requires considerable skill and its use in the emergency situation is doubtful, particularly where more familiar alternatives are available. If it is necessary to proceed with surgery in patients at risk of aspiration, using the LMA with maintained cricoid pressure may possibly be the safest option. The presence of the LMA does not compromise cricoid pressure although cricoid pressure may make LMA insertion slightly more difficult.

Although the LMA has a role in failed intubation, it is still a matter of some debate as to whether it should be used by non-anaesthetic staff for resuscitation. Several studies have indicated that unskilled personnel insert the LMA more reliably than the ETT, although its superiority over the facemask and Guedel airway has been questioned. Some authors have suggested that it should be available in all areas where resuscitation is performed, since it may reduce the incidence of irreversible hypoxic damage. Further research is required to help define the place of the LMA in primary care and to decide what level of initial and continued training is needed.

Opinion is polarised over the best mode of removing the LMA, since several potential problems can occur at this time. Brain recommends that the LMA be left in position until the full recovery of pharyngeal reflexes and has stressed the importance of not disturbing the patient during emergence. Others have suggested that the problems associated with recovery could be avoided by removal of the LMA under anaesthesia. The optimal position for removal of the LMA has also been questioned, since gastric contents are prevented from escaping via the pharynx. Delegating responsibility for removal of the LMA is also controversial and should only be undertaken after consideration of theatre layout, nursing expertise and the immediate availability of an anaesthetist.

There have been a wide variety of reported complications associated with the LMA, the most serious of which are aspiration and airway obstruction. Often these result from inappropriate use rather than defects with the device itself. Careful patient selection and meticulous attention to the guidelines in the manual[7] are essential prerequisites to safe use of the LMA. We would urge caution when using the LMA in some specialised areas where its benefits are uncertain and experience is limited.

The next ten years should see the LMA firmly established in clinical practice and its role in many specialised areas better understood. Future studies will hopefully resolve many of the controversies and confirm or refute its perceived advantages over other airways. The story of LMA development is certainly far from over. Future versions will include ones with a flexometallic or a large-bore tube. The possibilities of incorporating a pulse oximeter into the LMA are also being explored. The biggest challenge, however, is to develop an LMA which will protect the lungs from gastric contents, the "ultimate-LMA". An early attempt at such a device may be forthcoming in this anniversary year.

And so we would like to raise a toast to Dr Brain and the LMA. Those of you with your "hands free" will no doubt be happy to join us.

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The Geoffrey Kaye Oration

Adelaide AGM, 1992—October 19th

J. RICHARDS

President of the Australian Society of Anaesthetists

"THE MAN, THE VISION, THE REALITY, THE RESULT"

Mr President, Mr President of the Australian and New Zealand College of Anaesthetists, Members of the Australian Society of Anaesthetists Executive, Members of the Society, Ladies and Gentlemen.

I have much pleasure in presenting the Third Geoffrey Kaye Oration.

In his memorable Presidential Address of 1978, Dr Peter Brine opened by saying that:

> "even if it failed to inform, the spoken word presentation should at least entertain and that you had a fair chance of being able to class it, according to the source of the opening quotation; there being an ascending order of merit from:
>
> Shakespeare, Oscar Wilde, G. B. Shaw, The Bible, Confucius, Lewis Carroll and obscure poets all the way up to Milton!"

My quotation comes not from any of those august sources. In the foreword of the book, "The Last Lion, Winston Spencer Churchill", there is the following by President John F. Kennedy, who was speaking of Theodore Roosevelt:

> "The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause; who at best, if he wins, knows the thrill of high achievement, and, if he fails, at least fails daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat!"

When Geoffrey Kaye passed away on October 28th 1986, the Australian Society of Anaesthetists lost one of its seven founders.

This remarkably complex, diverse man left Australian Anaesthesia many legacies. He was privileged to be involved with the formation of our Society. In fact, were it not for his suggestions, persistence and organising skills, our Society may not have been formed till after the Second World War.

He acted as the Society's Honorary Secretary, he all but single handedly held the Society together, provided the direction for development, encouraged communication, ran the Society's Newsletter and was its major contributor. He established a collection of anaesthesia equipment and archives and historic material. He was committed to the professional development of the specialty of anaesthesia and as such the establishment of a centre of academic excellence, using his own resources and energy.

Sadly, circumstances in 1955 caused Geoffrey Kaye to "bow out" of his active involvement with the Society. He was only 52.

In what amounts to twenty short years, six of which were interrupted by the Second World War, Geoffrey Kaye, like no other single person, left his indelible mark on Anaesthesia in Australia.

This is the Third Geoffrey Kaye Oration. In my researching for this oration, I have had the opportunity to review much historical material.

I must pay special homage to Dr Gwen Wilson, whose history of the Society, "Fifty Years", will stand forever as a reference source for members. The book is compiled with the detail necessary for a comprehensive history, yet has the personal overview of someone who knew all the main players personally. We have a debt to Geoffrey Kaye but no-one would deny that we owe much to Gwen Wilson.

In the first Geoffrey Kaye Oration, Dr Ben Barry, a man whose contribution to our Society would deserve orational recognition, presented a most detailed summary of the life and work of Geoffrey Kaye.

In the second Oration, Dr John Ashton, who only yesterday retired from the executive after many years of selfless commitment and energy, followed on with an expansion on the life and times of Geoffrey Kaye.

I would like to briefly remind you of Geoffrey Kaye's life and contribution to the Society, but then pass to the *vision* which he had for anaesthesia. The *reality* of changing times, persons and needs prematurely ended his contribution to our Society, but the *result* is what we have today and what we might have in the future.

Geoffrey Kaye was born in 1903 in Melbourne, but educated in Britain and returned to Melbourne where he enrolled in the Medical Course at the University of Melbourne. He graduated MBBS in 1926 and MD in

1929. He decided to do anaesthetics "because he liked it" as early as 1927.

He was fortunate to work with Dr Frederick Green (who became the first Vice President of the ASA). Fate stepped in and, because of the ill health of Dr Green, the young Kaye was asked to represent him at the BMA meeting in Sydney in 1929.

There he met Francis McMechan, an early pioneer in USA anaesthesia.

McMechan had been instrumental in the formation of the American Association of Anesthetists in 1912 which in 1925 became the International Anesthesia Research Society. McMechan died in 1939, tragically being denied anaesthesia for an acute gall-bladder infection; as he was so crippled with arthritis he was considered too high a risk for anaesthesia and surgery.

McMechan urged the young Kaye to establish a "Society of Anaesthetists" in Australia.

Geoffrey Kaye then went overseas in 1930/31 where he met, studied under, befriended and was influenced by the outstanding leaders in world anaesthesia at the time: Sir Ivor Magill, Sir Robert McIntosh, Arthur Guedel, but particularly, in the USA, Elmer McKesson and Ralph Waters.

These great pioneers activated and enthused Geoffrey Kaye (still only 28). He realised that anaesthesia had a rich academic potential, and the need for laboratory research to practical solutions of clinical problems was essential.

Kaye returned to Australia determined to develop the specialty by organisation, publication and research.

He was responsible for the eventual founding of the "Australian Society of Anaesthetists" following a meeting at Hadley's Hotel in Hobart.

I was fortunate to be able to attend a dinner in Hadley's in 1984 to commemorate this historic meeting fifty years previously. I invite those of you who haven't taken the opportunity to visit Hadley's to do so. It has occurred to me that the Society should have a plaque made for display in the hotel.

Geoffrey Kaye wrote incessantly, communicated between members around Australia, organised meetings, kept in contact with overseas anaesthetists and organisations. He eventually purchased a grand building with his own resources in Melbourne on Mathoura Road. He had high ideals, great vision and limitless energy.

However, all did not work out as planned, for as we know the reality of his vision for anaesthesia was not fulfilled and he sadly broke his ties with the ASA in 1954.

What was his vision? Why did it not come to fruition? What was the reality?

Here again I refer unashamedly to "Fifty Years" and extract from a letter to the ASA Executive by Geoffrey Kaye dated 7th March 1955.

He wished to make it clear to members the reasons for his decision to close the Mathoura Road building and the projects within.

Under the influence of the dying McMechan, Kaye had been strongly urged to establish a National Society Headquarters. In 1949 he secured the active support of the Victorian Section of the ASA and by 1951 he had secured the Mathoura Road property and had negotiated an agreement with the Society to grant access to the ground-floor and machine shop for one shilling a year, for a trial period of five years to August 1955.

His vision was the establishment of an Anaesthetic Centre of Research, experimentation and study with facilities for meetings, administration and preparation of papers and literature.

He had plans for a comprehensive library with the latest anaesthesia journals and a reference service for the use of all State Sections and members.

He had already had the basis of an equipment museum and once again saw the importance of extending its facilities to other States.

The office, for his use, was set up for everything needed for the secretarial duties and the production of a Newsletter. A dark room for the production of teaching material was also constructed.

The concept of his laboratory was years ahead of its time. The idea of testing all anaesthetic appliances and issuing of an approval rating was visionary.

This machine shop concept, where anaesthetists could develop more apparatus, was probably too late to be of any use as new equipment was being imported and anaesthetists did not have the interest or training to undertake equipment development.

As time went on, he felt that Victorian anaesthetists did not support the concept and as such other Australian anaesthetists were not interested. He was unable to find a Victorian Secretary and as a consequence the Secretariat moved to Sydney in 1954. He found that his visionary ideas of a library, machine shop and dark room attracted little interest. The Newsletter became a production almost entirely run by himself. He was unwilling to entertain the idea of working with a paid secretary, feeling that his independence and control would be subjugated to the Victorian State Section.

Inevitably, he became frustrated, feeling that the Society's members, and particularly the Victorians, felt he was manipulating anaesthesia to suit his (and McMechan's) ideals. He received no support for the concept of a Standards Committee to test equipment and no agreement from the Victorian members to a commitment of service to the Mathoura Road project.

He gave up and reconciled to close the centre. He stated in his letter:

"Nothing can be had for nothing, and a Society desirous of making progress must invest both labour and vision.

"I hope, for the sake of the future, that they (labour and vision) will be more evident in the Society's next venture. If they be not, the Society itself will go down, its place as trustee for the interests of Australian Anaesthetists being taken by another organisation."

As Gwen Wilson said, the great loss was not the Mathoura Road project but Geoffrey Kaye himself. There was much sadness and he withdrew from the activities of the Society and the Faculty.

Geoffrey Kaye had concepts, ideals and visions inappropriate for his time. He was working from an American and world model that post-war Australian anaesthetists neither understood nor wished to entertain. Few had the education, the experience or the ability to conceptually rationalise what Geoffrey Kaye was on about.

However, as Ben Barry pointed out, the headquarters project failure was also partly the fault of Geoffrey Kaye. He had fixed and uncompromising ideas. He failed to realise the directions anaesthesia was taking. He took offence at criticism. He tried to confine the headquarters to his own control and influence, thus establishing social opportunities and intellectual security for himself.

At this point I digress, in an attempt to further understand why Geoffrey Kaye could not make the Headquarters work.

I refer to and quote from the writing of Sir William Osler. (I wonder, where does he come on the Peter Brine scale of worthwhile quotes?)

Osler declared that:

"happiness lies in absorption in some vocation which satisfies the soul; that we are here to add what we can to, not to get what we can from life."

In his Valedictory Address to recent graduates of the University of Pennsylvania in 1889, Osler drew to the attention of his audience of recent graduates, "lean and pale, leaden-eyed with study" as they were, two elements which contribute to success or help in days of failure.

Firstly, no quality takes rank over *imperturbability*, the essential bodily virtue. This means, I quote, "coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril, immobility, impassiveness or to use an old and expressive word, *phlegm*".

It is—

"The quality most appreciated by the laity though often misunderstood. The physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients.

"With education and practice and experience one could expect to attain 'a fair' measure.

"The physician or surgeon who shows in his face the slightest alteration, expression or anxiety of fear, has not his medullary centres under the highest control, and is liable to disaster at any moment."

Surely, imperturbability would appear to be one of the primary necessities of the anaesthetist.

Secondly, the mental equivalent of the bodily endowment of imperturbability is a calm *equanimity*. I quote again—

"One of the first essentials in securing a good natured equanimity is not to expect too much of the people amongst whom you dwell.

"In seeking dissolute truth we aim at the unattainable, and must be content with finding broken portions. There is a struggle with defeat which some will have to bear, and it will be well in that day to have cultivated a cheerful equanimity."

Geoffrey Kaye was widely read and had many diverse interests.

Surely, it would seem, that much hurt, disappointment and bitterness would have been avoided had more people (in 1955) read and acted upon Osler's wise philosophies in "Aequanimitas".

He closed with—

"The more we study human nature, the more surely is the conviction borne in upon us of the likeness of others' weaknesses to our own."

So what of the result?

Whilst preparing for this oration, I took the opportunity of reviewing the Presidential Orations back to 1972. Presidents before then and after have taken up the challenge of Geoffrey Kaye with both labour and vision.

Kaye's vision is about to be fulfilled when the Australian and New Zealand College of Anaesthetists purchase a suitable building in Melbourne. Although not a Society Building, it will be the Centre of Anaesthesia in Australia, a focus for training, standards, examinations, the housing of the College Library and the heritage of the Geoffrey Kaye Museum.

One of the problems of Mathoura Road, which was alluded to recently, was that it was too far out of the way to be a useful venture. I know the College Building Search committee is aware of the importance of a convenient, accessible property.

I think Geoffrey Kaye would be very proud and pleased with the formation of our College in Australia. His whole philosophy and aims would have been directed at such an event. He would also be pleased at the diversity of research that is occurring and the formation of academic Chairs of Anaesthesia which has occurred in the last 15 years.

But what of his beloved Society?

Once again I turn to Osler for a perspective:

"The past is always with us, never to be escaped; it alone is enduring, but amidst the changes and chances which succeed one another so rapidly in this life, we are apt to live too much for the present and too much in the future."

And—

"The great possession of any Society is its great names. It is not the pride, pomp amd circumstance of an organisation 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 thorny road through toil, even through hate."

Despite what Osler said, I am immensely proud to address you knowing that the ASA is growing in size in all aspects. We have nearly 2000 members. We have seen the activities of the Fees Subcommittee become so diverse that it became the Economics Advisory Subcommittee. Dr Greg Deacon, its Convenor, deserves special mention for his commitment, sacrifice and dedication. Members of his committee now oversee issues as diverse as Manpower, The National Health Strategy, Case-Mix Funding and DRGs. The Newsletter has been upgraded and is now a publication of considerable merit. I can see it becoming a vital conduit for advising members of the Society's activities. I would encourage all members to get behind the Newsletter, have input, criticise, complain and voice your views. Geoffrey Kaye knew how difficult it was to publish in virtual isolation.

The activities of the Society now range far beyond what even Geoffrey Kaye's futuristic vision could have contemplated.

The Society's involvement with all aspects of anaesthesia and medicine is reflected in the increasing size and complexity of the agenda for the Federal Executive meetings.

In the Constitution of the ASA are the Objects of the Society. I don't intend going through each of those, as Dr Brian Pollard in 1976 used these objects as the basis for his Presidential Oration. However, when one considers each objective in relation to current ASA activities, clearly the Society is fulfilling each, more than adequately.

Our CME programmes at State and Federal levels are almost too frequent and the ASA supports and encourages research and academic achievement. We have an active, enthusiastic overseas aid programme in conjunction with the World Federation of Societies of Anaesthetists.

The journal "Anaesthesia and Intensive Care" goes from strength to strength and is one of the world's leading Anaesthesia publications. The Society, through its association with the AMA, the Australian Association of Surgeons, Standards Organisations, the WFSA and many other societies is enhancing the status of anaesthesia and anaesthetists in Australia.

I can't resist quoting Dr Robert H. Orton, the 1947 President, who, in his Presidential Address of 1948, said, on improving the status of anaesthetists:

"Educate the surgeons, educate ourselves, produce a proper scale of fees so that the anaesthetist can give all his time to the specialty and more time to each patient."

To this I would add:

"Educate the public and their elected representatives."

We still have a long way to go on those issues as demonstrated recently when a passport application signed by an anaesthetist was rejected because anaesthetists were perceived not to be doctors.

The Society is currently viable, active in Medical Politics, committed to greater CME initiatives and encouraging young under- and postgraduates to actively participate in Society affairs. We have purchased the impressive adjoining suite next to the Secretariat in Sydney which will service our needs for some years to come.

I think Geoffrey Kaye would be well pleased with the Society today.

Finally, although not strictly within the bounds of the title of this Oration, I would like to consider the future of the Society and anaesthesia.

These are difficult times for medicine in Australia. There are many influences outside our profession which will change the way we practise anaesthesia and related disciplines.

Anaesthetists are not large in number compared to other medical sub-groups. We do not have a substantial percentage of the Commonwealth Medical expenditure allocated to us. We are often forgotten. We are, however, becoming a greater political force disproportionate to our numbers. Why is this so? Anaesthetist training in Australia is now recognised as being at least equal to, if not the best, in the world. We have contact with most of the surgical sub-specialties and other medical sub-groups. It has always been said, that if you want to know what's going on around town, ask an anaesthetist. In this role we can and do seem to be able to reach all branches of medicine and probably suffer less

from specialty "tunnel-vision" than other groups. Using this ability to communicate successfuly we gain in status and respect.

The recent formation of the College of Anaesthetists has enhanced this process. Only now are surgeons beginning to realise that we have our own College. We will gradually learn to use our new status in the medico-political and education and standards affairs. Dr Peter Livingstone, the College's first President, deserves high praise for initiating the formation of our College.

What of the effect of college formation on the activities of the ASA? Will the formation of a College affect the ASA? In the long term, yes! Currently and for the foreseeable future I perceive both organisations working even closer together on all issues which affect anaesthesia. The environment is becoming increasingly complex, fast moving, politically charged and stressful.

No government or associated bodies' proposals exclusively influence the realms of responsibility of the ASA without having its effects upon standards, safety, training and education, i.e. roles traditionally considered Faculty (College) responsibility. Similarly, no changes, by the College or government, to education, exams, accreditation or standards goes without influence on the financial and workplace structures of anaesthetists, i.e. traditional ASA areas.

This is demonstrated in the process of Recertification or "Certification of Maintenance of Standards". Although a standards issue, and in the realm of responsibility of the College, the ASA is aware that there are significant medico-political and work-practice implications. In time both organisations will be working closely together to initiate meaningful, efficient and worthwhile standards.

The future of the ASA in CME activities is becoming focused on the World Congress in Sydney in 1996. This will be a significant event in the history of Australian anaesthesia. Apart from this major event, rationalisation of the major annual meetings will occur. There will always be a need for two major meetings annually. But whether they continue to be one College and one ASA, we will see.

I foresee the ASA, along with the growing status of our College, becoming more confident when dealing with politicians, bureaucrats, the media and the public. There will be increasing activity in the sphere of overseas aid, teaching and liaison with our Pacific Island and Asian colleagues.

In closing, I return to the writings of Osler:

"On the educational value of the medical society—

The first, and in some respects, the most important function is to lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the professions. *Unity* and *friendship*. How we all long for them, but how difficult to attain. Strife seems rather to be the very life of the practitioner, whose warfare is incessant against disease and against ignorance and prejudice, and, sad to have to admit, he too often lets his angry passions rise against his professional brother. The quarrels of doctors make a pretty chapter in the history of medicine."

Geoffrey Kaye helped found this Society on the principles of unity and friendship. The greatest benefit I have attained is working for the Society in an atmosphere of unity of the Federal Executive and its many associated committed persons. The friendship, above all, however, is what I value most.

I wish John Hains and all future Presidents well and hope that they gain as much as I have from their time serving this Society.

I thank you for giving me the privilege and honour of serving the Australian Society of Anaesthetists as its President.