SURGEON

PUBLICATION OF THE ASSOCIATION OF SURGEONS IN JAMAICA

1958 –

– 1983

25th ANNIVERSARY COMMEMORATIVE MAGAZINE

SURGEON

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25th Anniversary

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THE ASSOCIATION OF SURGEONS IN JAMAICA

BY
AUBREY McFARLANE

IT WAS twenty five years ago that "The Association of Surgeons in Jamaica" was founded on April 24th, 1958, at a meeting of the profession held at the Mona Hotel.

Mr. John Golding, acting head of the Department of Orthopaedic Surgery at the U.C.W.I., later to be made the first Professor of Orthopaedic Surgery of the U.W.I., started the idea, and meeting with universal approval, he succeeded in getting together the leading members of the profession to form the Association, and full credit must be given to Prof. John Golding as the Founder of the Association.

Sir Arthur Porritt, K.C.M.G., K.C.V.O., CMG., F.R.C.S., who was in Jamaica at the time as a visiting examiner consented to be our Patron.

The officers elected were:-

A.L. McFarlane, M.B., B.S., F.R.C.S. (Edin.) – President
Peter Weston, M.B., B.S., F.R.C.S., – Secretary

Committee Members:-

R.A.S. Cory, O.B.E., M.B., B.S.,
S.W.P. Street, F.R.C.S.
G.V. Harry, F.R.C.S. (Ed.)
Frazer McConnell, M.B., Ch.B.

Mr. John Golding refused to accept the position of first President although asked to do so, but has been one of the staunchest supporters of the Association throughout the 25 years of its existence and has given us invaluable support. He was actually our first Secretary during the formative months of the Association.

The objects of the Association are:-

(1) The Advancement of all branches of Surgery in Jamaica.

(2) The Promotion of Social and Professional intercourse, between the widely scattered surgeons in the island, and in other Caribbean territories.

The meetings of the Association on the North Coast has become an annual event, it has become the main Social event of the year for the Medical profession in Jamaica.

The first of these was held at the Plantation Inn, the adjoining Jamaica Inn, and Silver Seas Hotel, providing the necessary extra accommodation.

A total of seventy persons attended including guests, and it is interesting to note that accommodation for Saturday night, Banquet and magnificent Buffet Lunch, cost Four Pounds (£4) per person including one free drink before the Banquet.

Shortly before the Banquet a rainstorm broke, and all the tables had to be brought indoors, and far from spoiling the evening's festivities, it brought us closer together, it certainly was a memorable occasion for those of us who were present.

We were fortunate to have the internationally famous Dr. George T. Pack as our Guest Speaker at the Banquet, who proved to be as excellent an after dinner speaker, as he was a famous surgeon and Cancer Specialist.

It was at this meeting that Dr. Pack urged that we should have a Cancer Hospital in Jamaica, and Ken McNeil, F.R.C.S., who was interested in the subject got to work, and the Hope Institute was founded as a result of his endeavours.

How well have the activities of the Association lived up to the expectations of the founding members? Not as much as some of us expected during the early period of enthusiasm which marked the foundation. And yet there is much to our credit.

The first aim stated, the advancement of all branches of Surgery in Jamaica.

Here it must be said that it is due chiefly to the support and the activities of the members of the department of Surgery of U.W.I. that the Association has been kept alive and vibrant. It is difficult to assess how much the Association has contributed to the advance of Surgery in Jamaica, I doubt if the structure of the Association is such as to contribute largely to this. However, the first of the aims of the Association has been fulfilled by the twice yearly clinical meetings, when papers of the highest standard are presented, new advances demonstrated, and an exchange of information and experience take place between the Surgeons from the different centres.

Doctors attending these meetings gave information of new advances being made, also information regarding what facilities are available, and where and to whom particular cases may be referred.

I have been greatly impressed with the ability of the younger generation of Surgeons and the continued progress being made in the 25 years since the Association was

founded. This has been verified by the cases demonstrated at the Clinical meetings of the Association, as well as by the papers presented by various Surgeons.

In 1977, the Association was instrumental in arranging the very successful meeting in Jamaica of the meeting of the Bronx Chapter of the American College of Surgeons.

In 1979, the Royal College of Surgeons of Edinburgh held its second overseas meeting, our Association contributed largely to the success of this meeting, and Prof. Reg. Carpenter and Mr. Peter Fletcher were elected Fellows of the Royal College of Surgeons of Edinburgh without examination.

The survival of any Association depends largely on a dedicated Secretary and the state of its finances. It is reassuring to know that the finances are in a healthy condition. It would be wise at this stage to offer a yearly prize for an essay on any surgical subject or any subject affecting the practice of surgery in Jamaica.

The second aim of the Association, namely, "The promotion of social and professional intercourse between the widely scattered surgeons in the island and in other Caribbean territories."

The annual conference on the North Coast has become the high point of the social activities of the medical profession, surgeons and physicians alike, though one must wish that in future we will see many more of our professional brothers from the rural parishes attending these meetings.

It is a pity that the other Caribbean territories are so far from Jamaica, so that the cost of travelling to Jamaica makes it expensive for Doctors in other islands to visit Jamaica for a short few days, but we have had the occasional visitor, and we should do our best to encourage this.

We must be satisfied with our achievements to date, and continue to make greater efforts to live up to the high aims of the Association.

Banquets

over

THE FUTURE OF THE ASSOCIATION OF SURGEONS

J.S.R. GOLDING

THE first two years for any Association as for a marriage is critical. By the time a Silver Anniversary arrives and is ready to be celebrated, success is assured. So it is with our Association of Surgeons; an Association which was founded with clear aims in mind. Firstly, to bring together all those interested in surgery in the widest sense. Thus from the beginning, Obstetricians and Anaesthetists have played a part in our discussions. Secondly, to bring together the various specialists groups of Surgeons so that they can get to know each other. Thirdly, to attract the country hospital doctors whose isolation tended to result in surgical stagnation so that they can meet their colleagues and therefore make referral easier and more personal. Fourthly, to stimulate research and study, particularly in the residents under training.

The further we look back, the more accurately we can see forwards. Of those four aims, the first and to some extent the last have been reasonably well fulfilled, but the second and third have not. Somehow, those who need an up-date in surgery and who should know their tertiary health colleagues personally, hardly attend our meetings. Professor Carpenter has made a real contribution by organizing visits of consultant surgeons to St. Ann's Bay, Mandeville and Montego Bay. However, this only touches the hospitals in the island which need this sort of contact least. Somehow, the improvement of the standard of surgery performed in the island which is the ultimate aim of this Association has to be met. Somehow, every hospital medical officer doing surgery must be made to want to attend our meetings. In many countries continuing education and recertification are becoming obligatory. Where hospitals are isolated and contact between doctors is rare, it should be thought essential for every medical officer to attend a post-graduate programme at least once a year. He should be able to claim his expenses. No better way to upgrade the morale and effectiveness of our medical service could be devised. The cost would be small but the effect great.

Our Association and particularly its Council should think deeply about what we are trying to achieve, what our future aims should be, and most importantly, how to achieve them. If we do not do this, we will simply degenerate into a "bum-chum's" reunion, contribute nothing except the self satisfaction of patting ourselves on the back and, eventually, peter out.

the years

The Work

and

the Play

Sex and Surgery

BY
MAVIS GILMOUR

IN THE late 40's and early 50's the first significant number of Jamaicans who had qualified as professionals began to return home. There were many Doctors in this group because Law and Medicine were the "safe and sure" professions for emerging colonials in those days. There was for the first time a significant percentage of women among these participants.

These post-war graduates had their education made possible by post-military service or were ambitious and enterprising young people who "worked their way" through University, as indeed this helps to explain the serious attitude and the real commitment of the young doctors in our group.

Most of us joined the Government Medical Service and immediately set about improving standards and facilities. Excellence in patient care and strict maintenance of professional ethics were our common motivators, because we had to exceed in every way the non-Jamaican Doctors who had provided the medical service of our country for hundreds of years.

We therefore had a common bond and differences like sex did not seem to matter. I cannot now think of a single hindrance that was put in my way because of my being female.

I took my turn equally with the men on all the strenuous duties and I did my rota as Duty Medical Officer in the Dependencies, serving my one year in Grand Cayman and Cayman Brac as the only medical practioner in the region at the time.

I did my rural parish assignment and was the only Surgeon at both the Port Antonio and Buff Bay Hospitals for 15 months. Dr. Herbert Morrison and I were the only two doctors at the St. James Hospital for 18 months. We did, between us, all the surgery and medical practice for St. James and surroundings. This meant being a true general surgeon, doing obstetrics, gynaecology, orthopaedics, chest and abdominal surgery and even brain surgery for trauma. Surgery at St. James Hospital was 7.00 a.m. to 2.00 p.m. four days per week and then followed Ward and Clinic work. My duty began at 7.00 a.m. and ended at 10.00 p.m. with one week-end off per month. The mortality and morbidity rate at that hospital could stand the keenest scrutiny. All this could not have been done without the excellent team of nurses whose dedication and ability are now legendary.

In January 1959 I proceeded to Edinburgh University to read for Fellowship of the Royal College of Surgeons and in January 1960 was appointed Consultant Surgeon at the Kingston Public Hospital, having obtained my fellowship.

My wards – Upper Nuttall – were nicknamed "the Sheraton" after the Hotel Sheraton – because we were able by physical good housekeeping to have clean, shining floors and clean walls. I had specially designed chart-trolleys, and the nurses' stations were redesigned and relocated. Centre-beds and prolonged over-crowding were avoided and Ward Sisters and nurses were so skilled and devoted that our patients were the envy of many other firms.

THOSE WERE THE HAPPIEST DAYS OF MY LIFE!

Kingston Public Hospital in the 60's had as high a standard of surgery as you could find anywhere and on Nuttall Wards we had some exciting 'firsts'–

- the first two para-thyroidectomies done at K.P.H.
- we organized the first post-mastectomy group born out of collaboration with the Radiologist Dr. Daphne DaCosta and myself.
- we organized the patients' introduction to their surroundings on the wards
- we supplied patients beds with individual paper-bags for waste disposal.
- we had weekly Doctors/Nurses meetings to discuss problem cases
- we had monthly morbidity and mortality reviews

When there were overseas visitors to the Kingston Public Hospital, Upper Nuttall Ward was often chosen as the place to visit. We worked hard – We worked long hours – but our patients did well and we had job satisfaction.

My sex has never been a hindrance to my professional achievement, maybe because of my own reaction. I have never seen myself in competition with men. I merely see a job to be done and it is the quality of the performance and not who performs that really matters.

Do we only eat ?

PAEDIATRIC SURGERY IN JAMAICA

REGINALD CARPENTER

THE BEGINNINGS of Paediatric Surgery in Jamaica came through the organisation of Dr. Leila Wynter-Wedderburn, who felt that the informal arrangement whereby any surgeon did such paediatric surgery as presented to him or her was unsatisfactory. Accordingly, she went into partnership with Mr. Henry Shaw at the Kingston Public Hospital, whereby she was responsible for the organisation, preparation, and post-operative care of infants and children requiring surgery, while he was responsible for the surgery itself. This proved to be a considerable improvement over the previous arrangement.

Soon after the Medical School began at the University College of the West Indies, the Department of Surgery was established. The University Hospital admitted its first patient in September, 1952, and as part of the development of the services provided there, it was subsequently decided that one of its staff, Mr. Carstairs Gardener, would spend a few months at the Hospital for Sick Children in Toronto, Canada, where he would improve his skills in the surgical care of infants and children. Unfortunately, for family reasons, shortly after his return to Jamaica Mr. Gardener had to leave Jamaica permanently and with his departure this development came to an end.

By 1962, the University College Hospital of the West Indies produced a Paediatric Unit, which consisted of three (3) wards, one of which was to be a Surgical Ward. This latter ward opened to its first patient on January 1, 1962, and Dr. Reginald Carpenter was appointed to work as a Senior Registrar with the responsibility for seeing to the day-to-day running of the ward on behalf of the several consultants who would be performing the actual paediatric surgery. Dr. Carpenter, who had joined the staff of the University College Hospital in January, 1961, became interested in Paediatric Surgery as a specialty after he had been on the ward for about three months. With the consierable help of Sister Juanita Espin who, unlike Dr. Carpenter, had training in paediatrics, and who had been appointed Sister in Charge of the ward, the organisation of Paediatric Surgery as a completely separate speciality was begun. In the autumn of 1962, Dr. Carpenter spent two months at the Hospital for Sick Children in Toronto, in order to gain some experience and to understand better what steps needed to be taken to produce the desired improvement in the standard of care.

General paediatric surgery at that time had to include the acute care of patients with ear, nose and throat diseases, and ophthalmic injuries. A strong link developed with Neurosurgery, which formally began in the same year, so that Dr. Carpenter also performed some of the acute neurosurgical operations as well as assisting Mr. John Golding with the orthopaedic operations which he performed on children. Gradually, as more specialities were added to what became the University Hospital of the West Indies, the admission pattern of the ward altered. An Ophthalmic unit was opened, and all children requiring this kind of care were admitted to it. An Ear, Nose and Throat Ward was also opened, and the same thing occurred. General Paediatric Surgery was established in its own right, retaining for a long period of time Thoracic Surgery, including the treatment of patients with persistent ductus arteriosus.

In September 1963, a Children's Hospital was opened in the old Army Hospital which had been used up to the time of Independence the previous year, by the British Garrison stationed in Jamaica. A number of young surgeons performed the role of Paediatric surgeon, but the first one trained in this specialty who served at the Children's Hospital was Miss Leela Kapila, who spent a year on secondment there from the Hospital for Sick Children, Great Ormond Street, London. During her period at the Hospital, Dr. William Dennis became interested in pursuing a career in Paediatric surgery, and at the completion of his training he returned to take up the post of Surgeon at the Children's Hospital in the early part of 1975.

In 1972, through the assistance of Project Hope, nine Paediatric Surgeons came to Jamaica in rotation. This provided an opportunity to assess the level of paediatric surgical care, which was found to be generally good, but specifically needing improvement in neonatal care. In 1975, the first moves to form the Paediatric Association of Jamaica were made. This still vibrant organisation and its active members have helped to provide care for infants and children which gets better year by year.

It became evident that the appointment of a third Paediatric Surgeon would allow a considerably wider range of service, teaching, and research. Eventually, a post became available, and to this post Mr. Venugopal was appointed in 1979. Mr. Venugopal brought with him extensive experience in neonatal care, gained at the Hospital for Sick Children in Toronto. Paediatric surgery now offers excellent teaching to undergraduates and graduates, limited only by the restriction of hospital services, and hopes to begin formal specialist training in the specialty soon.

"PHYSICIAN AND SURGEON"

KARL WILSON-JAMES

FIFTY YEARS is a fitting period within which to review the progress of medical practice in Jamaica. It is also a suitable number of years over which to assess the part played by surgeons in support of the health of the country, within which context the Association of Surgeons, undoubtedly has at some time played a part.

In the 1930's, there was no University Hospital, and the Kingston Public Hospital and one or two other hospitals, were the established seats of advanced medicine and surgery in the island. At that time, both the disciplines of medicine and surgery were conjoined and serviced by single doctors throughout the island.

It would be a tragedy if the present generation were to under-estimate or forget the stupendous contribution paid to the health of the nation by those pioneers of the past – giants of their generation – dedicated, unselfish and self-forgetting; often working with limited tools and drugs and sometimes with inadequate ancillary, laboratory and technical support.

More recent decades have witnessed dramatic changes in the field of medicine and even more so in the art of surgery. Commencing with a small, restricted group of specialising practitioners, medical science has mushroomed into an increasing number of specialist disciplines with their trained advocates and astonishing achievements.

In Jamaica during the 1930's, a single surgeon might face an operation list on a given day with such an assortment as: an enormous goitre, followed by an ovarian cyst; a hysterectomy or a gastrectomy, followed perhaps, by a mastectomy. It is to the never-to-be-forgotten credit of the surgeons of those times that the operations were performed with skill and success. Such was the spirit and enthusiasm of those times that we never seemed to tire and very rarely were on holiday.

Anaesthesia was then elementary and trained anaesthetists were few. In the country parts the Matron and Dispenser at the hospital would often have to function as such, unless the surgeon resorted to local, regional or spinal anaesthesia. Electric lighting was often non-existent, and operation by flashlight and lantern were the order of the day! Tonsil dissection was frequently done under local anaesthetic, whilst blood transfusions were not generally available.

Relief came to the beleagured profession with the establishment of the University Hospital and the firm separation and establishment of specialist departments, which had by that time been started on a restricted scale at Kingston Public Hospital.

Now, in the 80's, the world of medicine and surgery is about to take another great step forward. As the 30's was a period of more or less generalised medicine and surgery, and the 50's, a period of firmer developing of specialties, now in the 80's, the trend is towards comprehensive health care with the pooling of specialist disciplines, with nursing and ancillary contributions, in the treating of the whole patient and not just the isolated disease or pathological target.

No longer is disease and its treatment inevitably considered the province of any one person. As an example, the University Hospital and the Ministry of Health, together with the Jamaica Cancer Society, are now seeking to establish an Onocological Institute at Mona for the treatment of cancer. In this exercise, all the disciplines of research, medicine, surgery, radio-therapy and ancillary skills will be pooled for the benefit of the patient.

The Association of Surgeons has achieved much during the past 25 years and now faces a great challenge ahead. In the future its members will be called upon to play a decisive and dominant role in the advancement of surgery in this country and in the achievement of the inevitable approaching ideal of collaborative and comprehensive treatment of disease involving the uniting of skills so as to obtain maximum health care for the people of Jamaica.

Working with our guests

SECRETARIES OF ASSOCIATION

BY E.R. WALROND

SECRETARIES of professional associations are the essential lubricants of these organizations. They are held responsible for keeping the organization together and making sure that the activities decided by council are carried out. The secretaries of the Association of Surgeons have been no exception to this rule.

Mr. J. Golding was Secretary of the steering committee but once formed Mr. Peter Weston was the first Secretary of the Association itself. When the idea of the Association was mooted, Mr. Weston who was a lecturer in the Department of Surgery at the University College Hospital was the provisional secretary who, with Mr. J. Golding, outlined the aims of the Association and its proposed structure. It is noteworthy that Sir Arthur Porritt, the Patron in the inaugural speech pointed out the need for surgeons to meet not only to show their successes, but to deliberate on their failures and to make friends. In the four (4) years, 1958-1961, that Mr. Weston was secretary, there is very little doubt that the scientific and social aims of the Association were met in full measure. Indeed, the pattern of conferences away from Kingston to promote social intercourse and involvement of surgeons from outside of Kingston was established right from the start.

Mr. A. Masson was elected Secretary in 1962 after Mr. Weston left the island. Andrew Masson has so far been the longest serving secretary 1962-1969. Eight (8) years of unstinting service, during which the pattern of excellence in the scientific and social programmes was consolidated into a tradition. The tradition of having part of the scientific meeting away from Kingston was first broken during Andrew's time when disturbances on the campus in October 1968 interferred with making the usual arrangements. Andrew demitted office the following year and in 1971 was elected President of the Association.

Mr. E. Walrond was drafted into office in 1969 and served until 1973 when he left the island. During this period the University's postgraduate training programmes were begun, and the association attempted to focus on the development of the aspiring surgeons in the programmes as well as continuing its previous programmes.

Mr. McHardy served as Secretary in 1974 and this was the only time when a member of the University staff did not hold this office. His short period of tenure perhaps served best to emphasize the important role the secretarial staff of the Department of Surgery at UWI played in supporting the Administration of the Association.

Dr. P. Fletcher has served as Secretary from 1975 till now and will have become the longest serving Secretary. His tenure has been characterised by forging greater links with our American colleagues, as well as a period where the Association like other institutions has had to struggle to keep alive in the face of severe socio-political problems in the country and the migration of a number of its strongest members. The fact that at 25 years the Association is now a viable adult is due to his strenuous efforts to strengthen its activities in some troubled times.

P. Weston	–	1958 - 1961
A. Masson	–	1962 - 1969
E. Walrond	–	1969 - 1973
J. McHardy	–	1974 - 1975
P. Fletcher	–	1975 - to present

P.R.F. calls a Meeting !

ASSOCIATION OF SURGEONS IN JAMAICA — EXECUTIVE COMMITTEES 1958-1983

Year		President	Vice President	Treasurer	Secretary	Council Members
1958 1959	–	A. McFarlane	J.S.R. Golding	F. McConnell	P. Weston	R. Cory V. Harry S. Street
1959 1960	–	J.S.R. Golding	S. Street	F. McConnell	P. Weston	V. Harry S. Street A. McFarlane H. Shaw
1960 1961	–	S. Street	J. Gilmour	A. McFarlane	P. Weston	K. McNeill D. Stewart V. Harry H. Shaw
1961 1962	–	J. Gilmour	V. Harry	F. McConnell	P. Weston	H. Shaw G. Milner I. Parboosingh K. Hart
1962 1963	–	V. Harry	P. Wiles	F. McConnell	A. Masson	H. Shaw H. Annamunthodo I. Parboosingh G. Milner
1963 1964	–	P. Wiles	I. Parboosingh	F. McConnell	A. Masson	H. Annamunthodo H. Shaw J. Gilmour V. Rob
1964 1965	–	I. Parboosingh	D. Stewart	F. McConnell	A. Masson	M. Gilmour L. Jacobs J. McNeil-Smith H. Annamunthodo
1965 1966	–	D. Stewart	H. Annamunthodo	F. McConnell	A. Masson	J. McNeil-Smith G. Milner R. Lampart D. Degazon
1967 1968	–	K. Hart	J. McNeil-Smith	V. Brooks	A. Masson	R. Lampart I. Campbell J. Burrowes M. WooMing
1968 1969	–	J. McNeil-Smith	G. Milner	V. Brooks	A. Masson	J. Burrowes A. Cotterell
1969 1970	–	G. Milner	H. Shaw	V. Brooks	E. Walrond	J.T. Burrowes A. Masson A. Cotterell E. Khouri
1970 1971	–	H. Shaw	A. Masson	V. Brooks	E. Walrond	J. Williams J. Burrowes A. Cotterell E. Khouri
1971 1972	–	A. Masson	V. Brooks	M. WooMing	E. Walrond	J. Williams A. Cotterell R. Lampart M. Anderson

ASSOCIATION OF SURGEONS IN JAMAICA — EXECUTIVE COMMITTEES 1958-1983

1972 – 1973	–	V. Brooks	R. Lampart	M. WooMing	E. Walrond	J. Williams R. Carpenter A. Cotterell M. Anderson
1973 – 1974	–	R. Lampart	D. Gore	M. WooMing	E. Walrond/ P. Fletcher	J. McHardy R. Carpenter G. Burkett J. Williams
1974 – 1975	–	D. Gore	J. Williams	M. WooMing	J. McHardy	A. Cotterell R. Carpenter G. Burkett
1975 – 1976	–	J. Williams	M. WooMing	H. Spencer	P. Fletcher	J. McHardy F. Roper A. Cotterell M. Anderson
1976 – 1977	–	M. WooMing	A. Cotterell	H. Spencer	P. Fletcher	J. McHardy C. Fletcher K. Baugh W. Dennis
1977 – 1978	–	A. Cotterell	R. Carpenter	H. Spencer	P. Fletcher	W. Dennis R. Wan L. Douglas R. McNeil
1978 – 1979	–	R. Carpenter	W. Wilson	H. Spencer	P. Fletcher	W. Dennis H. Jackson L. Douglas
1979 – 1980	–	R. Carpenter	W. Wilson	H. Spencer	P. Fletcher	D. Raje R. DuQuesnay H. Jackson W. Dennis
1980 – 1981	–	R. Carpenter	W. Wilson	H. Spencer	P. Fletcher	D. Raje R. DuQuesnay J. Jackson W. Dennis
1981 – 1982	–	W. Wilson	J. McHardy	H. Spencer	P. Fletcher	A. Cotterell D. Raje W. Dennis P. Wellington
1982 – 1983	–	W. Wilson	J. McHardy	H. Spencer	P. Fletcher	P. Brown W. Dennis A. Cotterell D. DuQuesnay

Members and our guests.

LEST WE

THE HON. DR. HENRY SHAW, M.B., Ch.B., F.R.C.S.(Ed.) F.A.C.S.

Dr. Shaw was born in 1914 and educated at Cornwall College, Montego Bay. He first became a teacher, teaching Physics and Mathematics first at Cornwall College and later and Mannings High School. Later, in 1943 he was awarded a Government Medical Scholarship and studied at Liverpool University, England where he gained the M.B. Ch.B. degrees. He joined the Government Medical Service on his return to Jamaica in 1949, and after spending a year as Medical Officer in the Cayman Islands, went to the United Kingdom on study leave. While there he became a Fellow of the Royal College of Surgeons of Edinburgh. In 1955 he returned to Kingston Public Hospital first as a Surgical Registrar and later as a Specialist Medical Officer. At the time of his death he had been a Senior Consultant Surgeon for many years and had at one time served as Senior Medical Officer for Kingston Public Hospital.

He served as President of the Jamaica Branch of the British Medical Association and also of the Association of Surgeons in Jamaica. In 1973, he became Custos of St. Andrew.

Following his appointment as Specialist Medical Officer at KPH, he was appointed an Associate Lecturer in Surgery at the University of the West Indies. He was one of the truly great surgical teachers and was beloved of generations of medical students, trainee surgeons, colleagues and patients.

Dr. Henry Shaw

His extrovert personality and considerable enthusiasm were the hallmarks of this very talented man. He enjoyed surgery even as he enjoyed bridge, golf, deep-sea fishing and bird shooting. Above all he enjoyed people. He died in 1976.

DR. GERVAISE VALENTINE HARRY

Dr. Harry was born in Canal Zone, Panama on February 14, 1910. He was educated in Panama to age 10 years, then "remigrated" to Jamaica to live with his grandfather Dr. Archipus Harry who was a General Practitioner, in Kingston.

He attended Calabar High School, 1920-27 when he was captain of the Sunlight Cricket Team and also excelled in Latin, Mathematics and Spanish. He attended Edinburgh University from 1928 to 1933 for his medical training, and returned to Jamaica in 1933. He joined the Government Service which he continued to serve until his retirement.

He died in August 1, 1978, age 68 years. He was a truly rare and special individual still alive in the memory of family, friends and the many lives he touched in passing.

DR. LENWORTH MAYHEW JACOBS

The medical profession as a whole in Jamaica and most particularly the Association of Surgeons in Jamaica, experienced a great loss at the recent death of Dr. Lenworth Mayhew Jacobs, C.D., J.P., M.D., F.A.C.S., S.B. St. J. He died of cancer at his beautiful home in Mammee Bay, St. Ann, just three weeks short of his 72nd birthday, he was born in Portland on February 2, 1911. His loss is felt keenly by the members of the Association of Surgeons in Jamaica, for he was one of its founder members in 1958 and remained one of its most active and enthusiastic members.

Enthusiastic; perhaps that was one of the keywords that followed him throughout life, for he brought enthusiasm to everything that he did, whether it was to the long dedicated hours at the operating table; his unhurried attention when listening to his patients' complaints: his evening rounds to those patients who could not attend his surgery – sometimes covering many miles into the hills of St. Ann. Equal enthusiasm was brought to his upflagging work in the field of Family Planning – of which much has been written elsewhere, but it was of such vital importance that the value to the whole community cannot be overstressed, he was world acclaimed for his work in that field. One cannot separate his work in Family Planning from that of his wife, Beth Jacobs, for her drive and active support was always with him, they worked as a team, always towards the same goal. His work with the young people, in and around St. Ann's Bay, was close to his heart and occupied much of his time. His enthusiasm for sport was manifest – especially cricket – he was a member of the Kingston Cricket Club and made many trips from St. Ann to attend both local and international matches.

Although so many interests claimed his time and attention, surgery was perhaps the greatest love of his career and one of his proudest moments was when his son was awarded the F.A.C.S. He was a great family man, a devoted husband and father and a doting grandfather.

His courage never faltered and his sense of humour was undimmed up to almost the end of his life. When it became difficult for him to move around, he would sit in his reclining chair and play patience, read – he had always been a great reader of a wide range of subjects – or watch television, he especially enjoyed the sports programmes and various comedy series, whilst the cool breeze from the nearby ocean blew in and across and out through the louvres beside him, into the garden which he loved so much.

His manner to all people was courteous and natural, whether he spoke with a duchess or a market lady, he loved people and treated everyone with the same kindly attention, so that he was loved and greatly respected and will be sadly missed by all those with whom he came in contact.

His funeral was not termed as such but was called a Service of Thanksgiving, and that is what it was, a thanksgiving for the life of a good man and a dedicated doctor.

Philip Wiles, MS. FRCS:

Author of a famous Orthopaedic textbook, retired in Jamaica. For many years he taught medical students at the UWI and advised on the development of surgery. He was President of our Association and spoke out fearlessly for the highest standards of patient care whether the patient was paying fees or not.

John Maryatt M.B.B.S. DMRD

was the second radiologist at the University College Hospital. He was distinguished for his ingenuity. Having been trained as an electrical engineer, the maintenance of a department was never a problem. A man of great kindness, intellegence and integrity as well as a great host and chef.

Fred F. Ransome, FRCS:

An ENT surgeon and a perpetual student now lives in Florida having retired from active practice to pursue the great interest of his life Ornithology. An enthusiast for surgery and a great supporter of our association. His enthusiasm and interest has always been an inspiration to his younger colleagues.

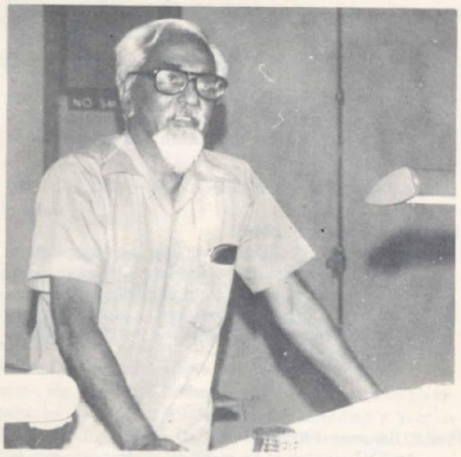
Maurice Thompson, FRCS:

was a quiet, gentle and determined surgeon interested particularly in Orthopaedics and Trauma. He had remarkable manual dexterity and a well supported reputation for the excellence of his work He died very young and was a sore loss to our Association.

Owen Tomlinson, FRCS:

Full of energy and activity. A most busy and popular surgeon who was reputed to have removed more appendices than any other surgeon in the Island. A regular attender of our meeting from the inception of the Association until the days when he could work no longer.

FORGET!



Did they make their points ?

Dental Surgery

DR. LEO D. C. MARCH, DENTAL SURGEON, in a letter to the Association states:

I qualified in London June 1939, and after working briefly in London I joined the British Army as a Dental Officer in December 1939. I was the first West Indian to receive a commission in the British Army. After one year's service in England, a group of us were given a course of Facio-Maxillary Surgery in Aldershot and posted to the Middle East. Three years in the Middle East saw my return to England. After a much more advanced course in Facio-Maxillary surgery at East Grinstead Hospital, I rejoined my hospital unit for service in the European war for the next 18 months, from July 1944. I will never forget the first night we began to admit casualties four hours after their wounds in a 1400-bed tented hospital, and by sunrise there were 102 cases of gunshot wounds of the jaw and face.

I returned to Jamaica in February 1946 and joined the staff at the Kingston Public Hospital as full time Dental Surgeon, along with Dr. Henry Lopez. Starting at 7:30 a.m. we would get through approximately 75 patients for extractions of teeth and then go on to see another 15 or 20 swollen faces which ranged from osteomyelitis to fractures, from cysts to tumours. One of us would do the afternoon session on alternate days. Dr. Henry Lopez left on extended leave after a month and Dr. Ken McNeil and I formed the first Facio-Maxillary team. We operated on over 100 cases of Adamantinoma and a number of cases of carcinoma of the jaw and related structures. Indeed there were so many cases of carcinoma that Dr. Ken McNeil thought fit to invite the post-operative cases to his home in Deanery Road where they were shown films and generally entertained by way of rehabilitation. All surgeons were invited and we had some interesting discussions. Dr. McNeil's mother and sisters would provide refreshments which patients with obturators replacing large parts of their faces could partake of.

Out of this the Jamaica Cancer Society was formed. My technician, George Phillips, was instrumental in fabricating the Facio-maxillary appliances which included noses, eyes and obturators, without which the patients' speech would not have been understandable. He also furnished appliances for the introduction of radium needles to the womb and other structures. All such appliances were constructed in my private laboratory and I had by then started a private practice while continuing on a part-time basis at the K.P.H. This work was at no cost to the patient or hospital. I was fortunate to have had such a dedicated technician and we both found the work very rewarding. George Phillips was subsequently employed to operate a laboratory at K.P.H. on a part-time basis while continuing to work with me until his early death at age 42.

Just before this, I relinquished my post at K.P.H. though I was recalled a few times to operate on special cases. I was fully occupied in private practice till I was offered the post at the University College Hospital as consultant and associate lecturer in Dental and Oral Surgery in 1953. I then embarked on 24 years of the most rewarding work.

Lectures were given once weekly for the first term on Friday afternoons. On Friday mornings the students attended the Dental Clinic for one hour in batches of 3 which increased to 5. Each had 5 such clinics and by the end of the first clinic each and everyone could inject and extract teeth. I instituted a method where the patient was unaware that the student was operating until one day a male patient objected. This account was mentioned at a send-off party which the Hospital Board kindly gave in my honour, by one of the Deans who was the student involved. The patient said he refused to have a student extract his teeth, to which I replied that I was once a student and if I had not been given that chance I would not be there to help him. He calmly sat back, smiled and allowed the student to carry on.

This, I might emphasize was one of the great objects of the exercise, to see that the student was properly taught, and the only way was for them to have the practical experience to enable them to help the patients when they are on their own. I used to have an operating session on Wednesday afternoons when the students used to be present. Indeed I was ably assisted by many in operating on over 2000 cases of jaw fractures cysts, tumours etc. The team work with Sir Harry Annamunthodo was responsible for 25 cases of adamantinoma. Also with Sir Harry we had seminars with the students on some Friday mornings. With Doctors Don Gore and Viv Brooks, I had similar relationships. There were a few cases of cleft palate work with Professor Reg Carpenter. I prepared obturators to replace two cases of skull defects and assisted Dr. Andrew Masson in inserting them in two boys age 9 and 14. They both did well till the younger boy died from drowning at age 16. I worked alongside the earliest expatriate surgeons. I had a very rewarding partnership with the visiting E.N.T. surgeons who used to come from London on a 10 year secondment. Each must have passed the word as there was no time wasted in getting together. We operated as a team on all the serious jaw and E.N.T. cases.

At our second Dental Convention, some 17 years ago, Professor Harry Archer head of the Department of Surgery, Pittsburgh University, U.S.A. was enthused with some

slides I had shown and asked my permission to publish some in the 5th edition of his book on Oral Surgery. This textbook is translated into 7 different languages used worldwide. I had to follow this up by sending him histories, specimens, slides and miniature x-rays of future cases. He very kindly sent me a complimentary copy of the book.

The problem of producing the miniature x-rays was solved, after many experiments, by photographing the usual x-rays with a Starex camera, holding the x-ray up to a clear sky. The smallest cloud in the sky would be reproduced. This relationship with Professor Archer continued for some years during which time I was invited to Washington D.C. to receive a Fellowship in the American College of Dentists.

I must mention the anaesthetists who were always most co-operative; Dr. Siva, who apart from theatre work, would attend at the Dental Clinic when we had severe cardiac cases, and stand by with his bag of tricks and keep counselling the patient while the work was being done. He took a great personal interest in such cases. Back to our first head and only anaesthetist at that time, Dr. Victor Keating. On many occasions after work we would visit my farm, joined on some week-ends by Professor Gerald Ovens. Such was the relationship and co-operation in those days.

I must make special mention of Sister Morgan who was then staff nurse in charge of the Dental Clinic and without whom I could not have single-handedly managed to teach the students who used to extract teeth from 20-25 patients in the first hour and then I would go on to completing the remaining 40 or more patients. She would then walk from one end of the corridor to the other, where the patients used to wait shouting "Has everybody heard his or her name?"

From about the mid 1950's many hours were spent on planning for a Dental School. Soon after Sir Arthur Lewis assumed the post as Vice-Chancellor of the University, he summoned me to his residence for discussions as he had been informed that I had been working on this. A great deal of time was spent with teams from U.N., PAHO., Inter-American Development Bank, the Hope Ship etc., all with serious promises, but no results. Professor Anderson was seconded from Bristol University to teach Physiology here and who was on the Board at Bristol had many discussions with me on my balcony and out of this the Bristol Scheme evolved. This enabled our students to do the first 2 years here and proceed to Bristol for completion.

Finally, the most rewarding of my experiences at the University manifests itself in the fact that when I travel the countryside and meet any of our old students they are immediately grateful for what I managed to teach them as they were happily operating on and caring for so many conditions of the jaws.

Caries: keeping Leo March in business !

The Influence of Social Reality on Trauma and Musculo—Skeletal Disease

J.S.R. GOLDING

IN THE last few years there has been a radical alteration in the direction medical planning has taken. Much of this is due to the work of Dr. Mahler, the Director General of World Health Organization. He has pointed out to us quite clearly that the aim of Medicine has to be a Healthy Community and that the cure of disease, the concern of hospitals and the object of our medical student teaching, is little related to Health. Disease largely results from inadequate Health Services or the natural processes of aging. In an advanced First World country, the causes of ill health – malnutrition, poor water supply, inadequate sanitation and a lack of knowledge of personal hygiene – are hardly important factors. In the Third World they are the major problems we have to face. Whether we like it or not, we live in the Third World and have to recognize what this implies. If our aim is to assist the community to pull itself up, then we have to avoid living in the Third World as though we were in the First.

It is this last point which should concern us most because Medicine will always be concerned with caring for the needs of the sick at all levels. Those who have interesting conditions and those who have not, those who can pay and those who cannot, those who can appreciate fully what we are trying to do for them and those who cannot. The fact is that our treatment should be geared to the needs of the patient and his condition, not to the social status of the person or his family.

Because this was the medical philosophy of physicians in the first half of this century, the whole spectrum of disease altered so that the 19th Century distribution which we saw in the 1950's has completely changed. This was due to the effects our profession had whilst working alongside and being part of the development of a real social conscience in Society. In England, the most affluent country in the world at the end of the 19th Century, more than 50 per cent of the population had not the money to pay for a coffin to be buried in. The welfare state of today is faulty in many respects but it is infinitely preferable to the situation our great grandparents had to face. The medical profession had a major input into the amazing progress which characterized the first half of this century. We had learnt that the 19th century idea that Society was based on the survival of the fittest or strongest was only partially true. We had come to realize that the strength and fitness to survive come mainly from co-operation and working together.

We may well be in danger of forgetting the lessons of the past. As the pendulum has come to swing too far away from the ideas that had been proved to be so successful. It needs someone to stand back and view the whole process and to point out that the present characteristic of our profession and particularly the para-medical professions is the belief that their future relies on personal self-interest. This simply is not true. It is forgetting what we should have learnt, forgetting that an improvement across all levels of Society gives us a bigger "cake" to divide up for ourselves and our children. It gives us a better, happier, and more cohesive Society in which to live. The sense of injustice which has destroyed communities from time immemorial will diminish only when continue to treat all levels of Society as did our medical forefathers in the days when to be a "doctor" was the highest title which could be awarded.

We have entered the late 20th Century spectrum of disease and face the same problems as the First World. We cannot help but know that the advancing fringe of curative Medicine depends on the most advanced technology. The Law of Diminishing Returns has come into play so that the whole world of investigations on which curative Medicine is now based has become so expensive that it has practically brought the National Health Service in the United Kingdom to its knees and resulted in illness being a major tragedy in the life of those even in the most affluent Societies.

It is therefore obvious that we have to rethink our role in the community. Since we cannot afford to cure disease as effectively as it can be done, then we have to try and prevent the need to cure. We have to think of the ways of prevention.

As far as Orthopaedics and Traumatology are concerned, this means early and effective "triage". The seriousness of an injury has to be recognised very early and if it is beyond the facilities available where the injury has occurred, that patient should be immediately transferred. The primary care of an injury determines the whole outcome. The level of disability that the patient will eventually be left with is dependent on the efficiency of the primary treatment. However good the secondary treatment given may be, it can never restore the loss of power and joint stiffness which results from infection and massive scarrings.

If we consider the two commonest major injuries which we have to treat, namely, a fracture of the femur and a fracture of the tibia, the direction our argument is taking us

becomes clear. The fracture of the shaft of the femur – a bone surrounded by muscle – is rarely compound. The problem is simply to finish up with a leg of the original length, with a mobile knee and the patient in hospital for the minimum time because of the pressure on hospital beds which always faces us. This problem has been largely solved by the use of Perkin's traction which brings the leg rapidly out to length and allows early knee movement. This can be followed by a cast-brace using a simple Newberger type of knee hinge which can be made in any workshop. This illustrates one type of research problem. How to adapt First World technology stripped of all its frills to suit our needs.

The tibia, being a subcutaneous bone, is very often a compound injury. Leg length and knee mobility are less of a problem. The primary need is to give good skin cover to the bone to prevent infection. Any serious breach in the skin surface needs early expert attention, thorough debridement and probably the application of a split skin graft, if there is any defects or any tension present. Tight suturing is dangerous as a compartment syndrome endangering the leg may develop and even if this does not occur, the wound will usually break down and the bone become infected. Where the tibia has been severely crushed with soft tissue destruction, early amputation will save the patient much fruitless pain and hospitalization. This is a decision for which wide experience is needed. Triage – the early decision that the injury is too severe to be treated in a small hospital – so that the definitive treatment can be instituted within 12 hours of injury, will mean either a patient able to use his leg again and return to work or one with a permanent major disability. Early triage is essential in hand injuries where infection prevents free finger movement by producing massive scarring and causes even more disability than a severely damaged leg.

From the point of view of future research and planning the way ahead is clear. Our aim is to prevent disability with the cheapest most appropriate treatment methods possible. This can be achieved by:-

1. Teaching the student to recognise the seriousness of an injury so that immediate triage is undertaken leading to early definitive surgery within 12 hours of injury.
2. Recognizing that musculo-skeletal injury needs long hospitalization and occupies so many beds that preventitive methods need to be investigated to reduce their number. The commonest cause of major injuries is road traffic accidents. The statistical performance of these injuries on our West Indian roads is so bad, so much worse than in the First World, that any political action tested and proved to be effective in other countries will be highly successful here. This will relieve the pressure on us more effectively than any minor improvement in treatment that can be envisaged.
3. Concentrating on primary research into conditions that are particularly common in our area. We have the basic infrastructure and social organization to do this sort of research well. This accounts for the progress made by our Tropical Metabolism Research Unit in the problems of the malnourished infant. It accounts for the knowledge which we have of the natural history of the haemoglobinopathies. The work of the Epidemiological Research Unit in the "cohort" studies is the sort of approach which will always bring dividends. The study of the treatment of avascular necrosis of the hip in haemoglobinopathy is the sort of orthopaedic problem we are in a particularly favourable position to investigate.
4. Adapting First World knowledge to our Thid World problems should be the prime investigation of our Faculty. As the Lord High Executioner once described his problem as to "make the punishment fit the crime", it is ours to make our treatment fit the demands of the environment in which we live.

DOING IT MY WAY

AUBREY McFARLANE

Excerpts of address at the 19th Annual Clinical Meeting of the Association of Surgeons in Jamaica

My first introduction to the Medical Service in Jamaica was a telegram from the S.M.O. of the Island Medical Services instructing me to report for duty on 1st April, 1930 as D.M.O. of the Negril District. On reporting to the retiring D.M.O., I was courteously received by a very old gentleman, who after exchanging the usual pleasantries, handed me one small rubber stamp marked "Official Free" with the information that that was all the government property he had. There were no drugs, instruments, nor writing paper and no Government Office, nor anywhere to see patients. Apparently one was expected to rent an office to see private patients and to see the Government patients there as well!

Some months later, I was appointed to take over the Lucea Hospital. This was my first appointment in charge of a hospital and also the Matron's first appointment as a Matron. The dispenser who was also supposed to be my anaesthetist had never been inside an operating theatre. At that time chloroform was the standard anaesthetic and operations were sometimes a bit adventurous. As a result, we did most of our operations under spinal or regional anaesthesia and in time developed quite a high degree of skill.

Shortly after taking over the Lucea Hospital, I was called to see a portly lady of middle age who had known me since I was a child. She was obviously suffering from malaria, but she did not wish to be examined. I respected her wishes and prescribed for her. Some days later, I met a relative of hers and asked why the patient did not wish to be examined, to be told she said – "I don't want any little boy to come fingle me". It was some consolation to me therefore, that a few years later this lady and her immediate family used to travel the forty odd miles to Falmouth to consult me.

To sterilize instruments we wrapped them in a towel and placed them in water in a kerosene tin, which was then heated on an outside fireplace of three bricks, boiled for thirty minutes, then removed and placed in a basin of 1/40 carbolic or

lysol lotion. In spite of the poor equipment and the sterilizing method, the infection rate was remarkably low. We sometimes had alarming rises of temperature which an injection of quinine soon fixed, as in that area everyone had malaria and an attack often followed a surgical procedure.

In those early days the D.M.O. carried out a wide variety of duties, one of which was vaccinating school children. One day, at Cascade in Hanover, there must have been over a hundred to be done. I was about half way through the job when a District Constable approached and conversation went something like this:–

D.C. "Doctor, the Parson send for you Sah".

Doctor: "Tell him I'll come as soon as I finish vaccinating the children".

D.C. "Doctor you don't understand Sah, the Parson don't sick, him having a wedding up there and a lady having a baby in the Church, and she bleeding and the Midwife can't handle it".

I immediately stopped what I was doing and went to the Church about a quarter of a mile away at the top of a steep hill, and was shown into a side room. There was a young girl lying on the floor moaning and making a lot of noise with an elderly woman comforting her. A little distance off was a large tin that had once held a ham. I looked into the tin and recoiled in alarm at what appeared to be an enormous frog, or something I had not seen before. On closer examination, I realised it was an anencephalic monster, and attached to the same placenta was a small apparently normal twin. I did what was necessary for the patient and the bleeding checked. At this point the Minister asked if he could see me:–

Parson: "Doctor, can we proceed with the wedding?"

Doctor: "Yes, she will not make anymore noise now".

Parson: "Can she get up and come into the Church now?"

Doctor: No, but you go ahead with the service she will give you no further trouble."

Parson: (puzzled) "Doctor you don't understand. . . . . .this is the bride!

I was informed that the service was completed two weeks later and I hope they lived happily ever after.

Beside these lighter moments, there was a tremendous amount of work to be done in the Parish, and I ended the victim of an acute attack of malaria which laid me low for some time. Following convalescence, I took long leave and entered for the Fellowship in Surgery in Edinburgh in 1935. Having obtained this, and after a short sojourn at the Falmouth Hospital, I was called up to the Kingston Public Hospital. During my stay at Lucea, I had been gradually acquiring my own surgical instruments, and when I saw the antiquated implements that passed for instruments at Falmouth Hospital, I had no hesitation in packing them up and forwarding them to the Island Medical Office. This apparently had the desired effect, as I gradually received replacements.

One night the manager of a neighbouring estate brought in a man with a badly crushed leg, and it was decided that amputation would have to be performed. As there was not adequate lighting in the operating theatre, flash lights as well as a couple of borrowed cold man lamps were employed, with the manager watching the

whole proceedings. He was so impressed that a man's life could be saved under such circumstances, that he persuaded his employers to donate a lighting plant to the Hospital.

I was then transferred to the Kingston Public Hospital where a new operating theatre was eventually put into use sometime around 1938. In this theatre we had insisted on air conditioning. Operating under the theatre lamps with temperature up in the nineties in the summer was warm work. We had to wear sweat bands around our heads, and a nurse with small towel and a bowl of iced water mopped one's face and the back of the neck from time to time. The engineers had insisted that they be left alone to design and install the air conditioning.

They installed a large fan in a small room on the roof, and a cooling aparatus of sorts through which the air was forced into the theatre. It was a welcome improvement, though not fully adequate for the job, but we were very proud of it. We believed, rightly or wrongly, that it was the first of its kind to be used in an operating theatre in the West Indies. Unfortunately our joy was short lived, as it went up in smoke after a few weeks of almost continuous use. It was not until after the end of World II that an up-to-date system was installed. I was made to understand that the cost of installing this system exceeded the cost of the original theatre building.

It must have been about 1936 or 1937 that we did our first gastrectomy at the K.P.H. This first patient was a man of six feet, weighing 97 lbs, and suffering from a carcinoma of the pyloric antrum. He made an uneventful recovery. The next one two weeks later, in much the same condition, was treated likewise with the same result. We were soon doing quite a few cases, but our mortality rate of about 5%, chiefly among the cancer cases, was considered a bit high. However, one day two American Surgeons visiting the K.P.H. were asked what we could do to reduce our mortality rate, which was worrying us. We could hardly believe it when they told us that their mortality rate was much higher than ours. Needless to say this information inspired us to greater heights.

In comparison, it appeared that the explanation was quite simple. Our anaesthesia was so poor (chloroform and ether being the usual anaesthetics), and having no regular anaesthetist, the job usually fell to the junior member of the team, so we did all the cases under regional anaesthesia. There were no nasogastric tubes in those days, no intravenous drips nor blood transfusion, only rectal saline, about one pint in twenty four hours, so that the patients were probably thoroughly dehydrated. The advantages of regional anaesthesia were that there was little loss of blood, and more important, there was usually no post-operative vomiting. The commonest cause of death was due to leaking from the duodenal stump following post-operative vomiting or wound infection in the cancer cases. There was usually no infection in the ulcer cases. Our mortality rate fell when we learned to treat the cancer cases for anaemia and malnutrition before attempting operation, and protecting the wounds with abdominal cloths lined with a thin layer of rubber. But, in my opinion, the most useful advance in modern surgery has been the improvement in the art and science of anaesthesia and the modern anaesthetic drugs, allowing the surgeon to operate without undue hurry and with a feeling of safety.

The late 1930's and early 1940's were exciting years for surgery in Jamaica. Apart from the import restrictions on equipment and drugs, we were also very short of personnel due to the war, and we had to be very resourceful in seeking ways of improvising to fill the gaps. But this was also the commencement of the era of the wonder drugs which were to make such a difference in Medical and Surgical practice. Prior to this, there were very few specifics; we had quinine for malaria, emetine for amoebiasis, 606 (Salvarsan) for syphilis and yaws, and one or two others. Diseases like pneumococcal pneumonia, streptococcal septicaemia, thyphoid etc., carried a very high mortality, and the victims were often those in the prime of life. Disease like gonorrhoea required months of unpleasant treatment. Osteomyelitis was a particularly crippling and often fatal disease. In 1936 Sulphanilamide was introduced into medicine to be followed rapidly by others of the same group, but safer and more effective. Over five thousand Sulphonamides were synthesized, although only a few of those were actually used in clinical practice. At last we had a really potent drug with which to fight infections. It was only a few years later that Alexander Flemming and Florey produced Penicillin for use, to be followed by a host of new antibiotic drugs, more potent and quicker acting than the sulphur drugs.

It was about this time during the War years that we formed a group of seven at the K.P.H. calling ourselves the "Ressurection Gang". Whenever a particularly serious problem came in, or one of the group hit trouble, the word would pass around and we all gravitated to the point of action, sharing the decision making, and giving whatever assistance was necessary. I regret that three of this group are no longer alive, and only two are still doing some medical practice.

Of the many new things we tried, two are of special interest:–

1. Intravenous drips.
2. Blood transfusions.

The first bottles of normal saline were prepared half a dozen at a time by Dr. Ken Evans, who had read an article on some experiments in the Scientific Journal Nature. These were administered by means of a small red rubber tube, using Murphy's drip to control the rate of flow; the rubber tubes were re-sterilized, and used over and over again. Young doctors joining the staff were quite surprised to see what soon proved a popular and, in a way, a revolutionary method of treatment. Later we were able to obtain more sophisticated outfits and commercial supplies of various intravenous solutions. This was a great improvement in the days when surgical shock was an ever present danger. Blood transfusions were much more difficult. The group of doctors all volunterred as donors, and so did members of the "Toc H", the Y.M.C.A., and the Rover Scouts. The donor and recipient had to be cross-matched as we had no typing serum. This meant having several donors standing by for each transfusion. Having found a suitable donor, the donor and recipient were placed side by side, and a syringe called a Jube syringe, which could draw up the blood, and by turning the plunger, deliver 10 cc. of blood to the recipient. (The syringe was first filled with sodium citrate solution also the rubber tubes leading from the syringe to the needles in the arms of the donor/recipient). This procedure was a bit nerve racking and after a couple of attempts, both successful, we decided to draw the blood into a bowl containing sodium citrate solution and then pump it into the recipient. We also used auto transfusions in the cases of ruptured ectopic gestation and the occasional ruptured spleen that came our way with what seemed to us dramatic results.

I think it is a pity that Jamaican doctors have not found time to put into print more of the many and varied interesting conditions with which they have been confronted. For instance, I call to mind a little boy being brought by his grandmother to the Orthopaedic Clinic one day with bilateral genu recurvatum. Some time later I saw the mother, and she too had the same condition with small, but well developed patellae. This struck me as being very interesting and I decided to wait and see what would happen in the years to come. I waited seven years, having provided her with a special pass that would enable her to see me at anytime she or her family needed medical attention, and I promised to attend to them myself without delay. In the seven

Contd. on page 28

"MEMORIES"

THE EXPERIENCE of other addresses has taught me how important it is to be sure everyone understands, early on, the message you are trying to give. This evening, I am thinking of Churchill's words, "the further we look back, the further we see forward." At this stage in our development we certainly need all the foresight we can get.

I want to tell you what Jamaican surgery was like twenty-five years ago. The Senior Medical Officer at the Kingston Public Hospital was **Aubrey McFarlane.** He was also the first President of this Association of Surgeons, and there was no doubt in my mind that he was the right man to do it. His standard of work was so high. It was not just the fact that he was technically a good surgeon, but much more that he was such a good man. Absolutely straightforward, hardworking, just what surgery needed in a leader, and this is the way he has remained ever since. But, he was in no way alone in that group of surgeons at Kingston Public Hospital. **Morris Thompson,** very interested in Orthopaedics; one of the best technical surgeons that we ever had in the island. Unfortunately, he died very young, but I can still well remember the excellent work that he did. Then there was **Sam Street** of course. Later a Senior Medical Officer and then the Chief Medical Officer who went over to Bangladesh as part of the World Health Organisation.

The other great giant, a man of all parts, **Dr. Leighton Clark,** was then at the height of his career as a Practitioner, Surgeon and Ophthalmologist. The most popular and generous physician-surgeon of the lot.

This brings me to that group of people in the island who were the Senior Medical Officers in charge of hospitals. The one in the way I knew best, was **Dr. Leo Freeman** in Spanish Town, because we worked together for some eighteen years. He did all the general surgery and I did all the Orthopaedics. A remarkable man. Tremendously energetic, still working at May Pen and Linstead although much older than in fact he looks. Full of energy and a real deep interest in abdominal surgery. Then we had **Keith Jacobs** in Lionel Town. Again, very interested in Orthopaedics, very interested in hypnotism and running a hospital firmly, wisely and well. **Horace Henriques** in Mandeville always reminds me of the space of a May morning. Full of the joy of living. It made one feel better just to go and see Dr. Henriques. He had great charm and I used to think of him sometimes when I remembered that the real difference between rape and rapture is simply one of salesmanship. Further on was **George Campbell** in Black River doing excellent work. A man people came to see from far and wide. He had to be good because his neighbour on the other side was **Alfred Carnegie.** The real giant; the intellectual giant, probably the most academically orientated surgeon in the island medical service. A man who returned to Jamaica bearing every honour – his fellowship, his membership and every gold medal from the University of Edinburough. I think of him now remembering a little story that we sometimes tell about these academics, because it is said that when Alfred Carnegie's wife produced twins, one was baptised and the other one he kept as a control. Alfred Carnegie had as his northern neighbour, **Noel Holmes,** and Noel Holmes was a most loveable man. A very hard worker as indeed all these men were. He ran his little hospital at Lucea with a real deep interest. Greatly loved by his patients. I can remember having lunch with him on one occasion and in between courses, he nipped out, came back in again, nipped out at the end of the next course and then when I asked him what he had done he said, 'I put in the local anaesthetic the first time, I took out the tooth the second time and now I am going back after we have finished to make sure that he's all right before he goes.' This was typical of these men. Their whole lives were medicine and surgery. They really contributed to the community. Next door **Herbert Morrison** ran Montego Bay. Another giant of a man, Herbert Morrison was a man of tremendous integrity. The sort of person who did all kinds of real kindness to people you would never have known about. A man who would work endlessly, would go round his hospital at all hours, kept up a tremendous standard. In Falmouth was **Victor Magnus.** Full of fun. Greatly interested in Sports and of course in racing. **Lennie Jacobs** was in charge of St. Ann's Bay. The father of family planning in Jamaica and a man of international reputation. Next door to him one of the other real intellectuals, **Val Harry.** What a firstclass medical and surgical service Val used to run. I remember going down there on many, many occasions. We used to play Bridge together with **Ronnie Irvine.** The other Bridge player was **Sydney Martin.** A very good technical surgeon, not at all intellectual, but always coming to Val for help when any problems developed. The two of them worked together as a splendid team. If you went to Annotto Bay Hospital to see what it was like, you would see what Sydney meant when he used to say 'you can eat off the floor' because you really could. The way the hospital was run and the affection between the nurses and doctors was absolutely outstanding. Port Antonio had **John Martin.** There was John, full of vigour, full of sound advice and full of energy. What a pleasure to visit there. Next along the line was Hordley. Certainly the worst hospital in the island, in the way of facilities. There were tiny little wards dotted all over the place with absolutely no equipment. You had to walk from one ward to the other up a

Excerpts of an address at 20th Annual Clinical Meeting of the Association of Surgeons in Jamaica, May, 1978...

By Professor John Golding

steep slope. The patients were carried up on a stretcher to get into the ward. It really was a very primitive place, but the work done was outstanding. **Miss Neita Barrow,** the Chief Nursing Officer used to say that if she ever tried to move a nurse from Hordley she would find it almost impossible to persuade her to leave. It had such a wonderful atmosphere.

If you happen to go down to Princess Margaret Hospital in Morant Bay and you see **Dr. Lampart** there, you will be visiting a hospital in the old style. It's still Dr. Lampart's hospital and there is no doubt about that at all. You may see **Dr. Peat** working there, one of the best Chief Medical Officers we ever had in the island, and a very loveable man for whom I have the very greatest respect. You will see a matron who keeps the nurses looking happy and who works extremely well with the doctor and the administrator. There is a very high standard of nursing in that hospital. There is an administrator who works with and listens to the doctor and the matron. What a pleasure it is to go down there and see this. I think I would like to go on record at this time and really compliment Ronnie Lampart on what he has been able to achieve.

There are other people in their way even more outstanding. None of us, for instance, would ever forget **Dr. Rob** at Spaldings. I can remember him particularly well because at the time of the Kendall disaster, the University team went down with a team from the Public Hospital to Mandeville. The University group went up to Spaldings where several casualties had been admitted. The standard of work we saw there was remarkable. Every patient in bed; clean and tidy. Over the bed; the diagnosis, what treatment had been given and in large letters what drugs such as morphine had been administered. When we got down there, 90% of the work had already been done. The severe cases were transferred back to Kingston. From that moment onwards, I have always had the greatest respect for Dr. Rob, and of course over the years when he referred cases to us we knew that something coming from Rob was well thought of. Patients would come from all over the island to see him in Spaldings. He would work Saturdays through most of Sundays, quite unsparing. One of the most respected and loved doctors in the island.

Nearer home there were two men that we have to remember. There was **Dick Cory** at the T.B. Sanitorium. What a horrible little operating theatre they had. There was Dick Cory working away with no air-conditioning, sweating profusely as he worked, doing first-class chest surgery of those days which was mainly in the realm of tuberculosis. Again, the hospital was immaculately kept, where the relationship between the doctors and nurses was outstanding. The other hospital where this was true was the Victoria Jubilee, with that giant who we loved so well, **Dr. Ivan Parboosingh,** and his wife **Rose.** Again, such a remarkable man.

We had politicans in our midst. There was **Dr. Glendon Logan.** Then **Dr. Ivan Lloyd,** Minister of Health. **Dr. Herbert Eldermire** another Minister of Health and **Dr. Bonner.** More recently, the **Hon. Dr. Kenneth McNeil,** who I remember so well as a brilliant E.N.T. Surgeon. Remarkably dexterous and a firstclass teacher. These were the men who I was surrounded with and welcomed me to Jamaica.

We have left out of course everything about the University because at that time the University was rudimentary indeed, and played little part in the tone of surgery and medicine in the island. But, when I look back on the years and what the University has done, I remember certain people particularly and it's good to have the opportunity to recognise them now.

I remember particularly of course, **John Gilmour.** John Gilmour took over from me, who was acting head of the department after the death of Gerald Ovens. He came in to give us the stature to guide us in the very early years of our development. John Gilmour, the master with a scalpel. I do not think I have ever seen anybody dissect with a scalpel as John Gilmour could. It was frightening when you first joined him to see the way he would dissect along any major vessel unimpeded by anxiety without any hesitation at all. It was a thing of beauty when you realised how safe he was with it. That was something none of us could ever forget.

Amongst the other people who contributed so greatly to the tone of the Department of Surgery was **Andrew Masson.** Then a Registrar. Later he became greatly loved and really our great physician. I always thought of him as our Osler. If you had a problem, you could go to Andrew for wisdom. A man of great humor.

John Gilmour handed over to **Harry Annamunthodo.** I would like to take this opportunity of saying how very, very grateful I am to him because he shouldered the administrative work of the whole division and particularly of my department. On three occasions we had Orthopaedic Surgeons who came out to advise me and each of them thought we ought to separate the Orthopaedics from the Surgery, but I believe and I will continue to believe that there is a lot to be said for a benign dictatorship when you have somebody who enjoys administration and who you can trust. This was the way between Harry and myself. He let me develop; he gave me the time to spend at the Mona Rehabilitation Centre.

The thing I think which is outstanding in looking back was the wonderfully good relationship between all members of staff. Now, why was this? Well, we can all have our theories. But, one of the main factors was undoubtedly that when you thought of Hordley, you thought of **Dr. Hart** and when you thought of Montego Bay it was Dr. Morrison's Hospital, and so it went right round the island.

What about the Association of Surgeons? I am hoping that this Association will in the future direct its activities much more towards training than anything else. We at the University's Department of Surgery know that training is very much a part of our job but it is also the part of every surgeon's job. You cannot keep up-to-date unless you have people to rub your minds against. You have to attend meetings. Isolation is no good to anybody, when you are working in a subject which is rapidly expanding as surgery is.

I am a great believer in benign dictatorship. I know quite well the old saying that a camel is a horse designed by a committee is really very true. I think that when we have people with undoubted ability as we have in this Association, we should give them the job of getting on with it, and support them the whole way through to make sure that our training programmes are really the ones they should be. We don't want people trained abroad anymore, we want people trained here in Jamaica to do the job we need. They can go abroad for a period of time for additional training, once they have been properly orientated. We have the skills, we have the knowledge, and the facilities to give them that training, provided all of us here, whether we are in the University or outside or whatever hospital we are in, support the idea of local training and give up the idea of thinking that only abroad can training be good. Particularly we have to convince our Ministry of Health that this is so and stop them giving scholarships for training abroad.

DOING IT MY WAY

Contd from page 24

years she had three children, two boys and one girl, all had bilateral genu recurvatum, and all had different fathers. The case was of sufficient interest to be accepted for publication in the British Journal of Surgery (April 1947).

I had never seen enlargement of the liver and spleen with ascites in children (now known as veno-occlusive disease), in the country parishes in which I had been stationed before coming to Kingston, or if I had seen an occasional one, I must have made a mis-diagnosis. Dr. William Branday and I became interested in this condition, as quite a lot of cases were turning up at K.P.H., and in a period of two or three years we had collected about fifty such cases. The condition was probably more common in those days. We published our findings in the B.M.J., hoping our article would catch the eye of someone better equipped to carry out a thoroughly scientific research of the disease. Sure enough, some months later Dr. Waterlow sent by the Colonial Officer arrived at the K.P.H. with the article in hand, and through his efforts, a chain of investigation was started on which our University of the West Indies has spent so much time and expense, thus adding to the advancement of Medical Science.

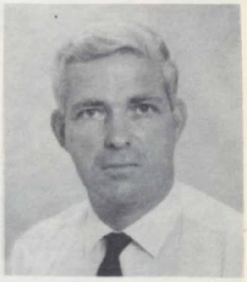
If I may be permitted to introduce a personal note, I feel it might give some encouragement to any of our younger colleagues who might have the misfortune to fall foul of their own specialty. In 1941 I underwent surgery abroad for the removal of a kidney stone, and I had the misfortune to lose my kidney following the complication of post-operative haemorrhage. In 1955, I had to undergo a gastrectomy, but that time I stayed at home in my own hospital, K.P.H., and had the job done by surgeons whom I had trained in this particular field. I do not think I could have had better treatment anywhere else in the world. I did retire from the Government Service the following year, but in due course carried on in private practice from wnich I finally retired in 1972. I have to thank the good lord that in his good will he saw fit to spare me, not only to carry on, but to see my sons grow up and present me with grandchildren whose presence give me so much pleasure in my retirement. Finally, if my fairy Godmother were to give me three wishes, I think the following would be the three I would make:—

1. To have someone write a book on the changing pattern in disease over the past fifty years, together with the changes in medical and surgical treatment.
2. To have someone write a book on the tongue, its importance in the diagnosis of physical ailments by examining it, and, if his sense of humour is highly developed enough, he could expand on the diagnosis of psychological conditions by listening to it.
3. The chance to be young again, and to do it all over again, and what's more, to be able to do it MY WAY.

Typical Andrew

Reminiscences

ANDREW MASSON



IT IS GOOD to know the Association of Surgeons in Jamaica still flourishes. I am sure that there is no end to the surgical work that must demand your skills. In these times of financial stringency with its attendant shortages of staff, material and medication, you must often work under very trying conditions. Fortunately, I am sure that you still find that there is much that you can do for your patients, and we know that that is what medicine and surgery are really about.

I hope that you will have a wonderful meeting – a great surgical and social event. There were always great stories told at the meetings, and often there was as much to learn and certainly much enjoyment in the anecdotes which came up in discussion following formal presentations or over drinks at the bar. One waited for Val Harry and Ivan Parboosingh or Henry Shaw to get going with the stories of their great experiences. Aubrey McFarlane in his usual quiet manner would tell of doing partial gastrectomies under "Local" in Lucea with instruments boiled up in a kerosene tin. In the history of surgery in Jamaica, "Dr. Mac" is a most important figure for he taught the people of Jamaica that major surgery could be done in the island by doing so much of it and doing it so well.

Just mention "WORMS" at your next meeting and that will get the surgeons going – Reg Carpenter will talk of buckets of them and Sam Street if he is in Jamaica these days will tell again of seeing hook worms copulating in the duodenum at gastrectomy.

Harry Annamunthado always had lots of slides of big and awful swellings, mostly arising below the belt. And even the beard and moustache could not hide the grin and glee as he talked of them.

Kenny McNeil meanwhile had some gruesome slides of noses, ears and lips missing – bitten off by other people – usually by members of the same sex I seem to remember him telling us.

Herby Whitelocke and Rudolph Aub, though not surgeons, never missed the main clinical presentations at Association meetings which were held in the large lecture theatre at the U.W.I. on the Saturday morning.

There was romance in the Association in the early days too. John Gilmour came from England in 1958 to take over the Department of Surgery at the University and soon captivated and was captured by Mavis always such a delightful member and an adornment of our Association.

And what of Neurosurgery? In January, 1962, I began to try to get Neurosurgery going at the U.W.I. Hospital. With no more than a year of neurosurgical training behind me, because operating never came easily to me. You will remember the ventriculograms and follow-ons that lasted all day. We used to fortify ourselves with snack lunches at my home at College Common, between the ventric and follow-on. I took hours to get in, and spent ages inside, and a long while to close up. One of those patients was Winston, then about fourteen (14), who had a cerebellar hemisphere astrocytoma. He had a recurrence and I operated again on him in the late '60's. I saw him just before I left Jamaica with a Bennett's fracture sustained when he got into a fight, Reg Carpenter often turned up to help while I was inside – the really difficult bit. He acted as my "conscience" – "I would not do that if I were you", was his most frequent utterance. Thanks Reg!

I recall so many patients – Frankie a fisherman who had a "beautiful" convexity meningieoma which caused him fits – I am sure that he was cured of his tumor. He came with a King drink – "nothing strong Doc" was what he wanted; but he ended up pouring himself "a gin and sherry" – a mix of half a tumbler each of gin and sherry drowned in one before he set off to catch a bus. And Trevor at fifteen was carrying a bundle of wood on his back near Mandeville when he fell and hurt himself. Following this trauma he developed an extradural spinal abscess which extended from the lumbar to the cervical region. We did laminectomies at two levels and saved his arms but the use of his legs was gone. Now Trevor has seen the world as a javelin thrower or rifle shot (I cannot recall which) for the Jamaican Paraplegic team – thanks to John Golding and all that he has done for disabled people and orthopaedic surgery in Jamaica. I add here that it was John Golding and Peter Weston who had the idea of forming an Association of Surgeons in Jamaica.

Now I have been rambling on for too long and I have not mentioned Dick Corey, Don Gore, Gwynn McNeil Smith, Maurice Thompson, Ronnie Browne, Ivor Campbell, Alfred Carnegie, Dr. Robb, David and Monica Atkinson, John Sandison, Viv Brooks, Phillip Wiles and Ivy Jones who was secretary to the secretary of the Association for so many years and really ran the show. There are many others of whom I could tell, please forgive me if I stop now.

My congratulations to the Association of Surgeons in Jamaica. It is my wish for the Association that it will continue to flourish. For its members I wish that they will long live to enjoy life, their families and friends and their grateful patients.


Runaway Bay
HOTEL


Runaway Bay


Runaway Bay

Were they really that interesting ?