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The Second Geoffrey Kaye Oration

John Ashton — President of the Australian Society of Anaesthetists, Hobart, October 1990

Geoffrey Kaye was born in 1903, in Ballarat, but underwent his primary and secondary education in England. He returned to Australia for his tertiary education and graduated M.B., B.S. in Melbourne in 1926. That was England's loss, but Australia's gain.

The overseas experience during his formative years encouraged him to develop a friendship with overseas colleagues, which proved to be of great help in the recognition and acceptance of the fledgling Australian Society of Anaesthetists in U.K. and U.S.A. Among those friends were the famous names of Waters, McMechan, Guedel and McKesson.

Kaye's interest in anaesthesia was immediate. He became a Junior Resident at his beloved Alfred Hospital in 1927, and at the same time, a research worker in anaesthetics at the highly esteemed Baker Institute next door. From there he gained his M.D. in Melbourne in 1929. While at the Baker Institute, he published 'Practical Anaesthesia', the first Australian anaesthetic textbook.

From 1929 to 1934, not much is recorded of his life. He was presumably learning the techniques and pitfalls of clinical anaesthesia, and formulating ideas of what was needed for the advancement of Australian anaesthesia. One idea bore fruit in September 1934, when he, along with six other visionary gentlemen, convened the historic meeting at Hadley's Hotel in Hobart. This led to a formation of the Australian Society of Anaesthetists, and first annual general meeting in 1935 in Melbourne. In 1935, there were 43 members: in 1990 there are 1750.

The relevance of history to the present is questioned by many.

There seems little point in looking back into the past, when there is so much to be done in the present, and the future holds such excitement. But to hold this view is to negate the importance of our Society and the efforts of all those who have contributed.

History demands constant re-evaluation of the efforts of previous generations. Thus is the present body of knowledge constructed and the groundwork laid for future advances. The vision, leadership and inventiveness of Geoffrey Kaye are seen to have had a great influence on modern Australasian anaesthesia.

In 1935, the new ASA was still to be associated with the BMA, and to be a member of the ASA it was necessary to be a financial member of the BMA. The formation of the ASA was not without heartache and opposition. The President of the AMA, Sir Henry Newland, a familiar name to South Australians, had been firmly opposed to the formation of scientific bodies outside the association. Some still hold this view, but the ASA adopts the directions given by Geoffrey Kaye and encourages the formation of groupings for education and scientific advancement and for bringing together men and women with like minds and ideas.

That was in 1935. Where is anaesthesia today?

Anaesthesia is a service industry. It was not so in the beginning. When Horace Wells gave the first clinical administration of nitrous oxide, he was laughed out of town because of his failure. (But that's not the reason it was called laughing gas.) He attempted to concentrate on both the administration of the anaesthetic and the extraction of the tooth. It was obvious that it was not possible to be both operator and administrator, and so the need for the anaesthetist was realised, and the profession of anaesthetics was born.

But it was not possible to sever the umbilical cord to the surgeon, and that situation persists. Like it or not, we are still intimately involved with surgery and surgeons. An unhappy symbiosis it may be at times, and one which we may pretend doesn't exist. This is an ostrich attitude.

In the intervening 150 years there have been many attempts by surgeons to divest themselves of the need for an anaesthetist. Regional anaesthesia for many years was thought to be the preserve of the surgeon. In Europe, the success of the surgeon to achieve anaesthesia in this way diminished the need for and the development of general anaesthesia and anaesthetists.

In addition, the all-powerful Professor Surgeon was reluctant to share his role with other colleagues, and to admit the need for another professional to enable him to perform his surgery.

The position of the anaesthetist as an equal with his surgical colleague was also questioned in the U.K., but equality was finally established with the founding of the English Faculty, the awarding of the Fellowship, and the acceptance in 1948 of

anaesthetists as full consultants within the newly formed NHS. Australia had to wait until 1956 before recognition of equal academic status with surgeons, with the awarding of the first Fellowship by examination.

Today, the need for anaesthesia to be administered by qualified professional anaesthetists is well-established with surgeons, obstetricians and nursing staff, and is becoming accepted by the community. But many in the general community are still not sure what anaesthetists are professionally, or what their role is. A colleague was pleased to receive a letter from a patient thanking him for his services, but his pleasure was short-lived when he went on to read 'I wish you well in whatever career you may choose in the future'. In our attempts at enlightenment, we often produce more confusion. I wonder if the reason for this is because we are unsure of the role ourselves. This dilemma will continue while we are thought of only as a basic service industry.

But we are not the only service industry in medicine. Radiology also is a service industry and like anaesthetists, radiologists feel undervalued even though their skills have also advanced the frontiers of medicine and are now appreciated by physicians and surgeons.

Anaesthesia is a service industry, but servile we are not. Anaesthetists can look with pride on their achievements. The present day anaesthetist is a well-trained, efficient entity that has taken twelve years to produce. They have achieved this end against the opposition of fellow practitioners, vying for the status this training has given them. They now have the respect and equality of other practitioners. Why then do some of us feel of lesser worth than our physician and surgeon friends? We must not.

The anaesthetist takes responsibility for the patient's anaesthetic single-handed. Rarely is the final responsibility for the patient's life shared during that time. Time forbids procrastination of decision while advice is sought from others. If invasive intervention for maintaining the physiological status is needed, we must have the skills necessary to achieve this. We cannot wait while help is sought from elsewhere. The anaesthetist often feels very alone.

On occasions, where support is available, it provides the anaesthetist with some emotional relief knowing that a problem shared is a problem halved. Perhaps we have become too independent. Perhaps we don't avail ourselves of help when it is available. Perhaps we have become too self-reliant, and, perhaps, we bear this burden of individual responsibility too heavily and unnecessarily. As registrars, we have all thought we did not want the help of the consultant. As a consultant, we are often too proud to ask for the help and advice of the registrar.

Anaesthetists have to serve three masters — the surgeon, the patient and themselves. The first and second are easy compared with the last. At the end of the day, we may look back in pride, knowing we have satisfied the surgeon, and that the patient is alive and well. But, we wonder, could we have done better? That is the nature of an anaesthetist. We are self-critical, and while we are, we will always be vulnerable. We must be confident of ourselves, and of our profession.

In 1948, when Geoffrey Kaye produced his report on Mishaps in Anaesthesia, the death rate was one in 2000. Now it is one in 30,000. As anaesthetists, we can all take pride in this achievement.

We feel satisfaction when we know we have fulfilled the surgeons' requirements. But what about patient satisfaction? How do we know about this? We don't unless we find out. There is no fee available to perform an unsolicited postoperative visit to patients, so the initiative must come from ourselves to see our patients afterwards.

At this time the gratitude which patients bestow on us is our reward for being an anaesthetist. Unfortunately, too few of us are there for the bestowal.

Anaesthetists must be individuals, but they are also part of a team of practitioners working together for the best interests of the patient. We are no more important or no less important than any other member of the team, no matter whether the action be in the ward, the theatre, or intensive care.

If anaesthetists want to practise in other clinical areas as well, so be it, but we are primarily still anaesthetists. As these other demands become stronger and more time-consuming, the attention to anaesthesia and the relationship with the operating theatre and the personnel become diminished. So the stage is reached where we are no longer purely anaesthetists. We have become pain therapists or intensivists in addition.

In this achievement, we have still not thrown off the shackles and become independent clinicians. We are still not autonomous. The patients come, referred by other practitioners, and so ingrained are we with this imagined subservience, that we are happy to accept this situation and not seek total patient control. But in this regard, we are avant-garde, for today medicine requires a large degree of interdependence and it may be that the future teaching of medical students has to change to emphasise this. Until now, emphasis has been to produce a self-sufficient doctor, totally capable of handling all situations at all times.

I suspect this lack of autonomy frustrated

Geoffrey Kaye just as it does anaesthetists today. He chose other avenues for escape. He was a respected anaesthetist but clinical anaesthesia was not the total challenge for him. He wanted to expand the horizons of his anaesthetic knowledge and encouraged those around him to do the same. He had many special interests, one of which was the development of anaesthetic equipment. A colleague who played a significant part in this regard was McKesson. McKesson was an American anaesthetist, and was best known in Australia for the modification of the machine he designed in 1933. This machine delivered gases directly from cylinders without reducing valves, and was an intermittent flow machine, dependent on patient demands. One such machine was shown on the cover of the May 1990 issue of 'Anaesthesia and Intensive Care'.

There are many other examples in the Geoffrey Kaye Museum of Anaesthetic History at the College of Surgeons and these were particularly popular for obstetric and dental analgesia. 1953 saw the demise of these machines when CIG, which had been formed in 1935, released the first of its Boyle's machines, incorporating the use of flowmeters.

McKesson was an anaesthetist with an engineering degree. Kaye inherited this interest after attending a course run by him in Toledo, Ohio in 1930. He returned to Australia to set up his own workshop, first at the University, and then at 49 Mathoura Road, Melbourne, the headquarters of the ASA. This obsession with equipment overflowed into his clinical practice. Once, his registrar was moved to write, 'assisting this intellectual giant was an absolute nightmare for trainee anaesthetists, for one was surrounded by a sea of dials, tubes, stopwatches, complicated monitoring apparatus, acres of charts which had to be meticulously filled in and the point of least concern was the level of the anaesthetic. A response to the skin incision was considered as an unnecessary interruption and humbug to this scientific activity'.

In order to give a better anaesthetic, it was necessary to develop pieces of equipment which would improve the certainty of the gas and vapour delivery to the patient. In this, his aim was the same as ours — how best to achieve a stable physiological state in the presence of constant variations, produced by the anaesthetic and the surgery. Previously, anaesthetia was an art which developed from experience, and an ability to have a speed of action of both body and mind, and a sixth sense that sometimes all was not well. This is still true, but Geoffrey Kaye introduced science to this art. He added precision to an area which was previously guesswork. In this he was a pioneer, not so much because of the equipment he produced, which was invaluable in its own right, but because he encouraged scientific accuracy in anaesthesia. The development and practice of clinical anaesthesia today is far more sophisticated but it still requires this same accuracy. We refer to this as monitoring.

Is this all that anaesthesia needs now and in the future? I believe we have reached a stage in anaesthesia where we need to pause a while in this headlong ambition to produce more and more complicated monitors, to ensure that we don't just become gauge-watchers, dial-fiddlers, and numbers-men. If we allow this to happen we will surely be relegated to the status of technicians.

If we are to retain our origins, that is to say membership of the medical profession, we must behave as doctors.

We have to be good general physicians, have a knowledge of surgery and a better than working knowledge of pharmacology. But also, we must be aware of the patients' fear of the unknown, as they approach an anaesthetic.

We must be sympathetic and have empathy in what, for many patients, may be the worst experience of their life. The foreign environment of the operating theatre makes it a frightening place. We have become immune to its unfriendliness and coldness, so it requires a conscious effort to remember the mental trauma the patient is suffering. They have different ways of expressing or hiding this fear, but it is for the anaesthetist to recognise it and respond accordingly. Anaesthetists should not be offended if asked by a patient to justify their ability and knowledge. This is not a vote of no confidence — it is a reaction to stress.

Present day medical teaching has recognised the communication need, and now, doctor-patient interaction is part of the medical curriculum. This realisation has not spread to the science of anaesthesia.

During their training, anaesthetists are meant to acquire patient communication skills, but there is no specific instruction. Anaesthetists must be able to show the image of the human face of anaesthesia rather than the mask. Developing rapport with the patient is not just an end-point in itself; the calmer the patient the less sympathetic overactivity there is.

The contact between patient and anaesthetist is thought by some to be perfunctory. The society has fought against this attitude and has at every opportunity impressed the need for in-depth consultation with the patient before the operation, so that a relationship of confidence and understanding is developed.

Regrettably, brief consultation with the patient prior to anaesthesia is becoming more prevalent.

This is the result of the increasing popularity of day surgery. The popularity of this is not due to anaesthetists, but rather to health administrators and patients: health administrators because of the cost savings which can be made, and patients because they are less cut off from a familiar environment, and because day surgery is cheaper.

The realisation of patients' demands have been heightened by day surgery, imposing an added burden on anaesthetists. In this environment, all the time relationships for the anaesthetist are shortened, including the patient's return to a normal physical and mental state. For the patient, day surgery means less hassle, for the anaesthetist it means more.

Today, patient expectation of a successful outcome from medical treatment without complications is increasing. Failure to fulfill this expectation is often a cause for discontent. Both expectation and discontent may be the result of poor doctor-patient communication, changing the discontent into aggression. The aggression is then fuelled by a minority of the community, who believe somebody must pay for this misadventure. So enters the lawyer.

Premiums for medical defence associations for anaesthetists have risen rapidly in Australia. Anaesthetists are now recognised as high-risk professionals, not because they are incompetent, but because results of misadventure are serious and expensive.

Day surgery, potential for litigation and increasing complexity of medical management have all increased the importance of a full preoperative consultation. This can best be achieved by a separate consultation with a suitable time-span between preoperative consultation and operation. Consultations in anaesthetists' rooms will increase, and so the anaesthetist's desire to be accepted by patients as a clinician in his or her own right will be better realised.

I have emphasised the anaesthetist as an individual, but Geoffrey Kaye recognised the importance for communion with other anaesthetists and through this, achieving dissemination of ideas and information, improvement of standards and the warmth of fellowship. He saw such communion being achieved through the ASA, and as its first Secretary, was able to generate enthusiasm for his ideas. To disseminate them, he wrote and distributed the newsletter, and this was to become the voice of the ASA. Scientific papers and reports of the AGMs were published in the Medical Journal of Australia and other journals, until the establishment of the Faculty, when many of the anaesthetic articles were submitted to The Australian and New Zealand Journal of Surgery.

Attempts to upgrade the ASA newsletter to a journal worthy of worldwide acceptance and distribution were unsuccessful until 1972 when the first issue of Anaesthesia and Intensive Care was published with Ben Barry as the founding editor. Today, the Journal is the Society's flagship.

In addition to the newsletter, the early AGMs provided a forum for anaesthetists for concentrated discussion, and they continue to do so. Mary Burnell recognised the need to overcome the isolation of Australian anaesthetists and through her efforts the concept of an overseas visitor as the focal point for the meeting was established. Professor John Gillies was the first in 1955. Many distinguished visitors have followed him, including our guest speakers who have graciously accepted the ASA's invitation to this the 49th AGM. But let us not forget Australia also has anaesthetists of world standing. The ASA is proud to recognise this by inviting an Australian guest speaker.

The most important role of the ASA, which was a legacy of Geoffrey Kaye's energies, is its association with other anaesthetic societies and in particular, with our regional body, The Asian and Australasian Regional Section and with the World Federation of Societies of Anaesthetists. Again the ASA is fortunate indeed in having the President, Dr. Zorab, as one of its guest speakers.

Membership of other associations carries with it obligations, and for Australia these are to our neighbours in the South Pacific. The ASA initiated a scheme for overseas aid in 1962, and in recent years this has been expanded to help upgrade anaesthetic standards in the South Pacific. You, as its members, are helping with this project, either directly or indirectly. Also, the direct linking of different island States with specific Australian locations is reaching finalisation, and will benefit both.

After the 1939-1945 war, the ASA, and the anaesthetists it represented, realised that if they were to be taken seriously by physicians and surgeons, there had to be the same high standards for qualification. The ASA had neither the numbers nor the finances to achieve this assessment, so appealed to the College of Surgeons for assistance. This was generously given and the Faculty of Anaesthetists was inaugurated in 1952.

Now in 1990, the wheel has turned another circle and anaesthetists are again agitating for recognition and independence, which some feel can only be achieved with the formation of a College of Anaesthesia. From concept to fruition this will require dedication and money. Are we prepared to give both? Certainly when the College is established the goal of professional independent identity which we seek will then be closer.

In 1939, Geoffrey Kaye needed room for his

museum and library, and this was first housed in the College of Surgeons. In 1946, this has to be vacated and was transferred to two rooms at Melbourne University. One was a lecture theatre, and this remained the Scientific Headquarters until Kaye persuaded the executive to join him in his grand plan of his purchase of 49 Mathoura Road, Melbourne, and of the Society renting space from him. Perhaps inevitably, disagreement put an end to this arrangement in 1955, and so the society had no permanent headquarters until 1970, when it moved into 86 Elizabeth Bay Road, Sydney, thanks to the Elizabeth Bay Road Group.

With the growth of the Society, the Journal and secretarial staff, the ASA sought the purchase of permanent premises at 50 Gurner Street, Paddington. This was in 1979, but again the Society was to outgrow this charming Victorian house and was relocated to its present address in 1985.

Is this the last move? Currently pressure exists for closer liaison with politicians and power brokers who are increasingly making decisions which affect the Society and its members.

The AMA and the Association of Surgeons have established offices in Canberra. When a College of Anaesthetists is established, it is logical that its headquarters also be sited in Canberra. It is therefore important for the ASA and the Faculty to keep in close communication for forward planning.

Before concluding, I must acknowledge Gwen Wilson's contribution to the Society. No oration to honour Geoffrey Kaye could be given without reference to 'Fifty Years — The History of the Australian Society of Anaesthetists 1934-84'. I, like future presidents will be, am indebted to her.

Finally, anaesthetists do not have a Moses amongst them who will lead them to the promised land. Each one has to make his own way. But when they arrive, they can join the team of individuals who have preceded them. They become part of their fellow fraternity, through the Society, through the Faculty and in time to come, through the College of Anaesthesia. In so doing, they share and contribute to the strengthening of the anaesthetic ideal so that it becomes a powerful and indispensable force for the welfare of Anaesthesia — for anaesthestists and for the advancement of Medicine.

When Geoffrey was asked why he became an anaesthetist, he replied simple, 'Because I like it'. I can't think of a better answer.

It has been an honour to serve as your President and I thank you for it.