The Geoffrey Kaye Oration — October 2002

Delivered at the National Scientific Congress

LEST WE FORGET

The ANZAC legend that has developed rests upon the assumption that Australia "came of age" as a nation when the ANZAC's landed on Gallipoli on 25 April 1915.

As Australia came of age with the landing at Gallipoli, so the Australian Society of Anaesthetists and Australian anaesthesia came of age when those seven medical practitioners interested in anaesthesia met on Friday 19th January 1934 at Hadley's Hotel in Hobart and decided to form an Australian Society of Anaesthetists.

God of our fathers, known of old,
Lord of our far-flung battle-line,
Beneath whose awful Hand we hold
Dominion over palm and pine —
Lord God of Hosts, be with us yet,
Lest we forget — lest we forget!

Rudyard Kipling was responsible for this recessional hymn sung whilst clergy and choir withdraw after services on imperial occasions.

As the phrase "lest we forget" acknowledges and commemorates the men and women who have served our nation, so the term acknowledges and commemorates those anaesthetists who have served anaesthesia and this Society.

After Geoffrey Kaye died in 1986, the Society discussed at its Executive Committee Meeting on Saturday 7th March 1987, a memorial to Dr Kaye. It was determined that an appropriate memorial would be to commission a portrait of Dr Kaye to be hung in the ASA Headquarters and to rename the Presidential Address, the Geoffrey Kaye Memorial Address. Somehow between the decision and when Dr Ben Barry completed his Presidency in 1988, the Memorial Address had become the Geoffrey Kaye Oration.

The life and contribution to anaesthesia, and particularly this Society, by Geoffrey Kaye have been well-documented in Dr Gwen Wilson's books *Fifty Years, The Australian Society of Anaesthetists 1934-1984* and *One Grand Chain*.

As Osler said:

"The great possession of any Society is its great names. It is not the pride, pomp and circumstance of an organization which brings honour, not its wealth, nor the number of its buildings, but the men and women who have trodden in its service along the road through toil, even through hate."

In this oration I aim to walk you through and recount some of the history of anaesthesia and the Society, some of the contributors, and some of the events that have influenced progress interposed with a few diversions.

What I do seek to do is raise some of the messages that can be learnt from some of these events.

This will all be done from a Tasmanian perspective.

As said by an unknown author: "There is nothing new in history except that which is forgotten."

The First Anaesthetic

The first anaesthetic given for a surgical procedure in Australia was by William Russ Pugh at St John's Hospital Launceston on Monday 7th June 1847. This is undisputed and was researched in great detail by the late Gwen Wilson. St John's Hospital remains as a building and is now a restaurant aptly called Morton House. Little recognition is given to William Russ Pugh and very few of the medical profession are aware of his contribution. The question still raises its head as to why the first anaesthetic was given in Launceston and why by Dr Pugh.

I cannot provide an answer but I can suggest that it was in Launceston because Van Dieman's Land was in those days a very important part of Australia and that much of the communication from England was directly to them.

Why Dr Pugh? I suggest again that it was because he was adventurous, showed initiative and had an inquiring and scientific mind. He was known to compound many of his own drugs in a laboratory attached to his house.

Communication, initiative and a scientific background remain important factors in progress in our specialty.

As I indicated earlier, little recognition has been given to the contribution by Dr Pugh.

In 1997 a group of Tasmanian medical practitioners and historians in Launceston established a committee to commemorate the sesquicentary of the giving of that first anaesthetic. A scientific program was organized with predominantly historical papers and a life-size bronze statue of Dr Pugh by the sculptor Peter Corbet, was unveiled. This statue stands on the steps leading to Princes Park in central Launceston.

Following the meeting, the sesquicentenary committee offered the Society a medal to commemorate Dr Pugh, which was accepted. Council has determined that this medal is to be awarded to an individual who has made an outstanding contribution to the advancement of anaesthesia, intensive care or related disciplines and I am pleased to announce that at its meeting on Friday October 25, 2002, Council determined to make the inaugural award to Professor John Severinghaus who developed the CO_2 electrode which is the basis of blood gas monitoring.

Just one final query about Dr Pugh — was he medically qualified? He stated that he had a medical qualification from Glasgow. Gwen Wilson could find no documentation to support this. Dr Pugh left Launceston quite suddenly and moved to Melbourne, where he also quite suddenly disappeared from sight. Were inquiries getting too close?

Victor Richard Ratten

Another medical practitioner with disputed medical qualifications influenced anaesthesia in Tasmania quite significantly.

Victor Richard Ratten was appointed Surgeon Superintendent of the Hobart General Hospital in 1917 and this appointment was to influence the medical landscape in Tasmania until his death in 1962. He effectively retarded the development of anaesthesia whilst he held that appointment. His time was accompanied by significant political intrigue.

Ratten was born in Kew, Victoria on 12 December 1878. He attended his father's school in Port Fairy, Victoria and subsequently became a dresser at the Maryborough Hospital, Victoria. He is next recorded as being a dentist in NSW registered with the NSW Dental Board, the sole requirement for registration being that you were in practice. In 1901 he moved to Queensland to set up a large dental practice in Queen Street in Brisbane.

The Queensland Dental Board refused to register him on the grounds that he had not been in practice long enough. Ratten then pursued a course of action he used throughout his life — if you have a problem, go to the politicians and better still, befriend them. He did that and somehow the Dental Board registered him. Letters in the Queensland Archives between Ratten, the Colonial Secretary and the Dental Board make fascinating reading. Ratten employed dentists and was in trouble with the Dental Board for advertising. An early entrepreneur.

At some point around 1903/04 Ratten went to America, returning from there in May 1907 with the qualification MD, Harvey Medical College, Chicago, 23 March 1907. Why Ratten went to America is uncertain but it is probably because an uncle had previously gone there, obtaining his PhD in Boston in 1899 and MD in Boston in 1900.

Ratten immediately registered in South Australia and Tasmania because they were the only States that would register American medical qualifications, and he commenced practice in Sheffield in northern Tasmania.

At the commencement of hostilities in 1914 he enlisted in the Army, leaving Australia in October but returning within months with an injured arm. He then commenced practice in Hobart in 1915, in dispute this time with local medical practitioners.

In 1917 the British Medical Association (BMA) threatened to withdraw its members from the Hobart General Hospital if the hospital did not cease the practice of allowing "well-to-do" private patients to be treated in the hospital. The Government called their bluff, the medical staff resigned and the Government then appointed Ratten as Surgeon Superintendent with two other medical practitioners.

The BMA was naturally furious and proceeded to investigate the background of Ratten. They ascertained that the Harvey Medical College had closed in 1905. Ratten's qualification was dated 1907. There was no record of Ratten ever being a student of the Harvey Medical College. His qualification was a fraud. I have his "diploma" and how I obtained that is another story.

A Royal Commission on paper evidence decreed that his qualification was valid. The Medical Council started to investigate him. The Government dismissed the Medical Council and appointed a new Council of doctors considered sympathetic to Ratten. The new Council proceeded to investigate Ratten and took the matter to the Supreme Court.

The Government resolved the matter by passing what is known as the Ratten Doubt Revocation Act which effectively invoked the Statute of Limitations such that the Council could not seek to deregister a medical practitioner if the events leading to the supposed fraud had occurred more than seven years previously.

Ratten was now secure and the BMA doctors remained locked out. Ratten, with the two other doctors, ran the Hobart General Hospital. The Matron gave the anaesthetics!

This situation persisted until 1931 when the BMA doctors agreed to return to the Hospital but it was against the wishes of Ratten.

The BMA doctors were effectively locked out of the hospital for some thirteen years but not without trying to get back. In 1925 a Dr Frank Fay arrived in Hobart. He was appointed to the Hospital Board. It took him six years of quiet diplomacy and persistence to negotiate the return of the BMA doctors.

Ratten was both loved and hated. The public adored him, the Government loved him. The profession hated him. The Chairman of the Hospital Board of Management, Father O'Donnell is on record in 1936 as describing Ratten as "the cancer of the hospital".

An historian, Amy Cumpston, who wrote her PhD thesis on the history of the BMA in Tasmania, is quoted in The Australian in 1984 as saying, "and even now gravestones can be found with the words — 'killed by Dr Ratten' ".

There are messages in all this. Never resign, because the moment you do so, you lose everything. You no longer have a voice and you cannot influence anything. Stay in there, keep talking and hopefully you will win out in the end. It is easy to withdraw from negotiations. It is very hard to re-establish them.

Don't underestimate the power of politics. Don't trust Government of any persuasion. As evidenced in this story and still evident today, they will remove people who oppose them and will legislate to get their own way.

Politics

Politics is something the Society must be involved in. We are a medicopolitical organization and we cannot escape from it. It is part of life and the Society needs to learn more about the political process and how to use it. It is a necessary evil.

As stated by the author Richard North Patterson in his novel *Protect and Defend*, "politics requires compromise, [is] a messy process, conducted to achieve a common goal". Politics require making a stand at times and as stated by Professor Bellamy, the internationally known environmentalist, "if

you want to make a difference throughout the world, you have to take sides."

Politics can, however, degenerate at times. As said by Winston Churchill, "Politics are almost as exacting as war and quite as dangerous. In war you can only be killed once, but in politics, many times."

How to use politics is a matter of judgement and there is no right or wrong way. The Society needs to become more politically astute and needs to assist those members who seek to be involved, learn and improve their skills.

In dealing with Government, it is important at times to step back to try to understand their position and where they are coming from. Knowing what they are thinking makes it easier for us to determine our approach to them. It can influence whether we cooperate or oppose.

I do believe this principle should be used in determining how to approach the problem of the shortage of anaesthetists in rural and remote communities and in public hospitals. I use the word shortage perhaps unwisely since I believe it is really more a maldistribution problem.

There are shortages of anaesthetists and the community is hurting and complaining.

Publically it appears that the only response of the specialty so far has been to push for improved salary and conditions of service, but this is far from the truth. Recruitment has been assisted and significant lobbying has occurred at State level and the Society has produced its position statement on what is required to attract and retain anaesthetists to rural and remote areas. More needs to be done, but realistically, the problem will never be completely overcome, partly because of unrealistic expectations.

The Government has responded by introducing more overseas trained specialists and in New Zealand by strongly advocating nurse anaesthetists.

If we were in the politician's position we would do exactly the same thing.

I offer the following comments:

There should be an increase in the number of medical student positions in Australia — not for overseas fee-paying students but for our children.

Overseas trained anaesthetists should be encouraged to settle here.

In this room there are medical graduates from overseas who have trained as specialists in anaesthesia in their own country. In this room there are Australian medical graduates who have obtained their anaesthetic training and qualifications overseas. In this room there are many Australian medical graduates including myself who have completed or complemented their anaesthetic training overseas.

Let us not be too precious about all this. We do need at this time these overseas trained specialists, we must ensure that standards are maintained and a little bit of fair competition doesn't hurt anyone.

There is a limit to the number of anaesthetists that the community can train and support and we should be looking at what roles we currently undertake that could be safely undertaken by other trained professionals. It is ridiculous that for a highly trained specialty, 30% of anaesthetic rebates are for endoscopic procedures.

I recently attended an international meeting of Presidents and other representatives of like anaesthetic organizations. There is an increasing indication that as a specialty we need to be seriously considering anaesthetic assistants in some form, but as was said, politically we need to retain control of whatever occurs and be on the side of both the winners and losers of the debate.

One final comment on this matter. There is a need for anaesthetists to put back into the system that trained them. It alarms me that some new Fellows turn their backs on the very public hospital system that trained them by not seeking appointments and helping train the next generation.

As a Society we should educate Government. This requires that firstly we can get their attention and then present them with accurate data and reference material. It was most reassuring that the Society was able to recently have a meeting with the Minister for Health and Ageing after a gap of some five years. More recently the Minister has contacted me.

The Society needs to cooperate with Government at times but this must be done with our eyes wide open. They have a huge bureaucracy and are able to out-wit and out-manoeuvre us if we are not careful.

Some people don't agree with cooperating with Government, and the Australian Doctors' Fund has its own quaint way of saying why it confronts rather than cooperates: "Don't pat the dog if every time you see someone else pat the dog, they end up with no arms."

The Society needs to negotiate with Government but again we must recognise the unevenness of the process with the huge Government bureaucracy on its side. The Society must use its best people in these negotiations. They must be provided with the best support we can give them and must be ever mindful of the danger of getting too close to the negotiators for the other side.

The Society must oppose Government when it is necessary to do so. There is a need to consider the repercussions before doing so but once that decision is made there is a need to marshall all available forces such as the AMA.

It is important to realise two things. Firstly, the Government yields to pressure, so if the Society seeks to influence Government it needs to have a large number of people communicating with it.

Secondly, the biggest problem for the Society is apathy. Many members are unhappy with things but they won't communicate with their local politician or put pen to paper or act in any way other than whinge to whoever unfortunately is nearby.

Things will not get better by themselves.

ORIGIN OF THE SOCIETY

Tasmania figures prominently in the formation of the Australian Society of Anaesthetists, the formation being the culmination of activities that had been going on for several years. A detailed

account of this is provided in Gwen Wilson's book on the history of the Society.

In 1925 Dr Francis McMechan, Secretary General of the International Anesthesia Research Society, wrote to the Federal Committee of the British Medical Association (BMA) in Australia suggesting that a Section of Anaesthetics be included in the Australian Medical Congress of the BMA being held in Dunedin in 1927. The first Section of Anesthetics meeting at a BMA Congress was held in Sydney from the 2nd to the 7th September 1929. The next Congress was held in Hobart from Monday 15 to Friday 19 January 1934 and included a symposium on endotracheal anaesthesia. It is noted dryly by Gwen Wilson that "all the men (except some of the Tasmanians) had had a deal of experience in endotracheal anaesthesia."

The historic meeting on Friday 19 January 1934 at which it was agreed that an Australian Society of Anaesthetists be formed, involved one Tasmanian, Dr Cedric Duncombe. He had been joint Secretary of the Section of Anaesthetics meeting with Geoffrey Kaye. He was a surgeon with apparently a particular interest in anaesthesia.

When the Society was formed it is noteworthy that the list of members did not include any Tasmanians.

The Secretary of the Tasmanian Branch of the BMA wrote to the ASA indicating that the invitation to appoint a representative was forwarded to members of the Branch but there was not enough interest shown to lead to the appointment of a representative. The ASA acknowledged the letter and it was pointed out that the Society would still welcome individual Tasmanians who might desire to become members.

It is fairly obvious that the interest in anaesthesia in Tasmania at that time was low, this probably being due to the ongoing influence of Ratten. There were other influences around this time which did not help with the formation of the Society.

In the 9 June 1934 issue of the Medical Journal of Australia, there was concern expressed at the formation of organizations representing special groups. The view expressed was that "the formation of special organizations was the inevitable accompaniment of progress, but at the same time care should be taken not to weaken the fabric of the large body, the BMA". It was said that the Government would only deal with the profession through the BMA and special organizations would weaken the influence of the profession as a whole.

There had been concern expressed at the formation of the ASA as there was when the Royal Australasian College of Surgeons was established in 1928. Interestingly there was little or no concern raised when the Royal Australasian College of Physicians was established in 1930. Fairly obviously, vested interests were involved with general practitioners not wishing to lose involvement in and earnings from surgery and anaesthesia.

The concern about divisions within the specialty and profession continues today, with new groups being formed all the time, weakening the voice of the specialty and the profession as a whole. A multitude of groups also provides the Government with increased opportunities to divide and conquer.

Specifically within anaesthesia we should be concerned about the potential implications resulting from the development of a joint Faculty of Intensive Care, Faculty of Pain Management and Special Interest Groups. If unity is not maintained and such groups separate from anaesthesia, I have great concerns.

At this point I would like to digress and talk a little about the organizational structure of and the relationship between the Society and other anaesthetic and medical organizations.

At the AGM in Perth two years ago, the Society changed from an Association Incorporated in South Australia to a Company Limited by Guarantee under Federal Corporation Law. This was and is still, I believe, a correct decision and recognises the size and national nature of the organization. There was a need for the Society to become more organized and formal without losing the traditional friendly, co-operative, somewhat casual yet effective way of functioning. We are a national body representing all our members, with a Council that has equal State and Territory representation. Since becoming a Company Limited by Guarantee there has been a management review of the Secretariat and most of the recommendations have or are in the process of being implemented. Some of these relate to compliance requirements of any company which had until then not been developed or even considered by the Society.

More recent changes have included an organizational restructure of the Secretariat such that there are now departments or sections within the Secretariat, which have their own staff, defined responsibilities and hence greater accountability. This will undoubtedly improve efficiency within the Secretariat and service the needs of the members more appropriately.

These changes hopefully will also reduce the reliance on office-bearers and other members of the Society doing work which more correctly and more efficiently could be done by Secretariat staff. Where there is a need, there should be paid staff doing a job rather than a Society member. Other organizations do this, and I note that at the negotiations with Government over the implementation of the Relative Value Guide, that the AMA was represented by paid staff rather than members of the AMA. The ASA in contrast had three and upwards of five members representing its interests at these meetings, that is, up to five members who gave up a day's work. We cannot continue this, as we will not get members who wish to seek office-bearer and other positions in the Society.

This increased efficiency needs to be extended to how the Society works and our relationship with other anaesthetic and medical organizations and how we work with them. There is duplication of activities with inefficiency of time and money, but to improve this situation is not easy and it is not without trying by current and past office-bearers.

It brings immediately to mind the statement about the difficulty in organizing doctors — "it is like herding a bunch of cats".

Internationally there is now a group of like anaesthetic organizations called the Common Issues Group. It comprises representatives from this Society, the American Society of Anesthesiologists, the Canadian Anesthesiologists' Society, the Association of Anaesthetists of Great Britain and Ireland and the International Anesthetic Research Society. The group meets annually.

It is a sharing process — we share problems, initiatives, strategies, experiences and data. It is immense help to this Society in allowing us to more efficiently progress issues that require consideration. It is not a junket and to travel to and from America in just seven days is not my idea of fun.

The Society has a close relationship with the New Zealand Society of Anaesthetists. Their President is invited to attend our Council meetings and ours theirs. There is a sharing again of experience and data. The current issue of nurse practitioners and dare I say, nurse anaesthetists, is actively being considered in New Zealand and we are following the debate closely. We have provided New Zealand with what data we have and they are keeping us briefed on developments. What occurs in New Zealand today will be on our Government's agenda tomorrow. We nearly always seem to catch their cold.

Within Australia the Society has relationships with many organizations, the closeness depending on the area of activity and the need.

We have a near relationship with the College — our roles are separate yet overlap and there are areas of confusion. These continually need addressing but creative tension is not altogether a bad thing and not unhealthy. The sleeper that creates questions in my mind is how the ACCC will regard cooperation between the Society and the College on particular issues.

It has been questioned that the Society is uncertain of its role. I categorically refute this. The Society is there to look after the interests of its members in all areas apart from the matters of training and examinations.

The Special Interest Groups are a worthy ideal but we have to work at getting them right. It would be hopeless if each of the three separate organizations — the ASA, the College and the NZSA all went their own way in educational matters.

The one organization which the Society should and must improve its working relationship with is the Australian Medical Association. We are both medicopolitical organizations — the ASA representing anaesthetists, the AMA an umbrella organization representing all medical practitioners.

I don't always agree with the AMA yet I have remained a member since I was a fourth year medical student. I believe all anaesthetists should be members of the ASA and the AMA. Currently approximately 62% of ASA ordinary members are also members of the AMA.

In 1999 the AMA produced a "Statement of Values" and these are very close to the mission statement and objectives of the ASA.

The AMA has around 27,000 members and this gives it clout with Government because this number cannot be ignored and this gives them buying power.

This buying power was such that the AMA had an agreement with Diners Club who provided free their credit card to members. This, by way of commission, earned the AMA nearly two million dollars in income per annum. Why cannot this Society have an arrangement with the AMA such that we encourage our members to be members of the AMA and that we, through this, access some of this commission on a pro rata basis?

Organizationally, the AMA is similar to the Society. It has a representative Council and elected Executive. There are committees, subcommittees and working parties in the usual professional areas. It has a secretariat with departments of health services, medical practice, public affairs, industrial and corporate services.

It has a national conference which is advisory to their Council. This conference is attended by about 100 delegates who represent different organizations on a proportional representation. Currently anaesthetists are entitled to three representatives.

There is an Anaesthetic Craft Group representative on the AMA Federal Council who by the Constitution, is elected by AMA members who are anaesthetists. Currently our representative is Dr Ian Woodforth of NSW. The Craft Group representative chairs the AMA Anaesthetic Coordinating Committee.

I believe that the Society should be exploring how it can use the AMA more to achieve its objectives. By the AMA Constitution, nationally recognised medical bodies can become associated or affiliated organizations of the AMA. I think the ASA should look at this.

The AMA represents the whole of the medical profession and it has the ear of the Government — often a red ear. It has an expert and functional secretariat, staff and resources. The AMA can help the Society do things which it is unable to do and do things that we can, more efficiently and effectively.

There is a good working relationship between the AMA and the ASA now. As your President I can contact their President at any time, mind you I have to go via a keeper. Their office-bearers and secretariat staff are available to assist the Society but I still feel that more can be done to improve our working relationship.

Office-bearers of your Society do not have the time to take on more roles and particularly join AMA committees. Perhaps there should be a liaison meeting between the two organizations to see how we can improve on this situation to our mutual advantage.

Reginald Abbott Lewis

Since the inception of the Society there has been one Tasmanian who has stood out and contributed more to the development of anaesthesia in Tasmania than any other: Reginald Abbott Lewis.

He was not a Tasmanian by birth but as so often happens, married a Tasmanian and stayed there.

Reg Lewis is the only Tasmanian who has been President of the Society before the current and is the only Tasmanian who has ever been elected a Life Member of the Society.

He was born in Victoria on 28 December 1912 and died in Hobart on 18 August 1997. He graduated in Medicine from the University of Melbourne in 1936 and commenced his internship at the Launceston General Hospital. He remained there for several years before joining up and serving in the Australian Army in Darwin and New Guinea. It was during this time that he came under the influence of Dr Stuart Marshall of Sydney and determined to pursue anaesthesia as a career, obtaining his Diploma of Anaesthesia from the University of Sydney in 1947.

He became the first specialist anaesthetist in Tasmania in 1947 and remained the sole specialist anaesthetist in Hobart until the Faculty of Anaesthetists was established, when Ken Kelly was elected to Fellowship and Jean Oakes was elected to Membership. Reg himself was a Founding Fellow of the Faculty.

He was appointed to the Executive of the Anaesthetic Section for the BMA Congress in Queensland in 1949. He convened and was appointed Chair of the first State meeting of the Tasmanian Section of the Society on 4 April 1954, the other attendees being T. C. James, K. M. Kelly and Jean Oakes. He became the first Tasmanian representative on the Executive Committee of the ASA.

Reg moved fairly quickly through the ranks of the ASA, being on the Executive Committee from 1954 to 1957, President Elect in 1959/60 and President 1960/62.

From early in his career, Reg showed that he had an inquiring mind and great skill. Poliomyelitis was in epidemic proportions in the late 1930s and Reg was justifiably proud of the success that he and others obtained in their management of these patients. His main anaesthetic area of interest was thoracic anaesthesia, where he worked with the late Peter Braithwaite who went on to become Treasurer of the Royal Australasian College of Surgeons. Two totally different personalities are hard to imagine — Peter noisy and aggressive, Reg quiet and unassuming — but both very competent. Early in his career, polio, tuberculosis and hydatid disease were prevalent in Tasmania and Reg collected quite a series of cases. Regrettably they were not published. Some basic open-heart surgery was done under hypothermia — essentially atrial septal defects but they were abandoned after a while because of inadequate diagnostic services.

Reg was a quiet, unassuming man with great humility and was a great source of knowledge and wisdom. I don't recall ever seeing him losing his temper, but he could be quite determined when he wanted and needed to be.

He earned great respect from all his colleagues within medicine in general and surgery in particular, and on many occasions a difficult problem, whether clinical or professional, was deferred to Reg.

His record keeping was incredible. When he first commenced specialist practice in 1947, he developed a habit of recording in theatre the basic information relating to the patient, the anaesthetic he gave and the operation performed in a May and Baker diary. When he got home he transcribed that information into a minute book. This practice he continued until his retirement. These records are now in the safekeeping of the Archives at the College and will be well worthy of analysis in the future. I figure in his records somewhere having been anaesthetized by him as an adolescent.

He did himself have an interest in history and was of great help to Gwen Wilson in providing information when she was writing her book on the history of the Society

He was the classic hoarder and when I was assisting his wife Judy go through his papers after he died, I came across a package wrapped in newspaper. The newspaper was dated 1937 and the contents, notes he had taken as a medical student. They had not seen the light of day for sixty years.

Reg had a real love for anaesthesia but this love unfortunately was so great that he could not let go and he continued in limited anaesthetic practice until he was aged 77 years.

If I have portrayed a man whose whole life was solely a commitment to anaesthesia I haven't meant to, because he was the perfect example of someone who balanced his professional and personal life.

He had a beautiful house on Sandy Bay Road with a garden that won a nationwide competition. He was the perfect host. His interests were many and varied and he was an accomplished golfer and dedicated club man. He "bequeathed" me the captaincy of his Calcutta table for the Hobart Cup at the Tasmania Club.

The preservation of many old Hobart buildings is due to the work of Reg through the National Trust of which he became President and later a Life Member.

I portray a man who was dedicated and unselfish, to anaesthesia and the community around him.

I will finish with a story.

Dr Bobby Roberts, my first Director of Anaesthetics in Hobart, obtained his DA in London in 1935 and was later a Founding Fellow of the Faculty of Anaesthetists, Royal College of Surgeons of England.

Dr Roberts is still alive and well in Hobart and is the oldest living retired member of the Society.

He is a most interesting person. He was a stimulating teacher and was responsible for assisting many trainees become competent all round anaesthetists.

A couple of years ago, I came across Bobby in a wheelchair, outside the X-ray Department of a Hobart private hospital. He looked quite concerned. Obviously I stopped and asked him what his problem was. His response was — "Well Mike, I crashed my car and bumped myself on the side — nothing broken but they think I have

paralytic ileus". After a few reassuring comments from me he went on "I'm concerned because I recall a patient I had to do a spinal on for paralytic ileus when I was a trainee (this being one of the forms of treatment). The patient died the next day and a few days later I got an invitation to the funeral — so did my anaesthetic boss and so did the surgeon".

The funeral was at Westminster Abbey — the patient had been Rudyard Kipling.

The tumult and the shouting dies;
The Captain and the Kings depart:
Still stands Thine ancient sacrifice,
An humble and a contrite heart.
Lord God of Hosts, be with us yet,
Lest we forget — lest we forget!

Finally I wish to thank the Society for having me as its President for the past two years. It has been hard work, there have been some difficult patches, but overall it has been most enjoyable.

I believe I have gained more from the Society than the Society has from me.

In closing I repeat an Irish saying I have used before:

"May the roof above us never fall in and may we friends gathered below never fall out."

MICHAEL HODGSON AM
President 2000-2002

History of Anaesthesia SIG

The newly established History of Anaesthesia Special Interest Group now meets twice a year at the ASA's National Scientific Congress and at the ANZCA's Annual Scientific Meeting.

So far, three very successful sessions of four to five historical papers at each session have been held.

This SIG welcomes new members. If you are at all interested, please contact Dr Jeanette Thirlwell Jones at jtjones@fed.asa.org.au or the Australian Society of Anaesthetists,

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Anaesthesia and Intensive Care Goes On-line!

An exciting new development in the publication of *Anaesthesia and Intensive Care* is the decision of the ASA Executive and Council to support full text on-line as of February 1, 2003. To facilitate this, our Journal website is being substantially upgraded by Icon Computer Publishing. There will be available full searchability of text through keywords and links to references as in our CDROM.

There will also be links to the National Library of Medicine's PubMed as well as links to CrossRef. This latter organization is a non-profit consortium of more than 150 publishers, including the well-known such as Blackwell, Elsevier, Springer etc as well as smaller Society publishers and many other publishers of original scientific research.

The upgrading of the website will include better legibility of text. ASA members and all other subscribers will be provided with password access. Non-subscribers will be able to purchase access on a time basis. On-line subscription will also be available.

Version 2 of our CDROM will be released shortly and will cover the years 1996 through to 2001, in fully searchable HTML and PDF print-out format.

Meantime new editorial staff need to be identified and recruited to process the increasing number of submissions.

Subscription rates have been substantially increased to keep abreast of increasing costs of printing and electronic publication. We are grateful to the Journal Working Party and Publications Committee for assuming this role in the financial management of AIC. In particular we thank Dr Rod Westhorpe for facilitating these important developments.

The recent substantial increase in confirmed bookings for advertising is very pleasing. This is particularly unusual at the end of a calendar year so it is of greater significance, showing confidence in the Journal and providing solid financial support.

I would like to take this opportunity to acknowledge the professional editorial input and expertise of Professor Teik Oh, who has with regret, offered his resignation from the Editorial Board. Teik has served for many years on the Board and the Journal has benefited greatly from his scientific and academic approach to publishing, as well as his input into editorial policy decision-making. We thank him sincerely.

Dr John Roberts indicated at the recent Editorial Board meeting in Adelaide that he has decided to step down as Chief Editor. John has directed the Journal very capably and extremely wisely over the last fourteen years. We will however, still enjoy his words of wisdom and his editorial skills as he has expressed his willingness to assist in any way he can with the more routine running of the Journal — reviewing, proofreading and in an advisory capacity. We thank John for his wonderful leadership over the many years and look forward to having him still with us on the Editorial Board.

JEANETTE THIRLWELL JONES
Executive Editor