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Australian Society of Anaesthetists Presidential Address 1984

The Winds of Change

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It is appropriate in a Presidential Address to this Society, on the occasion of its 50th Anniversary General Meeting, that one should pay homage to the past, look at the present and try to anticipate the future. No mean task you will grant me, but it is particularly necessary in our present position as practising anaesthetists in this country that we take note of what is happening and look at our history to see that we plot our course carefully.

It is many years since the standards and status of anaesthetists and the rest of the medical profession have been under such threat. The importance of this Society in advising and influencing the opinions and actions of Government, of our fellow colleagues in medicine and the general public has never been greater. Under threat! Why, you might ask? Yes, we are under threat because Governments of all persuasions have felt it necessary to seduce voters by offering to pay part or all their medical and hospital expenses. The public has been persuaded to believe that they have a *right* to 'free' medicine and that the State will provide. 'There is no such thing as a free lunch'! Someone always has to pay.

Today it is hospital practice in particular that is under examination and subject to reform. And it is in hospitals that anaesthetists spend their lives, practise their art and earn their livings. Anything which changes in hospitals, whether it be staffing levels, bed numbers, equipment, levels of financing, inquiries into practice methods, increasing bureaucratic controls or patient classification status — all of these affect anaesthetists at the very heart of the way in which they practise medicine.

From the very minute when Governments begin to pay for services (financed by the increasing taxes which they generously give back — less administrative costs), they have a need, indeed it becomes a 'fiscal duty', to be involved in the control of spending on one hand and the gaining of income on the other. One of the great problems as medicine becomes increasingly sophisticated, as diseases not previously treatable become amenable to treatment, is that the cost rises. Intensive care wards, virtually unknown till the 1960s and now almost universal in major hospitals, are a classic example of cost-intensive medicine as are CAT scanners and many other technical advances. And now major surgery is expanding at a great rate, frequently made possible by the increasing expertise in anaesthesia. Renal, cardiac and now liver transplant surgery are with us.

It is estimated that there is, on average, one operation per year for every ten of population in this country. In other words, almost every family will have someone having surgery this year. Is this overservicing? Whether it is or not, the Government will say it has a 'fiscal duty' to try to control it. And Government's response is apparent today — the Jamieson Commission of Inquiry into the Efficiency and Administration of Hospitals (1980), the Federal Government's Medical Fraud and Overservicing Committee, the Pennington Committee of Inquiry into Rights of Private Practice in Public Hospitals and a whole range of new Federal and State legislation introduced under the guise of

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implementing a tax-financed universal health scheme called Medicare. There is nothing wrong with Medicare. What is wrong is the excessive degree of control which is being sought, particularly in the field of hospital practice both public and private.

It is not appropriate to go into great detail on these matters now other than to refer to various amendments to the Health Insurance Act passed through Federal Parliament in September 1983 which met with such enormous reaction from the medical profession. The Society has been heavily involved in these matters and continues to be so, as it is apparent that the whole practice of anaesthesia, its standards and methods of remuneration are at stake. Anaesthetists in all States are at risk. The new amendments to the Health Insurance Act give the Minister for Health enormously wide powers to control the practice of medicine in all our hospitals, both public and private.

The initial application of the legislation has been to public hospitals only, though the provision is there for private hospitals to be involved also, as those who presently feel safe might well take note. Right from the outset anaesthetists in some areas of practice, such as perfusionists, were to be affected. It was only through the strongest action on the part of this Society, assisted by the A.M.A., that we were able to persuade the Government for the time being at least to exclude anaesthetists from the provisions of the Act which would have required them to sign a totally new and unacceptable contract with their hospitals as a condition of their patients receiving Medicare benefits.

The new contract would have imposed a third party (the Government or its hospital agent) into the professional relationship between anaesthetists and their patients at considerable cost to both patient and doctor. Both Federal and State Governments are attempting to do this at many levels and will continue to do so. The current Federal Minister for Health has stated on many occasions that he sees it as a duty to intrude into this relationship in the name of containing costs. It was only through unprecedented industrial action on the part of all doctors, with anaesthetists well and truly in the forefront, that some review has been obtained and that a Committee of Review into Rights of Private Practice in Public Hospitals was established. It is however worthy of note that the Minister has emphasised that he does not feel obliged to be bound by the recommendations of this committee.

Further, the legislation as it stands can still exert control of practice in private and public hospitals, through denial of insurance benefits to patients in those hospitals if their doctors do not agree to conditions which the Minister (subject now to the approval of Parliament) may determine from time to time in agreement with the individual State Minister for Health. Such a situation could not have been better devised in fiction by George Orwell. Appropriately enough it applies in the year 1984.

I have referred to the professional relationship between patient and anaesthetist. This must be ever present in *our* minds if it is to be understood by others. Anaesthetists have an unusual and not always easily visible relationship with their patients compared with physicians and surgeons. Our place of practice is in hospitals and patients come to hospitals in one of several ways whether directly 'off the streets' or referred by a particular surgeon or general practitioner. It is not usually till after the patient sees a surgeon that the anaesthetist becomes involved. It is at this stage that the professional relationship begins and it is usually as part of the surgical team that the patient first encounters his anaesthesist.

It is a rare patient (and a very unwise one) who does not choose his team carefully whether through the reputation of the surgeon or of the hospital as a whole. All surgeons are well aware that their reputation is deeply affected by the type of anaesthetist with whom they work — his skills, his personality, his manner and his relationship with the patient before and after surgery. These days patients are well aware that their lives, for a period, rest in the hands of their anaesthetists. I stress this professional relationship for several reasons. It is vital that a patient continues to relate directly to his or her anaesthetist and that no third party should ever interfere in any way affecting standards, the confidence of the patient or the sometimes delicate financial arrangements between patient and anaesthetist.

The anaesthetist must not be interfered with

in any way which might cause him to lessen his sense of direct responsibility to his patient. This responsibility exists not only in a moral and ethical sense but in a very real way in a true legal sense. My point in stressing all this is that again 'Big Brother' is a worry and is looking over our shoulders. Whatever right Governments, whether Federal or State, may have to control their expenditures, this Society will regard it as a duty to protect the standards of our practice and our professional relationship with our patients.

In this regard too, I cannot emphasise too strongly the value of the pre-operative attendance of the patient by the anaesthetist attending the patient. This is so not only for direct medical reasons but for professional and ethical reasons. The patient needs to know *who his anaesthetist is, his name*, to be reassured by him and to develop a rapport with him. The time to do this is preferably the day before operation but it is equally important even if only a short time before the patient comes to theatre. Our professional standing in the community and our joint reputation as anaesthetists largely depend on this attendance and no amount of money spent on public relations will replace it. Give it your every effort and spend time on it, and remember that these comments apply equally in public hospitals as well as in private.

When I look about this room and see so many of the faces of those who have helped shape this Society over the last 50 years into the great body which it now is I must pay homage to them and to the great wisdom of our forefathers who founded this Society. It was in January 1934 that they met in Hadley's Hotel in Hobart following the second Australian Medical Congress of the B.M.A. held in that city. Those present were Gilbert Brown who became the first President, Geoffrey Kaye who was the first Secretary, Leonard Lillies, Gilbert Troup, Cedric Duncombe, Harry Daly and Ivor Hotten. Much work and thought had gone into the meeting. The idea of having a Society had been considered for several years but it was Geoffrey Kaye who played the most active role in the early organisation. Following the meeting in Hobart the first Annual General Meeting of the Society was arranged and was held in Melbourne the following year, 1935. It was at this first Annual General Meeting that the first constitution was adopted. Among other regulations (and I am grateful to Dr. Gwen Wilson for this information) was item 8, 'that all members of the Society shall attend each meeting or show good cause for their failure to do so'!

Since the first Annual General Meeting the Society has grown from an initial 34 members to just under 1600 and is now among the largest specialist societies in Australia. It is well to look at the aims and objectives of the Society and its basic structure to see the wide range of its interests covering every aspect of anaesthetic life. The early fathers were very concerned about education, standards and the status of anaesthetists. Remember that they virtually all began medical life in general practice and *grew into* the speciality of anaesthesia. Only the very few who were the elite had formal training in anaesthesia. This could only be obtained by travel overseas by long sea voyage at considerable expense.

The Society realised very early that if the specialty was to expand in numbers and knowledge that a training and examining body was needed with the awarding of diplomas to those attaining the required standard. To this end diploma courses were established at the Universities of Sydney and Melbourne. However, it was later felt that a national body with status and a uniform standard should be set up. Approaches were made initially by the Society in 1947 to a conjoint board of the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians to introduce an examination for a Diploma in Anaesthetics. However, this was not permitted under their constitution. In 1949 Harry Daly, who had travelled widely abroad and established an international reputation, had conferred on him the Diploma of Fellowship of the newly formed Faculty of Anaesthetists of the Royal College of Surgeons of England. It seemed natural to him to establish a similar Faculty of Anaesthetists of the Royal Australasian College of Surgeons. Harry Daly as a past President of the Society (1946) and a founding member used his influence in the Society to encourage the President, Douglas Renton, to enter into negotiations with the Royal Australasian College of Surgeons in 1949. The negotiations

were long and drawn out but eventually in 1952 the Faculty of Anaesthetists was inaugurated with Douglas Renton as the first Dean and Harry Daly as Vice-Dean.

This was a major achievement of the Society on its road to establishing the standards of anaesthesia in this country. A continuing close relationship between the Society and the Faculty is not only natural but necessary to the wellbeing of anaesthesia and anaesthetists. For this reason the Society includes the Dean of the Faculty by invitation in all its Federal Executive Meetings and an A.S.A./Faculty Liaison Committee has been established comprising of the President and President-elect of the Society and the Dean and Vice-Dean of the Faculty. The purpose of this committee is to discuss matters of joint interest such as continuing education and standards in order to prevent duplication of activities and to concentrate expertise from each body.

According to Dr. Gwen Wilson, the Faculty historian, it was decided in 1963 by both Society and Faculty that the Society was clearly the body to represent the views of anaesthetists in the area of medical politics. This followed considerable discussion which was often heated. It was obviously a waste of resources and also confusing to have two bodies doing this. In any case the College of Surgeons and the Faculty had legal opinion that their involvement in matters other than those to do with standards was unwise and carried legal risks to their status as a tax-exempt body. There were worries among some that as the constitution of the Society did not originally define 'specialist' membership, it could not speak officially as the body representing trained anaesthetists. With the change in the constitution in 1982 the Society clearly defined all specialist anaesthetists in Australia including those not necessarily Fellows of the Australasian Faculty as being those eligible for ordinary membership. This was a milestone in the development of the Society and enabled an easier relationship with the Faculty.

Thus it was that I was able to write to the Dean of the Faculty recently indicating my great concern at the threat posed to the standards of anaesthesia by the policies of the present Federal Government and to ask him to bring to the attention of all those whom he might influence the great concern that we had for the decline in standards which we saw coming to public hospitals if their policies were pursued. I note the Dean's recent statement on 'Politics and the Faculty' in the July 1984 R.A.C.S. Bulletin. I see the Faculty's interest in the politics of maintaining standards in our hospitals as proper and welcome the interest of our fellow body. This is the one political area where the Faculty has to be involved.

From time to time Governments, State and Federal, direct problems of a political nature, but often relating at least partly to standards, to our Royal Colleges. Hence items of this nature, *affecting the daily lives* of anaesthetists, sometimes come before the Faculty with no input from the Society. I, as President, feel it is not in the interests of anaesthetists that this should happen. The controversy that exists today concerning the standards relating to anaesthesia produced by the Australian Council on Hospital Standards might have been avoided if the Society had been involved at an early stage. I do wish to make clear on this delicate topic that my feeling here is one of family and that relationships between the Society and Faculty are most cordial. Having held office both in the Faculty as well as in the Society I firmly believe that the Society should always have the prime role in dealing with government and semi-government bodies, particularly where the matter in hand involves the daily lives and working conditions of anaesthetists.

There is one particular group of anaesthetists who have had great influence on both me and this Society. I refer to the anaesthetic group originally known as 'Shanaway' (after Harry Daly's family home place in Ireland) and now known as General Anaesthetic Services or the GAS Company at Elizabeth Bay, Sydney. This remarkable group, the first of its kind in Australia, was founded in 1944 by Harry Daly and Stuart Marshall (both former Presidents of this Society) towards the end of the Second World War. I was privileged to be invited to join the group in 1960 but elected to spend some time in Oxford before taking up the invitation in 1962. In the forty years since 1944 the group has had a total of only 30 members. Currently there are 11. Yet the group has contributed no less than seven Presidents to this Society of whom four were also Deans of the

Faculty. There have been three Federal Secretaries of the Society, numerous N.S.W. State Chairmen, Secretaries and other office-bearers. In addition your newly chosen President-elect, Dr. Barry, was the first editor and prime-mover in the establishment of the Society's journal 'Anaesthesia and Intensive Care'. Among the group were the seven Presidents, Harry Daly, Stuart Marshall, James McCullock, Bob Speirs, Len Shea, Brian Pollard and myself. Ben Barry will become the eighth. The four Deans of the Faculty have been Harry Daly, James McCullock, Bob Speirs and Len Shea. I mention the GAS group not only for its influence on me and this Society but as an example to other practice groups. It has always been a major consideration of the group that those invited to join it were expected to give back to anaesthesia something of themselves in return for the knowledge and skills they had learned. I would commend this principle to all young anaesthetists.

Future problems facing the Society will undoubtedly continue to be many. Anaesthetic manpower is still a problem with the worry that an oversupply situation may develop. Already with one member of this Society for every 9,000 of population in the country we are ahead of the United Kingdom with one in 15,000 and the United States with one in 16,000.

At the Eighth World Congress of Anaesthesiologists in Manila earlier this year, it was shown that Australia had easily the highest density of anaesthetists per head of population in the world. Dr. Lindsay Thompson, President of the Australian Medical Association, in his Presidential Statement to the 23rd Federal Assembly of the A.M.A. earlier this year gave some interesting figures on 'medical personpower' taken from estimates from the Commonwealth Department of Health, April 1984. The department's figures on doctor supply are:

* Medical manpower will increase by 63% between 1981 and 2001 from 28,650 doctors to 46,680.
* Population will increase by only 27%.
* Greying of population will call for only three extra services per doctor per week.

Doctor population Ratio	
1981	1 to 521
2002	1 to 405

Female factor

* In 1981, 18% of doctors were women (5,100).
* In 2001, 28% will be women (13,300).
* This is a 160% increase in women doctors.
* The increased proportion of women will reduce the productivity of the profession by a marginal 2%.

General practitioners

* In 1981, 42% of doctors were G.P.s (12,148).
* In 2001, 55% will be G.P.s (25,771).
* On current utilisation rates this means that workloads will be reduced from 4,400 services per G.P. per year to 2,900 services per G.P. per year, or 55 in a week.
* If G.P. utilisation increases by 25% it will add $500 million to the cost of medical benefits by 2001 (in current dollar terms).

As Dr. Thompson pointed out: 'If these predictions are anywhere near being right, the tragedy is not the effect on doctors' incomes but decreasing standards and loss of job satisfaction. We (the A.M.A.) as an organisation must continue to put pressure on medical educators and government to stem the present trends.' The message for the A.S.A. is loud and clear.

Another growing problem which we are yet to face is the problem of retirement for anaesthetists, who unlike any other medical group have no consulting or other non-hospital-based work to fall back on when they reach an age when they are unable to give anaesthetics in hospitals. The number reaching this age will grow rapidly in the next few years. It is essential that anaesthetists' incomes and financial planning should enable them to retire gracefully as it is likely that no other alternative medical earnings will be available to them after retirement. It may be appropriate for the Society to consider this problem in detail and to provide professional advice on planning for retirement. The political problems with State and Federal Governments will no doubt continue and our work in advancing knowledge and standards in anaesthesia will continue to expand both in Australia and in the surrounding developing countries which we influence.

An area where the A.S.A. will undoubtedly expand in the future is in its contacts and associations with the Societies of other countries. We have long had an association

with the New Zealand Society through combined meetings, the last of them being in Brisbane last year. Next year we will be holding a combined meeting in Toronto with the Canadian Society, the first such meeting of the A.S.A. with another Society other than New Zealand. Our links with other Societies up till now have not been strong. However beginning with the Post World Congress in Sydney this year we have begun to forge closer links with many overseas Societies. The letters of congratulations to us on the occasion of our Golden Jubilee from all over the world are a source of great pleasure to me and the A.S.A.

In 1982 our President, Bob Hare, presented a plaque from this Society to the Association of Anaesthetists of Great Britain and Ireland on the occasion of their 50th Anniversary. Our guest Professor for this year, John Nunn, has now in return brought with him the best wishes of that Society.

It would be natural for the A.S.A. to expand its contact with our fellow Society of Great Britain and Ireland and I am sure this will occur. I look forward, too, to closer links with many other overseas Societies, particularly those who have honoured us with their representatives and congratulations on this occasion.

This Society has accomplished much in its first 50 years but there is a great deal more to do yet! The health and vigour that is apparent in the Society today will be fully tested in the years to come.

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