and argued: "This means that our examiners must be men who can take charge of any section of the examination as do the English Examiners." The sense of identification with the English college was probably never greater than in the late 1940s and early 1950s, and partly this reflects the increasing proportion of members of Council who held the FRCS England. Of the thirteen members of Council appointed in the 1920s, only five held the English Fellowship, while of the ten

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27 This is not to imply that the relationship was necessarily detrimental to Australasia. Donald Simpson, for instance, has argued strongly for mutual benefit from this trans-global pattern of training. Donald Simpson, "The Adelaide Medical School 1885-1914, A study of Anglo-Australian Synergies in Medical Education" (MD, University of Adelaide, 2000).
28 The Minutes are held in the Archives of the RACS in Melbourne and papers for Council are bound into the same volumes as the Minutes. During the 1950s and 1960s there was a rapid growth in the amount of paperwork associated with Council Meetings, but there is no consistent system of page numbering and the Minutes are not always in date order. In addition, sometimes it is not clear to which meeting a paper was presented: the one before it in the bound volume, or the one following.
members of Council appointed in the 1940s, seven held the FRCS England and one the FRCS Edinburgh. In the postwar era, most members of Council had been to England, studied there, and gone through the enormously difficult process of passing the Final for the FRCS in England. They shared a very important rite of passage with their English colleagues. Ties with the Edinburgh, Glasgow and Irish Colleges were also important but feature far less strongly in the debates in Council.

However, during the 1960s there was a subtle shift in the overall tone of the relationship between the English and Australasian Colleges. Whereas in the late 1940s, the attitude to English views bordered on the respectful, by the 1960s debate was more common. Although anything approaching open disagreement only appeared once, by the late 1960s the relationship had become one between independent-minded colleagues, albeit with a clear memory of the earlier somewhat hierarchical interaction. But as will be shown below, time and again throughout this period, the RACS specifically imitated the Royal College of Surgeons of England. Even in the late 1960s, when putting in place the changes that would bring about an independent training program in Australia, the RACS did so with direct reference to broadly analogous changes in Britain. However, by then it is not clear how much the changes were the result of similar pressures from members of the surgical specialties and how much a matter of direct imitation.

31 Ibid.
33 Such disparate authors as English journalist Michael Davie and Australian historian Stuart Ward have both recently identified Britain’s failed attempt to enter the Common Market in 1961 as marking a turning point in relations between Australia and Britain. Michael Davie, Anglo-Australian Attitudes (London: Martin Secker & Warburg, 2000); Stuart Ward, Australia and the British Embrace, The Demise of the Imperial Ideal (Melbourne: Melbourne University Press, 2001). The Minutes of Council of the RACS broadly support this timing for a shift in attitude.
34 The disagreement was over English moves to make the Fellowships fully reciprocal. This is an interesting story in its own right. From the minutes of the Royal College of Surgeons of England Committee on the Training of Surgeons, and the Minutes of Council of the RACS, it would appear that Julian Smith (President of the RACS 1962-64) may have misinterpreted the intentions of the English College. He thought their proposals would effectively downgrade the status of the FRACS: Minutes and Council Papers, 17 October 1962. However, far more information is required to clarify this issue, and the controversy lies outside the scope of this study. See, for instance: Ibid., “Royal College of Surgeons of England, Seventh Interim Report, dated 11th January 1962 of the Committee on the Training of Surgeons” and “Memorandum received from H. C. Barry on Postgraduate Surgical Training in England and Australia”. See also: Minutes of the Executive of the Royal Australasian College of Surgeons, passim 1962-63.
35 This issue is discussed in more detail below, and also in chapters 8 and 9.
In the early postwar years, in contrast, the copying of English patterns does seem to have been quite overt. This is clear in the case of the formation of the Faculty of Anaesthetists of the RACS, for instance. Harry Daly, who was President of the Australian Society of Anaesthetists in 1947, has argued that representations to the RACP and the RACS to set up a national qualification in anaesthesia were unsuccessful until after the formation of the Faculty of Anaesthetists of the Royal College of Surgeons of England.36 This was inaugurated on 21 March 1948 and following this example, Adelaide surgeons Ivan Jose (who replaced Sir Henry Newland on Council in 1946) and G. H. Burnell supported a similar move in Australasia.37 The faculty of Anaesthetists of the RACS was inaugurated on 5 August 1952.38 On both sides of the globe, the Faculties of Anaesthetists not only marked the increasing professionalisation of anaesthesia; they also brought significant numbers of women under the umbrella of the surgical colleges. While surgeons remained almost exclusively male until at least the 1970s, in the 1950s increasing numbers of women doctors began to work in operating theatres as anaesthetists. By 1961, 34 out of the 194 Fellows of the Faculty of Anaesthetists of the RACS were women (17.5%).39 In contrast, of the 1,411 surgeons admitted to the FRACS between its founding and 1960, only 12 were women.40

Another instance in which the pattern of change in Australia and New Zealand was a direct imitation of Britain is surgical education. In its efforts to persuade Australian and New Zealand surgeons to take the FRACS, in the 1960s the College began running courses for candidates for its Primary examination.41 By the 1950s, as has already been noted, the attempts to run courses for the Final examination at the Prince Henry Hospital, Sydney and

37 Ibid., p. 310.
40 Register of Fellows.
41 In his history of the RACS, Beasley agrees that the imitation of the English courses was deliberate and specific: Beasley, The Mantle of Surgery, The First Seventy-Five Years of the Royal Australasian College of Surgeons, pp. 133-135.
Prince Henry's Hospital, Melbourne had both failed. When the RACS returned to the idea of running courses in the early 1960s, the model was very different and it closely followed that developed by the Royal College of Surgeons in London.

The English College was already running courses in the basic sciences during the war years, and these continued despite the disruptions of the bombing.\(^4^2\) When the College was rebuilt after the blitz, it became a major teaching centre for students from all over the Commonwealth. In 1948, Lord Nuffield provided money to convert two houses next door to the College in Lincoln's Inn Fields into a postgraduate hostel with the grand name of the "Nuffield College of Surgical Sciences." Nuffield College took its first Commonwealth residents in 1949, although the full accommodation for 80 was not completed until 1957. Australasian surgeons (among others) were invited to contribute to the building costs.\(^4^3\)

In order to qualify for funding from the University Grants Committee, the Royal College of Surgeons, in conjunction with the British Postgraduate Medical Federation, set up the Institute of Basic Medical Sciences in 1950 and became affiliated with the University of London.\(^4^4\) The College had had a research facility at the Buckston Browne Farm since 1933 and from 1942 there was a Department of Ophthalmic Research at Lincoln's Inn Fields. Chairs in pathology and anatomy were endowed during the war and the first Professor of Anatomy was Frederic Wood Jones.\(^4^5\) The Departments of Anatomy, Physiology and Pathology were incorporated into the Institute of Basic Medical Sciences in 1950 and in 1959, following a major appeal for funds, the College began building new laboratories for

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\(^{4^3}\) Minutes and Council Papers, 5 December 1948.

\(^{4^4}\) Blandy and Lumley, eds., *The Royal College of Surgeons of England 200 Years of History at the Millennium*.


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anatomy, pathology, dental science and research in ophthalmology. Queen Elizabeth II opened the new facilities in 1962.\footnote{Blandy and Lumley, eds., \textit{The Royal College of Surgeons of England 200 Years of History at the Millennium}.} Although it explored the idea of a relationship with the University of Melbourne, the Royal Australasian College of Surgeons was never formally affiliated with a University in the way that the teaching and research of the English College was. However, in 1958 like the English College it set about raising money from Fellows so that it could expand.\footnote{Royal Australasian College of Surgeons, "Development Fund," \textit{Australian and New Zealand Journal of Surgery} 28 (1958).} In 1960 the RACS set up a National Appeal Committee.\footnote{Minutes and Council Papers, 17 October 1963.} A public appeal for funds was launched in October 1961 by Sir Harry Platt, ex President of the RCS England. The appeal raised £304,000, which was used to extend the College buildings and provide for teaching in the basic sciences.\footnote{Ibid., 15 March 1962; Rank, "Historical Summary," pp. 17-18.} Professor Gault was appointed as Curator of the College Museum in 1962 and also began planning a teaching program in the basic sciences. In December 1963, the RACS was recognised by the National Health and Medical Research Council as an approved research institute, without any need for formal university affiliation. The Department of Pathology was set up first, in 1962, followed by Anatomy in 1965 and Physiology in 1967.\footnote{Minutes and Council Papers, 23 February 1967. Rank, "Historical Summary," pp. 21-23.}

The Professors were responsible for running two or three short intensive courses per year in Melbourne, plus longer evening courses in the basic sciences, but essentially they always ran both the teaching and their research on a shoestring with virtually no support staff. However, the small-scale imitation of the English model was very clear. Unfortunately for the RACS, the geography of Australasia bears no resemblance to that of England and neither did Melbourne offer the attractions of London.\footnote{Chambers has challenged Blainey's concept of the "tyranny of distance" and prefers Bernard Smith's notion of "the myth of isolation": David Wade Chambers, "Does distance tyrannize science?," in \textit{International Science and National Scientific Identity, Australisa Between Britain and America}, ed. R. W. Home and Sally Gregory Kohlstedt (Dordrecht: Kluwer Academic Publishers, 1991). But Chambers' argument mainly concerns Australia's external relations. For relationships between the States, distance did matter, not in the absolute sense of kilometres but in the relative sense of kilometres multiplied by social, economic, family, cultural and intellectual ties. The capital cities of all the States had strong ties of this kind to Britain and in some instances these could be stronger than the ties they had to each other.} Queenslanders and Western Australians...
Attracting surgeons to the FRACS

seem to have been more prepared to travel to London to take the course there and sit for
the Primary than to travel to Melbourne.\textsuperscript{52}

\textit{Qualifying for the FRACS 1949-1972:}

\textbf{The Primary Examination}

The RACS followed the Royal College of Surgeons of England in many things but, apart
from a period in the early 1950s, it continued to constitute the FRACS as an "exit" exam, the
benchmark of a fully qualified surgeon at the end of training, while the FRCS England was
taken significantly earlier in the training process. Indeed, from 1948 the FRCS England was
a pre-requisite for candidates for some registrar and all senior registrar (training) posts in
surgery in England.\textsuperscript{53}

The Royal College of Surgeons of England's courses were attended by doctors from all over
the Commonwealth. Taking this course could substantially increase their chances of passing
the Primary exam. The other major attraction of Britain was that it also offered a large
number of short-term resident positions for registrars within the National Health Service.
The number of posts for consultant surgeons remained tightly limited. Young British
surgeons could remain as senior registrars for years waiting for a vacancy. Consequently, the
number of young British doctors opting for a surgical career did not match the relatively
large number of resident junior surgeons in training needed to staff the NHS. Broadly
speaking, young overseas doctors, including Australians, filled these short-term posts.\textsuperscript{54}

There were few career prospects for them in Britain, but this did not matter if they used
these junior positions to provide the experience they needed before they could take the

\textsuperscript{52} Fielding, "The Rise of the Royal Australasian College of Surgeons in Queensland".
\textsuperscript{53} Blandy and Lumley, eds., \textit{The Royal College of Surgeons of England 200 Years of History at the
Millennium}, p. 102.

\textsuperscript{54} Hedley Atkins, \textit{The Surgeon's Craft} (Manchester: Manchester University Press, 1965). This slim volume,
published when Atkins was Vice-President of the RCS England, describes the context for British surgery
in this era, including the workings of the National Health Service. Pp. 37-59 provide a good outline of
English surgical training and career structures in the 1960s. Atkins was President of the RCS England
1966-69.
Fellowship of the Royal College of Surgeons of England, (or Edinburgh, or Ireland or Glasgow), and then return to their country of origin.55

This colonial relationship between trainee surgeons and Britain was facilitated by the system of reciprocity in the Primary examinations across the Commonwealth. From 1948, the Australasian and English Primaries were fully reciprocal and from the early 1950s, there was also reciprocity with the Primaries conducted by the Irish, Edinburgh and Glasgow colleges.56 Consequently, the requirements for the Australasian examination closely followed the requirements for the Primary examinations of the British colleges. Australians and New Zealanders had been able to sit for the English Primary at home since 1934, but in 1949 the RACS conducted its own Primary for the first time, and a pass exempted candidates who wished to sit for the English Fellowship.57 It remained an exceedingly tough hurdle in the basic sciences and few candidates passed without taking a period of time off from their clinical studies. The examiners for the Primary were not surgeons. They were all academics in the relevant specialties of anatomy, physiology and surgical pathology.58

In 1955, a Joint Conference on Reciprocity of Primary Fellowship Examinations was held and proved to be a useful forum for broader discussions of matters of interest to the Royal surgical colleges.59 Consequently, the name was changed to the Joint Conference of Surgical Colleges. The RACS was entitled to send representatives to meetings of this body, but in fact did not do so on a systematic basis, although an appropriate observer was sometimes in Britain at the right time to attend. For instance, Benjamin Rank was at the meeting on 7 May 1965 and provides some evidence of the shift in attitude to the Royal College of Surgeons of England by that date. He noted how "tied up" the Royal Colleges of Britain and Ireland were with one another and wrote "how fortunate we are to have a certain line of independent thought and action."60 Council of the RACS received and debated minutes of the meetings

55 Heslop, "The History of Basic Surgical Science Examinations in the Royal Australasian College of Surgeons," 529-536.
56 Ibid., p. 532; Minutes and Council Papers, Memorandum for the Council concerning reciprocity in Primary examinations, 24 June 1948.
57 Ibid.
58 Minutes and Council Papers, S F Reid, Memorandum on the Examinations for the College, 1 June 1965.
59 Blandy and Lumley, eds., The Royal College of Surgeons of England 200 Years of History at the Millennium.
60 Minutes and Council Papers, 4 June 1965.
of the Joint Conference and in May 1968, at the instigation of Benjamin Rank (President of
the RACS at the time), a meeting of the Joint Conference was held in Melbourne.\textsuperscript{61}

One of the matters that continued to concern the Joint Conference of Surgical Colleges was
the low pass rate in the Primary examinations. With minor variations, this applied to all the
Colleges with reciprocal Primaries: the Royal College of Surgeons of England, the Royal
College of Surgeons in Ireland, the Royal College of Surgeons of Edinburgh, the Royal
College of Physicians and Surgeons of Glasgow and the RACS. There were also links with
the Royal College of Physicians and Surgeons of Canada, although it ceased to hold two part
examinations in 1945, and the College of Physicians, Surgeons and Gynaecologists of South
Africa. The pass rate in the Primary was generally around 25 per cent and in some years it
was significantly lower.\textsuperscript{62} In September 1958, for instance, only 16 out of 87 candidates
passed the Primaries held in Melbourne and Sydney.\textsuperscript{63} Year after year, many candidates
failed, even at their third and later attempts. The courses offered by the English College were
highly regarded and encouraged many commonwealth doctors to travel to London to sit for
their Primary, but for those who lived near one of the other centres where the Primary was
held, taking it at home remained a less expensive and popular option, even for those who
subsequently travelled to England to study for the Final.\textsuperscript{64} Something of the scale of the role
of England in Commonwealth surgical training can be gauged from the fact that in 1952, 20
per cent of candidates for the Final examination for the FRCS Eng (which, unlike the
Primary, was always held in London) had passed the Primary elsewhere but by 1960, this had
risen to 50 per cent.\textsuperscript{65} Besides Australia, New Zealand and South Africa, candidates came
from the Indian sub-continent and South East Asia.

In the 1930s, the Primary was sometimes taken by undergraduates, but from 1946 there was
a requirement for at least one year's postgraduate experience. Never the less, it could still in
theory be taken very early in a doctor's career. In practice, as has already been noted, a

\textsuperscript{61} Ibid., June 1968.
\textsuperscript{62} In the period 1958-63, the pass rates in the Primary averaged 25.1 per cent for the FRACS, 19.9 per cent
for the FRCS England, 29.4 per cent for the FRCS Edinburgh, 26.1 per cent for the FRCS Ireland and 25.8
per cent for the FRCS Glasgow. Ibid., 17 October 1963.
\textsuperscript{63} Ibid.
\textsuperscript{64} Ibid. 1962, for instance, the Royal College of Surgeons of England sent examiners for the Primary to
Lahore, Cairo, Khartoum, Colombo and Calcutta. Ibid., 15 March 1962.
significant period of full-time study in the basic sciences, especially anatomy, was needed. As early as March 1958 the RACS was organising courses for the Primary examinations that it conducted in Singapore, (initially under the Colombo Plan) and in 1960 it embarked on organised courses in Australia and New Zealand.  

Whether they chose to work as an anatomy demonstrator at one of the universities or to take a course in Australia or England, successful candidates for the Primary had almost invariably taken significant time away from clinical work. By the mid-1960s, in both Britain and Australasia, this was coming to be seen as an unsatisfactory interruption to surgical training. In September 1966, only 21 out of 81 candidates passed the Australian Primary, but even more disturbingly, only 12 out of 54 candidates passed at their first attempt. Passing the Primary was often a very time-consuming business, spread out over several years. The role of the Primary in discouraging and blocking candidates who were not likely to ever pass the Final continued to be valued, but by the mid-1960s the Primary examination as it stood was coming to be seen as having limited relevance for later training in surgery. The level of detail in anatomy, in particular, came to be regarded as both inappropriate for most surgeons and too academic. As a result, there were moves in both Britain and Australasia to significantly modify the exam.

In the process, in the late 1960s Council of the RACS began to realise that members of Council no longer valued reciprocity with Britain as much as they had a decade earlier. In 1965, S. F. Reid, Censor-in-Chief, argued that the existing Primary should be changed and described some aspects of it as "ridiculous", "judicious" and "silly". He argued that the RACS should go ahead and change the Primary to suit itself. Waiting for the other colleges

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66 A course for the Primary was held in Singapore in March 1958, attended by 40 candidates: Minutes and Council Papers, Se 7, 21 May 1958. From 1957 onwards, minutes of Council record the moves to hold examinations in Singapore and although the first was held under the auspices of the Colombo Plan, the 1959 Primary was not. Initially, candidates from other Asian countries travelled to Singapore to take the Primary, but exams were later held in other centres, including Hong Kong and Kuala Lumpur. Douglas Miller, A Surgeon's Story (Sydney: John Ferguson, 1985). Heslop, "The History of Basic Surgical Science Examinations in the Royal Australasian College of Surgeons,": 529-536. Courses were held in Sydney and Melbourne in 1960. Minutes and Council Papers, 19 February 1960.
67 Minutes and Council Papers, S F Reid, Memorandum on the Examinations for the College.
68 Minutes and Council Papers, October 1966.
69 Minutes and Council Papers, S F Reid, Memorandum on the Examinations for the College.
in order to maintain reciprocity should not be a priority, because "the College gains little, if
anything" from the reciprocal system of primaries.\textsuperscript{71} Candidates with the Australasian
Primary could take a British Final, but few candidates with a British Primary took the
Australasian Final. In essence, Reid argued that reciprocity contributed to the problems of
persuading all Australasian surgeons to take the FRACS.\textsuperscript{72} In 1968, Council of the RACS
even debated whether to abolish the Primary altogether and move to something more closely
resembling the Canadian examination. However, in the end Councillors voted to retain a
modified Primary.\textsuperscript{73} Following a wide range of changes, the Primary was renamed as the Part
I exam from 1973. Although the Part I exam was still criticised as being too difficult, pass
rates rose to about 40 per cent.\textsuperscript{74}

\textit{Qualifying for the FRACS 1949-1972:}
The Final Examinations, the RACS and the Surgical Specialties

From the beginning, the RACS included specialist surgeons. Among the 40 Founders,
eleven were listed as specialists in the Register of Fellows and between 1926 and 1946, one
out of every three surgeons enrolled on the Register of Fellows was a specialist of some
kind.\textsuperscript{75} But the Executive and Council of the College behaved as if general surgery was the
gold standard. Ad hoc arrangements were made to accommodate the various specialties as if
they were some sort of temporary inconvenience, rather than an integral part of the College.
In the early years, this "us and them" attitude was reinforced by the fact that the College was
effectively run by a small coterie of Melbourne general surgeons.\textsuperscript{76}

Unlike the position in the United States where certification of surgeons by the specialty
boards took place specialty by specialty, British and Australasian certification by the Royal

\textsuperscript{70} Ibid., pp. 1-3.
\textsuperscript{71} Ibid. Reid's paper includes a summary of training and examination in Canada and the United States.
\textsuperscript{72} Minutes and Council Papers, June 1965.
\textsuperscript{73} Ibid., 22-23 February 1968.
\textsuperscript{74} Heslop, "The History of Basic Surgical Science Examinations in the Royal Australasian College of
Surgeons," 529-536.
\textsuperscript{75} Register of Fellows.
\textsuperscript{76} With the exception of Kenny, who was an ophthalmologist, all the early members of the Executive were
general surgeons, including Hugh Devine and a succession of general surgeons from the Melbourne
Hospital: Syme, Newton, Hurley, Hailes and Searby.
Colleges was generalist.\textsuperscript{77} Hospital based consultants were divided into physicians and surgeons and had been since at least the middle of the nineteenth century. New specialties tended to develop under the umbrella of one or the other, often in the face of very considerable opposition from the general surgeons or general physicians.\textsuperscript{78} In 1946, when the RACS first proposed a system of holding its own examinations for fellowship, as opposed to recognising qualifications obtained elsewhere, the exam was offered in general surgery, otolaryngology, gynaecology and operative obstetrics, ophthalmology, orthopaedics and urology.\textsuperscript{79} This threatened to directly compete with the University of Sydney, which was offering its MS in otolaryngology, ophthalmology and obstetrics and gynaecology, as well as in general surgery.\textsuperscript{80} The University of Melbourne, in contrast, took the purist general surgical approach to its MS. It should be noted that by 1948, the Executive of the College was of the view that the MS should be a research qualification only.\textsuperscript{81}

The RACS had already admitted Fellows in all the above specialties under its old regulations. The largest specialist group were the obstetricians and gynaecologists (92 out of 787 Fellows admitted by 1946), but the formation of the Australian Regional Council of the Royal College of Obstetricians and Gynaecologists was already threatening to take members from the RACS.\textsuperscript{82} From one perspective, the story of the Royal Australasian College of Surgeons is the story of a fight against centrifugal forces, as over the years a number of specialties have either broken away from the College, or threatened to break away from the College and set


\textsuperscript{80} Minutes and Council Papers, September 1946.

\textsuperscript{81} The Executive argued that teaching hospitals should recognise the FRACS (and by implication not the MS) and the universities should "alter the pattern of the Mustership in Surgery in such a way as to convert it into an academic and research distinction to be awarded only to those who attain a high standard." Minutes and Council Papers, Memorandum for the Council concerning reciprocity in Primary examinations, 24 June 1948.

up on their own. By the 1950s, several of the surgical specialties had formed their own organisations. In addition, a number of specialties had set up organisations under the umbrella of the RACS, and this was the pattern preferred by the hierarchy. The Section of Thoracic surgery, for instance, was formed in 1950, and Plastic surgery in 1956. But the orthopaedic surgeons, urologists, ophthalmologists and neurosurgeons all had their own independent societies by 1949, and did not necessarily require a FRACS for full membership. In particular, the degree of MCh(Orth.) from the University of Liverpool was a widely recognised specialist qualification in orthopaedics. The first holder of the degree, E. B. Vance, was an Australian, and Sir Robert Jones and the Liverpool school of orthopaedic surgery had an important influence on the founders of the Australian Orthopaedic Association.

Attitudes to the specialties varied, but the hard line view among general surgeons was that all surgeons had to be qualified general surgeons first, and only then should they specialise in a particular branch of surgery. This view was particularly strongly represented in Melbourne, but it made little sense in the case of ophthalmology or otolaryngology and they were generally acknowledged to be special cases, perhaps not even strictly needing the detailed anatomical knowledge of the whole body that was required for the Primary. A number of

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83 In 1968, Ophthalmologists formed their own college, and in 2001, Orthopaedic surgeons were threatening to do the same. As has already been noted, the Faculty of Anaesthetists of the RACS was formed in 1952, but in 1992, the anaesthetists went their own way, setting up the Australia and New Zealand College of Anaesthetists.


85 Minutes and Council Papers, 2 December 1950.

86 See, for instance, Curtis, Miller, and Simpson, "The Neurosurgical Society of Australasia: The First Forty Years," 434-437. In its early years, the requirements for membership of the Neurosurgical Society of Australasia were a senior surgical qualification, adequate training in neurosurgery, and a neurosurgical appointment at a recognised hospital. There was no mention of a FRACS.


88 This was the pattern for many of the early specialists, including Albert Coates, L. C. E. Lendon and Douglas Miller, all founders of the Neurosurgical Society of Australasia. Curtis, Miller, and Simpson, "The Neurosurgical Society of Australasia: The First Forty Years," 434-437, p. 434.
Sydney surgeons, including Professor Dew and Douglas Miller, believed that the College should accommodate the specialties by providing some form of modified examination, and this view seems to have prevailed in 1946. However, many general surgeons were not kindly disposed towards accrediting specialists in other areas, and this view seems to have been even more strongly held in London than it was in Melbourne.

From 1948, the RCS England examined in ophthalmology and otolaryngology, but Lord Webb-Johnson in particular was against examining in orthopaedics, urology or gynaecology.\(^8^9\) When the RACS began conducting its own Final examinations in five specialties as well as general surgery, there was disapproval from London. In 1952, the Chairman of the Court of Examiners of the Royal College of Surgeons of England attended the Australasian Finals in Melbourne and expressed the view that the examinations in the specialties should be abolished.\(^9^0\) He did not even think the Fellowship should be offered in otolaryngology. The RACS set up a sub-committee to examine the issue and by December, Council had been persuaded to adopt the English position. Even Professor Dew, who had argued in favour of examining in the specialties, changed his mind.\(^9^1\) How far this was the result of a desire to stay in line with English wishes, and how far it represented the views of senior general surgeons in Melbourne and Adelaide is not clear, but at the end of 1952, Council proposed that the Final should be offered in general surgery and ophthalmology only. This provoked a storm of protest from the specialties and consequently, the Final was offered in the specialties (supposedly for the last time) in 1954.\(^9^2\)

Over the next 25 years, the requirements for Final examination for the FRACS were modified many times and the changes often ran counter to the wishes of the various specialty groups.\(^9^3\) The Final of the RCS Eng could be taken at the end of the third postgraduate year and it was always regarded as an entry qualification for the real business of surgical training: gaining supervised experience in a public hospital. The Australasian

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\(^8^9\) Minutes and Council Papers, 2 June 1951.
\(^9^0\) Ibid., 22 June 1952.
\(^9^1\) Ibid., 6 December 1952. By 1952, Councillors Lindon, Wilson and Dew were all opposed to specialist finals and Lindon argued that "this was the view of the RCS England": Ibid., 22 June 1952. See also: Beasley, The Mantle of Surgery, The First Seventy-Five Years of the Royal Australasian College of Surgeons, p. 86-89.
fellowship, in contrast, had been envisaged by Newton and Devine as an exit qualification, the mark of a fully qualified surgeon at the end of training.\textsuperscript{94} Originally, the Final FRACS examination could not be taken until at least five years after graduating in medicine, and one of those years had to be spent as a resident medical officer in an approved hospital. However, as has already been noted, most Australasian surgeons went to England to take the English fellowship. One of the reasons for this was that young surgeons did not wish to hang around for the extra two years before they could take the Australasian qualification, and so they set off for England.\textsuperscript{95} Consequently, the RACS began to reduce the qualifying period for the FRACS—to four years in 1949 and three years in 1950, but Australasian surgeons continued to travel to England for a fellowship. Meanwhile, the status of the FRACS was in danger of slipping. So in 1952, the three year period was tightened to include one year in a surgical post in an approved hospital, as well as one year as a resident medical officer, and in 1954 Council increased the qualifying period again, to four years.\textsuperscript{96}

By this stage, Douglas Miller had become a very important figure in the College and a number of changes had reduced the power of the Melbourne oligarchy.\textsuperscript{97} The "Sydney view" was gaining greater weight and it was helped by a solution put forward by Ivan Jose from South Australia. Jose was against allowing the specialists to be certified as surgeons unless they had first qualified in general surgery. He himself was principally a urologist, although he continued to practise some general surgery. (Hailes actually appointed him as an examiner in both in 1945.) In 1955, Jose proposed that the FRACS Final examination should be available in eight specialties, but only for those surgeons who already held the FRACS or a FRCS of England, Edinburgh or Ireland (which all by this stage had reciprocal Primary examinations with the FRACS). This proposal gained the influential support of Julian Ormond Smith, who by then was Censor-in-Chief.\textsuperscript{98} It also had the support of many specialist surgeons, who took the view that this would show that they were better qualified

\textsuperscript{93} Ibid.
\textsuperscript{94} Devine, "Fellowship of the Royal Australasian College of Surgeons,": 57-60.
\textsuperscript{95} RACS Archives Melbourne: Douglas Miller SB 65/25, Memorandum concerning Fellows of other Royal Colleges practicing in NSW and Queensland, c. 1952.
\textsuperscript{96} Minutes and Council Papers, 4 December 1954.
\textsuperscript{97} Fielding, "The Rise of the Royal Australasian College of Surgeons in Queensland".
than the general surgeons. The specialist finals offered surgical specialists a way of adding the FRACS to their FRCS, without facing the potential humiliation of the high failure rates of the Final in general surgery.

Therefore, in 1956 the RACS went back to offering the Final in a range of specialties, but only to those surgeons who already held a British fellowship. The 1956 Finals were the biggest ever, including two successful candidates in the first ever Final in plastic surgery. There were 107 successful candidates, 47 of them in the specialties, the largest number of new Fellows admitted in a single year since 1927. (There had only been 23 passes in 1955 and 33 in 1954.) But partially accommodating the specialties did not resolve the problem of the relative unpopularity of the FRACS. By 1961, there were nearly 500 surgeons working in Australia who held a fellowship of an overseas college, but not the FRACS. In 1962, therefore, the RACS attempted to coax specialists to take the FRACS without going to England first for a fellowship. The Final exam was offered in all the specialties to candidates who had passed one of the reciprocal Primaries. The Final in general surgery could be taken after four years and the Final in the specialties after five postgraduate years.

Many surgeons seem to have returned from England with a fellowship, but without the kind of experience that was considered necessary to sit for the Australasian Final. It was perfectly possible to be awarded a fellowship of one of the British colleges of surgeons without spending any time in a teaching hospital or a "good general or special hospital." In 1962 Benjamin Rank, who was the Censor-in-Chief at the time, even drew up a table to illustrate this, showing the experience of fellows of overseas colleges who failed the FRACS. It is

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99 In 1961, Eric Price submitted a report on orthopaedic training to the Australian Orthopaedic Association meeting in Surfers Paradise. This suggested that qualification for full membership of the AOA consist of the FRACS, or an equivalent qualification, plus two years experience and research in orthopaedics, in other words a qualification in general surgery, plus training in orthopaedics: Barry, *Orthopaedics in Australia, The History of the Australian Orthopaedic Association* p. 287.
102 Register of Fellows.
103 Minutes and Council Papers, 18 February 1961.
also clear from entries in the Minutes of Council that repeated failure by established surgeons who held a British fellowship was becoming an embarrassment.

We have recently failed a junior Honorary Surgeon at a Teaching Hospital in Sydney [wrote P. J. Kenny in 1966]. We very nearly passed the junior Honorary's Registrar! A year or two back, it took a great deal of talk at the Court of Examiners Meeting to stop an Associate Professor of Surgery in a NSW University being failed for the fourth time. He is a good surgeon and a poor examinee.

I fully agree with not giving our diploma to the overseas Fellow who is so dangerous as to be prepared to leave half an acute appendix in, because it was hard to get out, and with rebuffing the Registrar whose ability is proven defective, but I doubt if the purpose of our aim is to fail those practising surgeons who have not read up on Surgical Pathology, and are not quite aware of recent advances in treatment.106

But there were also many instances of failure by those who chose to stay in Australia and take the FRACS first. In 1957, Douglas Miller was President and he argued that the RACS should help those who wanted to train as surgeons. He argued that all candidates for the Primary should have a registrar post in mind, and if they did not, it "would be a proper task for the College to help them obtain such posts..." He further argued that the College should particularly help all those who passed the Primary. "We should nurse our Primary men into proper training posts..."107 Miller seems to have been well ahead of his time with this idea and only a few trainees in specialties such as orthopaedics were in any way "nursed" through a training system before the 1970s.

Pass rates in the Final were generally higher than in the Primary, but they were usually less than 50 per cent. However, pass rates in the Final in the specialties were generally higher than this. Some argued that this was because the specialist Finals covered less ground and were thus easier to pass. However, an additional explanation is that candidates in the specialties were generally better prepared and had more relevant experience. In 1949, Douglas Miller noted the particular atmosphere created by the specialist surgical societies.

107 Ibid., 20 August 1957.
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Describing the Australian Orthopaedic Association, the Urological Society of Australasia and the Neurosurgical Society of Australasia he wrote: "There is a certain family feeling and privacy in their meetings and the subject matter is, as it were, strictly domestic to their household." More than forty years later Rowan Webb, a general surgeon, noted the camaraderie within the specialty of urology and hoped to be accepted "as one of the extended family". His son, David Webb, had become a urologist. Those who were admitted to membership of one of the specialist societies "belonged" to a group that was much less anonymous than the RACS. This was especially true in the 1950s and 1960s when the number of specialists was small. There are some indications that this family feeling extended to specialty trainees who were "fostered" or "adopted" by more senior specialists.

In Australia, orthopaedic surgeons were the first to organise a national training scheme and there was at least a plan for training from 1962. The Australian Orthopaedic Association (AOA) saw its role as including acting as an advisor to orthopaedic trainees in planning their training, and liaising with hospitals in an attempt to set up rotating appointments for orthopaedic registrars. The argument was that no one hospital could provide the range of experience necessary for proper training, and registrars should ideally spend a period of time in two or more posts. In addition, the AOA believed that "Once a graduate is accepted by the AOA as a trainee it should give him considerable priority in application for designated posts." In other words, by the mid 1960s, orthopaedic trainees were already being "nurse[d]... into proper training posts." Interestingly, the orthopaedic surgeons specifically set up their training program in imitation of the American (rather than the British) model, advocating a four year training period after obtaining the Primary, one year of accident and emergency surgery, one year of elective orthopaedic surgery, one year in the orthopaedic department of a children's hospital and one year which could include research or work in another specialty.

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108 RACS Archives Melbourne: Douglas Miller to Professor Dew, SB 65/9, 14 July 1949.
112 Ibid. For the American influence after World War II, see also: H. D. D. Tyer, "The history of orthopaedic surgery at Royal Prince Alfred Hospital, Sydney," Australian and New Zealand Journal of
The AOA believed that orthopaedic surgeons should train as general surgeons first and then go on to specialist training and this was also the emerging pattern in England in the 1960s, as general surgeons reluctantly yielded territory to the specialists.\(^{113}\) The FRCS Eng in general surgery was taken before a three- or four-year period of training in one of the specialties. Those specialists who adopted this pattern argued that they needed more training than general surgeons. In Australia in a limited group of specialties—obstetrics and gynaecology, ophthalmology and otolaryngology—an independent route to training was becoming clearer by the late 1960s. (In 1968 the Ophthalmological Society of Australia gave way to the Australian College of Ophthalmologists.) But for orthopaedics, urology, neurosurgery, plastic surgery and the newer specialties such as cardiothoracic surgery, the route to training was through general surgery first.

By the 1960s, it was becoming increasingly difficult for general surgeons to behave as if the specialties were peripheral to the business of surgery. In most major hospitals, general surgeons were now outnumbered by specialists, and specialist departments were growing rapidly in number and size. At the Mater Misericordiae Hospitals in Brisbane, for instance, in 1932 there were eleven general surgeons at various levels of seniority and nine specialist surgeons (three ENT, three ophthalmologists, two orthopaedic surgeons and one urologist).\(^{114}\) In 1959, there were twenty-two general surgeons, but they were significantly outnumbered by the thirty-three specialists, including eight orthopaedic surgeons, eight ENT surgeons and three urologists.\(^{115}\)

The Mater Hospitals had a particularly important orthopaedic department, largely as a result of the strong personalities of Arthur Meehan and John Lahz in the early years of the Mater

\(^{113}\) Ibid.


Attracting surgeons to the FRACS

Children's Hospital. However, orthopaedic departments elsewhere also grew rapidly in the 1950s and 1960s. Melbourne orthopaedic surgeon, Kevin King, has noted how enthusiasm for new procedures varies over time. Some procedures, including a number of methods for the treatment of lower back pain, enjoyed a rapid rise in international popularity and then sank into disfavour. In contrast, other treatments such as the use of leg braces continued to be employed when the conditions such as poliomyelitis for which they were devised no longer existed. As King so wittily shows, the growth in the specialty of orthopaedics was by no means simply the result of the development of an increasing range of popular procedures. However, the availability of a growing range of antibiotics after World War II did make an increased scope for bone and joint surgery possible, and orthopaedics ceased to be principally about straightening children (as the name implies) and treating osteomyelitis, and became increasingly about hip, knee and spinal surgery.

The growth of orthopaedics as a specialty was also linked to the major twentieth-century epidemic of motor vehicle injuries. A number of other specialties also developed in association with this epidemic, including neurosurgery for head injuries, emergency medicine and trauma management. But in the 1960s in particular, as car ownership increased and accident rates rose, it was principally the orthopaedic surgeons who were kept busy with the rising number of emergency admissions. In 1974, a retrospective study of traffic injuries in Brisbane found an average of 62.5 injuries per month in 1963 and 142 injuries per month in

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118 Ibid., pp. 429-430.
120 Since the 1980s, all Australian trainee surgeons have received training in the early management of severe trauma (EMST). Ian Civil, "The history of the EMST course," Australian and New Zealand Journal of Surgery 69 (1999): 551-553.
121 Royal Melbourne Hospital, Annual Report, Statement of Accounts, List of Subscribers and Donors and Statistical Returns (Parkville 1968), p. 3.
1973.\(^{122}\) Over this period, the introduction of compulsory seat belts reduced the mortality and the severity of head and chest injuries, but did not affect the growth in the number of injuries to the spine and limbs.\(^{123}\)

In this period, it was the accident and emergency departments of hospitals that tended to be the focus of glamorisation on television, rather than elective surgery for varicose veins or gall bladder stones, and most general surgeons were also on the periphery of possibly the most glamorised surgery of all in the 1960s—organ transplants. Kidney transplants, for instance, attracted the attention of many outside surgery, including sociologists.\(^{124}\) They were team efforts involving a range of specialties, including immunologists and nephrologists, as well as general surgeons.\(^{125}\) By 1972 around the world there had been 202 heart transplants, 179 liver transplants and 11,589 kidney transplants, besides a smaller number of lung and pancreas transplants.\(^{126}\) Rejection problems remained severe and although kidney transplant patients were surviving for fairly long periods by the 1970s, in 1972 no other transplant patient had survived for longer than four and a half years.\(^{127}\)

By the mid-1960s, even British general surgeons had to accept that specialisation within surgery had come to stay and that they could not perform kidney transplants one day and neurosurgery the next. In 1966, the British colleges of surgeons set up Specialist Advisory Committees (SACs) in nine surgical specialties.\(^{128}\) Each SAC included representatives from the four surgical colleges, plus representatives from the relevant specialist association. The brief of the SACs was to ensure appropriate training for registrars in their specialty, and to keep an eye on the numbers needed to fill forecast vacancies in the NHS at consultant


\(^{123}\) Ibid., p.152.


\(^{128}\) Blandy and Lumley, eds., *The Royal College of Surgeons of England 200 Years of History at the Millennium*, p. 64.
level.\textsuperscript{129} There was also an overarching committee on higher surgical training. In 1968, this Joint Committee for Higher Surgical Training, consisting of representatives of the four surgical colleges, plus the Association of Professors of Surgery and various specialist surgical societies, produced a report on postgraduate surgical training.\textsuperscript{130} This formalised the criteria for the training needed between being awarded a Fellowship of one of the royal colleges and reaching consultant status. Certificates of Specialist Training were to be awarded at the satisfactory completion of this period, but without any further examination. These certificates would be awarded in general surgery, orthopaedics, urology, thoracic surgery, plastic surgery, ophthalmology, otolaryngology, paediatric surgery and neurological surgery.\textsuperscript{131} Effectively, in Britain general surgery became one of the specialties, and each specialty had its own training program, with varying requirements as to length and details of experience.

Earlier the same year, Council of the RACS advised setting up "organised training programmes in the hospitals of Australasia" with surgical supervisors in each of the hospitals concerned.\textsuperscript{132} Clearly, the RACS was moving towards more organised training programs before the publication of the British report. However, events in Britain may have accelerated the rate of change. On 13 July 1969, at the instigation of the Neurosurgical Society of Australasia, a seminar on specialist surgical training was held in Melbourne, attended by representatives of the various specialty societies.\textsuperscript{133} This seminar reinforced moves to change the Primary because, as one of the orthopaedic surgeons put it, the Primary wasted "the energies of the young at a critical period...". But most of the discussion centred around training and examining for the Final in the surgical specialties. D'Arcy Sutherland, a thoracic surgeon, repeatedly told the delegates to look at the English example, and with the British

\textsuperscript{129} Editorial, "Training Surgeons,": 401-2; Training, "Postgraduate Training in Surgery,:": 153-162.
\textsuperscript{130} Ibid.
\textsuperscript{131} Ibid., pp. 159-162.
\textsuperscript{132} Minutes and Council Papers, 22-23 February 1968.
\textsuperscript{133} There were three representatives of the Neurosurgical Society of Australasia (including the secretary to the seminar), two from the Otolaryngological Society of Australia, two from the AOA, two from the Plastic Surgery Section of the RACS, one urologist, two from the Australian College of Ophthalmology, one from the Paediatric Section of the RACS, two from the Section of Thoracic Surgery of the RACS and E. S. R. Hughes, the Censor-in-Chief of the College. Minutes of the Seminar on Specialist Surgical Training and Accreditation, 13 July 1969, Minutes and Council Papers, 29 October 1969.

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Joint Committee's report on postgraduate training in mind, Specialist Surgical Training Committees were set up by Council in February 1970.\textsuperscript{134}

Possibly the single most important move to emerge from this seminar was that henceforth, regional committees of the Specialist Surgical Training Committees were to recommend candidates for training positions to hospital managements. Resolution 8 of the seminar read "That regional program committees be formed, to recommend to hospital management committees on appointment to training positions."\textsuperscript{135} In other words, all the specialist groups, including general surgery, were beginning to sponsor their own trainees; in the words of Douglas Miller in 1957, to "nurse their Primary men into proper training posts." This move marked a significant departure from the British model. The report published in the \textit{Annals of Surgery} noted:

> It must be emphatically stated at the outset that the Joint Committee of the Colleges and Associations is not preparing to arrogate to itself the power either to direct trainees into specific posts or to usurp the right of appointing bodies to select their own candidates. Either of these things would be unthinkable.\textsuperscript{136}

However, in Australia, orthopaedic surgeons had been recommending candidates to training posts for some years, and the other specialties began to follow suit.\textsuperscript{137} Groups of surgeons, whether or not constituted as "regional program" or "regional training" committees had no power to make hospital appointments. But over time, for most hospitals in most specialties, training committees under the auspices of the RACS came to have a major voice in appointments to training posts accredited by the College.\textsuperscript{138}

\textsuperscript{134} Minutes and Council Papers, 19 October 1969, Minutes of the Seminar on Specialist Surgical Training and Accreditation, 13 July 1969.

\textsuperscript{135} Minutes of the Seminar on Specialist Surgical Training and Accreditation, 13 July 1969.


\textsuperscript{137} "There were considerable difficulties at first in persuading the executive officers of the hospitals and the Health Commission to approve orthopaedic registrar posts selected by the Board of Studies. However, when it became obvious that the Board was providing good candidates, the hospitals gradually acquiesced and were happy to accept the nominees of the Association." Barry, \textit{Orthopaedics in Australia. The History of the Australian Orthopaedic Association}, p. 287-288.

\textsuperscript{138} Hughes, "Surgical Training in Australia in 1977," : 731-733.
This changed attitude to trainees and the beginnings of a national training program was put together with new terminology. The Primary became the Part I exam and the Final the Part II.\textsuperscript{139} Two years were allotted for basic surgical training, and the Part I could be taken before the end of that period. Once embarked on advanced surgical training, an increasing proportion of trainees were appointed to accredited specialist posts and began to come under the wing of the group representing their chosen specialty. In 1971, the RACS published its first two-part \textit{Handbook on Surgical Training}. The introduction to Book 2 noted that "Training requires training posts."\textsuperscript{140} For the first time, these were listed by specialty for the benefit of candidates. There was also a list of "Supervisors of Surgical Training", one for each hospital with approved posts. Cardio-thoracic and paediatric surgery were added to the list of specialties, making nine, including general surgery. (Gynaecology had been dropped from the list). Each specialist group produced a syllabus for advanced training and the trainees could see what they needed to do in order to have a reasonable chance of passing the Part II. There was still a long way to go, but a coherent national training program in surgery was beginning to emerge.

The model of training that formed the basis for this program was of paid full-time work in a junior surgical post in a public hospital. This was also the model that emerged in both North America and Britain.\textsuperscript{141} We have become so accustomed to the concept of registrars (residents in the United States)—that is, junior doctors being paid while they gain experience and undergo specialty training—that it seems an obvious way to both staff hospitals and conduct advanced training. But in Australia before the 1950s it was not the obvious answer at all. On the contrary, as has been described in chapter 5, the founders of the RACS had a very different model of training in mind, and this continued to influence thinking within Council of the College until well into the 1950s.

\textsuperscript{139} Heslop, "The History of Basic Surgical Science Examinations in the Royal Australasian College of Surgeons," 529-536.
\textsuperscript{140} Royal Australasian College of Surgeons, \textit{Surgical Training, Committees, Co-ordinators, Supervisors and Approved Posts} (Melbourne: RACS, 1971).
Attracting surgeons to the FRACS

The "Melbourne model" of training, which dominated RACS policy on training for twenty years, was based on an apprenticeship in surgery. Importantly, what Council meant by an apprenticeship post at a public hospital was an unpaid, honorary appointment as assistant to one of the honorary surgeons to inpatients. The idea was that apprentices assist their chiefs in both their public (unpaid) and private (paid) work. It was not clear how they were supposed to support themselves in the interim. Some of them were awarded Gordon Craig Scholarships. Some received assist fees for their work on private patients. But many took part time jobs, whether as locums in general practice or as university tutors or lecturers to undergraduates. Being on the "honorary" side of the gulf that divided the honorary from the paid medical staff of the public hospital gave them status, and in theory this could help them build up their own private practice. But it was not clear to aspiring surgeons, or even hospitals, that placing surgical training within the "gift" component of the hospital economy was the best way to proceed. Unlike their paid (resident) colleagues, "Honorary" apprentice surgeons were not on call at all hours of the day and night.

In fact, by the late 1950s, the gift economy in hospitals was in retreat on many fronts. In England, it had been more or less replaced by the National Health Service and the honorary system no longer existed there. Consultants were paid on a sessional basis. Within Australia, the honorary system was also ceasing to be the dominant model for public hospitals. It no longer applied in Queensland and in the other States, public hospitals had long since ceased to rely on gifts for a significant proportion of their funding. In 1964, the Joint Advisory Committee of the clinical colleges called for sessional payment for work in public hospitals, and also wanted universities to pay clinical staff for undergraduate teaching in the hospitals. It was to be some time before these calls were answered, but it is clear that the demise of the honorary system was on the agenda from within the elite levels of the medical profession. The end of the honorary system is described in greater detail in chapter 9 below.

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142 Minutes and Council Papers, 10 June 1946.
143 Interview with "Bas", 8 November, 2001.
However, there was an alternative model for surgical training. In Sydney, the established model was to appoint trainee surgeons on the paid side of the honorary/paid divide.\textsuperscript{145} Generally, while trainees under the Melbourne model worked with both public and private patients, trainees under the Sydney model worked full-time with public patients. This pattern was complicated in the various surgical specialties, because the public/private mix of patients varied enormously. By 1969, for instance, most plastic surgery was done in private, while most neurosurgery was performed in public hospitals.\textsuperscript{147} Also, by the end of the 1960s, general surgeons were complaining about the shortage of "clinical material" for teaching in the public hospitals.\textsuperscript{148} Some argued that increasing affluence and wider insurance coverage (including government subsidised coverage) was leading to a greater proportion of general surgery in private, while others argued that general surgeons were losing patients to the specialties.\textsuperscript{149} Whatever the explanation, there was a widespread perception among general surgeons of a falling public hospital workload and consequent problems in providing sufficient public hospital experience for trainees.

While the "Melbourne model" of training dominated thinking on the Council of the RACS, this did not go unchallenged. As a part of a wider move objecting to Melbourne dominance of the College, on 17 August 1954, a General Meeting of Fellows called for registrar training, comparable to that of the British Registrar and American Resident. But Julian Smith (Honorary Surgeon to Inpatients at the Royal Melbourne Hospital) was Censor-in-Chief and he was opposed to the "surgical registrar type of appointment". Instead, he advocated an extension of the pattern of unpaid part-time associate assistant surgeons, as at the RMH.\textsuperscript{150} By the early 1960s, the terminology was changing, and Minutes of Council refer to "day-boy"

\textsuperscript{145} Minutes and Council Papers, 4 March 1964.
\textsuperscript{146} See the report of a conference in Sydney on 2 March 1955 on the training of specialists. It was noted that in New South Wales, full time training was preferred, while in Victoria associate surgeon type posts were preferred: Minutes and Council Papers, 25 June 1955.
\textsuperscript{147} Minutes and Council Papers, Minutes of the Seminar on Specialist Surgical Training and Accreditation, 13 July 1969.
\textsuperscript{148} Minutes of the Executive, Report on Specialist Surgical Training, 1970.
\textsuperscript{149} A drop in both in-patient and out-patient numbers at the Royal Melbourne Hospital was noted as early as 1959-60, and by 1966-67 this was clearly affecting undergraduate teaching. By 1969-70, the shortage of surgical patients, especially in outpatients, was leading to problems in providing sufficient postgraduate experience in surgery; Royal Melbourne Hospital, \textit{Annual Report, Statement of Accounts, List of Subscribers and Donors and Statistical Returns}, (Parkville 1970).
\textsuperscript{150} Minutes and Council Papers, 4 December 1954.
type of posts. The idea was that while registrars lived in the hospital, "day-boys" did not, although they might work there five and half days a week.  

However, it is clear that more and more hospitals were appointing registrars, as opposed to "day-boys." As early as 1948, Hugh Devine noted that trainee surgeons, by whatever name, were useful to the hospitals:

…the advent of this keen-minded extra surgical personnel was that operating theatre efficiency, clinical ward work, the experience of the hospital resident, undergraduate education, and the good of the patient all benefited not only from [the] service value of this additional staff, but also from the teaching that it demanded.  

In the United States in the same era the number of internships and residencies rose dramatically, purely on the initiative of the hospitals. In many cases, any training content was purely incidental. In Australia, while the supply of registrar positions never exceeded the demand in quite the same dramatic way as residencies in the United States, it was the staffing convenience of hospitals rather than the wishes of the RACS which determined the provision of posts. By 1964, one report to Council complained that "day-boy" posts were almost extinct. It suited hospitals to have low-paid trainee surgeons on call twenty four hours a day and while it may not have suited the trainees quite as well, there were advantages to being paid and provided with board and lodging.  

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151 See, for example: Minutes and Council Papers, Report on Royal Melbourne Hospital Surgical Training Scheme, 20 February 1959; Censor-in-Chief's report to Council, 17 October 1963; letter from College Secretary, R. A. Chapman, to hospital boards re: "Training posts for the Final Fellowship Examination for The Royal Australasian College of Surgeons," 25 June 1964.  
154 According to Rosemary Stevens, in 1953, 20 per cent of residents and interns were overseas graduates and 5,000 positions remained vacant. Ibid., p. 12.  
156 By 1957-58, the Royal Melbourne Hospital had 14 paid registrars of various kinds and was expanding quarters for its resident medical staff: Royal Melbourne Hospital, Annual Report, Statement of Accounts, List of Subscribers and Donors and Statistical Returns (Parkville 1958).
the "gift economy" model of training was more or less complete and the paid registrar model had triumphed.\textsuperscript{157}

\textsuperscript{157} In 1966-67, the Royal Melbourne Hospital expressed doubts about the future of the honorary system because of problems in attracting new young junior specialists. In 1969-70, clinical teachers were threatening to withdraw from the work if they were not paid and by 1970-71, the Hospital Committee of Management was arguing that honorary staff should give way to paid staff at the hospital, for both teaching and clinical work: Royal Melbourne Hospital, \textit{Annual Reports}. 

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"I don't think you should do this operation until you've done ten of them."

Practising surgery in the 1950s and 1960s

One of the frequent themes of the stories that surgeons tell when interviewed about their training in the 1950s and 1960s is that they obtained very limited hands-on operating experience in Australia. As one recalled: "When I was progressing through the Australian system, the main deficiency was practical hands-on training." Another said that in Melbourne's teaching hospitals it was "unlikely even an appendix would be done by an incompletely qualified individual," while a Brisbane surgeon said that "there isn't any doubt that in the 1950s and 1960s the overwhelming majority of cases were done by the consultants."

This chapter looks at what happened inside operating theatres in the 1950s and 1960s and asks questions about the power relationships between consultants and trainees. What were the implications for surgical training, and how and why did these power relationships change? In particular, why were trainees given so few opportunities to practise surgery in Australia (and New Zealand), compared to the experience that was open to them in England?

1 Joke current at the Royal Melbourne Hospital in the late 1950s and early 1960s. Interview with "Bas", 8 November 2001. This chapter is based on interviews with surgeons who trained in the 1950s and 1960s at either the Royal Melbourne Hospital in Melbourne or the Princess Alexandra Hospital in Brisbane.
3 Interview with "Bas", 8 November 2001.
Why were Australian Trainee Surgeons Given so Few Opportunities to Practice?

The simplest answer to this question is that not all senior surgeons thought that training was any part of their business.\(^4\) This was not altered by the fact that some hospitals had paid positions for junior surgical staff. In contrast to the ideas prevailing since the 1970s, in the 1950s and 1960s, such "registrar" posts were not often designed mainly to assist junior surgeons with their training.\(^5\) They were service positions, set up principally to help the hospital get through its workload.\(^6\)

There are three main roles that trainee surgeons may take in the operating theatre: assisting and watching a senior surgeon; operating themselves with the assistance of an experienced surgeon; and performing surgery alone. By the 1970s it was believed that ideally, trainees performed these roles in succession with each new surgical procedure that they learned.\(^8\) In Melbourne and Adelaide, the "Associate Assistant" type of apprentices typically had an honorary appointment at a public hospital and assisted their chief in his private practice.\(^9\) They were generally allowed to perform a wider range of surgery in the public hospital than the paid registrar type of "apprentices", but neither model of surgical training incorporated a commitment of much time by the senior surgeon to assisting when the trainee was

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\(^4\) Interview with Neville Davis, 11 July 2002.

\(^5\) One of the surgeons interviewed disagreed with the basic proposition behind this chapter. He argued that senior surgeons did give priority to training and that the training in Australia was good by the standards of the time. Further, he argued that surgeons went to England because of the cultural cringe, rather than because of any problems with their training in Australia. Interview with "Hunter", 26 November, 2001. It is certainly true that a significant group of surgeons at the Royal Melbourne Hospital, in their role as members of the Executive of the RACS, devoted an enormous amount of their time and energy over many years to the issue of training, and that was in addition to any training they provided themselves. Members of Council from elsewhere in Australia also spent considerable energy on the problems of training. Training and examinations dominated the business of the Executive and Council in the 1950s and 1960s. See above, chapter 7. But there is no evidence that the issue was similarly important to the many Australian surgeons (especially outside Melbourne) who were not Fellows of the RACS, for instance, or to Fellows who paid their annual subscriptions but took no other part in College affairs.


\(^7\) For the perennial conflicts between the demands of "training" and "service" positions in the United States see: Kenneth M. Ludmerer, *Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999), pp. 180-195.


performing surgery. Trainees mainly gained experience watching and assisting their seniors. Most performed some emergency surgery alone, especially at night. "You were taught by a registrar older than yourself with emergency surgery."  

There was an enormous amount of cutting here to do... but only a limited amount was given to the juniors... enormous lists, no overtime, you worked until the work was finished—tough on the nurses. As you got better you were allocated lesser surgery, usually unsupervised—hernias, piles, varicose veins, removal of simple lumps, might even do a gall bladder... amputations in orthopaedics... there was a time constraint. Registrars are slower...  

But senior surgeons did not often take any steps to train young doctors by assisting them to perform elective surgery. As one Brisbane surgeon put it: "They'd let you do operations, but they wouldn't assist you."  

The context for this pattern of behaviour is that, generally speaking, surgeons like to operate. Douglas Miller argued that he became interested in surgery while an undergraduate: "It was all very exciting, and I found myself fascinated by surgical technique and enjoying the drama of it all". One surgeon said that he enjoyed surgery: "I enjoyed the doing". Another argued that surgeons are happy when they are performing surgery and feel that they are...

10 In the recent history of the Royal College of Surgeons of England, it was argued that during World War II: "A new concept crept in... that surgical skills could be taught practically, not merely by holding a retractor." The idea of hands on skills training for surgeons supposedly followed the training developed for RAF Spitfire pilots. This may be the case, but it does not seem to have followed that many surgeons thought that they ought to be involved in providing this kind of training. John Blandy and John S. P. Lumley, eds., The Royal College of Surgeons of England 200 Years of History at the Millennium (London: The Royal College of Surgeons of England and Blackwell Science, 2000), p. 45. Of the immediate post-war period, Rowan Nicks wrote: "In those days of apprentice training little encouragement was given to personal supervised training of assistants." Rowan Nicks, The Dance of Life. The Life and Times of an Antipodean Surgeon (Melbourne: Royal Australasian College of Surgeons, 1996), p. 55.  
11 Interview with George Fielding, 17 July 2002.  
12 Interview with "Mozart", 11 July 2002.  
14 Interview with John Herron, 23 July 2002.  
15 Douglas Miller, A Surgeon's Story (Sydney: John Ferguson, 1985), p. 18.  
16 Interview with "Dormouse", 26 October 2001.
doing good.\textsuperscript{17} A third also highlighted the enjoyment that he got out of operating.\textsuperscript{18} As Douglas Miller noted, surgery can be exciting. In the North American context, Joan Cassell quoted one surgeon who reported that his pulse rose from 70 to 135 while he was operating.\textsuperscript{19} In addition, surgeons often have reservations about the competence of their colleagues. One Brisbane surgeon argued that:

\ldots as you know, surgeons had a god complex\ldots less so now [but in the 1950s and 1960s] the consultant really felt that he was the only person who could do [the operation]\ldots every surgeon thinks he's better than the next person\ldots The reputation of a hospital depended on the surgical results and they were very jealous of their results.\textsuperscript{20}

At the Royal Melbourne Hospital, registrars usually rotated through a range of surgical specialties, spending three or four months in each. One surgeon outlined how none of the senior surgeons in these units allowed him any hands-on experience:

[In thoracic surgery] it was conventional for registrars if they really took the boss's eye to do one thoracotomy—to open the chest on one occasion. I never quite got to do that. I did very little [in plastic surgery. The boss] didn't have a high opinion of my skills. The thoracic surgeon\ldots did, but he just felt scared about anybody but himself operating, and the neurosurgeon—well, I wasn't up to any neurosurgery much—it was purely assisting.\textsuperscript{21}

For many years, it has been acknowledged that the task of supervising trainee surgeons requires enormous patience and self-restraint: "\ldots it is necessary for the senior surgeon to be unselfish and to be willing to depute work to his juniors in order to assist and encourage them" wrote a senior Sydney surgeon in 1934.\textsuperscript{22} One recent American text book on surgical

\begin{threeparttable}
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\textsuperscript{17} Interview with George Fielding, 17 July 2002.  \\
\textsuperscript{18} Interview with John Herron, 23 July 2002.  \\
\textsuperscript{20} Interview with Neville Davis, 11 July 2002.  \\
\textsuperscript{21} Interview with "Bemoulli", 12 November 2001.  \\
\textsuperscript{22} R. B. Wade, "Surgical training," \textit{Australian and New Zealand Journal of Surgery} 3 (1934).  \\
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ethics suggested that supervising surgeons should be paid extra for the task. The supervisor is "there both to teach the resident and to protect the patient. This supervising role often takes a great deal more skill, emotional toll, and effort than would be expended by simply performing the procedure oneself."23 Few senior Australian surgeons of the 1950s and 1960s, it seems, had the patience to let trainees perform many operations themselves. Trainees, generally speaking, operate very much more slowly than experienced surgeons. As has already been noted, in Brisbane in the 1950s and 1960s they had very long operating lists and often did not finish until nine o'clock at night. "If you gave a gastrectomy to the registrar, you'd be there till 11 p.m."24 Another agreed. "It was a matter of getting through the list... a factory situation... we had a lot of work to do and got on and did it, rather than being delayed by slow operators."25 Or as a Melbourne surgeon put it: "Julian Smith would take an abdominal resection fast. He wasn't going to wait around while I did it."26

However, trainee surgeons wanted to operate and they wanted to take on the more difficult and interesting cases, not just the routine appendicectomies and hernia repairs that their chiefs allowed them to perform in Australia. Although there was no agreement as to the exact framework within which experience should be acquired, it was widely accepted that trainee surgeons had to practise.27 Surgical skills were learned by imitation and repetition. Surgeons argued that you couldn't learn their craft by just reading books and articles, or as Charles Bosk noted, surgery is a body contact sport.28 Even the most basic act of cutting the skin has to be learned through practice. As one surgeon put it "you don't know how hard to push."29 Another recalled his anxiety as a young surgeon:

I remember quite vividly being very apprehensive when going in to operate... almost praying that I'd be able to cope with it... you wonder if you're good enough to cope...

23 Interview with Neville Davis, 11 July 2002.
24 Interview with Jeff Watson, 4 April 2002.
26 See chapter 7 for the debates over the apprenticeship model (favoured in Melbourne and Adelaide) and something closer to the American residency model, favoured in Sydney.
28 Interview with "Mozart", 11 July 2002.
that apprehension decreases with experience... you know what you can do; you know what has to be done...\footnote{10}

Recently, there have been moves towards teaching surgical trainees at least some basic skills such as suturing in surgical skills laboratories.\footnote{11} But in Australia in the 1950s and 1960s, the only place where trainees could practise was on a patient, generally a public hospital patient.\footnote{32} The consequence of this was an inherent potential for tension between trainees and consultants. Trainees wanted to practise (under supervision) and consultants found it easier and less stressful to do the surgery themselves. The problem for the trainees was that the consultants controlled access to surgical experience and, especially, to supervised elective surgical experience. This is the context for another important theme of the stories which surgeons tell of their own training in this era: the theme of the power of the consultant.

The Power of the Consultant

In interviews with surgeons who trained in the 1950s and 1960s there are repeated references to hierarchies, and the authoritarian style of their superiors. Part of this may be explained by analogy with the phenomenon that the world looks big when you are young and small. No current registrars were interviewed for this study but they, too, might regard their superiors as authoritarian. Nevertheless, an important component of the "story" of surgical training in the 1950s and 1960s, as told by those who went through it, is that many

\footnote{10} Interview with Neville Davis, 11 July 2002.  
\footnote{32} Other possible places to practise are on animals and on cadavers. In Australia, practising surgical techniques on animals seems to have been more or less confined to research, that is, established surgeons practicing new techniques, rather than trainees practicing established techniques. See Nicks, \textit{The Dance of Life. The Life and Times of an Antipodean Surgeon}. Use of cadavers for this purpose seems to have been even more limited.
I don't think you should do this operation ...

senior surgeons then acted in a more autocratic and arrogant manner than senior surgeons now.

I've seen [a senior surgeon] walk down the corridor and some poor cleaner have a bucket in the middle of the floor which he'd deftly pick up with his foot and toss the full length of the corridor—dreadful things—you couldn't do them now. You'd be up in front of the management.33

This was at a time when surgery as a profession enjoyed a very high level of prestige. For instance, a 1972 Australian study found that surgery was considered to be the most prestigious medical specialty by a large proportion of both male and female doctors.34 There is also evidence that surgery enjoyed considerable prestige in Britain and America during the 1960s.35 It is not clear that medicine as a whole has enjoyed such prestige since the 1960s.36 The work of Thomas McKeown, for instance, shifted thinking on how much difference western medicine had made to health, by pointing out that the fall in death rates in Britain in the nineteenth century preceded any medical therapeutic capacity to significantly influence mortality.37 In addition, the work of Ivan Illich highlighted the potential of western medicine for doing actual harm.38 But within medicine, surgery remained a relatively prestigious specialty, and there were no major signs of any drop in its status as an occupation in the early 1970s.

However, it should not be assumed that in the 1950s and 1960s all surgeons behaved in an arrogant manner and threw tantrums in the operating theatre. Many surgeons tell stories of seniors whom they admired, who they thought were fine men and fine surgeons and who

helped them with their careers. While those who trained in the 1950s and 1960s show no particular tendency to place their bosses on a pedestal, and on the contrary, tell many stories about their weaknesses, they do tell stories of the skill of some of the surgeons of that era. Of the senior general surgeons at the Royal Melbourne Hospital, one said:

Grayton Brown was very good. E. S. R. Hughes was slower, but methodical and very meticulous and good. The best of them all was Graham McKenzie who was just wonderful with his hands.\textsuperscript{39}

Praise for the skills of the senior surgeons at the Princess Alexandra Hospital in Brisbane was also not infrequent. One surgeon thought that Sir Evan Thomson was possibly the best surgeon, technically, that he had ever seen anywhere, while Sir Clarence Leggett combined technical skills that were almost as good with great personal charm in dealing with patients.\textsuperscript{40}

But there is no doubt that some surgeons of the 1950s and 1960s did, at least sometimes, behave like primadonnas and get away with it. It was said of Sir Evan Thomson that because of his behaviour and skills, he was known as "god" at the major private hospital in town.\textsuperscript{41}

There are also a number of stories about arrangements within hospitals which supported authoritarian behaviour by consultants. For instance, at the Royal Melbourne Hospital there were separate dining rooms for honorary medical staff, paid medical staff and nurses. Within each of these dining rooms, there were further subdivisions. In the dining room for paid medical staff, for instance, the medical superintendent, registrars, senior residents and junior residents each had their place. "Junior residents never went to that [table]... we were below the salt."\textsuperscript{42} For the non-clinical staff, their place in the hospital was particularly clear. They had a cafeteria on the floor below and, unlike the clinical staff, they had to pay for their meals.

Senior surgeons were able to use their power, should they so desire, to influence many aspects of the careers of those who wished to become surgeons. Training positions were in

\textsuperscript{39} Interview with "Bernoulli", 12 November 2001.
\textsuperscript{40} Interview with John Herron, 23 July 2002.
\textsuperscript{41} Ibid.
\textsuperscript{42} Interview with "Dormouse", 26 October 2001.
short supply and senior surgeons could have a major impact on who got such positions. Senior surgeons also had a considerable degree of control over how much teaching they provided in the wards, in out-patients clinics and in the operating theatre. They could also use their contacts and influence to help aspiring surgeons to get prestigious training positions overseas and to help them to get teaching hospital jobs when they returned to Australia.

In theory, the training ladder for those wishing to specialise in surgery began with two years as resident medical officer at an approved hospital, immediately after finishing medical school. Generally, residents rotated through three or six month terms, gaining experience in various aspects of medicine as well as surgery. From the mid-1950s, resident medical officer positions were usually available for all who wanted them, but not necessarily at the most prestigious hospitals. Two years as a resident was ideally followed by two or three years as a registrar in surgery, rotating through a range of surgical positions, including, for instance, terms in orthopaedics and plastic surgery as well as experience in general surgery, (or a period as an Associate to a senior surgeon). These posts were not always filled by people who went on to become surgeons, and consultants were more likely to take the time to help trainees who showed evidence of being serious about a surgical career. In particular, young doctors who had passed the Primary tended to receive more help with their training.

Evidence is anecdotal, but while specialty training posts in some hospitals may have been hard to fill, competition for training posts in general surgery at the Royal Melbourne Hospital seems to have been significant. Job titles in hospital annual reports are not a reliable guide to the availability of training positions. In the 1950s, for instance, the Brisbane General Hospital instituted three positions for registrars in general surgery and one in orthopaedics that were, supposedly, training posts. But there were very few other training positions for aspiring surgeons in Brisbane. Those posts that did exist for "registrars" were either for "hospital registrars" (i.e. service positions) or for the so-called "teaching registrars"

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44 Interview with George Fielding, 17 July 2002.
who carried considerable responsibility for university undergraduate teaching. In 1959 there was only one position for a general surgical registrar at the Mater Misericordiae Hospital in Brisbane, (one of Brisbane's three main teaching hospitals at the time), plus a position for an orthopaedic registrar, and it is not clear that either post was a true training position. Training opportunities in Brisbane increased when the Princess Alexandra Hospital opened in 1956, but it had only two general surgical units and initially only two openings for aspiring general surgeons, although this was later increased to four. Training positions were also in short supply in Sydney. The first surgical registrar at St Vincent's Hospital in Sydney, for instance, was not appointed until 1954.

As has already been noted, in the United States and Britain in the 1950s, there were so many registrar and residency positions that they could not be filled from local applicants and as a consequence, large numbers of overseas doctors were appointed to these positions. But in Australia overall, there does not seem to have been any comparable surplus of surgical registrar positions, at least at the prestigious teaching hospitals. On the contrary, access to these positions was always competitive. One surgeon, who was a surgical registrar at the Royal Melbourne in the early 1960s, described how he succeeded in being appointed to the position he wanted:

My residency saw me working with Julian Smith... because I was always able to present—as a secretary, not as a doctor—the material that they needed to know—what's this patient's haemoglobin? What tests have they had? And I was a fairly well

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52 Ludmerer, Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care, pp. 180-190; Rosemary Stevens, Medical Practice in Modern England and the Impact of Specialization and State Medicine (New Haven: Yale University Press, 1966).
organised and enthusiastic junior resident, and Julian Smith ensured that I got on a surgical training program in subsequent years.\textsuperscript{53}

Another surgeon agreed that in the early 1960s, Julian Smith and Benny Rank effectively decided on who would be appointed as surgical registrars at the Royal Melbourne Hospital:

They [the honorary surgical staff] were all Melbourne Club men. The way the registrars and interns were appointed—nowadays it is all computerised and such forth—in those days, for the registrars anyway, Julian Smith and Benny would go down the Melbourne Club... while they chatted about what they thought about the various candidates. They’d spend three or four hours there sorting it out and they’d let the medical superintendent know the next morning... that was how it worked.\textsuperscript{54}

Control over Teaching

Senior surgeons had control over how much teaching they provided, whether on the wards, in out-patients' clinics or in the operating theatre. At the Princess Alexandra Hospital in Brisbane, Sir Clarence Leggett liked to be met on the steps of the hospital by his registrar and his junior and senior residents. They would have to stand there for varying lengths of time, parrying the jibes of their passing colleagues, until he arrived.\textsuperscript{55} The power relationships within hospitals, then and now, are indicated by who can be late with impunity, by who waits for whom.\textsuperscript{56} Sir Clarence would be met at the ward by the ward sister, who would place a fresh carnation in his buttonhole. The registrar and residents would brief him on the progress of the patients and then the ward round proper would begin, with the patients "sitting to attention".\textsuperscript{57} Sir Clarence was a distinguished looking man, even without the aid of the carnation, and he had a very large private practice. During ward rounds in the public hospital, he would work the room. He kept notes on the family and interests of those

\textsuperscript{53} Interview with "Bas", 8 November 2001.
\textsuperscript{54} Interview with "Bernoulli", 12 November 2001.
\textsuperscript{55} Interview with "Leo", 27 May 2002.
patients who saw him privately, which meant that if they had their surgery in the public hospital, they would get special attention at ward rounds, while he made informed small talk with them about their families or the state of their farm animals. A varying group of medical students, plus uniformed and veiled probationary nurses, usually joined the rather large party as it moved from bed to bed, while the residents conscientiously noted down the boss’s words of wisdom.

Throughout their time as residents and registrars, junior [paid] medical staff worked the long hours that were standard whether in Manchester or Massachusetts or Melbourne and have since passed into legend. A survey of residents in Brisbane in the late 1950s found that they were averaging 100 hours a week with effectively no nights off. This meant that they had plenty of time in the hospital to gain experience:

In those days by the time you ... finished your registrar training you wouldn’t have done nearly as much operating yourself as they do now [but] you did more nights on call and longer hours... [you did] appendicectomies, curettes, compound fractures and there was a lot of trauma, but you wouldn’t have done too many colectomies, radical mastectomies, gastrectomies... you’d have done a few gall bladders; you’d have been generally experienced, but not a lot of major surgery.

57 Interview with "Leo", 27 May 2002.
58 Interview with John Herron, 23 July 2002.
59 Interview with "Leo", 27 May 2002. Like so many other aspects of Australian surgery in the 1950s and 1960s, the way that this ward round was structured is strikingly similar to ward rounds in Britain. In Doctor in the House, for instance, a fictionalised account of a London teaching hospital first published in 1952, Richard Gordon describes a ward round conducted by Sir Lancelot Spratt. This Brisbane surgeon might almost have used it as his model. Like him, Sir Lancelot was greeted on the steps of the hospital by the members of his “firm”. They all then processed in strict order to the ward, where an equally hierarchical group of nurses joined the procession, medical students bringing up the rear. The whole troupe moved from bed to bed in Sir Lancelot’s wake, while he played out his own authoritarian version of Socratic teaching: Richard Gordon, Doctor in the House; Doctor at Sea (London: The Reprint Society, 1955), pp. 60-67.
60 For the United States see: Ludmerer, Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care, pp. 96-98, for the position in the inter-war years and pp. 190-195 for the 1950s. See also Richard C. Friedman, J. Thomas Bigger, and Donald S. Kornfeld, “The Intern and Sleep Loss,” New England Journal of Medicine 285 (1971): 201-203.
61 Interview with John Herron, 23 July 2002.
62 Interview with Jon Cohen, 30 July 2002.
Zerubavel has outlined for the United States in the 1970s how nurses, interns and residents in hospitals had their time closely controlled and patterned. One surgeon, who trained at the Royal Melbourne Hospital, recalled:

We did work hard. I can remember my worst week as a junior resident. We used to receive on a Monday night and I was up all Monday night, had about two hours' sleep Tuesday night, then slept in Wednesday morning when the Assistant Surgeon was doing a ward round at 8 o'clock; he reported me... because I hadn't turned up on time.

Residents and registrars, on call twenty-four hours a day, had the added moral obligation noted by Zerubavel. Time away from duty was not time stolen from an employer as in factory work, for instance, but potentially time putting patients at risk. Once qualified and with an honorary appointment, surgeons were largely freed from such routines and they could come and go as they pleased. But the moral obligation to patients was, if anything, stronger than that applying to Registrars, and it became a kind of trump card. For instance, this obligation to patients could be used to over ride the reasonable expectations of other staff—orderlies and nurses—about working hours. At the Royal Melbourne Hospital in the 1950s Sir Edward Dunlop (universally known as "Weary") would start his operating list at 8.30 in the morning and often not finish it until the early hours of the next day.

...with 12 or 14 cases on the list and the girls screaming at him: "You can't do this Mr Dunlop—the girls have got to go off. We don't have enough nurses." "We're saving patients' lives here sister," he'd say. "Let's not worry about details like that" and he'd go on operating [until one or two in the morning].

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64 Interview with "Dormouse", 26 October 2001.


66 Interview with "Bernoulli", 12 November 2001. For a great deal more evidence on his cavalier attitude to time see: Margaret Geddes, Remembering Weary (Ringwood: Viking, 1996), especially chapter 8.
Long working hours left registrars with very little time to study for examinations. In July 1970, in response to the high failure rate in the examination for the Primary of the FRACS, training posts in Brisbane were inspected by two visitors from Melbourne. They found that registrars at the Royal Brisbane and Princess Alexandra Hospitals in theory had one afternoon off a week, but in practice seldom left the hospital before 4 p.m. on this afternoon off, and that they were unable to attend evening courses because they were so often rostered on duty. The position at the Mater Hospital was a little better because of a more cooperative attitude from senior staff, but not a lot.\textsuperscript{67} From the point of view of trainee surgeons, the other important power held by their seniors in the operating theatre in addition to control of time, was control over access to surgery. At the Princess Alexandra Hospital in Brisbane:

The hierarchical system existed very forcefully... We used to meet every afternoon at the end of out-patients on the day before the lists... and [the senior surgeon] allocated cases. You didn't really have any say and the lower down you were on the totem pole, the more you got the varicose veins and piles to do and the higher up you were you got the goitres and the gastrectomies and the cancers of the rectum and so forth to do. And there was no question that the senior was the senior, the junior was the junior and the assistant was the assistant.\textsuperscript{68}

In other words, the hierarchy was used not only to dole out surgery to trainees, but also to dole out surgery to junior consultants. One senior surgeon used to do this following ward rounds. Patients' charts would be produced and the consultant would sit down and allocate the surgery to the members of his team, strictly on the grounds of seniority. The more major (or interesting) the case, the more senior the surgeon.\textsuperscript{69} At the Royal Melbourne Hospital the system was equally hierarchical:


\textsuperscript{68} Interview with Neville Davis, 11 July 2002.

\textsuperscript{69} Interview with "Leo", 27 May 2002.
Out-patient surgeons in theory had no operating list, but in practice were usually given one by the In-patient surgeon. Even so, in many of the Units, the In-patient surgeon would determine what the Out-patient surgeon did—who he operated on... quite often the In-patient surgeon would take whatever was the most attractive patient that'd come through the clinic... whoever the boss felt like operating on at the time, whatever his interests were. Then he'd hand [the rest of the patients] down the hierarchy.  

Surgeons might rule the roost in their own operating theatre, but what they got to do there in the public hospital (as opposed to in private practice) depended on their position within the hierarchy of the unit. This system meant that the range of surgery a trainee could observe depended on the status of the surgeon he was observing. All of this served to associate complex procedures with high status surgeons.

High status surgeons were also in a position to provide considerable help with a young surgeon's career.  

70 There was no obligation on senior surgeons to provide any mentoring or advice in this era, and it was a very personal matter of individual relationships. Some young surgeons were helped enormously. John Herron, for instance, said that Evan Thomson took him under his wing and provided a great deal of help.  

71 But perhaps more characteristic of this era are the surgeons who felt they were on their own and had to fend for themselves:

No-one took any interest in us except Neville Davis, and he was so busy that he didn't have time for training, but he encouraged young men to consider a future in surgery... 

No-one ever asked us how we were going with our postgraduate studies...  

Another surgeon argued that they were not so much apprentices as journeymen. "You took your tools and went from place to place where you thought the training was best."  

72 Where

74 For a recent view on the importance of mentoring in surgery see: Patricia Davidson et al., A Pilot Study of Facilitated Personal Mentoring Scheme for Female Basic Surgical Trainees (Melbourne: Royal Australasian College of Surgeons, 2002).
positive mentoring was provided, it seems to have been linked to hands-on assistance with surgery. A senior figure taking a personal interest in a young surgeon's career almost by definition thought there was something worth fostering, and was more likely to take the trouble to also help with teaching. Many Australian surgeons who trained in the 1950s and 1960s seem to have found such assistance in Britain, rather than in Australia.

Operating Theatres as Classrooms

In 1991, Stefan Hirschauer noted that observational studies of operating theatres were surprisingly rare. He went on to cite studies by Irving Goffman, Pearl Katz, Joan Cassell and R. Wilson. There have also been important studies by Charles Bosk and Nick Fox. But if observational studies of operating theatres are still relatively rare, they far outnumber studies of other aspects of surgical work such as ward rounds and out-patient consultations. Operative surgery seems to have held a particular fascination for scholars

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75 Interview with George Fielding, 17 July 2002.
76 Interview with Jeff Watson, 4 April 2002.
77 Interview with Jeff Watson, 4 April 2002 and Jon Cohen, 30 July 2002.
interested in the work and culture of surgeons. Recurring themes include the intersections between drama, ritual, power, taboo and the procedures associated with aseptic surgery.\(^8\)

In 1994, Harry Collins criticized the emphasis on ritual in a number of these studies and made a simple point.\(^8\) Strangers entering an operating theatre might read what they see as ritual, but to those who work in operating theatres, much of what takes place there is simply routine.\(^8\) It was an operating theatre nurse who pointed out that operating theatre life is even more routine for nurses (and presumably orderlies and anaesthetists) than it is for surgeons.\(^8\) That is where they spend their working days, day in, day out, while surgeons (and trainee surgeons) come and go from office consultations, out-patients' clinics and ward rounds. But it follows that operating theatres loom larger in the nurses' lives, because that is the only stage on which they get to play their professional role.\(^8\)

Partly, the discussion of ritual versus routine hinges on definitions. While surgery might be a transforming event for the patient, analogous to the rites of passage discussed by anthropologists such as Victor Turner, the patient is not transformed by the ritual/routine of the operating theatre.\(^8\) The patient is transformed by the matter of fact business of cutting and sewing.\(^8\) Writers such as David Kertzer and David Cannadine have taken a rather

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82 Ibid., p. 311.

83 Jennifer Rabach, personal communication.


86 Surgery is not what Bourdieu has called a rite of consecration or institution, with symbolic efficacy, but is, of itself, for the patient potentially a transforming experience. Pierre Bourdieu, *Language and Symbolic Power*, ed. John B. Thompson, Gino Raymond and Matthew Adamson trans. (Cambridge: Polity Press,
I don't think you should do this operation...

different view of ritual and shown how it can be used to obtain and retain power and status.\textsuperscript{47} This is not inconsistent with the view of what happens in surgery adopted by both Nick Fox and Harry Collins.\textsuperscript{48} They disagree with each other, but they do agree that at least some of what goes on in operating theatres is about reinforcing the power, status and authority of surgeons.\textsuperscript{49} There is some evidence that this was the case in Australia in the 1950s and 1960s:

I've seen Mr Julian Smith pick up a tray of instruments and say: "sister if you don't mend your ways I'm going to throw these instruments against the wall" and she said: "but you can't do that Mr Smith" and he said: "right, you watch me," and over they went.\textsuperscript{50}

Similar behaviour is reported of other surgeons in other hospitals. For instance, a nurse who trained in Melbourne in the 1960s reported being at the centre of a power battle between the surgeon and the theatre sister, during which the surgeon threw every instrument she handed him onto the floor.\textsuperscript{51} But operating theatres can also be sites for heightened tension, and a number of the stories that surgeons tell about their training concern the management of stress, rather than the exercise of power.\textsuperscript{52}


\textsuperscript{50} Interview with "Bernoulli", 12 November 2001.

\textsuperscript{51} Interview with "Jane", 6 July 2002.

\textsuperscript{52} For England, Hedley Atkins argued that there was less tension in operating theatres in the 1960s than there had been in the 1930s and that surgeons had ceased to be primadonnas. The strong implication is that tantrums in theatre were not uncommon before the 1960s: Hedley Atkins, \textit{The Surgeon's Craft} (Manchester: Manchester University Press, 1965), pp. 83-5.
In an operating theatre you'll see the best and the worst of human emotions... I tried at all times to show respect to those who were working with me... Sometimes things don't go right... the pathology at hand had made things difficult... you would see all the emotions, good and bad... I never threw anything—I might swear. I tried to act as though my mother was there—she always behaved impeccably... if I heard a registrar joking in the operating theatre, I'd tell him to watch his step or he's out the door... Some men can be very rude to the operating theatre staff.93

Most of surgery is routine: "70-80 per cent of everybody's work is absolutely routine..."94 but a number of surgeons argued that you could identify moments of tension by silence: "you'll hear conversation cease, this is the crunch bit"95 "Some can talk in theatre, some can't; it's a personality thing... an anaesthetist who had seen me ever since my resident days knew when to talk, when to shut up; we'd talk about opera and so on...."96 In his autobiography, Sir Benjamin Rank, a plastic surgeon at the Royal Melbourne Hospital in this era, agreed on the importance of the anaesthetist:

Len [Travers] was not only good at his job, he was also good for me. In early years, I was edgy in the operating room and consequently a trying person to work with. Those around me often took the brunt for conditions not of their making. At such times Len knew the value of silence, of a quiet gulp or of simply telling me to shut up and get on with it.97

Something happens in operating theatres that may become routine, but is certainly not ordinary. During surgery, the privacy of the patient is invaded in ways that would not be acceptable in other places, and what takes place would be criminal assault if the patient had not given prior permission for the procedure. When asked about these issues one surgeon, who trained in Melbourne in the 1950s, described his early views of surgery in the following terms:

93 Interview with George Fielding, 17 July 2002.
94 Interview with Jon Cohen, 30 July 2002.
95 Interview with "Mozart", 11 July 2002
Like any young boy I used to go to the films... if anyone got stabbed there they groaned and dropped dead... and here I was suddenly in an environment where a bunch of surgeons were telling me that they made an incision from here to here and they pulled this out here and pulled that out there and my every instinct was to feel "you can't do that"... "people die if you do that"... Now I still reckon I'm fairly correct in that assumption [laughs]. I think it's amazing what you can get away with in surgery...

In regards to taboos in theatre, I suppose there are, but every surgeon sort of sets his own agenda and I think it's not called a theatre for nothing, but the surgeons of my early years—not so much now—were some of the greatest actors you'd ever meet anywhere and they performed in theatre just like an actor would on the stage, so they were wonderful people—awful, to great, to engaging, to disgraceful in some cases, but all with their own agenda...98

Sociologists have overcome the absence of a lay audience for the theatre metaphor by emphasising the roles that actors in an operating theatre play for each other, by how they wear their masks, or distance themselves from their roles.99 From the point of view of surgical training, the theatre metaphor is useful in that it suggests the idea of the trainee as a member of the supporting cast, but wanting to step into the leading role. Within this environment, where the atmosphere varied from the mundane to high drama depending on the nature of the procedure and the personality of the senior surgeon, trainees learned by watching. Australian trainees may have generally spent much more time assisting—holding a retractor and observing surgery—than they spent being assisted to perform the surgery themselves. But this does not mean that they did not learn a very great deal.

Holding the retractor is a very good part of the training. You learn surgery—and I can speak with some confidence now in my twilight years—you learn more by watching

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98 Interview with "Bemouli" 12 November 2001.
good surgery than by doing hands-on work. I believe in the old saying that the eyes never see what the mind does not know—that is why it is so very necessary.\textsuperscript{100}

Watching was considered to be vitally important preparation for when trainees came to perform the procedure themselves:

Evan Thomson taught me to write my own text book of surgery—he counted every movement—he was absolutely brilliant, bloodless, gentle in handling tissues... I used to write down what movements you needed to do a gall bladder, what movements you needed to do a hernia... \textsuperscript{101}

Sir Edward Hughes (sometimes known by his initials as ESR) was renowned for teaching a set of rules in the operating theatre:

He had didactic rules for undergraduate teaching. If you just learned the rules of surgery according to ESR, you could pass any exam anywhere, because it was absolutely dogmatic—not necessarily terribly scientific. For instance on statistics he said: "If something's common, tell them its 85 per cent; if its uncommon, tell them its 15 per cent; if its rare its 1 per cent; if its virtually never heard of its 0.1 per cent. That's all you ever need to know about statistics." When he was in theatre, everything was done by the rule. "We'll do this next" and he did it very nicely, and I think he made a great contribution, actually.\textsuperscript{102}

For America, Charles Bosk has emphasised the importance of the variations in the way a particular surgical procedure is performed for the process of training. Fully qualified

\textsuperscript{100} Interview with "Joe", 13 November 2001.
\textsuperscript{101} Interview with John Herron, 23 July 2002. This suggests a rather different view of ritual in the operating theatre. See: Sir Berkeley G. A. Moynihan, "The Ritual of a Surgical Operation," \textit{British Journal of Surgery} 8 (1920): 27-35. For Moynihan, arguably the most eminent British surgeon of his generation, the ritual of an operation was about aseptic procedures but it was above all about the careful handling of tissues. This was in contrast to the hurried and often rough technique of much of the surgery that he had seen during his training in the second half of the nineteenth century.
\textsuperscript{102} Interview with "Bernoulli", 12 November 2001.
surgeons can make up their own minds about how to perform a procedure, but in training, they have to do it the way their chief wants.\textsuperscript{103} This also applied to Australia.

In terms of operating, I'm going to do everything first up and show them how I do it... I say "I know you've done a bit of operating around the place, but I'm going to show you what I want"... so I do the operation... "so this is how you do a hand sutured single layer anastomosis—you put the first stitch in at the back and the reason you do that in that position is that because if you don't the muscle slips away" and so on—so all the tricks that I have learned I show him... "this is what I want you to do when you're with me. Down the track a bit you'll take the best of what you see "[and make up your own mind what to do].\textsuperscript{104}

This surgeon trained in the 1960s, but he is describing his own teaching in the 1970s, when registrars were shown how to do a procedure and then assisted to do it themselves. Observant registrars could learn a great deal from watching, but at some stage they needed to try and put what they saw into practice.

**Australian Surgical Training in England**

There were two main reasons that Australian surgeons travelled to Britain in the 1950s and 1960s. As has already been discussed, the first was to pass exams, and the second was to gain the hands-on surgical experience that they could not get in Australia. A typical pattern was to obtain a position as a ship's surgeon and travel to England by sea.\textsuperscript{105} If the Primary had not been passed in Australia, the first task was to attend the course run by the Royal College of Surgeons of England in Lincoln's Inn Fields, while living next door at Nuffield College. Ray Last from Adelaide succeeded Frederic Wood Jones as Professor of Anatomy and seems to have been an inspirational teacher for a whole generation of Australians. "His


\textsuperscript{104} Interview with Jon Cohen, 30 July 2002.

I don't think you should do this operation...

book was the bible to all of us." Passing the examinations in England was considered by some to be easier than in Australia, but it was still difficult, and there are many, many stories of repeated attempts, finally crowned by success. The porter at the Royal College of Surgeons in London used to tell candidates that they only needed two things to pass the exams: a hammer and a nail, so that they could nail their scrotum to a chair and study.107

Some Australians went on to study for the Final straight after passing the Primary, but others took a position in a British hospital.108 Locum jobs seem to have been fairly easy to get. A trainee, especially one who had the Primary, could move freely around London's operating theatres, donning pyjamas and observing surgery.109 Short term jobs often seem to have been picked up through contacts made in this way, but many Australians were pointed in the direction of good jobs by Sir Gordon Gordon Taylor.110 He ran what was effectively an informal employment service, sitting in his office at the RCS half a day a week.111 Aspiring surgeons then rolled up their sleeves for a stint of what was sometimes referred to as "practising on the Poms".

You'd practise on the Poms... the equivalent of the whole population of Australia lived in London. Every hospital had lots of patients; the consultants were not keen to come in at night... We were receiving every other night... got bone injuries as well as hernias and appendices.112

106 Interview with George Fielding, 17 July 2002; Interview with John Upjohn, 22 October 2001. Ray Last was renowned for his beautiful anatomical drawings and his snuff-taking.
107 Interview with John Herron, 23 July 2002.
108 John Upjohn and Chester Troy, for instance, both worked while studying for the Final, while George Fielding took both the Primary and the Final in one year of full time study and Neville Davis only took a job after he had passed the Final. Interviews with John Upjohn, 22 October 2001, Chester Troy, 26 October 2001, George Fielding, 17 July 2002 and Neville Davis 11 July 2002. For a contemporary discussion of the RCS examinations and typical career patterns for young surgeons see: Atkins, *The Surgeon's Craft*, especially pp. 37-55.
109 Interview with "Bas", 8 November 2001.
112 Interview with John Upjohn, 22 October 2001.
England was where you got the cutting... you needed a good two years in England. There was a different philosophy, that in the NHS [the patients] took [their] chances. The attitude was "they're all trained surgeons; you can't have an experienced surgeon for everything."  

In Brisbane the residents didn't do anything of any consequence. If you wanted to get cutting you had to get to England. I had my own list in North Wales, but you had to be known, you had to have been observed, you had to have the Primary... No matter where you went out of London you could get experience...  

If you had your English Fellowship you wouldn't be regarded as a consultant surgeon, but you could do a reasonable number of operations reasonably well and the English population were very amenable and if you'd say: "you need your stomach taking out", they'd say "when, doctor?" They wouldn't ask you why it was necessary or "aren't you too young to be doing this sort of thing?" They just accepted that if you're on the staff of a teaching hospital as a surgeon you knew what you were doing. In actual fact you didn't half the time, but that's what they thought.  

I wanted to get cutting experience so I volunteered to do an extra operating session on Saturday. They had a ten year waiting list for hernias. I wanted to learn varicose veins. So I used to operate like mad, really, in England. [Once the consultants saw that he was competent, they allowed him to do most of the surgery.] I ran Rugby Hospital for two years to my heart's content and I had a ball, basically.  

Although the Australasian Fellowship was supposed to be an "exit" qualification at the end of training, in fact neither the Australasian nor the English Fellowship examined in operative competence. As one surgeon put it: "I got my Fellowship and no-one, apart from my own peers here... knew whether I could operate." It follows that substantial operative experience was not strictly necessary in order to pass either the English or the Australasian Fellowship, although it probably did make it somewhat easier to pass the Final. "They could

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114 Interview with Jeff Watson, 4 April 2002.  
115 Interview with Neville Davis, 11 July 2002.  
117 In contrast to the Fellowship of the American College of Surgeons, which was initially based on reports of surgical competence, rather than examination: Loyal Davis, Fellowship of Surgeons - A history of the American College of Surgeons (Springfield: Charles C. Thomas, 1966).
ask questions about operative technique during the exam and an experienced person could tell whether you knew what you were talking about. Generally, however, trainees did not want operative experience in order to help them pass the examinations. They wanted operative experience while they were still under some sort of supervision, so that when they went into practice on their own they were competent to deal with the problems that came their way. What they wanted to avoid was precisely the position reported by one Melbourne surgeon who said: "suddenly you're a consultant and you're doing operations you've never done before." A fellowship of one of the colleges of surgeons provided accreditation, but if a trainee wanted to become a good surgeon he also needed experience. As one put it: "We had to go to England. You had two years [as a resident] and three years as a registrar, then you were out. You're not really ripe for the public at that stage." 

As has already been noted, some surgeons found mentors in Australia, but many found major inspiration and assistance overseas. In Britain, Australian trainees were exposed to a wider range of surgical influences from a much bigger pool of surgical talent. Many of them stayed on in Britain for a period after they had passed the FRCS, particularly if they were interested in one of the specialties. Most began by gaining experience in general surgery, and then went on to specialise in some way, seeking out surgeons working at the leading edge of some new field and working with them in Britain, or America, or both, before returning to Australia. Each specialty had its own sub-culture within surgery, its own scientific meetings, and its own network of contacts. Young surgeons quickly worked out the most prestigious and/or useful surgeons to work with at the leading edge of new developments. For instance colo-rectal surgeons tried to spend time at St Mark's Hospital in London, while urologists headed for St Peter's Hospital for Stone and orthopaedic surgeons headed for Liverpool. If they were successful in getting experience with one or more of the big names

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118 Interview with "Mozart", 11 July 2002.
119 Interview with Neville Davis, 11 July 2002.
121 Interview with "Mozart", 11 July 2002.
123 Interviews with Brian Buxton, 24 October 2001, "Bas", 8 November 2001, "Bernoulli", 12 November 2001 and Jeff Watson, 4 April 2002. For more examples of this pattern of specialisation, see the surgical biographies of Sir Benjamin Rank and Rowan Nicks: Nicks, The Dance of Life. The Life and Times of an Antipodean Surgeon; Rank, Heads and Hands, an era of plastic surgery.
in their chosen field, this could establish their career on a firm footing when they returned to Australia. When they "came back", they brought with them to Australia the latest techniques and the latest ideas, having moved on beyond what their seniors in Australia would have been able to teach them.

It's almost a rite of passage of young surgeons that they "go away" (and not necessarily overseas any more). You see how else things can be done. It's not so much the actual cutting—you re-examine your own thing. You learn a new trick or two and bring them back home to your patch. We try to get our best young men back to our hospital.

It should be emphasised that even at this point, returning to Australia with one or more fellowships and two or three years' overseas experience, surgeons might still have difficulty establishing themselves. Building a successful private practice required an appointment (in the southern states unpaid) at a teaching hospital, and it might be several years after "coming back" before a surgeon was established with a reasonable income from private practice. Few surgeons would have considered themselves either fully trained or financially secure until they were in their mid-thirties, and many would have been over forty.

Was There a "New" Surgical Trainee in the 1970s?

On the whole, in the 1950s junior staff may have been impressed and even shocked by the larger than life personalities of their chiefs, but they did not seriously challenge the status quo. One surgeon who trained in this era said that he did not understand the behaviour of...
the autocratic senior surgeons at the time, but that he understood them now: "Those were guys who could look after themselves masterfully and that was why they got to where they were." In their classic study of Kansas medical students in the late 1950s, Becker et al noted that the students had considerable autonomy, but that they nevertheless largely did what the faculty wanted them to do and became what the faculty wanted them to become. "Superiors in an organization control the behaviour of their subordinates in part because the subordinates consent to having their behaviour controlled." Drawing on French experience, in 1965 Pierre Bourdieu wrote: "Alienated by the system and protesting against it, university students yet remain dominated by the ends it pursues and the values it reveres." Those comments could equally well apply to Australian surgical registrars and their chiefs in the 1950s and early 1960s.

Australian patients, too, seem to have accepted the status quo. They did not sue their surgeons in the 1950s, or not very often. The surgeon who said that in the 1950s you could cut a patient's head off and sew it back on and they'd say thank you was, of course, exaggerating, but his basic point is well made. Another emphasised the trust in the surgeon/patient relationship. Some patients would be thanking the surgeon as they died. A number of surgeons of this era, including some of the most autocratic, were treated almost with adulation by their patients. Weary Dunlop ran a sort of informal out-patients' clinic on his ward:

He did this right from the end of the war until he retired and it was basically for the old returned soldiers... two thirds of the guys coming along would be returned veterans with various problems. He was just god to them, an amazing relationship. If

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131 Pierre Bourdieu, Jean-Claude Passeron, and Monique de Saint Martin, eds., Academic Discourse, Linguistic Misunderstanding and Professorial Power, 1994 ed. (Cambridge: Polity Press, 1965). p. 110. He later developed these ideas in conjunction with his concept of symbolic power: "For symbolic power is that invisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it." Bourdieu, Language and Symbolic Power. p. 164.
132 Interview with Jeff Watson, 4 April 2002.
you'd said anything bad against him, you'd have been out the back being done over... they sort of worshipped the man.134

Since the 1950s, the authority of surgeons with respect to both their registrars and their patients has been very significantly reduced. The 1960s saw a major shift in attitudes to established authority, which triggered a complex process of change in hierarchical structures. In the United States, this was associated with the civil rights movement and with opposition to the Vietnam War, but the shift in attitudes was far more widespread than just America. The events of the Cultural Revolution in China have since fallen into disrepute, but in the late 1960s and early 1970s, there was considerable support in the West for the ideas of high volume, low technology, low cost solutions to problems ranging from dam building to education. The ideas behind A Barefoot Doctor's Manual, for instance, were highly influential (although not among those who wrote the curricula for western medical schools) and it was published in translation by the U.S. Department of Health.135

In the 1950s and 1960s there was a dramatic and widespread expansion of tertiary education, and university campuses were often foci of what came to be called the protest movement. Students in France were particularly active, but there were also organised and well-supported protest movements in places as far apart as Mexico, Pakistan and Japan.136 Medical schools did not escape this period of intellectual ferment.

In 1974, Renee Fox asked whether there was a "new" medical student in America in the 1970s, as distinct from the more conformist and conservative medical students of the 1950s.137 She argued that there was, and that a generation gap had emerged between the medical students of the 1970s and their teachers.138 Students of the 1970s were more likely to

133 Interview with John Herron, 23 July 2002.
137 Fox, "Is There a "New" Medical Student?: A Comparative View of Medical Socialization in the 1960s and 1970s," 78-101.
138 Ibid., p. 93.
see their teachers as negative role models and to want to become more socially responsible, egalitarian and less authoritarian in their relationships with patients and "non-physician members of the medical team."\textsuperscript{139}

Kenneth Ludmerer has noted that there was a generation effect on graduate medical education. While protest among medical students peaked in the late 1960s, militancy among the junior medical staff of hospitals was most notable in the 1970s, after campus unrest had more or less died down.\textsuperscript{140} There was also a shift in emphasis. Although the egalitarian, anti-racist, anti-authoritarian and pacifist strands, so prominent in the 1960s protest movement, were not absent from the agenda, most interns and residents in the 1970s were more concerned about pay, conditions of work and training programs. By 1972, 70 per cent of all American hospitals with a graduate training program had a house staff organisation, but these came to resemble trade unions in many respects.\textsuperscript{141}

In Australia, the protest movement similarly had its impact on medicine, as some "subordinates" ceased to consent to having their behaviour controlled by their "superiors". In 1965 one of those superiors, who later served two terms as an army officer in Vietnam, took up a teaching post at the University of Queensland. He thought that in 1965 medical students in Brisbane were much like their counterparts in Boston or London or Melbourne. "They were usually neat and conservatively dressed in ties and sports coats or dresses and were reasonably polite but not deferential."\textsuperscript{142} However, this soon changed:\textsuperscript{143}

The Vietnam War brought a change in students' beliefs and attitudes. The militant and self-righteous amongst them seemed eager to cross swords with lecturers and clinicians... It was the Age of Aquarius and the young, being more conformist than

\textsuperscript{139} Ibid., pp. 96-100.
\textsuperscript{140} Ludmerer, \textit{Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care}, p. 244.
\textsuperscript{141} Ibid., pp. 244-248.
their elders, decked themselves out in carefully designed, expensively faded, scruffy and tatty clothing and wild hairstyles; the medical students dressed accordingly... I also had the distinct impression from some students that showering was no longer in vogue... While on occasion I encountered unpleasantness and direct confrontation with medical students it was uncommon and nothing like the similar confrontations with Social Work students who took themselves much more seriously. 144

This critic of student unrest argued that in the later years of their course, medical students tended to pay more attention to passing exams and less to protest. 145 Writing in 1988 he noted: "Students maintained their rage for a few years, but the wheels of human behaviour keep on turning and nowadays they are quite themselves again." 146 However, there were some lasting changes. In 1968, for instance, the Faculty of the University of Queensland Medical School added the President of the University of Queensland Medical Society to its number, and further student representatives were added in 1969 and 1975. 147 As a result of direct pressure from recent medical graduates, there was also a reduction in the working hours of resident medical staff. The case was taken up by the Queensland Professional Officers' Association and in 1969 the dispute went through the Industrial Conciliation and Arbitration Commission. 148 In March 1970 Junior Resident Medical Officers, Senior Resident Medical Officers and Registrars won a 54 hour week, still significantly longer than that considered acceptable for other occupations, but a major change from unregulated hours. This regulation of hours had an important impact on surgical training. Because it reduced the sheer number of contact hours between trainees and patients, it reduced the volume of surgical experience. 149 This helped bring the issue of quality, as opposed to quantity, of surgical experience to the fore, and contributed to pressures to improve the quality of surgical training.

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144 Smithurst, "Reflections of a Teacher," p. 175.
145 Ibid., p. 176.
146 Ibid., p. 177.
More broadly within hospitals, the rigid hierarchy among senior medical staff began to loosen. Typical of general surgical units were those at the Princess Alexandra Hospital, Brisbane, which consisted of a Senior Surgeon, Junior Surgeon, two Assistant Surgeons and two Senior RMOs in 1970. Similarly, the Urology Unit at the Royal Melbourne Hospital in 1971 had two Urologists (one of them head of the unit), two Assistant Urologists, two Associates and a Urology Registrar. Such units began to have a flatter structure. In 1971, for instance, St Vincent's Hospital in Sydney dropped the title of "honorary assistant" and all the surgical staff were given the title "honorary surgeon". At the Princess Alexandra Hospital in Brisbane, the practice of the senior surgeon doling out cases to the other surgeons ceased with the retirement of Sir Clarence Leggett and Sir Evan Thomson. In addition, the extremes of autocratic behaviour from senior surgeons were becoming unacceptable and the style of surgical leadership was changing. One surgeon, whose father was also a surgeon at the Royal Melbourne Hospital, identified a change from what he called the clubbish phase in the 1950s and 1960s, concerned with prestige and making money, to a greater emphasis on academic surgery in the 1970s.

This change within surgery coincided with a general shift in attitudes to authority within middle class society. Janet McCalman has argued that between Harold Holt's commitment to the Vietnam War in 1966 and the dismissal of the Whitlam Government in 1975, Australia underwent a cultural transformation, changing profoundly in just a decade. Importantly, in this same decade attitudes to surgical training also changed and some consultants began to take positive steps to assist trainees to acquire surgical experience and to pass the Fellowship of the RACS, rather than going to England to take the FRCS. How and why this happened is the subject of the next chapter.

153 Interview with Neville Davis, 11 July 2001.
9: Gifts and time

The gift by the consultant and the gift by the patient

During the decade 1966 to 1975, those doctors who were calling for the end of the honorary system of staffing public hospitals found increasing support for their position. All those hospitals which had not already ended the honorary system, did so with the introduction of Medibank in 1975. The end of the honorary system and the introduction of Medibank together profoundly affected the attitudes of many senior clinicians to public hospitals. There is evidence of resentment of both changes, even, or perhaps especially, by those who had been calling for an end to the honorary system.¹

At about the same time, in the period 1969-73, the RACS (and Royal Australasian College of Physicians) introduced their training programs. These had evolved within the ethos of a gift economy and relied on senior clinicians teaching registrars without being specifically paid to do so. This gift relationship, and the associated goodwill from clinicians, was maintained and strengthened even after the introduction of Medibank. The trust and fostering of what Julian Le Grand has called "the knight" within the individual were in danger of being lost in the resentment that some surgeons felt over sessional payments (as opposed to fee for service) for their public hospital work after 1975.² However, the training system helped to maintain goodwill. Surgeons might feel their honour and status and autonomy slipping as they moved from being honorary staff to paid visiting medical officers, but their honour and status and autonomy were retained in a different form through their role as teachers. The training system, with its moral economy of the gift, helped maintain the commitment of some surgeons to public hospitals, after the bitterness surrounding the introduction of Medibank, particularly in New South Wales.

This chapter examines the shifts in relationships between surgeons, trainees and hospitals during this period of change in the moral and financial economies of hospitals in the southern States. (Surgeons had long been paid sessionally in Queensland). But through all of these dramatic alterations in gift relationships, it was assumed that the role of the public hospital patient in training would remain the same—patiently allowing themselves to be practised upon by trainee surgeons (and physicians). In the final section of this chapter the role of the patient in training is examined, in the light of the changing moral and legal framework of the last quarter of the twentieth century. It is concluded that there is no longer any moral or ethical reason why private and public patients should be treated differently in regard to training.

A: The gift by the consultant

Training Hands: "When I came back..."

By the late 1960s it was becoming more widely accepted not only that trainee surgeons had to practise, but also that consultants working in major public hospitals should play a role in helping them to do so. Gradually, senior surgeons began to behave in what was regarded as a more generous manner and patiently allow trainee surgeons under their guidance to gain more hands-on operative experience as assisted surgeon and as sole surgeon. E.S.R. Hughes, for instance, who was a leading figure in the changes to training introduced by the Royal Australasian College of Surgeons, began to modify his own behaviour. One of his registrars described him as a miser about his cases, but said that he "changed to being very generous later. He did give cases away." Use of the word "generous" in regard to allowing trainees to operate was quite common:

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4 Interview with "Bas", 8 November 2001.
I had a public list at the beginning of the week... and my registrar was virtually able and encouraged—if he was up to it—to do every procedure on the public list. Later in the week he would come and help me do my private work... I prided myself that when I started in the consultant role that I would give registrars cases. I was popular for that. I was at that era when a generous surgeon gave cases to the trainee.¹

When I came back in '69... I didn't really like training people very much. Up until 1979 we had fourth year [undergraduate] students... Fourth years asked strange questions... I didn't like lecturing... The ones I enjoyed most were the registrars—teaching registrars on a one-to-one basis I enjoyed doing—I think I was generous. I would let them do all public cases unscrubbed; major cases I'd scrub; private cases I did... they assisted at private ones in the public hospital.²

There is no mention of the patients' wishes in all of this. Note, however, that clearly trainee surgeons needed to practise and wanted to practise. The person they saw as being in a position to give them an opportunity to do so was not the patient but the consultant. Thus the phrases: "he did give cases away" and "I would give the registrars cases". It has recently been argued that many consultants allow trainees to perform surgery as a form of reward: "Consultants often allow a good and competent trainee to gain operative experience as a reward for good patient care outside the operating room."³ The same author noted that: "Trainees enjoy operating and want more but most surgeons enjoy operating too and are not keen to give too much away."⁴ The implication is that assisted hands-on surgical training is seen as requiring a certain amount of generosity from the trainer, even in the twenty-first century. American surgeon Owen Wangensteen wrote that: "There is probably a time in every young surgeon's life when he would rather operate than eat or sleep."⁵ In this context, senior surgeons who were prepared to assist trainees to perform surgery themselves were "generous". They were seen as making a gift to the trainee.

¹ Ibid.
² Interview with "Dormouse", 26 October 2001.
⁴ Ibid., p. 307.
In 1965, leading English surgeon Hedley Atkins, downplayed the importance of manual dexterity in surgery: "The decision to operate, when to operate and what operation to do, is in nearly every circumstance more important for the patient's welfare than precisely how the operation is done." Historically, this kind of view has been associated with sayings such as "you can teach a monkey to operate". (See above, chapters 5 and 6). Although they do not seem to have disagreed about the importance of clinical decision-making, among the young Australian surgeons who returned home in the 1960s were a number who expressed a rather different view of the importance of manual dexterity. For instance, one surgeon who did not consider himself to be particularly dexterous noted:

Surgical dexterity is very helpful... I was meticulous but not fast. If you are fast, you are popular with the theatre staff. It's more important to be popular with the ward sister. Your cases don't go wrong; they go home.

I came back fired up... Father said give something back... I came back to the PA [hospital] and had a group of young men, two of whom had the Primary... I used to assist them—stand and watch... I've always believed that knowledge and the practical went hand in hand. I always assisted registrars in operating. If I believed he should not sit the Fellowship because of inadequacy at the operating table, I told him he should go to a different position... no-one from our hospital should sit for the Fellowship unless he was more than adequate practically...

To be an outstanding surgeon you need manual dexterity of a high order as well as everything else... When I was training registrars I let them do the procedure and I'd stand and assist them... I suppose I've always been interested in young people and assisting them... Surgery is a hands-on thing... I'm a firm believer in that manual dexterity... if you're gentle with tissue and stop bleeding—now the only way you can

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12 Interview with "Dormouse", 26 October 2001.
13 Interview with George Fielding, 17 July 2002.
teach that is to get them to do it... teaching the technical aspects, you can't do it from books; you've got to show people.\textsuperscript{14}

Very few [trainees] got through [the examinations] who were bad with their hands, but they did get through... Yes, it does [matter]. People who can't do things with their hands performed surgery that was less than perfect and sometimes not good at all... but even among the good surgeons there are variations in the favourable outcomes of surgery—percentage differences, but consistently there. The best example I can give you currently is the difference in surgical outcomes in vascular surgery—if it's done by a vascular surgeon the results are significantly better than if [it is] done by general surgeons.\textsuperscript{15}

There is an important group of ideas here that may be summed up under the heading of "practice makes perfect". The implication is that a surgeon who performs a procedure once a week gets better results than the surgeon who performs it once a year. This proposition is associated with the view that technical skills do matter and that trainees need to practise under supervision, as opposed to watching an experienced surgeon and then performing a procedure themselves.\textsuperscript{16} Some surgeons, including those quoted above, emphasise innate manual skills. But not all surgeons have the benefit of above average manual dexterity, and a more recent argument is not to downplay the importance of manual skills, but to argue that they can be learned and that the key component is practice.

The issue of manual skills in surgery came to particular prominence in the early 1990s with the introduction of laparoscopic techniques, that had to be learned by established surgeons as well as trainees.\textsuperscript{17} In the 1960s, the acquisition of manual skills by surgeons was not the

\textsuperscript{14} Interview with John Herron, 23 July 2002.
\textsuperscript{15} Interview with "Mozart", 11 July 2002.
\textsuperscript{16} "See one, do one, teach one" is a common saying in surgery throughout the English speaking world, not as recommended behaviour, but supposedly as a description of how things used to be done in the "bad old days". In a recent book, American surgeon Atul Gawande notes that the saying is only half in jest: Atul Gawande, \textit{Complications, A Surgeon's Notes on an Imperfect Science} (New York: Metropolitan Books, 2002), p. 33.
subject of scientific study, but that changed dramatically in the 1990s. For instance, one recent study noted: "A training programme... must... overcome differences in aptitude and manual dexterity. Our data are evidence that this can be done."18 Discussion of "learning curves" for surgical procedures is now commonplace.19 However, evidence on how outcomes from surgery vary with the experience and skill of the surgeon is sometimes equivocal because it is difficult to control for all the possible variables that affect the prognosis for the patient.20 This is complicated by the attitudes of the surgeons concerned. One recent study found that specialists are more likely than general surgeons to argue that specialists get better results.21 There is considerable evidence that trainees are slower than experienced surgeons, and that surgery performed by trainees is consequently more


expensive, because of extra operating theatre time. However, it is by no means clear from
the available evidence that supervised surgery performed by trainees has an overall negative
impact on patients. On the contrary, there are a number of studies which purport to show
that this is not the case.

In the late 1960s, the focus was not yet on collecting evidence for any variation in the results
of surgery according to the experience of the surgeon, but increasing attention was being
paid to the process of acquiring manual skills, and members of the surgical specialties played
a leading role in this change in emphasis. Surgical training in hospitals does not just happen,
even if there are registrars appointed to what are supposed to be training posts. Surgical
training requires a commitment of time and effort by senior surgeons. They have to be
prepared to devote energy to the tasks of assisting trainees in theatre to acquire graduated
experience, and teaching trainees at out-patients and on ward rounds. For a variety of
reasons, members of the surgical specialties seem to have taken a more personal interest in
mentoring trainees than most general surgeons, advising them and helping them to choose
the right places to move to in order to gain specialist experience and further their careers.

It was the Australian Orthopaedic Association which pioneered the move towards organised
training in Australia, drawing up training plans by 1962. Under this scheme, the first
trainees began work at St Vincent's and the Royal Alexandra Hospital for Children in Sydney

22 M. Bridges and D. L. Diamond, "The financial impact of teaching surgical residents in the operating
Farnworth et al., "A comparison of operative times in arthrosopic ACL reconstruction between
orthopaedic faculty and residents: the financial impact of orthopaedic surgical training in the operating

Heart British Cardiac Society 85 (2001): 454-7; William H. Isbister, "Colorectal operative experience in
al., "Role of the surgical trainee in upper gastrointestinal resectional surgery," Annals of the Royal College
P. Schol et al., "Laparoscopic cholecystectomy in a surgical training programme," European Journal of

24 See, for example: R. D. McKellar Hall, Reflections of an Orthopaedic Surgeon (Victoria Park: Hesperion
Press, 1983); Douglas Miller, A Surgeon’s Story (Sydney: John Ferguson, 1985).

25 Hugh Barry, Orthopaedics in Australia. The History of the Australian Orthopaedic Association (Sydney:
Australian Orthopaedic Association, 1983), pp. 286-296; RACS Archives Melbourne: Minutes and Council
and at the Mater Misericordiae Hospital in Brisbane in 1965. There were also training initiatives from the neurosurgeons and plastic surgeons. However, during the 1960s there were also a number of attempts by general surgeons to improve training. The New South Wales State Committee of the RACS, for instance, produced proposals for training programs in 1966 and the South Australian State Committee held a seminar on training in 1968 and circulated the proceedings in a bound booklet to other State committees. Medical specialists other than surgeons were also beginning to look at how training could be improved and in Queensland, for instance, from at least 1966, physicians were trying to organise better training posts under the auspices of the Queensland Branch of the AMA. Importantly, in 1970, the Committee on Physician Training of the Royal Australasian College of Physicians produced a report which was followed by a redesigned system of physician training.

In the 1960s, some senior surgeons began to devote considerable effort to training, because they thought it was the right thing to do. In the 1970s, many more began to do this because the RACS put in place structures to pressure them to do so. The RACS took steps to try and persuade most surgeons, not just an isolated few, that they should be prepared to take the time and trouble to help trainees to gain hands-on operative experience. In June 1969, Council of the RACS set up a subcommittee to review surgical training in Australasia and

28 RACS Archives Brisbane, 1964-71 box, folder 2, RACS Seminar on Surgical Training, South Australian State Committee, Adelaide, 30 November 1968; RACS Archives Brisbane, 1964-71 box, folder 2, RACS 1966-70, John Goldie, Honorary Secretary, N. S. W. State Committee, letter to R. E. Aitken, Honorary Secretary Queensland State Committee, Royal Australasian College of Surgeons, 9 August 1966, including "Recommendations of the Sub Committee on Surgical Training at the meeting held on October 21st 1966".
29 RACS Archives Brisbane, 1964-71 box, folder 2, RACS 1966-70, H. A. Copeman, letter to The Honorary Secretary, Australian Medical Association, Brisbane, 27 May 1966 re registrar training for physicians, neurologists, dermatologists and allergists.
elsewhere, including training in the surgical specialties. The subcommittee wasted no time in producing its report and the recommendations were approved by Council in February 1970. Training was to be divided into two distinct phases: basic, essentially for candidates for the Primary and advanced training for those who had passed the Primary and been accepted by one of the nine Specialist Surgical Training Committees. Advanced training was to be offered in general surgery, (which effectively became a surgical specialty itself, although still very much larger than any of the others), ophthalmology, laryngology, otolaryngology, orthopaedics, urology, thoracic surgery, neurosurgery, plastic surgery and paediatric surgery. The RACS set out to expand its role to supervising training in the craft of surgery, as well as running courses to teach the surgical sciences. In other words, it began to concern itself with training hands as well as teaching heads.

In 1972, a report by the Ad-hoc Combined Education Committee of the Clinical Colleges noted that each had until recently played a considerable role in teaching, but not in training. It was noted that training had been somewhat haphazard, that the clinical colleges were to blame and that they had each recently (and independently) established their own committees to rectify this. This particular view of the past was politically astute. Universities and the AMA had played a limited role in postgraduate medical teaching, but the clinical colleges

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33 Similar thinking informed the changes to training introduced by the RACP at around the same time, with the division of physician training into "professional" for the first two years and "vocational" for another three or more years: Benson, "The History of the College Examination," 1-6, pp. 3-5.

34 The original 1970 list included gynaecology, but this was dropped in the publication of the first Guide to Surgical Training in 1971 in the interests of maintaining good relations with the Royal College of Obstetricians and Gynaecologists: Minutes and Council Papers, 8 October 1970, General report from examination subcommittee to Council; Royal Australasian College of Surgeons, Surgical Training, Committees, Co-ordinators, Supervisors and Approved Posts (Melbourne: RACS, 1971).

35 Minutes and Council Papers, 8 October 1970, Resolutions arising from the report of the examination subcommittee; Ibid., General report from examination subcommittee to Council.

36 Ad hoc Combined Education Committee, "Postgraduate Medical Training in Australia," Medical Journal of Australia 1 (1972): 534-538, p. 536. The clinical colleges involved were the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal College of Obstetricians and Gynaecologists (Australian Regional Council) and the Royal Australian College of General Practitioners.
carved out postgraduate medical training as their own particular preserve. In the case of the RACS, this was aided by the association between training and apprenticeship. Who could train apprentice surgeons if not master surgeons?

The revised examination structure introduced by the RACS from 1973 still included no direct assessment of operative competence, but advanced surgical trainees (those who had passed the Primary, now renamed the Part I) began to be offered increasing levels of supervision. In particular, from 1970 the RACS issued log books to candidates for its examinations. Conditions for approval of posts were modified to include the requirement for: "adequate personal operative experience for the trainee, under the supervision of surgeons possessing higher surgical qualifications recognised by the College. The trainee shall keep a log book detailing such experience." The log book pages provided space to insert whether the trainee performed a procedure as surgeon or as assistant, as well as space for the name of the attending senior surgeon (if there was one). This allowed the examiners to check up on trainees, but it also allowed them to check up on those who were supposed to be providing the training opportunities. In other words, for the first time it was theoretically possible for examiners to see how many procedures a trainee had performed, and in which role: as assistant surgeon, as assisted surgeon, or as sole surgeon. As E. S. R. Hughes noted in 1977:

37 Postgraduate teaching organised by the various State postgraduate committees and run by the universities and/or the AMA was particularly important for the professional development of general practitioners: Sally Wilde, A History of the Royal Australian College of General Practitioners Training program (Melbourne: RACGP, 1998).
39 Minutes and Council Papers, 19 October 1969.
40 Interestingly, one trainee's log book makes it possible to verify the amount of assistance provided by one of the surgeons quoted at the beginning of this chapter. During 1970 (the first year that log books were issued), this particular trainee assisted sixteen different surgeons. Eleven of these surgeons in turn assisted him, but generally only once or twice. However, one of the surgeons quoted above was present on 17 of the 48 occasions on which this trainee was assisted to perform a procedure. During this his fifth post-graduate year the trainee performed 135 (mainly minor) procedures as sole surgeon, 48 more major cases with assistance and assisted a senior surgeon in a further 90 cases. The relative paucity of assisted surgery, and the importance of an individual surgeon who was prepared to be helpful, are both clear. "Surgical Training Log Book, Royal Australasian College of Surgeons, 1970", personal possession of the surgeon concerned.
Log books... set out the work completed by the trainee and therefore the workload offered by the post itself—information that is vitally important for the Censor-in-Chief of the College who advises the Council of the College on the approval of posts for training.\textsuperscript{41}

In practice, the log books were filled in by the trainees more or less conscientiously, at some time after the event. Early log books were probably more important in theory than in practice, but they marked a significant shift in emphasis. Assisted hands-on operative experience became a formal requirement for the trainee, but perhaps more importantly, it became a formal requirement for accredited training posts, thus giving the College leverage over both hospitals and senior surgeons.

Hospitals and consultants wanted approved training posts in surgery because this encouraged the best applicants to apply for registrar positions, and because approved training posts gave them kudos. From 1928, the Executive of the RACS had appointed Hospital Committees in each State.\textsuperscript{42} Members of these committees inspected posts when there was an application for recognition, but little attention seems to have been paid to training content. The RACS concentrated on ensuring that hospitals with training posts met its requirements for supervision by qualified surgeons, availability of X-ray and pathology facilities and College representation on the hospital appointments board.\textsuperscript{43} From 1972 this changed and training posts had to be approved by the relevant Specialist Surgical Training Committee.\textsuperscript{44} Initially, this made little difference in general surgery, but in the surgical specialties it introduced a very significant potential for peer review of training. Most of the specialties were small. Everybody knew everybody and whether or not a post was approved for training was a matter of very considerable importance for the kudos and professional standing of the surgeons who were supposed to be providing the training. If surgeons wanted approved registrar posts, they had to put some effort into training.

\textsuperscript{42} RACS Archives Melbourne: Agency No 5, Hospital Committees, August 1928- March 1972.
\textsuperscript{43} See, for instance: RACS Archives Brisbane: 1964-71 box, folder 10, Hospital Selection Committees Correspondence 1962-1970.
\textsuperscript{44} Royal Australasian College of Surgeons and Faculty of Anaesthetists Archives, (Melbourne), Agency Registration, Agency No 5, Hospital Committees, August 1928- March 1972.
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During the 1970s, registrar positions increased significantly in numbers, but the major increases were in the specialties, rather than in general surgery. The RACS did not publish full lists of accredited training posts until 1971, but it did occasionally circulate lists to its State Committees.\textsuperscript{45} The October 1968 list allows comparison between training posts just before the introduction of the new system of accreditation, and the position a decade later. Between 1968 and 1979, the number of approved training posts in Australia in all the surgical specialties increased from 280 to 414 (48 per cent), but the number of posts in general surgery only increased from 151 to 168 (11 per cent), and the number of general surgical positions consequently fell as a proportion of the total from 54 per cent to 41 per

cent. (See Table 3.)

In contrast, the rise in the number of training positions in some of the specialties was very marked—there was an 89 per cent increase in the number of training posts in orthopaedics, for instance, from 37 to 70. One specialist consultant argued that he consequently had more time to teach in the 1970s. "The Registrars were doing a lot of mundane tasks that we normally did... that left more time to teach... we had more time in the 1970s than in the 1960s." 47

Besides the enormous increase in the number of training positions in the specialties, there were moves to incorporate experience in some country hospitals into training programs, especially for general surgeons. For a number of years it had been recognised that trainees who were prepared to go and work in hospitals in Australian country towns were likely to get more hands-on surgical experience than those who stayed in the teaching hospitals in the major cities. 48 In 1969, Sir Clarence Leggett from the Princess Alexandra Hospital in Brisbane and E. S. R. Hughes from the Royal Melbourne Hospital (both members of Council of the RACS) visited a number of Queensland towns to see for themselves the standard of training in surgery outside the metropolitan areas. 49 They visited Cairns, Rockhampton, Townsville and Toowoomba hospitals, each of which had a surgical registrar, and expressed reservations about the nature of training there.

At the present time, the Registrar in these posts does not experience the intellectual stimulation that prevails in a teaching hospital. Most teaching hospitals provide a good deal less technical work but greater opportunities to be taught and to teach, and they implant the urge to enquire and research. An inquisitive search after the truth is

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47 Interview with Jeff Watson, 4 April 2002.
48 This was partly because of the relative shortage of surgeons outside the metropolitan areas and partly because of variations in the public/private mix of patients. Private patients were not generally used for teaching purposes. One major exception was at the Royal Newcastle Hospital where there was a different philosophy. Most of the medical staff were full-time, and private, intermediate and public patients were all treated in the same way, by residents, registrars and senior staff. Leo Butler, ed., Chris McCaffrey, A Great Administrator, A Memorial Recollection by his Colleagues (Newcastle: The Hunter Valley Research Foundation, 1985), p. 156. For the particular contribution of the Royal Newcastle Hospital to surgical training, see also: J. E. Wright, "Jack Smyth: A Major Contribution to Surgery," Australian and New Zealand Journal of Surgery 71 (2001): 132-133.
an important aspect of the work done in any surgical unit. It seems quite non-existent at any of the hospitals visited on this tour... Country trainee surgeons should be encouraged to develop surgical curiosity because there is a wealth of surgical material in these country centres which is not available to their city colleagues.

They argued that country trainees had plenty of "surgical material" or a "good range of clinical material" but rather less intellectual stimulation. In Cairns, for instance, the surgical registrar had his (was it ever her?) own operating list. Experience of this kind, without training, was recognised as "increasing confidence but not skill". The answer to both the lack of training in country hospitals and the shortage of "clinical material" in some teaching hospitals such as the Royal Melbourne was seen to be a system of rotating registrars in metropolitan hospitals through terms in country base hospitals. In 1976, for instance, the first general surgical trainees from the Princess Alexandra Hospital in Brisbane spent time in Rockhampton, Cairns and Ipswich.

Teaching Heads

In the late 1960s and early 1970s, there was also a shift in attitudes towards teaching surgical science to candidates for the Primary. In the minutes of Council of the RACS for 20 October 1966, there is a report on the courses being run for the Primary in Dunedin, Melbourne and Sydney. It was believed that those who were running the courses were not well informed on the details of the Primary exam, for which there was no clearly defined syllabus. However, tutors and supervisors could see previous examination papers. It was:

...believed it was most unfair to candidates not doing the various courses if there was any closer cooperation between the examiners and the tutors running the courses...

44 Ibid., p. 2.
46 Ibid., pp. 2-5.
47 Evidence has since been collected which supports this proposition: T. M. Marteau et al., "Resuscitation: Experience without feedback increases confidence but not skill," British Medical Journal 300 (1990): 849-50.
[they were not] coaching for an examination but merely teaching a background of surgery to candidates of a certain standard.\textsuperscript{55}

In other words, the courses were there to help candidates pass the examinations, but they should not help candidates too much. The failure rate was, perhaps not surprisingly, very high. (See above chapter 7.) It was particularly difficult for candidates to pass from centres such as Brisbane and Perth, where there were no courses. By 1973, this attitude had decisively changed. In 1968, Professor Howard Eddy (Chairman of the Board of Examiners) persuaded Council of the RACS to introduce a defined syllabus for the Primary.\textsuperscript{56} The new Part I examination based on multiple choice questions was first run in March 1973 and conducted simultaneously in all Australasian capital cities, Kuala Lumpur, Singapore and Hong Kong.\textsuperscript{57} For the RACS, it represented a major logistical exercise and required new staff simply to run it, but for the trainees, especially in Western Australia and Queensland, it represented vastly improved access. The Part I was supposed to be an exam that could be taken from a hospital post, without full-time study elsewhere, but as it turned out the candidates did not agree and there was considerable demand for courses.\textsuperscript{58} These were run in all major centres, breaking the Melbourne-centred pattern of the 1960s.\textsuperscript{59}

The College was beginning to behave as if it considered the interests of surgeons outside Melbourne and Sydney. This was an important component of the changes brought about by the RACS, as it set out to persuade surgeons in States other than Victoria and South

\textsuperscript{55} Minutes and Council Papers, 20 October 1966.
Australia that the College was relevant to them. George Fielding argued that the change in thinking at the College was particularly associated with John Loewenthal (from Sydney) and E.S.R. Hughes (from Melbourne).

There's a different philosophy with Hughes and Loewenthal. Their ideas spread through the College. All of a sudden instead of this idea of being down on the young men, we want to lift them up... Loewenthal [would] come up to all the State Committee meetings [in Brisbane], Hughes would come and they'd be at all of the College meetings and they'd be talking it up. "How can we improve things for these boys? We want to build the College up."

This change in thinking was to transform surgical training in Australia, and one of the key features was the idea of actually helping trainees to gain experience and pass examinations. As Neville Davis noted: "There are those who are prepared to help trainees and those who regard it as a nuisance." The College put its considerable moral support behind those who were trying to help trainees.

RACS Control of Training

The RACS emerged from this period of change with an extraordinary degree of control over the production of future Australian surgeons. In the 1970s, basic trainees who had not yet

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60 In the early 1960s, while about 80 per cent of surgeons were Fellows of the RACS in Victoria, Tasmania and South Australia, membership was much lower in New South Wales, Queensland and Western Australia, where as many as one in three surgeons were not FRACS. See above chapter 7.
62 Interview with George Fielding, 17 July 2002.
63 Interview with Neville Davis, 11 July 2002.
passed the Part I remained outside the fold. As June Lehmann (Head of the Department of Examination and Training) put it, basic trainees "regularly reported that no-one wanted to know them as a basic trainee." However, once they passed the Part I and were accepted into advanced training by one of the nine specialties, they were firmly under the umbrella of the College. The Specialty Boards selected their trainees, accredited the training posts and decided on the length and content of training. A vital link in this chain was the willingness of hospitals to cooperate in the provision of suitable training posts and the appointment to them of candidates approved by the relevant Specialty Board.

From July 1970, the College was involved in joint discussions with the Royal Australasian College of Physicians, the Royal College of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners. Together they formed the Ad-hoc Combined Education Committee under the chairmanship of E. S. R. Hughes. This body was able to present hospitals and governments with a united front on specialist medical training. In 1972, the Ad-hoc Combined Education Committee published a report on "Postgraduate Medical Training in Australia" with the objective of informing "those persons responsible for the overall administration of health services and for the medical staffing of individual hospitals." The colleges agreed on two years' basic training after the pre-registration year, followed by an examination and then a period of vocational training, which varied in length by specialty. It was noted that "each of the Colleges relies upon hospitals throughout Australia to provide posts in which training can take place". Although hospitals were increasingly providing training time for postgraduates "subject to the normal service requirements of the hospitals" the appointment of interns, residents and registrars was in the hands of the hospitals: "The individual Colleges represented in this report do not influence,

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(to supply experience), and the Government (to recognize experience). Hughes, "Surgical Training in Australia in 1977,": 731-733, p. 731.
66 Committee, "Postgraduate Medical Training in Australia,": 534-538.
67 Ibid., p. 534.
69 Committee, "Postgraduate Medical Training in Australia,": 534-538, p. 536.
nor have they sought to influence, hospital authorities in the appointment of particular individuals to their house staff.70

This was the official line, but in practice, most hospitals most of the time appointed candidates approved by the various colleges. The hospitals wanted accredited training posts, because they attracted the best candidates, and posts were unlikely to be accredited or re-accredited without this de facto power of the various colleges to nominate approved candidates to training posts. In the case of the RACS, the College was not involved in the appointment of basic surgical trainees. These were selected by the hospitals concerned.71 However, by 1977 E. S. R. Hughes was arguing that the College had very considerable influence over the selection of candidates for advanced training:

The hospitals appoint the advanced surgical trainees and have jealously guarded this privilege. The College has not sought representation, nor does it wish to interfere with this system.

However, if the trainee belongs to an advanced surgical training programme organized on a State or national basis, strong outside pressure may be brought to bear on the hospital for the appointment of a particular trainee... these hospitals are assured of a good trainee and are mostly prepared to cooperate.

If the trainee is in a specialty without a highly organized training programme he is forced to take his chance, as does the basic trainee, but once appointed, the trainee is almost assured of at least three years of advanced training at most hospitals.72

In the 1970s, there emerged what the Sheldrake Report described as a "tug-of-war" between the University medical schools and the clinical colleges over their respective roles in vocational postgraduate training and education.73 However, the Universities suffered from

70 Ibid., p. 536.
72 Ibid., p. 732.
73 Peter F. Sheldrake et al., Medical Education in Australia: present trends and future prospects in Australian medical schools, (Canberra: Commonwealth Education Research and Development Committee, 1978), p. 102. There were a number of reports on medical education in the 1970s, most of them produced under the auspices of the Universities and most of them making some claim that greater University involvement in postgraduate education would be desirable. See, for example: Peter Karmel, Expansion of Medical Education; Report of the Committee on Medical Schools to the Australian Universities

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the disadvantage that the clinical colleges got there first. It was the clinical colleges and not
the Universities which had taken the initiative and developed viable programs of vocational
training, education and accreditation. In addition, the colleges were able to persuade their
members to provide teaching within a gift economy. As has already been noted, the 1988
Doherty report noted that Australian medical schools more or less handed over the business
of postgraduate medical education to the clinical colleges in 1949, following the
recommendations of the British Goodenough Committee.74 In the case of surgery, it was
agreed in 1949 that the MS degrees should become research, rather than vocational,
qualifications.75 This did not stop Sir Victor Coppeloson and others from pushing for a
greater role for the Post-Graduate Committee in Medicine of the University of Sydney and
subsequently the Australian Postgraduate Federation in Medicine.76 This body met a number
of times, but managed to alienate not only the clinical colleges, but also the younger
Universities, with talk of favouring the "Senior University in each State".77 The role of the
various State postgraduate committees remained essentially one of fostering continuing
medical education for general practitioners, although there was cooperation and some
overlapping of personnel in the running of courses for the RACS Primary.78 The RACS and
the various specialist surgical societies were effectively the only bodies providing vocational
postgraduate training in surgery in Australia even before 1969, and their position was
strengthened in the early 1970s.79

Education in Australia: present trends and future prospects in Australian medical schools, p. 90;
74 Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of
Inquiry into Medical Education and Medical Workforce, p. 292. See above, chapter 7.
75 In 1948, Council of the RACS proposed that the MS become a research degree, in other words before the
publication of the Goodenough report the following year. Minutes and Council Papers, 24 June 1948. See
above chapter 7.
76 "Sir Victor Coppeloson and Post-graduate medical education in Australia", editorial, The Medical Journal
of Australia, April 24, 1965, p. 626.
77 Minutes and Council Papers, 7 March 1962, S. F. Reid, The Australian Postgraduate Federation in
Medicine, Report of Attendance at Meeting held Saturday 10th February 1962, B.M.A. Hall, Melbourne.
The report to Council of an April 1964 meeting in Canberra noted: "Many facets and problems of Post-
graduate Education were aired and discussed, but no decisions were made concerning matters of interest to
ourselves. The amount of paper associated with one of these meetings has to be seen to be believed..."Ibid.
78 See for example, "The Post-graduate Committee in Medicine in the University of Sydney" and the "Post-
graduate Committee in Medicine of the University of Adelaide" The Medical Journal of Australia May 1,
1965, p. 668; "The Melbourne Medical Post-graduate Committee", The Medical Journal of Australia June
These changes to vocational medical training raised the issue of the appropriate numbers of medical specialists and how many should be trained. There was no State or Federal body with the responsibility for considering the overall number of medical specialists until the Australian Medical Workforce Advisory Committee was set up following the recommendations of the 1988 Doherty Report. However, in the 1970s, the various clinical colleges found that they had acquired considerable de facto influence over the numbers in their own specialties. Some believed that the RACS should exercise this power to consciously influence numbers, and there were subsequently various efforts by specialty groups of surgeons to do so. In the 1980s some groups, particularly orthopaedic surgeons and ophthalmologists, were accused of limiting the number of entrants to the specialty, creating a shortage. This debate falls outside the scope of this thesis, but it is important to note that whatever the subsequent developments, the various surgical training programs were not originally set up to limit entry to the profession.

Between 1969 and 1973, the RACS put in place measures that gave surgeons as a group a quite extraordinary degree of control over surgical training. But whatever the ultimate impact, those measures were not originally designed to limit access to surgical training. On the contrary, they were designed to help trainee surgeons gain experience and accreditation, with

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80 Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce. For a detailed examination of the question of numbers of specialists see pp. 393-506.
82 Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce, p. 503. See also Baume, the Baume report, and Royal Australasian College of Surgeons, Response to 'A Cutting Edge: Australia's Surgical Workforce 1994' by Peter Baume, (Melbourne: RACS, 1995). See also the various reports by the Australian Medical Workforce Advisory Committee, for instance: Australian Medical Workforce Advisory Committee, "The Urology Workforce in Australia, Supply, Requirements and Projections 1995-2006, AMWAC Report 1996.4," (Sydney, 1996). Recently, there has been considerable scrutiny of procedures for trainee selection. See: Peter Brennan, Trainee Selection in Australian Medical Colleges, (Canberra: Medical Training Review Panel, Health Workforce Section, 1998). The RACS has also come under scrutiny by the ACCC and (voluntarily) by the Australian Medical Council. It has responded by setting up an Education Policy.
the aim of encouraging them to train in Australia and take the FRACS, rather than going to England and taking the FRCS. The driving ideas behind the changes to surgical training in the early 1970s were all concerned with improving and expanding the scope of training that was provided in Australia and increasing the proportion of surgeons who were Fellows of the RACS.

In one sense there was a competitive market in accreditation for Australian surgeons before the 1970s, and for many surgeons, English accreditation was more attractive. In the 1950s and 1960s, the RACS competed (with only limited success) by making a series of changes to the examination requirements and by setting up courses to teach the basic surgical sciences. (See above, chapter 7). In the late 1960s and early 1970s, Council of the RACS developed ways of competing (successfully) by taking positive steps to provide training in Australia. It was aided by the beginnings of restrictions on the freedom of Australian doctors to train in England. Restrictions on the flow of doctors in general and surgeons in particular into Australia depended on their ability to register with the various State Medical Boards. In 1970, Specialist Recognition Advisory Committees were set up in each State and Territory to deal with decisions as to which doctors were eligible for the higher medical benefits.

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83 Figures on the exact proportion of Australian surgeons who were not FRACS are not available, but some indication of the scale of overseas training before the 1970s is provided in the Doherty report, where it was estimated that in 1988 still only about 75 per cent of Australian surgeons were FRACS. Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce, p. 399.

84 Until 1992, English medical graduates were able to register to practice in Australia without taking the Australian Medical Council examinations. In the 1970s and 1980s, Australian graduates were able to work in English training posts, provided they passed a language test. However, not all posts were available to overseas graduates, some being designated as career posts for those who would remain to work within the British National Health Service. The position was complicated when Britain joined the EEC, and a different set of accreditation procedures were introduced. See G. J. A. Clunie, "Surgical training links between the United Kingdom and Australasia," Australian and New Zealand Journal of Surgery 63 (1993): 85-86; John Lister, Postgraduate Medical Education (London: The Nuffield Provincial Hospitals trust, 1993).

85 Before September 1978, each State had its own requirements for the registration of overseas trained doctors. From 1978, there was a system of national examinations for overseas trained doctors whose qualifications were not recognised in Australia. Initially, these were conducted by the Australian Medical Examinining Council. However, this became one of the roles of the Australian Medical Council (AMC) after it was set up in 1984. The AMC also accredits Australian and New Zealand medical schools and medical courses, and programs of specialist medical training: Judy Conroy, AMC Accreditation Officer, personal communication, 20 January 2003; www.amc.org.au.

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payments which the Federal Government introduced for specialists. From 1972, these decisions were coordinated nationally through the National Specialist Qualification Advisory Committee. However, the FRCS continued to be a recognised specialist qualification.

Conditional Gifts and the End of the Honorary System

In the 1960s, consultants at most Australian hospitals outside Queensland were honorary. They made their living in private practice and worked in the public hospital for free. The registrars worked full time in the public hospital and were paid a salary. This honorary system of staffing Australian public hospitals came to an end at more or less the same time as the introduction of Medibank in 1975. There has been a tendency to conflate the two events, as if the end of the honorary system, like the introduction of Medibank, was imposed on an unwilling medical profession by the Whitlam Labor Government. Some of those doctors who were opposed to the introduction of Medibank looked back on what preceded it, including the honorary system, through rose-coloured spectacles. In this context, it is important to point out that many doctors had been calling for the end of the honorary system for more than a decade before the introduction of Medibank. At its annual Federal Assembly in 1965, under the heading "Hospital Policy" the Australian Medical Association passed a resolution that:

It is desirable that there should be adequate payment by universities for members of visiting staffs engaged in teaching... Where it is desired, there should be some method of payment for patient care of public ward patients by members of the visiting staffs of teaching hospitals.

87 Doherty, Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce, pp. 293-294.
In the 1960s, patients at public hospitals like the Royal Melbourne paid the hospital varying amounts of money for their care, depending on assessments of their ability to pay and on their level of insurance coverage. The system was enormously complex, but from 1952 to 1975 it was only "free" to a limited group of patients, mainly Queenslanders, Tasmanians before the mid-1960s, and those who passed a means test in the other States. However, unless they were a private or intermediate patient in a specially designated bed, patients did not pay their doctor for their medical care. Between 1965 and 1975, both this financial framework and the moral framework within which training took place changed. Many doctors wanted an end to the honorary system and referred to it as an "anachronism". They argued that while they might be happy to treat the genuinely poor for free, they were not happy to provide free services for public hospital patients as a whole, when this group included many who could afford to pay for medical care. As one doctor wrote in 1966:

With public ward rates at £8.20 per day, no patient who is admitted would consider himself to be a 'charity' patient, and in fact most believe that the medical personnel who look after them are all paid by someone...

It would seem from the English experience, that a fully-paid system destroys a great deal of the profession's incentive, converts the patient from a person to a disease and is most expensive. The ideal must be that whereby the patient accepts some responsibility for finances and has some choice, and the medical attendant receives an extra recognition for extra effort. This presupposes some form of part payment and abandonment of the outdated and outmoded honorary system.

Essentially, in the 1960s the gift that honorary staff made of their services was conditional. They were prepared to work for free under certain circumstances, but under other circumstances, their services were to be paid for. Sometimes the medical care that they provided was a gift, and sometimes it was a commodity. Following the AMA resolution of 1965, there was pressure from the honorary staff of many hospitals to bring the system to an

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end, but with little success, mainly because hospitals and State governments argued that they could not afford to pay their honorary staff.

In South Australia, for instance, the State Branch of the AMA informed the Minister of Health of AMA policy on the matter in October 1965, while the honorary staff of the Royal Adelaide and Queen Elizabeth Hospitals approached their respective Boards of Management. At a joint meeting with the Minister of Health in August 1966 the Minister was sympathetic, but said there was no money available and he would consider the matter again in 1967. When representatives of the AMA and the honorary staff met the Minister again in May 1967 he said that "whilst he appreciated the need for payment and was in favour of it personally, unfortunately there was still no money available to the Government for this purpose." The story in Tasmania was slightly different. In 1965, the Tasmanian Government proposed establishing pay beds in its public hospitals and allowing the honorary staff limited rights to treat some private patients in the public hospital. "In return the Government has asked the AMA not to press for the payment of honorary medical officers for the treatment of public patients." The Tasmanian Branch of the AMA agreed, because it wanted to be able to use some public hospital beds for private patients (as had been possible in the larger States for many years.)

At the Royal Melbourne Hospital, the conditional nature of the gift by the honorary staff was explicit from at least the 1950s. The 1956 report of the Committee of Management noted approvingly that the BMA "agreed to continue to favour the principle of honorary service provided an income test was reintroduced, to ensure that such service was only for those unable to pay for private treatment". In the 1960s, the hospital was expressing doubts

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about the future of the honorary system, because of the problems of attracting new young specialists.\textsuperscript{96} By 1969, some of the staff involved in undergraduate teaching were threatening to withdraw their services if they weren't paid.\textsuperscript{97} The report of the Committee of Management featured a tribute to more than 100 years of provision of unpaid clinical instruction at the Royal Melbourne Hospital and gave "sympathetic support to the view that the system of medical instruction by honorary teachers is no longer appropriate...."\textsuperscript{98} The following year, the Committee of Management gave particular emphasis to its support for an end to the honorary system in patient care as well as clinical teaching, describing it as "an anachronism", and the report of the Medical Staff for 1971 was headed "Payment Sought for Honoraries."\textsuperscript{99} Payment for clinical teaching was introduced from January 1973, but negotiations over payment for patient care dragged on until 1975.\textsuperscript{100}

In July 1975 the Australian Government introduced a nationwide system of taxpayer funded, free, un-meanstested access to public hospital care under the provisions of the Medibank legislation. This was widely opposed by members of the Australian medical profession, who objected to "socialised medicine" on political grounds.\textsuperscript{101} Medical practitioners were not

\textsuperscript{96} Ibid., 1966-67. At the Mater Misericordiae Hospitals in Brisbane, there was agreement that the honorary system "places an undue burden on younger men striving to establish themselves economically..." Mater Misericordiae Public Hospitals Brisbane, Annual Report, (1959), Chairman's report, p. 12.

\textsuperscript{97} Royal Melbourne Hospital, Annual Report, Statement of Accounts, List of Subscribers and Donors and Statistical Returns, (1970).

\textsuperscript{98} Ibid.

\textsuperscript{99} Ibid., 1971.

\textsuperscript{100} Ibid., 1973.

\textsuperscript{101} Not all doctors opposed the introduction of Medibank. See, for example Thelma Hunter, "Medical Politics: Decline in the Hegemony of the Australian Medical Association?", Social Science and Medicine 18 (1984): 973-980. Indeed, the AMA campaign against Medibank may have contributed to declining membership. Diane Mackay, "Politics of reaction: the Australian Medical Association as a pressure group," in The Politics of Health: the Australian experience, ed. Heather Gardner (Melbourne: Churchill Livingstone, 1989), pp. 293-297. However, opposition from doctors to socialised medicine in general and Medibank in particular was widespread: "Our Branch of the Australian Medical Association is opposed to this free hospital system [in Queensland] without the use of a means test. We have found, and doubtless many agree with us, that a person does not appreciate what he does not pay for directly and personally." Robert Miller, "The Winds of Change," Medical Journal of Australia II (1966): 37-40, p. 38. "For three years (1959-1962) I worked in general practice in the National Health Service [in England] until I could stand it no longer. I then emigrated to this country," The writer referred to "my three years of slavery". "Surely no Commonwealth Government would be naïve enough to imagine that the hundreds of doctors who have fled from the British N. H. S. would remain in Australia if a similar system were started here!" David E. Taylor, "Nationalized Medicine: A Social Illusion," Medical Journal of Australia I (1965): Supplement 108. For an overall survey of the conflict see: Sidney Sax, A Strife of Interests. Politics and Policies in Australian health services (Sydney: George Allen and Unwin, 1984). More broadly, see the articles in the special edition of The Medical Journal of Australia Vol 173, No 1, 3 July 2000.
prepared (or expected) to work for free under these new circumstances and the debate shifted to the form that payment would take.  

It is not clear exactly what impact these changes had on training, but the end of the honorary system and the introduction of Medibank (however briefly) do seem to have been associated with changes in the attitude of surgeons to their work in public hospitals.  

At the Mater Misericordiae Hospitals in Brisbane, a group of Catholic Hospitals which kept the honorary system until March 1974, the 1973/4 Annual Report noted:

Because of the introduction of the paid scheme, the standard of medical care within the Hospital has been significantly improved. The senior consultant staff are willing and able to spend a longer period of time in the Hospital involved in direct patient care and supervision and education of the resident staff.  

In other words, surgeons got more training once the consultants were paid. Whether or not there was a causal connection here, it does appear that attitudes to the hospital changed after the introduction of Medibank. Those who believe that economic self-interest is the principal human motivation might expect senior medical and surgical staff to have worked harder in the public hospitals once they were paid, but that does not seem to have been what happened. On the contrary some of those specialists who were most opposed to Medibank and subsequently to sessional payment (rather than fee-for-service) seem to have resented the public hospitals by association. For some, there appears rather to have been a danger of "crowding out" of the intrinsic motivation to give more than they were paid for, especially

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102 For a description of the conflict in New South Wales from a doctor's perspective see: Kommer, "The national Association of Medical Specialists: A Failed Horatius?": 118-140.


106 Kommer, "Witnesses to 20th-Century Medicine The national Association of Medical Specialists: A Failed Horatius?": 118-140.
where there was a feeling that they were being pressured to behave in certain ways.\textsuperscript{107} Recent research has indicated that people may be influenced to act out of self-interest (as "knaves") by payment, rather than altruistically (as "knights").\textsuperscript{108} People feel good about doing good because there is some sacrifice involved. If they are paid a small amount, "for expenses", they may continue to feel good about the activity and supported for having undertaken it. But if they are paid "fully", especially where a degree of manipulation is perceived, motivation may well change.\textsuperscript{109} Earlier research on work and motivation arrived at related conclusions on the importance of social, as opposed to purely economic, motivation.\textsuperscript{110} For Britain, Ken Starkey has argued that where hospital consultants felt their time was being managed by others and there was a loss of trust, they were inclined to give less in return.\textsuperscript{111}

In essence, in 1975 the work of surgeons in public hospitals in patient care ceased to be a gift. In subsequent years this changed, at least partly because the sessional payments to consultants were seen as being less than they could earn in private practice. However, the work of surgeons in postgraduate training was never specifically paid and remained a "gift". The "knight" was fostered in the training sphere, at exactly the same time as the "knave" was being fostered in the sphere of patient care. Whether, in some cases, this accelerated the trend towards allowing trainees more opportunities for assisted hands-on surgical experience can only be speculation.

**Silence and Surgical Training**

American surgeon Atul Gawande has argued that the process of learning surgery is hidden and that this applies not only to trainees but also to established surgeons learning new procedures.\textsuperscript{112}

\textsuperscript{108} Ibid.
\textsuperscript{109} Ibid.
\textsuperscript{110} A. Fox, Beyond Contract: Work, Power and Trust Relations (London: Faber, 1974).
\textsuperscript{112} Gawande, Complications, A Surgeon's Notes on an Imperfect Science, p. 24.
By traditional ethics (not to mention court rulings) a patient's right to the best care possible must trump the objective of training novices. We want perfection without practice... So learning is hidden... Given the stakes, who in their right mind would agree to be practised upon?\footnote{\textit{\textsuperscript{113}}}

In Australia in the 1970s, to state the position very baldly, trainee surgeons stopped travelling to England to practise on National Health Service patients there and stayed home to practise on public hospital patients in Australia. This was not deliberately or systematically hidden from the public, but it was covered by coded language on choice of doctor. In his MA thesis on the history of Queensland's hospitals, Brisbane surgeon Sir Clarence Leggett argued that the principal advantage of private medical practice was "the right to select a doctor of one's choice."\footnote{\textit{\textsuperscript{114}}} He went on: "The right to be treated by a selected doctor is the prime reason for a patient seeking private hospital attention in my experience."\footnote{\textit{\textsuperscript{115}}} In Sir Clarence's heyday, this meant what it said. No trainee was ever likely to perform surgery on a public hospital patient under his care, unless the operation was minor or an emergency in the middle of the night. Sir Clarence would perform the most interesting or major cases himself and allocate the rest to the various members of his team. But this changed when he retired in 1969.

Sir Clarence did not write that in private practice the patient could expect a consultant whereas in a public hospital he or she was very likely to be treated by one or more trainees. Yet he was perfectly well aware that public hospitals were staffed on a day-to-day basis largely by trainees, even in the 1960s.

The appreciation on the part of the hospital administration that the major hospitals had an important and vital role in post-graduate education represented a major advance. Even as late as 1969, the medical superintendent pointed out that the administration of the Royal Brisbane Hospital still largely expected a recent medical graduate to be a fully trained doctor at graduation when in fact he had no skills of any

\footnote{\textit{\textsuperscript{113}}} Ibid., p. 24; p. 30.\footnote{\textit{\textsuperscript{114}}} C. A. C. Leggett, "The Organisation and Development of the Queensland Hospitals in the Twentieth Century" (MA, University of Queensland), p. 173.\footnote{\textit{\textsuperscript{115}}} Ibid., p. 174.
magnitude and required several years on the resident medical staff in order to obtain essential post-graduate knowledge and abilities.\textsuperscript{116}

This view of young doctors as fully qualified was still widespread in the early 1970s. The 1974 Federal Government report on hospitals noted the recent rapid rise in the number of residents and registrars, but downplayed the role of registrars as trainees: [Registrars] "often possess specialist qualifications and many play important roles in the educational and research functions of the hospital, in addition to their roles in supervision and control of quality of medical care."\textsuperscript{117}

The contrast with the description of nurses in the same report is striking: "Within the public hospital system nurses are trained according to the apprenticeship method. As a result, students are responsible for the delivery of a large amount of patient care."\textsuperscript{118}

Surgeons were perfectly clear about the difference between a trainee and a qualified surgeon, to the extent that E. S. R. Hughes expressed concern at the legal implications if trainees were involved in the care of private patients:

Surgical training has encountered a serious problem with the development of private insurance and more recently Medibank.\textsuperscript{119} Whereas previously the teaching hospitals provided adequate experience, now nearly all elective consulting is carried out in private consulting rooms, and much of the elective surgery and straightforward emergency work is done in private hospitals—areas not accessible to the trainee.\textsuperscript{120}

He raised the possibility of a partial return to the old style associate apprentice, who worked with his master in private as well as in public. "This raises the question of the ethics of teaching on private patients—a matter that has been referred to the Hospital and Allied

\textsuperscript{116} Ibid., p. 178.
\textsuperscript{118} Ibid., p.170.
\textsuperscript{119} Presumably he meant Medibank II, introduced by the Fraser Liberal government in 1976, with a return to a greater emphasis on private insurance. Scotton, "Milestones on the road to Medibank and Medicare."
\textsuperscript{120}
Services Advisory Council for legal direction."¹²¹ But some health administrators at least acted as if they either did not know that public hospital surgery was performed by registrars, or as if they believed that registrars were qualified surgeons. This was associated with the older view that medical graduates were qualified to perform at least some surgical procedures.¹²² This view was also associated with the way that the teaching issue was glossed over in the debates about the introduction of Medibank: "Many people maintained their private hospital insurance cover, possibly because of inertia, but mainly to be sure of receiving treatment from specialists chosen by themselves or by their doctors."¹²³ Here Sax is repeating an argument used by the medical profession associating private medical care with choice of doctor. But in fact very few patients are in a position to make an informed choice about a medical specialist, even with the aid of their general practitioner. GPs actually have very unsystematic and patchy information on specialists, and seldom have more than anecdotal evidence about surgeons' results, for instance. Patients are also likely to have trouble obtaining reliable information on specialists, even if they are prepared to take the time and trouble to engage in "doctor-shopping".¹²⁴ The whole argument about choice of doctor in the private system is actually code for: "In the public hospital you may well be treated by trainees. In private, you will be treated by a qualified specialist of your choice."

During the 1970s, much, if not most, public hospital surgery in Australia came to be performed by trainee surgeons. Arguably, this was because the Royal Australasian College of Surgeons put in place measures to provide more structured and formal training programs for aspiring surgeons. However, this happened at the same time as the honorary system of hospital staffing finally came to an end in the southern States of Australia. Practising surgery on public hospital patients in Australia was not just or even mainly a feature of the days of the charitable hospital and the honorary system of staffing. If anything it was a more pronounced feature of the Australian training system in the 1970s, when public hospital patients were not the recipients of discretionary or conditional gifts from hospitals or

¹²² Ibid., p. 732.
¹²³ See, for example, Sax, Medical Care in the Melting Pot, pp. 40-43.
¹²⁴ Sax, A Strife of Interests: Politics and Policies in Australian health services, p. 118.
¹²⁴ Interview with "Leo", 2002.
medical staff, but were using a facility paid for out of their taxes. Was this because medical staff somehow continued to see free public hospital care as representing a "gift" to patients?

B: The gift by the patient

In the 1960s, senior members of the general surgical staff of the Royal Melbourne Hospital thought they were short of patients. This somewhat startling state of affairs highlighted just how much they needed patients. In 1960, the hospital's annual report noted a drop in the number of patients on the wards as well as in the number of outpatients, and announced that this was leading to problems teaching medical students. Medical education, it was argued, needed teaching material that "must be present in quality and quantity". The reasons advanced for the drop in the number of patients included the growing number of people who had private insurance and therefore opted for private treatment; the growing number of suburban hospitals; the rising cost for public patients at the Royal Melbourne Hospital (up from £1.16.0 to £3 per day from 1 May 1960); and the availability of workers' compensation insurance. Another factor, not mentioned in the Annual Report, was the increasing popularity of the various medical and surgical specialties. It should also be noted that the problem of falling numbers of general surgical patients did not apply to Brisbane's (free) public hospitals, or to Brisbane's Catholic hospital group. But in the 1960s, leading figures at the Royal Melbourne Hospital thought they were short of patients, or rather general surgical patients suitable for teaching. At the same time, emergency admissions were increasing and these, it was argued, were taking up beds. Most of these patients are of an orthopaedic nature or are patients in the older age groups, and as such are of limited value in a programme of clinical instruction. In 1968, the medical staff suggested using some of their private patients for teaching and as a result:

126 Ibid., p. 15.
127 In 1965, for instance, the Mater Children's Hospital was so full that there were beds in the middle of the wards and children were being turned away and sent to other hospitals, and in 1968: "the volume of work presenting is reaching almost overwhelming proportions": Mater Misericordiae Public Hospitals Brisbane, Annual Report, (1965), p. 16; Ibid., 1968, p. 10.
Converted thirty public beds to be utilised as "Intermediate Special Beds". These beds, available in designated wards, may be occupied by patients who are private patients of members of the Medical Staff, are considered to be suitable for undergraduate clinical instruction and who have consented in writing to be available as subjects for such teaching.\textsuperscript{129}

This did not, however, solve the problem as far as the University Department of Surgery was concerned. Unlike the majority of the senior medical staff of the Royal Melbourne Hospital, who were part-time and unpaid, staff of the University Department of Surgery were full-time and paid. In 1970 they complained:

Bearing in mind that one of the major responsibilities of staff members is in the post-graduate training of residents and registrars, we have viewed with increasing concern the progressive fall-off in the number of patients presenting in the Surgical Outpatient Clinics. This is a matter of critical importance to the members of the full-time staff of a University Department of Surgery, since they are almost entirely dependent on their hospital practice for their total surgical experience.\textsuperscript{130}

In 1972, the University Department of Surgery reported:

There is no indication that the progressive decline in outpatient numbers... is levelling off... a source of acute embarrassment to the Unit in every aspect of undergraduate and postgraduate education and also research... It is no longer possible to offer to surgeons in training in the Unit the requisite practical experience.\textsuperscript{131}

In 1971, the report of the Clinical School includes the following:

\textsuperscript{129}Royal Melbourne Hospital, Annual Report, Statement of Accounts, List of Subscribers and Donors and Statistical Returns, (1968), p. 3.
\textsuperscript{130} Ibid., 1970, p. 11.
\textsuperscript{131} Ibid., 1972, p. 11.
The Clinical School owes a great debt to the large number of patients who, year by year, readily lend themselves to the proper clinical training of the undergraduate. Without their ready co-operation, the Clinical School could not function.\textsuperscript{132}

In other words, in 1971, after a decade in which those responsible for medical training in the hospital were made acutely aware of how much they needed patients, those patients were thanked for their contribution to medical training. That single entry in 1971 is most uncommon, if not unique. As a genre, hospital annual reports were overflowing with thanks. Before the 1970s, they typically began with a listing of honorary (unpaid) medical staff and ended with a list of those who had donated in cash or kind to the hospital.\textsuperscript{133} One of the main functions of the annual report as a document was as a vehicle for thanking those who had given to the hospital during the year, and asking for their continued support. In contrast, thanking patients for their contribution to medical training was exceedingly rare, yet that contribution was clearly vital.

This gift by the patient is essential to the process of learning surgery, but it is seldom acknowledged. It forms part of a larger network of often unarticulated and unrecognised debts and obligations in medicine. In the 1960s there was a tacit understanding that patients owed something to the doctor or the nurses or the hospital in return for their treatment. Surgeons learned surgery by practising on patients, and on the whole, patients accepted that this was reasonable. This was an enormously valuable gift that patients provided.

\textsuperscript{132} Ibid., 1971, Report of the Clinical School, p.9.
\textsuperscript{133} See, for example, \textit{Annual Report of the Ballarat Base Hospital}, (1970), which begins with a listing of "honorary professional staff". In his report, the President of the board of the hospital registers thanks for bequests to the hospital during the year, as well as thanking members of the hospital auxiliary, local members of Parliament, the Hospitals and Charities Commission, the Red Cross Blood Bank, the Ballarat "Courier" and local radio stations. The \textit{Annual Report of the West Gippsland Hospital}, (1970), begins with a list of members of the committee of management and honorary medical staff. Unusually, it includes the "Directress of Nursing" on this initial page, but is conventional in thanking members of the public, for their contribution to the hospital building program, and a very wide range of others, including the Sewing Guild, the Victoria Police and the local farmers for their donation of calves to the Annual Calf Sale. More concisely, in \textit{Mater Misericordiae Public Hospitals Brisbane}, \textit{Annual Report}. 1959, the Matron, Sister Mary Virginia, R. S. M., thanked (on behalf of the nurses), the general staff, the honorary medical staff, the resident medical staff and the members of all the other departments. p. 15. No trace has been found in any of these reports of thanks to the patients.
Surgical training, of course, is just a particular instance of the broader medical training paradigm. Medical training is based on the availability of patients who are prepared to allow themselves to be used for teaching purposes. Moreover, this gift by the patient to medical training is just one of many gifts within the framework of the health care system. In a recent article in the *Annals of Internal Medicine* Frank Davidoff notes eleven examples of gift relationships in medicine, and this is clearly not a complete list. He did not mention volunteer workers in the hospital, for example, or the private foundations which fund medical research, let alone the gift of the patient to training. Nurses, too, were an integral part of the gift economy of the hospital. The subject of nursing falls outside the scope of this thesis, but the fact that their contribution to the social capital of the hospital was not rewarded with the same honour and status accorded to doctors raises some interesting questions. In 1949 it was argued in a straightforward fashion that the rewards of nursing were social rather than economic. Presumably nurses were all expected to be "knights" rather than "knaves": "The monetary rewards, though much higher than formerly, are not rich. But nursing provided other rewards less tangible but perhaps more satisfying... the satisfaction of helping to relieve suffering and to save lives."

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Guenter Risse has argued that: "For many, hospitals still embody the human gift relation, a moral commitment to giving and receiving removed from the purely commercial realm and its cold, bottom-line mentality."138

There is a sense in which the practice of medicine was fundamentally about gift relationships, although there have been suggestions that this is now changing.139 This was obviously the case where no money changed hands—when, for instance, honorary surgeons and physicians at public hospitals treated (poor) patients for free.140 But this also applied where the doctors were paid. Sandra Opdycke has noted for New York: "In earlier years, a stay on a New York Hospital ward had represented a clear trade: the patient provided the hospital with clinical material and, in exchange, received free care."141 Although by the 1950s, the New York Hospital was more a private than a charity hospital, it continued to be very much a teaching hospital. Traditionally, only the open wards with their charity patients were used for teaching and research, but in the early 1950s many of these wards were converted to semi-private rooms and half of these semi-private rooms were opened to the teaching program.142 Following the introduction of Medicare/Medicaid in the 1960s, Opdycke notes that the New York Hospital opened all of its semi-private and even some of its private beds to teaching. To quote Opdycke again: "Only in public hospitals like Bellevue can one count on receiving free care as a right. Elsewhere it is becoming more like a commodity—usually sold, sometimes given away, but recognised as having a cash value."143

This raises the question: Is health care a gift, or a commodity? In private practice, it would appear to be a commodity. To many doctors it is clearly a commodity. That is how they make their living. They provide health care, and in return they receive money. But is it as

142 Ibid., p. 109.
straightforward as that? Why do doctors so often have trouble thinking of their patients as customers or, perhaps more significantly, treating them like customers? In fact, the relationship between doctor and patient very often displays important characteristics of a gift relationship, even when the patient pays for the doctor's services. It is clear that in some times and places medical care has been a gift and it is also clear that in some times and places it has been a commodity, bought and sold for profit. These are not mutually exclusive categories. Health care can be, and often is, both a gift and a commodity at the same time.\textsuperscript{144}

This idea is not new. Erasmus argued more or less the same thing in the sixteenth century, and he was drawing his inspiration from Aristotle. Randall Albury and G. M. Weisz in their recent review of his work argue that Erasmus believed that even if the patient gave his physician both honour and money, he still had not fully repaid what he owed to him.\textsuperscript{145} This was because the physician provided the gift of life, and this therefore put the patient in a literally incalculable debt to the physician.

Clearly this is an extreme case. Most doctors do not usually or even often provide the gift of life. But most doctors are in the business of attempting to provide an improvement in health, and the stories of patients giving their doctors gifts in return are so commonplace as to be almost banal. There have been few studies of the process, but so far it would appear that the reasons why patients give gifts are complex. In his work on the legal and moral relationship between doctors and patients, Jay Katz quoted Isaiah Berlin in support of his view that “human beings complain less about a lack of liberty than about being ignored, or patronized, or being taken too much for granted.”\textsuperscript{146} Gifts are often linked to trying to redress this sense of powerlessness that patients feel, as well as their more obvious sense of gratitude.\textsuperscript{147} Psychiatrists have taken an interest in this and there is now a body of literature

\textsuperscript{143} Ibid., p. 44.
\textsuperscript{144} For an examples of how one person's gift can become another person's commodity, and vice versa, see: Nicholas Thomas, \textit{Entangled Objects: Exchange, Material Culture and Colonialism in the Pacific} (Cambridge Massachusetts: Harvard University Press, 1991).
on why psychiatrists think their patients give them presents. Clearly many patients think they owe a debt to their doctor that is not discharged when they pay the bill. Perhaps health care is sometimes a commodity from the point of view of the doctor, but a gift from the point of view of the patient.

Many writers on the concept of the gift have regarded gift exchange as about self-interest and the pursuit of power. Jean-Paul Sartre expressed this view in an extreme form when he wrote: "to give is to enslave". Those who can afford to give most are those who have the most power. In contrast, a number of other writers have taken a more idealised view of gifts. They have emphasised that gifts are about ongoing relationships between people, in a way that commodity exchange is not, and that gifts can be about altruism. Mary Douglas has argued that a "gift that does nothing to enhance solidarity is a contradiction." James Carrier draws the distinction between the self appropriate to gift relations as "situated" or "ennmeshed" in relations with others, while the self appropriate to commodity relations is free, autonomous and unconstrained. In the twenty-first century, most of us display

149 In her recent book on the gift in sixteenth century France, Natalie Zemon Davis describes gifts as a sort of social cement that reinforced existing social relationships of status, class and sex, while commodities — the buying and selling of goods and services — were neutral in this regard. But Davis argues that in sixteenth century France, some things were more appropriately rewarded by gifts. The French thought it appropriate to give their doctors gifts as well as money Natalie Zemon Davis, The Gift in sixteenth-century France (Oxford: Oxford University Press, 2000), especially pp. 82-86.
154 Carrier, Gifts and Commodities, Exchange and Western Capitalism since 1700.
elements of both of these selves at different times: autonomous as we do our shopping in
the supermarket, situated as we give gifts to members of our family at Christmas.  

Within medicine, the literature on the gift in the last forty years or so has covered a range of
topics, including blood donation, tissue and organ donation, gifts to psychiatrists and gifts
from the pharmaceutical industry to doctors. Gifts may be about altruism, but there is also
a strong school of thought that they are often about attempting to place the recipient under
an obligation. There is a point along the spectrum of possible gifts where they shade into
bribes, and this includes gifts to doctors. Recent writers on the gift have tended to emphasise
this complexity and the multiple possible meanings of gifts. Natalie Davis, for instance,
writes about "Gifts Gone Wrong", but also argues that gifts could soften "oppressive
relations across lines of class and status."  

I would argue that gifts are not inherently about power, any more than any other human
interaction, but neither are they inherently about altruism. How gifts are used depends upon
the personalities of the donor and the recipient, and on the nature of their relationship
before the first gift between them was given. Gifts between social equals are not at all the
same as gifts across a class divide. Gifts between employer and employee (remembering
the helicopter pilot who gave one of his kidneys to his media-magnate employer) are not the
same as gifts between parents and children or gifts between lovers. In the doctor/patient
relationship, the doctor is inherently rich in resources—the perceived power to heal—that

155 Katherine Young has argued that doctors are particularly situated in their medical roles: "it is not proper
to challenge a physician [at the boundary between ordinary and medical space]... they are understood to be
inextricably enfolded in their roles..." p. 13: Katherine Young, Presence in the Flesh—The Body in
156 Renee Fox and Judith P. Swazey, The Courage to Fail, A Social View of Organ Transplants and
Dialysis (Chicago: The University of Chicago Press, 1974); Richard Titmuss, The Gift Relationship
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the patient lacks. Nevertheless, doctors treating high status patients such as film stars, for instance, or lawyers, or sporting heroes, may feel at a disadvantage and think that the best that could possibly happen would be for nothing to go wrong with the treatment. In contrast, the innate inequality in the doctor/patient relationship is reinforced when there is also—as is often the case between public hospital patient and surgeon—inequality in their status outside the hospital.

The gifts in medicine are seldom freely given on either side. The patient initiates the relationship as a supplicant, asking for the gift of health. This inherently places the patient at a disadvantage, and the more the doctor appears to be giving, by working for free for instance, the greater the patient's debt. This sense of obligation that so many patients feel, has essentially provided the moral and spiritual underpinning for a huge proportion of medical education. Patients have at least partly discharged the debt that they are perceived to owe to their doctors or their nurses or their hospital by allowing themselves to be used as "clinical material" for teaching and research. But it is not clear that patients and doctors have always shared a view of the nature of this debt. At least until the end of the honorary system, most surgeons regarded public and private hospital patients differently. Public hospital patients were understood to be under some sort of obligation. They were in receipt of gifts to do with healing, which they were expected to pass on to future generations of healers and patients by participating in the training process. Private patients were not understood to be under a similar obligation. But it has been argued that the underlying gift in medicine, the gift of healing, remains whether or not money changes hands, in public and in private hospitals, for rich patients and for poor. The social meaning of the gift varies with the social relationship between donor and recipient, but not the fact that a gift is asked for by the patient. As Jay Katz has emphasised in the American context, patients want to be treated as individuals and valued in their own right as competent human beings, whereas too often doctors treat them like children, unable to make their own decisions. Giving something back may help redress their sense of powerlessness.

Where doctors are seen as giving literally invaluable gifts and patients are seen as being in their debt, it follows that patients have significantly lower status within the hospital than
doctors. Giving such gifts confers honour and status on the donor and it is no coincidence that in the British and Australian system of voluntary hospitals, doctors working for free were called *honorary* surgeons or physicians. The concept of the gift helps us understand the disempowering of the patient. Under this system, patients were often given no choice as to whether or not they were used for teaching, just as they had no choice as to whether or not they were sick. Public patients may not even have been aware that they were being used for teaching, but it should not be assumed that they would have been opposed to participation in training if they had known. There have been occasions when private patients have been asked to participate in training, and they have given their consent.\(^{160}\)

In Australia, the general assumption has been that teaching should take place on public, not private patients. The tacit bargains about this that may have applied in the past are no longer valid, and to teach in public but not in private hospitals is to reinforce the inequality between public hospital patients and doctors. This is especially true where patients are not aware that they are doing their doctors a favour. If the gift is hidden in this way, it cannot empower the giver. There is no longer any moral or ethical reason why private and public patients should be treated differently in this regard. There are significant organisational reasons, but is that a sufficient basis for continuing the tacit assumption that private patients are out of bounds for teaching, while public hospital patients are not?

In 1970, Richard Titmuss published his well-known (and highly controversial) book on blood as gift and blood as commodity.\(^{161}\) Towards the end, he raised the issue of other instances of gifts to strangers and non-economic transactions, and floated ideas of other books he might have written:

> We could, for example, have taken for study the giving role of the patient as "teaching material", and as research material for experimentation and the testing of new drugs and other diagnostic and therapeutic measures. Millions of people in Western societies


\(^{161}\) For some of the debates over Titmuss' work see: J. Garrott Allen, "Comments on Titmuss-Anderson-Surgenor debate over The Gift Relationship," *International Journal of Health Services* 3 (1973): 519-520.
every year are expected to give themselves, without price or a contractual reward, in these situations… To qualify as a doctor in Britain, it is probable that the average medical student now needs access to or contact with in one form or another some 300 different patients… They are no longer "charity" patients and could not in the 1970s, whatever the future of the National Health Service, be treated as such. Should their contribution to medical education, therefore, be paid on market criteria?\(^{162}\)

Titmuss does not answer his own question, but to ask it is to help illuminate, in this era of the commodification of everything, some of the implications of the hidden gifts at the heart of the public hospital. There are ethical reasons why this gift should be made explicit, but there are also legal reasons why the gift by the patient may not remain obscure for very much longer.

Informed Consent: Its Impact on the Surgical Training Paradigm

In the 1990s, two levers appeared which may be used to move at least some of the patterns of behaviour and attitudes which are entrenched within the public hospital system. One is the legal case of Rogers v Whittaker, and the other is the case of Chappel v Hart.\(^{163}\) Both cases were essentially about informed consent. In the case of Rogers v Whittaker, the patient, Mrs Whittaker, was blind in one eye, but there was nothing wrong with the other eye. Following surgery to improve the appearance of the blind eye, she developed sympathetic ophthalmia and lost the sight in her good eye. It was found that Dr Rogers should have informed her of this risk before surgery, even though it is a very rare occurrence. The risk has been estimated as 1/14,000. But the judge ruled that it was a material risk to Mrs Whittaker because she was especially worried about losing her good eye. Since that decision, doctors have had to take steps to ensure that patients are more fully informed about the potential risks and side effects of treatment, especially the risks, however slight, that are material to them.


The case of *Chappel v Hart* is at present less well known, even among doctors. Mrs Hart lost her voice during surgery, and it emerged that if she had known there was a more experienced surgeon available, she would not have gone to Dr Chappel. As a result, it appears that the patient should be informed not just about the potential risks of treatment, but also about the level of experience of his or her surgeon. In April 2000, Michael Gorton, honorary solicitor to the RACS, wrote of the case of *Chappel v Hart*:

It was alleged that the doctor was of average experience in relation to the particular procedure, and that more experienced doctors may have produced a better result. It seems implicit from the case, although it was not finally decided, that Mrs Hart should have been warned that the doctor was only of average competence in relation to this procedure, and that there were more experienced surgeons available.\(^{164}\)

Gorton went on to note that:

Most of the community will accept that public hospitals are training hospitals and that junior doctors and trainees must gain experience and learn under supervision. However, the Courts are likely to also require that patients be adequately informed when a trainee or junior doctor is performing a procedure, and probably the level of supervision involved.\(^{165}\)

In other words, the legal advice to surgeons is that a patient should be told if a trainee is going to perform the surgery. Gorton suggested that patients could be given this information in a non-threatening way, that emphasised the close supervision to be provided by the consultant. The problem, of course, is that *Chappel v Hart* does threaten to jeopardise the training paradigm. If patients are specifically informed—specifically and not generally or vaguely—that they are going to be used for teaching purposes, how long will it be before the current system of training comes under considerable stress? It might soon become clearer to all concerned that the patient is the one giving the gift by allowing themselves to be practised upon, and that perhaps it is the advanced surgical trainee who should be patient and grateful.


\(^{165}\) Ibid.
The implications of this case have been modified somewhat by a recent decision of the High Court. Callinan J argued that a more experienced surgeon would not necessarily have produced a better result:

A less experienced surgeon might very well be able to compensate for any lesser experience by the taking of greater pains. A less experienced one might also be better versed in modern techniques. And reputation is not always a reliable guide to competence assuming that there are ways and means available to a patient to ascertain who has the best reputation.

Legal interpretations of the exact nature of a doctor's duty to provide informed consent are still evolving, but the need to provide informed consent has been widely accepted, in theory if not yet always in practice. The RACS has also taken on board the need to provide more preliminary training that does not involve patients. Since at least the beginning of the 1990s, there have been moves to train surgeons in a range of techniques outside the operating theatre and there has also been considerable work on developing computer simulation for surgical training. However, at some stage surgeons still have to build up experience on real patients.

Conclusion

The College of Surgeons of Australasia was formed in 1927, with significant American influence, to try and stop general practitioners performing surgery. This was received badly by GPs and also by the press. However, as was discussed in Part I, by 1932 the College had succeeded in using public gifts and "invented tradition" to portray itself as above politics and financial considerations. The dignified ceremony devised for the bestowal of the gift of a ceremonial mace by the Royal College of Surgeons of England in 1932 was a particular public relations triumph. Together with the granting of the prefix "Royal", this was used to borrow a surgical past through association with British surgery, and anoint the RACS as custodian of surgical standards in Australia and New Zealand.

The RACS decided to make its Fellowship even harder to obtain than the Fellowship of the Royal College of Surgeons of England, in an attempt to make it a more prestigious qualification. However, the RACS did not conduct its own examinations until 1946. Instead, it recognised a range of other qualifications, especially the degree of Master of Surgery from an Australian university, and the FRCS Eng. Many Australian surgeons travelled to England to take the FRCS, even if they had already obtained an Australian MS, and as was discussed in Part II, many more travelled to America in search of further surgical experience. Throughout the period covered by this study, the universities did not offer either accreditation or training that could effectively compete with that provided by the surgical colleges.

Once the RACS began to conduct its own examinations from the late 1940s, it became clear that the Royal College of Surgeons of England was still the most important body providing accreditation for Australian surgeons. As was discussed in Part III, the extensive surgical experience and training available to young surgeons working in the British National Health Service added to the attraction of travelling to England to sit for the Final of the FRCS. When the RACS succeeded in taking effective control over the training of Australian surgeons in the early 1970s, it did so in competition with the English college, but also,
paradoxically, by implementing a group of changes to specialty training at least partly in imitation of the RCS. Whatever the intentions of individual specialty groups, the RACS did not try to take control of training in order to limit access to the profession of surgery. On the contrary, the objective was to make surgical training in Australasia more attractive, in an attempt to persuade aspiring surgeons to stay and train in Australia or New Zealand and take the FRACS, rather than travelling to England and taking the FRCS.

In the late 1960s and early 1970s, each of the clinical colleges was attempting to make its training programs more organised and effective, and the RACS, the Royal Australasian College of Physicians, the Royal College of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners all cooperated in publicising their revised training and examination plans. However, although the Royal Australian College of General Practitioners developed an excellent training program, it did so with the aid of government funding, and the RACGP subsequently lost control of GP training.\(^1\) In contrast, the training provided by the RACS, the RACP and the RCOG (later the Royal Australian and New Zealand College of Obstetricians and Gynaecologists) remained independent. These colleges were able to provide training that was independent of government funding because of their evolving relationship with public hospitals. By the late 1960s, the possibilities of simultaneously meeting the service needs of hospitals and the training needs of young doctors were widely recognised, partly on the basis of Australian experience and partly by analogy with developments in the United States and Britain.

The training system for Australian surgeons (and physicians) that emerged from this period of change relied upon a network of gift relationships. In particular, it relied upon the gift by the consultant, who taught without being specifically paid to do so, and it relied upon the gift by public hospital patients, who allowed themselves to be practised upon. The Australian public hospital system has come to depend financially on these gifts. Public hospitals are largely staffed by junior doctors. They are much cheaper than consultants, but junior doctors work in public hospitals on the understanding that that is where they are trained. The public hospital system and specialist clinical training have become inextricably

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intertwined. It used to be that surgeons and physicians obtained honour and status from working in public hospitals, while they depended financially on their private patients. Most still depend financially on their private practice (although many specialists now earn a significant proportion of their income from sessional work in public hospitals), but public hospitals are now where they train, whether as trainees or trainers.

It has been shown that the gift by the patient is vital to the continuation of this pattern of training, yet that gift is scarcely recognised. In a report to Fellows of the RACS in 2001, it was noted that: "The College needs to demonstrate [that] while it may have an exclusive role in the training of surgeons this is in the public interest and serves to protect standards of health care." The report went on to emphasise that: "This service is also provided at no cost to the community." The Chief Executive of the College, Vin Massaro, was quoted as saying that: "We want the public to realise that their surgeons have had the best possible training, which we provide at no cost to the public or the government." The College chose to argue that training is provided as a contribution to social capital, "at no cost to the public or the government", but it should be clear by now that this is misleading. The public hospital patient makes a very significant contribution to postgraduate clinical training, a contribution which is not acknowledged by the RACS or by the Federal or State governments. Although trainees, consultants, nurses and hospital administrators all know that public hospital patients are practised upon, they do not generally acknowledge this, or accord any power or respect to the patient in return for this gift. Surgeons have been able to use their gifts to reinforce their power, status and autonomy, while the gift by the patient is rarely even acknowledged.

Little research has been conducted on whether or not patients benefit clinically from participation in training. Most of the studies that have been conducted conclude that trainees are slow, but do not provide worse outcomes for the patient. However, there is a conflicting body of evidence that the number of procedures performed does affect outcomes (practice

\[ RACS \textbf{Surgical News}, \text{Vol. 2 No. 4 May 2001, pp. 8-9} \]

makes perfect). Some patients may benefit from training and some may not. Until better evidence is available there is much to be said for the view expressed by William Osler one hundred years ago:

The work of an institution in which there is no teaching is rarely first class. There is not that keen interest, nor the thorough study of the cases, nor amid the exigencies of the busy life is the hospital physician able to escape clinical slovenliness unless he teaches and in turn is taught by assistants and students. It is, I think, safe to say that in a hospital with students in the wards the patients are more carefully looked after, their diseases are more fully studied and fewer mistakes are made.

In conclusion, no good ethical reason has been found why private patients should not join public patients in playing a role in the training process. If training took place in private as well as in public, the role of the patient in training would almost certainly be more openly acknowledged. The current partly obscured nature of training is not in the interest of the public hospital patient. Where gifts are silently appropriated, they empower the one who takes rather than the one who gives. Registrars are understandably uneasy about making the gifts in training more obvious and open. But surely this would be a better beginning to a surgeon's career than the current silences about training, with their ever-present uncomfortable proximity to paternalism?

Clearly, participation in training is in the interests of patients in a global sense. Surgical patients need trained surgeons now, and for the future. But the reluctance to openly acknowledge the role of patients in training masks an unspoken unease as to whether this role is always in the best interests of the individual patient. More research is required to resolve this ambiguity and to determine whether or not patients benefit from their participation in training. Meanwhile, it is suggested that in future both public and private patients should be invited to take part in training, on a fully informed basis, and recognised for their contribution with grateful thanks.

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APPENDICES

University of Melbourne Ethics Committee Requirements,
HREC 010412

1: Plain Language Statement
2: Consent Form
3: Interview Schedule
Appendix 1: Plain Language Statement
Information sent to prospective interviewees

Project: A History of Surgical Training in Australia
Principal Investigator: Sally Wilde, phone: (03) 9439 6477,
email: s.wilde@pgrad.unimelb.edu.au
Supervisor: Associate Professor Janet McCalman, phone: (03) 8344 0053,
email: j.mccalm@csss.unimelb.edu.au
Research for the degree of Doctor of Philosophy

Dear Dr (Queensland)/ Mr (Victoria),

A History of Surgical Training in Australia

I would like to invite you to participate in the oral history component of a research project on the history of surgical training in Australia. It is hoped that this research will help contribute to informed decision making on future training policy. The research is being conducted as a part of a PhD in the Centre for the Study of Health and Society at the University of Melbourne. Your participation would involve spending about one and a half to two hours, while an interview with you is tape recorded.

A total of about thirty general surgeons and urologists are being interviewed, chosen to include those who can provide information on training from the late 1950s, through to the late 1980s. Their recollections of individual experiences as both trainers and trainees will be used to supplement information from the archives of the RACS and various public hospitals. Participation in the project is voluntary. You may choose not to participate and if you do participate, you may withdraw at any time. Those who do withdraw, will have any tapes of interview and/or notes returned to them without question.

Information collected from participating surgeons will be used in the PhD thesis, and may also be used in subsequent academic articles. Participants will be sent drafts of any written material where they are quoted, and will be invited to comment. At this stage, participants may choose to modify what they are recorded as having said.

All participants will be invited to choose their own pseudonym for use in the PhD and any published material. However, participants should be aware that the small number of surgeons involved in this study means that it may well be possible for some readers to identify the individuals concerned. In addition, confidentiality of information is subject to any legal requirements. For instance the Australian Competition and Consumer Commission, which is currently reviewing the procedures of the RACS, has the power to subpoena information, should it so wish.

If you would like to participate, I can be contacted by phone on (03) 9439 6477 or by email at s.wilde@pgrad.unimelb.edu.au, so that a mutually convenient time can be arranged.

For any concerns or questions regarding the conduct of this research, please feel free to contact: The Executive Officer, Human Research Ethics, The University of Melbourne VIC 3010, Phone: (03) 8344 7507, fax: (03) 9347 6739

Yours sincerely
Consent form for persons participating in research projects

Project Title: a History of Surgical Training in Australia

Principal Investigator: Sally Wilde Phone: (03) 9439 6477 email: s.wilde@purad.unimelb.edu.au

I, _______________________________________________
(name of interviewee)

of _______________________________________________
(address)

authorise Sally Wilde to conduct a tape recorded interview with me, and I agree to the use of this tape recorded interview for the purposes of research into the history of surgical training in Australia.
I acknowledge that the particulars of the research project have been explained to me and a written copy of the information has been given to me to keep.
I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data previously supplied.
I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements, but I am aware that it may be possible to identify me, because of the small number of surgeons interviewed for this research project (about 30).
I choose to be referred to by the following pseudonym in the PhD and in any publications arising from this research: _______________________________________________

However, I recognise that it may still be possible for some readers to identify me from the context.

Signature: __________________________________ Date _____________________________
(participant)

I authorise this tape to be held in the medical history museum of the University of Melbourne, so that it may be available in the future for use by bona fide researchers.

Signature: __________________________________ Date _____________________________
(participant)
Appendix 3: Interview Schedule

PREAMBLE
I would like you to feel free to tell me what it is that you consider I should know about surgical training, rather than feeling constrained by a set list of questions.

PART 1
However, to begin, perhaps you could tell me about your own experiences as a trainee. At what stage in your medical training did you decide that you wanted to become a general surgeon?

Prompt questions might include:
- Dates of MBBS
- Which fellowship - FRCS(Eng), FRACS, etc
- Principal hospital(s) in Australia - why chosen
- Principal hospital(s) overseas - why chosen
- Influential figures/mentors during the training process
- Relationships between participant and those senior to him during his training (I was unable to find any women surgeons to interview who trained in this period).
- Hands on experience of surgery - degree of supervision at various stages
- Any practice on animals/cadavers
- Working hours
- Problems, including dealing with difficult cases and complications

After covering the details of the participant's own training (about 3/4 hour), I asked him to sum up. What is at the heart of surgical training? Is it about acquiring technical competencies - is it about 'good hands'? or is it about clinical judgment? Or what? I tried not to put words into their mouths.

PART 2
I'd now like to turn to your experience on the other side of the fence, as a trainer, rather than a trainee.
When did you first become involved in teaching surgery?

Prompt questions might include:

Changes in training content and method since his days as a trainee, e.g. closed circuit TV for training in endoscopic surgery

Mentoring

Process of choosing candidates for advanced surgical training/ quality of trainees/ what makes a good surgeon?

Numbers trained vs numbers needed

Standards of overseas training vs Australia

Any involvement with the College of Surgeons (based on my prior knowledge of the c.v.)

Length of this section varied, depending on how active the individual had been, e.g. as an examiner, on State training committee, etc. After 1/2 to 3/4 hour, invite summing up:

What are the main problems in teaching surgery?

It was sometimes also appropriate to invite some speculation, depending on the individual:

Way forward for the future? Implications of ACCC interest in RACS monopoly on training.
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