The History of the Royal Australasian College of Surgeons from Foudation to 1935

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PREFACE

This thesis looks at the history of the Royal Australasian College of Surgeons up to 1935, My purpose is to account for the foundation and early development of the College.

This study will involve particular attention to the following: the motives of the founders, the declared aims of the College, the policies by which the College pursued these aims, and the measure of its success in its first decade of operation.

These elements are best examined within the context of events. I have, therefore, adopted a chronological approach as follows. The Introduction outlines the situation which induced a small number of surgeons to attempt to establish a body which would regulate the practice of surgery in Australasia. Chapter 1 examines the process of founding the College. Chapter 2 gives an account of the establishment of the College up to the time of the death of its first president in 1929. The expansion of the College's activities between 1929 and 1933 is examined in Chapter 3. Chapter 4 analyses events up to the opening of the College's permanent headquarters in 1935.

The only previous works on the Royal Australasian College of Surgeons have been the two historical summaries written by two former presidents of the College, Julian Smith and Alan Newton. This study, therefore, represents the only detailed history of the College during this period.

The principal sources for this study have been the original material held in the College's archives, including a number of personal memoirs and the minutes of the College Council meetings. Several secondary works on medical history, notably histories of Australian hospitals, have been consulted, together with two unpublished theses on the organization of the medical profession.

INTRODUCTION

The forty years prior to 1920 witnessed spectacular advances in surgical knowledge and technique coupled with a growing inability of the medical profession to adapt to these changes.

Lister's development of antiseptics had revolutionised the field of surgery. His methods came into general use in Australia during the 1880s and by 1920 almost every part of the human body was subject to surgery.[2] During these forty years, surgical treatment became increasingly available for a variety of ailments.[3]

These advances were accelerated by the Great War, during which. surgical treatment was applied to a seemingly endless supply and variety of cases.[4] A number of important developments were achieved, most notably the use of blood transfusions in the control of surgical shock.

Advances of these kinds promoted two conflicting trends within the medical profession. The first was towards specialisation, in which, some

1. Tony Pensabene, 'The Rise of the General Practitioner in Victoria, 1870-1930', M.Ec. Thesis, Monash University, 1979, p. 47.

2. Ibid., p. 51. See also, B.T. Zwar, 'An Address', M.J.A., 1929, II, P 874.

3. See, for example, the following record of the number of operations performed at St. Vincent's Hospital, Sydney: 1867 - 4, 1877 - 15, 1887 - 75, 1897 - 708, 1907 - 1049, 1917 - 3019. Source: Douglas Miller, Earlier Days, A Story of St. Vincent's Hospital, Sydney (Angus and Robertson, Sydney, 1969), p. 49.

4. See, for example, A.G. Butler, Official History of the Australian Army Medical Services, 1914-18, Vol. Ill (Australian War Memorial, Canberra, 1943), p. 286; Ann M, Mitchell, The Hospital South of the Yarra, A history of Alfred Hospital Melbourne from foundation to the nineteen-forties (Alfred Hospital, Melbourne, 1977), p. 151.

5. these were first employed in Victoria in 1922. See Pensabene, op. cit., p. 45.

medical practitioners devoted themselves entirely to surgery in order to master the new techniques. The second trend was towards the widespread application of these advanced surgical techniques to cases which formerly had been treated by other means, if at all, and a willingness by doctors in general practice to perform these operations themselves.

Thus the practice of surgery was not confined to the small emerging group of specialist surgeons. On the contrary, surgery was generally considered to be entirely within the domain of the ordinary practitioner; the recently developed techniques constituting simply another string to his bow. Throughout the period to 1920, and for some years afterward, most doctors were 'occasional operators', performing both in hospitals and in their own consulting rooms. Major surgery was commonly undertaken by general practitioners with no special surgical expertise, 'though adequately equipped with what is popularly known as nerve'.[8]

This situation was compounded by the widespread practice of fee-splitting, whereby some practitioners specialised in surgery without acquiring any special training and attracted custom by paying a commission to general practitioners who referred patients to them for surgical treatment.[9] The financial attraction of surgery combined with, the

6. Sir Charles Blackburn, 'The Growth of Specialism in Australia during Fifty Years and its Significance for the Future', M.J.A, , 6 January 1951, p. 20,

7. R. Scot Skirving, 'General Practice in Australia at the Dawn of the Century', M.J.A., 6 January 1951, p. 11.

8. Professor L.E. Barnett, speaking in 1927 on the objects of the College of Surgeons of Australasia, quoted by A.G. McGrath, 'History of Medical Organization in Australia', Ph.D. Thesis, Sydney University, 1975, p. 77.

9. This practice was also known as 'division of fees'.

practice of fee-splitting, produced in some general practitioners the following priority of interests: first, to perform the operation themselves; secondly, to refer the patient to another practitioner for financial reward; lastly, to call in a trained specialist surgeon. Thus the interests of the general practitioner were frequently opposed to those of the patient requiring surgery.

There was no official body to control this situation. The State made little attempt to regulate the medical profession. The various State Medical Acts were not uniform and the Bachelor of Surgery degree, which every medical graduate held, was considered sufficient qualification for any operation. Fee-splitting was a criminal offence under the Secret Commission Act, but this was never policed.

In turn, the medical profession made no attempt to regulate itself through its professional organisation, the British Medical Association,[12] Since its introduction into Australia in 1881, the B.M.A. had been the most politically motivated of the medical associations, intending to

> take up subjects which, while strictly of a medical nature, have a more immediate relation to the general interest than those which are commonly discussed in medical societies.13

During the early 1900s the B.M.A, superseded its nineteenth century rivals. By 1920 the B.M.A. had become the dominant medical organisation, encompassing the entire profession. Each State branch of the B.M.A.

10. Professional pride further contributed to this reluctance to refer a patient to another practitioner for treatment.

11. See J.C.S.A., Vol. I, July 1928, p. 148.

12. Hereafter referred to as the B.M.A.

13. Australian Medical Gazette, November 1881, p. 24, cited by G.J. Davison, The Rise and Fall of Marvellous Melbourne (Melbourne University Press, 1978), p. 100.

14. Australia-wide membership of the B,M.A. was as follows: 1899 - 248, 1915 - 841, 1920 - 983, 1925 - 1260, 1930 - 1340, 1935 - 1399. Pensabene, op. cit., p. 252.

was autonomous. Its Federal Committee, established in 1912, was only a co-ordinating body without executive powers.[15]

In the 1920s only ten per cent of medical practitioners were specialists, not all of whom were surgeons. Those engaged in general practice dominated the B.M.A. and had no wish to forgo the lucrative field of surgery. The B.M.A.'s only concession to surgery as a specialty was the surgical section that it convened as part of its periodic congresses; As meetings of this section were open to all members of the Association, they did little to discourage the general practitioner from his sorties with the scalpel. The practice of fee-splitting was prohibited under the ethical rules of the B.M.A. but these were rarely enforced.

In the absence of any official regulation, the public had no means of distinguishing between the surgeon with special competence and the surgeon-cum-general practitioner.

Just as the 'authorities' had done little to regulate these existing technical deficiencies and ethical abuses, they did little to prepare for the future. In Australia and New Zealand there was no body of any kind providing the community with a supply of specially trained surgeons. Master of Surgery degrees existed at the Universities of Melbourne and Adelaide but were rarely sought. Nor was their study encouraged.[19] The

15. In 1921 provision was made for the state branches to form a Federal Council with executive powers but this was not realised until 1933. See McGrath, op. cit., p. 83.

16. Pensabene, op. cit., p. 164.

17. There were, nevertheless, a number of specialists in prominent positions within the B.M.A. : ibid.

18. See, for example, Minutes of Council, B.M.A, Victorian Branch, October 1925 - October 1926, p. 154,

19. In any case, these degrees consisted solely of an examination in the theory of surgery; they did not provide any training in practical surgery. See chapter 2.

Universities of Sydney and New Zealand offered no post-graduate surgical qualification.

Until 1920 neither the State nor the profession provided any form of post-graduate education in surgery.[20] Would-be surgeons with money went abroad to obtain post-graduate training.[21] 'Those who aspired to be surgeons and could not afford to travel became surgeons without training'.[22]

During the 1880s and 1890s the B.M.A, and other medical societies had waged a campaign against the 'unqualified' practitioner - the herbalist, the homeopath - the man without the general medical training of a university degree.[23] The medical profession was slow to realise that with the advent of specialist medicine, the question of 'qualification' turned less on general training at undergraduate level than on particular post-graduate training in the chosen specialty'. Indeed, the view that the practice of surgery required any special training at all was strongly opposed not only before 1920 but for many years afterwards.[24]

The lesson of the period between 1880 arid 1920 was plain: the requirements of competent 'modern' surgery had grown incompatible with the training undertaken by those engaged in large-scale general practice. The

20. In 1920 the Victorian Branch of the B.M.A. instituted the Permanent Post-Graduate Committee. Similar bodies were formed in New South Wales in 1929 and in South Australia in 1928. They covered all fields of medicine and were not particularly active in surgical education. See A.M. McIntosh, 'The Development of Post-Graduate Training in Medicine in Australia', M.J.A., 6 January 1951, p. 28.

21. Many sat for the fellowships of the Royal Colleges of Surgeons of England and Edinburgh.

22. Author unknown, 'Why a Surgical College was Necessary in Australasia', undated, R.A.C.S. Archives.

23. See Davison, op. cit., p. 100.

24. See, for example, M.J.A,, 1928, I, p. 507,

rapid increase in surgical knowledge of all kinds was not acquired by those who were performing many of the operations.

A similar situation in the United States had led to the formation of the American College of Surgeons in 1913.[25] In Australia and New Zealand the attempt to confine the explosion of medical knowledge within the traditional structure of the medical profession led to a professional exodus as each of the medical specialties in turn broke away to establish its own existence within a separate organisation. The key period in this process was the 1920s and 1930s. By 1939 these independent specialties included physicians, radiologists, anaesthetists, pediatricians, gynaecologists and ophthalmologists.

In 1920 surgery was in the vanguard of medical advance. Accordingly, it was the first specialty to break away and the first to encounter the reaction from the wider medical profession. Thus the chapters which follow can be viewed as a case study in this process *of* professional stratification. In the wider perspective, they form part of the study of the growth of professional organisation in Australia during the inter-war period.

Finally, it is important to bear in mind that these movements were not designed to usurp functions or displace existing organisations. They moved to fill a vacuum, which the advance of medical science and the limitations of the profession had combined to expose.

25. Franklin Martin, Fifty Years of Medicine and Surgery, An Autobiographical Sketch (Surgical Publishing Company of Chicago, 1934), p. 321.

26. McIntosh, op. cit., p. 30; McGrath, op. cit., p, 87.

CHAPTER 1 ; 1920-1926

During the 1920s a series of attempts was made by a coterie of concerned surgeons to form an association which would address itself to the situation outlined above.

In 1920 the Surgical Association of Melbourne was formed by members of the honorary surgical staffs of the Melbourne, Alfred and St. Vincent's Hospitals.[2] It was designed to overcome the insularity of these three clinical schools.[3] Its membership was deliberately limited to fifty surgeons, in order to exclude non-specialists.[4] The Association confined its activities to the exchange of information on surgical subjects and no reports of its meetings were published. Accordingly, the Association exerted no influence on the practice of surgery outside its own restricted circle. Some years later one prominent member recalled:

> The underlying thought was to form an association like that of the "Association of Surgeons of Great Britain and Ireland"; that is to found a State organisation which in the future would possibly form a surgical nucleus around which would grow an Australasian College of Surgeons, but nothing happened.5

Throughout the remainder of the 1920s the influence of America was paramount in the successive attempts to found an Australasian controlling body.

1. Upon the admission of some country surgeons the name was changed to the Surgical Association of Victoria.

2. See, generally, J.O. Smith (former president R.A,C.S.), The History of the Royal Australasian College of Surgeons from 1920 to 1935, p. 4.

3. McGrath, op. cit., p. 65.

4. A very few outstanding surgeons outside these three hospitals were included. See Smith, op. cit., p. 3.

5. H.B. Devine, 'The Early Days of the College', (undated), R.A.C.S. Archives, p. 2.

The first such attempt occurred during the Eleventh Australasian Medical Congress held in Brisbane in 1920 under the auspices of the British Medical Association, Professor Louis Barnett, Professor of Surgery at the University of Otago, New Zealand, had been travelling in America, where he had come into contact with the recently established American College of Surgeons, He wrote to the honorary secretary of the Surgical Section of the Brisbane Congress suggesting the formation of a similar body in Australia and New Zealand:

> In this letter he wrote of the revolutionary changes which this new College had made in regard to the treatment of the American people, and was making In their hospitals, and how, through these measures, wonderful results were beginning to appear in the surgical treatment of the people.... It was to an extent specialised senior surgery, almost divorced from that which was part of the training required for qualification of a general practitioner,7

Professor Barnett proposed two main functions for this Australasian body: to promote greater efficiency In surgical work and to provide a, 'hallmark' in order to indicate to the public that Its Fellows were competent surgeons. These were In fact the twin alms of the American College.[8]

Members of the surgical section appreciated the need for some kind of action along these lines. But Barnett's particular solution was opposed by a formidable array of prominent surgeons Including G.A, Syme, R.S, Newland,

6. Sir Louis (Edward) Barnett (1865-1946), C.M,G,, Knight of Grace of the Order of St, John of Jerusalem , 1935; Hon, Surgeon to Dunedin Hospital and lecturer and professor of surgery, Otago University, 1895-1925 (retired); President, New Zealand Medical Association, 1907; President, Australasian Medical Congress, Dunedin, 1927; President, Royal Australasian College of Surgeons, 1937-8; Hon, Fellow, American College of Surgeons,

7. Devine, op. cit., pp. 1-2; the letter has not been preserved.

8. See Martin, op. cit., p. 317.

Gordon Craig and R. Worrall.[9] Their thinking conformed to the traditional arrangements of the medical profession: universities were the appropriate body to distinguish between those who were 'qualified' and those who were not; and the B.M.A. was the appropriate body to regulate professional practice. Almost all the speakers deprecated any attempt to divert support from the B.M.A. Dr Newland went so far as to describe such a body as 'a dagger in the heart of the British Medical Association'.[10]

The motion was supported by only three surgeons. One of these, H.B. Devine, stressed that the issue was not the simple question of 'the B.M.A. or not the B.M.A.',[12] but rather of action specifically on the practice of surgery to complement the B.M.A.'s activity in medicine generally.

Nevertheless, Barnett's proposal was ultimately rejected in favour of a resolution which advocated two courses of action.- First, each B.M.A. State branch was to form a surgical subsection, membership of which would be sufficient indication of those who specialised in surgery. Secondly, steps were to be taken to secure uniformity among the degrees of

9. Syme and Newland subsequently became the first and second presidents of the College of Surgeons of Australasia. Craig and Worrall were both Founders of the College and members of its first Council.

10. Australasian Medical Congress, Transactions of the Eleventh Session held in Brisbane, Queensland, 1920 (Brisbane, Government Printer, 1921), p. 150.

11. Sir Hugh (Berchmans) Devine, 1878-1959; Kt (cr. 1936); M.B,,B,S. 1906; M.S., Melb., 1914; Hon. F.R.C.S. England; F,R.A,C.S.; F.A.C.S.; Hon. Surgeon to In-Patients and Clinical Lecturer in Surgery, St. Vincent's Hospital, Melbourne (dates unknown); President, R.A.C.S., 1939-41; Hon. Fellow International College of Surgeons; Hon. Fellow Royal Society of Medicine; Hon. Fellow Association of Surgeons of Great Britain and Ireland.

12* Australasian Medical Congress, op. cit., p. 150.

Master of Surgery and to encourage aspiring surgeons to sit for them.

These diluted proposals suffered from a number of deficiencies. The possibility of a national or even Australasian body was forgone in favour of unco-ordinated action within the State brandies. Moreover, all B.M.A. members would be eligible for membership of the. proposed surgical subsections, whose scope for innovative action against the surgical activities of general practitioners would be correspondingly diminished. The confidence placed in the universities to hallmark the competent surgeon was sadly misplaced. Masters degrees in surgery were **not** provided in Sydney or New Zealand; those at Melbourne and Adelaide were rarely sought.[13] In any case, the M.S. degree constituted only a further academic qualification. It gave no indication that its holder was competent or experienced in. the practice of surgery.

In the event, neither proposal was fully implemented. M.S. degrees at Sydney and Otago were added to those at Melbourne and Adelaide$_5$ although no two of these four exhibited significant uniformity.[14] A surgical subsection was formed in New South Wales, but nowhere else.

Thus the 1920 exercise in surgical independence was aborted. The proposals failed because they were premature in that they inspired the support of the few, while the weight of established opinion remained satisfied with the prevailing institutions. The resulting requests to the existing academic and professional bodies went little way towards a solution because neither of them was directly concerned with the problem. Like the Surgical Association of Melbourne, the Brisbane Congress was an exercise in introspection, in which most eyes were focussed on the internal

13. See, for example, statistics cited in chapter 2.

14. This situation was finally resolved by the College in 1933, See chapter 2.

resources of the profession and ignored the wider possibilities of independent action. But the failure of both the attempts in 1920 provided valuable lessons for the future, the most significant of which was the futility of trying to exert control over surgery without surgeons being in control.

This laissez faire situation extended into the early 1920s, The N.S.W. surgical subsection and the Surgical Association of Victoria continued to function in their own separate fields.

In 1924 the United States of America once again provided the inspiration for renewed interest in an Australasian surgical association. This influence took the form of a visit to Australia by several distinguished members of the American College of Surgeons, including Dr William Mayo and Dr Franklin Martin, who,

> entirely independent of instructions from the College, undertook a delightful vacation trip to Australia and New Zealand. What at first was intended as a" purely personal contact with the profession of these two interesting countries developed into a series of meetings and conferences at which we were asked to discuss the American College of Surgeons,17

These meetings were convened under the auspices of the B.M.A. State branches. The Americans spoke particularly of the

> improvement in hospital practice which followed the recent foundation of their College and the regeneration of hospitals which it carried with it. They described the lessened morbidity and lowered death rate that this brought about.18

The American College of Surgeons was very practically minded. Unlike

15. Head of the Mayo Clinic and former President of the American College of Surgeons.

16. First Director-General of the American College.

17. Martin, op. cit., p. 355.

18. Devine, op. cit., p. 3.

its British counterparts,[19] which functioned primarily as examining bodies, the American College was not overly concerned with academic qualifications. It aimed to classify as Fellows those medical practitioners who had attained high standards of practical surgery - as 'a hallmark for the people'[20]

At the end of the Americans' tour a number[21] of distinguished Australian and New Zealand surgeons were offered the Fellowship of the American College.[22] Franklin Martin went a step further and suggested that this group might be used as a nucleus for the establishment of an Australasian College of Surgeons.[23] The American College compounded this influence by inviting some members of this Australasian group to read papers at the College's Annual Meeting in New York in 1925. Eight surgeons accepted these invitations, including Hamilton Russell, Ralph Worrall and H.B. Devine.

This visit proved to be the catalyst for events in Australia, Devine in particular was inspired by his first-hand experience of the American College's involvement in the practice of medicine and by the discussions he had with William Mayo, Devine later recalled that it was this experience which -

19. Royal College of Surgeons of England, Royal College of Surgeons of Edinburgh.

20. Devine, op. cit., p. 5.

21. Smith says sixteen fellowships were offered (op. cit., p. 6); the College handbook's historical summary says twenty-five (p. 1}

22. This group included Gordon Craig, H.S. Newland, Alan Newton and H.B. Devine.

23. Devine, op. cit., p. 4.

> fired me to make a supreme effort to strive for the foundation of an Australasian College of Surgeons the moment 1 reached home. It had so much to it for the health of the people.24

From the moment of his return to Australia late in 1925 he assumed the dominant role in orchestrating the formation of a surgical college on the western shores of the Pacific.

Devine took steps to avoid a repetition of the collapse of Barnett's original initiative at the 1920 Congress. He immediately embarked on a programme to win the widest possible support for the formation of a surgical association. He intended the college to embody all the surgical specialties, and to comprise New Zealanders as well as Australians. Most importantly, since the unsuccessful attempt had been made through a, non-surgical body, the B.M.A., Devine's fresh, attempt would be wholly surgical. It would be a voluntary act of surgeons completely unrelated to any existing organisation. 'In these ways this College would include a substantial part of the medical profession and therefore wield from the first a considerable influence'.[25]

But good intentions and constructive proposals alone might proye insufficient to win over the whole-hearted support of surgeons in Australia and New Zealand, especially coming from a single advocate of less than senior standing. Accordingly, the day after he returned from America, Devine approached Sir George Syme with a proposal to form an Australasian

24. Ibid., p. 6.

25. Ibid., p. 8.

26. Sir George Adlington Syme (1859-1929), K.B.E. (1924); M.B.,B.S., 1881; M.S., 1888; F.R.C.S. England; F.R.A.C.S.; Hon. Outpatient Surgeon, Melbourne Hospital, 1887-1903; Hon. In-patient Surgeon, Melbourne Hospital, 1903-1919; President, Victorian branch, B.M.A., 1900, 1908, 1920; Chairman, Federal Committee B.M.A. in Australia 1922-29; President, Medical Defence Association of Victoria, 1895-1929; nominated to the Royal Commission on Health, 1924; retired from practice 1924; President.Melbourne Hospital, 1929; President, College of Surgeons of Australasia, 1926-29.

Surgical College.

> My reasons for approaching Sir George were:- that he had retired; that he was regarded as the doyen of the profession; that he was trusted by the B.M.A. and the profession as a whole; but above all, that If he believed in this great surgical cause, the greatest confidence could be reposed in his honest quaker soul to carry it through.27

Devine's proposals were accepted by Syme[28] and by Hamilton Russell,[29] who had been favourably impressed by his own experience of the American College's activities. The three men drafted a letter which expressed, in a necessarily vague way, the principles which later governed the formation and early activities of the College,[30] This letter was sent to all in-patient surgeons of every university teaching hospital tn Australia and New Zealand and to several outstanding senior surgeons who operated in prominent non-teaching hospitals. They replied unanimously In favour of the triumvirate's proposals.[31] Moreover, the idea was approved not merely by the Surgical Association of Victoria, but by the surgical subsection

27. Devine, op. cit., p. 6.

28. Since his initial opposition to the idea at the 1920 Brisbane Congress, Syme's views had changed owing to the inactivity of the B.M.A.; 'It was felt that notwithstanding the provision of higher surgical degrees and the existence of the surgical section of the N.S.W, Branch, and the Surgical Association of Victoria, not very much success had been attained in promoting better surgery, better hospitals, or in removing ethical abuses'.- Syme's Address to the College's 1st A.G.M,, 1928, R.A.C.S. Archives.

29. Robert Hamilton Russell CL860-1933}, House Surgeon to Lord Lister 1883-4; Surgeon, Children's Hospital, Melbourne, 1892-1901; Alfred Hospital, 1901-20.

30. This letter is reproduced in Appendix 1.

31. Eighty-five surgeons were willing to become Foundation Members, three approved of the idea but did not wish to play an active role, three were overseas and two did not reply.

of the New South Wales B.M.A..[32]

Events followed swiftly from this promising beginning.[33] Meetings of those who had signified their willingness to act as Foundation Members were held in New Zealand and in all the Australian States during the first half of 1926.[34] At each of these meetings, two delegates were elected, all of whom met in Sydney on 25 and 26 August 1926, This Delegates Meeting decided that the formation of the College should be undertaken by a group of forty Founders, selected from the original group that replied to the letter. It proceeded to elect these Founders in proportion to the population of each of the Australian States and of New Zealand.[35]

This same Delegates Meeting drafted a Constitution, which outlined the objects of the College as follows, drawing heavily on those of the

32. historical Summary', R.A.C.S. Handbook 1977, p. 1.

33. See, generally, Smith, op. cit., pp. 10-20, for a more detailed account of this process.

34. The College holds records of the following meetings: Sydney, April and 1 June; Melbourne, 24 May and 12 July; Adelaide, 9 August; R.A.C.S. Archives.

35. See Appendix II.

American College:

(a) To cultivate and maintain the highest principles of surgical practice and ethics;
(b) to safeguard the welfare of the community By indicating that its Fellows have attained a high, standard of surgical competency and are of high character;
(c) to educate the public to recognize that the practice of Surgery demands adequate and special training;
(d) to promote the practice of Surgery under proper conditions by securing the improvement of hospitals and hospital methods;
(e) to arrange for adequate post-graduate surgical training at Universities and hospitals;
(f) to promote research in Surgery;
(g) to bring together the surgeons of Australia and New Zealand periodically for scientific discussion and practical demonstration of surgical subjects;
(h) to do all other things that may help to the better achievement of these objects, including the right to acquire and hold property.

The Constitution was prefaced by an Exordium, which, outlined the reasons for the formation of the College.[37] Each of the elected Pounders was sent a copy of both documents, together with, the minutes of the Delegates Meeting. They signed the Exordium and returned It to Dr A.L. Kenny[38] and in September 1926 the College of Surgeons of Australasia, came Into existence.

The Founders met for the first time on 5 February 1927[39] and

36. The object of the American College of Surgeons was as follows; 'to elevate the standard of surgery, to establish a standard of competency and of character for practitioners of surgery, to provide a method of granting fellowship in the organisation, and to educate the public and the profession to understand that the practice of surgery calls for special training, and that the surgeon elected to fellowship in this College has had such training and is properly qualified to practise surgery'. Martin, op. cit., p. 317,

37. The Exordium and Constitution are reproduced in Appendix III,

38. Provisional Honorary Secretary.

39. At the University of Otago, during the second session of the Australasian Medical Congress.

elected the following office bearers and Council:[40]

President:	Sir George Syme
Vice Presidents:	Sir Alexander MacCormick
	Professor L.E. Barnett
Director-General:	Sir George Syme
Hon. Secretary and Treasurer:	A.L. Kenny
Council Members:	R. Gordon Craig, H.B. Devine, ILS. Newland, W.N. Robertson, R, Hamilton Russell, F.P. Sandes, Ralph Worrall.

One of the Council's first substantial acts[41] was to elect as Foundation Fellows those remaining surgeons who had consented to accept foundation membership. By the end of 1927 the College comprised the most eminent and influential specialist surgeons in Australia and New Zealand - numbering some two hundred in all. Devine's ideas and Syme's prestige had won the day; the weapon had been forged. The course of events immediately quickened as the College sought to apply its newly-wrought momentum to the practice of surgery throughout Australasia.

40. R.A.C.S. Council Minutes, 5 February 1927, pp. 7-8.

41. Council Meeting, 28 September 1927.

CHAPTER 2 : 1926-1929

During its first nine years the College came to influence virtually every aspect of surgical education and practice. Within this context the years 1926-29 form a period of consolidation. During these early years the College acted on the fundamental issues which had led to its formation. These included the provision of special surgical training and education, the improvement of hospital conditions and the regulation of medical ethics. These three issues had been the original stimulants for both attempts to form the College and they directly reflected the motives of the Founders as embodied in the Exordium and the aims of the College as declared in its Constitution. The College was turning words into deeds.

Action on these issues raised a further theme of this period: the process of defining a relationship with the British Medical Association and its predominantly general practitioner members. But the College's Fellowship was the cornerstone upon which all these policies were built. Its effectiveness in distinguishing between the skilled and the unskilled surgeon would determine the regard in which the College was held and, therefore, its ability to influence other aspects of medical practice.

At its first meeting the Council enacted by-laws to establish a system of admission. This selection procedure reflected the fundamental and continuing influence of the American College of Surgeons, For both the criteria for eligibility and the selection mechanism closely followed those of the American College.[2]

1. R.A.C.S. Council Minutes, February 1927, Dunedin, New Zealand.

2. Martin, op. cit., pp. 333-4.

The candidate seeking admission had to be nominated by three Fellows of the College. He had to be a qualified medical practitioner with at least five years surgical practice. He was required to submit information on his medical training, including any post-graduate work, surgical research, publications and details of hospital appointments. The candidate had to provide five personal referees, each of whom was asked to comment on the candidate's surgical judgement and ability, and to provide confidential information on his moral and ethical standing.

The application and confidential reports were submitted to the Director-General who referred them to the appropriate Credentials Committee,[3] comprised of prominent Fellows appointed in each State and in New Zealand. These Committees scrutinised the information to determine whether the applicant was competent in the practice of surgery. The Credentials Committee decided whether to accept, reject or defer the application. This recommendation was considered by Council which decided whether to admit the candidate, reject the application, or require him to submit a series of case histories of personally conducted operations.[4]

A single uniquely Australasian requirement was superimposed on this American model. After a period of five years, candidates for the College Fellowship would be required to possess a 'senior surgical qualification[1]. This qualification was later defined to consist of a primary examination in anatomy and physiology and a final examination in surgery. Under

3. 'Director-General' and 'Credentials Committee' were the titles employed by the American College of Surgeons.

4. The common practice in the American College of Surgeons.

5. That is, from February 1932.

6. R.A.C.S. Council Minutes, 9 March 1929, p. 62.

this system the practical- emphasis of the American College would be retained in the Australasian selection procedure, but complemented by formal academic training in surgery.

This system seems to have been shrewdly conceived. It recognised the need to include immediately a number of skilled senior surgeons who did not possess a senior qualification. This process would be completed within five years, during which time younger men intending to specialise in surgery would undertake formal academic training.

Under this system one hundred and twenty-four new Fellows were admitted during 1928 and early 1929. Thirty-eight applications were suspended and seven candidates were rejected. By March 1929 the College boasted three hundred and thirty Fellows.[8]

From the outset the College accepted the responsibility to regulate the ethical behaviour of its Fellows. Every Fellow who was admitted to the College was required to take a Pledge,[9] part of which stated:

> I further declare that I will not practise division of fees either directly or indirectly in any manner whatsoever.10

Each Fellow further pledged to submit to discipline by the College, Whereas the B.M.A. had a provision against division of fees and had done little to police it, the original by-laws of the College included provision for a Fellow to be expelled by the vote of a two-thirds majority of Council,

7. Details are given in Appendix IV.

8. R.A.C.S. Council Minutes, 5 March 1929. Note: All Fellows paid an annual subscription of five guineas. Ibid., 25, 26 August 1926, p. 1.

9. This was similar to the Pledge of the American College of Surgeons; see Martin, op. cit., pp. 323-4.

10. See M.J.A., 1927, II, 556. This part of the Pledge was deleted in 1932 in favour of a Council regulation against fee-splitting: R.A.C.S. Council Minutes., 3 September 1932.

11. See, for example, Minutes of Council, B.M.A., Victorian Branch, October 1925-October 1926, p. 154.

at which the Fellow had the right to be heard. No Fellow was expelled, but the College investigated three incidents of apparent advertising by Fellows.[12] In each case it was satisfied by the Fellow's explanation.[13]

The College instituted a number of other initiatives in the late 1920s, both to provide the special training which its admission criteria required and to influence other aspects of surgical practice. These will be examined below. But it is worth noting at this point the opposition which the College's formation engendered among elements of the British Medical Association in Australia.

The principal criticisms of the College were directed against its aim of restricting the practice of surgery to specially trained surgeons and its method of instituting a special organisation independent of the B.M.A. This opposition took a variety of forms: letters to the College office-bearers, resolutions at B.M.A. meetings, and organised debates with College representatives.

Generally speaking, the source of this opposition was not widespread within the B.M.A. It was quite muted at the official level of State Branches.[14] For example, the minutes of the Victorian Branch Council between 1926 and 1935 contain very few references to the College. This may have been the result of the composition of the Council. Fellows of the College held office in the B.M.A. branches throughout the period under

12. See R.A.C.S. Council Minutes, 31 March 1928; 6 August 1928; 5 March 1929.

13. Ibid., 9 March 1929. The Council further resolved that Fellows should not display the letters F.C.S.A, on their name plates: iLbid.

14. This opposition was also hampered by the lack of a national executive body to deal with the Australasian College.

study. It is more likely, however, that the senior practitioners on the B.M.A. State Councils were not fundamentally opposed to the College's aims. In any case, this comparative lack of concern at the official level of the B.M.A. undermined the more ardent opponents of the College, who initially directed their criticisms by way of resolutions to the State Councils, in order to promote the idea of 'the College versus the B.M.A.'. This approach proved ineffective and was supplanted in the early 1930s by a campaign of opposition to the College entirely independent of the official B.M.A. organisation.

As early as 1926 the B.M.A.'s Queensland Branch criticised the method used to establish the College. Significantly, even this criticism was voiced in terms of the American experience. The Queensland Branch pointed out, quite correctly, that the American College of Surgeons had originated from a resolution of the Clinical Congress of American Surgeons: the Australasian College could point to no equivalent authority. Furthermore, the Branch asserted that the Founders should have been chosen by the B.M.A. members in each State, not by the self-appointed Delegates Meeting.[18] Both these criticisms ignored the lesson of the 1920 Australasian Medical Congress which had refused to authorise the creation of a surgical association.

The most coherent expression of B.M.A. opposition was contained in a unanimous resolution of the Eastern Suburbs sub-division of the Victorian

15. For example, in the late 1920s both Syme and Kenny held places on the Victorian Council. Both were re-elected in 192S. Syme remained President of the Federal Committee of the B.M.A, until his death.

16. See chapter 3.

17. See M.J.A., 5 March 1927, 350 ff.

18. Letter from Jackson to Syme, 9 October 1926, R.A.C.S. Archives.

Branch:

> That the qualification F.C.S.A. as at present constituted is inimical to the best interests of the profession and the community.19

The sub-division supported this resolution with several reasons. Some of these reiterated the impotent proposals of the 1920 Brisbane Congress: universities were the appropriate body to bestow qualifications; any surgical association ought to be contained within the British Medical Association. But the sub-division also voiced new objections in reasoning against the College as follows. The formation of a body of surgical specialists would 'cast aspersions' on the surgical ability of non-Fellows.[20] Accordingly, the practice of surgery would be limited to the few. This state of affairs would be 'economically undesirable for the profession'.[21] These protests highlighted the fundamental issue between the College and the B.M.A. : whether general practitioners ought to practise surgery.

As a result of this resolution and similar agitation, the B.M.A. Victorian Branch Council invited Sir George Syme to address a special meeting of the Branch on the 'Aims and Objects of the College of Surgeons of Australasia'.[22]

This meeting took place on 1 March 1928,[23] In his address, Syme related the history of the College and observed that those who had opposed the idea in 1920 had become the strongest supporters of the College:

19. Minutes of Council, B.M.A. Victorian Branch, 1928, p. 279.

20. Ibid., p. 293.

21. Ibid.

22. Ibid.

23. See generally, M.J.A., 1928, I, 488-507.

> I might have stated that the College was so convinced of the need for its foundation and was so firmly established, that it intended to carry on its activities whether this Branch approved of them or not, leaving it to the public to decide whether the College was inimical to the community.24

A number of general practitioners spoke against the College. Their principal criticisms echoed those of the earlier Eastern Suburbs resolution. Once again the central issue was whether general practitioners should practise surgery. Strong views were held on both sides of this question. General practitioners maintained that they were fully entitled to operate: their university degrees qualified them to operate; the law allowed them to operate; and the professional organisation, the B.M.A., supported this situation. If standards of surgery were not satisfactory, the universities should raise the standards of their degrees. The implementation of the College's proposals would affect the incomes of general practitioners, but more importantly, it constituted a professional slight. It would produce a situation in which the ordinary practitioner was incompetent to handle many of the ailments of his patients.[25]

The two sides agreed to differ. The B.M.A. had failed to persuade the College to modify its proposals while the College had no need to seek co-operation from the B.M.A.. For the College could not prevent general practitioners from operating and never pretended otherwise. Indeed, the key factor in the College's relationship with general practitioners was that, strictly speaking, there was no relationship. This irony was well stated by the Medical Journal of Australia;

24. Ibid., p. 488.

25. Ibid., pp. 504-7.

> It [the College] will have no jurisdiction over the general practitioner who regards himself as a surgeon, but who has undergone no special training to justify his claim. On the other hand it will embrace in its membership all the leaders in the surgical world and within a short time the only criticism will be from those who seek in vain to be admitted. 26

This was not to say that the College was not influenced by this opposition. The Council at its meeting of September 1927, had resolved that no applicant engaged in general practice in a capital city would be eligible for admission. This needlessly antagonized the B.M.A. and was rescinded at the following meeting, after which Sir George Syme wrote a letter of explanation to the Medical Journal of Australia. He pointed out that the College would admit anyone who satisfied the Council and Credentials Committee that he 'has been adequately trained in surgery and is a competent and ethical surgeon.'[27] This was not only expedient but accurately reflected the College's concern for surgery and not with, placing restrictions on general practitioners.

Viewed overall, this early opposition came from a determined section of the B.M.A., although it was not vigorously represented at official levels. It was based on a sincerely-held interpretation of the interests of general practitioners, whereas the College was only interested in ensuring the highest possible standard of surgery. Perhaps the greatest significance of this opposition was that, in an inverted way, it revealed the impact which the College was beginning to make on the practice of surgery.

In the midst of this debate with the wider profession,the College

26. M.J.A., 1928, I, 21.

27. Ibid., p. 418.

pressed on with the promotion of surgical training and education. The emphasis which the College proposed to place on a senior surgical qualification brought the almost moribund Master of Surgery degrees into prominence. If these degrees were to act as senior surgical qualifications they would have to conform to the College's definition of a two-part examination with a primary in anatomy and physiology and a final examination in surgery. The College embarked on a programme to obtain uniformity among the regulations of the four Australasian medical faculties.

This programme was begun at the Council Meeting of September 1927, when the College's recommendations on the two-part examination were sent to the universities. The Universities of Melbourne and Adelaide quickly adopted the College's recommendations.[28] The University of Sydney agreed 'in principle' in early 1929[29] but did not actually conform until late 1931.[30] The University of Otago, New Zealand, did not conform until late 1933, and this was only achieved by equating high marks in the undergraduate subjects of anatomy and physiology with the primary examination for its M.S. degree.[31]

This six-year crusade highlights the futility of looking to the universities to establish standards of surgery, as had been advocated by B.M.A. members throughout the 1920s.[32]

28. R.A.C.S. Council Minutes, 9 March 1929, p. 62. See also Faculty of Medicine Minutes, 21 March and 14 November 1929, University of Melbourne Archives.

29. R.A.C.S. Council Minutes, 9 March 1929, p. 62.

30. Ibid., 14 February 1932, p. 10.

31. Ibid., 10 April 1933, p. 97; 26 August 1933, p. 138.

32. Note the following statistics on the number of Master of Surgery degrees awarded between 1922 and 1932: M.S. (Melbourne) 18; M.S. (Adelaide) 6; M.S. (Sydney) 0. R.A.C.S, Council Minutes, 14-16 February 1932, p. 27.

An alternative to the Australasian M.S. degrees as a senior surgical qualification was the Fellowship of the Royal College of Surgeons of England. But the time and expense involved in completing the primary and final examinations in England, in addition to that involved in establishing a practice, had prevented many from seeking this qualification.

In order to encourage aspiring surgeons to acquire this qualification, the Council instructed its Honorary Secretary to write to the English College concerning the possibility of holding its primary examination in Australia and New Zealand. This resolution in January 1928, is the first mention of the Royal College of Surgeons of England. It is important to note the absolute influence of the American College up to this point and the corresponding neglect of the English College.

Several factors figured in this approach to the English College. In the absence of Australasian facilities, Britain was the traditional venue for post-graduate surgical training. Many of the most eminent surgeons held the English Fellowship and were keen to encourage young men to sit for it. Conducting the primary examination in Australasia would make it easier for surgeons to travel to England to sit the final examination for Fellowship of the English College. The Australasian College would gain prestige through having its Fellows meet the standards of the English College. These factors may have been accentuated by the difficulties

33

encountered with the Australasian M.S. degrees. Thus the attractions of the English College at this stage were practical rather than imperial.

The College acted to improve the standards of hospitals. At its

33. Between 1922 and 1932, when 24 M.S. degrees were awarded at Australasian universities, 49 Australians and 25 New Zealanders gained the Fellowship of the Royal College of Surgeons of England. R.A.C.S. Council Minutes, 14-16 February 1932, p. 27,

first Annual General Meeting at Canberra in March 1928, two Fellows presented papers on this subject. These papers, together with copies of five resolutions on hospital policy, were sent to the Federal Government and to State Premiers.[34] A Hospital Committee was formed and its services were offered to the Commonwealth Government in an advisory capacity. It met with little success as Devine later recalled: 'Nothing was ever heard from the Government'.[35] Later initiatives in hospital matters were more successful.

The College was quick to initiate publication of a journal.[37] The idea was first mentioned at the meeting of senior surgeons to discuss the formation of a College, in Melbourne on 12 July 1926. It was discussed at the Council's first meeting[39] and the first volume of the Journal of the College of Surgeons of Australasia appeared in 1928.[40] This contained four hundred and fifty pages, including forty-seven original articles, of which forty had been read at College meetings, and fifteen book reviews.[41]

34. H.B. Devine, 'The Genesis of the Australasian College of Surgeons[1], undated, R.A.C.S. Archives.

35. Ibid.

36. See chapter 3.

37. About 400 Australasian surgeons were subscribing to the journal of the American College of Surgeons. See L.E. Barnett, 'The History of the American College of Surgeons', J.C.S.A., Vol. I, 1928-29, p. 32.

38. See 'Recommendations and Suggestions for the Initiation and Constitution of the College of Surgeons of Australasia of a Committee appointed by the prospective Victorian Foundation Members, 12 July, 1926', R.A.C.S. Archives.

39. R.A.C.S. Council Minutes, February 1926, p. 13,

40. The original name of the publication was later thought to suggest a record of activities rather than a scientific journal. The name was altered to the Australian and New Zealand Journal of Surgery. R.A.C.S. Council Minutes, 30 March 1931, p. 131.

41. Ibid., 5 March 1929, p. 56. The journal was distributed to all Fellows.

These activities had required much work. The Council met six times between 1927 and early 1929.[42] Between these meetings the affairs of the College were conducted by the Executive Committee consisting of Sir George Syme, A. L. Kenny and H. B. Devine, all from Melbourne, Sir Henry Newland of Adelaide, and Professor Sandes of Sydney. For the first eighteen months the Executive had met in the consulting rooms of Devine or Kenny. But as the activities of the College expanded, so did the need for an office and for administrative support. Since the President, Secretary and Devine all resided in Melbourne, the office was established in that city. In 1929 the College rented a single room at No. 6 Collins Street.[43]

> This was the first headquarters of the Australasian College of Surgeons. A formidable brass plate advertised this fact.44

From the beginning the question of a permanent headquarters building had been considered.[45] It was originally intended that this should be built in Canberra, alongside other scientific institutions. Discussions to this end were conducted by Syme, Kenny and Devine with Sir John Butters, Chairman of the Federal Capital Commission, and a three acre site was reserved for the College in October 1927.[46]

42. 5 February 1927, Dunedin; 28 September 1927, Sydney; 26 January 1928, Melbourne; March-April 1928, Canberra; 6 August 1928, Sydney; 5, 9 March 1929, Sydney.

43. In the same year the College employed Miss Oldham as typist. She remained with the College for twenty-five years.

44. H. B. Devine, '0n the Headquarters of the College', p. 3, undated, R.A.C.S. Archives.

45. The first mention was at the Sydney meeting of prospective Foundation Members, 1 June 1926. See the Minutes of this meeting, R.A.CS. Archives.

46. J.C.S.A., Vol. I, 156.

The first Annual General Meeting opened in Canberra on 31 March 1928. Fellows assembled on the proposed College site on 2 April, where their enthusiasm got out of hand under the influence of Sir Neville Howse V.C. (Minister for Home and Territories). Howse urged the College to commence building:

> He called upon every man present who was not prepared to put up 100 pounds (as a debenture to form a Building Fund) to raise his hand.(No hand was raised.) 47

Sir Neville Howse also circulated a subscription sheet on which Fellows entered amounts as gifts to the College Building Fund in addition to the debentures already promised.[48]

The College Council, however, was less keen than the Commonwealth Government. The same evening, Sir George Syme announced that the Council could not undertake building operations in the immediate future and had no means to pay interest on any debentures. The whole question of building was postponed.[49]

During the period 1927-29 the College of Surgeons of Australasia established the foundations of its later activities. Its admission system had been widely framed to attract the support of all specialist surgeons in the immediate future and with provision for a more demanding standard for future aspirants. The College had gone some way toward providing special training for surgeons, the improvement of hospitals and the regulation of ethical practice. It had weathered the B.M.A. storm and had established its own office with the ultimate intention of building a permanent headquarters.

47. J.C.S.A., Vol. I, 1928, 159,

48. Ibid.

49. Ibid.

Sir George Syme had .been the pre-eminent figure throughout this process. His professional standing calmed opponents and won support. One of many letters he received, critical of the College, went on to say:

> But for your participation in the scheme I would be suspicious of it ... You have a thousand friends and are trusted by all.50

This period of consolidation ended on 19 April 1929, with the death of Sir George Syme. Dr Kenny had recently retired as Honorary Secretary. This passing of the old guard caused great concern to H.B. Devine:

> To me this was a great blow.... I felt desolated: the bottom had fallen out of our new College. Together we had weathered some storms in its foundation. I felt I could not get on without him. I had just lost Dr Kenny ... I had, however, some consolation: I had just gained the help of Alan Newton 52 as Honorary Secretary. This would mean much.53

50. Letter from W. Grant, 10 November 1927.

51. Syme[f]s memory was later commemorated by the Syme Oration, given as the opening address at the College's Annual General Meetings, and by the Syme Research Scholarship - both the result of a gift from Lady Syme.

52. Sir (Hibbert) Alan (Stephen) Newton, 1886-1949; Kt Ccr. 1936); M.B., B.S., Melb. 1909; M.S., 1912; F.R.C.S., England 1919; F.R.A.C.S.; F.A.C.S.; Hon. Surgeon to In-Patients and Clinical Lecturer in Surgery, Melbourne Hospital, 1927-46; Hon, Consulting Surgeon, Royal Melbourne Hospital, 1946-49; Stewart Lecturer in Surgery, University of Melbourne, 1947; Member Central Medical Co-ordinating Committee, 1939-45; Chairman, Medical Equipment Control Committee, 1940-45; Consulting Surgeon, Army H.Q., A.M.F., 1940-42; Member Medical Board of Victoria; Member Board, Walter and Eliza Hall Institute of Research; President, Royal Australasian College of Surgeons, 1943-45; Junior Vice-President, Victorian Branch B.M.A., 1937-8; Hon. Fellow, British Association of Surgeons; Hon. Fellow, Royal Society of Medicine.

53. H.B. Devine, 'Sir George Syme's Death', undated, R.A.C.S. Archives.

CHAPTER 3 : 1929-1933

Between 1929 and 1933 the College of Surgeons of Australasia expanded its activities to include a wide range of matters related to surgical training and practice. It developed its policy of admission and continued its efforts towards the provision of academic post-graduate training in surgery and the improvement of hospitals. These fundamental concerns were supplemented by the creation of opportunities for aspiring surgeons to undertake practical training at major hospitals, the promotion of surgical research, the formation of a library and the provision of information on overseas post-graduate training.

This period of expansion was reflected in three accompanying trends. Firstly, as the College asserted its predominance in surgery, opposition from the British Medical Association waned and became confined to a militant clique of general practitioners. Secondly, as the Australasian College became securely established, it acquired the symbols of its professional status in a Coat of Arms and the use of the prefix 'Royal'. Finally, the College illustrated its self-confidence by deciding to build its own permanent headquarters.

The driving force behind this expansion was the increasingly energetic executive committee of Council. Following the death of Sir George Syme, the office bearers of the College were reorganized as follows:

President:	Sir Henry Newland (Adelaide)
Vice-Presidents:	Sir Alexander MacCormick (Sydney)
	Professor Louis Barnett (New Zealand)
Director-General:	Hamilton Russell (Melbourne)
Hon. Secretary and Treasurer:	Alan Newton (Melbourne)1

[1]- R.A.C.S. Council Minutes, 8 June 1929, p. 65.

Following the establishment of the office in Melbourne, the executive committee comprised the President and those Council members who lived in Melbourne.[2]

> ... the executive committee met every Wednesday at 12.45 p.m.. Hamilton Russell, then an old man, crippled with arthritis, would take the chair. Alan Newton would wind up and set the alarm clock. He would then take a seat in company with A.L. Kenny and Hugh Devine.... The meeting would begin. Hamilton Russell would shortly fall asleep, and Miss Oldham would take down the proceedings in shorthand. At 2.00 p.m. the alarm clock would explode, and the meeting would adjourn.3

Since the full Council met only every six months, the executive committee was largely responsible for handling the affairs of the College. Owing to the advanced age of Russell and Kenny, this responsibility fell to Devine and Newton. Indeed, on almost every matter of importance, 'a sub-committee of Newton and Devine' was formed to investigate and report. Moreover, from the outset of Newton's term as Honorary. Secretary and Treasurer, Council meetings began with the receipt of the report of the executive committee, largely the work of Newton and Devine. The remainder of the meeting was given over to the discussion and, in nearly all cases, approval of the executive committee's action. This situation concentrated the conduct of the College's affairs, subject to the concurrence of the President and biannual ratification by Council, in the hands of Alan Newton and Hugh Devine, both eminent surgeons and men of considerable energy. The dominance of these two men was a prime factor in the rapid expansion of the College's activities in the 1930s.

2. The President received a latter following each meeting of the executive committee, to which he replied before the next meeting,

3. Contemporary account by the Honorary Assistant Secretary, J.O. Smith, op. cit., p. 23.

The College's admission policy continued to attract surgeons: by early 1933 its Fellowship numbered five hundred and forty-six.[4] The introduction of the requirement of a senior surgical qualification,together with the need to state what the College considered to be adequate and special training in surgery, prompted a review of the admission system. This was undertaken by Devine and Newton, and their report was considered at the meeting of Council in February 1932. This report revealed that there were a number of surgeons worthy of Fellowship who did not hold a senior surgical qualification, and would be ineligible under the proposed admission procedure. The report cited statistics to show that over half the Fellowship did not possess any kind of senior surgical degree and that only one-third held a qualification which conformed to the Council's definition of a senior surgical qualification. The report concluded that the requirement of such a qualification alone would not significantly improve the standard of Fellowship: on the contrary it would highlight the comparatively poor academic qualifications held by the bulk of the

4. R.A.C.S. Council Minutes, 10 April 1933, p. 93.

5. Ibid., 14-16 February 1932, p. 22.

6.

F.R.C.S.,England M.S., Adelaide M.S., Melbourne	131	(26.55%)
M.D., Sydney	11	(2.28%)
F.R.C.S., Edinburgh F.R.C.S., Ireland	88	(18.25%)
No senior degree	252	(52.49%)
Total:	482	

(R.A.C.S. Council Minutes, 14-16 February 1932)

Note: Under the regulations of the Australasian College the Fellowship of the Royal College of Surgeons of Edinburgh acted only as a final examination, not as a complete senior surgical qualification. R.A.C.S. Council Minutes, 26 August 1933.

Fellowship and reduce the standing of the College.

Devine and Newton referred to a number of defects in the original admission system. Firstly, it was almost impossible to assess candidates on the basis of confidential reports, which 'were frequently diluted by benevolence and occasionally acidulated with malice'. 7 Secondly, differing standards were being enforced by the various credentials committees in the Australian States and New Zealand. In this decentralized fashion the College would achieve as little in the field of surgery as the fragmented B.M.A, had accomplished in medicine generally.

In the light of these deficiencies and the inadequacy of the proposed senior surgical qualification, Devine and Newton suggested a new system of admission which was endorsed by Council and approved at a General Meeting of Fellows.[8] They advocated a centralized system of admission and outlined a comprehensive programme of training which would prepare a candidate for Fellowship. This new system required a minimum of five years post-graduate experience in surgery, including one year as Resident Medical Officer, and the acquisition of a senior surgical qualification.[9] Upon these basic requirements the College superimposed a period of surgical apprenticeship to a recognized senior surgeon. By this practical method the College sought to raise the standard of candidates,

The mechanism of admission was altered to provide centralized control

7. Sir Alan Newton, Halford Oration: '0n Surgical Education', 1936, p. 6.

8. R.A.C.S, Council Minutes, 14-16 February 1932; Annual General Meeting, 17-20 February 1932; see A.N.Z.J.S., I, 1932, 446,

9. The requirement of a senior surgical qualification could be waived by Council in the case of candidates of exceptional surgical ability. R.A.C.S. Council Minutes, 14-16 February 1932, p.26.

and more uniform standards. Candidates submitted details of their training to the Censor in Chief. If he considered this sufficient, he permitted the candidate to appear before a national Board of Censors, convened in each country and comprising six prominent Fellows, These Boards scrutinized details of the applicant's training and reports from his supervising surgeons. It also tested the candidate's practical surgical knowledge in an oral examination. The Board's recommendations were considered by Council, which decided whether to admit the candidate.[12]

This new admission system won the admiration of both the President of the American Surgical Association and a senior Council member of the Royal College of Surgeons of England,[14] and was adopted by the American Board of Internal Medicine.

Not only was the standard of the College Fellowship raised but its categories were extended. Specialists in opthalmology and laryngo-otology who gained the M.S. degrees in these specialties were eligible for admission. Specialists in gynaecology and obstetrics, for which, there

10. A new name for Director-General. The title had been altered at Council Meeting, 24 March 1930.

11. Replaced the previous Credentials Committees.

12. An entrance fee of twenty-five guineas was levied on Fellows admitted after February 1932. R.A.C.S. Council Minutes, 14-16 February 1932, p. 8.

13. See Professor E.W. Archibald, Presidential Address to the American Surgical Association, 1935, in which he examined the qualifications of the surgical bodies of Britain, America, Australasia, Canada, France and Germany, and concluded that the Australasian Fellowship was the best. Annals of Surgery, October 1935, p. 486.

14. C.H. Fagge, 'Syme Oration', 1932, A.N.Z.J.S., Vol. 2, 1932-33, 13,

15. Newton, Halford Oration, op. cit., p. 6.

16. R.A.C.S. Council Minutes, 14-16 February 1932, p. 9; these degrees were available at the Universities of Adelaide and Sydney.

existed no special qualification, were eligible.if they acquired a senior surgical qualification in general surgery. Junior membership was offered to candidates who held a senior qualification and were suitably trained but who possessed less than five years surgical experience.[18]

These refinements were supplemented by the promulgation of Rules of Conduct, which specifically precluded the practice of fee-splitting.[19] In short, through all these measures the College systematically extended its responsibility for, and control over, the admission of Fellows and their practice of surgery.

These new admission requirements highlighted the need for post-graduate surgical training between graduation and admission to Fellowship. The College proceeded with discussions to gain uniformity among the Master of Surgery degrees at Australasian universities.[20] In addition, the College pressed on with negotiations with the English College for it to conduct its primary examination in Australia or New Zealand, Agreement was reached on the basis that the two Colleges would share equally the anticipated deficit of eight hundred pounds.[21] The College arranged courses of lectures to prepare candidates, and the examination was held in Melbourne

17. Ibid., 10 April 1933, p. 111.

18. Ibid., 24 March 1930, p. 81. This was abolished in 1933; ibid., 10 April 1933. A similar category of junior membership existed in the American College of Surgeons; see Martin, op. cit., p. 335.

19. R.A.C.S. Council Minutes, 24 March 1930, p. 92.

20. This was finally achieved in 1933. See chapter 2.

21. The eventual cost to the Australasian College was 246 pounds, two shillings and seven pence; R.A.C.S. Council Minutes, 3 September 1932, p. 58.

in August 1931.[22] Ten of the twenty candidates passed, which represented a higher proportion than was normal in England.[23] Arrangements were undertaken to repeat the examination in 1935.[24]

In addition to these efforts to provide academic qualifications, the College, through its near monopoly of honorary surgeons, exerted considerable influence on all teaching hospitals in Australia and New Zealand to provide positions as Associate Surgical Assistants to aspiring surgeons, who could thereby gain the practical experience which the College's new admission policy required. A number of hospitals provided such posts,[25] and many young men profited by these periods of surgical apprenticeship.[26] For example, between 1928 and 1935 thirty men held posts as Associate Surgical Assistants in Melbourne hospitals.[27]

The College continued to concern itself with wider issues of surgical practice. Hospital Committees were instituted in four States and New Zealand.[28]

22. These courses were conducted by the Melbourne Permanent Committee for Post-Graduaite Work, the Post-Graduate Committee of the New South Wales Branch of the B.M.A., and the Faculty of Medicine at the University of Adelaide; R.A.C.S. Council Minutes, 29 September 1930, p. 114..

23. Ibid., 27 September 1931, p. 158.

24- Ibid., 10 April 1933, p. 97.

25. Melbourne Hospital, Alfred Hospital (Melbourne), St. Vincent's Hospital (Melbourne), Children's Hospital (Melbourne), Royal Prince Alfred Hospital (Sydney), Royal Alexandra Hospital for Children (Sydney), Adelaide Hospital, Mater Misericordiae Hospital (Brisbane); A.N.Z.J.S., Vol. 4, 1934-35, 205.

26. The College found that candidates with this training invariably performed better at examinations conducted by the Boards of Censors. See, for example,, R.A.C.S. Council Minutes, 18 March 1936, p. 298.

27. Ibid.

28. Victoria, New South Wales, South Australia and Queensland; J.C.S.A., Vol. 3, 1930-31, 133.

Although these bodies reported on a number of aspects of hospital practice, they had little practical effect.[29] Hospitals were suspicious of advice from a purely surgical body and the College had no authority over any hospital. The limited success which the College obtained in hospital matters came from individual Fellows who held influential hospital posts.

The College promoted surgical research. In 1929 its first research grant of fifty pounds was awarded to Dr F.M. Burnet.[30] In the early 1930s, three research scholarships for Fellows were founded as a result of bequests.[31]

Following suggestions from the New Zealand Fellows, the College established a Registry of Hydatid Disease in 1930.[32] This disease was more prevalent in Australia and New Zealand than elsewhere in the western world. By 1935 the Registry held records of four hundred and twenty-eight cases, which formed the data for subsequent research.[33]

Apart from these activities on general medical matters, the College extended the services it offered towards its own members. Most of the College's Annual General Meetings were devoted to operations, clinical demonstrations and lectures designed to improve the surgical knowledge of

29. The Victorian Hospital Committee reported on hospital methods in America and formulated a system of hospital records; R.A.C.S. Council Minutes, 30 March 1931, p. 130. The New Zealand Committee was particularly active in the staffing of hospitals and was approached by the New Zealand Director-General of Health to undertake the grading of hospitals; Ibid., 11 April 1933.

30. Later Sir Macfarlane Burnet, O.M., K.B.E., awarded the Nobel Prize for Medicine, 1960.

31. The Syme Research Scholarship and two T.F. Ryan Scholarships in Surgery; see R.A.C.S. Council Minutes, 30 March 1931, p. 128; and 31 August 1934, p. 189.

32. Ibid., 24 March 1930, p. 95.

33. Ibid., 3 March 1935, p. 243.

Fellows.[34] Similar meetings were conducted by the State and New Zealand Committees of the College.[35]

The College journal continued its informative and educational role. It welcomed contributions from non-Fellows and every Fellow received a copy as part of his subscription fee. Many copies were sold outside the College's Fellowship.[37]

In 1933 the College began to form the nucleus of a library as part of its post-graduate teaching facilities. Fellows donated books and the College journal was exchanged for a number of overseas periodicals.

In the same year the College established a Post-Graduate Bureau, designed to foster post-graduate education by gathering information on all teaching hospitals and centres of post-graduate activity both within Australasia and overseas.[39]

The expansion of the College's activities was paralleled by a narrowing of opposition from the British Medical Association. Following the confrontations of the 1920s, the two organizations had co-existed quite peacefully, independently of each other. Certainly during the 1930s there is little evidence of opposition to the College from the official

34. For example, the 1930 A.C.M. in Melbourne was attended by one hundred and seventy Fellows; J.C.S.A., Vol. 3, 1930-31, 131.

35. For example, sixty-two demonstrations and eight lectures were held in Melbourne during 1930-31; ibid., 145-8.

36. The journal experienced some financial difficulties in the early 1930s, but profitability returned by 1933. R.A.C.S. Council Minutes, 30 March 1931, p. 131 and 26 August 1933, p. 145.

37. For example, in March 1932, two hundred and twenty-three copies were sold to non-Fellows; ibid., 3 September 1932, p. 83.

38. Ibid., 10 April 1933, p. 99. The library was a principal beneficiary of a bequest to the College of more than fifty thousand pounds by Gordon Craig; ibid., 27 September 1931.

39. Ibid., 10 April 1933, p. 98.

B.M.A. bodies at Federal or State level. In the face of this official acquiescence, opposition passed into the hands of a militant group of general practitioners. In 1929 a General Practitioner Section was formed within the Victorian Branch. This Section quickly abandoned the attempt to work through the B.M.A. State Council, which it described as 'puerile or partisan'. In 1930 the Section formed its own Advisory Committee:

> To watch the interests of general practitioners, ascertain and express their views on any matters, obtain legal opinion when needed, and keep the general practitioners aware of the trends of events affecting them. 42

In the same year the Section began producing its own monthly journal, The G.P..[43] Criticism of the College of Surgeons featured prominantly in the issues of this journal.[44]

The Section's principal objections were contained in a resolution which was communicated to the College Council in June 1930.[45] This resolution criticized publicity of College activities and the College's object of educating the public. It continued as follows:

40. Indeed, when Sir George Syme died, Sir Henry Newland not only became President of the College, but also of the Federal Committee of the B.M.A., a position he held until 1949. See J.E. Hughes, Henry Simpson Newland (Adelaide, The Griffin Press, 1972), p. 86.

41. The G.P., Vol. 1, No. 1, May 1930, 3.

42. Ibid., 1.

43. The naine of the journal varied: Vols. 1-2 (1930-31) - The G.P.; Vols. 3-5 (1932-35) - The General Practitioner of Australasia; Vols. 6-16 (1936-45) - The General Practitioner of Australia and New Zealand.

44. See, for example, The G.P,, October 1930, 81.

45. R.A.C.S. Council Minutes, 29 September 1930, p. 116.

> That the College of Surgeons should ... 3, Recognize the supreme authority of the British Medical Association over its members in all matters of public policy and those affecting the whole of the profession, particularly in regard to such subjects as "Hospital policy", and "The Division and Scale of Fees" and "Nationalization and National Insurance" and Ethics. 4. Recognize the British Medical Association as the sole intermediary between the profession and the public.46

This resolution illustrated the attitude which had hindered the development of specialist surgery in Australia. It exhibited the same wishful-thinking which had characterized the B.M.A. view throughout the 1920s.

The protests of the General Practitioner Section had a slight effect on the College.[47] They had a greater effect on the B.M.A.. For toward the end of 1930 the Victorian Branch Council set up a committee to investigate the medico-political activities of the Section.[48] Moreover, in the following year the Council wrote to the Association in Britain to disassociate itself from the opinion expressed in The G.P., which, significantly, was no longer sub-titled 'The official organ of the G.P. Section. [49] Thus the attempt to confine the activities of the College came to nothing.

Perhaps the most revealing aspect of this opposition was the comments on the College made by the Chairman of the General Practitioner Section at its first Annual General Meeting:

46. Ibid.

47. The College was incorporated under the Victorian Companies Act on 24 October 1930. The Memorandum of Association drawn from the original Constitution omitted the clause relating to the education of the public. Ibid., 30 March 1931, p. 124.

48. Minutes of Council, B.M.A. Victorian Branch, 1930, p. 95.

49. Ibid., 1931, p. 43.

> One thing much to their credit was that they were a well-organized body. They knew what they wanted, and intended by all means to get it. They had brains at the head of it, and they had money. Each Member and each Fellow paid five guineas a year extra to the B.M.A.; and, what was more they allowed a great many of their powers to be transferred to what they called their governing body. What their Executive said, did go, and that was not the case with, the B.M.A.. In addition, the point lie most wanted to stress was that the College of Surgeons had determined to improve their knowledge. They were going to make the College worth, something. In the long run, it was knowledge that counted most in the profession, and if they, as G.P.s, were to compete with the Surgeons, victory would be gained, not by newspaper arguments but by increasing their knowledge of their own job, and the way in which, they ran their practices.50

As the College of Surgeons of Australasia became securely established in the early 1930s, it sought the outward expression of an established professional body, which in Australia and New Zealand at this time was distinctively British. In 1931 the College acquired both a Coat of Arms and the prefix 'Royal', 'in order to emphasise the Imperial significance of the College'. In February 1932, Mr C.H. Fagge, on behalf of the English College, presented a Mace to the Royal Australasian College of Surgeons 'as a spirit of affection which has passed from Mother Country to her sons'.

The acquisition of these British symbols illustrates the British character of life in Australia and New Zealand in the 1930s, rather than any affinity with the Royal College of Surgeons of England, Throughout the period,the Fellowship of the Australasian College represented an

50. The G.P., May 1930, 9.

51. 'Historical Summary', R.A.C.S. Jubilee Year Handbook, 1977, p. 10.

52. C.H. Fagge quoted in A.N.Z.J.S., Vol. 1, 1932, 341. In 1933 the College adopted its own academic costume. R.A.C.S. Council Minutes, 10 April 1933, p. 113.

adaptation of the American model. The English College was purely an examining body in competition with the universities.[53] Apart from its name it had little in common with the active, reforming surgical colleges in America and Australasia.

The Royal College of Surgeons of England held two attractions for the Australasian College. The first was its Fellowship examination in surgical theory, which was particularly demanding and carried considerable prestige. This examination was employed by the Australasian College as a senior surgical qualification for its own admission requirements. The second and over-riding attraction was that it was the Mother Country's surgical organization. The relationship between the Australasian and English Colleges during the 1930s must be seen more in general imperial terms than in any narrow professional sense.

Perhaps the best illustration of the progress of the College was the decision in only its fourth year and in the midst of the Depression, to build its own permanent headquarters. The original enthusiasm for the Canberra site had waned. A headquarters in Canberra would not suit any member of Council and would impede the administration of the College's affairs. Still less would it suit the New Zealand Fellows.[54] In 1931 a General Meeting of Fellows decided to locate the headquarters in one of the Australian State capitals. Melbourne was chosen owing to its 'central geographical position'.

53. Fellowship of the English College was a wholly academic qualification. Any qualified medical practitioner with six months continuous service as a house surgeon in a recognized hospital could sit its examination. See Newton, Halford Oration, op, cit., p. 5.

54. Travelling to Canberra from New Zealand would require a two-leg journey. It was also undesirable for the headquarters of an Australasian body to be located in the Australian Capital.

55. A.N.Z.J.S., Vol. 2, 1932-33, p. 3.

Newton and Devine took charge of this matter. After some unproductive negotiations with the Royal Society of Victoria, Devine approached the Victorian Premier, Mr Edward Hogan, informed him of the objects of the College and the effect it would have on the health of the community, and asked if there were any government buildings in Melbourne which could be given to the College, Hogan suggested the Model School on a three-and-a-quarter acre site in Spring Street, Hogan proposed a number of terms for the lease of this site to the College at one pound a year. In spite of Devine's reply, 'Sir, being surgeons we only deal in guineas', a lease was signed on 14 April 1932.

Shortly afterwards the terms of the lease were modified to the advantage of the College by the incoming Ministry under the leadership of Sir Stanley Argyle, a friend of Devine. Under these modified terms the College leased the whole site for one pound per year, and undertook to erect within two years a building worth eight thousand pounds. The Melbourne City Council was given responsibility for constructing and maintaining gardens on the site.

56. This site was reserved by deed for educational purposes. The eighty-year old school building had become unsuitable for use,

57. These included the lease of the southern half of the site for fifty years with the option of a further fifty; the lease of the northern half for ten years; the College to pay all rates and taxes; the College to erect fences and construct gardens and maintain the site open to the public; the College to spend 15,000 pounds on the erection of buildings within ten years, R.A.C.S. Council Minutes, 3 September 1932, p. 54,

58. Devine, '0n the Headquarters of the College[1], undated, R.A.C.S, Archives, p. 5.

59. R.A.C.S. Council Minutes, 3 September 1932, p. 55.

60. A full account of Devine's efforts to secure these modified terms is contained in Appendix V.

61. See R.A.C.S. Council Minutes, 10 April 1933, p. 95, and 26 August 1933, p. 130.

In September 1933 the College Council approved plans of the building, designed to facilitate the College's educational function. A building fund was established and held more than four thousand pounds by April 1933,

Thus between 1929 and 1933 the College had extended each of its fundamental policies relating to admission, ethics, surgical education and hospital practice. These had been supplemented by fresh initiatives involving surgical research, the provision of a library and post-graduate information services. Opposition from the B.M.A. had been subdued and the College looked forward to the impending establishment of its own headquarters. This period of expansion was interrupted by the death, of the Censor in Chief, Hamilton Russell, in early 1933, and the reorganization of office-bearers which this imposed.

62. The plans included a foyer, lecture room to seat 280, a room for meetings, executive offices, a large library and a large room underneath (taking advantage of the sloping site) to seat 225 people or serve as a museum. See A.N.Z.J.S., Vol. 2, 1932-33, 222. The architect was Leighton Irwin, President of the Royal Victorian Institute of Architects. The building later won the Instituted Street Architecture Medal in 1937 as the best building constructed in Melbourne during the previous three years. A.N.Z.J.S., Vol. 8, 1938-39, 109.

63. 4,364 pounds donated by 141 Fellows; R.A.C.S. Council Minutes, 10 April 1933, p. 107.

CHAPTER 4 : 1933-1935

The years 1933 to 1935 mark the flowering of the College's activities. During this period the College pressed on with all the initiatives that have been outlined in the previous chapters. Most of these policies were firmly established by 1935. The period can therefore be used to assess the progress of the College in its first decade of operation.

The pre-eminent contribution of Devine and Newton toward the progress of the College was recognized in the reorganization of office-bearers in 1933.[1] Devine became Vice-President.[2] Newton became Censor in Chief.[3] These two men became the senior members of the Executive Committee at its meetings in Melbourne. Both men continued to supply the driving force behind the College's activities and their influence was magnified by their occupation of these offices.

Newton's authority was accentuated by a reallocation of duties within the College's organization. As a result of the revised admission system, formulated during Hamilton Russell's term of office, the duties of the Censor in Chief were no longer confined to the scrutiny of applications. They extended to the provision and supervision of the comprehensive programme of surgical training which candidates for the

1. Sir Alexander MacCormick, the original Vice-President, resigned in 1933 without ever attending a Council meeting. He had been overseas for most of the previous six years. R.A.C.S. Council Minutes, 26 August 1933, p. 129,

2. J.O. Smith was appointed Honorary Secretary and Treasurer; ibid.

3. The President, Sir Henry Newland was, of course, the senior member of the Executive, but he rarely attended the Melbourne meetings.

College Fellowship were.required to undertake.[4] Accordingly, the Censor in Chief assumed complete control of the training of surgeons, all teaching activities and the administration of examinations and research funds. The Honorary Secretary assumed responsibility for all remaining administrative duties. Thus the routine affairs of the College were separated from its executive functions which were directed towards the fulfilment of the College's original objects. Following these reorganizations, the aims of the College were pursued with still greater efficiency and considerable success.

The revised admission policy began to operate at the beginning of 1934. The combination of high academic standards and a thorough oral examination of candidates' practical knowledge proved to be a formidable test. During the first year of its operation, forty-nine candidates were admitted and thirty-five rejected.

This strengthened admission policy signified the establishment of the College as an authoritative professional body. It no longer needed to gain strength by enlisting the support of individual practising surgeons. By the mid-1930s it was exerting its own influence on those individuals who aspired to-be surgeons - one of the principal aims of the College.

The attractions of the Fellowship ensured that aspiring surgeons undertook the rigorous surgical training programme which the College specified and which it had worked to provide. One example of this

4. See chapter 3.

5. R.A.C.S. Council Minutes, 28 February 1934, p- 153.

6. Ibid.

7. See Appendix IV.

programme was the increased number of candidates for the Fellowship of the Royal College of Surgeons of England. When its Primary Examination was held for the second time in Australasia in late 1934, sixty-eight candidates presented themselves, of whom thirty-four passed.[8] The surplus gained from conducting this examination almost compensated for the loss which the College had sustained on the 1931 examination.[9] The College proposed to repeat this examination in 1937.

The educational objects of the College were furthered by the affiliation of Prince Henry's Hospital, Melbourne, as a post-graduate teaching centre. Devine and Newton undertook this project in late 1932 and agreement was reached with the Hospital's Board of Management in early 1935.[12] Under this agreement the Hospital would provide facilities for post-graduate surgical education to students registered by the College. Significantly, the Hospital accepted that every member of its surgical staff should be a Fellow of the College. Instruction was to be divided between the Hospital's staff and lecturers appointed by the College.[13] This proposed post-graduate teaching hospital was to be the first of its kind in the southern hemisphere and illustrated the College's desire to improve facilities for surgical education. More

8. 22 out of 45 in Melbourne; 12 out of 23 in Dunedin, R.A.C.S. Council Minutes, 3 March 1935, p. 225.

9. Ibid.

10. Ibid., 9 September 1935, p. 267.

11. Its name was changed from the Homeopathic Hospital in 1934. See, generally, Jacqueline Templeton, Prince Henry's, The Evolution of a Melbourne Hospital 1869-1969, (Melbourne, 1969), pp. 165-170,

12. R.A.C.S. Council Minutes, 3 March 1935, p. 250.

13. Ibid., 31 August 1934, p. 201.

14. Templeton, op. cit., p. 166.

importantly, it signalled the acceptance of the College's ideas on specialist education within the wider medical community.

This progress towards the attainment of the College's objects was well illustrated by the construction of the College headquarters during 1934. That it was built at all reflects the College's self-confidence. The type of building illustrated the College's commitment to its educational role. The building was completed, free of debt, in late 1934, when the administration moved in. The official opening was delayed in order to coincide with the Melbourne Centenary celebrations early the following year. On 4 March 1935, in the presence of representatives of all the surgical colleges and a number of distinguished surgeons from overseas, the President of the Royal College of Surgeons of England, Sir Holburt Waring, declared the building open. All the elements of the College's wide-ranging activities were installed in a permanent headquarters - at once a functional centre indicative of the College's priorities, and a symbol of the College's secure position in control of Australasian surgery.

Perhaps the best evidence of the College's accelerated progress in the mid-1930s comes from the British Medical Association. The earlier opposition from this organization had entirely dissipated by that time. Indeed, all the evidence in these years points to the acknowledged authority of the College in surgical matters. For example, the College rejected the suggestion from the central B.M.A. Council in

15. The building costs of nearly 14,000 pounds were met from the College's own resources, including its Building Fund, and through the generosity of several prominent citizens: Dr A.E. Rowden White gave 1000 pounds; Mr J.F. Cato gave 500 pounds. R.A.C.S. Council Minutes, 31 August 1934.

16. R.A.C.S. Council Minutes, 3 March 1935.

London to delay the opening of the College building to coincide with the Annual General Meeting of the entire British Medical Association to be held in Melbourne in September 1935:

> Council was loth to risk that the Opening of its building might suffer in importance, if held at the same time as the meeting of the B.M.A. 17

Events within the Victorian Branch of the B.M.A. illustrated even more clearly the position which the College had attained. On 27 February 1935, the Branch Council met and considered 'whether the British Medical Association had gone out of surgery entirely'.[18] Such was the extent of its progress that within nine years of its foundation, the Royal Australasian College of Surgeons had broken the professional monopoly of the B.M.A. and assumed unquestioned responsibility for the practice of surgery throughout Australasia. The Victorian Counctl was addressing itself to the wrong side of the question: the B.M.A. had not 'gone out' of surgery, the College of Surgeons had come in.

17. R.A.C.S. Council Minutes, 31 August 1934.

18. Minutes of Council, B.M.A. Victorian Branch, 1935, p, 37,

CONCLUSION

In the Introduction I outlined a situation in which the advances in surgery of the nineteenth and early twentieth centuries were becoming increasingly incompatible with the training provided by the universities, the organization of the medical profession, and the attitude of most practitioners. Chapter 1 outlined the successive attempts to establish a body which would redress this situation. The first substantial attempt, formulated at the 1920 Brisbane Congress, aimed to influence the practice of surgery through the existing educational and professional institutions. Only when these bodies failed to act, was an independent organization formed. The cardinal aim of the College of Surgeons of Australasia was to ensure the highest standard of surgical practice. Each of its specific objects related to an aspect of surgery which was not receiving the attention of any existing institution.

In the remaining chapters I have related the successive phases of the College's attempts to implement its ideals. Throughout this period the original objects of the College were faithfully pursued and within nine years it had instituted a range of largely original initiatives. The College's greatest successes came when it acted on its own initiative, independently of other Australasian organizations. It was least successful when it relied on corresponding motivation and energy in existing institutions. It was obstructed by the universities, suspected by hospital boards, ignored by government authorities and opposed by the organized profession. Throughout the period studied there is abundant

1. For example, its Fellowship requirements and selection procedure; providing the primary examination of the English College in Australasia; the education and regulation of its Fellows.

evidence of the irrelevance of existing medical institutions to the trend of events. They were all too preoccupied with their own interests to address themselves to the issues involved in the emergence of specialist medicine. As Dr Kenny had forecast accurately in 1926:

> Very many difficulties and much opposition will necessarily have to be encountered, but in a sense, the difficulties and opposition will be a measure of the wisdom of the movement.2

In its relations with the British Medical Association, the College revealed its concern for surgery and not for surgeons. Anyone could practise surgery - provided that they were specially trained. The B.M.A. in this period was a loosely-knit, poorly organized agglomeration of medical practitioners which seemed to be composed of two groups, one of which was indifferent to the College's activities, while the other refused to concede that surgery was the prerogative of the trained specialist. The B.M.A. was too much dominated by general practitioners to recognize the place of specialised medicine, let alone to foster its development. It was quite incapable of achieving the changes which the trend of medical advances necessitated.

Throughout the period studied, the achievements of the College were the result of the energy of a small number of concerned surgeons, although this activity was supported by most practising surgeons. In a sense, the College's early years represented a movement <u>for</u> surgery rather than <u>by</u> the surgical fraternity as a whole. But this period cannot be interpreted as a movement for individual surgeons. The College of Surgeons did not lobby governments for the exclusion of other practitioners as the

2. Meeting of prospective Foundation Members in Melbourne, 24 May 1926, quoted by Smith, <u>op. cit</u>., p. 12.

B.M.A. had done in the nineteenth century. Nor did it interfere directly in the activities of general practitioners. Its only authority was that which was surrendered to it by its Fellows.

Prestige is frequently mentioned as a factor in the growth of professional organizations. Indeed, the foundation of the College has been depicted as an attempt by surgeons to establish themselves as elite

4

doctors. This was not the case. The first three decades of this century mark the fundamental division of the profession in Australia into surgeons and physicians. Surgery thus became the first of many professional elites which today comprise the field of medicine. It would be incorrect to argue that specialised medicine, or its representative organizations, were inspired by motives of personal aggrandizement. Professional prestige was not the cause, but the result, of the stratification of the medical profession into specialist fields. For example, in the case of the College of Surgeons, the Council did not allow Fellows to display the qualification F.R.A.C.S. until 1933.

It is difficult to assess precisely the effect which the College exerted on the practice of surgery up to 1935. There is no evidence to compare the number or success of operations performed by Fellows of the College and general practitioners. But the influence of the College can be inferred from other sources. For example, of the six members of the surgical teaching staff of the University of Melbourne's Faculty of

3. See Davison, op. cit., p. 100.

4. Pensabene, op. cit., p. 54,

5. See Blackburn, op. cit., p. 6 and L. Gardiner, Royal Children's Hospital, Melbourne, 1870-1970, a history, (Melbourne, Royal Children's Hospital, 1970), p. 108.

6. R.A.C.S. Council Minutes, 10 April 1933, p- 110.

Medicine in 1925, only one held the English Fellowship. By 1939, all six held either the Australasian or English Fellowship.[8] The response of the B.M.A. and the acceptance by Australasian universities of the College's proposals relating to Master of Surgery degrees also reflected the College's influence. This indirect evidence suggests that the College was successful in changing the profession's perception of the place of specialist surgery within the field of medicine. It undermined the restrictive monopoly of the B.M.A. and destroyed the legitimacy which had attached to general practitioners' surgical activities. The College guided aspiring surgeons toward the special training which it, virtually alone, had worked to provide. It ensured that its Fellows were competent surgeons and provided facilities for them to maintain and improve their knowledge. Moreover, the College provided the community with some means by which to distinguish the skilled surgeon from the adventurous general practitioner.

As an organizational phenomenon, the College blazed the trail of professional specialisation. The establishment of the College by 1935 marked a new maturity in Australasian medicine. In Australia today there are Royal Colleges of Physicians, Psychiatrists, General Practitioners, Obstreticians and Gynaecologists, together with a host of differently named institutions.

But in the period studied in this thesis, specialisation was a comparatively new concept, especially in its organizational implications.

7. Melbourne University Calendar, 1925, List of Staff.

8. Melbourne University Calendar, 1939, List of Staff. Note: the qualification F.R.A.C.S. was first displayed in the Calendar's list of staff and their qualifications in 1939.

The College of Surgeons promoted its own specialty with vigour in the interests of the science of surgery and in the knowledge of the benefits it would have on the Australasian community. This lead could never have been given by any of the existing institutions. It was from first to last the act of a voluntary association and the product of its own resources. It operated in the face of much opposition and without significant support from any outside body. The foundation of the Royal Australasian College of Surgeons and its first decade of operation were truly a case of 'Physician, heal thyself'.

APPENDIX V

H.B. Devine, 'On the College Headquarters', R.A.C.S. Archives, pp. 5-7.

Sir Stanley Argyle, who had been a personal friend of mine, became Premier, I had lunched with him almost every day for years.

One day I happened to say to him at lunch that we had gathered together enough money to build a one storey College on the south half of the Model School site in Spring St.; that I thought from the point of view of City planning it was a pity that an artistically designed two-storey building appropriate to the beautiful surroundings was not being built on the centre of the block; and that with gardens dotted through the whole block, there would be a complete belt of gardens running from the Exhibition almost to Government House - a project in which he was interested. Two things had prevented the College from taking the whole block, I told him. The first was the cost of the bigger building; and the second was the cost of forming and maintaining the considerable area of garden.

His reply astonished me. He said 'the Government will give you the northern half of this Model School site if your College will build its headquarters on the centre of the block. Further, if you do this, I shall arrange that the cost of the formation and maintenance of the garden shall be carried out by the City Council, for the Government is just about to reorganize and arrange financially with the City Council the maintenance of that belt of gardens which extends from the Exhibition to the Treasury and Fitzroy Gardens.'

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(ii) Private

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Bibliographical Note

The principal source of information on the College's activities has been the Council Minutes of the College, These are detailed and contain reports of the executive committee's actions. Additional material, such as reports of meetings, is contained in the Medical Journal of Australia and throughout the College's own journal. Sir Hugh Devine has written a number of undated memoirs on aspects of the College's early history. These contain references to events which occurred later than the period covered in this work and appear to have been written after the Second World War. Smith's history deals almost exclusively with the formalities of the College's foundation. Neither this, nor Newton's 'Historical Summary', attempt to deal with the College's specific policies or to place them in the context of Australasian medicine.

Material on the British Medical Association comes from the Victorian Branch's Council Minutes, The G.P., reports in the Medical Journal of Australia, and letters held in the College archives.

Aspects of Australian medical education are the subject of several journal articles, notably those by Blackburn, Hurley, McIntosh and Skirving. The two unpublished theses on the organization of the medical profession in Australia have been useful, Davison's book gives a good account of the state of Australia's professions in the late nineteenth century.

Details of the American College of Surgeons are well documented in Franklin Martin's book and Barnett's article.

The general histories of Australian hospitals contain some material which has been used to outline the state of medical organization and practice up to 1920, The College is rarely mentioned in any of these studies. This is a conspicuous weakness, considering the extent of most

hospitals' involvement in. surgery. It seems to reflect the lack of any detailed study of the College, rather than a lack of influence by the College on the hospitals.

Gandevia's medical bibliography contains a comprehensive list of works on medical history up to the 1950s, although it has been outdated by the appearance of many substantial works in this field during the last fifteen years.

Professor A.J. Youngson's book, The Scientific Revolution in Victorian Medicine (A.N.U. Press, 1979), was published too late to be considered in this study, although it promises to contain relevant material.