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Oration

Geoffrey Kaye Oration:† Anaesthesia — Ideals and Reality

B. J. BARRY*

Geoffrey Kaye was an idealist. His vision as a young man in the early 1930s was for a specialty of anaesthetics, with trained specialist anaesthetists who would base new knowledge and practice on scholarly, objective research, be committed to teaching and be dedicated to developing the scientific foundations of anaesthesia.

Throughout the world at the time, these concepts of medical professionalism in anaesthesia were but dreams to a handful of enlightened pioneers. Geoffrey Kaye, as one of those pioneers, set about developing the specialty of anaesthetics in Australia with an enthusiastic idealism. He was responsible for the foundation of the Australian Society of Anaesthetists (ASA) and exerted great influence on the Society and the specialty during vital formative years. Unfortunately the realities of the developing specialty coupled with his complex personality led to his disenchantment. At the age of fifty-two he turned his back in frustration and anger on the Society he founded, the specialty he loved and the colleagues for whom he had done so much.

Following the death of Geoffrey Kaye in 1986 the Society determined that future Presidential Addresses would be named as a memorial to the man responsible for the foundation of the ASA. I am indeed honoured to be the President in Office for this first Geoffrey Kaye Oration. I will attempt in the short time available to highlight some aspects of the life and ideals of Geoffrey Kaye and to correlate these with some aspects of the present-day specialty of anaesthetics in Australia.

Geoffrey Kaye (Figure 1) was born in 1903 in Melbourne. Subsequently educated in Britain, he returned to Melbourne in 1920 and

FIGURE 1.—Geoffrey Kaye.

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*M.B., B.S., F.F.A.R.A.C.S., F.F.A.R.C.S.(Eng.), President, Australian Society of Anaesthetists 1986-1988.

Address for Reprints: Dr. B. J. Barry, P.O. Box 471, Woollahra, New South Wales 2025, Australia.

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entered the University of Melbourne's medical course in 1921. He graduated M.B., B.S. in 1926 and gained by thesis and examination the M.D. (Melbourne) in 1929.

While he was a resident medical officer at the Alfred Hospital, Melbourne, in 1927 he decided to become an anaesthetist, because, as he said, 'I liked it.'

What was it he liked? I quote from a paper presented by Geoffrey Kaye to the Victorian section of the ASA in 1963 in which he spoke of the scene in Australia in 1927.

'There were three specialist anaesthetists, Brown in Adelaide and Hornabrook and Green in Melbourne. Anaesthetics was then a calling poorly esteemed, being thought fit for the physically handicapped or for those unsuccessful in other branches of medicine. Indeed anaesthetics could not be rated highly for it had no formal training and no formal examination. One merely watched senior anaesthetists at work and copied their methods as best one could. Surgeons averred that the best anaesthetists they had known were the orderlies of the Kaiser's war for these did as they were told! The Senior Surgeon at the Alfred Hospital, when told that I proposed to become an anaesthetist, said "Why waste your opportunities?" The senior paediatrician was envoked to anaesthetise a child suffering from empyema on the grounds that he knew more than any one else about children! Anaesthesia was wholly pragmatic and any attempt to equate it with the basic sciences was resented, even by anaesthetists themselves, as dragging theory into a subject essentially practical. Pre- and postoperative care for the patient was rudimentary. Preoperative visits were unknown — patient and anaesthetist met as strangers in the operating room. Pre-medication was unusual for the patient was expected to walk to the operating theatre after a long ritual of purgation and starvation. The anaesthetist was not expected to share in the postoperative care of the patient, nor in the then state of training could he have done so effectively.'

It was in this environment that Geoffrey Kaye decided to be a specialist anaesthetist. He was appointd Honorary Anaesthetist to the Alfred Hospital, where he had worked with Dr. Frederick Green, who was

FIGURE 2.—Dr. Francis H. McMechan and his wife Mrs. Laurette McMechan.

subsequently the first Vice-President of the ASA, and almost certainly would have been its second President if ill-health had not intervened. Green was a great influence on the young Kaye. Because of ill-health he asked Geoffrey to prepare and present for him his paper on Anaesthesia Mortality at the British Medical Association Congress in Sydney in 1929. This meeting was Kaye's launching pad because it was there that he met Dr. Francis H. McMechan (Figure 2).

McMechan was one of the earliest pioneer physicians in anaesthesia in the U.S.A. Crippled in 1910 by generalised arthritis which confined him to a wheelchair for the rest of his life, McMechan abandoned clinical practice to direct his many talents to the organisation of anaesthesia and national societies. With the help of his wife, Laurette McMechan, widely regarded as the mother of our specialty, he was the driving force behind the formation of the American Association of Anesthetists in 1912, later the Association of

Anesthetists in the United States and Canada, which in 1925 became the International Anesthesia Research Society. He founded and edited the first publication in the U.S.A. on anaesthesia in 1914, and in 1922 the Journal *Current Researches in Anesthesia and Analgesia*, which his wife continued to edit after he died in 1939. It continues today as one of the major publications in anaesthesia. His death was very sad. Crippled and bent over with arthritis, he developed an acute gall bladder infection, but because of his fixed jack-knife position he was declared inoperable and left to die of cholangitis.

McMechan recognised that organisation and scientific publication were essential for the establishment of anaesthesia as a scientific discipline. He travelled the world preaching the establishment of national societies and publications in anaesthesia and he urged Geoffrey to establish a Society of Anaesthetists as a necessary basis for the specialty in Australia.

McMechan assisted Geoffrey in planning his overseas trip in 1930/31 when he went to the United Kingdom, Germany, the United States of America and Canada. He met the leaders of the emerging specialty, observed them at work, learned their techniques, heard them lecture and teach. He studied their research and formed life-long friendships. His understanding of anaesthesia was influenced by many, such as Sir Ivor Magill, Sir Robert McIntosh and Arthur Guedel, but in the United States, in addition to McMechan, two other great pioneers had particular influence on him as he formulated his ideals for anaesthesia.

Elmer I. McKesson was a clinician, author and engineer, who designed and manufactured equipment, so that for the first time safe equipment essential for the safe administration of anaesthetics was produced on a scale to make it available to all anaesthetists. He conducted a course in workshop mechanical engineering which Geoffrey Kaye attended and which influenced indelibly Kaye's concept of anaesthetics. It also led to the collection of apparatus and the many pieces sectioned brilliantly by Geoffrey and now displayed by the Faculty of Anaesthetists in the Geoffrey Kaye Museum at the Royal Australasian College of Surgeons in Melbourne.

FIGURE 3.—Ralph M. Waters.

Ralph M. Waters (Figure 3), the first academic professor of anaesthesiology in the U.S.A., had a vision of anaesthesia different from those who had preceded him. He also had the talent and intellect to put into effect the changes he perceived as necessary to advance anaesthesiology beyond a pragmatic technical exercise. He saw beyond the clinical limitations of anaesthesia, recognised its rich academic potential and saw the necessity of applying principles of laboratory research to the practical solution of clinical problems. Waters established in anaesthesia the concept that not only was scholarly activity outside the operating theatre compatible with excellent clinical care but that it was essential to it. He saw the need for formal educational programs. He influenced all who came to his department, not only in regard to their own opinion of themselves but also their concepts of how

anaesthesia could and should be practised. His biographer, Noel Gillespie, concluded with a quotation he attributed to Geoffrey Kaye, who, when asked to write his impression of Water's Department in Madison, said 'I should be a bad Moslem, I fear, for I demand not one but many Meccas. Of my Meccas of anaesthesia, however, Madison will ever remain among the most rewarding and most revered.'

The time that Geoffrey spent in the best and also developing departments paid rich dividends for anaesthesia in Australia. He returned in 1931 with a total and enlightened commitment to anaesthesia and was inspired to develop the specialty by organisation, publication and research.

He was responsible for founding the ASA in 1934 and nurturing it during formative years. He was the organiser, the Honorary Federal Secretary who communicated, encouraged, persuaded and influenced. He founded and edited the Newsletter which for many years played an essential information and educational role, the scientific content written by Geoffrey being frequently based on his own research. He established a national headquarters for the ASA at Mathoura Road, Melbourne (Figure 4). This was to be a centre for communication, education and research.

It was the Society's office and administrative base with facilities for publication and distribution of the newsletter and other educational and scientific material. It contained a research laboratory and workshop to which individuals would come for training, a teaching centre with library, museum, slide-making, typing and duplicating facilities, and a laboratory for the testing, approval and servicing of anaesthetic equipment.

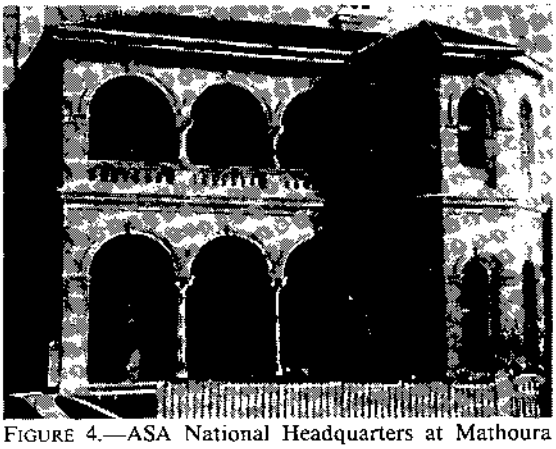

FIGURE 4.—ASA National Headquarters at Mathoura Road, Melbourne.

This headquarters was planned to embody Geoffrey's ideals for the specialty — a teaching and research centre which would constitute the base to developing the scientific content of anaesthesia — a centre through which anaesthetists would make a commitment to research, teaching and participation in the centre's many activities. But the project failed — it was, at the time, over-ambitious and unrealistic — Geoffrey's ideals could not be met.

But there was an additional factor in the headquarters' failure which must be acknowledged and that was Geoffrey Kaye himself. He had fixed and uncompromising ideas and understanding of anaesthesia, based on the mechanico-engineering influence of McKesson, and did not recognise that anaesthesia was going, and indeed had gone, far beyond mechanical equipment and gadgetry. He was intolerant of opposing views and took offence at criticism. He tried to confine the headquarters to his own control and influence. This was not only to pursue his own research concepts but also to satisfy his need for companionship and professional intellectual intercourse. Mathoura Road was to be a hive of activity with Geoffrey Kaye at the centre of the action, surrounded by committed enthusiasts like himself. He needed and sought to set up not only his ideals for a headquarters for the Society but also social opportunity and intellectual security for himself.

Geoffrey was committed totally to developing the specialty, teaching and research. He was critical and impatient of those who gave anything less than total involvement. But his colleagues had to live in the real world of anaesthetics, to earn a living and to support families. They could not give to the centre the commitment and time which Geoffrey demanded. Also they could not tolerate Geoffrey's insistence on being part of everything. If they did not agree with his ideas they were accused of being unsupportive and unsympathetic to the ideals of the Society.

FIGURE 5.—Geoffrey Kaye lecturing at the University of Melbourne, 1946.

This they resented. Geoffrey's complex, sometimes childish, reactions and spiteful accusations against colleagues were all part of the inevitable failure of Mathoura Road, and his unfortunate and sad withdrawal from the Society, his colleagues and anaesthesia. Fortunately he returned to the fold later in life and accepted honours from the Faculty of Anaesthetists and the ASA but in characteristic style never forgave or withdrew his criticisms of colleagues, nor did he ever admit that his regrettable sojourn outside the Society he founded and the specialty he loved was entirely his own fault.

Geoffrey Kaye was a man of great intellect. His personal characteristics and circumstances set him apart from his colleagues and the real world of medical practice. But he was without doubt a great pioneer of anaesthesia whose contribution towards the development of the specialty in Australia must always be acknowledged and appreciated (Figures 5 and 6).

FIGURE 6.—Geoffrey Kaye addresses an international meeting of anaesthetists at Sydney Opera House in 1984 — fifty years after he founded the ASA.

Despite the vast development of the specialty since the 1950s, the basic ideals of a fully developed specialty and an established science of anaesthesia remain goals not yet fully realised.

We have achieved much by organisation, as initiated by Geoffrey Kaye, through the ASA, the Faculty of Anaesthetists and their Committees in the numerous situations where they have represented us and influenced opinion. We have training, certification and continuing education programs second to none in the world. Patients receive the highest standards of care from well-trained anaesthetists whose clinical role is understood and appreciated increasingly by clinical colleagues. We have a political presence, an international influence, an economic and industrial security. These are some of the rungs to our ladder of ideals; but there are more to be climbed. In particular, we must give urgent attention to deficiencies in two related matters which seriously inhibit the scientific development and the organisational influence of our specialty. I refer to academia in anaesthesia and the status of anaesthetists.

Academia and anaesthesia

The dearth of academic departments has had subtle but profound effects on the specialty in Australia. It has delayed the acceptance of anaesthesia as an intellectual discipline and this in turn has lead to the specialty itself settling for something less than the ideal. Universities and clinical academicians have been unable to achieve a clear concept of anaesthesia in academic terms and this has reinforced the academic world's tendency to retain the status quo, or worse, regard anaesthesia as part of departments of surgery.

Most present day anaesthetists either did not have or did not take the opportunity to work in departments which had sufficient resources, personnel or vision, to inspire them to academic goals. It is indeed incongruous that with the threatened oversupply of clinical

manpower (with its origins in the need for a large influx of specialists to meet the clinical load), there is a financial imperative for young anaesthetists to establish themselves in the marketplace as quickly as possible. There are no secure alternative career prospects in academic anaesthesia and research. There is little incentive or opportunity for our best recruits to spend extra time developing research attitudes and techniques. Scientific and academic productivity (the main determinants of the future viability of our specialty) are limited and the ability of young and emerging leaders to develop and foster research departments is seriously restricted. The lack of funds, facilities and research trained personnel leads to a vicious cycle of inability to compete in the academic and research world and stagnation of the specialty.

Governments and health administrators must understand that clinical research is a necessary component of quality medical care and that active research departments of anaesthesia are a necessary part of all teaching hospitals. Research should be a basic part of any health care system and funding and staff establishments should be allocated so that researchers have a stable and secure career structure. They should not be dependent on the award of scarce research grants, nor should they be dependent on clinical earnings to maintain a research establishment, since clinical demands will consume increasing and unacceptable proportions of the individual researcher's time.

Clinical research is of course becoming more difficult to perform, with increasingly complex technology and administrative demands. This must lead to more and more research in anaesthesia being performed by non-clinical scientists, but for this to develop there must be clinical expertise and leadership to establish the facility and to guide and maintain the special significance and clinical relevance.

The specialty in Australia must give greater emphasis to academia and research, and work for full university Departments of Anaesthesia in every university with a medical faculty. This is no easy task, particularly because in Australia anaesthesia lacks academic status and many university authorities and academicians have yet to be persuaded of the merits of Chairs of Anaesthesia. In addition, the present economic climate and the shortage of funds for universities makes it extremely unlikely that the initiative will come from the universities. The specialty itself must take the initiative, define its academic role, find ways to fund academic departments and produce within its ranks individuals with the necessary training and qualification to take up academic appointments. The future of anaesthesia as an exciting science will be secured only when opportunity is provided for the bright, talented present-day recruits to the specialty to develop their full intellectual potential.

Status of anaesthesia

Finally, let us look again at Geoffrey Kaye's ASA national headquarters. It was in existence before departments and directors of anaesthesia or training programs. The concept, at least in its earliest years, could have been the seeds of a College of Anaesthetists. Geoffrey Kaye was against the formation of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He saw it as a divisive weakening of the ASA and a loss of autonomy for anaesthetists. But his persuasion and influence within the specialty had been spent and the Society elected to found the Faculty. This step was taken mainly because there was a need for a single, nationally recognised Diploma in Anaesthesia. Why didn't the Society establish this within its own ranks?

The precedent had been set in England. The Australasian College of Surgeons, strong and influential, agreed to support and foster a faculty in Australia as a means to a better standard of anaesthesia. As in England anaesthetists were politically weak, few in number and lacking status, influence and financial resources. The College of Surgeons presented anaesthetists with what they saw as their only opportunity of organising and having accepted a national diploma and training program which they saw correctly as vital and urgent.

Individual Presidents and Councils of the College of Surgeons have been extraordinarily supportive and generous to anaesthetists with a genuine respect for, and understanding of,

the needs of the specialty. At the same time individual Deans of the Faculty and Members of the Board of Faculty have earned a status within the College which has allowed the Faculty to develop and prosper as the confident, respected and influential organisation it is today. This is something in which all anaesthetists take pride. But the Faculty remains part of a college of surgeons and this perpetuates problems for the organisational ideals of anaesthetists. Anaesthesia is seen to be an appendage of surgery and consequently anaesthetists are seen to lack the individuality and authority of some other specialist disciplines. The status and autonomy of anaesthetists remains in question.

There is confusion about who represents anaesthetists. Many, including our clinical colleagues, think it is the College of Surgeons, with the Faculty a relatively minor and unimportant part of the College. In many academic circles, anaesthesia is still regarded as part of surgery and is not recognised as a sophisticated specialty which, while involved with much the same patient population as surgeons, has completely different clinical objectives and academic orientations. This influences adversely the attitudes to anaesthesia and anaesthetists.

Others think the ASA represents anaesthetists and many more are not sure who represents them. There is duplication which we within the specialty see as wasteful of resources and manpower, but outside the specialty it reflects an image of lack of authority and status for either the ASA or the Faculty. This inevitably influences attitudes and the status of the specialty.

Anaesthetists themselves must be concerned with status — not because they want to be centre-stage, for they are inherently retiring and humble people, but because by accepting less they are selling short both themselves and their specialty.

Anaesthesia in Australia needs a College of Anaesthetists. Such a college must be totally independent and autonomous, based on the highest ethical principles and responsible for standards, training, certification and continuing education in anaesthesia and be concerned with the welfare of anaesthetists and all matters pertaining to their specialty.

Only when a College is established will the status of anaesthetists and the specialty equate with that of other disciplines which have achieved similar organisational development. The circumstances that prevented its formation when the ASA negotiated with the College of Surgeons to form the Faculty have been overcome. The specialty now has the necessary numbers, expertise, influence and resources for a College. We lack only the resolve.

The specialty has come a long way since the idealistic Geoffrey Kaye formed the ASA, but we must face today's realities and recognise our shortcomings. We must not let complacency, limited expectations or acceptance of the *status quo* deny us and future generations of anaesthetists the ideals of our specialty.

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