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THE GEOFFREY KAYE ORATION

Dr Guy Christie-Taylor presented the Geoffrey Kaye Oration at the ASA National Scientific Congress 2016.

Geoffrey Kaye was "arguably the most influential anaesthetist in Australia."[1] He helped start the Australian Society of Anaesthetists in 1934 and was instrumental in founding the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1952. We could leave the discussion there; but it is far more interesting and compelling to examine why he was the subject of 'wounding remarks', why '49' failed and why he ultimately withdrew from the anaesthetic community? Does an examination of this man and his relationship to the speciality cast some light on the 'culture' of not only our Society but of that of our speciality? Does an examination of our origins, in which he played such a central role, help us to understand our present state and empower us to deal more effectively with our current challenges? What do we mean when we talk of the 'culture' of an organisation, what are the current determinants of our culture, do we grasp the destructive potential of a 'wrong' culture, does leadership determine culture, does 'culture eat strategy for breakfast' and can we fix culture? Does our culture contain the seeds of our own destruction or is it our culture that has, and will continue to sustain us?

Well, let us begin our cultural and historical journey at two addresses in Melbourne.

The first is 161 Drummond Street Carlton, a home that sold for $960,000 in 2007.

The home was inhabited in the late 1800s by David Adam Brown and his Australian born wife, Mary Elizabeth (Smyth) who were married in the Clarendon Street Presbyterian Church in South Melbourne on April 7th 1893.

Of note is that just two years prior to this in May of 1891 a young man of 32 died during chloroform administration at the Melbourne Hospital. This was the precursor to the Royal Melbourne Hospital and was located at that time in a 10-bed, two-storey cottage on the corner of Lonsdale and Swanston Streets. At inquest, the City Coroner declared that an expert should supervise chloroform administration. "It appeared to him, that cases of death under chloroform occurred far too frequently at the Melbourne Hospital. Students were allowed to give chloroform without any supervision. The wonder was not that deaths should occasionally occur, but that they did not happen more frequently.[5]

It is of note as well that in 1891 the inevitable happened: a spectacular crash brought the boom in Melbourne to an abrupt end. Banks and other businesses failed in large numbers, thousands of

shareholders lost their money, tens of thousands of workers were put out of work. Although there are no reliable statistics, there was probably 20% unemployment in Melbourne throughout the 1890s.

Melbourne had 490,000 people in 1890, and this figure scarcely changed for the next 15 years as a result of the crash and subsequent long slump. Immigration dried up and emigration to the goldfields of Western Australia and South Africa began.

The moderate recession began in 1890, there was a brief recovery in 1891, but a full-blown depression from 1892.

David Brown counted as a good friend a certain James Christie, also resident in Carlton.

So apart from being good friends and residing in the same neighbourhood what did these two men have in common?

Well they are my great-grandfathers. Which might come as a bit of a surprise when considering my accent. So what am I: a Scottish, Presbyterian, Victorian or an Anglican, South African, South Australian or maybe just a mixed up blend of all those cultural elements? What I would ask you, are the determinants of your particular 'cultural make up', what is it that determines the values and beliefs that define you?

But let us shift to a posher part of town: 49 Mathoura Road Toorak Gardens. Otherwise known as 'Beswicke'. The home was built in 1888 by renowned architect John Beswicke and has been meticulously restored within its original footprint. The home sold in 2012 for $5,220,000

Geoffrey Kaye inhabited the home in 1951 and tragically this home could have been ours – all of ours! This was for a while the headquarters of the ASA. It could have been our 'Ulimaroa'.

So what exactly happened at 49 Mathoura Road and was Geoffrey Kaye's '49' an early example of a failed attempt at 'culture change'?

Anaesthesia's recognition as a specialty was at the heart of '49'.[2] Kaye hoped his work "increased (the) status of anaesthetists and promoted acceptance of anaesthetics as a specialty" – one characterised by "departments of anaesthesia distinct from surgery, with salaried university faculty conducting clinical research at affiliated hospitals".

Kaye hoped that Australian anesthesia would gain international prominence by incorporating the elements of clinical anesthesia practiced in the United Kingdom and the anesthesia research seen in the United States.

One of Kaye's long-time goals was to build a great 'diffusion centre' of scientific and technical information for the Australian Society of Anaesthetists. This centre would house a library, museum, meeting spaces, apparatus, a journal of the highest calibre and machinery and laboratory facilities. In 1951, when plans for the Faculty of Anaesthetists were approved, Kaye established the Society's 'centre of excellence' at 49 Mathoura Road, Toorak, Melbourne.

The ASA however likely viewed the centre as a 'stable place for its records, secretariat, its museum and its library' and by 1955 the promise of '49' had failed. The mutual misunderstanding of the goals of '49' may be partly explained by the ASA's failure to state its intent for the centre at the outset.[2] The argument has been put that the ASA was too small and only 5years removed from its 'rebirth after the war' to sustain Kaye's grand vision for the centre. This was a period of transition for the burgeoning specialty, with few 'qualified members' and "only the early beginnings of salaried Services and Departments."

Kaye blamed the failure of '49' on a lack of support from the ASA[2] and its membership. Kaye's attitude was one that the work required to maintain the centre and fulfil its mandate should have been done as a matter of obligation, interest and pride, by members of the Society. It may well be that he failed to understand the situation of the ordinary anaesthetist. Practising physicians in difficult economic times were trying 'to make their way in a new environment, with young families to support'. And I might add were more likely to be inhabiting the likes of 161 Drummond Street than Mathoura Road?

He wrote in exasperation: "How does one get members of a Society to WORK? We have given 'em every amenity, but all they want is a monthly meeting – if someone else gets it up for them! The older men are tired, tied and over-taxed: the younger men are cynical and their attitude is summed up by the naval adage, 'Blast you, Jack; I'm on the raft!' Till they work for their Society, they won't really value it – and how does one induce 'em to begin working?"[3]

He went on to lament: "The Australian Society reminds me very much of what I saw at Petra, viz. a stupendous facade with nothing very much behind it."

Members showed '49' to visitors, but did not use it. Members attended regular meetings at the facility, but only if others managed the logistics. Members were not interested in "making use of the darkroom or workshop, or assisting in the duplication and distribution of the newsletter, or keeping the grounds in order, nothing could be further from their thoughts."

He went on: "The whole show ['49'] is thrown back upon individuals, and mighty few of them at that. For this lamentable state of things, I do not blame entirely apathy in our members: it is all part of what one might call 'the tyranny of the Private Case.' Our fellows live by private practice, and they dare not miss a case, lest they forfeit their surgeon's goodwill and patronage for the future. Hence, the most sacred obligations are at the mercy of the surgeon's telephone calls. One can see the hopes of better times only in some form of national medical service, which by relieving anaesthetists from economic insecurity, might set them free to follow

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their own bent on occasions. Such a service could easily be brought in, in this country, by a turn of the political wheel.[3]

"If I like to cut the lawns, or paint the fences, or fold the newsletters into an envelope, that's OK: it's my 'hobby,' but they have no obligation to help in it! In consequence, I have had to point out to my Committee, that '49' is not serving the purpose for which I designed and equipped it.

"I was amusingly naïve to suppose that, if one gave chaps facilities, they'd want to make use of them. My American friends warned me of what might happen, but I wouldn't listen. They can chant in unison, like so many black crows, those blessed words, 'We told you so!' The joke is on me."[3]

Kaye noted that Macintosh, at the opening ceremony for '49,' predicted its failure to Kaye's sister because the anaesthetists were not behind it. In the same letter, Kaye in part blames his anaesthetist colleagues, declaring, "Certainly, those who entered the specialty at the end of the war were a pedestrian lot, looking for an easier life than in other forms of medical practice…"

Although Kaye did express some level of understanding about the plight of the practicing anaesthetist, we do not know if that translated into actions consistent with that understanding. Further, even if Kaye was wholly sympathetic with their troubles, the perception that he was not sympathetic contributed to the failure of '49.'

Kaye's faults can in part be attributed to his deep and binding love of what '49' could have meant to the Australian anaesthesia community. Kaye felt that he was "gambling in 'anaesthesia futures' for heavy stakes." Kaye took the failure as a personal one, and he withdrew from the anaesthesia community.[3]

In fact, Kaye carried the anger for many years. In correspondence in 1981, Wilson suggested that Kaye took it too personally. Kaye objected "By thunder it was, and not without reason."[3]

In the same 1981 letter, Kaye recounts decades-old slights. "I was the subject of wounding remarks in those years. One was an accusation of 'election-rigging'." "Another accusation that hurt was that I was trying to 'make myself the director of the ASA'." Indeed, Kaye recounts the comment from the Society's president that '49' was ""my hobby, as his was gardening'." Kaye also noted, "The nub lies in your remark about personalization, if we may use a noun so barbaric. Had the ASA of 1950–1955 been made-up of Dalys or McCauls, the scheme would have worked."

We do not know if the idea of '49' had an effect on the subsequent success of Australian anaesthesia. Wilson seems to think so, writing in a letter to Kaye that "…the failure of the project had an effect of cementing the society." Or perhaps its most enduring legacy is the estrangement of Kaye. We can only speculate how that may have helped or hindered the development of anaesthesia in Australia.[3]

Walter Mushin writing in an essay on anaesthesia's history states: "It is not enough to rake over the ashes of the past, or to examine in ever-increasing detail the lives of our pioneers unless we can extract from the process a greater understanding of our present-day problems and so a greater likelihood of solving them.

"Between the two world wars interest in anaesthesia was confined to a mere handful of men who had to stand up to what almost amounted to the contempt of their colleagues, because it was still widely held everywhere in Europe and the United States that anaesthesia was an occupation that hardly demanded a medical education."

We owe a debt of gratitude to Rupert Hornabrook who had the courage (sense, gumption, gall, insight?) to write in the AMJ in 1914: "Some of the difficulties the anaesthetist has to contend against… One of the greatest difficulties the teacher has to contend with is the inborn idea that any fool can administer an anaesthetic." He related the remark of a senior Melbourne surgeon that "a dray- man could administer chloroform."[4]

In 1927, a senior surgeon at the Alfred hospital told Geoffrey Kaye, when contemplating a career in anaesthesia, "Why waste your opportunities". Kaye recalled that anaesthetics was poorly regarded as a specialty, the province of the physically handicapped or those who had failed in other branches of medicine. The surgeons of the day found that the best anaesthetists were the medical orderlies of the 1914 War, "because those blokes did as they were told".

The first years of the Society were difficult times. Non-anaesthetists did not appreciate the necessity of a separate society; the BMA did not take kindly to the establishment of a group 'in opposition' to the State Sections of Anaesthetics; the members of the Executive were idealistic in their expectations of the Society; and the general members struggled to make a living. Nevertheless, Kaye's dogged efforts as secretary ensured that the Society survived.[1]

So might we attribute this outcome to Kaye's failure to grasp the prevailing 'organisational culture' of the early emerging specialty? Is the 'organisational culture' different today; do we even have a grasp of what our 'culture' might be? What exactly do we mean or understand about organisational culture?

'All eyes are on culture as the cause and the cure.'[6]

'Bullying is endemic in surgery; common in training and the surgical workplace; and central to the culture of surgery.'[7] This powerful generalisation about the 'culture' of surgery is made by the Expert Advisory Group on discrimination, bullying and sexual harassment advising the Royal Australasian College of Surgeons (RACS), in its report to RACS.[7]

RACS has therefore logically committed itself to working to make changes in three key areas; the first of which is 'Cultural change and leadership'.[8]

The report[7] also made reference to a 'Culture of fear and reprisal' and made it clear that it's authors support the notion put forward by Major General David Morrison to his personnel that "everyone is responsible for culture."

It is somewhat ironic that a culture of competition and perfection could have given rise to a culture of 'bullying'.[7]

So where else has 'culture' been invoked as the cause of harm and chaos? Was it a culture of 'every dollar counts' at BP that lead to the Deepwater Horizon disaster[9] and the US's worst ever oil spill, or 'lapses in character and culture' that lead to the 2014 Veterans Administration scandal in which clinical delays were alleged to have caused scores of deaths as well as the 2008 Mid-Staffordshire scandal which showed pervasive clinical lapses and gaming of the system to meet targets[10], or was it a 'club culture' as described in the Kennedy Report[11] that lead to the Bristol Children's Heart Surgery scandal, or was our Prime Minister correct to invoke 'big cultural issues' as being central to the recent behaviour of the banks in which ''Some, regrettably, as we know have taken advantage of fellow Australians and the savings they've spent a lifetime accumulating"?[12]

So if the above examples are true then it seems reasonable that the Australian Institute of Company Directors should intend over 2016 to focus on boardroom culture by continuing to work with governance leaders to "drive performance through culture." The AICD continues to believe that directors creating and nurturing the 'right culture' or setting the right tone from the top are crucial to organisations success.[13]

Greg Medcraft, Chairman of the Australian Securities and Investment Commission upped the ante recently when he issued a veiled threat that the watchdog might move to extend the laws to enforce corporate culture if certain companies fail to lift their standards.[14]

As far back as 1997, an issue of Quality in Health Care was devoted to considerations of organisational change in health care calling it the 'key to quality improvement.' In discussing how such change can be managed one of the authors asserted that 'cultural change' needs to be wrought alongside structural reorganisation and systems reforms to bring about ' a culture in which excellence can flourish.'[15]

The Labour Government elected in 1997 in the UK made quality the central reform issue in the NHS.[15] Its strategy aimed to:

- Define appropriate quality standards
- Deliver health care congruent with those standards
- Monitor to ensure that uniformly high quality of care is achieved.

It was in the delivery of health care that a consideration of organisational culture was seen as having the most to offer.

In articulating the strategy needed to deliver this new care official documents stressed the interlinking of three different strands: clinical governance, life-long learning, and professional self-regulation. Underpinning and binding each of these was the notion of 'cultural transformation as a primary driver to deliver improved quality of care.' Specifically "Achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally."[15]

Some of the desired 'cultural changes' are listed below:[15]

	Vision for the NHS, mid 1980s to mid 1990s (General Management and The Internal Market)	*Vision for Labour's "New NHS", late 1990s (The Third Way)*
Macro/system level factors		
Basis of economic relationships:	Competition (contracts)	Cooperation/partnership (long term service agreements
Governance:	Market discipline	"Third Way"
Key objectives:	Efficiency	Efficiency/equity/quality
Rate of change:	"Big bang"	Evolutionary
Locus of change	Top down	"Everyone's business"
Flows of information:	Confidential/commercially sensitive	Open/transparent
Basis of performance assessment:	Finance/activity/volume	"Balanced scorecard"
Micro/clinician level factors		
Basis of practice:	Professional judgement	Evidence based
Basis of control:	Mutuality trust	Audit, external verification
Clinical performance information:	Confidential	Publicly available
Participation in audit (e.g. confidential enquiries	Discretionary	Mandatory
Accountability:	Largely opaque (professional self-regulation)	Transparent: corporate and clinical governance
Public confidence:	High	Diminished
Continuing professional development:	Discretionary	Mandatory
Ethical basis:	Hippocratic oath/patient first	Corporate objectives

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Old expectations	*New expectations*
Physician responsible only for individual patient	Physician responsible for individual patient and populations of patients
Individual clinical responsibility for patient	Team or group, and patient, responsibility
Credibility and trust largely based on professional mystique and prestige	Credibility and trust based on data and documented evidence of effective practice
Profession determines performance and accountability criteria	Profession and others (governments, purchasers, public, community groups etc) determine performance and accountability criteria
Physician accountable to patients and the profession	Physician also accountable to health care organisation and external groups
Organisations exist to serve individual physician's interests	Organisations exist to serve patient, community and physician interests

And accompanying this was a desire for a 'new moral fabric' (see table above).[15]

An examination of the above tables might well give the reader pause for thought as one recognises how many of these changes have come to profoundly impact our current practice and it might be useful to acknowledge where they had their origin?!

If culture is such an apparent key ingredient for success (or for failure!) are we able to define it? Is there a clear definition of organisational culture?

It is interesting to note the comments made by John Traphagan in his recent article in the Harvard Business Review (HBR) entitled 'Why Company Culture is a Misleading term':[16]

"Today, the idea that organizations have cultures is rarely questioned by the media, by corporate executives, or by the consultants who make a living helping organizations improve their 'cultures.' Organizational culture is assumed to be important to making sure that employees are happy and productivity is good. At the same time, the concept, meaning, and function of culture rarely garners much thought. When I ask business people to define culture – or even when I ask students in my class on organizational culture to do so – it turns out to be difficult. I either get a simple definition, such as 'the values of a group' or I get 'interesting question' and something of a blank look as a response. The problem here is that while we use the term 'culture' constantly, most of us give very little thought to what that term means and how its use influences behavior and thought within organizations."

He goes on in more detail to explain: "In fact, anthropologists – the group of academics who first used the term in an analytical sense – have never really agreed on what exactly culture means. In the 19th century, E. B. Tylor defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society." Most of the definitions of culture used in books about organisational culture and values follow the Tylorian definition. Culture is the values, practices, beliefs, etc. of a group of people. In other words, culture is everything; which basically means it's nothing from an analytical perspective. The only really useful aspect of this definition is that culture involves groups (society) and that those groups share something. Otherwise, it's pretty vague."[16]

In a paper in the HBR[17] in May 2013 Michael Watkins wrote: "If you want to provoke a vigorous debate, start a conversation on organizational culture. While there is universal agreement that 1 it exists, and 2 that it plays a crucial role in shaping behavior in organizations, there is little consensus on what organizational culture actually is, never mind how it influences behavior and whether it is something leaders can change."

This is a problem, he goes on to argue, "because without a reasonable definition (or definitions) of culture, we cannot hope to understand its connections to other key elements of the organization, such as structure and incentive systems. Nor can we develop good approaches to analyzing, preserving and transforming cultures. If we can define what organizational culture is, it gives us a handle on how to diagnose problems and even to design and develop better cultures."

In his paper he distilled the feedback he received to the following potential definitions or conceptualisations of culture:

Culture is how organisations do things, in large part; culture is a product of compensation; organisational culture defines a jointly shared description of an organisation from within; organisational culture is the sum of values and rituals which serve as 'glue' to integrate the members of the organisation; organisational culture is civilisation in the workplace; culture is the organisation's immune system; organisational culture [is shaped by] the main culture of the society we live in, albeit with greater emphasis on particular parts of it; it over simplifies the situation in large organisations to assume there is only one culture… and it's risky for new leaders to ignore the sub-cultures; an organisation [is] a living culture… that can adapt to the reality as fast as possible.[17]

At the core of a modernist approach is the view that organisational phenomena (including cultures, structures and performance) are concrete entities, which can be systematically described and

explained. If, as this approach suggests, culture is something that an organisation has, then it may be possible to create, change and manage culture in the pursuit of wider organisational objectives. It is clear looking at the examples sited above and in reading the management literature that this is all based on the (possibly false?) assumption that cultures are an attribute of an organisation and are open to manipulation.

A post-modern perspective on organisational culture would not focus on culture as a means of control. It would instead encourage dialogue on the nature and course of change amongst stakeholders, particularly those who have traditionally been disenfranchised or marginalised from such discussions.[15]

A recent discussion in the HBR written by Jay Lorsch and Emily McTague[6] suggests that there is an emerging opinion, particularly amongst CEOs who have lead major transformations within their organisations that culture in not something that you fix. Rather, in their experience cultural change is what you get after you've put new processes or structures in place to tackle tough business challenges like reworking an outdated strategy or business model. They all show in a range of settings that culture isn't a final destination but that it morphs right along with the company's competitive environment and objectives.

John Traphagan[16] suggests:

"The problem with the term 'culture' is that it tends to essentialize groups: it simplistically represents a particular group of people as a unified whole that share simple common values, ideas, practices, and beliefs. But the fact is, such groups really don't exist. Within any group characterized as having a culture, there are numerous contested opinions, beliefs, and behaviors. People may align themselves to behave in a way that seems as though they buy into expressed corporate values and 'culture,' but this is just as likely to be a product of self-preservation as it is of actually believing in those values or identifying with some sloganized organizational culture.

And he goes on:

"So I think we need to stop using the term 'culture' to talk about what's going on in our organizations. By using the culture concept, we tend to artificially ossify the diverse, complex, and constantly changing social environment that is any organization. As a result, it becomes easy to misinterpret or misunderstand the nature and influence of power, conflict, cooperation, and change in relation to both individual and group behaviors. Corporations and other organizations do not have cultures; they have philosophies and ideologies that form a process in which there is a constant discourse about the nature and expression of values, beliefs, practices, ideas, and goals. This discourse happens in sales meetings, interactions with customers, board meetings, and in conversations around the water cooler. It's a constantly moving target."[16]

If defining and understanding our conceptualization of organizational culture is hard enough then it is even more sobering to consider how complex the problem in health is when you attempt to explain the NHS (or our own health system!) with a simple sketch (see next page).[18]

From the above it can be readily appreciated that the culture within an organisation may be far from uniform or coherent and that looking for commonality might be less rewarding than an examination of differences. Some cultural attributes may be seen across an organisation others may be prominent only in some sections of that organisation. Thus different cultures may emerge within different occupational or professional groups. Hence we have the emergence of subcultures. Some of these might be malleable and others resistant-giving rise to the so-called 'counter culture'.[15]

Organisations receive many cultural influences from outside the organisation and these influences may be at odds with the internal culture.

For all the influence in defining and assessing organisational cultures the crucial generic question of whether and how organisational culture impacts on organisational success operformance remain empirically, poorly explored.[15]

A simple causal relationship between cultural characteristics and success has not yet been demonstrated-unsurprisingly; any relationship is highly contingent on definitions of success and a wide range of other internal and external factors. Such evidence as exists is equivocal at best.

In the concluding remarks to their paper[15] Hu Davies et al say: "In the UK the Governments quality strategy emphasizes the importance of cultural transformation. If such an approach is to bear fruit a number of assumptions that are implicit in the approach must be verified as having some substance. Firstly there must be such a thing as organizational culture; secondly, the nature of this culture must have some bearing on clinical performance and health care quality; thirdly it should be possible to identify particular cultural attributes that are facilitative of performance and finally there must be some hope that interventions and management strategies can have a predictable impact on cultural attributes as a precursor to bringing about performance improvements."

At the very least this paper[15] demonstrates that these assumptions are far from trivial or self-evident. Indeed empirical thinking illuminates contention rather than consensus.

This in turn suggests that a more sober assessment of the task of cultural transformation in health care is warranted.[15]

We see emerging in our healthcare environment a number of 'cultures', which

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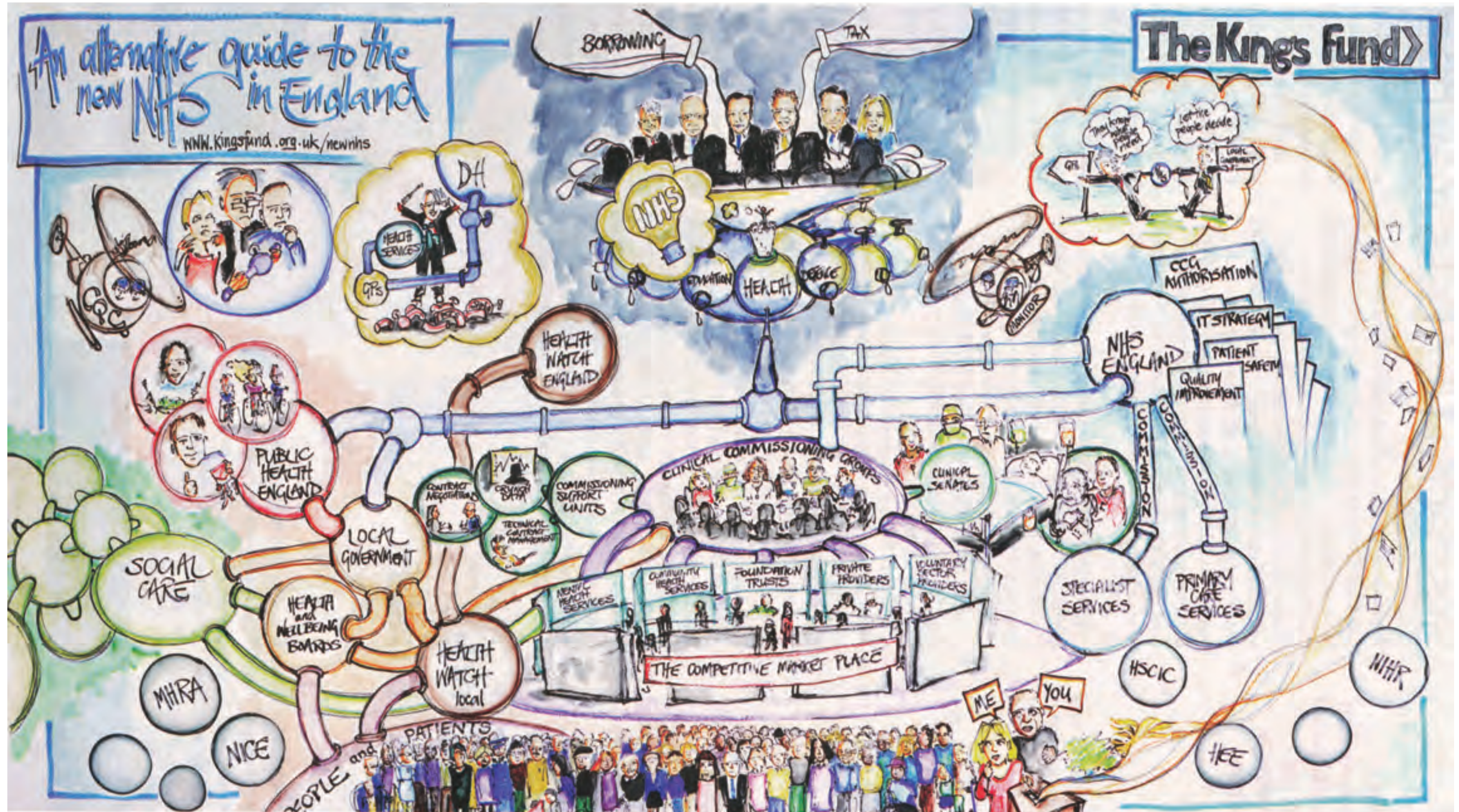

Image courtesy of The King's Fund, London. http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

have an impact on how we deliver care.

Medical Taylorism: advocates of this, lecture clinicians about Toyota's 'Lean' practices arguing that patient care should follow standardised systems like those deployed in manufacturing automobiles. The Electronic Health Record has become a key instrument for measuring the duration and standardising the content of patient-doctor interactions in pursuit of the 'one best way'. The authors of a critique of Taylorism[19] believe that the standardisation integral to Taylorism or the Toyota manufacturing process cannot be applied to many vital aspect of medicine. Arguing that if patients were cars we would all be used care of different years and models with different and often multiple problems many of which had previously been repaired by various mechanics. Moreover those cars would all communicate in different languages and express individual preferences regarding when how and even whether they wanted to be fixed. The inescapable truth of medicine is that patients are genetically, physiologically, psychologically and culturally diverse.

Instead of gaining happiness minutes clinicians are increasingly experiencing dissatisfaction and burnout as they're subjected to the time pressures of Taylorism and scientific management in the name of efficiency.

Michael Porter's 'Value' culture[20]: the underlying notion here is that healthcare is shifting focus from the volume of services delivered to the value created for patients with 'value' defined as the outcomes achieved relative to the costs. The argument goes that providers, payers, patient advocacy groups and regulators can come together to create a process to agree on a minimum sufficient set of outcomes for each important medical condition.

Choosing wisely culture[21]: perhaps the most visible effort so far to reduce inappropriate use of medical treatments and tests has been the Choosing Wisely campaign. In this campaign medical societies have identified tests, medications and treatments that are used inappropriately. The success of such efforts however may be limited by the tendency of human beings to overestimate the effects of their actions.

Choosing Wisely may be an ambitious attempt to address the problem of overtreatment but its not realistic to think that any single solution will be effective.

The Choosing Wisely Campaign has recently begun to be addressed by the College via the Safety and Quality Committee and in a recent email seeking

Fellows input the aim of the campaign was described as "to promote a culture where inappropriate clinical interventions are avoided. Improved care is the core objective and each recommendation should be evidence-based."

A patient-centred care culture: is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of patient centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care. Surveys measuring patients' experience of health care are typically based on these domains.

The phrase 'nothing about me without me'[22] was their guiding principle; this phrase has since been popularised by authors and regulators and is considered synonymous with efforts to advance a vision for patient-centred care.

There is an attempt to foster the notion that the medical specialists have a common 'culture of greed' and that the sustainability of healthcare in Australia is under threat as a result of this.[24] This culture manifests itself in unreasonable out of pocket expenses for the patient and 'bill shock'. Offering to change this culture are the private health insurers who seek to increase their stake in the provision of healthcare claiming that they are able to make savings of $100 billion over 10 years with no change in standard of care.[23] The profession is under a constant barrage of negative press with no apparent end in sight as the culture of the Medicare Rebate Freeze continues.

RACS's idea of 'Building a culture of respect and collaboration in surgical practice and education'[25]. This is one of the cornerstones of the RACS action plan to address DBSH in their profession. It is a very powerful example of an organisation that embraces the idea of culture as an item that is possessed and can be altered to achieve an outcome. As anaesthetists we are at risk of harm from the culture of bullying that appears endemic to surgery and nursing.

A culture of submerging or hiding the truth that trade offs between quality and cost are embedded in budget constraints[10]: this is one of the most destructive and I would argue most pervasive and prevalent cultures to which we are subjected. In discussing the crisis in the VA in 2014 the prevailing narrative was one of breakdowns of character and culture: dishonesty, callousness and ineptitude. In the same way the Mid-Staffordshire scandal resulted in politicians blaming individual perpetrators and one another and the prevailing narrative highlighted lapses of character and culture.

However, closer scrutiny reveals another parallel with important implications for cost control efforts. In both cases performance standards often proved incompatible with resource constraints. Yet the gap between the two remained unmentionable amid pressure to make care both better and cheaper. Outbreaks of dishonesty resulted as personnel tried to finesse failures with fakery. The fakery was discovered and the perpetrators were punished. But the truth that trade-offs between quality and cost were embedded in budget constraints remained submerged.

We need to dispel the myth that we can control costs without forgoing therapeutic benefit. Mounting evidence to the contrary is belying this myth.

Open discussion of how to make real cost-quality trade offs is essential to stopping the progression from impossibility to the breakdown of professionalism and compassion – a progression that leads to scandal.

So how are we to respond to the many cultural challenges above and the challenge of 'culture' as either an attribute that we have or the sum of what we are?

Recognising that there is more to 'organisational culture' than we might have realised and being able to identify where 'culture' and 'cultural change' might be being used to manipulate us are a good first step.

Taking time to ponder (reflect?) what our key assumptions or 'taken for granted' views of the world are and how they are being altered and challenged is insightful. Re-stating and articulating the values that form the basic foundation for our making judgements and distinguishing right from wrong behavior is a crucial and ongoing process and examining the 'artefacts' that are the physical and behavioural manifestations of our 'culture' gives us useful clues as to how we are adapting and evolving.

To try and centre our own thinking it might be useful to re-visit the World Medical Association Declaration of Geneva:

At the time of being admitted as a member of the medical profession:

I SOLEMNLY PLEDGE
to consecrate my life to the service of humanity.

I WILL GIVE
to my teachers the respect and gratitude that is their due.

THE HEALTH OF MY PATIENT
will be my first consideration.

I WILL RESPECT
the secrets that are confided in me, even after the patient has died.

I WILL MAINTAIN
by all the means in my power, the honour and the noble traditions of the medical profession.

MY COLLEAGUES
will be my sisters and brothers

I WILL NOT PERMIT
considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any

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other factor to intervene between my duty and my patient.

I WILL MAINTAIN
the utmost respect for human life.

I WILL NOT USE
my medical knowledge to violate human rights and civil liberties even under threat.

I MAKE THESE PROMISES
solemnly, freely and upon my honour.

It is also in our associating via the mechanisms of our Society that we gain strength.

And it is a powerful encouragement to consider the words of Alexis DeTocqueville in his 'Democracy in America': "But what political power would ever be in a state to suffice for the innumerable multitude of small undertakings that American citizens execute with the aid of associations?

"The morality and intelligence of a democratic people would risk no fewer dangers than its business and its industry if the government came to take the place of associations everywhere.

"Sentiments and ideas renew themselves, the heart is enlarged and the human mind is developed only by the reciprocal action of men upon one another."

The challenge for us as a specialty is to determine whether we 'buy in' to the notion of culture as something we own or can identify and hence manipulate. If we do then we need to decide what particular 'cultural characteristics' we most espouse to have; say for example a 'culture of safety and quality' or a 'culture of patient-centredness' and then we need to identify what tools or processes we have at our disposal to achieve the desired 'culture'.

What we cannot do is fall into the category of 'risk-averse' culture (HBR May 2016)[26], which is likely to be an obstacle to innovation.

"The best and hardest work," according to Pixar's President, Ed Catmull, "is done in the spirit of adventure and challenge.. mistakes will be made." We need to regards mistakes not as a necessary evil but as the inevitable consequence of doing something new and we need to rigorously extract value from failure.

As I final word I would ask you to consider the words of Dr Harold Griffiths written in tribute to Dr F.H. McMehan: It is worth briefly contemplating the profound impact that McMehan had on Geoffrey Kaye. It was largely at the urging of McMehan that Kaye embarked on the many activities that he did. "Friendliness was the keynote of all his activities. He built up the foundation of cooperation, enthusiasm and friendship, which is present more strongly in the specialty of anesthesiology than in any other medical group."

Maybe in all of the complexity and challenge of our professional world we should foster a simple 'culture of friendliness and cooperation'?

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