

## **GEOFFREY KAYE ORATION**

### **THE ASA PAST, PRESENT AND FUTURE**

This oration is named after Geoffrey Kaye, one of the 7 founders of the Australian Society of Anaesthetists. This encouraged me to reflect on the early years of the ASA. This reflection combined with my own experience working for the Society are the reasons that I would like to speak today about , “The ASA, Past, Present and Future”.

By understanding our history it allows us to better assess our goals for the future.

#### **THE FOUNDATION**

The ASA was the 3<sup>rd</sup> medical organisation established in Australia being founded 72 years ago in January 1934.

It was preceded only by the Royal Australasian College of Surgeons, founded in 1927, and the Association of Physicians, later to become the Royal Australasian College of Physicians, which commenced in 1930.

Until 1927 the only medical association was the Australian branch of the British Medical Association, the AMA not being founded until 1962.

In 1929 there was established the Anaesthetic Section of the Australian Branch of the BMA.

The BMA was very critical of the formation of the ASA as an independent body much preferring there to continue the status quo with an anaesthetic section within the BMA.

Even in those days international links were a key part of Australian anaesthesia. Dr Frank McMechan, from Ohio, USA, played a vital role in the establishment of anaesthesia societies throughout the English speaking world including Australia.

Frank McMechan attended the 1929 BMA Australia National Congress in Sydney where the Section of Anaesthetics of the Australian Branch of the BMA was founded.

He met a young Geoffrey Kaye, aged 26, whom he inspired .

Shortly after Geoffrey Kaye set off to work at St Thomas’s Hospital, London also visiting the USA and Canada as the special guest of the International Anaesthesia Research Society.

On returning to Melbourne in 1931 he was now well prepared to set about establishing the Australian Society of Anaesthetists.

Geoffrey Kaye believed an independent Australian Society of Anaesthetists, rather than simply a Section within the BMA, would

- confer much needed status on anaesthetists
- allow the formation of regulations and committees with the sole purpose of promoting the affairs of anaesthetists, eventually without consultation with another organisation,
- have its own research and education programme,
- have its own museum and library, and
- its own journal.

The elements of Geoffrey Kaye's vision remain key features of the Society today and are exemplified in our present expansion of the headquarters putting space aside for a new purpose built museum and an historical library.

Geoffrey Kaye's dream became a reality when in 1934 the ASA was founded by seven men of great vision who met at Hadley's Hotel on, most likely, January 19. Those seven men were;

Gilbert Brown- Provisional President  
Geoffrey Kaye- Provisional Secretary  
Harry Daly  
Cedric Duncombe  
Ivor Hotten  
G Leonard Lillies  
Gilbert Troup

Those founding fathers clearly worked hard and were very enthusiastic.

They started the ASA from nothing and there were very few of them, there being very few full time anaesthetists in Australia. Most anaesthesia was provided in a very rudimentary fashion by General Practitioners. These founders however had great vision.

The objects of the ASA at its foundation were

1. To improve the status of anaesthesia in Australia
2. To facilitate the exchange of ideas between Australian Anaesthetists and between them and overseas anaesthetic organizations
3. To encourage research into questions appertaining to anaesthesia
4. To arrange the publishing of articles on anaesthesia

I would now like to look how these original objectives have evolved over time and translate into the goals of today's ASA.

## **INDUSTRIAL ADVOCACY**

Interestingly the Society did not set out to have a medico-political or industrial role. Perhaps to placate the BMA as much as anything else they informed the BMA that the new Society was to be, “Wholly disinterested in medical politics and will be guided in such by BMA rulings”.

Thus it would seem the Society had in some ways forsaken from the outset direct involvement in its first objective. Of course they had little choice as the Governments State and Federal then, and for many years hence, would only communicate with the BMA, or later the AMA, on industrial/medico political issues.

In fact Geoffrey Kaye and others must have seen that there was a need for the Society to become involved in industrial issues. At the 1947 AGM there was the first discussion about remuneration of the salaried anaesthetist. Geoffrey Kaye proposed that “The ASA approve the payment of anaesthetists at an annual salary equivalent to 5 pounds and 5 shillings per session of not more than 3 hours”. The motion was carried.

It is difficult to reconcile that Geoffrey Kaye throughout his life frequently criticised the ASA for having an industrial role, yet it was he who proposed that very first motion.

Today of course this is core Society business, but much argument ensued before we reached this point. It illustrates how we must remember our past but not be shackled to it. We need to remain flexible and remember the only reason for the Society existing is to serve its members in whatever way is necessary at the time.

So how did the ASA become an industrial advocate for anaesthetists?

The failure of the BMA to adequately represent anaesthetists led to great frustration. Even though the BMA was the only body with which jurisdictions would communicate over industrial issues it was disinclined to be an industrial advocate for anaesthetists. It went through the 1950's rarely ever replying to correspondence from the ASA yet it was implacably opposed to any independent approach! This suited the Government very well.

The Colleges were similarly hamstrung as they had had legal arrangements in place since 1943 not to participate in medico-political discussions.

The National Health Service Act was gazetted on 12<sup>th</sup> March 1953 and the Commonwealth National Health (Medical Benefits) service was introduced as from 31<sup>st</sup> July 1953.

There were innumerable anomalies for anaesthetists in this schedule, some of which were to be perpetuated for over 50 years. Despite numerous submissions being presented to the BMA by the ASA for changes to the schedule, nothing was done.

Communication was slow and meetings in those days occurred but yearly at the time of the AGM. Often many months or a year might pass between correspondence

Interestingly the schedule of Medical Benefits of 1953 for anaesthesia was considered by the ASA to be;

- Far too low
- No benefit existed for the pre anaesthesia consultation
- The items were inappropriate
- The time taken for the anaesthetic received minimal consideration

It was only with the introduction of the Relative Value Guide into the Medicare Benefits Schedule in 2001 and the new consultation structure which is being introduced this November that points 2,3 and 4 have been appropriately addressed, point one however is still true today.

Even in 1960 when some representation did occur by the BMA of ASA issues it is clear those representatives were very poorly versed in what those anaesthesia issues were.

The formation of the AMA in 1962 certainly led to a better relationship than that which had existed with the BMA however the next impediment to Australian anaesthetists gaining good industrial advocacy was an internal rift whereby from 1963 to 1969 there was a dispute within the profession as to whether the ASA or the Faculty of Anaesthetists should represent anaesthetists industrially.

Although the arguments are obvious now and we have clear delineation of College and ASA activity today, in the 1960's it was all a blur. Another 6 years thus passed before all agreed that it was the role of the ASA.

The ASA has grown to be today, apart from the AMA, far and away the best industrial advocate of any medical association or college in Australia. We meet independently with politicians, health insurers, medical defence insurers, health bureaucrats and whoever else is required while maintaining an excellent relationship with the AMA. I have met the Federal Health Minister, Tony Abbott, 4 times in the last 2 years. Our submissions are well researched and compelling based on frequent committee input via email and teleconferences. Underpinning that is a well run, well resourced secretariat which is efficient and productive. During the recent medical indemnity crisis no organization understood the issues as well as the ASA.

The last 15 years have brought a succession of advances that have greatly improved patient care whilst bringing large improvements in the income of anaesthetists. The introduction of the Relative Value Guide, new consultation items and better remuneration for the care of veterans by anaesthetists are all major steps forward.

We still however have much to achieve. We are still shackled with the rebate relativities that existed when the Society was founded in 1934. Despite the massive improvements that have occurred in the safety and quality of anaesthesia, anaesthesia rebates remain at

between 25% and 30% of the corresponding surgical rebate. The difference today however is that now more and more anaesthetists are charging what they are worth.

This of course leads to the existence of patient gaps which are best dealt with by informing patients about them in advance. This we hope will become universally routine as it not only improves patient satisfaction but also improves cash flow.

Succession planning is key to the Society maintaining its success. It is particularly vital in the area of industrial advocacy. A highly effective advocate for our members such as Andrew Mulcahy, Chairman of the Economics Advisory Committee, cannot last forever nor be replaced overnight. Ben Barry once told me that the minute you are appointed to a position you should commence the search for your replacement.

The next goal of the Society that I would like to look at is the role of education

## **EDUCATION**

From its inception education was core business of the ASA. Each of its original objectives was based on education. (show slide again, but don't read them out)

- *To improve the status of anaesthesia in Australia*
- *To facilitate the exchange of ideas between Australian Anaesthetists and between them and overseas anaesthetic organizations*
- *To encourage research into questions appertaining to anaesthesia*
- *To arrange the publishing of articles on anaesthesia*

Those founding fathers understood that the status of anaesthesia and of anaesthetists is so much based on the quality of the anaesthesia being provided. From excellence all else will flow, including, if combined with top grade advocacy, improvements in remuneration.

In 1934 there was much need for the ASA. Anaesthesia was very hazardous. Geoffrey Kaye's own work researched anaesthesia related deaths in Melbourne in 1936. He surveyed 500,000 operations at 14 hospitals and found a mortality of 1:1000. This he published in the Medical Journal of Australia and the British Journal of Anaesthesia.

Today's mortality figures for Australia reveal a mortality of 1:186,000 where the anaesthesia was the sole contributor to the death and 1:56000 where the anaesthesia played some role.

Such a huge improvement is above all else based on the education of anaesthetists in which the ASA has been participating since its inception.

A key component of education provided by the ASA is the NATIONAL SCIENTIFIC CONGRESS

The first ASA AGM in Melbourne in 1935, followed immediately the BMA's annual Australian congress and was also on this occasion the BMA's Annual General Meeting, being held out of the UK only for the 2<sup>nd</sup> time in its 103 year history. There were over 1000 delegates. As such the ASA had a wonderful opportunity to use some of these delegates as speakers at its own meeting.

So in 1935 the Society commenced the tradition of inviting an overseas speaker. Dr Zebulon Mennell was the first guest of the Society, a Senior Anaesthetist at St Thomas's Hospital, London where Geoffrey Kaye had worked. He was Treasurer of the Association of Anaesthetists of Great Britain and Ireland and later its President. This tradition has continued of course to this day.

Those early ASA National Meetings were far removed from the NSC's we are used to and which we are enjoying at Coolum. Recently, Dr Brian Pollard, former ASA President related to me his memories of his first NSC.

He was a first year registrar at St Vincent's Hospital, Sydney in 1954 when he was approached to join the ASA by Dr Len Shea, also a former ASA President and then Chairman of the NSW Section. He duly did so, but later in the year he was informed he had been elected unopposed as Honorary Secretary for the NSW Branch of the ASA. This he accepted manfully despite being only a first year registrar. Only a few months later it was explained to him that the ASA AGM and National Meeting was to be held in Sydney in March of the next year and as he was the NSW ASA Secretary, it was his responsibility to convene the meeting!! So he did. His future ASA Presidency was assured. I'm sure John Lauritz more than anyone would appreciate this story.

The ASA NSC has grown to be an extraordinarily well organized annual event combining excellent science with great social events.

Today we face the challenge of running an ever more popular event while maintaining the standard and finding venues large enough to adequately accommodate all who wish to attend. There are now few venues in Australia large enough to hold the ASA NSC. The NSC has become a mammoth task. I believe we must shoulder more of the administrative burden at the Sydney headquarters while retaining the wonderful local flavour so characteristic of ASA NSC's. It is a fine balance.

Another component of ASA education are the  
REGIONAL MEETINGS

The one day meeting or evening meeting organised by the State Sections has been an activity of the ASA since its inception. Since 1980 the Faculty later College and the ASA have combined to produce joint regular meetings in all States. This is the way of the future as the two organizations work together on such shared core business. This must continue to flourish.

At times if the subject matter is largely medico political or industrial the ASA runs the meeting independently. An example is our “Going into Practice or Part 3 Course” for our trainees who are completing their training. A “Part Zero Day” for new trainees to particularly focus on stress and lifestyle issues is also being introduced.

#### SPECIAL INTEREST GROUPS

Combining with ANZCA and the New Zealand Society of Anaesthetists (NZSA), the ASA has established 14 special interest groups which allow particular academic areas of anaesthesia to be pursued. These groups are another example of the closer relationship which has been steadily developing between the ASA, ANZCA and the NZSA. These special interest groups may put on separate meetings or contribute sessions to major meetings. It is hoped these SIGS become increasingly better established while remaining under the umbrella of the parent organizations.

Unity is strength, the fragmentation of the specialty is to be avoided at all costs. The key to our future is to maintain excellent lines of communication and cooperation with ANZCA, the NZSA, the AMA and other medical Colleges and Associations both in Australia and overseas.

#### ANAESTHESIA AND INTENSIVE CARE

Another of Geoffrey Kaye’s visions was that of an ASA Journal.

January 1935 marked the publishing of the first of a series of “Anaesthetic Numbers” in the Medical Journal of Australia.

Later the ASA Newsletter commenced. This was part scientific and part informative and was largely the work of Geoffrey Kaye who was its driving force for 20 years.

At the 12<sup>th</sup> AGM in Perth in 1954 a resolution was passed that the “Society should take steps to institute a Journal of Anaesthesia in Australia”. Unfortunately it did not eventuate for 18 more years.

It was in 1970 the Honorary Federal Secretary, Dr Benedict Barry, developed a plan to establish an Australian Journal of Anaesthesia. In August 1972 the first issue of “Anaesthesia and Intensive Care” was published with Ben Barry the editor.

Prior to this, anaesthesia articles were often published in the ‘Australian and New Zealand Journal of Surgery’ the College of Surgeons’ scientific journal. One of the key factors in the early success of “Anaesthesia and Intensive Care” was the very major decision by the Faculty of Anaesthetists to withdraw its active participation in, ‘The Australian and New Zealand Journal of Surgery’ so as to officially support the Society’s new journal. “Anaesthesia and Intensive Care” was therefore the sole scientific publication in Australia for Anaesthetists. This remains the position of ANZCA today.

The Journal has flourished and now 34 years later it is the ‘Jewel in the Crown’ of the Society. It is one of the leading 6 anaesthesia journals in the world and gives the Society enormous credibility and legitimacy as an educational body. This legitimacy is a major reason why politicians and health bureaucrats listen when we speak.

The future for the Journal is exciting. Last year the New Zealand Society of Anaesthetists joined the Australian and New Zealand Intensive Care Society in adopting ‘Anaesthesia and Intensive Care’ as its ‘Home’ journal. This brings great benefits to all 3 organizations. Future similar expansion is something to be sought.

The internet adds another level of complexity to Journal publication which will engage our editorial board into the future.

## **AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

In 1934 there was no formal pathway for anaesthetists to train and become qualified as specialist anaesthetists.

The Society declined an invitation to establish a national Diploma in Anaesthesia in 1945, as they believed it would fragment their fledgling membership to have 2 categories of membership, one for those with a diploma and the other for those without.

Nevertheless the need for a national Australian anaesthesia qualification was a major Society activity for the next 10 years. In 1946 the Executive established a subcommittee charged with commencing informal discussions with the College of Surgeons and the College of Physicians

Discussions ensued for years with both the Australian Colleges and with their English counterparts in order to find a way forward. Finally the Past President Harry Daly obtained a breakthrough in January 1950 when the College of Surgeons expressed some interest in his proposal of to have a Faculty of Anaesthetists within the College of Surgeons. At the AGM of May 1950 a motion was passed to formally approach the

College of Surgeons to found a Faculty of Anaesthetists within the College. This Faculty would be responsible for producing a national Diploma of Anaesthesia.

The College of Surgeons response was favourable so the ASA appointed a subcommittee to commence the detailed discussions with them. The Faculty of Anaesthetists was formally inaugurated in August 1952 with the first examinations being held in 1956. Undoubtedly one of the greatest achievements of the ASA was the formation of what is now the Australian and New Zealand College of Anaesthetists. It has become a superb College and in combination with the ASA serves to give anaesthetists and anaesthesia an excellent profile.

The future I believe must be one of ever increasing cooperation with ANZCA in areas of shared interest. We have tripartite Special Interest Groups, Joint Continuing Education and have established this year a tripartite Data Committee, with ANZCA and the NZSA, to establish on line reporting of anaesthesia critical incidents. We have to continue to improve our lines of communication so that each body, although totally independent, is fully informed of the other's activities. We clearly understand each other's areas of exclusive activity and of shared activity. The old time petty jealousies are long past as we move forward working together. This must be the way of the future.

## **INTERNATIONAL RELATIONS**

One of the ASA's original objectives was the facilitation of exchange of ideas between Australian and overseas anaesthetists.

Frank McMechan from the USA inspired Geoffrey Kaye to establish a Society and organized him to meet many of the most influential anaesthetists of the era. One of Geoffrey Kaye's lifelong friends became Ralph Waters, founder of the Post-Graduate School of Anesthesiology at Madison, Wisconsin. They corresponded for 50 years. Waters was a doyen of anaesthesia and clearly a man of vision.

He insightfully wrote to Geoffrey Kaye in 1937 of his impending trip to New Orleans expressing his doubt as to whether he should bother preparing a paper as the levees were likely to fail at any time and wash away the city.

International visitors to the National Scientific Congress were seen from the beginning as a vital component of the meetings.

The ASA was a foundation member of the World Federation of Societies of Anaesthesiologists (WFSA) in 1954 and has been very active ever since culminating in the Society hosting the 11<sup>th</sup> World Congress in Sydney in 1996. It had 10,000 in attendance and was the biggest medical meeting ever held in Australia up to that time. The ASA has supplied many office bearers to the WFSA including its President in 2000, Dr Kester Brown.

In 1971 the ASA established the ASA Action Fund with funds being allocated to provide assistance to anaesthesia in developing regions. This anaesthesia educational aid to third world countries has steadily grown under what is now the Overseas Aid Committee. This committee has made an enormous contribution through a succession of selfless anaesthetists who have given large quantities of their time and energy to educate anaesthetists in developing countries. I would like to make particular mention of the work done in this area by Steve Kinnear and Haydn Pemdt.

The Society's approach has always been rather than bringing anaesthetists to Australia to send Australian anaesthetists to the countries in need. The aim being to give the locals the skills to give and teach anaesthesia.

The ASA is proud to say we believe we spend more per member per annum on overseas educational aid than any other medical association or college in the world. Approximately \$50 per member per annum.

The ASA has long had a special relationship with the Association of Anaesthetists of Great Britain and Ireland (AAGBI). At its first AGM in 1935 Dr Mennell, the Treasurer of the AAGBI, formally invited the ASA to enter into affiliation with the AAGBI. This the ASA accepted. In 1949 the AAGBI inaugurated a travelling scholarship for a young ASA member to study in England for a year. This was a token of thanks for all the food parcels sent by the ASA to the AAGBI for distribution among its members during WWII and through to 1952. I should apologise to our guest Mike Harmer, recently retired AAGBI President, that when I visited their London meeting this January, I came empty handed, although I suspect, based on the great party the AAGBI threw at the Savoy that they are doing okay now even without the food parcels.

Similar close relationships have existed particularly with the New Zealand Society of Anaesthetists (NZSA), the American Society of Anesthesiologists (ASA, USA) and the Canadian Anesthesiologists Society (CAS). Since 1998 the Presidents and CEOs of the ASA, USA, the CAS and the AAGBI have met annually to discuss common issues. From this year the Presidents Elect will also attend.

These Common Issues Group Meetings have proved to be most valuable covering all areas of Society activity be it industrial, workforce, organization of meetings, publishing of journals, education or overseas aid. One of the many benefits has been the stimulus of the ASA to the other 3 Societies to spend more on anaesthesia aid to developing countries and the establishment of an exchange programme for one registrar member from each country to visit each Society's annual national scientific meeting. At this meeting we have with us Desmond Sweeney from Canada and Chris Meadows from the UK.

It is vital we continue and expand our communication with anaesthetists from other countries. The opportunity for anaesthetists to work overseas, including the USA, in clinical positions is not something nearly as available for other specialists as it is for anaesthetists. This is something to be fostered. The sharing of ideas with anaesthetists from other countries was one of the original objects of the ASA and it remains invaluable

both in improving our knowledge and skills and in the imparting of knowledge to others, particularly in developing countries.

## **FINANCES AND MEMBERSHIP**

The ASA is today in a sound financial position. In 1934 there was nothing. Annual subscriptions were initially set at 10 shillings and sixpence, 7% of the 7 guineas being charged by the College of Surgeons, a reflection of comparative incomes of the day. In 1948 Geoffrey Kaye estimated that anaesthesia fees were much the same as they were 40 years earlier despite the 40 years of inflation. Anaesthetists were very poorly rewarded so the subscriptions had to be low.

The ASA subscription is the best investment one could ever make. In the last 2 years alone the increases in anaesthesia rebates and direct payments for anaesthesia services per ASA member per annum average \$20,000 or 18 times the annual subscription in perpetuity. In the last 12 years a number of similar gains have been achieved for members making the ASA far and away the most effective medical industrial advocate in Australia. These improvements have been inextricably linked with cost savings to the community due to anaesthesia advances and changes in practice that can be documented irrefutably.

The future involves a continuation of the above. The challenge with a voluntary organization such as the ASA is to continue to be relevant remembering that the reason for its existence is to serve its members. Complacency is not possible. Unlike the Colleges there is no perception that one has to be a member.

As well as providing value for money, excellent service and being relevant, the Society must inform its members and future members of its achievements so as to both attract and retain members.

The membership has steadily grown. Today we have 2401 members.

A regular review of the ASA's aims and objectives through its Strategic Plan has been occurring at least annually for the last 5 years. This must continue as it provides clear direction for the staff and office bearers of the way forward.

## **LIBRARY AND MUSEUM**

The library and museum have always been key components of the Society. In 1939 the library and museum were officially founded. Geoffrey Kaye was far and away the largest contributor to both. The library and museum grew steadily even during WW2.

In 1955 when the Society had to vacate its headquarters in Geoffrey Kaye's home in Melbourne the College of Surgeons were asked if they would temporarily house the museum and library. They agreed on the condition that it not be a loan but rather a donation to the new Faculty of Anaesthetists. This was agreed and so was lost the first 20 years of the Society's collection.

Despite this loss the museum and historical library has grown again to substantial proportions. Our recent expansion of the headquarters have allowed there to be established a purpose built museum and library. The aim for the future is to have every artefact in the museum on the website with its photograph and a summary of its background. A virtual museum accessible to all members at any time. In addition we plan to make the museum at the headquarters open to the public.

## **HEADQUARTERS**

Apart from a period from 1951 to 1955 when the Society was located in Geoffrey Kaye's home in Melbourne the Society had no physical headquarters until space was made available in Sydney in the rooms of the anaesthesia group, General Anaesthetic Services in 1970. Before then all the Society documentation was transferred in boxes from one Honorary Federal Secretary to the next. In 1979 the ASA for the first time purchased property for its headquarters, a small terrace house in Sydney. In 1984 the first office suite at Edgecliff was purchased. Since then 2 further contiguous suites have been acquired providing now excellent facilities for office bearers and the staff that are now 12 in number.

Undoubtedly further expansion will become necessary. Staff numbers will continue to increase as the Society grows. It is essential that we provide staff and office bearers a comfortable working environment so as to attract and retain the best.

Our State branches also need to be appropriately housed, mostly in shared arrangements with the College or other medical organizations.

Managing the expansion and development of the Society's offices is a vital component of its future success.

## **ANAESTHESIA WORKFORCE**

I believe workforce issues present the greatest challenges to the ASA in the foreseeable future.

In 1934 there were very few full time anaesthetists, most anaesthetists were General Practitioners who anaesthetised their patients when they required surgery. With the founding of the Faculty in 1952 there was a progressive increase in the number of specialists and a reduction in the proportion of anaesthetics given by non specialists.

The ASA has always been inclusive welcoming both specialist and non specialist anaesthetists as members along with trainees and retirees. It therefore truly represents the whole anaesthesia workforce. Over the last 10 years there has been a determined effort by the Society to better represent Salaried Specialists, Trainees and Non Specialists. The formation of the Group of ASA Clinical Trainees (GASACT), the Salaried Specialists Advisory Committee and the General Practitioner Advisory Committee are testament to these efforts.

In addition we have established a Workforce and Survey Committee to specifically gather information which can be provided to the membership about any issue but in particular about the anaesthesia workforce.

The workforce needs to be studied because it is changing and the ASA I believe has to be aware of the increased emphasis on lifestyle of its members. This is a good thing up to a point but it does bring with it particular challenges. As well as this emphasis on lifestyle, the feminisation of the anaesthesia workforce has to be factored into our workforce analysis.

The after hours commitments are for many anaesthetists the very worst part of their profession.

These attitudes of modern anaesthetists contrast with the community's desire to have their surgery and their babies in every tiny town across this huge country with perfect results.

Compromise from both parties is the only solution.

The Society's position for some years has been that there needs to be a consolidation of surgery into large centres. Much better health care is provided in large, busy hospitals where skills can be maintained through the high volume of work. It is far easier to attract and retain specialist anaesthetists to a centre which has at least 6 specialist anaesthetists, allowing for a reasonable after hours roster with the ability to have time off for holidays and conference leave. If when one is on call one is generally busy then it is possible to take the next morning off as a reasonable income will have been generated through the night.

Such a scheme for the country must be coupled with sophisticated rapid transportation of emergency cases to the large surgical hub.

For those smaller country hospitals to continue to provide some surgical services it will be essential that there continue to be general practitioner anaesthetists with the skills and enthusiasm to provide much of the anaesthesia, strongly supported by specialist anaesthetists either in the town or available for support at a distance. We must encourage and cultivate our GP anaesthetists. They are one of the key components in our campaign to maintain the standard of anaesthesia in Australia which allows us to rightfully claim that there is no place safer in the world to be anaesthetised. The loss of the GP anaesthetist creates a vacuum which may well be attempted to be filled by non medical anaesthesia providers.

The risk to patient safety by the introduction of inferiorly trained non doctors to provide anaesthesia is one of the biggest challenges facing the Society in the future. This threat is not new and was spoken of by Dr Gilbert Troup in a paper he delivered at the Society's first NSC in 1935 when he said of nurse anaesthesia, "It is a phase of anaesthesia of which we in Australia are fortunately free".

Together ASA and ANZCA must be constantly vigilant as there will always be amongst us people who use the politics of envy to denigrate what we have achieved in 72 years and suggest anaesthesia is less complex and requires far less than the minimum of 13 years of training presently required. The proponents of non medical anaesthesia however are yet to consent to have their mother, sister or daughter anaesthetised by a non doctor. Hypocrisy is rife. To suggest such a system will benefit the community is hard to imagine. It will not save money nor provide a better anaesthesia service. What it will almost certainly do is introduce a 2 tiered anaesthesia system where the poor and isolated receive inferior anaesthesia care from lesser trained non doctors. Inevitable increases in anaesthesia morbidity and mortality will have huge cost implications to the community.

The Society's position is clear. Anaesthesia is a medical act. The long established anaesthesia care team is the model we must preserve whereby nurses and other paramedical personnel work with anaesthetists as highly valued members of a team.

The Society has a vital role in communicating to the public the advantages of having highly trained doctors providing their anaesthesia and the risks of the alternative.

I believe that every anaesthetist has a responsibility to pass this message on to their patients so that we can gain widespread community support for our position.

## SUMMARY

It can be seen therefore that the original aims and objectives of the Society remain current to this day. The Society has only ever been here for one purpose, to represent its members, in whatever way is required at the time. How we do that depends in part on what is needed however there are some basic principles which I believe should always be followed by the Society and all its members.

1. Aim for excellence in all we do. By maintaining ever increasing standards of anaesthesia then we legitimise all our subsequent submissions and negotiations.
2. Encourage, cultivate and provide anaesthesia education both in Australia and overseas. The education of anaesthetists is core Society business.
3. Encourage ASA membership. The Society must remain relevant and cost effective. Each one of us can encourage our non member colleagues to join the Society.
4. The Society must continue to be in a strong financial position to allow it to adequately represent its members and deal with major and unexpected issues.
5. To represent and support our members to maintain their clinical and financial independence. To ensure they adequately value the work they do.
6. Communication with the community by both the Society and its members to better inform them about Australian anaesthetists.

Geoffrey Kaye and his fellow founders turned the dream of an Australian Society of Anaesthetists into a reality. Our legacy is to keep the Society strong , independent and relevant.

