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The Geoffrey Kaye Oration

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Every President on his or her election is aware that in two years time they will be required to deliver this oration. All of those I have attended have been of the highest standard and it is this concern of not making the grade or living up to expectations that makes this task one of the most difficult of the Presidency. There are no guidelines but fortunately some previous orations have been reprinted in our Journal so there is some precedent on how I should proceed. These also provide a valuable historical record of the progress of the Society and a copy of each one will be exhibited with a photograph of the respective President when decorations of the office are completed.

Many of my predecessors have dwelt on the life of Geoffrey Kaye and this is fitting, as he probably did more for the Society than any other person, and my own vision for anaesthesia is not dissimilar from his. However since this has already been documented by more adequate historians than myself, I will only briefly refer to his work. The cover of the 80th anniversary issue of the "Medical Journal of Australia" commemorates his contribution to anaesthesia. The other person on this cover is Tess Brophy (Professor Tess Cramond) who was Secretary of the Society from 1960 to 1964. She is affectionately known as the Godmother, having provided many of us with vocational offers we were unable to refuse and is largely responsible for my being in this position today.

I would like to digress and talk a little of the Hains medical history, and then to discuss where the Society is at present and then what I believe out future directions should be.

John Hains arrived in Adelaide as a child in 1850 and amongst his children were George and Ivan, my grandfather. George graduated in medicine in 1898, Ivan in 1911, and my father John Ivan in 1938, so there is now almost 100 years of continuous family involvement with medicine. While this has occasionally given me assistance in obtaining jobs, it has also given me an insight into medicine in general and emphasised the importance of such things as the provision of medical services for the poor, the requirement for adequate leave and recreation for anaesthetists and the absolutely essential need for continuing medical education.

It was somewhat bewildering for me then to enter into negotiations for improved levels of remuneration with Senator Richardson when he had spent only three months in the Health portfolio and was now telling us how the system should be run. In my opinion the changes to the health system that this government have introduced, removal of tax deductibility for private insurance, removal of bed subsidies etc. have led to more people competing for fewer places in the public system. This has meant that the poor, the elderly and the chronically ill, which Labor parties have in the past traditionally represented, have been severely disadvantaged. It seemed that our roles should be reversed and he should be running the ASA with his knowledge of numbers and I should be reforming the health system.

Another Labor Senator was quick to point out that Richardson was not a union man but a party man and it was apparent that within the party there are many fundamental ideological differences and it is vital that we understand this and the different philosophies that are represented. This left-wing unionist was having his prostatic resection in a private hospital and it is amazing how we change from "money grubbing doctors" to "intelligent people with incredible skills" when we have one of these politicians in our care.

Our presentation to the ACTU/Caucus Committee provided a further insight into the workings of the Labor Party. It showed exactly who is running the Health Policy and probably the country. These people are so preoccupied with the thought that if private health insurance rates are improved, doctors will make more money, that they cannot understand that with declining numbers of people with insurance, the burden on the public system will increase. In some States the system has been underfunded for years and is already in a state of collapse. Attempts to prop it up with more funds will not work unless there is a fundamental change to the system and our recommendations for these changes were presented to the Committee.

For all his failings and the anxieties he caused us

I quite liked Richardson. You will recall that in the past Ministers would only talk to the AMA and this was the first time, to my knowledge, that anaesthetists had been able to talk directly to the Minister and effectively bypass the AMA. We are only a small group within a large structure. The AMA withdrew from negotiations for some time so all in all I do not believe we have been effectively represented. This can be seen in all financial indicators and can be clearly demonstrated in anaesthetists' share of total medical expenditure declining from 2.9% to 2.1% between 1984-1991. Richardson said, "You'll get nowhere with the AMA, you don't have the numbers. You'll be better off negotiating with me". It was clearly our task to arrest this trend and reverse it if possible.

There is an attitude creeping into Australia that if something happens to you, someone else should pay or the Government should do something about it. This is fostered by near-universal bulk billing whereby people can go to a general practitioner at any time at no cost to themselves. Eighty-five per cent of these services are currently bulk billed and general practitioners are thereby effectively nationalized. Levels of remuneration for these services are increasing more slowly than other levels of cost/price increases. However, they have the capacity to increase the number of services (the revolving door principle), which anaesthetists do not have. Various schemes which may look superficially attractive are currently being floated. However these must be examined carefully as short-term gains may lead to longterm disaster.

During our discussions it became apparent that anaesthetists have an image problem. We are only a small group, only an enlightened few know what we do and we are generally perceived as inferior to other medical specialists. Typical publicity we receive is a sensational bad report such as "Anaesthetists Kill 35 a Year" which was one of the headlines which coincided with our national meeting in Hobart. We currently do not have anyone to coach us in negotiating techniques, to collect media releases and press cuttings, and to prepare our own releases. There is an urgent need to begin to publicize our level of education and training, our commitment to maintenance of competence and our dedication to patient safety when the complexity of surgery is advancing and the community expectations of quality of life are changing.

The fact that we had direct contact with the Minister, and had a solid case to present, had an indirect consequence. It improved our image within the profession. The other event which, probably more than any other, did the same thing was the separation of the Faculty from the College of Surgeons, the formation of the Australian and New Zealand College of Anaesthetists and the physical move to a new and separate headquarters—Ulimaroa in St Kilda Rd, Melbourne. No longer are anaesthetists perceived as requiring support from surgeons, but appear as an independent professional group. Greater use is also being made of the media though on many occasions this is only to correct misconceptions or false statements. If you read something in the paper or hear something on the radio which upsets you, write a letter to the Editor or ring the producer and let them know that we are out there and wish to be represented. The ASA Executive will require professional assistance in this area in the near future.

You will recall that one of my ambitions has been for a much closer liaison with the College, with eventual amalgamation, and four years ago a discussion paper was presented on this subject. Historically the Faculty was an offshoot of the ASA and then moved under the umbrella of the College of Surgeons. For many years I believed this to be a mistake. During my time as President I was fortunate to speak to many people who are living historians and I began to appreciate the tremendous support, both academic and financial, that the College of Surgeons provided to the Faculty. However I believe now is the time to reverse the process. I do not believe the College should be submerged within the ASA or vice versa. Within the community of anaesthetists, there are people with a vast array of talents and interests. Some are educators, examiners, researchers and others medico-political negotiators while still others like to spread the word in remote locations. All these people should be working within the specialty as a whole, to further enhance the goals of the specialty which is the safe delivery of a first class anaesthesia service for an appropriate level of remuneration. For a time I thought I was the only one thinking this way but was delighted to read the comments of Brian Dwyer (a former Dean of the Faculty and former President of the ASA) in delivering the toast to the College at its official opening dinner. He said "in my mind, the separation of the ASA and the College tends to drain the physical and financial resources of anaesthetists who are largely members of both groups. Although I am aware of the arguments used to justify the *status quo* of the past four decades, the continual reduplication and financial drain induced by professional activities conducted by both groups is now becoming an unwarranted burden. I can see no significant obstacle to unity that cannot be overcome by suitable constitutional changes within the two now fully autonomous bodies. Nor should any changes leading to unity threaten the security of professional status of the individual anaesthetist?"

This is not a new idea, as you will recall when the

symbol of the ASA was designed, the colours selected were black and gold, the colours of the Faculty gown. It will require people with vision and foresight, similar to that displayed by Geoffrey Kaye, to bring about this change which I believe will eventually occur.

The theme I have attempted to develop is one of image, unity and strength. The high standards of anaesthesia which have been achieved must be maintained, but there is a need to broaden our perspective and work together within one anaesthesia group. This will assist us to define objectives for the specialty and establish our position in all areas of negotiation. With this in place we can indicate to the image makers what we require to be projected to the public, rather than what sensationalizing media deliver in a distorted fashion. A unique opportunity exists for us to press our claims as a distinct professional body and this should not be lost.

I would like to quote from John Ashton who initially suggested I should join the Executive. "It has been an honour to serve as your President and I thank you for it."