Association of Surgeons in Jamaica

60TH Anniversary

April 1958

"Enhancing Health Care in Jamaica"

Pre-eminent surgical association

SIXTY YEARS in the life of an organisation is a significant milestone. It engenders reflection on where the organisation is coming from. It provides an opportunity to celebrate its past achievements and opportunities to hopefully learn from its past failures, with an attitude of gratitude for both. At the same time, we must be looking ahead and charting a course forward for growth, expanded impact and even greater achievement in the future in an atmosphere of expectancy and hopeful anticipation.

The Association of Surgeons in Jamaica (ASJ) is the pre-eminent surgical association that serves as an umbrella organisation for all the surgical subspecialties represented in Jamaica. It was founded in 1958 by a group of visionary surgeons, led by the late Professor Sir John Golding. The ASJ fosters continuing surgical education and serves as a vehicle for the ready exchange of ideas, camaraderie and networking among local, regional and international surgeons that redounds to the benefit of our patients.

The ASJ has grown numerically in terms of membership to its current level of 160 members, but of equal importance, it has grown in its positive impact on the local and regional surgical landscape. Members of the ASJ provide competent and compassionate surgical care every day to people of Jamaica and the region. Many of our members are medical chiefs of staff and senior medical officers leading many of our nation's hospitals islandwide. Additionally, many of our members provide leadership at universities in the region, in sports administration, public administration and in the political arena.

Dr William Aiken

The ASJ has been fortunate to have been led over the years by many exemplary surgeons who have served as presidents and members of the ASJ Council. They have not only provided sterling leadership, but have expanded the role of the ASJ over the years. More recently, the ASJ, as part of its corporate social responsibility has launched an annual fundraising event called 'Scrubs' which has so far raised J$3 million which has been donated to the Jamaica Cancer Society.

The primary focus of the ASJ is to engender excellent surgical care of Jamaican patients by being a vehicle through which there are opportunities for networking, knowledge transfer, skills acquisition and camaraderie. This is achieved by the ASJ hosting an annual scientific conference and banquet, as well as having a yearly luncheon meeting and weekend retreat. These all provide opportunities for networking, camaraderie and continuing surgical education. Under the auspices of the ASJ, laparoscopic surgery was introduced into Jamaica through the efforts of Dr Clive Thomas. Other initiatives of the ASJ over the years have included surgical outreach to rural hospitals, fact-finding missions to Cuba, and meetings held in other territories such as Grenada. Our members have also provided surgical care to other territories, in times of disaster and to provide relief.

As we look ahead, we are grateful for our founders and past leaders and we commit to continuing their legacy of engendering competent, compassionate and ethical, surgical care of Jamaican patients through creating opportunities for continuing surgical education in an environment of mutual respect. We commit to continue to expand the role of the ASJ and its positive impact on Jamaica and the region by lobbying and advocating for resources/facilities that allow for an acceptable standard of surgical care in our nation's hospitals, on behalf of our members and for the benefit of our patients. We also commit to work more closely with The University of the West Indies to formulate local guidelines for the surgical care of a number of diseases, a process that has already begun.

DR WILLIAM D. AIKEN
President
Association of Surgeons in Jamaica

Recognition of its outstanding contribution

THE MINISTRY of Health salutes the Association of Surgeons Jamaica (ASJ) in recognition of its outstanding contribution to the medical fraternity over the last 60 years. The association has promoted among its members the maintenance of high standards of practice and the continuous quest for knowledge through its clinical meetings. It provides opportunities for the sharing of ideas among its members and opportunities for the advancing of all branches of surgery.

The association, over the years, has supported the continued medical education of all doctors. The sustained success of the ASJ annual clinical conference, that sees between 600-700 attendees each year, is a testament to the high regard and respect that is attributed to the association. The medical fraternity and, by extension, the people of Jamaica have benefited from the lessons learnt and shared in these conferences.

Jacqueline Bisasor-McKenzie

The community of surgeons in Jamaica has seen several great physicians, such as John Golding and Sir Harry Annamunthodo, who have dedicated their time and energy into building a fraternity that has stood the test of time. It is hoped that this group will continue to nurture young and aspiring doctors into skilled and dedicated surgeons and responsible citizens who will make a difference not only in Jamaica, but across the world.

As the association embarks on a next decade of achievement, I encourage your members to be steadfast in the practice of our noble profession, to continue to heal our nation, and to ensure that the practice of medicine is faithfully passed on to the next generations.

JACQUELINE BISASOR-MCKENZIE
Chief Medical Officer

Dr Christopher Tufton

A worthy celebration

I CONGRATULATE the Association of Surgeons in Jamaica (ASJ) on its 60th anniversary. It is a significant milestone worthy of celebration, especially as one considers the association's achievements, including your annual clinical meetings, which allow for research and exchange of information and experiences between surgeons from across the region. Additionally, the Association's annual conference, which assembles physicians, surgeons and medical professionals from across the island, has served as a high point to further establish the association's mission of improving medical care in the Caribbean.

Our clinicians are the backbone of our health system, and it is the associations like yours that give rise to the social and professional intercourse between surgeons in Jamaica and the region. As you continue to develop analysis on health research management in Jamaica, with a view to giving health professionals working knowledge of issues that affect patients, the Ministry of Health will continue to provide the policy framework that creates an even more enabling environment. Together we can offer superior clinical and customer service to Jamaicans and all who use our health system.

Again, I commend the efforts of the ASJ and wish you all the very best in your 60th anniversary celebrations and beyond. I look forward to working with the members of the association as we continue to make the health sector a valuable contributor to our nation's development.

CHRISTOPHER TUFTON, MP
Minister of Health

Honoured to be the founding president

IT IS a great privilege to note the 60th anniversary of the Association of Surgeons in Jamaica, especially as I have the honour to be the founding president of the Association of Consultant Physicians in Jamaica. Langston Hughes, the American poet, maintained that if we don't celebrate ourselves, who else will? The Jamaican father of modern surgery in our country, George Baxter, of blessed memory, would be a happy and proud man today to note that his vision and aspirations for his beloved specialty was not lost with the passage of time since he graduated from King's College London in the 1930s. History will also record the sterling contributions of Sam Street and Henry Uriah Shaw, who enthusiastically opened the doors to a flood of talent during the decades of the '60s and '70s at the Kingston Public Hospital. The result was a spate of fellows of the Royal College of Surgeons, including several female doctors.

The association has a duty to our country to continue this journey during the 21st century with unswerving integrity and unquestioned skill.

Dr John Hall

DR JOHN A. S. HALL
Chairman of the Medical Council of Jamaica.

We salute the ASJ

THE MEDICAL Association of Jamaica (MAJ) congratulates the Association of Surgeons of Jamaica (ASJ) for achieving its diamond jubilee milestone. A jubilee for any association gives an opportunity to look back on the distance travelled, and to look forward to the journey that is ahead.

1958 was the year that Pele became a football star, scoring in the finals for the world champions Brazil. It was the same year that NASA was created and the first transatlantic passenger jetliner flight made. But it was the year that the late Professor Sir John Golding was instrumental in the formation of the ASJ.

Since its inception, the ASJ has grown in stature in advancing surgery in Jamaica, and has certainly made an impact on the society with its many achievements. Surgery has been taken to newer heights, with many patients benefiting from cutting edge technology and the expertise of the surgeons. At the ASJ scientific meetings, papers of the highest standards are presented and there is exchange of information and experience between the surgeons from different centres so as to improve efficiency, promote high quality healthcare and to depreciate litigation claims from patients.

Clive Lai

We are therefore proud to salute the ASJ on this monumental occasion, and we wish for them all that is best for the future as they take on the challenges of the next 60 years.

DR CIVE LAI
President
MAJ

Mancare Medical centre limited
Wellness Centre & Pain Treatment Centre

Treatment Centre for:
Pain, Seizures, Nausea & Cancer Patients

ALSO AVAILABLE
• Physiotherapy • Laboratory Service
• Outpatient • Same Day Surgery
• Advanced Mobile IT Optical System

REMOVE HERNIAS, LUMPS, SOFT TISSUE TUMORS, HEMMORRHOIDS
FAMILY PRACTICE & DAY CARE SURGERY
PROF. ARCHIE McDONALD (SURGEON) DR. TERRENCE NUNES
OPENING HOURS: 9:00 am - 9:00 pm (INCLUDING SUNDAYS & PUBLIC HOLIDAYS)
Tel: (876) 929-8426 • (876) 929-3033 Fax: (876) 968-6372
68 Hagley Park Road, Kingston 10 • Email: mancaremedical@gmail.com

A strong and vibrant organisation

THE FACULTY of Medical Sciences at the University of the West Indies (UWI), Mona, congratulates the Association of Surgeons of Jamaica (ASJ) on the achievement of its 60th anniversary. This outstanding lifespan is testimony to a strong and vibrant organisation that has been making a significant contribution to improving health and well-being in Jamaica and the Caribbean.

Our surgeons are at the forefront of saving lives in the context of Jamaican society. The epidemic of injuries facing our population with violence and road traffic accidents as the main perpetrators, calls for skilled surgical intervention and care in our hospitals across the country. These demands are always competing with surgical care for other conditions ranging from the management of an inflamed appendix to removal of dreaded cancerous tumours. The reality is that we must be very grateful for the 60 years of service given by the ASJ to the country.

The Faculty is particularly proud of the Association, whose many members were trained through postgraduate Doctor of Medicine programmes in surgery developed and delivered by the UWI. In the past decades, we have seen growth and development of training to include a wide range of surgical specialties and increased use of technology in surgical care and treatment such as laparoscopic surgery. Additionally, the membership of the Association has given of their time and expertise to our training programmes and are key in building a partnership of quality in training. We are indeed very grateful.

The Faculty along with the University, celebrated 70 years of service in education in 2018. However, there can be no celebration without partners and so, we join with the Association in celebrating now and in anticipating the future. We welcome the crafting of an era of further strengthening of collaboration in training, research and service in the coming decades to benefit Jamaica and the region.

Tomlin Paul
Dean, Faculty of Medical Sciences, UWI, Mona

Tomlin Paul

We thank you and the ASJ for this contribution

Carmen Johnson

NURSES ASSOCIATION of Jamaica (NAJ) is delighted to offer sincere congratulations to the President and members of the Association of Surgeons in Jamaica (ASJ) on this your 60th anniversary celebrations. You have done well to maintain the vision and foresight of your fore-runners and I make special mention of John Golding who conceived the thought but did not allow it to fall on stony ground, however, ensured that the idea germinated into a legacy, that still lives on and remains very relevant after 60 years.

Your aims and objectives have nurtured, educated and impacted not only members of your profession, but also nursing and other health groups through your annual conferences and grand rounds in rural hospitals, and we thank you and the ASJ for this contribution.

The ASJ has achieved much; you have come a long way and your members have ensured that the goal of 'Health for All' will be achieved. Much has changed over 60 years. We recall that in most rural hospitals, the General Surgeon was the one who performed hysterectomies, Caesarian Sections and Orthopaedic surgeries, but now we are blessed with the various specialties in most of our institutions where your members perform deliberate and targeted specialised interventions to improve the health of the populace. You are also now moving ahead to be on par with other first world countries, as we have seen a tremendous increase in the use of cutting edge technology such as the use of laparascopy and laser treatment that aid in earlier recovery period for our patients, which was unimaginable in Jamaica 60 years ago. This did not happen by chance but through the commitment of your members to ensure greater improvements in health care and sometimes with very little or at your own expense. The NAJ thank your members on behalf of the populace, because we believe the Jamaican population should have access to the best available treatment to present and respond to their health care needs.

A milestone of 60 years provides the ideal opportunity to reflect on

PLEASE SEE **ASJ,** 5

ISLAND
Medical Specialists
For All Your Specialist Medical Needs.
Full Service Laboratory
Pain Free Procedures, Widest Range of Specialists
Dr. Trevor Murphy, Consultant Gastroeniterologist
Dr. Rohan Clarke, Consultant Gastroenterologist
Dr. Trevor Seaton, Consultant Gastroenterologist
Dr. Mark Newnham, Consultant General Breast & Vascular Surgeon
Dr. Allie Martin, Consultant General Breast & Vascular Surgeon
Dr. Althea Aquart - Stewart, Consultant Internist/Pulmonologist
Dr. Kathy-Ann Pate-Robinson, Consultant Infectious Diseases and Wellness Specialist
OPEN
Mon - Fri:
8 am - 5 pm
Sat:
8 am - 12 pm

Dr. Warren Chin, Consultant Urologist
Dr. William Aiken, Consultant Urologist
Dr. Sheray Ward Chin, Consultant Medical Oncologist
Dr. Phillip Barrow, Consultant Anaesthetist
Dr. Nicole Seaga, Psychology Consultant
Dr. Patrice Pinkney, Thoracic Surgeon
Dr. Daidre Rowe, Consultant Neurosurgeon
Dr. Nadia Williams, Consultant Pathologist
2A Beverley Vale Close, Kingston 6. Tel: (876) 618-4633, 634-5510-19, 978-7508, 622-4396 876-927-3049 • Fax: 876-978-8414
www.islandmedicalspecialists.com
All Major Debit, Credit and Health Cards Accepted Including International Health Cards

ASJ

CONTINUED FROM 4

the history and achievements of the ASJ and your tremendous impact. It creates the context within which to chart the course to achieve your ultimate mission to improve surgical care in the Caribbean; with present and new technologies, the possibilities are endless. The NAJ thereof wishes for the present and future executive abundant success in this regard.

As you look to the future, our members will continue to work with your members to ensure Jamaicans live longer, healthier, happier and fruitful lives.

As you move forward into the next decade, we trust that you will become stronger, because of the respect the ASJ has earned for striving to improve your profession and the health of the Jamaican people. Your accomplishment is the result of hard work, courage and strong determination. Continue to push your limitations, you have already made the unthinkable possible, so continue to serve with pride.

The NAJ would like to once again commend all members, including past executive members who have built the ASJ into one of the most prestigious associations. You can be proud that your efforts have made a lasting, positive contribution to the well-being of the populace, and not only in Jamaica, but from the Caribbean and other territories. You have made many families happier and hopeful. A big congratulation from the NAJ, and please accept our best wishes for continued success in the years to come!

CARMEN JOHNSON
President of the Nurses Association of Jamaica

60 years of existence

THE ASSOCIATION of Anaesthetists in Jamaica (AAJ) joins the rest of the medical fraternity in paying homage to the Association of Surgeons in Jamaica (ASJ) on the occasion of achieving the milestone of 60 years of existence. Congratulations to the ASJ and its membership for the leadership role it has played in the development of medicine in Jamaica since its inception in 1958. It is noteworthy that this organisation pre-dated the birth of the Jamaican nation, and there is no doubt that the ASJ has made a seminal contribution to national progress and development.

From its position at the vanguard of the health education and healthcare delivery efforts in Jamaica and the Caribbean, this august body of some of the country's brightest and best has worked with purpose to actualise its primary mission of improving medical care in the Caribbean. They have focused on the development of a

detailed analysis of health research management in Jamaica, with the aim to provide doctors and other healthcare professionals with an administrative overview of health issues that affect patients within hospitals in the Caribbean and other parts of the world.

The symbiosis between surgeons and anaesthetic professionals is one of the most celebrated in medicine. Each profession literally owes its existence and development to the presence of the other. The surgeon's scalpel is the symbol of his or her quest to restore health to patients. The role of the anaesthetist as the protector and preserver of the patient while the surgical process is being undertaken, literally makes the process possible. Needless to say, if the surgeon had no knife, the anaesthetic professional would have no raison d'etre.

It is therefore from a proximate vantage point that the AAJ salutes the ASJ on the achievement of this important landmark. Six decades of contribution and leadership of an important sector of national development is worthy of note and we are proud to have stood with you during this time. It is our hope that the ASJ continues its sterling work in the Jamaican healthcare landscape, and we pledge our steadfast support of your quest to lead Jamaica along the cutting edge of global healthcare development.

DR BRIAN JAMES
President
AAJ

CONSULTANT UROLOGIST

Dr. Reaud Gafoor
- Advanced Kidney Stone Surgery (ShockWave, Laser, Keyhole)
- Cancer (Prostate, Bladder, Kidney, Testis)
- Kidney Obstruction / Urinary Tract Infection
- Erectile dysfunction / Low Testosterone / Male Infertility
- Enlarged Prostate/ Urine Flow Problems
- Overactive Bladder / Urinary Incontinence

CALL
876 - 906 1284
876 - 428 7489

10 Ripon Road, Kingston 5

The birth of the ASJ and when the association almost died

IN MY opinion, the most important aspect of the ASJ was the fact that, of the four major clinical departments at the University College Hospital of the West Indies, medicine, obstetrics and gynaecology, and pathology were represented by local branches of overseas organisations, while surgery was the first to be represented by a local professional association. John Golding, who arrived in 1954 as senior lecturer in orthopaedics, believed that a local association was not only possible, but essential. He entered into discussions with the established surgeons in discussions with the established surgeons in the government medical service and the result was the formation of the Association of Surgeons in Jamaica (ASJ), based on a similar body in Great Britain. This was a big deal because it brought together the government and university surgeons as a united body.

Professor John Golding mingles with the crowd.

Prof Carpenter looks on at Honourable Mavis Gilmore and her husband, Dr Gilmore.

During the latter part of the 1970s, because of the political tensions at the time and the high level of crime, there was a feeling of being in a 'civil war', and the resulting marked public anxiety led to a state of panic. No one wanted to travel from or to areas around the island for scientific meetings.

A state of emergency was declared (1976-1977). Carpenter recalls a 2 a.m. journey from Half-Way Tree to the Bustamante Hospital for Children being a terrifying experience because of the deathly quiet roadways, with the reports of hold-ups by criminals in just such a circumstance. This was the decade the ASJ nearly died! Meetings were difficult to organise and it seemed that that the organisation was about to collapse. One Saturday, Sir Harry Annamunthudo volunteered Carpenter to give the president of the Royal College of Surgeons of Edinburgh, here on WHO business, a guided tour of the University Hospital. During the tour asked, he spoke about their first attempt at an overseas meeting which had been held in Egypt, but this had not gone well. Carpenter, with hope rather than expectation, asked whether there would be the possibility of holding a second one in Jamaica. He seemed open to the possibility, and, in due course, arrangements were set up between the college and the ASJ for a meeting at the end of 1978. The programmes were printed by the college and brought by their attendees. A few weeks before the due date, a political statement from Jamaica caused a significant number of cancellations, but by having their travel agent come to Jamaica on an all-expenses paid visit to see for himself, most of the cancelled bookings were restored. The college group was booked on British Airways and Air Jamaica. The day before the start of the conference, while the college group was at the airport, Air Jamaica cancelled its flight, but chaos was averted as the two airlines were persuaded to cooperate in making sure that the programmes and first-day presenters were all on British Airways. In the end, the meeting was a resounding success! Everyone celebrated!

Harry Annamunthodo and Prof Michael Woo Ming.

Carpenter has fond memories of the last night of the meeting. During the closing banquet, there was torrential rain and the flooded roads made driving hazardous, but Carpenter and wife managed until near home when the car stalled on a side road near their home at Half-Way Tree. Carpenter stripped to his underwear, pushed the car into the heavy waters pouring down Hope Road, which would carry it down to the gate of their home, his wife at the wheel while Carpenter, in underwear only, ran after it. A passing police car paused, presumably intrigued by the sight, shook their heads and drove on. Fortunately, or the ASJ president may have had some explaining to do! Next morning, after all our guests had departed, we found that one of our lecture rooms was under water. This meeting turned out to be the stimulus that was needed.

The ASJ was alive again.

(Memories of Professor Carpenter as told by Dr Mark Newnham)

PROFESSOR REGINALD CARPENTER
Former Head
The Department of Surgery
University Hospital of the West Indies

The role of surgery and surgeons in public health

The evolution of surgical disease as a public health problem

PUBLIC HEALTH may be concisely defined as the societal practices geared towards the maintenance and improvement of the health of the population as a whole. These practices involve not only the systems specifically dedicated to healthcare, but also social services, such as provision of safe water supply, sanitation, food-safety controls, food security, and even poverty alleviation.

In traditional public health practice, there has been greater emphasis on disease prevention rather than on treatment – for the simple reason that prevention strategies achieve proportionally much greater gains in population health than curative services. This was particularly true in the era in Jamaica when communicable and nutritional illnesses posed the predominant threat to population health. Prevention strategies, including immunisation programmes and the social services mentioned above, have been phenomenally successful in improving population health in Jamaica, enabling us to achieve life expectancy approaching that in developed countries. This success story should not be taken for granted; our successive governments, over the past 60 years, have served us well in this regard, as they remained steadfast in support of progressive public health policy, ideological differences in approach to governance notwithstanding.

In this scenario, surgery, being a curative discipline involving secondary care or treatment after the occurrence of illness, did not play a proportionally major role in improving overall population health. Surgery improves the quality of life of individuals afflicted by surgically treatable illness, and, of course, individuals make up a population. But in the era of high infectious disease prevalence, surgical disease constituted a relatively small proportion of illnesses in general and, therefore, could not be considered a significant threat to population health. Surgical diseases, which are diseases completely or partially treatable by surgery and excluding obstetric emergencies for the purposes of this discussion, include 60 per cent of cancers, orthopaedic and other injuries, diabetic foot complications, blindness from cataracts, congenital abnormalities, and other miscellaneous conditions.

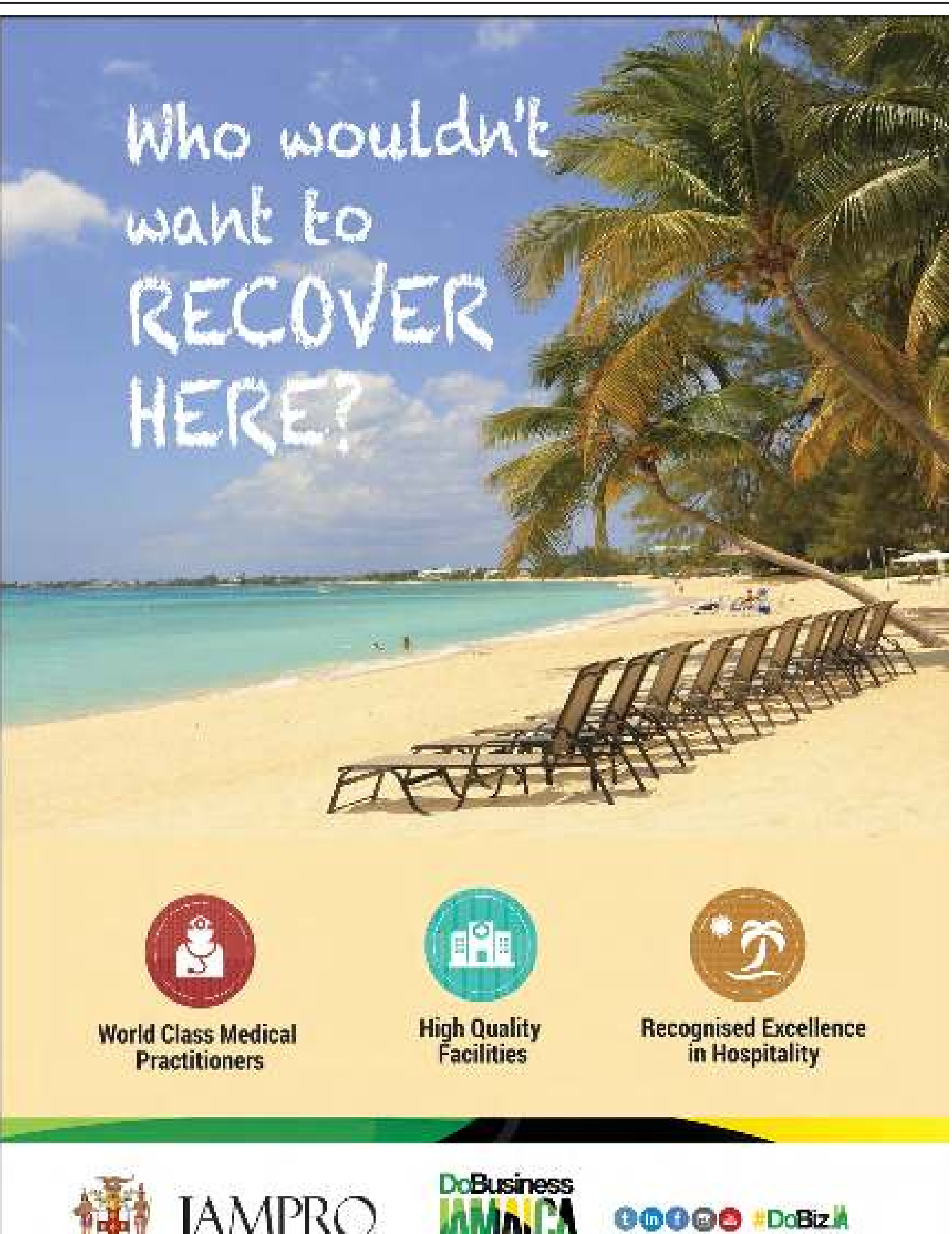
But because of local societal changes – such as almost complete reliance on motor vehicles for transportation, the ready availability of guns, which are more destructive implements of interpersonal violence than the population hitherto had access, the ageing of our population and the success of public health strategies in controlling communicable diseases – surgical and other non-communicable disease now constitutes a much larger proportion of illnesses in general. This transition from predominantly communicable to non-communicable disease as the major threats to population health, referred to in public health jargon as the epidemiological transition, occurred in Jamaica towards the end of the 1970s into the 1980s. Except for the threat of reversal of this trend from HIV at the height of the epidemic, now reasonably well controlled, the transition is essentially complete.

'NEGLECTED STEPCHILD'

Internationally, this trend towards an increasing threat to population health from surgical disease has been recognised by the World Health Organization (WHO) and World Bank for at least a decade. In 2008, Jim Kim, current president of the World Bank, along with Paul Farmer, a co-founder along with Kim and others of the organisation Partners in Health, made the momentous declaration that "surgery may be thought of as the neglected stepchild of global public health". The trend is occurring even in populations that have yet to experience the epidemiological transition, aggravated in these poor countries by woefully inadequate surgical services; a study by Weiser and others published in the journal **Lancet** in 2008 estimated that the poorest third of the world's population receives only 3.5 per cent of the surgical operations undertaken worldwide.

So, what do we know about the current ranking of surgical disease as a cause of morbidity in the Jamaican population? There are no statistics available which specifically separate 'surgical disease' from other

PLEASE SEE **SURGERY,** 8



Congratulations

Association of Surgeons

60 YEARS!

You perform life-saving miracles in theatre.
We provide the air quality that
you need to perform these miracles.

COMMERCIAL AIR CONDITIONING IN JAMAICA FOR MORE THAN 40 YEARS

info@denndock.comn, (876) 926-6858

SURGERY

CONTINUED FROM 7

non-communicable disease, but some inferences may be drawn from statistics on other measures of disease effect.

For example, according to the WHO, the leading causes of death (mortality) in Jamaica in 2016 were as follows:

- 30% - Cardiovascular diseases
- 20% - Cancers
- 15% - Other NCDs
- 12% - Diabetes
- 11% - Communicable, maternal, perinatal and nutritional conditions
- 9% - Injuries
- 3% - Chronic respiratory illnesses

Mortality tables reflect the prevalence of disease in a population only to the extent that the disease is ultimately lethal. Disability-adjusted life-years (DALYS) present a more accurate picture of the burden of disease in a population, since this measure takes into account years of life lost both to premature mortality and disability occurring in people living with disease. However, given that a large percentage of surgical diseases are cured by surgery, thereby curtailing any deleterious effect the disease might have on life expectancy, this statistic also presents only an indirect and partial picture.

According to the WHO, the top 10 causes of DALYS in Jamaica in 2004 were:

- 21.3% - Neuropsychiatric conditions
- 12.3% - Infectious and parasitic diseases
- 10.7% - Cardiovascular diseases
- 8.4% - Intentional injuries
- 6.4% - Malignant neoplasms (cancer)
- 5.8% - Respiratory diseases
- 5.3% - Sense organ diseases
- 5% - Unintentional injuries
- 4.9% - Perinatal conditions
- 2.9% - Musculoskeletal diseases

Thanks to general and specialist postgraduate surgical training programmes at The University of The West Indies and prior to that, the Royal Colleges of Surgeons in the UK, particularly the colleges in Edinburgh and Glasgow, and fellowship training in North America, Jamaica now has an adequate complement of surgeons capable of offering the full spectrum of surgical specialties; most if not all of these surgeons, across the specialties, are members of the ASJ. All Jamaicans now have access to advanced surgical services at or through all public hospitals, private hospitals and the University Hospital of the West Indies, as ASJ members are distributed throughout the country.

Research into the local clinical epidemiology of surgical disease is critical if we are to design effective public health interventions targeted specifically at our population. ASJ members have been acquiring the necessary skills and have been conducting advanced clinical research; this is a new trend, as surgeons now recognise and embrace our emerging role as clinical epidemiologists and public health advocates.

Under a collaboration between the ASJ and the Department of Surgery, Radiology, Anesthesia and Intensive Care at the UWI, soon-to-be published guidelines for management of the most common surgical diseases in Jamaica have been crafted. These guidelines will be distributed to all our members and hospitals, and are expected to standardise management of these conditions across the island.

Finally, as emphasised in traditional public health practice, the ASJ acknowledges that disease prevention, where this is possible, is more impactful on overall population health than treatment. The National Road Safety Council, with its mandate to promote safe driving practices and advocate for legislation aimed at reducing motor vehicle accidents, was convened on the basis of a paper written by one of the founding fathers of the ASJ, Professor Sir John Golding. Also, several ASJ members partner with the Jamaica Cancer Society in its drive to promote screening for breast, prostate and colon cancers, three of the most common cancers in the Jamaican population.

DR JEFFREY EAST
Consultant General Surgeon and Former Deputy Dean
Faculty of Medical Sciences
University of the West Indies

1 (876) 754-4169
1 (876) 702-2950

We accept:
MC/Visa/Key Cards
Health Insurance

3T MRI

- THE ONLY 3T MRI IN JAMAICA!
- SUPERIOR IMAGE QUALITY COMPARED TO THE STANDARD 1.5T MRI.
- FASTER SCANNING TIMES.

NOW OFFERING:
Interventional Radiology Procedures

Procedures Offered:

- ASPIRATIONS & BIOPSY
- CATHETER INSERTIONS (Perm Cath, PIIC Lines, Nephrostomy)
- ANGIOGRAMS
- SELECTIVE HSG & RECANALIZATION
- SCLEROTHERAPHY
- LUMBAR PUNCTURE
- IMPLANT PLACEMENT (Ports, IVC Filters)

GE 64 Slice VCT Lightspeed CT Scanner

- 64 ROWS OF WIDE DETECTORS PRODUCING SUPERIOR IMAGES WITH FASTER SCANNING TIME.

The role of the surgeon as an administrator

MEDICAL HISTORY has shown that surgeons have always been given the task of administrators, this is not only a local phenomenon, but reflects the trend in the International health community. There is the expectation that surgeons will not only excel as clinicians, educators and researchers, but also as leaders of the health team and, ultimately, administrators. Global changes in the delivery of healthcare demand that some academic surgeons become as skilled in administration as they are in operative surgery. Whilst excelling in this additional role, the value of surgeons as administrators has been commensurate with the advances in technology and administrative processes. Formal training in hospital or business administration is absolutely necessary. The timing of the entry of the surgeon into the administrative role is very important in an effort to achieve a successful outcome.

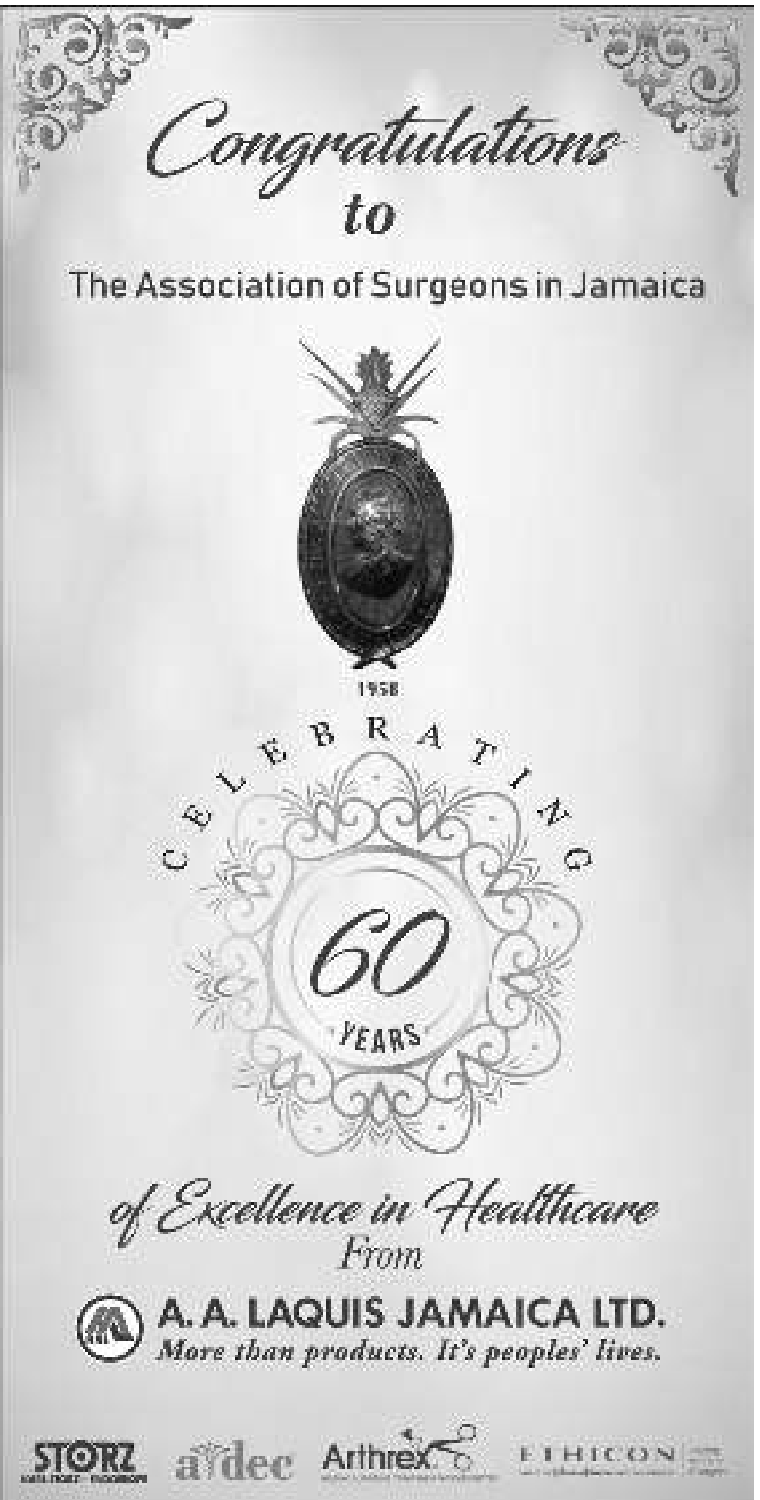
The surgeon should first focus on developing and excelling in his/her clinical practice and research, and become established as an expert in their chosen field, which is essential in gaining the respect of both the academic community and the wider health team. Your colleagues will need to have that confidence in you and your abilities before following your lead in the management and development of the health services. A young surgeon, yet to be established, may find that this new role may adversely affect their academic and clinical growth, and later lead to disillusionment and frustration. Alternatively, embarking on an administrative role later in one's career may be problematic, as the advances in technology and administrative systems may become too onerous to effect a satisfactory outcome. It is therefore important that a structured, careful selection of persons to adopt a career in administration is pursued, rather than selecting young,enthusiastic candidates, who may be better advised to develop a track record of clinical successes which will ease them seamlessly into the administrative position.

It is important that as an administrator, you have a clear vision of the direction your institution should take and adopt a strategic plan, which clearly outlines the methodology of effecting change and the means of achieving these ends. Initially, it is useful to select 'low-hanging fruits' (easily achieved objectives), as the successes achieved will build confidence in your team and ensure continued interest in the long-term objectives. The buy-in by your staff and recognition of their successes is essential to a successful outcome and ensures the maintenance of enthusiasm in meeting all the stated targets in the expected time frames.

An administrator must be careful not to appear to do everything alone; delegation of responsibility to carefully selected persons is oftentimes the key to the overall success of projects and programmes. There is one attribute of an administrator which stand out above anything else, and that is the ability to have open and effective communication skills. Clear communication avoids misunderstanding and misconception of the roles and responsibility of your staff; however, do not ignore the need to listen. Listening to all staff and colleagues you represent is vital to your success as an administrator.

The years of surgical training, with an emphasis on detail, continued monitoring of activities, precise decision-making and the willingness to take on full responsibility for projects and outcomes, makes the surgeon an exceptional candidate for the role of an administrator. However, it is important to bridle enthusiasm with reality when seeking positions of authority, in an effort to ensure a successful career as an administrator.

TREVOR McCARTNEY
Former Senior Medical Officer
Kingston Public Hospital



Congratulations
to
The Association of Surgeons in Jamaica
ON 60 YEARS OF
GREAT SERVICE

JAMAICA REALTY
YOUR TRUSTED REAL ESTATE PARTNERS
RESIDENTIAL - COMMERCIAL - SALES - RENTALS - VILLAS - PROPERTY MANAGEMENT
86 Hope Road, Kingston 6: +1 (876) 946 0007 // sales@cbjamaica.com // www.cbjamaica.com

ASSOCIATION OF SURGEONS IN JAMAICA (ASJ)

Scrubs 3/0 : CHARITY EVENT

An *Ultra* All Inclusive Party

$12,000 presold

LIMITED DISCOUNTED TICKETS AVAILABLE FOR NURSES, & MEDICAL STUDENTS.
Conditions Apply

Entertainment by
DJ NARITY & COURTNEY

Live Performance by
TARRUS RILEY
& The Black Soil Band

Featuring
Dean Fraser

Ticket Outlets

Jamaica Cancer Society - 16 Lady Musgrave Road, Kgn 5 • Smart Mobile Solutions (SMS) - 12 Ruthven Road, Kgn 10
Department of Surgery - University Hospital, (876) 927-1270 • Ribbiz - Barbican & Downtown

*Tickets also available from any **ASJ Council Member***

PART PROCEEDS GO TO THE JAMAICA CANCER SOCIETY'S FIGHT AGAINST PROSTATE CANCER.

*For further info email us at **asjparty@gmail.com***
Must be 18 years or older to drink. Drink Responsibly.

The rural surgeon

THE RURAL-BASED surgeon has a special place in the history of Jamaican medicine, and the present set of such individuals stand on the shoulders of giants who were willing to leave the bright lights of the capital to bring much-needed expertise to the rural parishes.

Such giants of Jamaican rural surgery included Dr R.G. Lampart in St Thomas, Dr Alfred Carnegie in Sav-la-Mar, Dr Antonio in Port Antonio, Dr Arthur Wint in Linstead, Dr Francis in Black River, Dr 'Buddy' Wilson in St Ann's Bay; and Dr Freeman in Spanish Town, to name those who came readily to mind from the era of the 1950s. These were the first set of trained surgeons, most of whom had fellowships in the English or Scottish colleges of surgeons.

The second wave would include eminent surgeons such as Peter Wellington in Mandeville, Williams in Spanish Town, Winston Dawes in May Pen, and Ken Baugh in Montego Bay, to name a few.

These men, and others not mentioned, were appointed to these hospitals with directives from the Ministry of Health to bring ethical medical care to the rural population. Their practice guideline and protocols were not distinctly written and promulgated by the Ministry of Health. They were expected to practise to the level of their competence, consistent with their training and experience which, by and large, would have been gained from British hospitals and further burnished by stints at the Kingston Public Hospital before being assigned to a rural hospital. In those days, there were no manuals produced locally.

DAUNTING JOB

In 1958, the establishment of the Association of Surgeons of Jamaica would help to foment and focus discussions on local issues and diseases. It would also focus discussions on the peculiarities of Jamaican disease patterns and assist these surgeons in continuing medical/surgical education.

What made the job even more daunting is that in many cases, and for many decades, these persons were the *de facto* leaders of the hospital management team. They were administrators and technocrats at the same time. They were always senior medical officers whose presence was mandatory at hospital management meetings, and no significant hospital decision was taken without them.

They were almost always the only specialist in any rural hospital, so they had to be broad in clinical outlook – treating not only surgical patients, but also medical, obstetric, gynaecological and paediatric patients. Most had to be fairly proficient at performing common urological and othopaedic procedures, and these were those who even did burn holes for haematomas – at a time when neurosurgeons were not a part of the landscape.

It goes without saying that these individuals had to be resourceful and very good clinical practitioners, as they were faced with limited laboratory and imaging services. These are true stories about patients being treated for a puenothorax or haenothorax without even having an xray; of patients being taken to elective and emergency surgery without appropriate laboratory investigations.

It is instructive that many rural hospitals up to the 1980s had no consistent clinical chemistry services and even now, many have no in-house fluoroscopic or ultrasound.

Pathology services up to the 1980s were Kingston-based, and so the rural surgeons had to decide on which specimens had to be sent to the lone pathologist at the then Government Medical Laboratory.

Networking with one's colleagues in the metropole of Kingston was very important, as complex and unusual cases could be discussed and referred, especially surgical cases requiring sophisticated anaesthetic skills or large quantities of blood products.

In the last three decades, the landscape has been changing. In many respects, the rural general surgeon has been joined by gynaecologists, starting first in Montego Bay, Mandeville, then Spanish Town, and now in most rural hospitals. My hospital, the Princess Margaret Hospital, received its first trained obestetrician/gynaecologist in 2009.

As the University of the West Indies has graduated more specialists, the rural surgeon is now able to refer more patients to clinics in urology, orthopaedics, plastic surgery, paediatric surgery, etc.

It is hoped that with more specialist services moving into rural hospitals, there will be a commensurate increase in sophisticated laboratory and imaging services and, to some extent, the private sector is leading the way.

In order to attract young specialist staff, hospitals such as Mandeville, Annotto Bay, Princess Margaret and Spanish town have found novel ways to bring in laparoscopic and endoscopic services, thus decreasing the need for patients to travel for complex procedures and investigations.

The rural surgeon is now able to concentrate on advancing his own specialty of general surgery and trauma, and no longer has to see himself or herself as a jack of all trades.

DR CECIL BATCHELOR
Former Senior Medical Officer
Princess Margaret Hospital,
Morant Bay

Women in surgery

FOR CENTURIES, women have been involved in surgery, albeit not at the forefront until recently. In the last few centuries, there have been reports of women who sought to disguise their identity to enable themselves to practise the craft of surgery. Surgery has largely been a specialty pursued by males. This may be so because of the lifestyle, which may not be attractive to women, or the paucity of female mentors in the field. In the early years of the Faculty of Medical Sciences, University of the West Indies (UWI), females comprised a small proportion of medical students. Despite the fact that majority of the current graduates of the faculty are females, male applicants still outnumber females who seek to pursue postgraduate training in surgery.

Dr Belinda Morrison-Blidgen, consultant urologist, University Hospital of the West Indies.

Many surgical specialties have been stereotyped as 'old boys' clubs' and this has been a discouragement to several females. In addition, gender-based stereotypes of what women can and cannot do serve as a deterrent for prospective female surgeons. Surgical training programes across the world are generally competitive and demanding, with surgical residents having long and grueling working hours, many sleepless nights, and starting a family under these conditions may be considered an obstacle. It is no secret that many persons in our culture are uncomfortable with the idea of a female doctor or surgeon. Many female surgeons have grown accustomed to being referred to as 'nurse', despite efforts to introduce themselves as the 'doctor.'

One of the female pioneers in surgery in Jamaica is Dr Mavis Gilmore. Dr Gilmore, the first female fellow of the Royal College of Surgeons of Edinburgh to practise in the Caribbean, served at the Kingston Public Hospital from as early as 1960. Sheer intellect and adept surgical skill rubbished any suggestion at the time of lack of competence for the job solely because of gender. Dr Gilmore proved herself as a well-trained surgeon and obtained the respect of many of her colleagues. Even then, there were very few female surgeons.

With the emergence of the doctor of medicine postgraduate training programme at the UWI, Mona, in 1981, the opportunity for local training in general surgery and the subspecialties became more readily available. In 1986, Dr Barbara Salmon-Grandison became the first female graduate of the postgraduate surgical training programme in Otorhinolaryngology (ENT) at UWI, Mona. Dr Carolyn Pinnock later graduated from the paediatric surgery programme in 2002. However, it was not until 2003 that the first female graduated from the general surgery training programme. Dr Lisa Johnson, a native of Belize, completed the doctor of medicine degree in general surgery, and later served in rural Jamaica. There has been a steady increase in the number of female graduates from the doctor of medicine training programme, at the UWI, Mona, with 36 female graduates since its inception (22 per cent of total graduates). Of these, there are currently five general surgeons, one subspecialising in thoracic surgery, two neurosurgeons, four urologists, five ENT surgeons, seven ophthalmologists and four paediatric surgeons working in Jamaica.

The postgraduate training programme at UWI, Mona, currently has 37 per cent female surgical residents in training. This may be partially attributed to female surgeons excelling in their field and serving as mentors to prospective female surgical residents. For example, Dr Tanya Hamilton, a general surgeon currently serves as senior medical officer, St Ann's Bay Hospital, and Dr Natalie Whylie serves as senior medical officer at the Kingston Public Hospital. These females and others have helped to eliminate gender-stereotyping in surgery in Jamaica.

A career in surgery is filled with the satisfaction of changing human lives, while visibly seeing an effect on patient health. It allows for continuous growth and development of mental fortitude. Apart from clinical practice, it allows for focus on specific areas, such as research or teaching. The wide array of surgical subspecialties allows prospective females surgeons to choose appropriate fields according to their skills and future desires. I have found my career in surgery very rewarding and enjoy it immensely.

DR BELINDA MORRISON-BLIDGEN
Consultant Urologist, University Hospital of the West Indies
Senior Lecturer and Head, Division of Urology, University of the West Indies

Relevance of the doctorate of medicine programme

The contribution of the University of West Indies postgraduate training programmes to the Association of Surgeons in Jamaica (ASJ)

Surgeons Keith Wedderburn, Trevor McCartney and Delroy Fray being honoured by the Medical Association of Jamaica in 2016.

WHY A DOCTORATE OF MEDICINE (DM)?

The establishment of the medical school in 1948 and its first graduating class in 1954 established a steady and dependable stream of adequately trained doctors to meet the needs of Jamaica and Commonwealth Caribbean nations. Once this need was met, the next step was to address the acute shortage of general and specialist-trained surgeons.

The opportunity to do so came in 1972 when a DM programme in surgery was established by The University of the West Indies (UWI) with funding from the Government of Jamaica. Critical expertise was provided by the Hope Foundation (Project HOPE). The first graduates were Ronald DuQuesnay in general surgery and, soon after, Charles Lyn and Halda Shaw in otorhinolaryngology (ORL). These three pioneers ushered in a new category, the academic surgeon, whose responsibilities included their development as academic teachers at the Mona campus. Now in the retirement phase of their careers, they have become household names in surgical practice in Jamaica through their significant influence on the development of surgery in Jamaica.

In general surgery, Ronald DuQuesnay was a master surgeon, a surgeon's surgeon, especially well known for his no-nonsense opinions in situations where the decision to operate or not was being discussed. He also provided a critical overhaul of the surgical programme when this was needed and for well over a decade, he was in charge of postgraduate surgical training at the UWI, Mona campus. Drs Lyn and Shaw similarly contributed to the development of teaching, to both undergraduates and graduates in their specialty. As the programmes developed, graduates had the opportunity to learn basic management techniques, which were especially useful for those subsequently appointed senior medical officers in charge of government hospitals.

THE EARLY YEARS

Once the quality of the DM graduate in general surgery and ORL was confirmed and accepted throughout the region, the period of the 1980s and '90s saw the establishment of additional training programmes in orthopaedics, urology, cardiothoracic surgery, neurosurgery, and paediatric surgery. More recently, DM programmes in ophthalmology and plastic surgery have been established to provide the necessary trained specialists to meet the needs of the region. Our DM in the various subspecialties of surgery is recognised by the accreditation bodies of the United Kingdom, Canada and Australia, which has allowed our graduates the opportunity to complete fellowships in these countries. As a result, there are now super-specialists in laparoscopic surgery, hepatobiliary surgery and colorectal surgery, among other areas.

CONSOLIDATION

The DM programmes attract some of the brightest and best of the graduating class and over a period of at least five years, they are trained in the scientific and clinical methods of surgical diseases, as well as the technical skills required for providing high quality surgical care.

Today it is fair to say that the majority of the surgical consultant staff at our hospitals were trained in this programme in Jamaica. Currently, in addition to Jamaica, our graduates are active throughout the region – as far south as Trinidad and Tobago, and north as The Bahamas, and all the islands in between. Additionally, you will find graduates of the DM in surgery in established practice in the USA, Canada, United Kingdom, as well as several currently doing fellowship training in Australia.

CHALLENGES & CONCLUSION

Today, through globalisation and easy access to information through Google, our specialist surgeons aim for, and are held to, the highest level by a discerning public. The expectations of patients are not surprisingly real and they do not want a 'trainee doctor' to do their operation. Whereas with the right supervision and assistance, most residents in the later stages of their training can effectively perform many operations with similar outcomes as the consultant, this fact is sometimes unknown or lost to the public. No surgical procedure is without the possibility that even the appropriate direct actions may be associated with complications, some with harmful consequences. It is often said that a surgeon without complications is not operating often enough.

It would be remiss of me to conclude without some comments about the future of surgical training, given of the significant costs involved and the trend towards subspecialisation. The immediate challenge is to address the current shortage of specialist-trained surgeons throughout the island. This is despite the fact that in addition to the University Hospital of the West Indies, Kingston Public Hospital and Cornwall Regional Hospital as accredited training institutions, aspects of training are also now provided at Mandeville Regional Hospital and Spanish Town Hospital. We will have to engage international partners, such as the University of Toronto, to facilitate fellowship training for our super subspecialist-trained surgeons, but we must also regionalise care to areas of expertise and develop centres of excellence with restricting and matching surgical procedures to institutions and skill sets. Centres of excellence for cancer care and trauma care are areas that come readily to mind.

Whether it is minimal invasive surgery, endoscopic surgery or other means of reducing the trauma usually associated with accessing the disease or damaged body part, the majority of surgery performed nowadays is dependent on expensive technology which require significant capital expenditure and will need replacement over time. There may be enthusiasm for the latest robotic intervention, but careful cost analysis shows that even in the best hands, the robot may not yet be fully beneficial to the average patient. While there is good evidence of the superiority of laparoscopic surgery in the majority of elective abdominal operations compared to the conventional, open-surgical approaches, there is still a lot to be said for a well-performed open-surgical procedure done in a compassionate and caring environment.

For continued success in meeting the needs of Jamaica and the region, the Association of Surgeons of Jamaica (ASJ), the UWI and other professional bodies, such as the Caribbean College of Surgeons, must continue to work together, combining resources, forming partnerships, so that a fully equipped surgical skills laboratory is available for the professional development of the members and residents, offering workshops, short courses and structured training sessions as we strive to provide excellence in surgical care, training and research.

Evidence of partnership is provided by the '2018 Guidelines Initiative' and supported by the Stewart's Automotive Group, which saw the ASJ and the Department of Surgery, UWI, developing practice guidelines to standardise the quality of surgical care being delivered across the island. Such initiatives augur well for the future of surgery in Jamaica.

PROFESSOR JOSEPH PLUMMER
General and Colorectal Surgeon
Head of the Department of Surgery,
University Hospital of the West Indies

Trauma care in Jamaica since the 1980s

TRAUMA IS a major cause of morbidity and mortality in both the developed and developing world. It is perhaps the disease which has the most negative impact on healthcare systems and societies today. Injuries are the leading cause of death under the age of 40 in the USA and the fourth-leading cause of death for all Americans. It results in greater loss of potential years of life than cancer and cardiovascular diseases combined. In the developing world, injuries in males in the age group 15-44 years resulted in 55 million disability-adjusted life years lost. Presently, injuries account for one in seven healthy life years lost worldwide, and the World Health Organization predicts that this will increase to one in five by 2020, with low- and middle-income countries accounting for the majority of the increase.

Jamaica, with a murder rate of 36 per 100,000, is one of the highest in the world, while the death rate from motor vehicle accidents (MVA) is 18 per 100,000, compared to 10 and 10.2 for the Caribbean region and Britain, respectively. Trauma and injuries, therefore, have held the attention of surgeons and public health workers in Jamaica for a very long time. The main trauma hospital in Jamaica is the Kingston Regional Hospital (KPH). It should not be a surprise then that on the first day of my internship, two injured patients were brought to the ward, one with a gunshot wound and the other was a young man found in a ditch with multiple stab wounds. I started with the gunshot wound, as I thought that was the more serious injury. A nurse, however, pointed out to me that the young patient with the stab wounds was bleeding profusely from his wounds and was quite restless. After setting up an intravenous line, I went about suturing his wounds. However, after some time, I noticed that he was no longer restless but had become quite still. The nurse and I attempted to check his blood pressure, and then we realised that he was pulseless. Attempts at resuscitation failed. That incident was to have a profound influence on my career and led to my interest in trauma and injuries. It is because of this interest in trauma that I accepted the academic post at the University of the West Indies (UWI) when this was offered to me. My mandate was to transform the Casualty Department into a modern Accident and Emergency Department. I accepted because of my interest in trauma and injuries, which I still regard as a surgical disease. In the early years, the first Accident and Emergency Department in Jamaica was established at the University Hospital of the West Indies (commissioned in 1993) and later, the DM in Emergency Medicine Residency Programme and training in emergency nursing were established.

The need to define the epidemiology of injuries in Jamaica was clear. This was necessary for the development of preventative measures to control this epidemic. In the late 1980s and 1990s, I attempted to gather this information on injured patients. With no research assistants, no access to electronic databases, I attempted to collect this information from the dockets of admitted patients and visits to the Emergency Department. After collecting a lot of information, my first attempt at data analysis revealed to me the folly of my actions, as it was impossible to retrieve and analyse the data without coding. I therefore explored the possibility of establishing a Trauma Registry. My research led me to Professor Lenworth Jacobs, a UWI alumnus, who was one of the leading trauma specialists in the USA. He was significantly in the development and international promulgation of the Advanced Trauma Life Support Programme in the USA. Professor Jacobs assisted with the acquisition of the software for the Trauma Registry at no cost to the UWI and the Department of Surgery.

The importance of trauma and its impact on the health dollar led to the development of two projects, the Jamaica Injury Surveillance Survey (JISS) and the Trauma Registry at the University Hospital of the West Indies (UHWI). The JISS was developed by colleagues from the Ministry of Health and the KPH, with me as a collaborator from the UWI. The JISS collects data on all injuries presenting to the Accident and Emergency Departments at the government hospitals across the island and is administered by the Ministry of Health. Information is collected on demographics, mechanism of injury, location and circumstances which caused the injury, victim-perpetrator relationship, and disposition of the patient. These two databases enabled us to fairly define the epidemiology of injuries in Jamaica.

For the period 2000-2009, information from JISS revealed that 11 per cent of all accident and emergency visits were due to injuries. Road traffic accidents account for 17 per cent, unintentional injuries account for 45 per cent, and intentional injuries account for 38 per cent of injuries. Patients less than 19 years old accounted for 57 per cent of unintentional injuries, while 62 per cent of these injuries took place in the home. Relationship between the victim and the perpetrator in intentional injuries found 47 per cent being injured by an acquaintance. Thirty per cent of injuries in women were inflicted by an intimate partner.

The Trauma Registry at the UHWI was started in 1998 and it documents detailed information on all trauma admissions using the software programme Trauma! developed by Cales and Associates and now managed by Digital Innovation Inc. Analysis of data from 11,733 trauma admissions during the 10-year period, January 1, 2001 to December 31, 2010, revealed that 20 per cent of all admissions to the surgical wards were injury-related. The epidemiological data is similar to that of the JISS. The peak incidence was in the second and third decades with a male to female ratio of 2.5:1. Unintentional injuries accounted for 57 per cent of injury-related admissions, of which falls and MVA were the major contributors in this category. The majority of intentional injuries were as a result of penetrating trauma occurring in the home or on a nearby street. Knives, machetes and firearms were the weapons of choice. Overall, the mortality for the period was five per cent and, as expected, MVA and assaults by firearms accounted for the majority of deaths.

The estimated cost of hospital care for the treatment of injuries in

PLEASE SEE **TRAUMA,** 16

LIFE . HEALTH . PENSIONS

years of serving Jamaica

Since our inception in 1999, our greatest commitment has been to the well-being of the Jamaican people: facilitating healthcare, education, sports and community development.

As we celebrate our 20th year of growth in our island nation of Jamaica, we reflect, with gratitude, on the support of our customers throughout the years.

As we embark on the next chapter of our journey, we commit to continue operating as an integrated, customer-centric company which delivers its brand promise consistently and contributes with the same fervour to nation building.

Thank you for your unwavering support as we continue to help Jamaicans live securely and live 'easy'.

live secure | live easy

Congratulates

The Association of Surgeons in Jamaica

on the proud achievement of its milestone of *60 years!*

NEED INSURANCE?

No matter the circumstance Caribbean Assurance Brokers Ltd. has the right insurance policy for you.

INTERNATIONAL HEALTH, LIFE AND TRAVEL INSURANCE

International Comprehensive Health Insurance Programme (iCHIP):
For the unforseen at home & overseas

- Coverage maximum up to US$2 million per annum
- Comprehensive medical coverage (home & abroad)
- $0 deductible worldwide, excluding the USA*
- 100% coverage on all benefits including routine and major medical*
- 100% coverage for cancer treatment & drugs*
- 100% air ambulance
- No medical required
- Dental & optical coverage* and more

International Life Insurance:

- No medical required for coverage up to US$300,000, to include 'Return on Premium' options
- Coverage maximum up to US$5 Million
- Maximum issue age - 80 years

Assured Travel Insurance:
Short term medical insurance for individuals, families and groups.

- Medical coverage from US$50,000 up to US$5 million
- Option to choose your maximum benefit for less than US$5 per day
- Lost luggage
- Group discounts
- Easy online access
- 24/7 emergency assistance
- Trip cancellation & delay

LOCAL INSURANCE

- Individual Life
- Individual Health
- Critical Illness
- Investment
- Retirement
- Personal Accident

GENERAL INSURANCE

- Property Insurance [illegible]
- Professional Indemnity
- Public & Employers' Liability
- Directors & Officers Liability
- Bonds
- Motor Insurance
- Pecuniary Loss
- Consequential Loss

EMPLOYEE BENEFITS

- Group Life
- Group Health
- Group Pension
- Group Personal Accident

CREDIT UNION GOLD SERIES

- Group Health & Life Insurance for Credit Union Members [illegible]
- Major Medical

CREDIT UNION RELATED PRODUCTS

- FIP (Family Indemnity Plan)
- FCIP (Family Critical Illness Plan)
- FCIR (Family Critical Illness Rider Plan)

*Conditions apply

Speak to us about our customized insurance solutions made to suit your needs and budget. We've got you covered!

GIVE US A CALL TODAY!

Providing first class customer care, first time, on time, all the time!

Caribbean Assurance Brokers Limited

94D Old Hope Road, Kgn 6, | Tel: (876) 978-5508, (876) 619-1351
International Health, Life & Travel Insurance | Employee Benefits
Individual Life & Health Insurance | General Insurance | Credit Union related products

Follow us on Social Media:

caribbeanassurance | caribbeanassurancebrokersja | CABjamaica

TRAUMA

CONTINUED FROM 14

1998 was US$33.4 million, or 20 per cent of the health budget. The total cost of injuries to the Jamaican society has been put at US$1billion. This is approximately 7.2 per cent of the Jamaica's gross domestic product. Thus, a 50 per cent reduction in the incidence of injuries will save the country seven times the total health budget. This is especially important, given that for the 2010 national Budget, four per cent was projected to be spent on health – a fall from seven per cent in 1998 and 4.7 per cent in 2006. These data show that injuries are a major public health problem and place a heavy burden on the health services, as well as the Jamaican economy. There has been no significant change in the data over the years. There is therefore a need for a coordinated multidisciplinary approach to effect a significant decrease in the incidence of injuries.

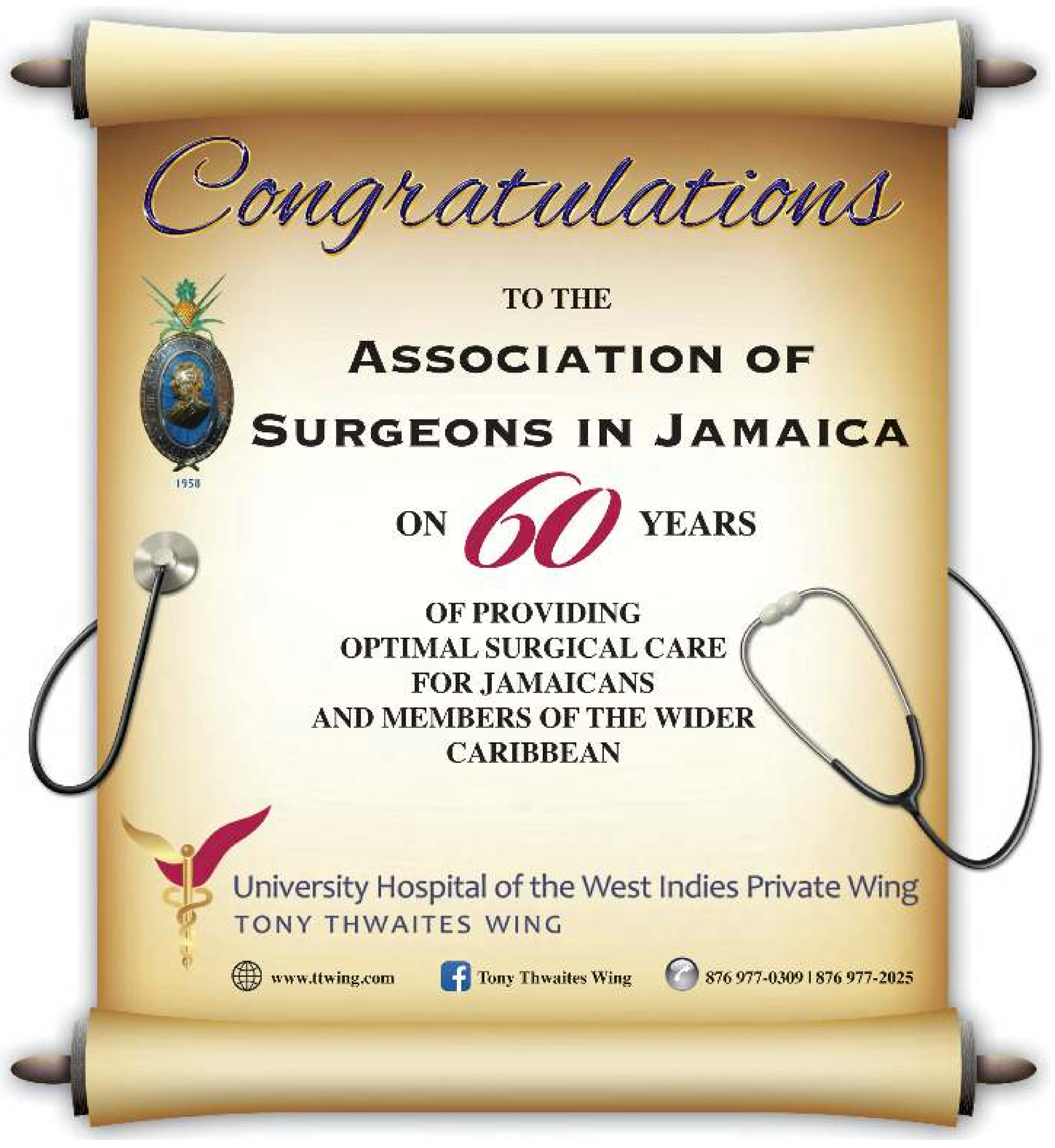
A significant initiative in the 1990s was the introduction of the advanced Trauma Life support course to Jamaica. This was facilitated by Professor Jameel Ali from the University of Toronto, Canada, who successfully lobbied the American College of Surgeons to introduce the programme in Jamaica at a much-reduced cost. He agreed to train the instructors and still provides support to the programme. The role of Sister Juliet Buchanan from the Accident and Emergency Department, as the nurse coordinator for the programme since its inception, should be noted.

An efficient system of trauma care involves intervention at least three levels. Primary prevention focuses on pre-event action and is facilitated by legislation and education. Secondary prevention aims to minimise injuries sustained in the event and include the use of helmets and seat belts, for example. Tertiary prevention focuses on care and rehabilitation of the affected individuals for the optimisation of outcome. As members of the healthcare team, there are some factors beyond our control; for example, getting each occupant of a motor vehicle to use seat belts. Our emphasis is usually placed at the tertiary level, where an improved quality of care will decrease the overall cost to society. Inclusive in this improved quality of care is better pre-hospital care and speedy transfer of the injured to the nearest appropriate facility where timely interventions can be effected, given that the greatest number of deaths occurs in the pre-hospital phase of care. This service is currently offered in Jamaica only privately. In addition a multifunctional rehabilitation centre, though in theory is present in Jamaica, is grossly inadequate. For these essential services to be more accessible and effective, they need to be deemed a public good. The urgency in changing the current *status quo* cannot be overstated. This is highlighted in a study using data from the Trauma Registry, which showed a preventable death rate of 22 per cent. This higher-than-expected death rate among our trauma patients would suggest that we need to act now. When it comes to trauma, time is truly a life-and-death matter.

Professor Archibald McDonald
Former Principal
University of the West Indies
Mona Campus

ASJ Presidents' list – 1958 to present

1. DR L. McFarlane 1958 – 1959
2. Dr J. S. R. Golding 1959 – 1960
3. Dr S. P. W Street 1960 - 1961
4. Dr J. Gilmour 1961 – 1962
5. Dr C.V. Harry 1962 – 1963
6. Dr P. Wiles 1963 – 1964
7. Dr I. S. Parboosingh 1964 – 1965
8. Dr D. B. Stewart 1965 – 1966
9. Dr H. Annamunthodo 1966 – 1967
10. Dr K. L. Hart 1967 – 1968
11. Dr J. D. McNeil-Smith 1968 – 1969
12. Dr G. W. Milner 1969 – 1970
13. Dr H. U. Shaw 1970 – 1971
14. Dr A. F. Mason 1971 – 1972
15. Dr V. E. Brooks 1972 – 1973
16. Dr R. G. Lampart 1973 – 1974
17. Dr D. O. Gore 1974 – 1975
18. Dr J. L. Williams 1975 – 1976
19. Dr A. H. Cotterell 1976 – 1978
20. Dr R. A. Carpenter 1978 – 1981
21. Dr W. W. Wilson 1981 – 1983
22. Dr J. A. McHardy 1983 – 1985
23. Dr L. Douglas 1985 – 1988
24. Dr F. Roper 1988 – 1990
25. Dr P. Fletcher 1990 – 1992
26. Dr B. Lyle-Harper 1992 – 1994
27. Dr H. Spencer 1994 – 1996
28. Dr W. Dennis 1996 – 1998
29. Dr P. Wellington 1998 – 2000
30. Dr R. D. DuQuesnay 2000 – 2002
31. Dr T. McCartney 2002 – 2004
32. Dr G. Williams 2004 – 2006
33. Dr A. McDonald 2006 – 2008
34. Dr P. Bhoorasingh 2008 – 2010
35. Dr L. Francis 2010 – 2011
36. Dr M. McFarlane 2011 – 2012
37. Dr C. Batchelor 2012 – 2014
38. Dr C. Thomas 2014 – 2016
39. Dr M. Newnham 2016 – 2018
40. Dr W. Aiken 2018 to Present


Congratulations
TO THE
ASSOCIATION OF
SURGEONS IN JAMAICA
1958
ON 60 YEARS
OF PROVIDING
OPTIMAL SURGICAL CARE
FOR JAMAICANS
AND MEMBERS OF THE WIDER
CARIBBEAN
University Hospital of the West Indies Private Wing
TONY THWAITES WING
www.ttwing.com
Tony Thwaites Wing
876 977-0309 | 876 977-2025

The Genesis of Haemodialysis and Renal Transplantation

THE SURGICAL technique employed in kidney transplantation is an example of this. In 1913, a German doctor-researcher, Dr Carel, remembered surgically for his development of the Carel suture, after many long-term failures at transplanting kidneys in animals, documented the surgical technique, which has remained basically unchanged until this day. He recognised that failure was due not to the surgery, but to some other factor now recognised as the immune response. Thus, the success of modern kidney transplantation is not a surgical triumph, but rather, due to the many researchers who recognised the immune response and developed various Immunosuppressive agents to help control this.

The first successful kidney transplant for management of end-stage renal disease (ESRD) was performed in the mid-1950s by Murray *et al* in Boston. No immunosuppression was required in that instance as the donor and recipient were identical twins. However, with the development of basic immunosuppression, other surgical teams began transplanting, with the Ottawa team starting in 1966. On to that scene came a young British-trained surgeon from Jamaica, who took a keen interest in the proceedings, taking the expertise and knowledge with him when he returned home to Jamaica in December 1969.

Kidney transplantation goes hand in glove with haemodialysis, which, in those days, not only confirmed that the patient had ESRD, but allowed time for a matching kidney to be found. Enter Dr Samuel Street, a Jamaica scholar and brilliant surgeon, who, as the senior medical officer (SMO) of the Kingston Public Hospital (KPH), decided that technological advances should not leave the island behind and in 1966 purchased a dialysis machine for the hospital!

Thus it was in January, 1970, the young surgeon from Ottawa, now consultant urologist to the Government, based at the KPH, wandering through the instrument storeroom at the hospital, came across this almost new Kolf dialysis machine. It was the identical model on which he had done his training at the Civic Hospital in Ottawa.

In March of 1970, DC, aged 13-years was admitted with ESRD, and after consultation with her parents, it was decided to dialyse her. A Brachio-Cephalic arterio-venous fistula was done to provide vascular access, and a month later, when it had matured, haemodialysis was started. This was done twice weekly.

At first, there was quite an audience to observe the new, strange treatment but soon things became mundane, and we were left on our own. After the first two or three sessions, nursing help became available.

DC did well on her dialysis, and in September, a motor vehicle accident left a young man seriously injured with no brain function. He was not only a perfect ABO blood-group match, but fitted all the criteria for organ donation. Preparations for transplantation were set in motion.

The operation went off without a hitch. First, the donor was taken off the ventilator, and after the heart had stopped beating, the left kidney was removed, sparing the blood supply to the upper ureter.

The kidney was flushed with cold normal saline until the effluent was clear then taken across to the room, where the recipient had been prepared by the team led by Dr Henry Shaw, and transplanted.

Urine was produced almost immediately, which is the most joyous sight for any transplant surgeon. In the surgeons' room, Dr Ali, Dr McHardy's Nigerian resident, declared it a significant occasion and that he was honoured to have been in on the first kidney transplant in the Caribbean and possibly the 'Third World' (the accuracy of that has never been verified).

Our longest-surviving transplant is MP, a retired nursing supervisor in Baltimore whose original transplant was done in 1971. This eventually failed about eight years ago and she had a second cadaver kidney placed by another Jamaican surgeon working in Maryland. She continues to do well.

The following were members of our transplant teams over the years without whose expertise and skills this programme would not have succeeded. Henry Uriah Shaw (my original surgical mentor), John McHardy, Micky Roper, Dr Ali (neurosurgical resident from Nigeria), Lawson Douglas (original transplant team), Guiermo Fraser, Peter Fletcher, 'Bangie' Samuels, Cecil Aird, Trevor McCartney, Patrick Bhoorasingh, Hope Russell, Robert Wan, and Mark Cadogan. Apologies to any significant player whose name I have erroneously omitted.

Professor Lawson Douglas
Consultant Urologist
Former Head of Department of Urology at the Kingston Public Hospital and University Hospital of The West Indies.

Professor, the Hon. L. Lawson Douglas was recently named a living legend in urology by the Canadian Journal of Urology.

Congratulations

Association of Surgeons in Jamaica

On your 60th Anniversary

With the compliments of

OPENING HOURS
Mondays to Thursdays 9:00am to 5:00pm
Fridays 9:00am to 4:00pm
Saturdays 10:00am - 2:00pm
72B Hope Road, Kingston 6
Tel: 618-3674, 618-3680, and 978-4242
Fax: 978-4272
Email: kingstonurology@gmail.com

Development of specialised surgery

AN INNOVATIVE method of treating infected non-unions of bones was born in the Siberian town of Kurgan, USSR in early 1950s by Professor GavriilIlizarov. The principle of the Ilizarov Method to treat large bone defects without bone grafts, utilised the bone's ability to form new bone (regenerate bone) during gradual distraction using wires, rings and rods, a process known as Distraction Osteogenesis. This unique method is used to treat congenital, developmental and acquired deformities, along with reconstruction of large bone and soft tissue defects and complex fractures.

The Ilizarov Technique was introduced into Jamaica in 1998. The greatest challenge was that of obtaining funding for the equipment. Ninety-nine percent of patients who required this specialised treatment are public patients, and many have difficulties obtaining funds to pay for their surgeries at the University Hospital of the West Indies (UHWI). The financial constraints of the UHWI over the past years resulted, understandably, in the funding of more urgently needed equipment. Financial assistance was therefore sought from the private sector. This annual financial assistance began in 2003 and has continued until 2017. All public patients received the use of the Ilizarov Circular Fixator free of cost.

The impact of this unique method of treatment can be measured in the following ways:

SALVAGE OF LIMBS

Trauma from gunshot wounds, motorbike and vehicle accidents continue to be prevalent in Jamaica, and often results in extensive open wounds with complex fractures. Some of these wounds become infected and fail to heal. Young males from the lower socio-economic communities are usually the victims of this type of trauma.

The problems in infected non-unions include: multiple draining sinuses, infected bone, bone and soft tissue loss, joint stiffness, complex deformities, limb-length inequalities and multiresistantinfection. Prior to the introduction of the specialised surgery in Jamaica, patients with the above problems were poorly treated, with many of them being left with deformed, short, and chronically infected limbs. In some patients, amputations were performed because of inability to control the infection as well as in those with significant limb-length discrepancies.

These extremely challenging cases are always managed by the Orthopaedic and Plastic and Reconstructive Services at the UHWI. Non-union, infection, shortening and deformity are all addressed simultaneously by the Ilizarov Technique.

The limbs of a large number of patients have been saved by this unique method of treatment combined with usually extensive soft tissue coverage.

RESTORATION OF EQUAL LIMB LENGTH

Limb length discrepancies in children are secondary to congenital and developmental abnormalities as well as growth plate injuries. The discrepancies can be as great as 8cm to 10cm. Limb inequalities in excess of 3cm can only be satisfactorily addressed by lengthening of the limb. Similarly, adults with large bone defects secondary to trauma or tumour have had their limbs restored by the same method.

CORRECTION OF LIMB DEFORMITY

Lower limb deformities when present in children and adults require correction (straightening of the limbs). Failure to correct the deformity will result in damage to part of the joint, usually the knee joint. These deformities such as Blount's in children are best corrected using the Ilizarov technique with a circular frame. At the UHWI, over the past 17 years, approximately 700 patients have been successfully treated. The most dramatic progress in orthopaedic surgery in the last two decades has been in the field of deformity correction and patients in Jamaica and other Caribbean islands have benefitted greatly from this revolutionary method of treatment.

Dr R E C Rose
Consultant and Former Head
Orthopaedic Surgery
University Hospital of the West Indies

Laparoscopic surgery in Jamaica

IN SAN Diego, California, in the summer of 1992, August to be exact, Dr Clive Thomas, a consultant general surgeon practising at the Kingston Public Hospital (KPH) met up with Dr James 'Butch' Rosser, and discussions were first held regarding laparoscopic surgery and the need for these procedures to be introduced to Jamaica. Rosser agreed with Thomas that Jamaica should not be left behind, and from that moment, the seed was planted.

The seed, however, needed nutrition to grow, and on his return to the island Dr Thomas approached Dr Trevor McCartney, who, at the time, was not only the head of surgery, but also the senior medical officer and chief executive officer of the KPH. A proposal was hatched to introduce laparoscopic surgery into Jamaica with Rosser being the tutor to spearhead the initiative. Thomas made contact with Ethicon Latin America and the Caribbean in order to source equipment for the inaugural training session as well as start-up equipment to get laparoscopy off the ground across the island, and they obliged. They donated equipment, which included disposables and three laparoscopic towers.

At the same time, Dr Ronald DuQuesnay, programme director of the DM Post-Graduate General Surgery Programme and collectively, along with McCartney and Thomas, believed that The University of the West Indies might be the most appropriate location to have the teaching course. It was organised to be held at the Old Library, and all qualified surgeons across the island were invited to participate free of cost.

The programme was developed by Thomas and Rosser and comprised a dexterity course, which involved the use of laparoscopic instruments to remove the skin off of chicken breasts (provided by Jamaica Broilers).

This was then followed by actual laparoscopic cholecystectomies (removal of the gallbladder) performed on actual (anaesthesised) pigs.

The animal laboratory was set up after consultation with the Veterinary Unit of the Ministry of Health. The pigs were procured by the surgeons that were being trained. The course was a huge success, and this signified the start of a new era.

Prior to James departure from Jamaica, laparoscopic operations were commenced at both The University Hospital and the KPH. The equipment used to conduct the course was donated to both hospitals as a gesture of goodwill in order to enhance the surgical development of this new skill across the country.

As we look back over the 25 years since the introduction of laparoscopic cholecystectomies to Jamaica, it is so apparent that thousands of patients have benefitted, and the private hospitals have embarked on providing this method of surgeryfor their patients.

We now have advanced laparoscopic surgery available. Nissen's Fundoplication and repair of hiatus (diaphragmatic) hernia, bariatric surgery, colectomies, appendectomies, splenectomies, prostatectomies, nephrectomies, and hepatic (liver) resections are now being performed laparoscopically in many hospitals across Jamaica.

We are eternally grateful for the unselfish philanthropic efforts and gesture of Dr James Rosser Jr. He has made such an impact on the practice of medicine in Jamaica. Our residents in training have benefited tremendously, and several of our DM (Doctor of Medicine) graduates have done fellowships abroad to improve their skills and have returned to give the knowledge and expertise to our people.

Contributions from:
Dr Clive Thomas
Consultant Surgeon
Past President
Association of Surgeons in Jamaica
Dr Trevor McCartney
Former Senior Medical Officer
Kingston Public Hospital

Let's talk about breast cancer

ASK ANY woman what concerns her about breast cancer and the questions are fairly consistent.

WHAT IS MY RISK AND HOW CAN I PREVENT BREAST CANCER?

Contrary to popular belief, a negative family history does not protect against breast cancer as the minority of cases, perhaps five-10 per cent, are hereditary. It is estimated that the lifetime risk for the development of breast cancer in a Jamaican woman is one in 21. There is nothing that one can do about age, genetics, or the presence of dense breasts on a mammogram (that makes detection harder), but in general, a healthy lifestyle is helpful.

DO I REALLY HAVE TO DO A MAMMOGRAM?

It was recently reported by the American Cancer Society in early 2019 that it was estimated that early detection using mammography, coupled with advances in treatment, has saved over 500,000 lives in the United States since 1989. The earlier that breast cancer is detected also means that there are more options of treatment, and the overall prognosis is better.

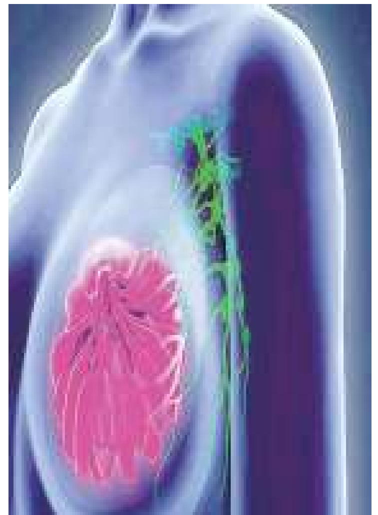
Mammography can detect breast lesions long before they are palpable. For women with dense breasts, a combined ultrasound is recommended. Apart from learning how to perform a breast self-examination and having frequent visits and clinical examinations with your physician, a mammogram and ultrasound examination done and examined by a qualified radiologist is the best way to detect early breast lesions including microcalcifications.

We currently recommend that Jamaican women over 40 start screening mammography, and at an earlier age, should there be any family history or proven genetic risk. It is not unreasonable either to start thinking about screening mammography between 35-39 years, and this should be discussed with your physician. If an abnormality is discovered on mammography, the abnormality may need to be biopsied, and there are several minimally invasive methods to do this.

IS A MASTECTOMY THE ONLY OPTION?

The earlier that one detects breast cancer, the more options are available for treatment. Many women with early breast cancer are candidates for breast conservation rather than a mastectomy. Breast-conservation surgery involves removal of a portion of the breast that contains the cancer and is usually combined with an assessment of the possibility of spread by sampling the lymph nodes under the arm using a minimally invasive sentinel lymph node biopsy technique. Typically, the whole breast is irradiated to lower the risk of a recurrence.

The traditional mastectomy is being replaced by newer techniques such as nipple and areolar sparing mastectomies, techniques that have been practised in Jamaica since



2000. Immediate reconstruction at the time of mastectomy allows the oncological (cancer treatment) aspects of the surgery to be combined with an acceptable aesthetic and cosmetic result.

Not every woman diagnosed with breast cancer needs chemotherapy, particularly in early stages. Certain tests will be done on the cancer, including standard pathological examination, additional receptor studies, and/or tumour genetics, and the medical oncologist will tailor the medications, including hormonal treatment, to the individual.

IF I NEED SURGERY, SHOULD I REMOVE BOTH BREASTS?

Since the advent of the newer more cosmetically acceptable techniques of mastectomies, and with some celebrities sharing their experiences with double mastectomies, more and more women are asking about this method. With proper treatment of the initial cancer, the risk of a second breast cancer is very low once there is no genetic risk. For some women, even this low risk is too much. The addition of a second procedure to the initial curative surgery, however, does increase the risks of the surgery and may delay treatment. It is also obviously an irreversible step. As such, Discussions have to be had where all the pros and cons are explored at length to arrive at the best decision for the individual patient. The discussions are best held over several visits with an experienced breast surgeon and medical oncologist.

Dr Mark S. Newnham,
Senior Lecturer and Consultant General Surgeon,
University Hospital of The West Indies

We Are Open on **Sundays** To Serve You

Services

- Ultrasound
- Digital Mammogram
- Breast Biopsy
- X-Ray Services
- MD CT Scans

SENIOR CITIZENS DISCOUNT

SAME DAY RESULTS
In Most Instances

WALK-INS WELCOME

MasterCard VISA MULTILINK

MedeCus Health Sagicor

Opening Hours: Mon - Fri 9:00am - 6:00pm
Sat 9:00am - 2:00pm • Sun: 11:00am - 3:00pm

PRECISION IMAGING CENTRE
PIC
BECAUSE YOUR HEALTH MATTERS

PRECISION IMAGING CENTRE
15 Caledonia Ave, (Cross Roads) Kingston 5
Tel: 876-906-8511 | 876-908-2443
Cell: 876-880-1973 • Fax: 876-908-2662
Email: precisionimaging101@gmail.com

Drive

AUTO LOAN

... because you're going places

UP TO **100%** FINANCING

LOW MONTHLY PAYMENTS

UP TO **9** YEARS TO REPAY

LOW PROCESSING FEES

FAST LOAN PROCESSING

LOW INTEREST RATE

Select your car. We'll finance it and get you going.

Apply Today!

876.754.VMBS(8627)
876.577.9172
www.vmbs.com

Conditions Apply

Building Your Financial Independence

View from the other side of the table

FEAR AND apprehension are common experiences of the interaction between doctors and their patients. In fact, it is not an overstatement to mention that an elevation of one's blood pressure is an expectation of a patient when facing his/her doctor.

Apprehension, yes, as one can never correctly predict the outcome of what might appear to be the most basic medical examination, as it ranges from the 'all is well', much to the patient's content, to something far more complex with the need for further intervention.

And such was my experience when I first sought to self-medicate on a September morning before panic and later, what can be described as a real crisis was experienced.

It started with what first appeared as the common cold, accompanied by stuffiness in the ears. This was similar to the symptoms I experienced when I was assessed as having a middle-ear infection. The ailment was treated with a course of Cephalosporin, which was effective after two days, so the remaining course was stored just in case it was needed again.

Remembering this, I carefully researched the tablets in order to deal with this new problem.

The next morning, I became concerned as I experienced a change in my voice, which was accompanied by a strange feeling of the tongue. The beginnings of the allergic reaction were self-assessed as the possibility of pharyngitis! Thankfully, the presence of the antihistamines taken for the runny nose slowed the onset of shortness of breath of the self-treating physician.

But greater panic was left to be experienced. The dyspnea created another level of alarm that required the need for urgent second opinion.

One cannot go to the doctor untidy, so it was imperative that a shower be had before the journey to the hospital, which was, fortunately, on the same compound. Knowing that my problems were in the upper airway, I thought best to find the Entertainment Service whose schedule I knew well as that was the last rotation, I had been placed on.

Tonsillectomy is a quick operation in the hands of the skilled Dr Johnson, so I decided to await the completion of this procedure. There must have been some difficulty as he did not seem to finish fast enough to avoid the onset of stridor.

The emergency room, fortunately, was adjacent to the operating suite. The initial blood investigation was excellent, and a thought of a supratentorial diagnosis must have been entertained. However, the struggles during hypoxia were followed by a wave of tiredness and then panic for my surrounding friends as the cyanosis now became evident in my peripheries. Next was the slowing of my heart rate; which I was not aware of as I was a distant spectator to the commotion around me.

My good friend whispered to me that he was going to administer adrenaline and that "I would feel bad". The possibility of death had not entered my mind as I was in a hospital surrounded by competent medical staff, all of whom were my friends. He did not lie! The adrenaline went straight to my heart and ripped it out or at least, that was how I felt. I was sure I had died, and I felt that I sat up and shouted the same, but no one can remember this event!

The next words I heard were, "I need more retractors", as the stab into my windpipe. The surgical clamps could be felt hanging off the neck, but there was no pain! The completion of the tracheostomy was done in the operating theatre.

I truly recognised the fortune that I had, being close to the hospital, and the fact that it happened during the early morning, when everyone was present. The lines were slowly being placed, but I grabbed the hand which seemed to be heading to insert the urinary catheter. Our eyes met, and I pleaded and hand-signalled that I could use a urinal.

Being on the other side has taught me what it is like to be a patient, experiencing anxiety, real fear, and eventual panic. Thankfully, many doctors may never experience ill health until well on into their careers.

This also illustrates the need for members of the medical team to

PLEASE SEE **VIEW,** 23

VIEW

CONTINUED FROM 22

members of the medical team to exercise patience, compassion and real understanding, especially when a patient panics, not being quite certain of the eventual results of what might first appear a simple intervention but which might lead to an unexpected crisis.

A truly traumatic and unforgettable experience has taught me many life lessons as a surgeon sitting, even momentarily on the other side of the table.

Dr Rajeev Venugopal
Lecturer and Consultant Plastic Surgeon
University Hospital of the West Indies

Where are we going?

BY NOW, if you are reading this, it means you have read a lot about the Association of Surgery in Jamaica (ASJ) and should be versed on its birth and history, but the question must always be asked, you know where we came from but where are we heading?

Over the past two decades, the number of surgeons in the association has tripled, for reasons mentioned earlier in this supplement, and this has resulted in an increase, in the number of female surgeons, more specialists in all surgical fields and an increase in the number of young surgeons. All of the above are illustrated in the executive council of the association, which has a good mix of young and older surgeons; female council members, with one holding the post of secretary; and many different specialties being represented over the last 10 to 15 years. While the association continues its role, administration and surgical education, its role in outreach had fallen behind. From time to time the association would visit rural hospitals to aid those surgeons remotely placed another view in the management of surgical patients. This programme has become regularised. Another milestone of the association was the resurrection of the annual surgeon's party. This event used to be hosted by The University Hospital of the West Indies Department of Surgery and was held annually around the Christmas season. It was funded by surgeons, along with the department. However, its time came to an end in the early part of the 2000s. In 2017, the ASJ decided to resurrect the event, but with a twist. It would no longer be free, but would be held as an all-inclusive charity event, with all of the proceeds being donated towards a surgical cause. To add a further twist to differentiate it from the previously held surgical parties and many other all-inclusive parties held across the island, live entertainment was included as well.

Some members, of course, objected. "What do surgeons know about throwing parties?" some said. Well, based on the success so far, the council replied, "A lot!" In February of 2017, the inaugural staging of SCRUBS, 'SCRUBS 1/0', was held at the Senior Common Room's grounds on the university campus, with live entertainment provided by one of Jamaica's greats, Freddie McGregor. That year approximately $500,000 was raised for the Jamaica Cancer Society to aid in their fight against breast cancer. The following year, the event was held at the same venue with a crowd that doubled in size, and with increased corporate sponsorship, $2,000,000 was handed over to the cancer society, thanks to Agent Sasco, who provided the live entertainment last year.

This year, the event promise to be even larger, and the hope is to surpass last year's donation to the cancer society. So far, the prognosis for SCRUBS appears to be positive, and this year's charity is still the Jamaica Cancer Society, in aid of their fight against prostate cancer. Hopefully, Tarrus Riley and friends can help us reach that goal.

Dr Hugh A Roberts
Consultant General Surgeon and Associate Lecturer (UWI)
Kingston Public Hospital

Articles on 'Sinus Surgery' and 'Updates on Prostate Cancer' can be viewed on our new website: **www.surgeonsja.org**

Design your Memories

Mortgage Plus gives you room to grow, with additional financing for deposit, closing costs and other home-related expenses.
Get a mortgage that suits your style.

Joint Financing Available

#JNBankDYM
#DesignYourMortgage

Let's Talk

We'll help you find a way!

888-438-5627 www.jnbank.com

A member of the JN Group

PRINTED BY THE GLEANER COMPANY (MEDIA) LIMITED • 7 NORTH STREET • KINGSTON • JAMAICA