20

UNFINISHED BUSINESS

Plus uno maneat perenne saeclo.
(May it live and last for more than a century.)

Catullus, *Carmina I* (c. 60BC)

John Hunter is described on his memorial brass in Westminster Abbey as 'the founder of scientific surgery', but his first published work was on the teeth, and he has also been claimed as the father of scientific dentistry. More than a century later a number of the pioneers of plastic surgery came into the business of reshaping faces by way of dentistry, but as the specialty evolved, relations between medically trained plastic surgeons and dentally trained oral surgeons became tense at organisational level, even though they were commonly cordial within individual hospitals.

Relations in Adelaide became more than tense in the early 1980s. Donald Simpson, himself a committed wasp, describes the scene as a 'wasps' nest... in which the chief wasps were an oral surgeon named Tideman and my friend David J. David'. Douglas Tracy, that renowned peacemaker, came on the scene where, Simpson goes on, he 'impressed me as a good diplomat'. The obvious longer-term solution, of a scheme of training and examination which could be equally fair regardless of the route by which a candidate had approached the specialty,[1] does not seem to have proved attractive to either side – but then, when people have painted themselves into their corners, it is difficult for them to appreciate the beauty of an icon placed in the middle of the room.

The issue grumbled on. In 1992 the president, J.C. Hanrahan, himself a plastic surgeon, sought the opinion of Fellows 'about a proposed conjoint Fellowship of the RACS and the Royal Australasian College of Dental Surgeons'. In his November newsletter he reported on the survey, in which 142 Fellows had provided their opinions:

> Some contained excellent arguments in favour, or against, but approximately 90% were strongly against this concept proceeding. Accordingly the Working Committee recommended to Council that the matter proceed no further and Council agreed. Thus, the conjoint Fellowship proposal will be dropped, and neither will the RACS alone proceed with a Fellowship in Oral and Faciomaxillary Surgery.[2]

But, like Horace, the idea did not altogether die.[3] In July 1998 B.H.

David Scott, who chaired the working party on oral and faciomaxillary surgery, has succeeded Dick Bennett as executive director of surgical affairs.

Barraclough, as president, reported on the progress of a topic that, he pointed out, had been discussed intermittently for about 40 years. Last year, he noted,

> a working party, chaired by David Scott, with representatives from the Divisions of Plastic and Reconstructive Surgery, Otolaryngology Head and Neck Surgery, General Surgery, the Royal Australasian College of Dental Surgeons and the Australian and New Zealand Association of Oral and Maxillofacial Surgeons defined an acceptable training programme for university graduates who hold both dental and medical qualifications. This proposed training pathway has been discussed by a number of groups in the College. Council, after very considerable deliberation, now considers it appropriate that the College offer a Diploma in Oral and Maxillofacial Surgery. This Diploma programme would be administered by a Division and a Board of the College through a subspecialty training Board. Detailed discussions and negotiations still need to be undertaken to define the membership of the subspecialty Board and indeed, the fine details of the training programme. It does, however, mean that our College and the RACDS will be able jointly to influence the direction and development of Oral and Maxillofacial Surgery into the future.[4]

Here, plainly, was an idea whose time had now come. Even then, though, that time was delayed by a contretemps that arose in October 2000, when the Federal health authorities, at the request of the Association of Oral and Maxillofacial Surgeons and without consulting either this College or the Royal Australasian College of Dental Surgeons, added to the list of approved procedures for dentally qualified surgeons a number of operations that had been regarded as properly undertaken by surgically qualified surgeons. (I have avoided the term 'proper surgeons' in an effort to avoid stoking the fires!) The Federal bureaucracy was left in no doubt of the views of the two Colleges and of various other groups and promised to review the situation, but the episode is a good indication of the trouble that can result from ill-considered, even unthinking, bureaucratic moves. In this case, anything which erodes a fragile state of mutual trust is utterly deplorable. The Federal folly (if I may use the term) promptly scuttled arrangements for the appraisal and acceptance of the joint training process which was to have taken place during the October 2000 Council meeting.

Not until August 2001 was the project back on the rails. By then the Commonwealth Department of Health had recommended changes for the November 2001 'Grey Schedule' which would go a long way to meet the College's concerns; and the October 2001 Council meeting was to address the delayed resolution to form an interim Board in Oral and Faciomaxillary Surgery. A year had been lost by the latest contretemps but then, as Kingsley Faulkner remarked in his presidential newsletter, 'this issue has been bedevilling the various parties for 30 years or more. In my view, it needs resolution and, with a modicum of good will on both sides, this should be achievable.'

I have referred earlier to the belief of a number of specialist disciplines – and most notably the orthopaedic surgeons – that the general surgeons enjoyed preferential treatment within the College, having their 'housekeeping' done without charge, whereas specialty associations did the housekeeping for their own specialty, and orthopaedic surgeons, for instance, paid a substantial subscription to their association, in addition to their College subscription.

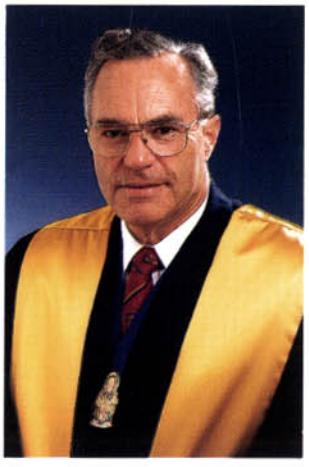
When they went further and asked, 'What does the College do for me?' they tended to close their eyes to the large number of things that a surgical college does perform for the benefit of all its Fellows. When they confined themselves to proposing that their association should be subsidised by the College for the work it does for its members – or else that general surgeons should be charged an additional levy to cover the work the College does for them *as a specialty group* – their argument had more force.

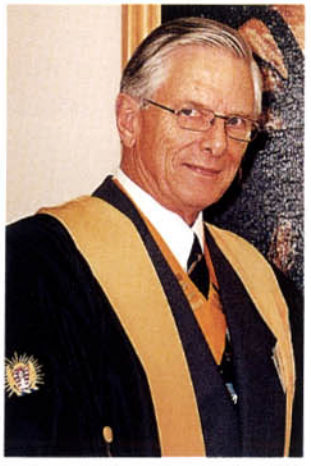
Better still, the orthopaedic surgeons went on, let the general surgeons accept their present status as one (admittedly major) specialty among specialties, form their own specialty association, do their own housekeeping and pay for it, thus relieving the College of the covert subsidy it had been paying them.

The 1990s were a period of orthopaedic involvement at high level within the Council. B.J. Dooley was censor-in-chief 1991-95, being succeeded by D.H. Gray who held the post until he became vice-president in 1998. E.H. Bates was a well-respected chairman of the Court of Examiners for six years from 1993. But even their contribution could not allay the feeling of injustice that concerned a number of orthopaedic Fellows.

That view was well summarised (distortions and all!) in a paper by David J. Marshall of Adelaide, who was a member of the Future Strategies sub-committee set up in 1995. He wrote at a time when general surgeons in New Zealand had taken steps to form their own association, but their Australian colleagues had not. The orthopaedic grievance thus remained when he wrote:

David Marshall summed up the concerns of orthopaedic surgeons in a *Bulletin* article in 1997.





Three orthopaedic surgeons, below from left, Brendan Dooley, Harley Gray and Bill Bates, have made a major contribution to the College during the 1990s.

> Orthopaedic surgeons are people of action and through my representation on this sub-committee, there was some anticipation that certain matters of difference would be resolved... Unfortunately this has not occurred, but I consider the Mission Statement will lay the groundwork for more concrete discussions... These... must include the very difficult dilemma of the level of subscription/fees paid to the RACS by the Fellows.

But he well recognised the College role and was able to end on a positive note:

> It is my belief that the RACS should act as a coordinating or 'umbrella' body, providing services of which all surgical specialties can avail themselves... May I suggest we all unite as Fellows of the RACS to produce a more communicative, more efficient, more proactive and a more Fellow-oriented organisation in the future. This will then ensure that we all have long-term security in our profession.[5]

It would have helped if the Australian general surgeons had moved promptly to heed the urgings of their orthopaedic colleagues and follow the New Zealand example. In the event it was not until 2000 that they formed an association of their own, and ironically by this time the Australian Orthopaedic Association had another notice of motion to secede on its hands.[6]

Early in 1999 Peter Carter notified his intention to move on, after a decade of service in which he had been a part of several notable – often exciting – events. In his final *Bulletin* editorial he wrote:

> I leave the College after ten years content in the knowledge that your College is dynamic, forward thinking, well led and well managed. You can be confident that your interests and the interests of your patients are being pursued with vigour, insight and intelligence.

Dr Vin Massaro is the College's recently-appointed chief executive, having been selected after the Blackmur contretemps.

As his successor the Council appointed Dr Douglas Blackmur, then chief executive of the New Zealand Qualifications Authority. However, his appointment came at a time when 'golden handshakes' to chief executives had become a *cause célèbre* in his adopted country, and the size of his handshake attracted much public attention. The chairman of the authority resigned, the then Finance Minister, Bill English, became an instant expert on the administration of educational standards, asserting that 'in hindsight it appeared Dr Blackmur had been an unsuitable appointment'.

Blackmur, due to attend a Council meeting and meet his new bosses, felt in honour bound first to defer his attendance, then decline his appointment. The College had to start again. This time it appointed a historian who had moved into tertiary educational administration, Dr Vin Massaro. His role is a challenging one, since he is attempting to familiarise himself with an institution which has expanded so much in recent years (while losing a number of long-serving senior staff) as to be at risk of losing its corporate memory. An ideal challenge to bring out the best in a historian, perhaps...

In 1995 Donald M. Sheldon, then recently elected to the Council, gave the Graham Coupland Lecture to a New South Wales audience. He looked at the intrusion of bureaucracy into the process of 'health delivery', quoting an observation made by the illustrious Michael de Bakey, doyen of vascular surgeons, at the College's recent Perth meeting:

> High school drop-outs, who have become clerks in medical insurance companies, are now instructing surgeons on what type of operation to perform and how long their patient may remain in hospital.

Sheldon reminded his audience of a truth too often ignored by usurpers:

> The fundamental interaction in medical practice is between doctor and patient. All other contributors to health care are essentially a support cast. Rulers of the day however, always seem inclined to interfere with this basic interface.[7]

Unless the primacy of the doctor-patient relationship is recognised and honoured, patients and their surgeons will alike be short-changed. The problem, of course, is to bring politicians and bureaucrats to the point of recognising, let alone honouring, this primacy.

In its task of promoting awareness of the special qualities of surgery and the relations between its practitioners and their patients, the College has been fortunate in having been led into the 21st century by a greatly respected president. Bruce Barraclough has the ability to enunciate the deep truths of surgical philosophy in a way that leaves little room for misunderstanding or dispute.

His skills have been recognised and exploited by the Australian

Don Sheldon, who warned about the perils of interference with the doctor-patient relationship, is chairman of the College's continuing professional development programme.

Bruce Barraclough's presidency has been all that a three-year term connotes. He has enjoyed the wholehearted support of his wife Beverley.

authorities. He is chairman of the Australian Council for Safety and Quality in Health Care, which enjoys the support of state and federal health ministers. This council has taken steps to set up a national system of reporting of untoward events causing injury or death to patients, but its plans go much further than this. They include measures to identify and correct prescribing errors, using modern information technology; support for the reporting of incidents by patients (or 'consumers'); education programmes on matters of safe practice, quality improvement and communication; workforce issues related to patient safety; matters of audit and its use as an educational tool; a system for tracking surgical implants; the standardising of specialist registration and accreditation; and the planning of a conference on safety and quality issues.

Given that the July 2000 meeting of health ministers to which the council presented its first report was held in New Zealand, it is possible to envisage a truly Australasian outcome from the council's work. The council seeks to promote 'a change in the culture in which health professionals work from one of "judgment and blame" to one of "learning for quality improvement"'. To succeed it will need to educate politicians, bureaucrats and especially lawyers to eschew blame, then encourage practitioners to enjoy the learning and improving opportunities which result. Defensive medicine such as is being forced on the profession benefits no one, least of all, in many cases, the patient.

One of the fortunate outcomes of the ministers' conference was the decision to fund the work of the council to the tune of $50 million over five years. In an era of chronic underfunding of health services, it is encouraging to see ministerial endorsement of such an initiative. It was further encouragement when the Federal health minister, Dr M. Wooldridge, praised the work of the Safety and Quality Council:

> The Council was set up to take forward nationally led work to make our health system safer. I welcome their proposed way forward, which will make a real difference on the ground and support the efforts of all in the health system to improve the safety and quality of care.[8]

Bruce Barraclough has also been invited to join a working party set up by the Chief Justice of New South Wales, James Spiegelman, and his colleague Justice Alan Abadee, to devise guidelines for experts involved in professional negligence work in the state. If the group can produce a better system to operate under the new rules of the state's Supreme Court, it should be capable of application in other states.

It was encouraging to all who respect his ability and admire his commitment, to learn of his appointment as director of cancer care services for the Northern Sydney Health Area and to a personal chair in surgical oncology.

The work of David Theile's Pacific Islands Project has not been helped,

during 2000, by the coup in Fiji and civil unrest in the Solomons. It is to be hoped that the civil disturbance disease is not contagious through the Pacific: even Samoa was touched by political assassination in 1999, though here the process of law operated promptly and decisively.

The award of David Theile's Devine medal was made while the Fijian hostages were still in captivity. But, even if frustrated in the Pacific, he did have.the enjoyment of taking part in the relay which carried the Olympic torch round Australia on its way to the Sydney 2000 Games.[9]

On a sadder note, and soon after Theile's run, in July 2000, one of his presidential successors, Colin McRae, died at the age of only 58 – far too soon for a man who had lived with enthusiasm. As it happens, it was only a couple of months later that one of McRae's classmates, Murray Brennan, received further recognition. A Fellow from 1969, Brennan moved to the United States and a post at Sloan Kettering, to become one of New Zealand's most distinguished surgical expatriates. He was made an honorary FRACS in 1995 (when his old friend Colin McRae had the pleasure of reading his citation) and, in October 2000, the American College bestowed its Distinguished Service Award on him.

Over the years the College has acquired a variety of treasures, ranging from Farquhar McCrae's sword (which used to hang in the front hall under his portrait, until an excited Fellowship candidate tore it from its hangings; it has since been kept in a more secure place) to a Chinese junk modelled in silver.

One of the most touching gifts came at the end of 2000, when Neville Davis (who served in the Korean War) presented a bronze

Murray Brennan, who became a Fellow in 1969 and went on to a distinguished career in the USA, was awarded an honorary Fellowship in 1995. On the occasion of his 1998 Syme Oration, he is seen in procession with his contemporary and old friend Colin McRae.

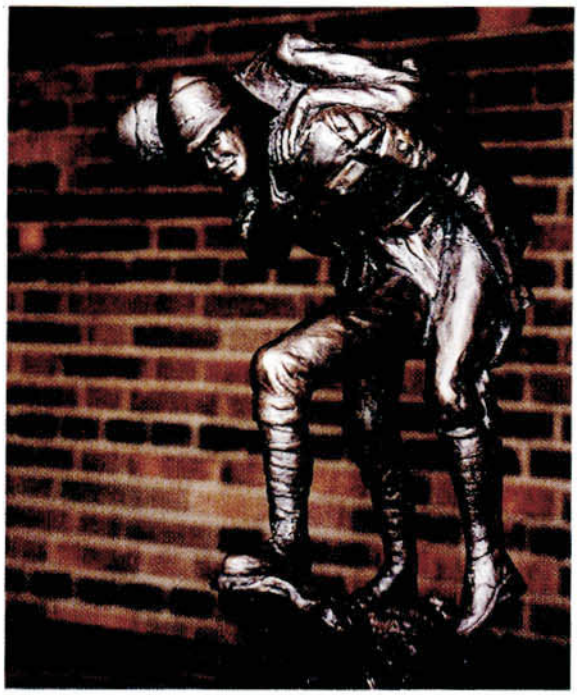
sculpture of the South African War episode in which his namesake (Sir) Neville Howse gained Australia's first VC. The award came for Howse's gallantry in rescuing a British soldier wounded by Boer fire at Vredefort. After having his horse shot from under him, he continued on foot, tended the man's bladder wound, then carried him back to safety. The bronze, sculpted by physiotherapist Peter Dornan, echoes the 1963 Dargie painting of the incident.

The year closed with a Council decision on the vexed question of the College site and its utilisation. A number of ambitious schemes had proved unworkable, and it was decided to refurbish the west wing so as to make better use of the space it contained. During this process temporary office space could be provided by partitioning the Great Hall which would, in any case, need some work done on it.

Then (as if to prove once again the truth of Malcolm Fraser's dictum) investigation revealed that the asbestos-proofing of the Great Hall, dating back to the period just before the purchase of the property in 1992, had not been adequate. The College is now faced with the need to demolish the hall. This is not, however, an unrelieved disaster, since the structure had proved too large to be often needed. It had been something of a white elephant, and its forced destruction will allow additional office space to be provided, while the Hughes Room can be expanded to cope with the local meeting needs of the College.

In place of the Great Hall, the architect Daryl Jackson has designed a four-storied new wing which will provide two floors of office accommodation together with two floors for a skills centre and its associated teaching areas. This centre, and a similar facility on the

Farquhar McCrae's sword hung beneath his portrait in the foyer of the College building, until it fell prey to an over-excited candidate. McCrae was one of Australia's surgical pioneers; his sister-in-law Georgiana McCrae, who painted him, brought courage and refinement to the early days of Victorian settlement.



The College's bronze statuette, of the deed which won Neville Howse his VC in 1900, was the gift in 2000 of Neville Davis.

campus of Sydney University (which will also be a third-generation New South Wales headquarters), represent a further flowering of the concept, described in chapter 10, that appeared first in Perth in 2000.

This project – and all the demands, even crises, of the immediate future – will be 'driven' by Kingsley Faulkner, who was chosen in February 2001 to succeed Barraclough as president at the conclusion of the May meeting in Canberra. Even the return to Canberra thus took on an aspect of *déjà vu*: for back in 1928 an infant College had gone to Canberra concerned about its home.

Kingsley Faulkner comes into office as the second Western Australian president, and like John Hanrahan, his predecessor in this respect, he is one who has joined the Council first by co-option and subsequently by election, going on to a term as treasurer before reaching the top. Their situation illustrates well the problem of the smaller state; their careers offer a solution to the problem.

Kingsley Faulkner, the second Western Australian to reach the presidency, has the distinction of being the first president elected in the new millennium.

It is a century and a half since Alphonse Karr observed that the more things change, the more they are the same.[10] The College has to guard against falling hostage to new fashions in administration, masquerading in management jargon, for it is not simply a company and cannot be managed simply as a company.

Yet the circumstances and challenges that face the College (after a period of existence only half as long as the road back to Karr) are different enough in detail now, as compared with the early days, to demand a constant effort of adaptation. This is the dilemma of any organisation:[11] to retain its principles, to retain its corporate memory

The proposed new skills centre in Melbourne.

As honorary treasurer Peter Woodruff has the task of dismantling the Subscriptions in Advance scheme, which is considered to have reached its 'use-by' date.

so that it does not forfeit wisdom, to recognise reincarnations of old threats, yet to be alive to new opportunities, alert against new threats.

'Nothing in progression,' wrote Edmund Burke in 1777, 'can rest on its original plan. We may as well think of rocking a grown man in the cradle of an infant.' The leadership, indeed the whole fellowship of the College, needs to have discarded the infant's cradle in order to rock the grown man that is the College today. Yet the underlying truths, the principles, that moved the founders in the 1920s – surgical standards and a means of designating those who can meet them – are unaltered.

The vision of the founders was sound and true enough. The efforts of their College to give form to that vision have been fruitful in many ways. The challenges remain; the work goes on. Men and women of goodwill continue to give freely of their time and their wisdom.[12] They wear the mantle of surgery today; their goodwill is the guarantee of Sandes' hopes.

NOTES

1. Though caught up as a protagonist in Adelaide in the 1980s, David had a clear understanding of the training needs of the craniofacial surgeon. In *Craniomaxillofacial Trauma*, which he co-authored with D.A. Simpson, he wrote (p.684):

> The craniofacial surgeon should be able to manage the facially traumatised patient. He should be able to perform the necessary major surgical procedures on the cranio-facial skeleton, but within a team of skilled peers. He should... have the respect of other team members. He should have a knowledge of the scientific method, and... sufficient administrative skills to be able to organize his team... Common in all this are medical skills, but the superadded expertise... is not necessarily embedded in any traditional discipline, whether medical or dental. Therefore the future craniofacial surgeon could enter the training programme from many origins.

2. Hanrahan, JC (1992) *President's Newsletter*, No.16

3. See chapter 5, note 14.

4. *RACS Bulletin* 18:2: 2.

5. Marshall, DJ (1997) *RACS Bulletin* 17:3: 30.

6. The secessionists would have done well to reflect on their own Association's presidential address for 1984, given by W.N. Gilmour of Perth. He said:

> Two years ago... this Association was shaken by the firm and clearly expressed intent of half of the body to separate from the College of Surgeons... I supported what these people were saying and understood them, but at the same time, I was totally opposed to seceding from the College. I based this opposition on the grounds that we would be breaking with a long tradition: we would be losing a common meeting ground with other surgeons and we would be creating a major problem for our friends in New Zealand. Most important of all, we would have created a precedent for sections of our own body, as they specialise, to break away in the future.
>
> One would have to be naive to imagine that the... issue will not come up again.

It has come up again, in the very year that the New Zealand Orthopaedic Association has documented its intention of remaining in alliance with the College. Only the dissidents in the AOA, it seems, are in step; but that does not allow the College to underestimate the threat they pose to the whole unity of surgery.

7. Sheldon, DM (1995) *RACS Bulletin* 15:3: 26.

8. *RACS Surgical News* 1:7; 6, August 2000.

9. David Theile has the distinction, unique among College presidents and rare even among Australian swimmers, of having won gold at two successive Olympics (100 metres backstroke, Melbourne 1956 and Rome 1960) – with a silver in the 1960 relay for good measure. A medical student at the time, he was still able to graduate with honours in 1962.

10. *Plus ça change, plus c'est la même chose* (1849). Karr was a novelist and journalist.

11. In the published version of his 1994 paper on change in the health service, RN Howie wrote (*NZ Med J* 2001: 114: 525):

> I believe planning and change in the health service should aim to:
>
> 1. Get things right rather than change things fast.
> 2. Develop a proper historical perspective, and recognise a need for continuity as well as change.
> 3. Properly recognise the importance of people in the enterprise – and the power of trust and goodwill.
> 4. Promote 'leadership' more than 'management', and cooperation more than competition.

It is not too bad a prescription.

12. Anyone who cares to tally up the 30 (or thereabouts) councillors, the members of the several state and New Zealand committees, the members of the specialty boards, the specialty executive committees (central and local), the executive committees of the various interdisciplinary sections; the members of the Court of Examiners, of the Board of Examiners and its

various banks and committees, the supervisors of surgical training (both basic and advanced) and the less formal groupings of Fellows in major cities, will be part-way towards determining how many Fellows of the College give willing unpaid service at any one time – and not just to the College, but ultimately to the community at large.

The census-taker will wish to discount the total number by as many as serve in more than one capacity, for many serve (as Mundinus dissected, according to Guy of Chauliac) *multoties*; but the recorder will then have to turn to a variety of *ad hoc* bodies which serve the cause, and to the teaching time contributed by individual Fellows to the postgraduate activities of their hospital.

It is the mere contemplation of this large array that makes an author appreciate just how inadequate his account must be, for so many of the College's loyal servants have gone unnamed – even if not forgotten – in these pages.