FROM
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"INCHCOLM,"
WICKHAM TERRACE,
BRISBANE

Presidential Address, Sydney, 1951.

~~Mr. President~~, Ladies and Gentlemen,

Custom demands that at this time I should inflict on you ~~with~~ what is so often charitably termed "An Address". I am certain that your distress in listening will only be surpassed by my own in talking, so I shall make my remarks as brief as decency permits.

I must first thank you for the great honour you have paid me in electing me your President. I am deeply sensible of this, as I feel that no greater honour can be conferred than recognition by one's professional colleagues, and more especially those in one's own branch of the profession.

I should now like to express my gratitude to those, who, throughout the year have <u>really</u> done the work, namely - John Barker and Henry Lyons, who, as Hon. Secretary and Hon.Treasurer have done all the administration - Drs. Renton, Travers and Gillespie, our Sub-Committee who have represented us in talks with the Royal Australasian College of Surgeons concerning the formation of the Faculty of Anaesthesia within the College, and last, but by no means least, our Curator -Geoffrey Kaye. To these people I give my grateful thanks .

Great ~~strides~~ EVENTS have ~~been made~~ occured in the Anaesthetic field in Australia this year. As you know, the Faculty of Anaesthesia is now in being. Its establishment was approved by the Council of the Royal Australasian College of Surgeons in December last. An interim board has already been formed consisting of 5 members of the Australian Society of Anaesthetists, and 2 from the College.

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Your executive committee at its meeting held in Melbourne in October last elected - Drs. Renton. Travers, Gillespie, Trouth + Daly to represent you on this Board. This Interim Board will function until the first General Meeting of the Faculty which will then elect its own office bearers. You will note that the A.S.A. representation is in the majority, and there is thus no chance of the Anaesthetists being "swamped" by the Surgeons. The A.S.A. representation, moreover, like the Australian Test Team, consist of a majority of Victorians, but in this case, it is a matter of practical politics. The Headquarters of both the A.S.A. and the R.A.C.S. being situated in Melbourne, it enables matters of urgency to be dealt with by people on the spot, and saves so much unsatisfactory paper work.

The Faculty has been formed in an endeavour to raise both the standards of practice, and of the teaching of Anaesthesia in Australia and New Zealand. It must enhance vastly the prestige of the specialty, as does the magnificent new home of the A.S.A. made possible by the great hearted generosity of Geoffrey Kaye. One has become used to the unselfish devotion of Geoffrey to the A.S.A., and to the cause of Anaesthesia in general, but this, his latest munificence beggars description. He has converted the A.S.A. from a body of Members widely scattered throughout Australia, carrying on an existence of Annual Meetings interspersed with spasmodic paper wars, and vainly struggling against the inertia of the various correspondents, into a body with a <u>heart</u>, a fixed centre from

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which its activities can radiate. If I may be permitted an analogy, it converts us into good solid citizens from a collection of vagrant mendicants with no fixed place of abode. Our routine workings will be much simplified, and the possession of such a fine Headquarters - it's like not being possessed by any other branch of the profession, save Surgery and Medicine - must surely help a great deal to enhance our prestige with the profession at large.

The question of prestige was forcibly brought home to me recently, when, in a review of all appointments at the Brisbane Hospital, the highest grading offered in Anaesthesia was that of the lowest grade possible - Junior Grade 11. (* Explain grading system c/f. Public Service. N.H.S.)

Meditating on this amazing example of medieval administration, my thoughts turned first to the Anaesthetist, and then to the conditions under which he works and lives. The main impression which emerges is just how much he is, irrespective of skill, dependent on others, and how vastly his practice differs from those more fortunate brethren practicing amongst their <u>own</u> patients.

The practitioner who becomes an Anaesthetist, knowingly or unknowingly, gives up a great deal to become such. First and foremost he gives up that, to me, most satisfying of all things in medical practice, the confidence and respect of <u>his own patients</u>. He is some mystic figure employed by the Surgeon, only incidental to the general course of the illness, not chosen by the patient and, therefore, not in fact, the personality to him that even his nurse becomes.
The Anaesthetist exchanges the goodwill of a large number of <u>his own</u>

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patients for that of, at most, a handful of Surgeons. He becomes dependent for his livelihood on the patronage of these few people, among whom, alas; inevitably, one finds supreme egotists demanding obeisance from all who surround them. To fall out with one such person is to lose, at least temporarily, up to 25% of his livelihood. Again, he works to satisfy the requirements of the Surgeon - whether or not his work attains the standard which he himself desires is purely incidental, and such things as the impatience of the Surgeon, the occasional sarcastic comment, and not infrequently, the blame for some short-coming of the mighty one, leads to frustration and a sense of unsatisfactory work. I would say that to-day nearly all Surgeons demand the high standard provided by modern methods of Anaesthesia in capable hands, but by no means are all prepared to return adequate recognition.

The Anaesthetist, whilst giving of his best to the patient, but still not always able to please the Surgeon, must indeed have the patience of Job in order to preserve the peace. Why then do people become Anaesthetists - obviously for more reasons than one - but I feel that most have a high sense of satisfaction with the work they are doing. The constant positive help that ~~one~~ THEY gives to patients, and the unconscious satisfaction of keeping human suffering at bay, rewards ~~one~~ THEM for the many unsatisfactory conditions.

The demands on the Anaesthetist are increasing, and they cannot be satisfied without much hard work, thought, application

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and considerable experience. Some Surgeons are aware of this and appreciate the worth of the Anaesthetist, who, by his efforts in the background, unrealised by the patient, ~~have~~ HAS produced the conditions which made HAVE possible the dramatic operations so loved by the [redacted] press, and so valuable to the Surgeon's prestige.

Others accept this help, and take it for granted that any achievement in the operation is theirs alone - whilst a number of ~~old~~ reprobats E are completely indifferent to anything but operating conditions, and are oblivious as to how they are obtained. In passing, it is worthy of note that the Oxford Dictionary defines 'reprobate' as a person cut off by God, hardened in sin, or of abondoned character

Now, what of the patient? The patient submitting to Anaesthesia hands over his life completely to the Anaesthetist, and I consider the activities of this ~~work~~ WORTHY contain more potential for morbidity and death than do those of the Surgeon. Whilst the majority of patients are completely ignorant of the real risks involved, and despite the fact that most of the terrors that an operation holds for a patient are fears of Anaesthesia, ~~engendered by the oft told tales of badly given Anaesthetics~~, they stoically submit to Anaesthesia administered by the veriest junior resident, or even student. It would appear, therefore, that we have a job before us to show the public in every possible way the meaning and worth of an efficient Anaesthetic service, and to create a demand for such a service.

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How is this to be done? It seems to me that there are three main problems. The first is associated primarily with the Surgeons, the second with the patient, and the third with the Hospital I freely confess at the outset that there is nothing new in anything I have to say about these problems. Though most of us are fully aware of them, I feel that our memories need jogging, and we all need a little prodding to spur us on to do ~~the~~ THOSE things which perhaps require that extra bit of effort.

Now for the Surgeon. It seems to me, and this applies to all our problems, that Service is the keystone. We must produce technical skill beyond reproach. As long as the Surgeon cannot complain on this score, recognition must come. I am sure we are gaining ground here, but unfortunately there are still a few sceptics and scoffers, MAINLY amongst the older Surgeons, and these people, sad to relate, wield much influence with Hospital Boards and the like. However, I believe that as the younger Surgeons attain Seniority, the recognition of the art of Anaesthesia will rise with them. This is because they have learnt their Surgery in the modern school which recognises that teamwork will achieve infinitely more than the brilliant individual effort.

We now come to the Patient. I think the vital aspect here is that we should become known to the patient as a person who is rendering him some very special service, the efficiency of which has a very important bearing on his recovery.

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In this regard, I think the pre and post-operative visits are all important. The pre-operative visit is very important from an Anaesthetic point of view, but it is also a very good time to get to know the patient and establish a feeling of friendliness and confidence. The Post-operative visit or visits, however, I consider more important in this regard. It shows the patients that we are interested in them and their illness, and enables them to associate the Anaesthetist with the whole picture of their Recovery, which, of course, is their absorbing interest at the time. To neglect these visits, or to show lack of sympathy or understanding is to ignore something which is vital to our prestige with the public, and we have only ourselves to blame if we are remiss.

With regard to the Hospital administrators, this varies from place to place - some are for us, some against us. In my own State the appointment of two visiting Anaesthetists to the most Junior Grade is considered adequate staff for a Hospital of over 1,000-beds. This, of course, is closely related to the fact that at the Brisbane Hospital, visiting staff are paid and the Honorary system no longer applies.* We must enlist the aid of our allies amongst the Surgeons here. Unless we can convince the administrators that Anaesthetists should have the same opportunities to develop skill and experience as those in other branches of the profession, and thus, like them, have the incentive for research, thereby improving the standards of comfort and safety for the patient, and so to widen the field of attack upon his ills, the Specialty cannot

Quote BAH figures.

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advance. I think too, that we should not divorce ourselves from the rest of Medicine. It is good for us to attend the monthly B. M. A. Meetings and the like, to keep abreast with developments in other branches - this also helps to make us personalities to our colleagues, rather than some outlandish pedlars of dope.

If the solution of these problems lies in the fulfilment of the ideas I have outlined, the Specialty of Anaesthesia will indeed have come of age, and the Anaesthetist must be paid an adult wage, for they cannot live on air, despite their special knowledge of the uses to which gasses may be put. An adequate reward is their due. Much effort will have to be expended in making the Surgeons, the Administrators and patients aware of the skill and time expended to achieve the Anaesthesia which is part of modern Surgery, or good men will not be attracted to the Specialty. Until this is achieved, the patient will not be receiving the just and skilled attention to which he is entitled.

To sum up then, the challenge which we must meet by good public-relations, as well as by the best in medical practice, is greater than that which older and MORE established fields of medical practice are obliged to face. We need more widespread appreciation as well as recognition. More is required than the provision of skilled and safe anaesthesia. It is necessary that both Surgeons and patients are aware of our activities and of the possibilities, if not the eventualities that occur repeatedly without our services.

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There is no place for bad Anaesthesia in Medicine. We cannot achieve advances alone. We must have co-operation from the Surgeons and receive encouragement from the Hospital administrators; we must get our story to the patients, but above all we must strive always for technical improvement and thus advance the Art of Anaesthesia.