15

DIVISIONS

'Do you suppose,' the Walrus said,
'That they could get it clear?'
'I doubt it,' said the Carpenter,
And shed a bitter tear.

Lewis Carroll, *Through the Looking-Glass* (1872)

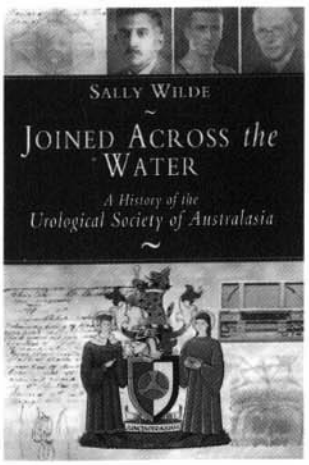
When the College moved, in 1944, to include the 'surgical specialties' in the structure of its Fellowship examination, it was well ahead of its time. Fellowship examinations in Britain were (with the exception of ophthalmology and otolaryngology, which have always been accepted as special cases) conducted in general surgery – or what might more accurately, perhaps, have been styled 'surgery-in-general'. They were to remain that way until the introduction of the Edinburgh Tertiary Fellowships. On the other hand, apart from the aberration of 1953-54, described in chapter 6, the Australasian Fellowship has been available in any of the recognised surgical disciplines for close on 60 years.

Such a progressive attitude might have been expected to endear the College to surgeons practising in 'the specialties'. That it did not universally succeed in doing so may be attributed to a number of factors. The first, I think, was the concept of the 'divine right' of Royal Colleges to which I referred earlier: it is bad enough when an ancient institution assumes such an attitude,[1] but in a young surgical college it is absurd. Yet, I think some of the leading figures of the early days were afflicted by it. Writing to his vice-president, Gordon Bell, at the end of 1944, Sir Alan Newton claimed:

> It has followed that the College has grown steadily in power and importance with the result that all surgeons in Australia wish to belong to it.

This is a claim that would be hard to substantiate, and with hindsight we can appreciate that a president who could make it in personal correspondence had some need of a 'reality check'.

For general surgeons within the College this corporate vanity did not amount to a great irritant; they had no other local institution to which they could offer their loyalty. But to the orthopaedic surgeons there was an alternative: their own associations in Australia and (after 1950) in New Zealand, and they in particular became ambivalent,



The history of the Urological Society of Australasia is able to record the past tensions between urologists and the College, and their more recent resolution.

some even hostile, towards a College which they regarded as pretentious.

Their disapproval – or prejudice, depending on how it was examined – was exacerbated by the feeling that the College was a cosy nest for general surgeons, who had no other body on which to focus their loyalty. Every distinction that was perceived to operate in favour of general surgeons was perceived as a slight. Thus, the concession which excused men with a UK fellowship from the written papers in general surgery, but not in orthopaedics or neurosurgery, was regarded by many orthopods as discriminatory – while neurosurgeons cared much less.

The same tensions existed in urology. The history of the Urological Society of Australasia, *Joined across the water*, was recently written by Sally Wilde. In her review in *Surgical News* Janet McCalman writes:

> The conflict between urology and general surgery pervades this history and the relationship between the RACS and the society. Issues of bed rights, theatre rights and referrals in the early days, and training and accreditation in later times, have largely been resolved due to the good will and hard work of men such as Joe Murnaghan, John Maddern, Durham Smith, Don Moss and Colin McRae.[2]

The underlying problem in all this lay in the confusion between general surgery in the sense of 'surgery-in-general' – the surgery of Henry Newland, for instance, who devoted himself to neurosurgical and plastic surgery enough to have made advances in both fields – which was an obsolescent concept by the 1950s, and latter-day general surgery, the 'residual surgery' of Salter's classification'.[3] General surgery, having had numerous surgical disciplines bud off from it, had become a specialty in its own right and was even developing its own subspecialties: upper gastrointestinal, colo-rectal, breast and endocrine, vascular surgery.

Bob Salter – president of the Canadian Orthopaedic Association as well as the Canadian College in his time, and an honorary FRACS – is a striking example of the compatibility of collegiate and specialty loyalties.

The examination which UK Fellows had passed was in surgery-in-general; some at least of the orthopods among them felt oppressed by being required to write papers in their specialty while 'specialised' general surgeons were not. They viewed the College's inclusion of 'the specialties' in its examination structure not as a progressive move deserving of credit, but as a discriminatory one in favour of the 'specialised' general surgeons because of that partial concession. By a natural enough process of resentment, they saw in every change in College regulations a further affront.

This resentment – principally, but not entirely, orthopaedic – has haunted the College for half a century.

All this is not to suggest that orthopaedic surgeons have been universally opposed to the College. Many have appreciated that the roles of College and specialist associations should, and can, be complementary rather than competitive. One exists to promote the unity of surgery without which surgery is doomed; the others, to

advance the interests of their members in their respective disciplines. And the truism that, if surgeons do not hang together, they will be hanged separately is not to be dismissed simply because it is so obvious.

But the friction has gone on, and it is orthopaedics – the largest of the 'specialties' – that has suffered in the process. It is instructive to look down the list of presidents. If we except Robert Blakeway Wade (president 1935-37, knighted in 1938, a proto-paediatric/orthopaedic surgeon), the first dozen were exclusively general surgeons of the old order. The second dozen included two neurosurgeons (Miller and Lindon in succession) and one plastic surgeon (Rank) and ended with that most specialised of general surgeons, Hughes the colo-rectal surgeon. The third contains two cardiothoracic surgeons (Sutherland and Clarebrough), a paediatric surgeon (Durham Smith), a second plastic surgeon (Hanrahan) and the first urologist (McRae), while the general surgeons (Reeve and Royle for instance) are themselves becoming more specialised. But orthopaedic surgeons? None. It has to be wondered if orthopaedic unrest has been damaging to the orthopaedic cause.

Sir Robert Wade, the third president, was a pioneer of paediatric and orthopaedic surgery.

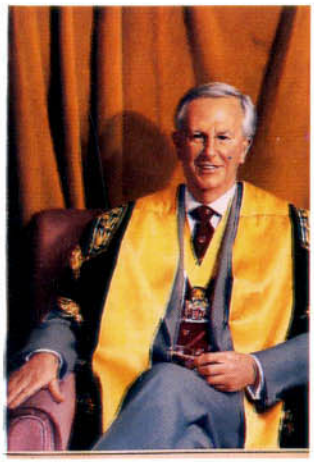
The Curtis-Hughes initiative of 1969 and after, leading to the creation of specialist surgical training committees (shortly surgical boards), helped to involve specialist associations (where these existed) with the College in determining the pattern of surgical training in Australasia. As a consequence of this joint involvement, the associations began to 'trade' good ideas, while the College came to appreciate what a very disparate collection of surgical disciplines needed to be gathered if the unity of surgery were to be preserved (or achieved, depending on how you look at it).

One major problem emerged from the dialogue: general surgery may have been the parent of the various 'specialties', but as these had grown up and left home 'poor old dad' was now, they felt, simply one among them. They were quick to resent any attempt at paternalism and sufficiently unfilial to disparage 'poor old dad' for his failure to look after himself as a specialty. They had their societies or associations or levy-paying sections – and here was general surgery sponging on the College!

To the more aggressive specialties at least, the College was suspect as being little more than a general surgeons' haven, and this mistrust threatened to frustrate the process of unification. At this point, a meeting of presidents of specialist societies with the Council was arranged, and this meeting, chaired by Doug Tracy as president, took place in October 1981. It was followed by a dinner at the Naval and Military Club in Melbourne, which was not without its excitement.

Excitement aside, it was a valuable meeting, because Tracy's obvious sincerity spread a warmth over what might otherwise have been little more than an airing of grievanvces. The grievances were aired, to be sure, but as a step towards their resolution, not simply as an exercise in catharsis. The meeting became an annual event and

Douglas Tracy was able to host an important dinner at the Naval and Military Club in Melbourne despite the handicap of an arm in plaster.



Durham Smith set himself the herculean task of bringing order to the disparate backgrounds and relationships of specialty associations and the College.

served to reinforce the activities of the conjoint surgical board. Tracy's contribution in this area alone would have been sufficient to justify the award, in October 1982, of his Hugh Devine medal.

Durham Smith had been elected to the Council in 1978. A paediatric surgeon in Melbourne, he was one of four from the staff of the Royal Children's Hospital to serve on the Council in the period.[4] A man of remarkably orderly mind, he conceived a grand design to coordinate the activities of all the specialties within the framework of the College. It was indeed too grand to allow for the independent spirit that characterises surgeons, and it did not allow adequately for the disparities of history, but it forced surgeons of all varieties to confront the issues.

He proposed a memorandum of understanding between the College and each of the specialty groups and planned that this could be uniform enough to override disparities rather than perpetuate them. He went so far as to hope that meetings might be coordinated with the College's own calendar, but the commitments of the several specialties to timetables that had grown up on an international circuit precluded such an arrangement. Unfortunately, the assumption that they were being manipulated to conform with the College, rather than being invited into a partnership with it, caused offence in some quarters. In 1982 the Australian Orthopaedic Association came within one vote of determining to secede from the College.

The problem of allowing some diversity in the interests of the greater unity borders on the insoluble. In November 1982, when O.R. Nicholson was president of the New Zealand Orthopaedic Association, the proposed Durham Smith memorandum had become available. Ross and I had examined together, and we set out to see, in the course of a weekend together in the cottage at Raurimu, how far we could make it acceptable to both sides. Our wives agreed privately, as we took our papers into another room, that we were both stubborn

Ross Nicholson has been a dominating figure in the development of orthopaedics in New Zealand. His contributions were recognised by the award of the Sir Louis Barnett medal in 1991.He and his wife Pauline were also very welcome house guests in 1982!

fellows and the task would be long and probably not very fruitful. In less than an hour we emerged, having solved the problem with (we considered) trivial amendments. It was a most enjoyable weekend, with a good South Australian white that Ross had brought for dinner on the Saturday night. We felt we had contributed to the unity of surgery.

But our amendments did not find favour in Melbourne, and the cause suffered accordingly. Some sort of compromise was cobbled together later but at some cost in goodwill.

This is not, however, to detract from the underlying importance of Durham Smith's vision. Out of what came to be known as the 'Durham Smith proposals' emerged a system of nomenclature for the several elements in the College and an arrangement for the delegation of College control to appropriate specialty bodies. The system was designed to accommodate the multiplicity of pathways by which the various disciplines had grown up.

In chapter 11 we saw how diverse these pathways had been and how their diversity was reflected in the six distinct formulae by which the membership of surgical boards was determined. A number of specialist sections had grown up within the College: those of cardiothoracic surgery, plastic surgery and paediatric surgery corresponded to specialties that were distinct for examination purposes,[5] but there were also College sections of colonic and rectal surgery (originally named 'proctology') and of vascular surgery, which were specialised elements of general surgery.

In neurosurgery and urology there were existing specialist associations which covered Australasia, and in orthopaedic surgery two strong and often restive national associations. Ophthalmology had, by 1969, developed into a College in Australia,[6] with a separate society in New Zealand. Otolaryngology was represented by a society in Australia but later to be organised in New Zealand.

Durham Smith's proposals tidied things up dramatically. The administrative bodies of the disciplines in which the College examined became 'divisions', and the name 'section' came to be applied to two distinct types of structure:

a. to subsets of a division, notably in general surgery, where the 'division of general surgery' absorbed the existing colo-rectal and vascular sections, then proceeded to form sections of breast surgery, endocrine surgery, upper gastrointestinal surgery and – somewhat paradoxically – general surgery, to look after the interests of 'undifferentiated' generalists.
b. to new and commonly interdisciplinary groups which emerged in the late 1980s to look after certain special interests: sections of military surgery, of road trauma (later of trauma in general), of the history of surgery and anaesthesia ('of surgical history' after the departure of the anaesthetists, on the basis that the term can still embrace anaesthesia and other topics as appropriate).

The significance of sections, in the sense of administrative units, and sections in the sense of elements in a scientific programme, no longer conflicted. The significance of the divisions, as the prime subdivisions of the College structure, was clear. And even if full coordination of meeting dates had proved too complex to be pursued, at least there was now a structure in which each discipline might contribute something for its members at the major College meetings, so as to free them from the feeling that College meetings were irrelevant to them. It is hard to persuade surgeons to attend College meetings simply out of loyalty to the College (or to become involved in its governance), if they find nothing of interest in the scientific programme.

It did not altogether happen. The orthopaedic surgeons managed to insert a CME topic, though their pre-existing schedule of major (and often combined Australasian or international) meetings fell elsewhere in the year. The urologists, on the other hand, progressively absented themselves from the College programme, and the paediatric surgeons, having their own relationship with paediatric physicians, limited their College meeting involvement to alternate years. The ophthalmologists, now with their own College to support, drifted away. The main recruits to the College programme were the otolaryngologists, from whose shared interest (along with general surgeons of the head and neck variety, and plastic surgeons with an interest in facial reconstruction)[7] in the surgery of the head and neck arose the interdisciplinary 'Head and Neck Group'.

All these reforms might have been expected to lead to a comfortable relationship between the College and the representatives of the disciplines that go to make it up. As it happens, they did not. The old bogey of the privileged position of the general surgeons still rankled.

For lack of their own specialty organisation general surgeons had their 'housekeeping administration' carried out in and by the College. Whereas the members of specialty associations paid a hefty annual subscription to their own society, as well as their College subscription, the general surgeons had their housekeeping expenses met by the College and paid only one subscription. The worst of it was that the general surgeons did not perceive a disparity. I can recall bringing a paper to the Council which set out the problem and proposed that Fellows in other disciplines than general surgery might qualify for a reduced subscription, or their specialty association for a grant – or that general surgeons might pay a 'housekeeping levy'. Even a modest gesture of good faith, I felt, would help matters. (I was probably wrong in this: it commonly takes more than a gesture to unrankle a grievance!) But my general surgical colleagues could not see what I was on about.

The recent formation of specialty associations of general surgeons, in New Zealand in the mid-1990s and in Australia in 2000, has provided

the basis for a resolution, but I am inclined to the view that past grievances may take a long time to settle.

There have been other evolutionary changes in the divisional structure. For a decade or more the Colleges of Surgeons and Ophthalmologists conducted a joint fellowship examination. Candidates could then elect to link up with either or both of the Colleges. But as the College of Ophthalmologists established its place as the logical body to represent eye surgeons, the conjoint examination arrangement lapsed in 1996 and the Division of Ophthalmology became defunct.

In paediatric surgery, the formation of the Australian (later Australasian) Association of Paediatric Surgeons rendered the old College section redundant. The College section was formed in October 1963, the Australian Association of Paediatric Surgeons in May 1979. At that stage the surgical section of the Australian College of Paediatrics was disbanded (though the two organisations continued to meet together in alternate years). In June 1981 AAPS took over the functions of the College section, becoming a Division in October 1983, to be joined in the mid-1980s by the New Zealand Society for Paediatric Surgery.[8] This 'evolutionary pathway' is representative of the process of rationalisation that Durham Smith sought to bring about. As a paediatric surgeon, he was able to help ensure that his own specialty's pathway was a smooth one.

Whether divisions are integrated within the College structure, or consist of specialist societies that have agreed or contracted to look after matters affecting their specialty, their role in the College is an important one. They now have almost total control over the nomination of the surgical boards, which in turn are influential in the selection of members of the Court of Examiners (and have, by co-option if necessary, the senior examiner in the specialty as a member). A division which consists of a specialist society is generally free to designate its society executive as the divisional executive, and, significantly, it is now the chairmen of the surgical boards who constitute the censor-in-chief's committee. No longer does a different committee, College-appointed, meet once a year with the leaders of the specialties and delude itself that it is adequately representative. (A generation ago we subscribed to that delusion.)

By the beginning of the 1990s the College had come quite a long way. A pioneer in accepting the specialties as subjects in which to award its fellowship, it had been to the fore in seeking their involvement – as partners, rather than as subordinates – in the training and administration of their discipline.

NOTES

1. In a speech in 1953 on the occasion of his admission as a Freeman of the Mercers' Company, HRH The Duke of Edinburgh said: 'It will be a very sad day if they [the City companies] forget their responsibility to the present and only think of their glorious past. If I may say so you would be like baboons – all behind and no forehead.'

Russell Howard was the first of a sequence of paediatric surgeons from the Royal Melbourne Children's Hospital to be elected to the Council. He was senior vice-president 1969-71 and later honorary archivist.

2. McCalman, J (2000) *RACS Surgical News* 1:2: 16.

3. I picked up the term from R.B. Salter, orthopaedic surgeon and former president of the Canadian Orthopaedic Association, but also a former president of the Canadian College and an honorary Fellow of the Australasian College – one who has seen no problem in spreading his loyalty to embrace both college and specialty association. Apart from this classification of surgical evolution, he and his colleague W.R. Harris provided mainstream orthopaedics with a classification of epiphyseal fractures.

4. The four were Russell Howard (1959-71), Douglas Stephens (1965-75), Durham Smith (1978-89) and Peter Jones (1987-94) – a remarkable contribution from one institution and in a small specialty.

5. The first College section to be established was the Section of Thoracic Surgery (precursor of the cardiothoracic section, later division) whose formation was agreed at a meeting in Adelaide in May 1950.

6. The Ophthalmological Society of Australia had been formed in 1938; after evolving into a college in 1969 it gained the title 'Royal' in 1977 and proceeded to obtain a grant of arms in 1982. The Letters Patent commit the awful error of describing the then president E.J. Donaldson (the petitioner for the grant) as a 'Fellow of the Royal *Australian* College of Surgeons'. Hugh Ryan, who was central to the original design of what became the RACO arms, described the process in a paper. [Ryan, MHM (1983) *Aust. J. Ophthalm.* 11: 247.] In 2000 the College evolved further to become the 'Royal Australian and New Zealand College of Ophthalmologists, even though the prospect of a qualification pronounced 'Franz Koh' had seemed daunting, as Keith Small remarked to me.

The College of Ophthalmologists gained a grant of arms in 1982. Emblems drawn from ancient Egypt and Greece, from Britain and the USA tell of the diverse origins of Australian eye surgery.

7. During the 1980s the plastic surgeons became 'plastic and reconstructive' surgeons.

8. A New Zealand Society of Paediatric Surgeons was formed in 1996 to take care of local issues, but it is an inclusive body designed to gather in surgeons who practise paediatric surgery as a special interest, as well as trained paediatric surgeons. It is thus outside the process of nominating to surgical boards and the like.