

TRAINING

So ingenious and able and studious to do good.

Samuel Pepys, *Diary* (11 July 1662)

The men who devised the idea of an Australasian College set out to combine the strengths, while eliminating what they saw as the weaknesses, of the English and American colleges. The Americans demanded a period of supervised training and evidence of operative experience¹ but imposed no examination; the English College had its examination – and a two-part one at that, at a time when the Edinburgh College, for instance, did not – but it demanded relatively little training before admitting its Fellows.

As we have seen, the members of the establishment of the new College demanded both elements and, although their system of examination was crude at first, it became progressively more precise, more elaborate and arguably more dispassionate. Their system of training likewise underwent a process of maturation.

For a start (as Alan Newton recorded in 1934, in the paper quoted in chapter 4) the requirement was ‘a minimum of five years’ post graduate training in surgery’ and this was not affected by the institution of the Boards of Censors in the year he wrote.² Some flexibility was allowed but no compromise of the principle of properly supervised training. ‘Credit is given,’ he wrote, ‘for the time spent as a resident medical officer, in work in university departments and in other countries, and in research but emphasis is laid upon the desirability of an apprenticeship period to a senior surgeon.’

This led the College to require the availability of suitable training posts. The 1940 handbook observed:

As an essential part of the training for Fellowship of the College consists in a period of surgical apprenticeship, the Council approached the large hospitals in Australia with a request that positions of assistants to indoor surgeons [i.e. senior surgeons; juniors did not have access to beds of their own, and were commonly designated ‘surgeons to out-patients’] should be made available in these institutions. The following hospitals have created positions of this type:- Royal Prince Alfred Hospital, Sydney; Royal Alexandra Hospital for Children, Sydney; Alfred Hospital, Melbourne; St Vincent’s Hospital, Melbourne, The Royal Melbourne Hospital [it became ‘Royal’ in 1935]; Adelaide Hospital [*sic*; though the Adelaide had become ‘Royal’ in 1939]; Brisbane Hospital; Mater



In 1940 (Sir) Leonard Lindon was among the founders of what became the Neurosurgical Society of Australasia. In 1959 he succeeded (Sir) Douglas Miller, to become the College's second neurosurgical president.



The protean Sir Henry Newland, and (Sir) Harold Dew (see page 90) were pioneers of neurosurgery and among the association's original honorary members.

Misericordiae Hospital, Brisbane. These positions are non-resident and are intended for men who have already been House Surgeons, and who wish to continue their surgical training with a view to obtaining the Fellowship of the College.

Nothing in Perth, we may observe; no mention of New Zealand – and nothing about women: it was still seen as a men's world by the likes of Newton, Devine and Barnett.

The regulations took up the threads, noting that 'every candidate... must furnish evidence that he has been engaged in the study and practice of his profession for at least five years subsequent to graduation'. They were generous in the range of credentials they allowed, seeking

- (g) Particulars of work done as Resident Officer to a hospital.
- (h) Particulars of work done as Assistant in the wards, out-patient departments and operating theatres other than specified in (g). [These are the posts, essentially training registrar posts, described above.]
- (i) Particulars of post graduate work done in any department of a university or research institute.
- (j) Particulars of any research work other than that specified under (i).
- (k) Particulars of work done elsewhere than in Australasia.
- (l) Particulars of specialisation in Surgery or one of its special departments.
- (m) List of contributions to medical literature.
- (n) Any other particulars... which may be helpful to the Board of Censors.

Then followed a note: 'The candidate is instructed to give the above information in great detail *and to include a list of the names of surgeons who have assisted in directing his studies and practice* [my italics].' The College was even then seeking properly supervised training, and its hospital committees were concerned not only with improving the standard of hospitals as places for the sick, but as places for teaching.

It is impossible to attempt to tally up the number of hours of voluntary work performed by Fellows of the College in the teaching of the next generation of surgeons. This is a pity, because it gives the lie to those in the community who brand surgeons selfish or accuse them of operating a 'closed shop'. For the very surgeons they train are the ones who will displace them from the leadership of the pack, yet they do it willingly, even eagerly, without fee and year after year.

The Neurosurgical Society of Australasia had been formed, under a more cumbersome name, in 1940. Its founders included two future presidents of the College, Douglas Miller and Leonard Lindon, and its original honorary members two other presidents, the durable Sir Henry Newland (1929-35) and Harold Dew of Sydney (1953-55). It is not surprising, then, that neurosurgery as a specialty has always taken a keen interest in College affairs. All but two of the Society's original members were 'established and busy general surgeons',³ but with a couple of exceptions they were men who had gained experience under

the great pioneers: Cushing, Cairns or Naffziger.

By 1955 neurosurgery in Australasia had evolved from the status of a 'special interest' within general surgery to become an exclusive discipline, and the Society required a constitution more elaborate than the one that had sufficed at its founding. Membership was henceforth to require not only a senior surgical qualification but adequate training in neurosurgery. This invited the question: what represented 'adequate training'?

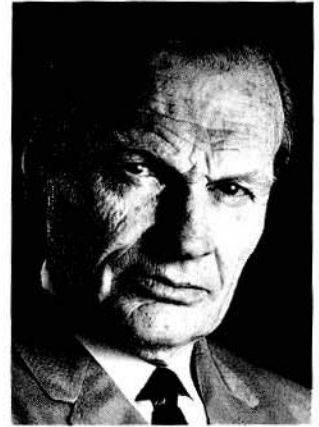
College regulations at the time worked on the basis of training posts, and indeed most neurosurgeons obtained their specialist training overseas, particularly in Britain. However, by 1960 Australasian neurosurgeons were thinking in terms of training programmes, as they embarked on the task of providing specialist training in their own units.

In 1964, during the Society presidency of J.B. Curtis (Fellow 1950) of Melbourne, a subcommittee for the coordination and standardisation of neurosurgical training was set up. To his colleague Keith Henderson (Fellow 1959 – the pattern of delegation is obvious)⁴ he gave the task of researching the well-developed American Board system, which provided a useful model. The resulting scheme promised enough that, five years later, Curtis convened a seminar in Melbourne to which he invited representatives of all the surgical disciplines and, as an observer, the censor-in-chief of the College, E.S.R. Hughes.

Meanwhile, orthopaedic surgeons throughout the English-speaking world had been developing a community of interest and planning that would influence the pattern of orthopaedic training beyond Australasia, while influencing the pattern of Australasian training beyond orthopaedics. Meetings of six orthopaedic associations began in 1952 in London.⁵ There, Her Majesty The Queen Mother, patron of the British Orthopaedic Association, presented jewels of office to the respective presidents. These bore the symbol of Andry's crooked tree, bound to a post by ropes of which the ends were held by cherubs.⁶ They were identical apart from the names of the associations and small distinguishing emblems in the borders; their similarity served to emphasise the unity of orthopaedics.

In September 1966 the New Zealand Orthopaedic Association invited Peter Williams of Melbourne to address its annual meeting on orthopaedic training in Australia and New Zealand. The time was ripe, he contended, for Australia and New Zealand to train their own orthopaedic surgeons. The Australian association, he reported, had made approaches to the College concerning orthopaedic training and accreditation, but the College had not been helpful. A New Zealand subcommittee was set up to confer with the Australians to arrange a programme of orthopaedic training which could achieve uniformity and collaboration between the two countries.⁷

At that time the College regulations merely specified that candidates



J.B. Curtis (his initials, I am told, led to a cheerfully blasphemous nickname) was a key figure in producing a structured programme of neurosurgical training, and then in persuading the College to interest itself in advanced training programmes.

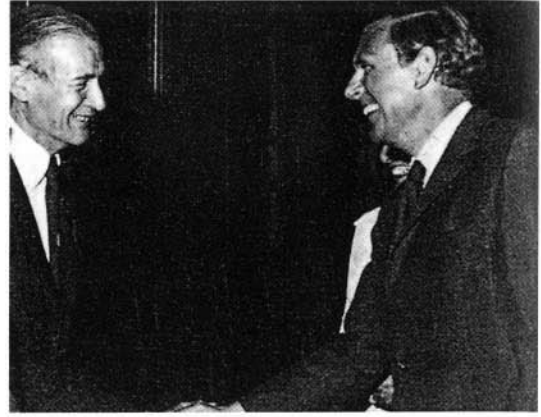


Orthopaedics gained its name and its symbol of the crooked tree from a French physician, Nicholas Andry, who wrote the *Orthopaedia* in 1741.



At the 1952 London meeting of English-speaking orthopaedic associations Esmond West, president of the Australian association, was a well-regarded ambassador for his country.

Peter Williams of Melbourne became influential in fostering 'indigenous' orthopaedic training programmes on both sides of the Tasman. Here he is greeting David Evans at a later London meeting.



presenting for the Final Fellowship examination should have four years of training in the case of general surgery, or five years in the specialties (one of these years to be in general surgical posts except in the case of ophthalmology). There was nothing specified as to the comprehensiveness or balance of this experience.

By the time of the meeting convened by Curtis in July 1969, therefore, neurosurgery and orthopaedics at least had arrived at the concept of training programmes supervised by the specialist associations concerned, leading towards the College Fellowship. It is an essential part of such programmes that they seek to deliver a rounded specialty training. But, as the 1992 handbook of the Neurosurgical Society of Australasia makes plain, although

some specialty groups were thinking on the same lines as the NSA, some were not and several delegates appeared unable even to grasp the issues.

E.S.R. Hughes (later Sir Edward but always 'Bill') became censor-in-chief in time to pick up the drive for structured advanced training and ensure that the College promoted it. His contributions led to the naming of the College's lecture room as the 'Hughes Room'; he and Doug Tracy are seen at the ceremony.



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Curtis however was not disconcerted by the diversity and indeed the stupidity of some of what was said. He had brought together these diverse speakers, chiefly so that the Censor in Chief could see for himself the emotional feeling among the specialties, and the need for leadership by the RACS. Hughes, himself a surgical statesman, saw this very clearly.

In E.S.R. Hughes, later Sir Edward but universally known as Bill Hughes, the meeting found the champion it needed. He was already a colo-rectal surgeon of international repute when he joined the Council only two years before this meeting and had taken over as censor-in-chief a mere three weeks earlier, but he was renowned as a man who got things done. He used his deafness as a weapon and somehow managed to hear what mattered to him. This meeting mattered.

Curtis, Miller and Simpson, in their paper, reflect on the importance of the seminar and what it achieved:

[It] had importance in the history of surgical education in Australia and New Zealand... there was broad agreement on the need for planned programmes in specialist surgical training under the supervision of an appropriate authority. The council of the College accepted and developed many of the recommendations of this historic meeting, and they are embodied in principle in the qualifications for the Fellowship diploma.³

That was in 1980, but the conclusion is still valid. At Bill Hughes' urging, the Council accepted the need for what were originally called Specialist Surgical Training Committees – but fortunately soon metamorphosed into the Surgical Boards. These exist for each discipline recognised for training and examination by the College. They are appointed by, and answerable to, the Council, but their

By 1970 the Council was working towards the concept of training programmes and an exit Fellowship. Back row: K. McCaul (Dean), J.W.E. Raine, A.C. McEachern, H.D. Sutherland, D.W. Fleming, J.W.F. Macky, J.E.D. Goldie, P. Braithwaite, C.A.C. Leggett, G.D. Tracy, J. Loewenthal. Front row: E.S.R. Hughes, R.N. Howard, P.J. Kenny, PRACS, B.T. Keon-Cohen, F.D. Stephens.



membership is largely determined by the body (commonly a specialist association, indeed more commonly now than three decades ago) which represents the surgeons of a particular discipline.

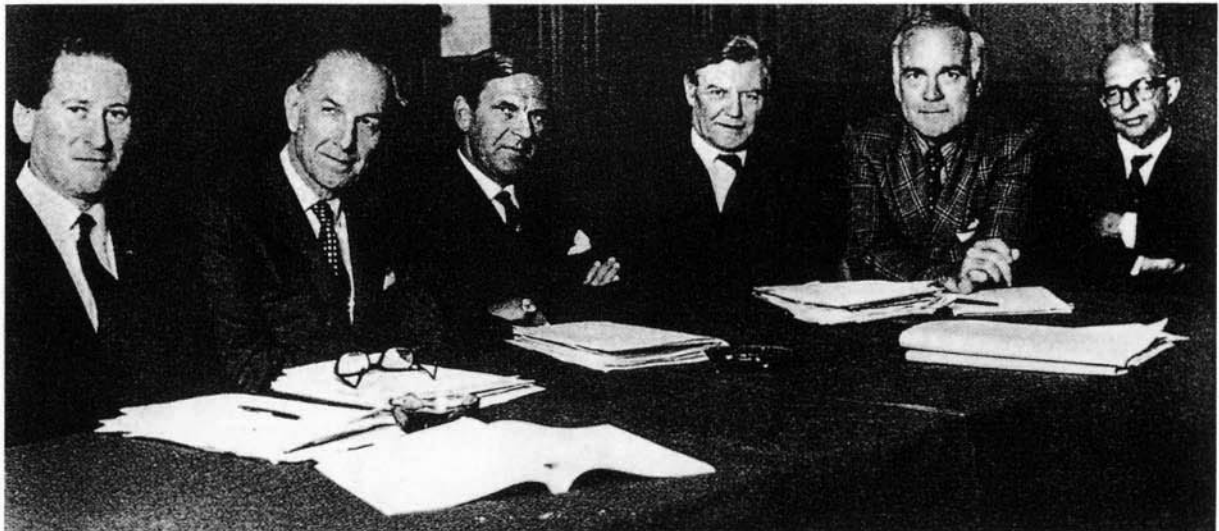
Curtis and his colleagues went on, after describing how neurosurgical board members were *ex officio* members of the Society's education subcommittee:

This arrangement should ensure continued close collaboration between College and Society, which indeed is easier to organise in our compact discipline than in some of the larger and more inchoate surgical specialties.

But it was not only 'more inchoate' larger specialties that sat less comfortably within the system of surgical boards. In orthopaedics, for example, it was the very cohesion of the specialty that created the potential for tension. Orthopaedics in Australasia, as well as being part of surgery (even if some orthopods do tend to overlook this at times), had identified itself as part of another unity: that of orthopaedics worldwide but, most demonstrably, within the six English-speaking associations. That unity was soon demonstrated as the six associations sought to devise a training system which would allow 'reciprocal recognition of education and training in approved centres in any of the six countries', that being the first principle enunciated by the inaugural meeting of the International Council for Orthopaedic Accreditation, held in Edinburgh in April 1971 and attended by Peter Williams and Colin Hooker as the representatives of Australia and New Zealand.

It is this disparity between disciplines, in the structure of their respective specialty groups, that complicates attempts to achieve uniformity, even consistency of process. In the College's 1979 *Guide to Surgical Training* were listed the 'Electoral Bodies responsible for nomination of members to the Surgical Boards': no fewer than six different formulae were set out:

At a meeting in Edinburgh in 1971, representatives of the six English-speaking associations set up the International Council for Orthopaedic Accreditation. From left: Colin Hooker (NZ), Paul Lipscomb (USA), Peter Williams (Australia), Jip James (UK), Jack Kennedy (Canada), George Dommis (South Africa).





- 3.4.1 Cardio-thoracic, Paediatric, and Plastic and Reconstructive Surgery – the appropriate Section of the College for all five members.
- 3.4.2 Neurosurgery and Urology – the Neurosurgical Society of Australasia and the Urological Society of Australia respectively for all five members.
- 3.4.3 Orthopaedic Surgery – the Australian Orthopaedic Association for four members and the New Zealand Orthopaedic Association for one.
- 3.4.4 Ophthalmology – the Royal Australian College of Ophthalmologists and the Ophthalmological Society of New Zealand for one member each. Council will appoint three members.
- 3.4.5 Otolaryngology – the Otolaryngological Society of Australia, two members. Council will appoint two members, and the New Zealand Committee one member.
- 3.4.6 General Surgery – Council will appoint all five members.

With such a level of disparity (and let us note that at this time general surgery, the largest discipline of all, had no body to attend to its affairs *as a discipline*) it is surprising and agreeable that the system worked tolerably well.

With the help of its boards the Council was able to work up a system of advanced training programmes that enjoyed both aptness and a measure of consistency (though at times it became a bit like trying to get a number of racehorses into the starting gates at Flemington). A conjoint surgical board was set up in which the censor-in-chief and members of his committee met the chairmen of the surgical boards at regular intervals.

In general, these advanced training programmes were for a four-year period in which, by suitably supervised groupings and sequences of hospital posts, a trainee might be expected to have enjoyed a balanced surgical education and one free of serious lacunae. Orthopaedics, by reason of its overseas network, was prompted to specify that one year (commonly the final one) might be spent overseas in approved posts. So – with an ‘old boy’ network that probably worked just as well – did neurosurgery.

One problem that soon became evident was that, although the

By 1974 the Council (marked C below) and the chairmen of the Specialist Surgical Training Committees had established a pattern of joint meetings. These committees were soon (and fortunately) renamed Surgical Boards. Back row: N.A. Myers (paediatric), J.K. Clarebrough (cardiothoracic, C), M.K. Smith (C), N.C. Newton (C), H.H. Eddey (C), R.A. Chapman (secretary), D.W. Fleming (C), J.W.F. Macky (urology, C), J.E.D. Goldie (general, C), Hugh Ryan (ophthalmology), P.F. Williams (orthopaedic), C.S. Richards (otolaryngology), D.N. Robinson (plastic), K.G. Jamieson (C), John Ludbrook (C). Front row: P. Braithwaite (C), G.D. Tracy (neurosurgery, C), F.D. Stephens (C), J.W.E. Raine (C), John Loewenthal PRACS, C.A.C Leggett (C), E.S.R. Hughes (C), Tess Brophy (Dean), H.D. Sutherland (C).

College and its specialty boards might settle on an ideal rotation of advanced trainees through certain posts, the service needs of individual hospitals might dictate quite different postings. The situation was eased as groups of hospitals were encouraged to coordinate their appointments into (often) regional schemes. The reward for the hospitals was an assured supply of approved – and by implication capable – young surgeons; the benefit to the College and its various disciplines, that provision of balanced programmes became more straightforward.

The selection of trainees to enter approved schemes became increasingly sophisticated. In New Zealand prospective orthopaedic trainees were 'vetted' at a weekend retreat with the members of the orthopaedic association's education committee. This worked well. Trainees were judged on something more than a brief interview, and in turn came to know some of the older surgeons who would, they hoped, become their mentors over the next several years. I can recall commending the idea to a general surgical colleague of mine who was involved in his own selection process. 'I see,' he commented, 'you fellows judge your trainees on how they hold their glass in the evenings, as well as on their reports.'

Once accepted into a programme of advanced training, trainees kept a log book of their experience. (Establishing a format that could apply to disparate specialties was one of the challenges to the planners; fortunately the advent of personal computers took over from handwritten log books and gave added scope and flexibility to the recording process.) Regular reports from their mentors enabled the few unsuitable trainees to be weeded out. Such unpleasant decisions, of course, need – in fairness to all concerned – to be taken as early as possible. The trainee concerned can, with less loss of time, be steered towards a more appropriate career, while the risk of turning out unsuitable surgeons is minimised.

But in an increasingly litigious age, rejection at the selection stage or dismissal from a programme affords much scope for complaint. During the 1990s there were a few time-consuming contretemps when disappointed trainees felt hard done by, and the College learned how elaborate must be the process by which it is seen to be just in its rulings.

The need for inspection of approved hospitals and their training posts, which the College had recognised from the earliest days, was not diminished, rather amplified, by the emergence of training programmes. Only by personal contact, with trainees and mentors alike, is it possible to gain a proper understanding of what a particular institution provides.

With programmes in several specialties often existing in one hospital, and several hospitals contributing to a regional programme, the scope and frequency of inspections tended to increase quite markedly. A censor-in-chief's inspection team could be followed

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rather soon by an inspection of the orthopaedic scheme, and the paediatric surgical element and so on. It was, one felt at times, an imposition on the hospital administration in particular, since the visitors needed to liaise with medical superintendents (and the several layers of manager that shortly supplanted them), whatever aspect of the hospital's training might be under scrutiny. The College tried to minimise 'inspection surfeit' as far as possible; but the importance of personal contact could not be denied.

One of my last tasks before quitting the Council was to undertake one of these visits with Sam Mellick, then censor-in-chief. We learned a great deal from what we were told and shown and in the process became adept at recognising dissimulation.

The effect of all these refinements in the training process has been to alter the significance of the final examination. From being an assessment of candidates about whose past several years' activity only the bare facts are known, it has changed to the equivalent of a 'pre-delivery check', to borrow from the car assembly industry. For candidates are now well known, well documented, well prepared and – if the process has been all it claims to be – ready to emerge powerful and well-polished (if the analogy is not by now too strained!) ready for a surgical career.

NOTES

1. Davis, L. *op. cit.* p.146-7.
2. Two colleagues, reading this account in manuscript, have found it difficult to accept my use of the plural 'Boards'. But Newton's account explains that 'for geographical reasons' which were cogent in 1934 'it was decided to appoint one Board... in Australia and another in New Zealand'. It is reminiscent of Athanasius.
3. Curtis, JB, Miller, ID & Simpson, DA. (1980) *Aust. N.Z. J. Surg.* 50:434.
4. This pattern is not unique to surgery: the senior has an idea, the junior works it up. (The reverse side is that a junior has an idea, works it up and then convinces the senior that it was his idea all along.)
5. These were the American association, founded in 1887, and the British (1918), Australian (1936), Canadian (1938), New Zealand (1950) and South African (1951) associations.
6. In 1741 Nicolas Andry, a French physician who despised surgeons, wrote a work called the *Orthopaedia*, in which he depicted the crooked tree which has become the universal symbol of orthopaedics: 'the same

method must be used,' he wrote, 'for recovering the shape of the leg, as is used for making straight the crooked trunk of a young tree.' Seeking a title for his work, he combined two Greek terms *orthos*, straight, and *paidion*, a child.

7. Hooker, C.H. (1996) *Orthopaedics in New Zealand*, Wellington, New Zealand Orthopaedic Association.