ASA PRESIDENTIAL ADDRESS

An Address

By H. J. DALY,

Retiring President of the Australian Society of Anæsthetists (British Medical Association), Sydney.

SYDNEY
AUSTRALASIAN MEDICAL PUBLISHING COMPANY LIMITED
1947

Reprinted from *The Medical Journal of Australia*,
August 30, 1947, page 253.

An Address.[1]

By H. J. Daly,
Retiring President of the Australian Society of Anæsthetists (British Medical Association), Sydney.

In addressing you, fellow members, I wish to express my deep appreciation of the honour you have paid me in choosing me as president of this society, which has in the past played and will in the future play an important part in the development of anæsthesia in this country.

At this stage I must refer to the great loss our society has suffered by the death of Basil Diethelm, at the early age of twenty-nine years. He died at his post, for he had just finished giving an anæsthetic when suddenly he collapsed, and he passed away in a few hours without regaining consciousness. He was very brave. He had known for some time that his blood pressure was abnormally high; in fact within a few weeks of his death his eyesight had been affected from retinal hæmorrhages. Yet, despite these warnings, he continued to serve his calling. He was the first to gain the diploma of anæsthesia from the University of Sydney. He held honorary anæsthetist appointments at Saint Vincent's Hospital, the Royal Prince Alfred Hospital and Sydney Hospital. He was a gentle and lovable man who had endeared himself to us all. Condolences were sent from the society to his widow and his family. I would ask you to stand with me and reflect for a moment on the passing of our colleague and friend.

Another matter to which attention should be drawn is the number of anæsthetists who felt the urge and answered the call to army service, often at great personal and financial loss. Others were disappointed, in that their services were not required, and although they worked hard to keep the standard of anæsthesia at a high level, they yet have a duty, and that is to endeavour to rehabilitate those who have returned.

[1] Read at the annual meeting of the Australian Society of Anæsthetists (British Medical Association) on April 15, 1947, at Adelaide.

As you are already aware, the Morton Centenary was celebrated in Boston and London in October, 1946, and on behalf of the society telegraphic greetings were dispatched, wishing them well at their junketings. In Melbourne a meeting was held to mark the occasion, and S. V. Marshall delivered the Morton Centenary Address before a representative gathering which included the Chancellor of the University of Melbourne. This meeting was held in a lecture room adjoining the anæsthetists' museum, and in passing I would mention that we have housed there a collection of which we may well be proud. The collection of exhibits and their arrangement are solely due to the painstaking efforts of Geoffrey Kaye has made, and they will preserve not only for us but for future members of this society all manner of anæsthetic equipment, both ancient and modern. I am sure that you will all agree we should refer to it as "the Geoffrey Kaye Museum".

I now claim the privilege commonly accorded an older member of any society—namely, to delve into the past, and so I shall look back and review some of our activities in the last twenty years.

Prior to 1927 anæsthesia in Australia was a sort of Tom Tiddler's ground, in which anyone could play. Junior physicians and surgeons began to leave the field lest they be fenced in and considered anæsthetists. More articles on anæsthesia began to creep into the medical journals, and men specially interested in this branch of medicine became vaguely aware of a place for the anæsthetist in the team. Ingenious machines for administering gaseous anæsthetics were coming into Australia from America, and we were all eager to try them. We in Sydney, aware as usual of the minor place we occupy in matters medical, were anxious to meet the big men in anæsthesia from the other States. There were Gilbert Brown of Adelaide, Geoffrey Kaye of Melbourne, and Gilbert Troup of Perth. Our wish was shortly to be gratified, for a section of anæsthesia was to be included in the Australasian Medical Congress (British Medical Association) to be held in Sydney in 1929. The South Australian Branch of the British Medical Association rightly proposed Gilbert Brown as first president of the first section of anæsthesia and he, with Geoffrey Kaye as organizer, arranged a fine programme for the section. It may be interesting to recall the papers and their readers. They were as follows: Presidential address; "Anæsthesia in Lung Surgery", Gilbert Brown; "Evaluation of the Surgical Risk", F. H. McMechan; "Endotracheal Anæsthesia", M. Kasner Moss; "Position of the Patient during Induction of Anæsthesia", R. W. Hornibrook; "Cardiac Disease in Relation to Anæsthesia", M. C. Lidwill; "Some Remarks on Local Anæsthesia", C. E. Corlette; "Spinal Anæsthesia", R. Fowler; "Recent Developments in the Use of Rectal Narcotics", Kempson Maddox; "Ethylene and Nitrous Oxide in Upper Abdominal and Thyreoid Surgery", L. Lillies; "The Intratracheal Administration of Ethylene", L. S. Lowenthal; "Deaths under Anæsthesia at

the Adelaide Hospital during 1928", T. W. Rollison; "Pathological Findings in Death during Anæsthesia", Geoffrey Kaye.

To show that we were keeping abreast of advances abroad, I shall call to your attention two interesting additions to the anæsthetist's drug cupboard. Ethylene was becoming the thing for the anæsthetist to give and the patient to have. Its virtues were extolled by L. Lillies of Melbourne and by L. S. Lowenthal, then a resident medical officer at the Royal Prince Alfred Hospital, Sydney. We were all interested in it because it enabled us to satisfy a demand by the patient for something other than ether. It was certainly less irritating and induction was relatively rapid and pleasant enough; moreover, recovery took place in a short time and was seldom accompanied by more than one bout of vomiting (and that at the close of anæsthesia), so the patient usually knew little of it. Muscular relaxation was satisfactory in those cases in which we could reasonably expect it to be so; but comparison with lower second plane ether anæsthesia would be cheating. The cost was about twice that of nitrous oxide, and as if to augment this there were the smell, the headache, and the Saturday afternoon drill cleaning the oily residues from the water chamber of the safety gas oxygen apparatus—no pleasant task indeed!

Kempson Maddox gave us his results of a painstaking research into "Avertin". He later published a book which was to become a reference book for us all. "Avertin" came to us at a time when patients were demanding to be put to sleep in their beds. It was a boon, and I think we have forgotten its value. From personal experience I can still recommend it to you. In the face of intravenous competitors I fear its revival would be difficult. When it is used with due caution and a knowledge of its limitations I consider that it is at least as safe as most of our present premedicaments. Recovery from a carefully considered dose is more certain and causes less anxiety to nursing staff than after the large amounts of "Pentothal Sodium" occasionally pumped in without regard to the patient's age or physical condition.

To this congress, travelling at his own expense from far-off Avon Lake, Ohio, came a missionary spreading the gospel of safer and better anæsthesia throughout the world. I refer to the late F. H. McMechan, who, though stricken down in a chair from a crippling form of arthritis so that he could scarcely move a limb, yet made this journey. His earnestness won the admiration of us all, and his presence certainly helped to make a success of our first meeting.

The next time we met was at Hobart, when the Australasian Medical Congress was held there. Leonard Lillies was president. The depression had lifted and all were in high spirits. We had some papers on endotracheal anæsthesia and an interesting discussion on drugs used for premedication and basal narcosis. Gilbert Brown, though

he did speak about "Nembutal", "Sodium Amytal" and "Pernocton" given intravenously, made no mention of "Evipan Sodium"—was it already beginning to go out of fashion? Kempson Maddox gave us a further paper on "Avertin". Its advantages and disadvantages were the subject of much discussion. A scheme for the teaching of anæsthesia was outlined by Geoffrey Kaye, which summed up the position at that time and gave suggestions which he will no doubt reiterate later at this meeting. The late Newport White, of Melbourne, read a paper on "The Accidents and Mistakes of Anæsthesia", which was most illuminating, for we learn good lessons from relating our misadventures. It was at the close of this session that a meeting took place at Hadley's Hotel to discuss the formation of an Australian society of anæsthetists. Geoffrey Kaye was elected temporary secretary and a tentative constitution was drawn up. He worked hard but willingly for us for years; his work has borne good fruit, and I hope he feels it was worth while.

The centenary of the foundation of Melbourne was celebrated in 1935 and the Australian Society of Anæsthetists held its first annual meeting there to mark the occasion. Gilbert Brown returned from England to be in time to act as president at this first session and gave an account of anæsthetic advances abroad. He told of the enormous increase of the use of gaseous anæsthetics in England and of the fashion to fit some form of carbon dioxide absorber to gas machines—a "Yankee" idea, and what a valuable one it has proved to be! He spoke of cyclopropane as a gas with a future. I saw it used for the first time by Nosworthy at Westminster Hospital in September, 1935. Brown mentioned spinal anæsthesia with "Percaine" (1 in 1,500 solution) for lobectomy, as used by Magill at the Brompton Hospital.

Gilbert Troup gave a talk on his American tour in search of newer means of anæsthesia. He visited Waters's clinic, where cyclopropane was tried out. He told of a new intravenous anæsthetic, "Thio-Nembutal", which Lundy was using. This, later known as "Pentothal Sodium", was destined to sweep all other intravenous anæsthetics aside. To this meeting came Z. Mennell, senior anæsthetist of Saint Thomas's Hospital, representing the Association of Anæsthetists of Great Britain and Ireland. His paper "Ether is not Dead" gave rise to a lively discussion and an exchange of letters in the journals later on.

The fifth session of the Australasian Medical Congress (British Medical Association) at Adelaide was the opportunity for a combined gathering of the Section of Anæsthesia and the Australian Society of Anæsthetists. Gilbert Troup presided, gave an account of the position of the anæsthetist at that time, and paid a tribute to the late Kasner Moss of Perth. There were four papers. One paper by Gilbert Brown on anæsthesia in pulmonary tuberculosis was based on his own experience in 208 cases. Gilbert Troup combined with Gilbert Brown in a paper to

detail their impressions of "Pentothal Sodium" and their results. S. V. Marshall gave a paper on cyclopropane, recording the results of 120 cases in which it was used by himself and myself in Sydney. The most interesting presentation was from Geoffrey Kaye, who made a collection of anæsthetic fatalities from general hospitals in the principal cities of Australia, from which he showed that one patient in a thousand undergoing anæsthesia died on the operating table.

No meeting was held during the war years, and it was not until the Sydney meeting of January, 1946, that we saw each other again. The material presented there is still fresh in your minds.

We are gaining many new members and inquiries are coming from a great number of the younger graduates concerning the prospects of an anæsthetist. When they ask me how to go about becoming an anæsthetist, I advise them to combine anæsthesia with general practice, and after a couple of years to make up their minds if they want to go into it, for I think many "interns" become fascinated by this blonde and glamorous lady and woo her ardently. It needs the knocks of general practice to make them decide whether they want to remain true to her for the rest of their days. A number of older general medical practitioners, seeking an easier life, consider retiring into anæsthesia; but the difficulty of gaining a surgical connexion and becoming familiar with modern methods has to be pointed out to them, hard though it is, lest they give up the substance for the shadow. The anæsthetist nowadays must know something about every branch of modern medicine and some branches of surgery, and moreover, must have a higher degree in anæsthesia to gain a hospital appointment.

Conclusion.

We all hear complaints from surgeons about the poor quality of present-day anæsthesia, and they attribute this to lack of teaching; but we know that it is due to the fact that specialized methods are not available to the average general practitioner—he has not the time to study or practise them. Talk of nationalization is in the air and we must see that the specialist in anæsthesia is adequately paid for his services. A pointer to the fact that his services are being recognized is the recent advertisement for a full-time anæsthetist to a New South Wales hospital at a salary of £1,500 rising to £2,000 per year. This is a valuable and significant change and will give us a basis for argument when the question of remuneration arises.