

GEOFFREY KAYE ORATION. 1998.

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When writing on the educational value of ‘medical societies’, Sir William Osler said “The first, and in some respects the most important function, is to lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the professions”. Educational activities and the fellowship are what drew me initially to organisational aspects of the ASA. The politics came later but probably really always remained a secondary interest. They are however, all essential elements of what the Society is about and we all contribute in different ways.

Preparing for this oration has been a complex and perplexing phenomenon, especially coming as it does at the end of one’s term as President. The relief and anticipation of completing your term are tinged with the thoughts of what might have been plus the uncertainties of the future and are then mixed with the hope that you have preserved and in some way strengthened the essential core and the soul of the Society. Being a named oration you are almost forced to look back at Geoffrey Kaye and the formation of the Society, after that you are driven to examine on your term and finally you sense the need to reflect on the future before deciding on your topic.

Previous orations have chronicled the contributions of Geoffrey Kaye. While I endorse those comments and acknowledge the immense contributions that Dr. Kaye made to both

anaesthesia in Australia and to the Society, I do not plan to concentrate on them. He was a dedicated, complex hard working idealist with a meticulous mind and intense interests, but he was also an individualist who found it hard to relate to those who could not match his vision, interests and enthusiasm for anaesthesia. He therefore in a real sense both contributed and to divided anaesthesia in this country.

Early on in my term, I thought that I could best serve the Society by contributing to a re-organisation of the structure and the Constitution. Perhaps, not a very exciting contribution but the process was long overdue. I, and many others, felt had that we needed to facilitate decision-making and allow more time for planning and policy decisions together with the adoption of a more proactive stance. However, life does not always go as planned. While, that process is underway, it has been delayed by the time and resources necessitated by the Trade Practices matter that has dogged the Society in recent years. That matter has indeed been the most frustrating element of the last two years but it also indicates how much the social and political environments have changed and emphasizes the need to review the emerging inter-relationships and accountabilities between the Society the community and the various levels of government. On the other hand, among the highlights have been the meetings of what is currently called the “Common Issues Group”. These are a recent development in which the Presidents of the British Association, the American, Canadian and Australian Societies and the Chair of the International Anaesthesia Research Society have met to discuss common issues, to learn more about how the other groups function and the problems that they face. We now have very good channels of communication at the highest levels in the organisations. The

Group is becoming a useful way of sharing information plus it allows us to gain insights into problems and achievements of these bodies.

It is interesting to reflect that all of these Societies, either directly or indirectly, owe aspects of their formation to the influence, determination and advocacy of Francis H McMechan, who was a founder and first Chairman of the International Anaesthesia Research Society. In the light of this Oration, it is interesting to note that McMechan is also a link to Geoffrey Kaye and there is also a passing association with Dunedin and meetings of the Society. For it was McMechan, who in 1926 wrote and suggested that the British Medical Association include a Section of Anaesthetics in the Australasian Congress (BMA) to be held, in Dunedin in 1927. It was too late for that to happen, but the idea was not lost and a Section of Anaesthetics (BMA), i.e.; the forerunner to the Society, was inaugurated at the 1929 Australasian Medical Congress, held in Sydney. McMechan attended that Congress and it was there that Geoffrey Kaye met McMechan and Kaye also presented his first paper. It is interesting to reflect that the paper was on 'Coronial Enquiries into Anaesthetic Fatalities in Melbourne 1919-1929' and was based on Frederick Green's work. This was innovative and surely a very early example of 'quality improvement' in anaesthesia at a time long before the bureaucracies had latched onto and tarnished the notion of quality .

Kaye was a young aspiring physician of independent means who had become interested in anaesthesia. McMechan was to become both a mentor and an inspiration to him and he assisted Kaye to work with both Waters and McKesson in the United States. From these

three gentlemen Kaye was imbued with both the ideals and many ideas on the organisation of anaesthesia, academia and engineering techniques that might benefit anaesthesia. On his return to Australia Kay, was to play a pivotal role in the formation of the ASA and he became the First Honorary Federal Secretary. He perhaps more than anyone else of the time was the driving force of the Society and he held the post of Secretary for the first 12 years. He later established and financed a national headquarters at 49 Mathoura Road in Melbourne that he hoped would to be the centre for communication, education and research. That grand experiment was to fail partly due to the immaturity of the Society, which could not finance nor live up to the ideals espoused by Dr. Kaye, and partly due to the complex personality of Dr. Kaye. He was critical of the formation of the Faculty because he wanted an independent College to be established at Mathoura Road under his control. He withdrew from both the Society and the Faculty for many years, however, he did eventually return to the fold and he was duly accorded the honours that he rightly deserved from both bodies.

Kaye would have approved of the “Common Interest Group”, as it would fit into the ideals espoused by both McMechan and himself. In 1938 at their last meeting McMechan is reported to have said to Kaye “And if you are not killed in the war, I want you to give yourself up to keeping international anaesthetists together and to healing the scars that will come.” It is also consistent with the ‘Subcommittee on International Relationships’ that was set up by this Society in 1946 at the suggestion of the American Society in order that ‘anaesthetists in different countries can co-operate with maximum efficiency’. Dr.

Kaye was appointed to that subcommittee, which might now be seen as a fore-runner for this Society's to the World Federation of Societies of Anaesthesia.

Turning now to the matter of restructuring and the review of the Constitution. The Constitution is being reviewed in order to bring it up to date, reflect the membership that we now have and to comply with changes to related to the Company's Act and the Trade Practices Act. Allied to that was the wish of the Federal Executive to review the Committee structure and the lines of reporting, in order to produce a more flexible, responsive and proactive body. There is also the need to clarify and cement the 'federal & state' relationships within the Society. How would Geoffrey Kaye have coped with the idea of restructuring the Society? Probably not very well as he always tried to have a controlling influence and he had mixed feeling when eventually the Honorary Federal Secretary was no longer a Victorian. Interestingly, he did support the restructuring that occurred with the review of the Constitution in 1946-48 because it was evident that the original constitution was far too vague. He would therefore understand the need to re-align the committee structures and to form an Executive and a Council. But he would be astonished to hear that the role of the Honorary Federal Secretary has diminished so much over the last 10 years that there is consideration of abolishing the role. I expect that he would resist that move. However, the complexity and the volume of work that goes through the various Committees plus the ease of modern communication have resulted in the President and the Chairs of the Committees handling most of the matters apart from the membership details. The imperative is to have an Executive that is in ready

communication with the Council and the various Committees through a full time Executive Officer in order to enhance the work of the Council and the Society as they attempt to produce improvements for the specialty and members. Kaye would be amazed at the extent of the work that is now done by the Society and overjoyed at the both strength of the Newsletter and the excellence of the Journal. His comment on the first edition of the Journal was “The layout and format of the journal is excellent and it is well printed upon good paper.” I am sure that his comments would be more effusive today as “Anaesthesia and Intensive Care” is now a leading, world-class and respected scientific journal.

Kaye of course did not have to cope with the Government bureaucracies that we have today. He opposed the move to rejoin with the British Medical Association and he greatly disliked the move to a more medico-political role. Being an idealist of independent means we can only guess at his attitudes to Medicare and the Federal Government’s funding of healthcare. From his letters I do know that he disapproved of the power-strike and the bank teller strike in 1972 but interestingly he worked with the new Environmental Protection Authority to try & reduce traffic noise. He would be amazed at the extension of the Trade Practices Act to cover the professions and the implications that it now has for anaesthetists. The implications are vast and have to also be considered in light of commercial changes in healthcare and the ‘globalisation’ of healthcare companies that will occur. Barring a major recession and a backlash against the currently fashionable mode of ‘economic rationalism’, I would suggest that we as a specialty to need to reflect on how we wish to organise both anaesthesia and our practice structures in the future.

Healthcare is changing so quickly that there are a myriad of questions and a host of possible scenarios.

- Who will control the input of patients into hospitals? Will it be the specialists, the general practitioners, the hospitals or the insurers?
- How will the funding be allocated? Will that allocation lead to a blending of the payment systems and/or a composite private/public system of health delivery?
 - How will hospitals change in the future? Some would suggest that there will be procedural and non-procedural hospitals while others favour ‘acute’ and ‘chronic’ hospitals. Who will look after the ‘whole’ patient?
 - Should we continue to be individual practitioners or should we enter partnerships to enable us to negotiate with hospitals or insurers? What are the implications of doing that?

When reflecting on these questions I remembered a cartoon from the Saturday Evening Post of some 25 years ago. I have always regretted not getting a copy of it but I would like to share this word picture with you. There is an operating theatre with the patient anesthetized and prepped on the operating table, the scrub nurse is all ready to start and the anaesthetist is saying to the circulating nurse “Could you go out into the sterile area and bring in a pack labeled ‘Gynaecologist’ and open it”. What is the way forward and can we influence it?

Anaesthetists as a group have a central and unique role especially amongst the procedural specialties and in the acute care setting. Our training and vast skills are directly focused on the care of the patient and that together with the ability to mediate and manage the peri-operative scenario, whether that be in day care or in more complex procedural admissions ensures that we are central entire process. In addition, in the procedural hospitals the anaesthetists could come to provide all the peri-operative care and you could of course go on from that vantage point to provide the managerial skill.

Hold on I hear you say. We were not trained for that and an anaesthetist to be credible must spend a major percentage of his/her time in the operating theatre. I would disagree in some measure with both of those comments. I would suggest that we are currently missing out on a lot of potential trainees, who do not want to be in theatre all the time but they are potential physicians like Dr. Kaye, who are attracted to the unique procedural and caring aspects of anaesthesia. The extent of any extra 'medical' training that might be required is not beyond us, our trainees or our training system if we put our minds to it.

Anaesthesia more than any other specialty is adaptable to the division and allocation of tasks. We all have a range of interests and talents that would allow us to adapt, as a group, to the new roles and to exert greater influence in both individual patient management and the direction of health care..

It may never happen but I consider that we now need to fully review our options in light of the way that both hospitals and healthcare are developing. We need to investigate whether there is a new paradigm that we can work in and that we can work to our advantage. We have lead the way with so many innovations in acute care and pain relief,

plus the organisation of the operating theatres that the jump may not be too big to make. A review may of course highlight other options, or indicate that a change is not possible but we owe it to ourselves as a specialty to examine our options.

Finally, there is another change that I would like to suggest we consider. That is that we change the name of the specialty from “anaesthesia” to anaesthesiology”. The distinction is important to bring us into line with most other Societies and to differentiate us and the science of our practice from anaesthetic technicians and nurse anaesthetists. As a sign of the times a visit to most internet sites is more fruitful when anaesthesiology is used instead of anaesthesia. I believe that this is an important debate that we should have in the near future as we set about determining our future. What would Geoffrey Kaye think of that? I am not sure, but with respect I would suggest that it probably does not matter. He is part of the past and while I believe that we have to respect and cherish our heritage, we also need to go and build the future. I urge the Society to continue to do just that.

Colleagues, ladies and gentlemen thank you. It has been an honour to have served as your President and I wish the Society every success in the future.