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Australian Society of Anaesthetists Presidential Address 1982

Anaesthetists — sell yourselves

R. M. HARE*

It is usual for Presidents at this stage of their office to become the corporate conscience of the Society and expound on matters of high principle, looking at what has been achieved during their term of office, and giving advice as to what should be done in the future — discussing such matters as The Dignity and Personality of the Patient — Malcolm Newland 1972; Reasonable Standards and Paying for our Expectations — Pat Maplestone 1974; The Aims of our Society and how far we have gone toward Achieving them — Brian Pollard 1976; The Image of Anaesthetists — Peter Brine 1978; The Inspiration of some Early Presidents — David McConnel 1980.

While touching on some matters of high principle I will also talk about political aspects of this Society's activities. The theme of status of anaesthetists will run through what I have to say — status in the eyes of our medical colleagues, the lay public and the administrators. I shall no doubt tread on some toes.

In Webster's New International Dictionary,[1] "society" is defined as "the relationship of men" (and women — my addition, it's a 1911 edition) "associated in any way to one another; companionship, fellowship; company". Without this relationship mankind would remain a herd, with it they become a society.

A number of persons associated for any temporary or permanent object, an association for mutual or joint usefulness pleasure or profit."

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The ecclesiastical definition interpreted with a bit of licence fits our own society, "In churches a corporation committed with a local church (read state sections) having control of the ownership of the church building (50 Gurner Street, Paddington) and determination and payment of the minister's salary (President). I shall say some more about that in a while. Besides church members it includes pewholders (the executive) and adult regular attendants (yourselves), admission being secured by election.

The institution is falling into disuse in many places, the church itself becoming incorporated (South Australia) and assuming the rights of the society."

Our Society has much of which we can be proud. We are one of the largest medical societies in Australia with 1,500 members. We own real estate, we produce a scientific journal and we have a history going back nearly fifty years. We are probably one of the oldest anaesthesia societies in the world. The Society of Anaesthetists of Great Britain and Ireland is only two years older and is celebrating its Golden Jubilee this year.

The structure of our Society is a closely knit one, comprising as it does, state sections and a federal body with representatives from each state section on the Executive Committee. Continuing input from the state sections is necessary to ensure that the wishes of members are being considered at the federal level. The appeal for change in the constitution of the Society regarding categories of membership was an example of a state section initiating action which was subsequently taken up by the Executive Committee.

Government to determine a suitable rebate, presumably based on a commonly charged fee. If the gap between the doctors fee and the rebate became too large, public outcry would ensure that it be redressed. This would be the possible situation if everybody charged the A.M.A. fee, and took steps to recover their bad debts.

An opposing view is naive co-operation with the Government, undervaluing our worth by agreeing to the abolition of certain items because of an incidence of abuse, or incorporation of items into a single comprehensive anaesthetic item to make it easier for Governmental administration. Incorporation of intravenous infusion for instance (at a decreased value) into the anaesthetic item would tend to check what might be considered by the Government to be overuse.

What happens in practice is that these matters are determined by a joint committee of Government and A.M.A. The need for this Society to continue to assert its influence on that committee is obvious. The Government would be quite happy to make decisions without the benefit of our input, decisions which would certainly not be in the patients' or our favour.

One of the items about which we are uncompromising is the preoperative consultation. I know that anaesthetists have stressed the fundamental importance of preoperative consultation in anaesthetic practice before, in this type of address. If we fail to demonstrate its importance by failing to do the consultation (feeling that it achieves nothing) or delegating the responsibility to the surgeon to assess the suitability of patients for anaesthesia and explain the role of the anaesthetist, then we are not only practising poor standards but are in grave danger of being construed by our patients, colleagues and Government as pure technicians, isolated as such and manipulated in a downward direction, no doubt, financially.

There is strength in numbers. The rebate for the consultative component of our practice is upgraded each year at the same rate as other consultations, and these constitute the bulk of medical practice.

The Government is looking at ways of halting the escalating health bill. They look at the easy things first, those about which there is a body of opinion both within and without the profession supporting a withdrawal of medical benefits. Cosmetic surgery is an example. Please let us make clear to all the worth of the things we do both by doing them well and by being able to justify their importance for the patient's well-being.

Utilisation profiles are being studied by the health department. They have discovered an increasing itemisation of the preoperative consultation. In their opinion the trend "has to be stopped". The fact that the preoperative consultation rate should be close to 100% if we are practising good anaesthesia is of little concern to them.

The Society has made repeated and strong representation to the health department emphasising the separate and additional skills involved. In the future it is still possible that the Government will accurately define the preoperative consultation and include a minimum duration between the consultation and commencement of anaesthesia.

The Executive Committee this year formulated policy on privileges in Anaesthesia in Australian Hospitals. It essentially follows Faculty policy, that anaesthetics should be administered by fully trained and certified specialists, except in areas where specialists are unavailable or in insufficient numbers to provide a complete service. The A.S.A. policy includes a provision that certain other experienced anaesthetists who are in existing anaesthetic practice but who do not qualify otherwise may be accredited for the work they are currently doing. The Executive Committee felt that it was necessary to represent the interests of non-specialist members.

"He doesn't know much about medicine but he gives the best anaesthetics in town." I remember that statement being made about a Sydney general practitioner some years ago. It was a party conversation opener when I mentioned to someone that I intended to pursue a career in anaesthesia. It demonstrates the ignorance some people show toward the practice of anaesthesia.

There are different criteria now as to what constitutes a good anaesthetist. When that

produced by the premedication ensured my complete anonymity there after.

Some patients fail to understand that we are caring for them throughout the entire operation. The size of the bill startles them. But we don't hear about these things — the surgeon does! In fact the surgeon screens out a good deal of the problems for us. I know that if a patient is expecting me and knows my name and something about me, then the surgeon and his secretary have done a good public relations job. This sort of advance 'publicity' makes it easier to build up good rapport with the patient and leaves one free of debtors and the litigation seekers of the future. It is our professional duty and highest calling to offer an explanation to patients as to what we are doing to them.

I believe there is a 'publicity' role for this Society.

I think we can take a lesson from some of our overseas visitors. In particular Michael Rosen and more recently Peter Baskett, have aggressively publicised the specialty of anaesthesia and encouraged us to do likewise. However, we seem to find it difficult to project our image.

A recent article in a Western Australian newspaper titled "Giving substance to a shadowy Dr. Sleep" and describing the good work that anaesthetists do was on the right track. However, the accompanying photograph showed a group of gowned and masked doctors in theatre with surgeon and his assistant prominent — the anaesthetist was just out of the frame.

Selling ourselves to the community at large can be done through newspapers, women's magazines (a favourite forum for plastic surgeons) and television. That excellent British production "This Yankee dodge beats mesmerism hollow" was a good one, but did not identify with Australian practice. I don't think it is beyond our capabilities to produce our own television documentary.

In conclusion, I should like to discuss briefly an aspect of our Society's activities which we all enjoy, and that is the Annual General Meeting, support for which has been diminishing in the last few years. I put this down to progressive cost increases, accommodation, time lost from work (the meeting lasts for nearly a week) and possibly the fact that the social fringe benefits are somewhat old-hat to the younger anaesthetists who "have been there and done that" during their relatively affluent years as students and registrars. There is good support, however, for weekend seminars, a significant number of people now travelling interstate to attend them.

The Executive Committee has been considering the desirability of altering the style of the Annual General Meeting, by shortening the duration and placing it toward the end of the week, say Thursday, Friday, Saturday and Sunday, keeping the busy part of the working week intact. There would be an emphasis on the refresher course component of the meeting. This may be too radical a change for the hard core of regular A.G.M. supporters, but this Society must keep abreast of the times and be prepared to adapt to the needs of members.

Mr. Chairman, the long-term future of our Society is a bright one, I trust that it will prosper under your guidance as president during the next two years.

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25th October 1982

REFERENCES

1. Webster's New International Dictionary. G. & C. Merrian Co, Springfield, Mass, USA, 1911.
2. Hart MH. The 100. A Ranking of the Most Influential persons in History. Hart Publishing Co Inc, New York, NY, 1978.