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The Geoffrey Kaye Oration

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President of the Australian Society of Anaesthetists, 1995-1996

The opportunity to deliver the Fifth Geoffrey Kaye Oration is accompanied by many emotions, not the least being an awareness that the official duties of the President have finally come to an end, even if only to be replaced by more of the same under another title.

The privilege of this occasion is heightened by my knowledge of the professional lives and contributions of those who have gone before us, those who established the fledgling specialty of anaesthesia, and laid the foundations of the precise discipline to which we now belong. One of those founders was Geoffrey Kaye.

On Wednesday, October 16, 1929, Dr Francis H. McMechan, a distinguished pioneer of American anaesthesia, delivered the following words in the Bullfinch Amphitheater of the Massachusetts General Hospital, Boston:

"The world has many feasts and holidays, but among them there is none that approaches in interest or importance the one which we celebrate today, and in commemorating 'Ether Day' we look back upon that momentous occasion which initiated the era of painless surgery, and we try to pay our respects and show our appreciation of Morton, the genius, who in this very amphitheater, 83 years ago, for the first time, publicly and successfully demonstrated the possibility and value of etherization.

"It is easy enough to conceive a new idea in the study, and work out its details in the laboratory, but to demonstrate its utility to a doubting public and a skeptical profession is quite another matter. Yet that is what Morton did and we cannot but admire him for his accomplishment, because in so doing he gave that gift of gifts—painless surgery—to suffering humanity, which had been awaiting this beneficence for untold ages and generations."

With these carefully chosen and measured words, Dr McMechan presented a bronze bust of William Thomas Green Morton to the Trustees of the Massachusetts General Hospital from the Associated Anesthetists of the United States and Canada and the International Anesthesia Research Society, as a token of their esteem for the part which the hospital played in the development of painless surgery.

McMechan continued:

"In his day, Morton flung us a torch, lit with the fire of his vision and burning with the inspiration of his ideals! In full confidence, ... this torch—the heritage of future generations of anaesthetists—was caught and has been carried by them proudly and with a full measure of achievement. Anesthetists were not long in learning the lesson that for anesthesia to achieve its full purposes, its organization must of necessity become world wide in scope and results."

Dr McMechan's style of writing and presentation owes a deal to his early training and innate ability in public oratory and essay writing, but it was his early choice of anaesthetics as a career in 1903, which paved the way for his special contribution to the fledgling specialty of American anaesthesia, and, serendipitously, to the formation of the Australian Society of Anaesthetists.

Despite his progressive severe incapacity from rheumatoid arthritis, McMechan attended the 1929 Australasian Medical Congress of the British Medical Association, held in the Great Hall and adjacent buildings of the University of Sydney, where, for the first time, a Section of Anaesthetics was included in the Congress. The young Geoffrey Kaye, at 26, was asked to prepare and read a paper for Dr Frederick Green, one of his Melbourne mentors and fellow founders of the Society. This paper brought him to the attention of McMechan, who ultimately facilitated his travels to North America where the foundations of Kaye's commitment to his life's work were laid.

The biographical details of Geoffrey Kaye's life and career have been covered exhaustively by previous ASA Presidents in this Oration, and I don't intend to add anything to that aspect of our history.

However, the life and style of Geoffrey Kaye provides an inspiration for a detailed examination of the situation in which our speciality finds itself today.

I am indebted to Dr Gwen Wilson, the Honorary Archivist of the Australian Society of Anaesthetists, for the opportunity to examine correspondence between Geoffrey Kaye and Ralph M. Waters. Geoffrey Kaye's letters display the considerable charm and wit of a man of learning and depth of culture, but of a retiring, even shy, nature who was well-known to only a handful of correspondents. The exchange of views between these two men took place from 1930 until 1976, when the last shaky script from Ralph Waters, penned on an aerogramme post-marked Orlando Florida, found its way to Melbourne, and ultimately, into the ASA archives. It has been a great privilege to have had access to these personal letters.

We must be grateful for those who are now preserving these priceless memories in our archives for the benefit of future generations. Documenting our history has been carried out by Gwen Wilson—*50 Years*, *The History of the Australian Society of Anaesthetists, 1934-1984*, and *One Grand Chain, The History of Anaesthesia in Australia, Volume 1, 1846-1934*. We eagerly await completion of Volume 2 of this splendid work about our heritage.

It is my intention to highlight several aspects of our lives as doctors, and, in particular, as anaesthetists. There is little doubt that, despite the assurance of popular opinion polls that attest to our pre-eminence in public esteem, our medical profession is not always well regarded by its potential consumers, customers, clients, or even, patients, and certainly rarely by our would-be political masters. In an era where cost-containment is the only catchphrase, quality of care may be seen to take second place. We have allowed this to happen by our reluctance to take charge of our destiny, and to promote convincingly the importance of what we do.

Almost since the beginnings of our specialty, spawned as it was as a task relegated to the assistant of the omnipotent surgeon, and always subordinate to him and his instructions, anaesthetists have been struggling to promote their own relevance and importance. The discarding of the mantle of the "unseen specialist" has been the ultimate goal, but more often than not, the public perception of anaesthetists is that they are not even doctors. A survey of visitors to an ASA-staffed exhibit at a large health industry exhibition in Sydney two years ago, revealed that 30% of those surveyed did not know we were medical graduates, let alone specialists who had completed up to 14 years of training since entering medical school.

The Editorial from the February 1996 edition of Anaesthesia stated :

"It is probably true to say that anaesthetists still suffer to some degree from an inferiority complex ... This is evidenced by the number of papers and ... letters in this journal commenting on the status of the anaesthetist ..."

Where does the fault for this perception lie? Who knows, but the remedy for it is most definitely in our hands, if only we care enough to apply it.

In 1995, the Australian Society of Anaesthetists resolved to embark on a major public relations exercise, under the Chairmanship and enthusiastic guidance of Dr John Matheson, the Immediate Past Chairman of the N.S.W. Section of the ASA. A firm of consultants was retained to unravel the problems that beset our specialty's public face, and to explore and promote means of addressing them. A particular result is that the process has produced as many questions as it has answered. The process continues, regrettably without the attention of John Matheson, whose recent sudden and untimely death robbed our specialty of a man of commitment and vision.

Additionally, we face prejudices from within. Within our specialty and within the medical profession in general.

One hundred years ago, the role of the anaesthetist was relegated to medical student or surgical dresser, who had the choice of only ether or chloroform to render the patient oblivious. From this, anaesthesia has evolved into a discipline whose skills and knowledge have permeated every other form of medicine.

Still, there are those in our ranks who have accepted a demeaned place in the patient care team, choosing to settle into as much clinical anonymity as is compatible with basic anaesthetic safety.

Despite the enormous advances in clinical and academic anaesthesia over the past twenty years, such that anaesthesia is now virtually a new specialty, old habits and misconceptions among other disciplines die hard. The much quoted "avoid hypoxia and hypotension" of the physician consulted by the surgeon to arbitrate on fitness for anaesthesia, is alive and kicking. And 'requests' by surgeons for particular forms of anaesthesia management still abound.

Recently, in a letter to the Editor of the Sydney Morning Herald, a professor of surgery stated:

"The surgeon does a full 'work-up' on a patient, communicates with the general practitioner, performs the operation, writes an operation report, sees the patient in hospital daily after surgery, telephones the relatives of the patient, communicates with the

GP (again!) and arranges a follow-up regimen for the patient. He/she maintains one or two 'rooms' with receptionists, sometimes nurses, and may write up to 100 letters per week.

"The anaesthetist briefly reviews the patient in the preoperative period, usually for about five minutes, unless the patient has specific risk factors (relatively rare), and gives the anaesthetic. For most anaesthetists there is no further patient contact."

While we might not agree with this comparative job description, there is no doubt that there are grains of truth in it. Does any one of us see himself/herself in this description? Are we behaving like consultants or subservient technicians of the surgeons?

We accepted a demeaned status when our craft was still very much an "art", but now that it is scientifically based, we must improve our game. We will do it only if we begin to accept that we are no longer itinerant "gassers", but applied physiologists whose every patient is in a life-or-death situation.

But the process of change must begin long before the operating room, and it begins with the training of anaesthetists themselves. Anaesthetists need to realise that they are doctors, that they must look like doctors, and they must behave like doctors. Is it really necessary, in 1996, to have to decry the casual appearance of a specialist anaesthetist in casual clothes and other garb more suited to a fun run, than that appropriate to a professional encounter with a patient about to entrust his very life to you?

Joseph P. Kriss MD, a physician from the Stanford University Medical Center, writing in the New England Journal of Medicine in 1975, said:

"The relation between a physician and his patient is serious and purposeful, not social, casual or random. In this relation the patient unburdens himself or herself of a set of concerns regarding health matters and transfers them to the accepting physician. For a very long time it has been customary for individuals in society to dress rather formally when conducting serious business, and less formally when they are at leisure. The physician's dress should convey to even his most anxious patient a sense of seriousness of purpose that helps to provide reassurance and confidence that his or her complaints will be dealt with competently.

"... Casual or slovenly dress is likely to convey, rightly or wrongly, casual or inattentive personal handling of their problem ..."

You may think that these sentiments represent an excessively formal attitude and are even out of step with today's style of practice. Or, on the other hand, you may have noted the favourable response from your patient to a formal consultation process.

Furthermore, do we need to attend to our mode and style of greeting and examining our patients? Generally, we have so little time to convey the importance and value of our services in their hospital interlude that we need all the help we can get. Do we demonstrate the necessary social graces, show consideration for privacy, modesty and other individual sensitivities?

Do we take the time to explain, reassure and otherwise engender as much confidence in us as is possible in the limited time now made available to us by same-day admission procedures, day stay surgery, late admissions and so on?

Seeing our patients in our own consulting room at some time prior to surgery is of enormous benefit in reinforcing the importance of our involvement as well as allowing the opportunity for ventilation of anxieties. It also allows for the demonstration of those all-too-often forgotten human touches which will assist in dispelling the technician image. Imagine yourself in your patient's position, give some thought to his fears and anxieties and respond accordingly. Behave like a doctor.

Attempts to rectify the perception of the unseen specialist by promoting media exposure have occurred in a desultory fashion but it is only with our commitment to seek professional assistance that there has been any real advance.

While those of us who are involved in promotion of anaesthesia and anaesthetists inevitably experience the buzz of personal media exposure, it is sobering to note that little of real value in the overall promotion of our worth as specialists doctors has been achieved. That is not to say that we should withdraw from media contacts—on the contrary, we need to consolidate, regroup and examine our goals.

After two years of intensive activity, there remains a major gap in the understanding of our role in health care by the population at large. Furthermore, this perception extends to politicians and bureaucrats, and to other health professionals, including our surgical colleagues who, we know, have a collective lack of appreciation of our worth.

Anaesthetists are in the forefront of the medical specialties when it comes to keeping their house in order. This has been acknowledged by the former Federal Minister for Health, MrGraham Richardson, on a number of occasions, and he referred to this again in his speech at ASA headquarters for the launch of National Anaesthesia Day. The specialty has published ten-year surveys of anaesthesia-related mortality over the past three decades, and has

demonstrated a halving of mortality rates over each of those surveys, such that Australian anaesthesia is demonstrably the safest in the world, with a mortality rate 2.5 to 3.0 times less than in North America or the United Kingdom. Despite the fact that we trumpet these facts loudly in the public domain, repetition is necessary to impart the message to the consumers of our services, the 1.8 million anaesthetics given every year in this country. We need to make the most of every single one of those patient contacts; every one is a potential publicist for our cause.

This result has not come to pass by accident; it is the product of an exhaustive postgraduate training and examination program, equivalent in complexity and duration to all other major specialist disciplines, as well as our own development and implementation of rigorous quality assurance, peer review and continuing medical education mechanisms.

1996 has been a remarkable year for the ASA. The hosting of the 11th World Congress of Anaesthesiologists in April was the culmination of a ten year period of preparation and planning by many committed members and their spouses, under the inspired Chairmanship of Dr Richard Walsh. This was the biggest medical congress ever held in Australia, with over 400 speakers.

This Combined Scientific Meeting, the first national combined meeting of the Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists, evolved out of the vision and goodwill of a number of our colleagues. It has been a singular success.

The younger generation of Australian anaesthetists are impatient to streamline the organizations which consume their dollar in the name of representation. Quietly, and without fuss, the elected office bearers of the ASA and the College are working towards a common goal, and that goal is the combination in as many mutual areas as possible, with their aim to minimize waste of talent and resources (dollars) and to improve efficiency for their constituents.

When the Faculty of Anaesthetists was founded by members of the ASA in the 1950s, it was never envisaged that there would be two bodies, composed essentially of the same people, intent on re-inventing the wheel. The formation of the College in 1992 offered the specialty a golden opportunity to think again and plan something better for Australia's anaesthetists, but the precious moment was lost.

The current College Presidency has already seen the formalization of ASA/College liaison as a permanent agenda item, and we have begun the eminently sensible process of moving towards an increasing number of joint activities.

Australian anaesthetists are well served by their professional organizations. Many distinguished and dedicated anaesthetists have served their profession in a variety of roles for many years and their names are chronicled in the archives.

But what does the average member or Fellow require from his annual subscription? Essentially, he needs to be properly and professionally represented while he goes about his practice. This means training, examination and formulation of standards; it means provision of a continuing education program of scientific meetings; it means looking after his professional and industrial well-being as he involves himself in the medical workforce; and it ought to provide supportive social interaction and fellowship as well.

It ought to be possible, given a dose of goodwill, vision and commitment, to explore a process of closer unity, to benefit us all.

That great President of the ASA and Dean of the Faculty, Dr Brian Dwyer, said it much better than I on Saturday, February 19, 1994, on the occasion of the opening of the College headquarters in Melbourne, when he stated:

"The present separation of the ASA and the College tends to drain the physical and financial resources of anaesthetists who are largely members of both organisations. Although I am aware of the arguments used to justify the status quo of the past four decades, the continual reduplication induced by professional activities conducted by both groups is now becoming an unwarranted burden."

Brian Dwyer saw "... no significant obstacle to unity that cannot be overcome by suitable constitutional changes within the two now fully autonomous bodies."

Australian anaesthetists facing real restrictions on incomes in the face of managed care, falling private health insurance rates, and increasing costs and overheads, will demand value from their representatives. Rising subscriptions require real justification.

The only certainty that we have as doctors, and anaesthetists is the knowledge that unity is strength and division is weakness.

Sir William Osler said:

"The first, and in some respects, the most important, function is that mentioned by the wise founders of your parent society—to lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the profession. Unity and friendship! How we all long for them, but how difficult to attain! Strife seems 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, we too often let our angry passions rise against our professional colleague. The quarrels of doctors make a pretty chapter in the history of medicine.

"So far as my observation goes, the fault lies with the older practitioners. The young ones, if handled aright and made to feel welcomed and not regarded as an intruder to be shunned, are only too ready to hold out the hand of fellowship. The society comes in here as professional cement. The meetings in a friendly social way lead to a free and open discussion of differences in a spirit that refuses to recognize differences of opinion on the non-essentials of life as a cause of personal animosity or ill-feeling.

"Most of the quarrels of doctors are about non-essential, miserable trifles and annoyances—the pin-pricks of practice—which would sometimes try the patience of Job, but the good fellowship and friendly interchange of the medical society should reduce these to a minimum."

"The beauty of presenting a Presidential Address is that one chooses the subject, speaks without interruption and finishes without question." So spoke Dr Peter Brine, retiring ASA President at the Society's Annual General meeting in this very city in October 1978. The warm friendship I have found in this part of Australia has impressed me greatly and it has been a pleasure to have been here at this important meeting.

Thank you for having me as your President.