19

KEEPING UP

That requisite combination of conservatism and progress

Anthony Trollope, *Can you forgive her?* (1864)

At one of my first Council meetings Bill Hughes asked each of us in turn, 'Do you believe in recertification?' It resembled a class for those about 'to be confirmed by the Bishop': we all solemnly answered 'Yes', then a number wondered what they had committed themselves to. Scotty Macleish subsequently pointed up the essence of the problem with a paper on 'Decertification' which emphasised that a recertification process which cannot identify the unfit and sanction those found unsuited to continue in surgical practice is simply a nuisance to which the fit should not be subjected.

But recertification as a topic reared its head from time to time during the 1980s, and as politicians and bureaucrats learned the word and began to think it might be worth exploring, the College in turn came to recognise that a benign recertification process devised by the College would be a much better bet than a bureaucratic or political imposition. The difficulty is that there are few forms of test, to which a practising surgeon can reasonably be subjected, that discriminate conveniently between those who remain as fit to practise as when their Fellowship was awarded and those who do not.

The most benign process is one which records involvement in scientific meetings, in hospital conferences and in surgical audit. It is not perfect, since there is no assured correlation between registering for (even attendance at) a meeting, sitting through (and staying awake and alert throughout) the programme, learning from this feat and then applying the lessons learned and so becoming a surgeon of better skill and judgment – but it is at least a straightforward measure of good intent, whereas failure to become involved is a short cut to incompetence.

By the end of the 1980s the need for continuing medical education was fully accepted and actively addressed. The desirability of recertification – on a courteous, rather than a combative, basis – was likewise now accepted, and the convenience of linking the two processes was apparent. What is more, the various Colleges had recognised the urgency of putting courteous schemes in place before

Professor J.P. Chalmers is seen here at his admission to honorary Fellowship in 1993.

outside influences could pre-empt good professional judgment.

A joint letter from the president of the Royal Australasian College of Physicians (Professor John Chalmers)[1] and the president (Professor Tom Reeve) and president-elect (Mr John Hanrahan) of the College of Surgeons was published in the July 1991 *RACS Bulletin*. They explained that:

> until now the Colleges have refrained from introducing [a mandatory] system [of CME or recertification]. Our reasons have been partly that, as professional bodies, we preferred a voluntary programme adhered to by all our members, and partly that there was no convincing evidence that mandatory CME would actually raise the clinical standards of participants. That evidence is still lacking, as is any convincing evidence to the contrary even though we know that individually we cannot maintain current standards without interaction between clinicians and without keeping abreast of the medical literature. So why are we now united in recommending the implementation of a system for recertification of our Fellows?...
>
> There are two main reasons...
>
> 1. Internal Accountability:
> We are unfortunately not in a position to give an unqualified affirmation that all our Fellows participate actively and adequately in available systems of voluntary CME.
> 2. External Pressures:
> Immense and growing political pressure is being exerted on the medical profession by our communities and our governments, to demonstrate that we are capable of effective self-regulation with assured maintenance of professional standards.

The system was outlined in general terms:

> 1. It will not be based on formal examinations, either written or clinical.
> 2. The specific process will be developed in consultation with our respective fellowships, and with all our special societies, over a period of around two years.
> 3. Elements that are being considered include:
> * evidence of participation in CME.
> * evidence of participation in audit, quality assurance and peer review.[2]
> * evidence of credentialling by a local group of peers based in a hospital or region.
> 4. Other models already in place overseas or for other medical specialties in Australia are being studied.
> 5. Every effort will be made to keep the system as simple as possible.

The presidents concluded:

> If we are to remain in control of our own fates and of the standards of clinical practice, we have no option. We must introduce recertification.[3] The alternative is further government intervention in our professional

lives, with the possibility of more draconian systems put in place by alternative bodies set up by government.
The other risk is that government, backed by the public, might dictate the shape of the system of re-certification to the Colleges and the medical profession.

Leigh Atkinson 'drove' the College's recertification programme.

The Council set up an advisory committee on recertification, but the task of 'driving' the programme for its introduction fell to R.L. Atkinson of Brisbane, who had been co-opted to the Council in 1986 and elected three years later. True to the time predictions of the presidents' letter, he and his committee produced a 'Green Paper' in February 1993. This set out the goals of the programme, listed the criteria (participation in appropriate CME and in personal surgical audit, accreditation to an approved hospital or day care centre) and defined the College structure that would handle the process.

The Green Paper was accompanied by a position paper on surgical audit. These documents accomplished, the committee turned to consideration of the 'minimal' [*sic*] standards of CME.

By July 1993 a definitive statement came out from what was now firmly established as the 'Board of Continuing Medical Education & Recertification'. It made nine points:

1. Recertification commences on 1 January 1994.
2. All Fellows involved in the clinical care of patients are expected to take part.
3. Recertification is based on annual:
   a. evidence of minimal standards of continuing medical education.
   b. evidence of involvement in a Hospital unit or group audit.
   c. evidence of credentialling to an Approved Hospital or Day Surgery Unit.
4. There will be no examinations.
5. There will be no withdrawal of the FRACS diploma for failure to comply.
6. At ten-yearly intervals Fellows must achieve the Certificate of Continuing Professional Standards.
7. As from 1996 Fellows who have held the RACS Diploma for more than ten years will be expected to apply for recertification based on evidence of conforming to the requirements in the previous two years, 1994 and 1995.
8. A booklet will be sent to all Fellows by December 1993 outlining each step in the process of recertification.
9. A surgical audit software programme will be available later in the year to those Fellows who do not have an alternative programme.

It will be noted that the process skirted round the challenge of 'Decertification' identifed by Macleish almost two decades earlier; the Certificate of Continuing Standards was to become the currency of approval. The advent of personal computers had made the whole business of audit straightforward, so that the timing of the intercollegiate decision to embark on recertification was quite fortunate.

The 1994 scientific congress was to be held in Hobart, and hosting such a meeting is always a challenge to the relatively small group of Tasmanian Fellows. In the past a turn-out of 500 registrants would have been regarded as satisfactory, but the organising committee planned generously and pencilled in many more hotel rooms. At the point when these had to be confirmed or surrendered, about 500 registrations had been received, and most of the unbooked rooms were therefore surrendered.

Then Fellows began to read their recertification literature and to appreciate that (at least for those of over ten years' seniority) participation in CME during 1994 was a matter of some importance. They registered forthwith – about another 500 of them! Their hosts were then confronted with the task of finding accommodation; much of what had been surrendered was now out of reach, taken up by non-surgical tourists and gamblers. In the event Fellows were accommodated over a circle of about 50kms radius, and the hurriedly assembled transport plan for getting them to and from the conference venues each day would not have disgraced the Normandy planners of 50 years earlier.

It was a massive challenge to the conference planners; they met it remarkably well, and the meeting was a vast success in every sense of the word.

Early in 1995 Leigh Atkinson reported in the College *Bulletin* on the progress of the first year's reporting. 'In the over 1,500 forms now returned,' he wrote, 'it is apparent that the compliance level of Fellows is very high.'[4] The demands on the College were equally high. It had to make sure that appropriate CME opportunities existed, especially for Fellows practising in remote areas. Meetings were held in Toowomba, Tamworth, Bendigo, Devonport in Tasmania and Whakatane in New Zealand. Doubtless a number of these would have taken place irrespective of the recertification issue (one-day meetings in provincial centres in New Zealand go back forty years), but the new requirement brought a new urgency and additional funding (to the extent of $50,000 for 1995).

Plans for distance learning were examined; the orthopaedic surgeons introduced a points system to keep their Fellows up to the mark. A College-sponsored software programme – RACS-AUDIT – was developed. The various initiatives necessitated the formation of a Department of CME and Recertification within the College. The Australian Council on Healthcare Standards endorsed the College requirements as a model for its surveys. But Leigh Atkinson was not satisfied. In November 1995 he confessed:

> Most of us find the majority of meetings disappointing... The slides, the voice, the authority are all fascinating, but where is the value? More often the presentations are as memorable as the Sunday sermon at the local church. Less than 25% of our Fellows attend our Annual Scientific

> Congress and only about 10% attend the State Scientific Meetings. We must acknowledge that some surgeons feel that our State and National Scientific Meetings have failed them as CME learning experiences.

He and his Board therefore joined forces with the Queensland Medical Education Centre to analyse the needs of Queensland Fellows. They also had the Council looking at 'innovative learning techniques' – a politically correct term which probably signifies 'innovative *presentation* techniques for *facilitating* learning'. Even these will not altogether supersede that most valuable learning technique, the morning-tea break, at which so much important but unpublished information is exchanged.

As an incentive for Fellows, the College diaries for 1998 and again for 2000 and 2001 have included additional pages designed for the recording of CME data for later reference. Recertification and its preliminaries had become a part of the surgeon's daily life.

Although CME (and the recertification in which it was an important element) was now available for Fellows of the College, those surgeons in Australasia who were not Australasian Fellows lacked both the opportunities and the challenge that their colleagues enjoyed. Their continued professional competence could not, therefore, be guaranteed, yet the College accepted a responsibility for seeing that high surgical standards prevailed in both countries. This was the basis of its very existence.

Already in February 1992 the Council had defined the FRACS as being, in future, the only valid surgical diploma in Australasia. Certainly there is a compelling argument that training and examination in the country of practice counts for more than qualifications obtained elsewhere, to this extent at the very least: the spectrum of disease and the pattern of its management is not a universal constant,[5] so that local training and experience has a particular value. By implication, therefore, a qualification gained locally is a desirable part of a surgeon's armamentarium.

At the same time, the claim in respect of the FRACS is a bold and monopolistic one, and in Australia the ACCC, under its chairman Professor Fels, has looked with a beady (some would say, jaundiced) eye on medical monopolies, without concern about their correlation with medical standards.[6] Such critics overlook the fact, implicit in the New Zealand terminology of recent years, that monopolies are bad in ideological terms, but if it is necessary to 'rehabilitate' a monopoly, this can be accomplished by referring to it as a 'single national provider', as was done in the case of the blood transfusion service. The same rehabilitation process aided the New Zealand Artificial Limb Board which, after a period of derision as a monopoly, was welcomed as offering a 'national service'.

Sir Barry Jackson enjoys the distinction of having attended every ASC during his presidency of the English College. He has given a number of important historical papers, and in 2000 (when he was awarded an honorary Fellowship) he spoke of the corrective measures adopted in the UK after the Bristol scandal turned the spotlight on the subject of surgical competence.

In June 1994 the Council agreed to make its CME freely available to

holders of other specialist surgical qualifications, but it soon repented of this concession, resolving at its October meeting to turn the concession into a pathway towards the FRACS, so that

> when a surgeon who is not a Fellow of the RACS requests involvement in the College's Recertification programme, provided that s/he is a registered surgical specialist in Australia or New Zealand, provided that s/he has been a practising surgeon in Australia or New Zealand for 5 years or more, and provided it is approved by the Board of CME and Recertification, that s/he be permitted to take part in the Recertification programme for a period of 5 years, but only as a lead up to an application for admission to Fellowship under the following conditions:
> 1. that no certification will be issued until admission to Fellowship is achieved.
> 2. that during this time, a mentor is appointed who will report to the College annually.
> 3. that at the end of this time, an application is made for entry to Fellowship by either assessment of training then by the Part 2 Examination, or by a site visit by a combined team of the College and his/her specialist organisation.
> 4. that the process be funded by the individual surgeons concerned.
> 5. that if entry to Fellowship is not sought, involvement in the Recertification Programme ceases.

This could be seen as a convenient means of bringing recognised surgeons 'into the fold', but since it applied only to those who had already achieved specialist recognition, it failed to address the cognate problem of those whose qualifications fell outside the registration criteria in New Zealand or in an Australian state. And they formed a tragic group, the surgical refugees, whose plight could so easily be manipulated by politicians or the media.

In many cases it did seem that they had been misled by immigration consultants, even by immigration authorities, into believing that they and their qualifications would be welcomed with open arms. Instead, they found themselves driving taxi cabs, while being faced with pre-registration examinations conducted in a strange language. It was a situation fraught with opportunities of deriding the College (the Colleges, in fact, for the problem did not simply involve surgeons) as a 'closed shop'. The irony of it all was that the College and its Fellows were constantly under pressure to sharpen up their own act (under threat of disciplinary processes much more draconian than surgeons would have welcomed), while they were subject to equal pressure not to demand of surgical refugees the standards they expected of their own.

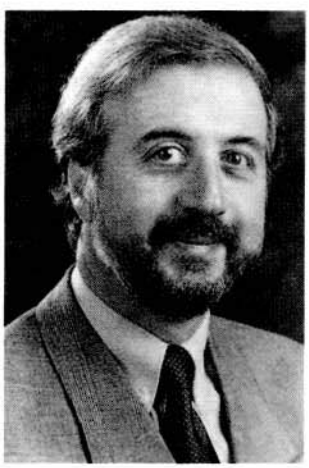
At the dawn of the 21st century it is probably fair to say that most or all migrant surgeons who have the ability to perform with credit in Australasia are in process of gaining the necessary recognition; but it is also true that the numbers presenting for entry into this process are increasing steadily.

The keeping-up process does not, however, affect only the individual surgeon's efforts to delay or avoid obsolescence. A surgical college has more far-reaching responsibilities. In the first place, it must foster the research that will lead to surgical progress; in the second, it must make critical study of surgical innovation to determine how much of it is indeed progress.

The College's commitment to research was given a substantial boost by the development of the Foundation, and the universal Fellows' support of the Foundation that was provided by the subscriptions-in-advance scheme allowed the College to attract additional funding from outside sources. By June 1992 it could claim – indeed J.C. Hanrahan, the president, reporting on a visit to overseas colleges, made the point at the Council meeting that month – that 'the College provided more money for research in dollar terms from its own resources than any other College in the world'. It was the second largest funder of surgical research in Australia.

A natural enough corollary to this growing research effort was the decision, in February 1995, to appoint a professor of surgical science. Unlike the Prince Henry's teaching hospital project of the late 1930s, which sought to establish an antipodean Hammersmith, or the Education Wing and its teaching pretensions of the 1960s which endeavoured to replicate Lincoln's Inn Fields, this was a concept that recognised and built upon the widely dispersed nature of the College. Professor James Toouli, who already occupied a surgical chair at the Flinders Medical Centre in Adelaide, was appointed to this part-time College post in June 1995, and later that year he defined his roles:

1. to establish a surgical research network; a database which could
   * inform trainees with research aspirations of opportunities in Australia or New Zealand;
   * provide a means by which trainees could explore possibilities for a period of research;
   * identify units with common interests and the potential for collaborative studies.
2. to develop a common structure for postgraduate research degrees;
3. to provide a focus for communication on research matters between academics, trainees, the research advisory committee and the Council.



Professor James Toouli combines, with his chair at Flinders, a part-time College appointment as professor of surgical science.

Within two years the network was in place, 'the first substantive component of the College's web page', Toouli called it. Its effect was to create what he described as 'a research institute without walls' – which, given the profile of the Australasian College, is arguably the best sort of institute.

It was shortly followed by a surgical science programme in which training time could include the opportunity of acquiring a PhD degree on the way to the Fellowship. A surgeon scientist, as Toouli defined the creature in November 1999, 'is a surgeon who is fully trained as a Fellow of the College in a sub specialty but in addition is fully trained as a Researcher in an area usually relevant to the sub specialty... It is

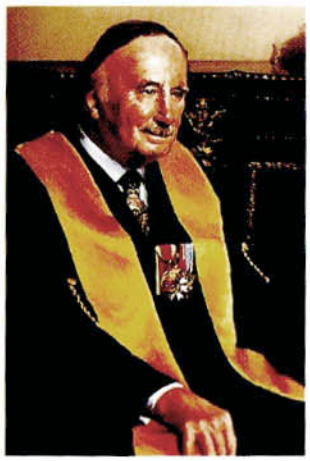
anticipated that Surgeons who have gone through the Surgeon Scientist programme will ultimately pursue academic careers in surgery. However, this is not an absolute expectation, as... surgeons may choose to alter their emphasis... at different stages of their lives.'

An earlier issue of the *RACS Bulletin* in 1999 had listed an impressive array of research awards offered by the College.[7] The John Mitchell Crouch Fellowship remained the College's premier research award, but it served to recognise mature researchers and their ongoing work. It was complemented by 24 other awards, mostly for research and many of them available to trainees as well as Fellows; several expressed a preference for candidates enrolled for a higher degree.

Notable among the awards listed in those pages were the Rowan Nicks Scholarships, for they existed not to assist first-world surgeons undertaking their own scientific research in their own environment, but third-world surgeons destined for leadership in their own countries, who were enabled by these scholarships to spend a period of some months – even up to a couple of years – in academic departments in Australia or New Zealand. The original endowment in 1987 embraced young surgeons from Africa, South East Asia, India, China, Papua New Guinea or the Pacific Islands. The first four scholars came from Zimbabwe, China, Malaysia and Bangladesh, the fifth from Nigeria, which is a fair spread! In 1999 the scheme was expanded by the inauguration of a separate Pacific Islands scholarship, for graduates of the Fiji School of Medicine.

The Rowan Nicks scholars come from the third world to enjoy the Australasian academic surgical scene for a period. Here their patron greets Dr Tahmina Banu, the 1995 Scholar.

It is appropriate here to mention also the scholarships that commemorate Rowan's old friend Weary Dunlop. Collaboration between the Thai and Australasian Royal Colleges began in 1986 with



The mantle of Weary Dunlop (left), has descended on Scotty Macleish (right), as the College's link with Thai surgery.

the initiative of the then president of the Thai college, Professor Kasarn Chartikavanij (who would be the first Thai surgeon made an honorary FRACS). At the same time, Western Australian ex-servicemen set about fundraising for a memorial of their prisoner-of-war colleagues who did not return. The process spread across the country, and its outcome was a surgical scholarship to which the names of Dunlop (the most charismatic of the prisoners on the Burma railroad) and Boon Pong (a Thai storekeeper who risked his life repeatedly to bring some assistance to the prisoners in their privations) were attached. The Thai College selects the scholars, the Australasian College places them in suitable training positions. After Sir Edward Dunlop's death, his role as Australian patron of the scheme was taken over by a recent past president, D.G. Macleish, who was already a good friend of Thai surgery and surgeons. His opposite number is Thira Limsila of the Royal Thai College.

Educational videos are no novelty these days, and there have been video sessions in a number of College meetings in recent years. In 1995 the College went further: it was instrumental in the production of *Old Dogs and New Tricks*, which dealt with infection control in surgery in AIDS and was described by a reviewer as 'an outstanding example of an effective peer education tool that is directed at changing attitudes and behaviour as well as introducing new knowledge'.[8] At a BMA Festival it was awarded a Certificate of Educational Merit. Its co-producer, R.H. West, went on to produce *Technically brilliant*, which set out to improve communication skills between surgeons and patients. It dramatised the reactions of a surgeon's wife diagnosed with breast cancer, her reaction to the diagnosis and her interaction with her surgeon and her family. Launched at the 1997 Brisbane meeting, it was highly topical at a time when breast cancer and its management was very much in the news.

Richard West has gone on from success as a television producer to become censor-in-chief in 2001.

The 'keeping-up' process entails not merely the promotion of research,

but the appraisal of new procedures and technology that arise either from such research or by introduction from overseas. Without such appraisal, there is a real risk that futile procedures will be adopted – because they are novel – or that potentially valuable procedures will be misused by surgeons not fully acquainted with their pitfalls.

In 1990 the explosive development of laparoscopic cholecystectomy prompted the College to publish a booklet, *Guidelines for the performance of laparoscopic cholecystectomy* and, four years later, a broader policy statement, *Implications of new technology for surgical practice.*

In Britain in 1996 the Academy of Royal Colleges and the Department of Health combined to set up SERNIP – a safety and efficiency register of new interventional procedures. Its formation coincided with the publication in Australia of a working party report which had looked at minimal access surgery on behalf of the NH&MRC's Health Technology Advisory Committee. That report made five significant points:

1. that surgical practice be evidence based (deemed essential for the protection of surgical patients).
2. that new procedures should be regarded as experimental until proven safe and efficacious.
3. that a mechanism be established to ensure new procedures have been adequately assessed (e.g. by centralised audit or trials).
4. that credentialling of surgeons to perform new procedures should be the responsibility of adequately constituted and protected Hospital Credentialling Committees.
5. that Medicare item numbers for new procedures should be facilitated, but only after such procedures have been demonstrated to be safe, clinically effective and cost-effective.

To give effect to this, a local version of SERNIP was set up with government funding the following year. The English acronym was daunting, the Australian variant – ASERNIP-S – even more so. The facility was established in the new South Australian headquarters, under the control of Professor Guy Maddern as surgical director and with D.W. Robinson of Queensland as chairman of the management committee.

Four categories were initially defined for such new procedures as the unit might examine:

1. safety and efficacy established: procedure may be used.
2. sufficiently close to a procedure of established safety and efficacy to warrant use, subject to continuing audit.
3. safety and efficacy not yet established: fully controlled evaluation required; procedure may be used only as part of systematic research – either an observational study or a randomised controlled trial.
4. safety and/or efficacy shown unsatisfactory: procedure should not be used.

Guy Maddern (left), of Adelaide has the frightening task of heading a programme named ASERNIP-S. David Robinson (right), of Brisbane was the first chairman of its management committee.

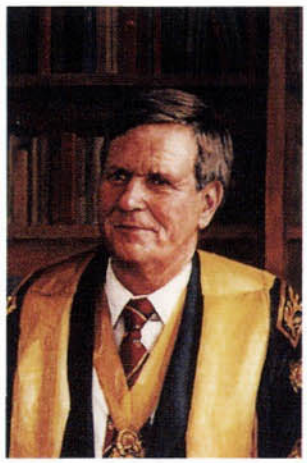
The first three procedures evaluated (laparoscopic live donor nephrectomy, lung volume reduction surgery and minimally invasive parathyroidectomy) all attracted a category 3 (recategorised 2.2 when the original UK-based version proved unworkable) classification, which may be regarded as justification of the scheme from the start. For these procedures to have been unleashed on the public without such scrutiny would have been unfortunate at best, and quite possibly scandalous.

Whatever form evaluation takes, it is important to ask the appropriate question. In a session at the 2000 Melbourne meeting, M.J. Solomon made the point, apropos randomised clinical trials, that

> recent trials in laparoscopic cholecystectomy have measured post-operative pain as their primary outcome measure even though it was obvious to both patients and surgeons that laparoscopic surgery is less painful. A more relevant question would be whether this new technology causes more major complications such as biliary injuries.[9]

One other attempt to 'keep up with the Joneses' did not succeed. In Australia the Committee of Presidents of Medical Colleges (CPMC) had had its ups and downs over the years. With presidents in office for varying periods from say one to three years, with member colleges of widely varying size and structure, with the necessary rotations of chairmanship, such a body is always at risk of becoming ineffective. (The equivalent body in New Zealand has experienced comparable vicissitudes over the years.)

During the latter part of the 1990s, the CPMC was, as a tiger, finding itself somewhat toothless, and it proposed to its constituent colleges that they should consider the formation of an umbrella organisation, an Academy of Medicine. This idea was welcomed by Colin McRae, the then president, who had been attracted to a similar idea floated in New Zealand several years before, and who was given to understand that the Academy of Royal Colleges in the United



Colin McRae (left), saw merit in the formation of an Academy, but the idea foundered on the apprehensions of Fellows who feared the loss of College independence, so that McRae's successor, Bruce Barraclough (right), was obliged instead to stimulate the existing council of presidents.

Kingdom (mentioned earlier in the context of SERNIP) was serving a useful purpose.

But the proposal put the cat fairly amongst the pigeons. In his presidential message in the March 1998 *Bulletin*, McRae sought to correct three false impressions that had gained circulation: that the government would fund such an Academy; that because the Health minister (who was evidently present when CPMC mooted the idea) had spoken favourably of it, a government might seek to manipulate such a body; and that an Academy would compete with the AMA.

But many Fellows' apprehensions went deeper. Within a couple of months the presidency had passed to B.H. Barraclough, who reported in the next *Bulletin* on his first CPMC meeting:

> I indicated that a significant number of our Fellows felt that the prestige, influence and indeed the autonomy of our College was threatened by the proposed Academy of Medicine and that because of these concerns, we would not be able to join such a body. I also indicated that if the main aim of such an Academy was to allow the Colleges to move forward together to improve the health of the Australian and New Zealand communities, the aim could not be achieved without the College of Surgeons. If indeed an Academy was formed without us, then in order to preserve the prestige, dignity, influence and authority of the RACS we... could not give even tacit support to the Academy... there was acceptance that to form an Academy in these circumstances was inappropriate. I have been given the opportunity to take back to the CPMC a structure that we would find acceptable and that would allow the Colleges to work effectively together... It is interesting that in the process of reviewing its structure and function the CPMC has already become a more effective body.[10]

In fact, the CPMC had received a very necessary 'wake-up call' and the College, indeed all the Colleges, had been spared an institution that could have combined all the worst features of Brussels and Strasbourg. It may be that conditions in the UK make an Academy appropriate there; it does seem that a purposeful CPMC can make it unnecessary half a world away from there.

NOTES

1. Professor Chalmers was admitted as an honorary FRACS in 1993.

2. It is sometimes assumed – especially by politicians – that the process of peer review is one that has just been invented. In fact, it existed at least two centuries before Christ. The elder Pliny recorded the arrival in Rome in 219BC of its first Greek practitioner, one Archagathus, who was given the hopeful title of *Vulnarius*, wound-curer; but his results caused him to be renamed *Carnifex*, the butcher. But then, perhaps surgical migrants have always been undervalued...

3. Already the Royal Colleges of Obstetrics and Gynaecology in both Australia and New Zealand (since merged) had introduced the system of a 'ten year time limited certificate at the time of admission to Fellowship, and five year renewable certificates thereafter'. The surgeons and physicians envisaged something much less rigid.

4. *RACS Bulletin* 15:1: 26.

5. I have often speculated that a fascinating treatise could be written on geographical orthopaedics – the relative immunity of the Chinaman to meniscal injuries; the propensity of the Polynesian races to clubfoot and so on.

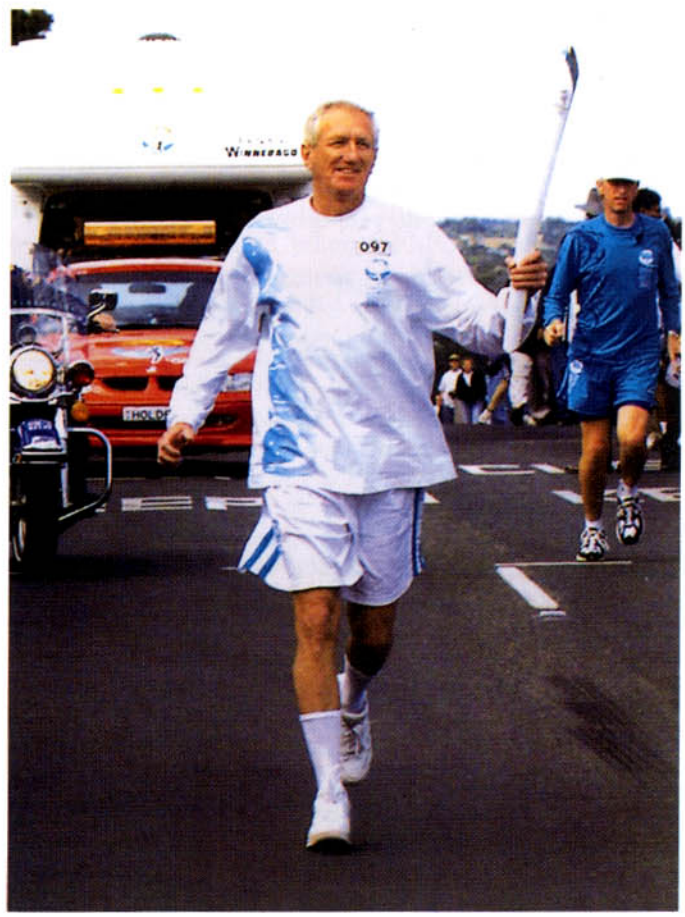
6. Indeed, Professor Fels and his commission seem to have fallen prey to the same chimera as did some general practitioners in 1928, of imagining that a concern for standards equates with a desire to feather one's own nest. It might have been hoped that understanding would creep in over seven decades; since it has not the College is faced with costly legal processes to prove, as it were, that the earth is round!

7. *RACS Bulletin* 19:1: 6 ff.

8. The review by Peter McDonald of Flinders Medical Centre was published in *Australian Health Review* (1995, vol.18: 1) and was reprinted by permission in the July 1995 issue of the *RACS Bulletin*.

9. Solomon, M,.J. (2000) *Aust. N.Z. J. Surg.* 70: A25.

10. *RACS Bulletin* 18:2: 1.



Few presidents of surgical colleges have won Olympic gold. David Theile did so in 1956 and 1960; in 2000 he took part in the relay that brought the Olympic torch to Sydney.