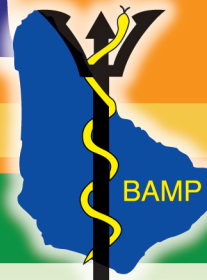


BAMP

B U L L E T I N

BARBADOS ASSOCIATION OF MEDICAL PRACTITIONERS BULLETIN
No 174 July/August 2011



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Faculty of Medical Sciences, UWI Cave Hill.	

Notes From The Editor

This third issue of the new Bulletin is even bigger and richer than the last. Once again our brilliant Art Director / Layout Artist has used a splendid photo to produce a brilliant cover, and the cover photo by Faculty photographer Emerson Haynes highlights the about-to-be created new Clinical Teaching Complex for the Faculty of Medical Sciences, in the historic Nightingale Home on the Old General Hospital grounds.

We lead off with three strong editorials, on the new **Medical Professional Act**, Alternative medicines or “**unconventional therapies**”, and the dilemma of the **Cuban medical programme and the Cuban graduates from CARICOM countries**, including Barbados. This editorial provides some of the answers to the many questions in Dr. DaSilva’s excellent and thought provoking **Commentary**. Other answers should certainly come from the relevant Ministries of Health and Education.

Special attention must be called to the Editorial on unconventional therapies and the related “**Cautionary tale**” in the Clinical Articles section. The notorious traditional “herbal / natural” Chinese **Da Shen Pills** with the toxic aristolochic acid, causes acute and often end-stage kidney failure, needing renal transplantation. It’s a continuing challenge to educate that all that’s “natural” is not safe!

Another Commentary highlights the issue of the availability of **Ambulatory Blood Pressure Monitoring**. Caribbean countries, like most developing countries, commonly follows state-of-the-art medicine by a decade or more. Barbados was the first to provide in the CARICOM region to provide a public health care state-of-the-art service, at the Queen Elizabeth Hospital in the essential tool for best practice management of hypertension, more than 10 years ago (and about 10 years behind the metropole) through a collaboration between the Faculty of Medical Sciences and the QEH nursing service. That service was tragically discontinued some nine months ago, and this article highlights its value, as we look forward to its reinstatement under the watchful eye of new Consultant and Lecturer in Medicine and Clinical Pharmacology, Dr. Kenneth Connell.

Three very important papers are the overview of health management – **Dr. Ermine Belle’s Special Lecture, Professor Hannu Savolainen’s review of vascular disease diagnostic and management needs and Dr. Priscilla Richardson’s essay on medical ethics in quality assurance**. Ethical issues are at the heart of the highest quality health care, and cannot be taken for granted, but need a combination of well designed comprehensive programmes from entering medical school to retirement.

We hope that these rich articles all stimulate discussion among members. Dr. Hoyos’s January paper on certifying the elderly to drive has prompted a very practical and on-the-ball letter from Dr. Herbert.

Our fascinating historical vignettes are again highlighted in Part 2 of **Dr. Shabier St. John’s** essay on the history of medicine in T & T, alongside the **History of Abortion, by Dr. Shadae Gill**, a joint winner of the last class.

And a really special treat was the gift of an ancient and excellent **photo from 1938** of the medical and senior nursing staff of the old General Hospital. What a gem!

Please see the back page for our **Instructions for Authors**.



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Medical Professional Act - BAMP's views

The Barbados Association of Medical Practitioners (BAMP) is very pleased that we have finally got the revised Medical Profession Act through parliament and that it will come into effect on June 1st 2011.

BAMP has been at the forefront of this new act for over 17 years and welcomes the effort to modernise the regulation of the discipline and monitoring of the practice of medicine in Barbados.

We are however, very concerned that certain areas where we see potential disadvantage to both doctors and the public appear not to have been taken into consideration by those charged with producing the new act, despite repeated protestations.

Let us look at a few areas of concern:

Three months for medical reports

A doctor has 3 months to produce a report on the request of a patient. It does not specify that the doctor must be paid for his work but goes on to list this as an offence if not completed. In public practice, there are many constraints and BAMP is concerned about missing notes at the QEH and polyclinics, and lack of secretarial support.

BAMP recommends that the three month period should start on receipt of payment for the report in private practice and in public practice on receipt of the notes by the doctor.

Three lay persons on the Medical Council

We now have 3 BAMP representatives on the 12 man council, a REDUCTION from 4 to 3, and 3 lay persons, 1 of whom is a lawyer.

BAMP recommended that a lawyer should be on the medical

council but sees no benefit to having 2 additional lay persons on the Medical Council. Additionally, they equal the number of BAMP representatives and one wonders why. Much time will be lost explaining medical situations and terminology. If a second lay member is indeed justified, at least it should be a member of another health profession, e.g. a physiotherapist, psychologist, or medical ethicist. How can an ordinary member of the public determine issues of medical licensure, credentialing, etc.?

Complaints, confidentiality of members of council and penalties for breach.

BAMP recommends that all complaints should come as sworn affidavits in an effort to prevent frivolous complaints and that there should be a signed confidentiality agreement for all involved in the proceedings. BAMP strongly recommends that there should be penalties for breaching that confidentiality. This should include council members and administrative staff, and the same penalty mentioned on page 42, # 45 should be applied to those who breach confidentiality (that is a fee up to \$25,000.00)..

CME credits-certification and determination

BAMP's view is that CME credentialing, recertification methodology, and certification of CME must be made clear by the council. It should be harmonized with the business trade and professionals act. The time period to obtain CME, what counts as CME, who certifies the CME (checks source, verifies number of credits, verifies certificate produced by the doctor, keeps running check of CME credits submitted, time value, etc, what happens if the requirements are not met, and how this can be rectified) need to be made crystal clear and the physicians need to be duly informed in a timely manner

The impaired physician and fitness for practice

BAMP seeks an unambiguous definition of the impaired physician and a distinction must be made to distinguish and differentiate impairment from disability

BAMP's position: If the general trend is towards an international norm then the international norm should prevail. There should be a provision for the voluntary submission of a doctor to treatment without prejudice and provision for rehabilitation of the doctor.

In conclusion, BAMP recognises the importance of an updated, relevant and comprehensive Medical Professions Act, and is relieved that, after so many years of effort in many important areas, its revision has finally been achieved. But there remain weaknesses and areas of difficulty, and the Act should therefore be kept under continuing review, so that improvements can continue to be made.

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**"Keep working for the Lord –
the pay isn't much but the retirement
plan is out of this world!"**

(Anonymous)

Nonconventional Pharmacists and Unconventional Therapies

Few physicians, and even fewer lay persons, are familiar with the strictures imposed by Law regarding the advertisement, sale, and recommendation for use of the substances used to treat conditions widely recognised as diseases, ailments, or "sickness". For these reasons we reproduce, below, relevant excerpts from the "Control of Drugs Regulations".

HEALTH SERVICES (CONTROL OF DRUGS) REGULATIONS, (1970)

Made by the Minister under section 10 of the Health Services Act.

1. These Regulations may be cited as the Health Services (Control of Drugs) Regulations; 1970
2. For the purposes of these regulations - "advertise" means to make any representation to the general public by any means whatever for the purpose of promoting directly or indirectly the sale or disposal of any drug, "drug" means any substance or mixture of substances manufactured, sold or represented for use in -
 - (a) The diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof in man or animal;
 - (b) restoring, correcting, or modifying organic functions in man or animal, and includes
 - (c) any substance or mixture of substances in common use when used or intended to be used as a drug;
4. No person shall -
 - (a) advertise any drug or device for the treatment, prevention or cure of any of the diseases mentioned in the First Schedule; or
 - (b) sell any drug or device that is represented by label or that he advertises for the treatment, prevention or cure of any of the diseases mentioned in the First Schedule.

The "Regulations" go on to describe and determine the production, storage, dispensing, and prescription of all drugs under specific licensing requirements. They constitute a comprehensive collection of "do's" and "don'ts" that examine and proscribe all activities in the legitimate "drug trade".

Here are the names of a few relevant and locally pertinent conditions in the FIRST SCHEDULE alluded to in 4 (b) above.

Regulation 6 FIRST SCHEDULE

Bright's or other Kidney Disease	Heart Diseases
Cancer	High Blood Pressure
Cataract	Obesity
Diabetes	Sexual Impotence
Disorders of Menstrual Flow	Tumours
Disorders of the Prostatic Gland (sic)	Ulcers of the Gastro-intestinal Tract
Dropsy	Venereal Disease

How then, one might reasonably ask, can one explain the deliberate and pervasive flouting of these regulations in the written and electronic media in Barbados? How does one react on seeing an advertisement for "non-conventional" therapy (commonly called alternative medicines) on a Government-owned Television Station? The Barbados "Health Services (Control of Drugs) Regulations" were

promulgated in 1970. One is astounded to discover that the European Union has as of May 1, 2011, introduced a ruling that seeks to license the production and sale of "traditional herbal medicines". A closer examination of existing British legislation indicates that the pharmaceutical industry in that country has indeed been "regulated", since 1968, by the Medicines Act, but this was written at a time when there were few herbal remedies available and only a few practitioners of "herbal medicine". It is anticipated that "hundreds of traditional and imported remedies on the shelves of health food shops and herbalists are now set to be banned under the new licensing rules".¹

The new EU Law is intended to protect consumers from hidden, possibly deleterious, side-effects from over-the-counter herbal medicines. Needless to say, there has been the expected outcry from the purveyors of these traditional nostrums of which the great majority are devoid of any scientific proof of efficacy, beyond the well-known placebo effect.

Surveys in Britain suggest that nearly 25% of adults have used a herbal medicine in the past two years². The new regulations are expected to affect widely used substances such as Echinacea, St. John's Wort (used for depression) and valerian as well as the ubiquitous Chinese and Indian herbs. Several of these products may and very often do contain unlisted components, and users, including pregnant women and their foetuses, may be unwittingly exposed to significant harm. Natural products may be "natural" but not necessarily harmless!

The announcement of this major restriction of what is, apparently, an extremely lucrative business, has been met with angry outbursts, including allegations of "racist" (sic) intent on the BBC. Clearly, purveyors of these herbal preparations are threatened by a serious restriction of their businesses and threat to their multi-million dollar industry.

Individuals who are planning to use some of the "traditional herbal medicines" need to be very clear about the various components in the package, and their known adverse effects. Many of these packets carry instructions written in a language other than English and this may lead to errors in the mode of employment. It has been alleged that the notorious "Coffin" was intended for external application; drinking the concoction (as a "tea"? - the mind boggles), is said to have led to fatal outcomes.

All health care professionals, and literate lay people should have a basic understanding of the lack of supporting evidence and the wide range of heavily promoted and popular "alternative" therapies out there, and there are many good books on the subject.³ The Bulletin will continue to address this very disturbing trend in future issues.

As the Chinese adage puts it, "Be careful what you ask for ... you might get it!"

References

1. Herbal remedies face licence rule; Nigel Cassidy; BBC News: Business, Jan 15, 2011.
2. New EU regulations on herbal medicines come into force; BBC News: Health, Apr 30, 2011
- 3.

Cuban Medical Graduates

Much emotion has recently been ventilated about the plight of Barbadians graduating in medicine in Cuba. BAMP's preliminary comments, invited by a journalist, were shared with members to gather wider views and were apparently passed to the organisers of the Cuban scholarships. They expressed the main facts, but the emotional outburst suggests that these facts are simply not understood by some.

The most important fact is that the Barbados Medical Council, like that of other CARICOM countries, is guided by the review and accreditation process of the legally authorised CARICOM body, the Caribbean Accreditation Authority for Medicine and other Health Programmes (CAAM-HP), in deciding the suitability for registration as a medical practitioner. As its website states: *"The Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) is the legally constituted body established in 2003 under the aegis of the Caribbean Community (CARICOM), empowered to determine and prescribe standards and to accredit programmes of medical, dental, veterinary and other health professions education on behalf of the contracting parties in CARICOM. Accreditation is an objective peer review process designed to attest to the educational quality of new, developing and established educational programmes." Its foremost aim is: "To certify that a medical education programme meets prescribed standards."*

The second key fact is that our Medical Council, like that of other major CARICOM countries, requires graduates of Caribbean medical schools not accredited by CAAM-HP, which includes those in Eastern Cuba to which our students are assigned, and most of the off-shore, "for profit" schools, except for Ross and St. Georges, to take the CAMC exam.

This CAMC exam has operated for some ten years expressly to ensure that doctors registered to practice in our countries have attained a certain acceptable standard of knowledge and clinical skills. In the words of CAMC's website: *"The fundamental purpose of the Caribbean Association of Medical Councils (CAMC) shall be to contribute to the attainment of the highest quality of affordable healthcare to the peoples of the Caribbean Region by ensuring that health professionals meet the highest standards of practice, and the protection of public health."*

These are the facts, and BAMP has no control over them, as it neither registers nor examines doctors.

What **DOES** concern BAMP is the difficult challenges imposed on our young students sent to study in Cuba, to be able to satisfy the requirements of Medical Council by passing the CAMC exam, and the quality of care provided for our people, which is dependent on the quality of education, training and skills of our doctors. And here the facts are incontrovertible.

First, there is a huge challenge for young people to study medicine, if they don't have the high academic grades in three sciences needed to enter UWI and most British universities (All grade 1, or 2 grade 1 and 1 grade 2, AND high levels of non-academic achievements in sports, debating, leadership, etc). They accept scholarships to Cuba. (The Dean and Deputy Dean of our Medical

Faculty had early on met and counselled students during summer vacations, to discuss their challenges and the CAMC exam).

In Cuba they spend the first year learning Spanish, and are taught and practice entirely in Spanish. They are not assigned to the prestigious universities in Havana or even Cienfuegos (Pearl of the South, the closest city to Havana) but to medical schools in the East. Our interviews with Caribbean students in Cuba have expressed eloquently the competition among them to transfer to Havana, a privilege accorded to very few. The fact is that while Havana has well-equipped centres of excellence such as their Eye Institute and Hospital, where many cataract surgeries are performed daily, this is not so in the East.

Other factors affect the skills of medical graduates. These include numbers of students and doctors, and the way procedures are divided between health personnel, so that the practical experience given to Caribbean students there is very different to that in the University of the West Indies, and certainly at QEH, where student numbers are small. Also, examination of the Cuban drug formulary, on the visit of our delegation to Cuba some five years ago, and confirmed by doctors met in Cienfuegos and medical students, indicates that many modern drugs are simply not available for use. Finally, the Cuban internship is understood to be nine months instead of the usual 12 months.

The consequence of these many differences in training and development of clinical skills, has been seen over a decade of the CAMC examination, with only one third of CARICOM graduates from Cuba passing the CAMC exam. We understand that this increased last year for Jamaicans but we await reports from the Exam Centre, and we have been unable to ascertain how many Barbadian graduates have taken the exam, but we understand most are working in special locum intern posts in Jamaican country hospitals.

Given the position of other CARICOM countries re their Cuban graduates' experiences, our Ministry of Health asked the University and the QEH to assist in preparing our own graduates (five in the first batch) to prepare for the exam by providing a six month post-graduation course, at the level of our final year course, but emphasising clinical skills and practice. This was done, involving all hospital consultant teams, but with only modest success because attendance and active participation was not at a high level. Performance records are available and a report was sent to the Ministry of Health.

Those students did not register for the CAMC exam because, it is understood, they said they expected the Government to pay their examination fee and passage to Jamaica. The University then arranged for the Part 1 paper to be taken at Cave Hill in a specially assigned computer room, but they did not turn up. It is understood that most of our small number of graduates of some four batches have gone to Jamaica, where there small and poorly staffed country hospitals are employing Cuban graduates as "Locum interns", at half of a normal intern salary, with "Special registration status".

BAMP and the Faculty of Medical Sciences are disappointed that it seems that our Cuban graduates have deferred taking the CAMC exam in spite of every effort to assist them. We recognise the challenges they have faced from School level up, and we question

the wisdom of Barbados sending students for a foreign language programme that is NOT geared to our country's needs or our students' needs, when the UWI, the regional university funded by our countries, has been asked to produce high quality graduates in sufficient numbers in programmes designed to fulfil the specific needs of the region. Successive Ministries of Health and Education have been advised over the years of the qualifications needed for medical training, and of Medical Council's requirements. And BAMP's concern is both for those being sent to Cuba without facing the facts, and for the quality of health care for our people.

The Amazing Dr Cecil Cyrus Museum

"Man is a museum of diseases, a home of impurities; he comes today and is gone tomorrow ..." (Mark Twain (Samuel Clemens))

For the last two centuries, medical museums have been at the centre of medical teaching. There were two reasons for this: firstly, with the development of the microscope and the art and science of pathology, the fundamental importance of the pathology of disease was recognised as underpinning all of medicine. Secondly, it is universally recognised that a picture is "worth a thousand words." (As an aside, this famous truth is probably most accurately attributed to newspaper editor Arthur Brisbane of the *Syracuse Advertising Men's Club*, in March 1911, who wrote: "Use a picture. It's worth a thousand words" ... and NOT to Confucius!)

The most famous museum in the world is the Royal College of Surgeons Hunterian Museum in London, an amazing collection begun by the famous anatomist John Hunter more than 200 years ago, and modernised with all the innovations of modern technology to make it an amazing learning experience. And with the interest of so many people in things medical and technological, it has become an attractive visitor experience for the layman as well as the health professional.

The Hunterian Museum is in fact one of a large network of health related museums in London – **London's Museums of Health and Medicine** (www.medicalmuseums.org/Royal-College-of-Surgeons-Hunterian).

The following list indicates the wide range of fascinating health museums that attract a vast public, beginning with the famous Alexander Fleming Laboratory Museum:

- Anaesthesia Heritage Centre
- Bethlem Royal Hospital Archives & Museum
- BDA Dental Museum
- British Optical Association Museum
- British Red Cross
- Chelsea Physic Garden
- Florence Nightingale Museum
- Foundling Museum
- Freud Museum
- Great Ormond Street Hospital Museum
- Museum of the Order of St John
- Royal Botanic Gardens, Kew
- Royal College of Physicians Museum
- Royal College of Surgeons Hunterian Museum
- Museum and Archives
- Museum of Royal Pharmaceutical Society
- Royal Society of Medicine
- Old Operating Theatre & Herb Garret
- Royal London Hospital Museum & Archives
- Science Museum
- St Bartholomew's Hospital Museum & Archives
- Wellcome Collection
- Wellcome Library
- Worshipful Society of Apothecaries

Here in the Caribbean, Dr. Cecil Cyrus, affectionately known throughout the region as "the Isolated Surgeon of St. Vincent" and an Honorary D.Sc. of the University of the West Indies, has developed over his 45 year career an extraordinary Medical and Pathology Museum. Located in his former surgery at the Botanic Hospital, Kingstown, St. Vincent, it was being incubated over 4 decades, and formally opened on his retirement. The original surgical consulting suite, waiting room and other spaces were filled with potted displays of pathology specimens of every kind, including Siamese twins, preserved with the permission of his patients; with hundreds of splendid colour photos; and with every possible "tool of the profession". There is a complete operating theatre, with 40 years plus of surgical equipment and another room of all kinds of educational displays, devices and instruments for "making do" in a third world country.

Dr. Cyrus has generously donated his museum to the University of the West Indies, Cave Hill Campus, for the benefit of the Faculty of Medical Sciences and all other health professionals in Barbados. The Museum has been visited by the Deputy Curator of the famous Mutter Museum of the College of Physicians in Philadelphia, Ms. Anna Dhody, who has described it as "a priceless and unique collection, which should be preserved at all costs." Its value for teaching is absolutely enormous, but it will also have huge value and interest to the general public.

The Faculty therefore urgently needs the funds to conserve the "wet specimens", pack, ship and store the collection until the space assigned in the new Clinical Teaching Complex at the Nightingale Home is ready (see photo of the Nightingale Home on the front cover: it is proposed to house the Museum in the West Wing, for easy access to the visiting public).

The Faculty is appealing to all Alumni and members of BAMP and all benefactors – to the entire public of Barbados who are interested in the quality of education of our doctors, nurses and other health professionals - to join in donating to the Faculty for this hugely worthy cause. We have to date received a donation of \$20,000 from ICB, \$5,000 from Mr. Peter Boos, and two donations from medical alumni. Cheques can be written to the Faculty of Medical Sciences and addressed to the Dean, Faculty of Medical Sciences, UWI Cave Hill, Bridgetown, Barbados.

The Cecil Cyrus Museum

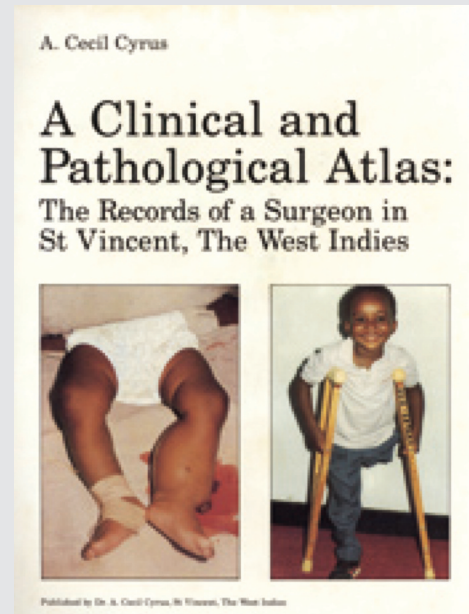


Kingstown, St. Vincent and the Grenadines, is a unique and irreplaceable collection of almost 800 Wet Specimens (pathology specimens preserved in pots), over 4000 photographs in 10 bound albums, bound pathology reports, X-rays and a complete operating theatre including instruments and items used over a period of 40 years. The collection has been made over 4 decades by Dr. Cyrus, a brilliant surgeon who for many years worked as the only trained surgeon on the island of St. Vincent - first at the Kingstown Public Hospital and later at his own private hospital, the Botanic Hospital.

Dr. Cyrus, trained in several specialties as well as general surgery, is also a superb photographer, and his wide ranging experience, often "making do" with limited equipment and facilities, has been thoroughly documented. With the permission of his patients he preserved almost 800 specimens, including rare tumors and anomalies (e.g. a Cyclops), and photographed unusual patients and specimens over his extraordinary career.

A unique compilation of hundreds of his photographs, captions and text comprise his highly praised magnum opus "A Clinical and Pathological Atlas of St. Vincent". Dr. Cyrus is famous throughout the Caribbean and beyond for his

innovative and life-saving surgery, and has been known for decades as "The Isolated Surgeon", presenting papers over many years to Caribbean medical meetings. He has also been known for his altruism, treating, free of cost, many patients who could not afford medical and surgical fees.



On retirement, Dr. Cyrus converted his clinic into a Medical and Pathological Museum, displaying his hundreds of well preserved specimens in glass display cabinets, along with 50 years of operating theatre, surgical and other medical instruments. The Museum has been open to the public, and visited annually by students of the University of the West Indies. **It is an extremely rare and valuable teaching tool for medical students and needs to be made more available to all the students.**

At this point in his life Dr. Cyrus is concerned about the future of his collection and is anxious to see it perpetuated under the care of the University of the West Indies at the nearby Cave Hill Campus

Afterwords: Some thoughts on the Cuban medical graduates.

Dr. P. Abdon DaSilva



The recent debate fuelled by concerns as expressed by Dr. Carlos Chase on the quality of graduates from Cuban medical schools, with its passion, complexities and convolutions, rhetoric and political posturing, is undoubtedly one in need of a full and final resolution.

From this viewpoint, some of the questions that must be asked are: How did this situation arise? If one were to buy into the arguments of The Clement Payne Movement, The Cuban

Barbadian Friendship Association, and The Caribbean Movement for Peace and Integration, their reasoning is one of opportunity for students who could not do so because of financial constraints. Beyond that pale however, was there ever any attempt on the part of those “do-gooders” to inform prospective students of the requirements for registration in keeping with the Medical Registration Regulations of Barbados? It seems that success at the CAMC examinations for registration was not common place knowledge among all candidates. Could it be that the Cabinet decision to mandate the equivalent of a UWI final year and CAMC examination for all Cuban trained doctors is its best kept secret?

Did the Ministry of Education do the same before approval of the program? Have they not abrogated their duties and/or responsibilities to the students and to the wider society? Did the students and their parents seek to acquaint themselves with the real or imagined hurdles in their path to local registration? If the answers to these questions are in the affirmative, then why is there all this fuss? Why not just accept reality and move on? A negative response to any or all of these questions puts the picture into a full and different perspective – doesn’t it? Why didn’t they see the need to seek answers and secure their future? Was it simply naivety or mere gullibility on their part? Did the students set their sights on studying in Cuba as their first choice, or was the opportunity to study there the chance of a lifetime and an impossible one to refuse? In real terms it may have been the only option available to them because of financial constraints or academic qualifications. Who among us would have turned down this opportunity under such circumstances? I suspect we’d all do the same as they did.

Was there really a need for training of doctors in Cuba specifically? Will they fill a void on returning to Barbados or find difficulty gaining employment? The answer certainly points to a national policy of sorts. Perhaps a lack thereof! Who stood to gain? Was it really the students or was it the ‘organizers’?

Is the President of BAMP to be blamed for his comments? He is certainly guilty of raising the flag on an issue that has surfaced many times before, and without any serious attempts at resolution to date; a necessary and pertinent evil in my estimation.

Were the graduates from Cuban schools of “lesser quality” as

reported, or was it some sort of biased opinion and/or unfair criticism? Would those individuals with the “first-hand knowledge” and bona-fide information please end their silence? Have some courage and take a stand on the issue for goodness sake!

Where do we go from here? Did Peter, Paul and Mary provide us with the answer in their lyrics when they sang “the answer my friend is blowing in the wind, the answer is blowing in the wind?” Perhaps! Maybe!

The time for an informed decision is, to borrow a cliché, “right here, right now.” Don’t you think? I hate clichés. Don’t you?

Ambulatory Blood Pressure Monitoring: A needed life saver

Professor Henry S. Fraser, MBBS, PhD, FACP, FRCP



Ambulatory Blood Pressure Monitoring (ABPM) was introduced at the Queen Elizabeth Hospital some 12 years ago. ABPM is a hugely valuable diagnostic and management tool, which provides comprehensive information for blood pressure (BP) and heart rate, over (for best results) a 24 hour period. It uses an above arm cuff and an electronic (oscillometric) monitor, placed over the brachial artery, and which feeds readings into a portable device worn around the waist. Readings are taken every 15 minutes during the day and every 30 – 45 minutes during sleep, for a total of 70 to 80 readings.

It has been known for many years that casual clinic readings are highly variable and notoriously unreliable for diagnosis, classification or effective management of hypertension. The ABPM device was introduced some thirty years ago, and was recognised very quickly as a great boon to accurate diagnosis and management. The many reasons for its great value include the following most important:

- It eliminates observer bias
- It provides many, many more readings
- It identifies the extremely common conditions of white coat hypertension (which may not need treatment at all) and masked hypertension
- It provides readings during the patient’s normal activities, thus more TRUE values
- It shows the circadian variability, identifying those whose BP does not fall at night (non-dippers), which has serious prognostic implications, especially for renal failure
- It correlates changes in BP with environmental conditions, e.g. work, emotional stressors, smoking and other behaviours
- It identifies patients who are over-treated or under-treated, with major implications for treatment and cost savings
- It Identifies large “swings” in BP which may place patients at an increased risk of stroke.

There is now a considerable literature on the subject, but it is sufficient to say that it has been shown in meta-analyses to be far superior to routine or once-off clinic BP readings in predicting

outcomes. Home blood pressure measurements are a valuable compromise, providing better and more accurate information than clinic readings, if the monitors used are reliable and correctly used and documented, but studies show that ABPM is far more reliable in sensitivity and specificity than clinic or home recordings. Because of the personnel and equipment costs (one well trained nurse-technologist working mornings for a modest-scale service, a computer and five or six monitors) and the thousands of hypertensives in our community, the indications for ABPM have to be carefully considered. And therefore home BP monitoring should be encouraged as widely as possible, as the next best approach to achieving good control.

For 12 years the Clinic for Resistant Hypertension at the QEH has been the base for an ABPM service. The main indications in this setting have been the diagnosis or exclusion of white coat hypertension, pre-operative assessment of uncontrolled hypertensives, and assessment of patients with resistant hypertension (failure to achieve goal BP on three or more drugs). The practical implications are that many, many patients with white coat hypertension, i.e. increases in BP occurring in the hospital, clinic or doctor setting, are seriously over treated. This may be bad for the patient, and has huge costs for the health service.

Our service was set up with the assistance of Dr. George Mansoor, a UWI Medical Alumnus of our own (Class of '86 at QEH) who is a recognised expert in this field. The need was clearly recognised by the mid-90s, when the value of the technology was well reviewed, but repeated submissions to the QEH budgetary exercises were repeatedly cut from the budget. Eventually a compromise was reached where the hospital provided a staff nurse to run the Hypertension Clinic, set up and take down the ABPM devices, compute the data and prepare the reports, and follow up the patients; while the Faculty of Medical Sciences agreed to arrange the training of a nurse in Connecticut with Dr. Mansoor's clinic, and to purchase and maintain multiple sets of ABPM devices. Dr. Mansoor himself has done valuable research on ABPM, and in a paper in the next issue some of his work will be reviewed. Meanwhile, a useful general review of ABPM and home BP monitoring can be found in a recent paper from his Division of Hypertension and Clinical Pharmacology in Connecticut by Ghuman, Campbell and White¹.

Unfortunately, following my retirement, the ABPM service, which has identified hundreds of patients with white coat hypertension and assisted hugely in the management of hypertension that is resistant to treatment, was unilaterally discontinued by QEH administration. With the arrival on staff of hypertension specialist and clinical pharmacologist Dr. Kenneth Connell, another distinguished UWI alumnus, it is hoped that this life saving and money saving facility will be made available once again, to bring patient care for our hypertensive patients back into the 21st century.

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From "A BOOK ADDICT'S TREASURY"

[Ed: My life has been a love affair with paper: I can be justifiably called a book addict, and this title attracted me like honey for a fly. The extract below, from Michael Foot, British Labour Party leader, on his father's book addiction strikes a familiar chord, and evokes tearful sympathy from my wife, who has to deal with my addiction.]

"Any suggestion that my father's association with books was governed by a developing strategy would be a wicked deceit. Apart from my mother and his music, they were the light of his life. They were his meat and drink. They were his bulwark against the world. They became – it is impossible to deny – an overpowering disease.

He bought them, read them, marked them, reread them, stored them, reallocated them on the shelves, which spread like erysipelas up every available wall, knew where each precious volume of the countless thousands nestled without the aid of a catalogue. His appetite was gargantuan and insatiable. He was a bibliophilial drunkard – with the difference that the taste never palled and he never had a hangover. The only stab of remorse he ever experienced was the rare recollection of how, at one of Hodgson's sales or in one of the second-hand shops where he spent another of his lifetimes, a temptation has been cravenly resisted. He would tell me over lunch how he had been at the bookshop prompt at nine o'clock that morning to repair some cowardly error of the day before. The treasure was still there on the shelf. Who could want further proof of the intervention of Providence.

Since the house in Cornwall had still to be run as a place of human habitation my mother often found the pressure intolerable. So my father became furtive. He would get up early to waylay the postman or set off for London on a Monday morning with several empty suitcases. When he went on a lecture tour to America he returned with eleven cratefuls. When each member of the family was old enough to leave home, the parting could be borne. Valuable wall space was released. Wordsworth or Napoleon or Montaigne or Dr. Johnson could at last have a room of his own, like John Milton."

Michael Foot, "Isaac Foot: A Rupert for the Roundheads" (1980)

(From A Book Addict's Treasury, by Julie Rugg & Lynda Murphy, Published by Frances Lincoln Limited, 2006. Highly recommended!)

The Role of Ethics in Quality Assurance: Perspectives in Medicine

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Medicine is a high stakes ethical relationship between doctor and patient and healthcare and society. As such, ethics should be seen as an integral element of quality care.

Ethics is not “beyond” medical care; it is an integral element of medical practice and delivery of care. If ethics demands scrutiny at the individual case and treating the whole person and not just the illness, then ethics is not “beyond” medicine, taken as diagnosis

and treatment, but essential to it.

QUALITY OF CARE & ETHICS

One of the 20th century’s most distinguished medical philosophers, the Spanish physician Pedro Lain Entralgo, wrote that “the medical act,” namely the transactions of diagnosis and therapy between patient and physician, cannot be completed without “a moral element, namely, attention to the dignity of the patient as a person.” (*La Historia Clinica*, Madrid, 1998). Also, the first major text of modern medical ethics, written by the theologian Paul Ramsey in 1970, was entitled *The Patient as Person*. This seminal book demonstrated that ethical judgment was not simply an adjunct to clinical decisions but shaped the very nature of the medical actions. While it is possible to perform a diagnostic procedure, such as a CAT scan or to administer a treatment, such as intubation for respiratory insufficiency, as a purely mechanical act, that act will not be a medical act unless it represents a human transaction, done with the intention of benefit to the patient and in accord with the desires and dignity of the patient. Thus, ethics should be seen as intrinsic to medicine. Best international practices propose that assessment of the quality of medical care must reflect competence in ethical judgment and appropriate ethical policy.

Because we at UWI-Faculty of Medical Sciences are also involved in a high stakes relationship, notably, educating future physicians, it is essential that we incorporate, within the medical curriculum, a comprehensive program that outlines, informs and guides ethical decision making. It follows that a physician armed with excellent clinical skills and a strong moral compass will favorably impact the quality of care in the environment in which she/he practices.

In his last book, *Introduction to Quality Assurance in Health Care*, the late Avedis Donabedian, the father of quality assurance studies in modern health care lists seven quality measures: **efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy and equity**. The first four of these seven components are familiar to most practitioners. Efficacy is the ability of health care to bring about

improvements in health. Effectiveness is the degree to which the attainable improvements are in fact attained. Efficiency is the ability to lower cost of care without diminishing attainable improvements. Optimality is the balancing of improvements against the costs of such improvements. Considerable effort has been made to specify these components and dimensions and to find quantifiable measures to assess them. Indeed, since it is often easier to identify failures and poor quality performance, quality assurance sometimes is better at measuring error rather than promoting, “optimality.”

The final three components - acceptability, legitimacy and equity, are less familiar. Acceptability refers to conformity to the wishes, desires and expectations of patients. Legitimacy means conformity to social preferences as expressed in ethical principles, values, norms, mores, laws, and regulations. Equity means conformity to a principle that determines what is just and fair in distribution of health care among members of the population. These three components, taken together, are the topics of modern medical ethics or bioethics as applied to the delivery of care.

Although the fields of quality assurance and bioethics have developed in parallel over the last thirty years, little or no effort has been made to link the two. The last three components have essentially been ignored by quality assurance activities; the first four have been distant from the concerns of bioethics. Hospitals have established quality assurance departments and instituted many measures of efficacy, effectiveness, efficiency and optimality. Hospitals have also established ethics committees, and in some rare cases, ethics services or departments. These usually operate quite peripherally to the main administrative functions of the hospital and have little, or no, input into policy making.

In light of the correspondences between ethics and quality, it appears obvious that a closer relationship between quality assurance and ethics would benefit patients, providers and institutions. The mere association of quality and ethics, as a conceptual unity, would send an important message about the institution’s understanding of its role.

Perhaps, as the FMS moves forward from the preclinical to the clinical areas, we can make these linkages. This requires an informed and active Ethics Committee in place that is responsive to physician and patient consult requests; formulates ethics policy; and promotes ethics education. This effort is a worthy one and one which would have great value for the way in which health care is delivered and evaluated here in Barbados.

When we turn to surveys about ethical health care practices, the picture is not encouraging. For example, several surveys have asked a number of questions under the general heading of “shared decision making.” These questions pertain most clearly to what we usually consider issues of medical ethics, that is, informed consent, decision making capacity, advance directives and surrogate decision making. These areas demonstrate conformity to the wishes, desires and expectations of patients and responsible members of their family. Only 30% of staff believed that clinicians are effective in integrating patients’ values and preferences into health care recommendations; 40% believed that patients are informed of the probability of a recommended treatment’s success and 14% stated that they did not

believe that patients were asked, outside their families' hearing, about how they wanted their family to be involved in their care.

End-of-life questions fall under the category of Legitimacy, that is, correspondence to social norms, laws and values. Only 28% of respondents judged that physicians provided effective pain relief; 16% considered that psychological distress was well managed. When asked whether clinicians decrease their interaction with dying patients when the goal of care is comfort only, 16% agreed, 17% disagreed, 10% were unsure and 56% answered "don't know." A significant majority of staff, 64%, disagreed that the facility educates staff about ethical issues in end of life care.

When asked about privacy and confidentiality, staff felt the facility educates staff about privacy and confidentiality (66.2% agree, 24.2% neutral, 9.6% disagree). However, the efficacy of this education is cast in doubt when two factual questions were posed. Only 20% answered correctly those two factual questions about application of HIPAA rules, and 66% agreed that private information about a patient is often discussed within earshot of others not involved in their care.

With regard to Equity, questions about resource allocation revealed major deficits in knowledge. About 44% do not understand the institution's decision-making process about resource allocation and do not think management communicates the reasoning behind these decisions. In addition, 44% disagree with the statement, "This facility makes resource allocation decisions consistent with its mission and values".

Although Donabedian does not include professionalism explicitly among his components, we note that physicians do not clearly understand the basic elements of professionalism, that is, the important ethical and legal concepts about conflict of interest. It is apparent that staff show notable deficits in knowledge about medical ethics and in their perception of the ethical standards and behavior at the institutional level. 42% of physicians surveyed do not think that the institution "provides practical assistance to staff members who want help with health care ethics concerns."

Certainly, this does not mean that practitioners are unethical; rather it means that important ethical matters are either ignored, poorly understood or taken for granted. If ethics is an essential component of quality assurance, a means to improve ethics education and to create ethics policies that will clarify and inform should be devised.

Both the FMS administration as well as the clinical teaching faculty should welcome and support such increased emphasis on education and policies. Ethics is an essential element of quality care and it does not come without effort, as philosophers and educators have stated for centuries.

THINGS MAY COME TO THOSE WHO WAIT,
BUT ONLY THE THINGS LEFT
BY THOSE WHO HUSTLE.

...Abraham Lincoln

Caribbean Wellness Day -

CARICOM countries' annual celebration of health and wellness, used to spark longer-term healthy behavior

With thanks to Dr. T Alafia Samuels, CARICOM Consultant on NCD prevention and control, and Sir George Alleyne, Director Emeritus, Pan American Health Organization; Katy Cooper, Senior Project Manager, C3 Collaborating for Health

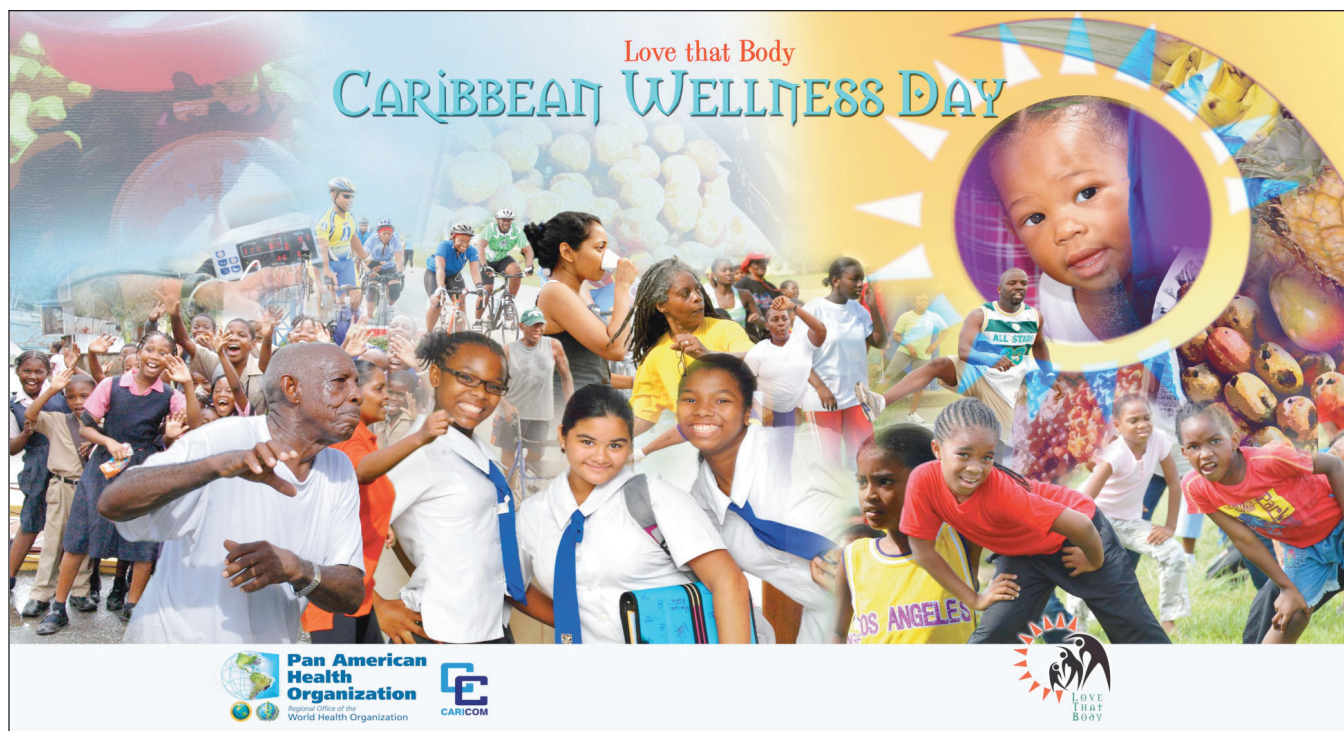
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This publication was commissioned by the Commonwealth Secretariat and circulated at the Commonwealth Health Ministers meeting in May on best practice in the prevention of non-communicable diseases in Commonwealth countries. CWD was chosen as an example of a "Good-Practice" case which was a multi-sector intervention to promote health and wellness.



In the 2007 Port of Spain Declaration 'Uniting to Stop the Epidemic of Chronic Non-communicable Diseases in the Caribbean Community (CARICOM)', the heads of government of CARICOM established the second Saturday in September as Caribbean Wellness Day (CWD).¹ Taking action is a priority, as NCD prevalence in the region is high – death rates from cardiovascular disease in Trinidad and Tobago, for example, are 84 per cent higher than in the USA and Canada, and diabetes mortality is 600 per cent higher. Obesity and high consumption of salt are the norm, and physical activity rates are well below the recommended levels. Alcohol abuse among men is also a growing public-health challenge – 4.5 per cent of deaths in the region are attributable to it, compared with 1.5 per cent globally.²





Caribbean Wellness Day aims to strengthen alliances within the community and create an environment that fosters behaviour change throughout the year. The messages are simple – no tobacco, exercise 30 minutes a day, eat less salt, less fat and less fried food, check your blood pressure, and no harmful use of alcohol – and are brought together under the slogan ‘Love That Body!’ It is a collaboration between the CARICOM Secretariat, the Pan American Health Organization/WHO and multi-sector CWD committees (including the faith community) within each country, and has attracted good participation and media coverage in the three years it has been held. Its multi-country and multi-sector approach is unique, and it highlights simple and fun steps that individuals and families can take to improve their health. Regional branding and reports are available on its website.³

National ownership is an important aspect of CWD, with each government allocating an average US\$22,000 (plus private-sector support) to promote the Day, tailoring the messaging to make it relevant and adapting the literature and posters provided. In 2010, for example, 19 countries took part.

Barbados has celebrated CWD every year since the Port of Spain Declaration. In 2009, the National Task Force on Physical Activity was announced, under the chairmanship of Mrs. Mara Thompson, wife of former Prime Minister David Thompson.

In 2010, there was a full day of activities focused around Browns Beach (see photos, including the Caribbean Wellness Day logos). On World Health Day 2011, the line dancing continued with a large, public dance off in Independence Square. Barbados’ sea-side boardwalk at Rockley is also a favorite for families.



The Bahamas chose ‘Love your body – portions count!’ as the theme, and encouraged a full week of healthy-living activities, culminating in a ‘Health Extravaganza’ on Caribbean Wellness Day itself, bringing together a wide range of people and organisations responsible for various aspects of health,

including a dawn walk-a-thon (held in conjunction with the Bahamas Cancer Society), cookery demonstrations (including information on both healthy eating and sensible portion sizing), and a variety of games, including hula-hoop and a watermelon-eating competition and a 'dance-off'. Other countries' initiatives included a six-month 'Biggest Loser' weight-loss competition for groups of employees in Grenada, and Million Milechallenge in Guyana.

Most countries have begun evaluation of the CWD, including budget, participation rates and plans for sustaining the activities, which is essential if long-term health benefits are to be achieved. Many countries have used the Day as a catalyst for the creation of year-round programmes – such as the 'Family Fitness Sundays' established in Diego Martin, Trinidad and Tobago, in which roads are closed for four hours to provide space for people to socialise, dance and eat healthy food – and others, such as St Lucia, have introduced physical activity in primary healthcare centres.

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Available for download at: www.thecommonwealth.org

CLINICAL ARTICLES & CASE REPORT

Mind the Gap!

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Introduction

Barbados has been referred to as “The Amputation Capital of the World”. The general public here seems to have the impression that legs are amputated at the drop of a hat and for minor indications. How true is this impression? A case control study carried out by the Chronic Disease Research Centre (CDRC) and Queen Elizabeth Hospital (Hambleton et al, (1), did show that amputations are common in Barbados

with a rate above that quoted from other developed countries. More importantly, postoperative mortality rate was high, likely due to ongoing sepsis and co-morbidities such as coronary heart disease. The key question is: how well do we compare with the rest of the world in reality, when similar patients are seen in the study.

Background

Travelling in London one constantly hears “Mind the Gap” at every Underground Station. I was reminded of “The Gap” in April this year while attending the Charing Cross Vascular Symposium at Imperial College in London. The CX meeting, as it is known, is one of the most important conferences in the field of angioplasty in the world.

The first coronary artery balloon angioplasty was performed by Andreas Gruenzig of Switzerland in 1977 (2). Even before that, Dotter and Judkins had described an angioplasty of the femoral artery in

1964 using rods (3). Since the 1980's, the amount of open operations to bypass coronary artery occlusions has steadily diminished worldwide, as new technologies have drastically improved the results of angioplasties. The use of drug-eluting stents has almost removed the early main obstacle, that of re-stenosis. At the moment, restenosis rates of less than 10% are achieved (4).

A similar trend is seen in peripheral vascular surgery. In Barbados, PTA or PTCA have up until now not been available at the QEHL. However, several colleagues have been working on it for several years now. A cardiac catheterization laboratory is available - which shows advancements are possible. Funding for invasive radiology has been very difficult to find, although cardiovascular disease kills one in three Barbadians. We are very soon going to take an important step in the development of health care in Barbados: we are assured that peripheral angioplasties will be started at the QEHL this year!

The present situation

At the QEHL, the most common indication for a major leg amputation is uncontrollable infection, not ischemia per se. It is known from recent studies that patients with gangrene and/or ulcers fare much worse even after successful bypass surgery. In the Department of Surgery, on any given day up to 65% of the patients are being treated for diabetic foot problems (5). The cost to the health care system is immense.

How much do we know about the healing of these ulcers? There are only a few studies on this subject. We do know that critical limb ischaemia (CLI) is a growing problem in an ageing population

CLINICAL ARTICLES & CASE REPORT... cont'd

6). CLI is a sign of severe generalized vascular disease and comes with a dismal prognosis, especially among elderly patients (7,8). What is crucial to understand is that the presence of tissue lesions is associated with a poorer prognosis than rest pain alone (9). It is also known that revascularization is cost-effective (10). Another significant feature is the fact that a foot ulcer will need a systolic pressure of at least 80 mmHg to heal. A weak but still palpable pulse may be present – and yet the foot is in need of revascularization. And in any case, pulse palpation is not very reliable at all, even in the best of hands (11).

In a study by Soderstrom et al., it was seen that even after successful revascularization, 40% of the ulcers healed in six months and 70% in one year (12). What was very significant is that at one year, 50% of these patients with CLI were alive with a leg. Her unit is an extremely busy angiology center performing 4800 vascular operations a year in a well-funded Scandinavian health care system. In real terms the co-morbidities of these patients, mainly coronary heart disease, are often fatal, even in the short term. The overall 5-year survival of these patients is typically around 40% (13) – similar to that of cancer patients.

Cost of amputation

A major amputation is always a much more expensive therapy option than revascularization (10). The patient may even be rendered bedridden. Even in the case where the life expectancy of the patient is low, it is far better for the patient and his/her family, and cheaper if a patient is at home, ambulant and independent.

Cost of diagnostics

Modern diagnostics make it easy to identify those patients who have critical ischaemia. An ankle-brachial index is completely unreliable in a diabetic patient – a value of 1.3 is fairly common and simply means the arteries are not compressible due to media calcinosis (13). Arterial insufficiency can be expected in 1 of 5 patients with any foot ulcerations (14) in the non-diabetic patient. The most common reason (up to 70%) for ulcers is venous insufficiency in non-diabetic patients. Neuropathic, metabolic and ischaemic factors all contribute to foot ulcers in diabetics. Also, the arterial manifestations of the disease tend to be much more distal than those in non-diabetics (15).

Basically, all that is needed in a modern clinical practice for diagnostics is toe pressure measurement and angiography (CT or MR Angiography). At the QEH, we do not have facilities for measuring toe pressures, which are more reliable in a diabetic patient due to the more sensitive method (strain gauge or laser Doppler). However, to treat patients with endovascular method used, a facility with standard angiography is needed. A CTA or MRA are not suitable for therapy, only for diagnostics.

Cost of PTA

The initial investments for a vascular laboratory are significant. Modern drug-eluting stents are expensive – though rarely if ever needed in the peripheral circulation. Although an infra-inguinal bypass operation may still be the gold standard for extensive infra-inguinal arterial disease (16), PTA is much less invasive for the patient and should be seen as the first line option if it is feasible (17). Surgery (debridement of the ulcers and possible late revascularizations)

will always be needed in this group of patients, which is why active co-operation between surgeons and radiologists is crucial in all cases (18). As not all patients are amenable to revascularization, a physiatrist should be a member of the team early on – perhaps even at the beginning, when the patient is still suffering from claudication – although 40% of CLI patients never experience this symptom (7). In any case, off-loading of the lesion is crucial and the services of a physiatrist and orthotist are needed.

Although a hospital bed is not normally needed for endovascular therapies as such, the need for ulcer surgery and the cost of the highly individualized PTA equipment (guide wires, catheters, balloons – let alone the angiography suite itself) is so high that it will make it virtually impossible to perform PTAs in a private setting in a small country such as Barbados – there simply aren't enough paying customers to cover the cost of the initial investment. Therefore, the QEH is the best solution to the problem. Whether a modern mobile C-arm or a standard angiography unit is used is less relevant.

Co-operation

The clinical management of diabetic foot ulcers requires seamless co-operation between internists, podiatrists, physiatrists, surgeons, radiologists and other key professionals. Inadequate footwear alone has been identified as one of the major reasons for amputations (1). Another question for the future will be the fact that successful bariatric surgery may possibly cure 70% of diabetic patients (19). Investments will be needed there as well.

Conclusions

There are still many misconceptions about the management of peripheral vascular disease in Barbados. Although problems and shortages exist, Bridgetown does not deserve the label “Amputation Capital” of the world. Because of diabetes, the patient material on the island is extremely complex and more distal vascular lesions not amenable to therapy are seen. Pulse palpation is not particularly reliable, and more patients should have angiography performed. Acute infections and chronic ulcers are common. In order to diminish the amputation rate, a non-invasive vascular laboratory is needed at the QEH. Endovascular therapy will have to be introduced with improved surgical services. The savings will be considerable, although ongoing investments are required. It is true that the amputation rate is much higher than it could be. In order to improve the situation, we will all have to improve the general care of diabetic patients (earlier diagnosis, glucose control, management of hypertension, loss of weight, better compliance) and get them to specialist care much earlier. That way we will avoid the problem of having to see only end-stage vasculopathies where very little can be done. We may still have some way to go, but this is the time to start – before we fall into the gap!

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The difference between a Neurotic
and a Psychotic:

A Psychotic thinks 2+2 is 5 ;
a Neurotic knows that 2+2 is 4 -
but he hates it!

(Anonymous)

Da Shen Pills - "A Cautionary Tale"

George D. Nicholson, DM (Oxf), FACP, FRCP
Professor Emeritus



'He who treats himself for a cold, has a fool for a physician' (Anon)

A 73-year-old man was admitted to hospital in a neighboring island with a six-week history of low back ache and pain radiating to the right thigh exacerbated by weight bearing. Significant additional history and symptoms included an increased frequency of micturition and an "orange" coloration of his urine related to his use of a "cocktail of herbs" over

that period. During the two weeks prior to his admission, additional symptoms of generalised abdominal pain, nausea, and vomiting had developed.

His immediate past medical history was remarkable for his treatment with amlodipine for hypertension, aspirin, and the use of "herbal medicines". The latter included Da Shen pills, and Zuo Gu Shen Jing Jong capsules.

On examination his blood pressure was 130/80 mmHg, pulse 56 bpm. There were no significant abnormalities in the remainder of the physical examination.

Initial laboratory investigations showed the following abnormalities: plasma creatinine 926 micromols/l; urea 33.9 mmols/l; potassium 6.1 mmols/l; Hb 7.9 G/l; PCV 22%; dipstick urinalysis – blood 2+; protein 2+.

The patient was treated with intravenous fluids and treatment to correct his hyperkalaemia. His subsequent progress showed relatively rapid improvement in his renal function parameters, his plasma creatinine falling to 248 micromols/l three weeks after admission.

Comment.

This gentleman clearly had significant, recoverable, acute-on-chronic renal failure. The severity of his anaemia on admission points to significant, pre-existing, renal impairment, but the referral letter did not speak to pre-existing symptoms (e.g. those suggestive of prostatism) that might have prompted his recourse to "exotic" medicaments.

Da Shen Pills, and other Chinese herbal preparations, contain a toxic substance "Aristolochic acid" (AA) whose well-documented, renal toxic effects were first reported from Europe in women using herbal medications in weight-loss "clinics". Regrettably this toxic substance has now found its way, (via the West Coast of the USA), to the Caribbean.

In 1991, Belgian physicians reported on an increasing number of women attending weight loss clinics who presented with acute, or often near-end-stage, renal failure, following the use of AA. Since that initial report, more than 300 cases have been documented and more than 100 of these unfortunate individuals have required renal transplantation. Several of these patients presented with "rapidly progressive renal failure" associated with the use of "Chinese Herbal

CLINICAL ARTICLES & CASE REPORT... *cont'd*

medications" and a publication by Debelle et al speaks of Aristolochic Acid nephropathy as a "world-wide problem".

One other problem with a package of "Chinese Herbs" is that the labeling does not necessarily reveal all the contents. So, as this month's editorial warns : -

"BE CAREFULL WHAT YOU ASK FOR" when you go to the "Drug Store".

Reference

Debelle FD, Vanherweghem JL. Aristolochic acid nephropathy: A world-wide problem. *Kidney Int.* 2008; 74:158.

"Never go to a doctor whose office plants have died."

Erma Bombeck

DISTINGUISHED LECTURE

Managing Your Health - The Spectrum of Ageing

Dr. Ermine Belle, MBBS, DM (Psych)

It is an honor to have been chosen by the National Insurance Scheme to deliver this, their annual lecture, on the occasion of their 44th Anniversary.

Their theme "Fostering a Healthy Environment" led me to reflect on the many facets there are in health and to make a decision to approach this lecture from a holistic point of view. Very recently there have been a number of issues being discussed in public fora which have spoken to individuals taking charge of their health, hence my choice of topic tonight. In a recent editorial and an equally recent comment in the print media, the headlines were "Choose to be Healthy" and "Stabilizing Health Care". This would suggest that note is being taken to address health from a different perspective.

Being somewhat Freudian, my free association of thought caused me to focus on "Managing Your Health" and the next association was "From the Cradle to the Grave." – the latter topic was rejected as it sounded a bit morbid. I therefore changed it to something I perceived was more palatable, and I arrived at "The Spectrum of Ageing" and hence the title of my lecture tonight.

Ageing starts from the time you are conceived and growth and development are part of the aging process. I say that to point out that ageing starts in utero. Care of an individual must therefore begin from the time of conception.

We in Barbados take a great many things for granted in relation to our health. Maternal and child health is an area which has been emphasized over the years, from the pregnant woman's point of view through the obstetric services offered prior to delivery, through delivery and post delivery. The infant child once delivered is put into the hands of the pediatrician as is expected.

Do we ever stop to think of what would transpire if these expected steps did not occur? A review of the maternal and child health statistics between the years 1983 -1985 and the years 2004 to 2006 made interesting reading. The annual report of the Chief Medical Officer for the year 1985 showed that approximately 60% of women whose babies were born alive received ante-natal care in the public clinics. Of the new attendees at these clinics, 27 % were teenagers,

36% were in the age group 20-24 and 23 % were in the 25-29 age group. A reduction in the number of births to teenage mothers was noted; there being 823 births in 1985 compared with 930 in 1984. It was also noted there that some of this reduction was possibly attributable to the work done in the adolescent health and family life education programmes.

In that same report it was documented that in 1985 immunization coverage in the less than one year age group was 79 % for diphtheria, pertussis and tetanus; 84% for poliomyelitis; and 84% for measles mumps and rubella. In children under five the coverage was 80% for diphtheria, pertussis and tetanus; 76% for poliomyelitis and 82% for measles, mumps and rubella.

The Chief Medical Officer's report for 2004-2006 showed that for one year olds, the immunization coverage was on average 89.5 % for oral polio vaccine, 90% for pentavalent vaccine and 94.4% for MMR1. In the age group 3-6 years, coverage for MMR2 was 97.5%. There were no reported cases of diphtheria, pertussis, tetanus, Haemophilus Influenza B or Hepatitis B in this age group for the period under review. These statistics strongly suggest that the primary health care programmes at the polyclinic level greatly enhanced the management of child health problems and had an impact on the maternal health needs of this country.

Let us now take a further look along the spectrum of ageing to the toddler stage. Infants and toddlers are able to do little or nothing for themselves re managing their health. Thankfully there are well established guidelines re the management of the physical aspects of a child's health. Charts guiding the immediate needs after birth, six week checks, and immunization regimens are well documented and parents are well aware of the requirements for entering school.

You may recall however that I spoke to a holistic approach at the very beginning of this presentation. Therefore at this point I must make reference to the emotional needs of small children. I here take the liberty to recount a story from my early days as a junior doctor at the Queen Elizabeth Hospital:

I was at the time working on the Pediatric ward, C8. I recall the

DISTINGUISHED LECTURE . . . cont'd

admission to the ward of a toddler in a state of acute respiratory distress. The mother gave way to the clinical team, leaving her distressed child in their care. She did not return to visit that child for another three days. I was present on the ward on the day she returned and was actually standing by the child's bedside. I remember registering with surprise the child's reaction to his mother whom he had not seen for three days. The mother stretched out her arms to the child who was looking straight at her having probably heard her voice as she came towards the bed with the nurse. As mother lifted child, the child turned his face away and noticeably looked in the opposite direction. The mother then said to the child "you not glad to see me" and started kissing and snuggling the child. The child's response was to cry fitfully until the nurse took him away and only then did he settle. I have said all that to ask "do we know what damage was done to that child during those three days? Is there really any way of forecasting the impact of that situation on that child?"

I could from here launch into a long discourse on the work of John Bowlby and Mary Ainsworth and many other developmental theorists and experimentalists to substantiate the Attachment Theories which help us to understand children's behaviors at times like this and later in early childhood such as on initially entering school.

However I will circumvent the detailed steps but will reinforce that Bowlby's major conclusion, grounded in empirical evidence, was that to grow up mentally healthy: "The infant and young child should experience a warm, intimate and continuous relationship with his mother (or a permanent mother substitute) in which both feel satisfaction and enjoyment."

Bowlby also made a wider call when he documented that just as children are absolutely dependant on their parents or parent figures for sustenance so, in all but primitive communities, are parents, especially mothers, dependant on a greater society for economic provision. If a community values its children it must cherish their parents.

In our society, as in most developing and developed societies, health guidelines continue to be well documented from the infant stage to the school age child up to late adolescence. How many of us have seen conditions such as marasmus and kwashiorkor, childhood conditions associated with malnutrition? Thanks to our diligent public health personnel and pediatricians of bygone days - and I take time out here to salute persons such as Edgar Cochrane, Sir Maurice Byer, Sir Frank Ramsey, Albert "Bertie" Graham and others who moved Barbados through the stages of mandatory immunization, breast feeding programmes and nutritional guidelines. This has ensured the control of many childhood conditions and ailments and eradication of infectious conditions such as malaria and poliomyelitis. Without their dedication and hard work involving both educational programmes and delivery of sound clinical medicine, these conditions would still be major concerns.

Most of the children in our society are healthy, vibrant individuals. Most settle into the school environment and aren't encumbered by any major physical challenges. Asthma is one of the challenges of children today and there are good protocols, both dealing with preventative measures and handling acute onset, that if adhered to will prevent catastrophes and save lives.

Children will damage themselves at play and will contract coughs and colds, scratches, bruises and cuts as well as broken limbs all of which our health care system is well geared to deal with.

You cannot prevent children from running and playing and falling and sustaining some degree of injury at times. However there are many other things that are preventable. I must stress therefore at this point that "An ounce of prevention is worth a pound of Cure."

Again at this stage of development parents and caregivers must be alert to the health needs of their children and ensure their protection. Educating them about good hygiene will go a long way to helping children to maintain good health.

As we proceed along the spectrum of ageing you must be aware that we are entering a period that is documented in many volumes as turbulent times. Here I refer to the period of Adolescence. - by definition the period between Puberty and Pregnancy! If that definition holds true in today's world we would have some children with very short adolescent periods and some of us would be permanent adolescents!

Is adolescence really that turbulent or is the handling of that developmental stage and the years before the real problem? I would like to suggest the latter. Adolescence is a transitional period. It really has no fixed beginning or end. It is much better to take the approach of the Social Scientists who study adolescence and differentiate Adolescence into Early, Middle and Late Stages. It also is equally sensible to appreciate that adolescence takes individuals from immaturity to maturity.

So why are we studying Adolescent development? This period in our lives and its management is critical to managing our health at that stage and in the years that follow. The fundamental changes of Adolescence are:

- Biological transitions
- Cognitive transitions
- Social transitions

Those fundamentals are universal but we must understand that they are operating in a given social context that varies from individual to individual and across space and time. This means that we must study adolescent development in the context of family, peer groups, schools and home and leisure settings. Most if not all of us are aware of the physical growth phenomena that occur in adolescence. Parents are advised to educate their children to these impending changes. Some parents hastily venture out to buy books which they give to their child to read. Others bury their heads and pretend that it's just not happening. Boys and girls alike are neglected in this respect.

Just as dramatic are the psychosocial changes in adolescence. Working in the mental health clinics in the Polyclinic system during the period 1987 to 1996 was quite an eye opener when it came to the varied presentation of adolescents in crisis. The presentations ranged from internalizing disorders such as depression, anxiety and phobias and externalizing problems such as delinquency, antisocial aggression and truancy. These behaviors are often referred to as "acting out" behaviors.

Let me now give you a few of the stressors that would cause these young people to present to our clinics. There are day to day hassles such as being teased about their appearance; school exams; not being good at sports; what they have in their lunch boxes; arguments with peers, siblings and parents. There are other life stressors more major in nature such as migration, changing school, illness or death of a close relative or friend constant family conflict, parental divorce, poverty and the list goes on.

What does happen when you are under continuous stress? You may not feel free to talk about the underlying problems because of

DISTINGUISHED LECTURE . . . cont'd

having to involve others e.g. parents. Acting-out behaviors may evolve into major conduct disorders. For others the manifestation may be in the form of substance misuse and abuse. Stealing, truancy, heightened sexual activity, may all be manifestations of stress and distress especially in adolescence. Recently it was drawn to the attention of persons at a Child Care Board seminar and via the media to the general public that we are now seeing a number of children presenting with self mutilation. This is also a manifestation of distress and must be recognized as such.

During this period, adolescents are going through physiological changes which may impact on their self esteem and coping skills. In addition there is psychological turmoil as a result of the physical as well as social and environmental problems leading to resentment against parents and other authority figures. This is the time that individuals should be consolidating information about healthy lifestyles. If you are so immersed in the difficult situations around you, how can you really concentrate on the many messages that are being sent to you about healthy lifestyles. We must address these psychological problems that are occurring in these young people's lives. Very often at this time, because they are searching for answers, those who are not coping, experience despondency, despair and disillusionment and they start to reject any beliefs, they would have had.

These individuals are clearly now fragmented. Their spirits are broken, their spirituality is abandoned and physically their hormones present a challenge as well as their physical growth and development. At this point let me state here that unless you can balance these aspects of self I would not consider you a totally healthy person. This really brings me to the conclusion that there is no good health without good mental health, to corrupt a health promotion slogan that was used some years ago. In life the course for the troubled adolescent and his / her parents / caregivers may seem long and arduous.

By the time young adulthood has been reached, there are new factors coming into play. Those children who had to be cared for are now expected to care for themselves. They may also be in the position of having to look after another individual as they might have become parents.

By this time you should be in a position to identify your own personal health needs. You are now responsible for establishing your own health list. What should your checklist look like at this time?

Here is a possible example:

- 1) Eat a healthy diet
- 2) Manage your weight
- 3) Manage your specific health needs
- 4) Get any necessary screenings and benefits.

Later in adulthood new dimensions creep in:

- 1) you must continue to maintain a healthy diet
- 2) Cope with the many inevitable stressors including from time to time grief.
- 3) Adjust to menopause and andropause

During this stage of your life unfortunately in this society we must acknowledge the presence of a huge health dilemma - chronic disease. Chronic non-communicable diseases are all life style diseases and can be brought on, worsened and managed by you with the assistance of your physician. There are things you must address:

- 1) Quit smoking
- 2) Drink wisely
- 3) Eat wisely
- 4) Get adequate exercise
- 5) Get adequate rest
- 6) Take any prescribed medications correctly
- 7) Get regular screenings and checkups

Along with your personal check list above you also may find it necessary as a family person to keep a checklist for your spouse / partner and children. Of course while helping them and monitoring them you should also be educating them. Let me stress yet again that prevention is worth a pound of cure. Make preventative visits to your doctor. Your doctor should screen you based on many factors a) Age b) gender c) overall health status d) personal health history e) current symptoms f) chronic health concerns. The sooner your physician can identify and treat a medical condition the better the outcome.

At every stage of your life there are differences. You must perform different activities in those different stages. At every stage of your life you need very special and specific health management. At this time we must remember the elderly. Thankfully there are some well elderly and we must take our hats off to them for managing their health well.

However we have many elderly with many illnesses that have to be managed. Unfortunately there is a major problem when elderly folk with specific health care needs cannot care for themselves, eg persons with dementia. The previous caregivers have to be cared for. Just a gentle reminder that many of us may at some point reach that stage. Many chronic non communicable diseases can lead to dementia. There is also Alzheimer's disease, although not only a condition of the elderly, progresses exponentially in the aging population.

Barbados is an ageing society. We have the centenarians multiplying at a rapid rate. We have the chronic non-communicable diseases multiplying at a great rate and we have out done ourselves by being known as the amputation capital of the world. The time for learning about Alzheimer's and other dementias is now. The time for living a healthy lifestyle to influence the type of ageing we will have is now. We must be prepared to cater to our ageing elderly and unwell elderly.

Be proactive: keep your bodies, minds and souls in good condition. One depends heavily on the other. Treating your health only after visiting your doctor and having been diagnosed with an ailment is not good. Being proactive will not only keep you well it will also keep you happy and help you to save money.

Let me now send you a final strong message. I will address it in question form.

The question is "What is the most powerful step you can take to dramatically improve your health?

The Answer Learn how to effectively manage emotional stress.

Question: *Why is emotional stress one of the most significant causes of chronic health challenges?*

The Answer: *The body cannot defend itself adequately against the assault and damage done to it by persistent emotional stress. Your body pays a very heavy price for every moment that you feel tense anxious frustrated and angry.*

DISTINGUISHED LECTURE... cont'd

Our world today is not only hectic, it is chaotic. It is in the throes of a recession which brings with it financial woes. It is out of control with natural disasters occurring at a phenomenal rate. In this world today many of us are experiencing problems of continuous over stimulation of our autonomic nervous system, on a continuous low grade level. We must deal with this stress.

I will now leave you with a message on how to go about getting rid of stress:

Know yourself
Identify your stress factors
Fix your money issues
Take breaks at work
Work hard but don't over exhaust yourself
Get adequate rest
Exercise
Have a hobby – make time for relaxation and recreation
Spend time with your family
Have quality time with your partner.
Never put off for tomorrow what you can do today.

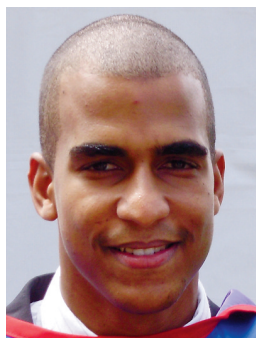
Thanks again to National Insurance for affording me this opportunity to discourse with you. I hope that some of what I have shared will redound to the better management of the health of those present tonight and that it will further impact the National Insurance Scheme to help in a reduction of some of those frequent payouts as a result of ill health and chronic and permanent disability.

The eminent specialist was on his way to a very big medical conference in Europe, where he was giving several talks and having several meetings, and brought his secretary along to organise his appointments. Their plane arrived late and they reached the hotel to find that they were assigned to just one room. Having to get up early next day, they took it. It was very cold that night, as they slipped under the covers. The secretary said to the doctor: "*Doctor Dogood, would you mind slipping out of bed to close the window?*" After a moment's hesitation, the doctor replied: "*Would you like to pretend that you're my wife tonight?*" "*Oh yes!*" cried the secretary. "*I was hoping you would ask me!*" "*Good,*" said the doctor, turning over, "*Then close the window yourself!*"

MEDICAL HISTORY

A Concise History of Medicine in Trinidad and Tobago: 1950 to 2000: Part 2

Dr. Shabier St. John,



(This paper was a joint first prize winning essay in the student Medical Humanities clerkship, Faculty of Medical Sciences, UWI Cave Hill Campus, in 2009, in the graduating class of 2010. Part I was published in the BAMP Bulletin for April / May. Prize winning essays which reach a sufficiently high standard will continue to be published in each issue of the Bulletin.)

The flourishing scientific community in Trinidad at this time (1950s) centered on the TRVL, the New York Zoological Society's field station at Simla, and the Imperial College of Agriculture provided an exciting pool of top-notch scholars. Much useful research was accomplished in archaeology, ornithology and parasitology. The lab also hosted many distinguished visiting scientists, conducting cutting-edge research in their fields, as well as photographers from National Geographic, while creating jobs for local people.

The most famous contribution of the TVRL was its work on yellow fever. Discovery in 1953 of a sick Red Howler monkey, found to be suffering from yellow fever, provided evidence that yellow fever was still endemic in Trinidad's forests, although there had been no a case reliably reported since a 1914 outbreak. It was discovered that a form of the disease "jungle yellow fever" was carried by the

Red Howler monkey *Alouatta seniculus insulanus*, which provided a continuous reservoir for the disease, spread by the *Haemagogus spegazzini* mosquito which inhabits rainforest regions, both at ground level and in the treetops.

After Government felling of large stands of native forest, yellow fever was isolated from a patient from Cumaca in the northern range in 1954. Human spread soon began by transmission via the common *Aedes aegypti* mosquitoes. Blood specimens were taken from over 4,500 humans in 1953 - 54, and checked for the presence of a wide variety of known viruses. Over 15% showed antibodies to yellow fever and more human cases followed.

Warnings were made that an epidemic was imminent and Downs and Hill began a program of inoculating health workers and stockpiling vaccine. Trinidad's health authorities followed up with large-scale vaccination and intensive anti-aegypti measures, including public education, regular inspection for breeding sites, and spraying of domestic residences with DDT. In spite of these measures, and the fact that an estimated 80% of Port of Spain's population were immune to yellow fever and dengue, several more cases were reported, but probably due to the health measures taken it did not develop into an epidemic.

An attempt was made to totally quarantine the island just before Christmas, 1954, but the disease quickly spread to the nearby Venezuela mainland and on to southern Mexico, probably killing several thousand people.

Large-scale surveys were made of viruses and antigens in the local population, and of domestic and wild animals. At the time the lab

was founded, there were a number of common but unidentified fever-causing viruses in Trinidad, usually referred to by descriptive names such as "Trinidad 3-day fever" and Trinidad 5-day fever". Some of these were soon isolated and identified. A bush camp was set up at Bush Bush Wildlife Sanctuary in the large Nariva Swamp in southeastern Trinidad and a large tree station built in the Vega de Oropouche rainforest near Sangre Grande, with platforms at 60, 90 and 120 feet (18, 27 and 36.6 metres) to facilitate collecting mosquitoes at various levels in the rainforest.

Dr. H. Metivier, a Veterinary Surgeon, who established in 1931 the connection between the bites of bats and paralytic rabies, and Dr. J. L. Pawan, Government Bacteriologist, found Negri bodies in the brain of a bat with unusual habits in September 1931, and finally demonstrated that rabies could be transmitted to humans by the infected saliva of vampire bats. In 1934, the Government began a program of vampire bat control, shooting, netting and trapping, while encouraging the screening of livestock buildings and free vaccination programs for exposed livestock. After the opening of the Virus laboratory in 1953 basic research on bats and rabies transmission progressed rapidly.

In the 1960s the disease patterns began to change from predominantly infectious diseases to chronic diseases such as diabetes mellitus and coronary heart disease. At this time however, infectious diseases were still the main scourge of society and continued to dominate the health care system. There were several epidemics of acute nephritis in this period and it was under this pressure that the Streptococcus Research Laboratory was founded in San Fernando. The lab worked in collaboration with North Western University and discovered 4 new strains of Nephritis-causing-streptococcus.

Dr. Poon-King was instrumental in founding the lab and wrote many research papers on a range of medical topics, including Scorpion Sting Myocarditis, Coronary Heart Disease, Hypertriglyceridaemia Diabetes, Post streptococcal acute nephritis, Acute rheumatic fever, Streptococcal Infections, Immunology of streptococcal disease, Yellow Fever and Paraquat Poisoning.

In 1964, a full assessment was done on the healthcare system by Dr. Gerald who drew up a national healthcare plan. It was out of this assessment that the medical firm system, used in the United Kingdom, was adopted by hospitals, while added focus was placed on developing subspecialties. Several doctors sent to study a variety of specialties returned to bolster the nation's flagging health care. By 1970, most subspecialties were covered.

After another assessment in 1967 by PAHO / WHO, a number of health centres were built. These were modeled after those built in Jamaica and Barbados under the guidance of Sir Kenneth Standard and public health pioneer Sir Maurice Byer. The centres were to provide immunization services, manage chronic diseases and be staffed with at least one general practitioner. In spite of these improvements, primary healthcare was still severely deficient. People continued to wait and seek emergency medical help as the concept of prevention was still in its fledgling stages.

In the 1970s, chronic diseases took off, with diabetes and heart disease becoming more prominent. It was under this pressure and the continuing infectious disease locally and in the wider Caribbean, that the Caribbean Epidemiology Centre (CAREC) was established in 1975. Caribbean Governments, through the Caribbean Health

Minister's Conference in Dominica in 1973, established CAREC under PAHO. Trinidad assumed the role of host country because of the existing strength of the Virus Laboratory and the first director was Dr. Patrick Hamilton, of the UK.

In 1975, CAREC's main priority was communicable disease surveillance. After an assessment of national surveillance systems, 16 countries agreed to appointment of an epidemiologist. Epidemiological principles and surveillance techniques were devised with a list of diseases for notification. Training programs in surveillance for health professionals were provided in four countries, with workshops held at CAREC drawing participants from 26 countries. The monthly CAREC Surveillance Report (CSR) started in March 1975, giving updates on disease notifications from member countries. By December, CAREC circulated over 1500 copies in 17 countries.

The mid '70s also saw movement to address the lack of facilities and infrastructure for intermediate, longer, outpatient and intensive care. Between 1975 and 1976, Intensive Care Units and Outpatient Clinics took shape at the major hospitals.

The International Conference on Primary Healthcare at Alma-Ata, USSR in September, 1978 and its slogan "Healthcare for all" brought fresh focus to the cause of medical care in Trinidad and Tobago. Multi-sector planning was undertaken throughout the nation. The push for more health centres was expanded.

Significant research in a variety of diseases punctuated the mid to late 1970s, spearheaded by CAREC in collaboration with the Government and various international research organizations. CAREC has recently released a publication titled *The Caribbean Epidemiology Centre CAREC Highlights 1975-1999: Celebrate the Past, Imagine the Future*.

In 1976, the increasing incidence of chronic non communicable disease led to establishment of a research group in cardiovascular disease in Trinidad, funded by the UK's Medical Research Council (UKMRC), in collaboration with CAREC and the Trinidad and Tobago Government, under Dr. George Miller – the St. James Coronary Risk Factor Study. The study examined obesity, hypertension and diabetes, and followed subjects over 10 years for outcomes. 300 men and women of mixed race showed a positive association of Low Density Lipoprotein (LDL) with Coronary Heart Disease (CHD), while the highest incidence of heart disease occurred in males of East Indian descent. Women showed higher levels of High Density (HDL) Lipoproteins and less CHD. The study went on to examine prevalence rates for diabetes, hypertension and outcomes such as stroke.

Work was also done in 1976 on the epidemiology of leptospirosis under Dr. C.O.R. Everard, also funded by the MRC. This work defined prevalence and high-risk groups in humans, rodents, domestic animals, mongoose and bats in disease spread. *Leptospira* serogroups were identified. Screening and serogroup diagnostic techniques were established, and this work was continued at the *Leptospira* Laboratory in Barbados.

A filariasis study was conducted on the North Coast (1977 to 1981), again in partnership with the Trinidad and Tobago Government and MRC funding. Infections with *W. bancrofti* and *M. ozzardi* were found and chemotherapy programmes were successfully implemented.

Also in 1977, with funding from the Canadian IDRC, a two year

study commenced to identify causative agents of gastroenteritis in infants under three in Guyana, St. Vincent and Trinidad and Tobago. Rotavirus was found to be the major culprit in St. Vincent and Trinidad, while there was a higher percentage of Shigella in Guyana. In the '80s and '90s research continued on diabetes, CHD and other chronic illnesses but a new disease would join the party - HIV/AIDS - and it provided fresh challenges.

In 1994 a move was made to regionalize health care systems. The Regional Health Authority was created by an Act of Parliament to decentralize management and provision of health care. Presently there are 5 RHAs – North West, North Central, South-West, Eastern and Tobago. Each region is governed by a non-executive Chairman and Board of Directors, to give the regions some independence and control over health needs specific to its population. Despite this regionalization, there is some level of Government overseeing and the infrastructure is still “a work in progress”.

To conclude, the fifty years from 1950 to 2000 have seen great developments in Trinidad and Tobago. It is a testament to these achievements that this paper can only be seen as a “highlights package”, giving a general idea of the time frame and focussing on key contributors in the medical field. It must be stressed that there were countless other individuals and organizations making medicine in Trinidad and Tobago what it is today. As author I chose to write about what most interested and intrigued me about the medical discipline of this proud nation. I hope those reading this paper have as much fun as I did writing it.

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A nervous new father rushed into the hospital maternity ward where his wife had given birth. The doctor greeted him.

"Mr. Jones, I think I should take you down to the nursery. I have something to show you."

"Doc, I'm so nervous," blurted out the man, when he got there, covering his eyes, I don't think I can look!"

"Well, I really think you ought to," said the doctor.

"Tell me what you see, doctor, is it a boy?"

The doctor hesitated: "Well, the one in the middle is."

MEDICAL HISTORY... cont'd

The Abortion Saga: A Glimpse throughout the Ages

Dr. Shanae Gill, MBBS



(Dr. Gill's Essay was joint winner of the History of Medicine Essay Prize for her class, and we continue the practice of publishing the outstanding, winning essays).

Abortion is defined as the premature expulsion of the products of conception (foetus or embryo, foetal membranes, and placenta) from the uterus¹. The word abortion is derived from the Latin word *abortio* which means to deliver prematurely or miscarry.

There are different types of abortions, spontaneous and induced, with the latter being the source of controversy for hundreds of years. A spontaneous abortion is also known as a miscarriage and occurs without any intervention - medical or otherwise - in perhaps 25% of all pregnancies and 15 % of recognised pregnancies. An induced abortion uses drugs or instruments to halt the normal course of pregnancy. The abortion debate has raged from ancient times and continues today in this modern era. Although the methods of inducing abortion have been modified over the years the moral issue of its acceptance into society shows no resolution in the near future.

The first recorded method of inducing abortion was found in the Egyptian Ebers Papyrus which was produced in 1550 BC. This papyrus gives instruction on “loosening” pregnancy using topical or oral remedies containing acacia (sub-family of Mimosoideae), beans, beetle, dates and pine. Thus, these ingredients would have been the first recorded abortifacients - any substance that induces abortion. It is now known that these plants -acacia, date seeds and pine - do contain natural oestrogens and have anti-fertility properties which give these early methods merit in their use as abortifacients. In 500 BC the Chinese records also show abortions being performed on the royal concubines, using the highly poisonous element, mercury, as the abortifacient. It is now known that mercury in high doses leads to mercury poisoning which is characterized by peripheral neuropathy, skin discolouration, oedema and desquamation.

The Bible also speaks about abortion in passages such as Numbers 5:11-31 where it describes a scenario in which a woman may become pregnant for a man other than her husband that she would be given “bitter water that causeth the curse” to drink. If found guilty of adultery the “curse” would be fulfilled and the “belly shall swell and the thigh shall rot”- which is interpreted as abortion; in the faithful women they “shall conceive seed.” This passage is used by many pro-choice groups as an example of endorsement of abortion in the Bible. Other verses throughout the Bible are used to suggest that life begins at the point of conception and hence abortion is an act of murder. In Isaiah 44:2 reference is made to the formation of Isaiah “Thus saith the LORD that made thee, and formed thee from the womb....” Although the writings in the Bible remain very open to interpretation by various sects, the writings in the Epistles of Barnabas

in the Codex Sinaiticus - a hand-written ancient Greek Bible - state very clearly "Thou shalt not slay the child by procuring abortion; nor, again, shalt thou destroy it after it is born"²

In the late 5th century BC the Hippocratic Oath was written by either Hippocrates or one of his students. Hippocrates is considered the "Father of western medicine" and the oath was made to be taken by doctors to uphold the highest ethical standards in medicine and patient care. The line at the centre of debate today is that which states "*I will not give a woman a pessary to cause an abortion.*"³" since in many countries abortion is now legal. The pessaries described refer to wool tampons inserted into the vagina which were soaked in a variety of substances-opium poppies, bitter almond oil, rose oil etc. to induce abortion. As an alternative to using pessaries however, physicians of that era prescribed other mechanical abortive techniques such as jumping up and down, vigorous exercise, diving and abdominal massage.

Throughout history a myriad of abortifacients had been discovered and each civilization had their own formula of herbs. These herbs worked in different ways, some stimulated uterine contractions and others were emmenagogues. The most popular abortifacients used were: pennyroyal, rue, juniper, savin, sage, cyperus, hellebore, worm fern, celery etc. They were marketed to "relieve blockages" and to "restore regularity".

The law regarding abortion was also constantly being amended in different societies as the debate to when life began raged on. Plato and Aristotle both argued in favour of abortion under certain circumstances while Hippocrates was strongly against it. Aristotle believed that abortion could take place before the conceptus had human life "*The line between lawful and unlawful abortion will be marked by the fact of having sensation and being alive*"⁴. Years later, in 1593, the Catholic church declared that abortion and contraception were "crimes of nature and sins against marriage", a policy which it still holds today. The English and American common law, in the 18th century, allowed for abortion if it took place before "quickening" which is the point where the first movements of the foetus are felt and it occurs at 18-21 weeks in the primiparous and 16-18 weeks in the multiparous mother.

The laws became more stringent in the 19th century with the movement of the newly formed specialty of obstetrics. In this era where contraception was not yet developed abortion was one of the main methods of family planning. These procedures were undertaken by the women themselves or midwives using herbal remedies. At this time there was a high demand for abortions, especially among the poor, and the newly trained obstetricians of that era decided to encroach on this profitable market. A campaign was started against abortions carried out by midwives referring to their methods as unsafe and a shift towards surgical methods of abortion took place.

Far away from the politics of Europe and America, abortions were being undertaken by the enslaved women in the Caribbean long before the 18th century. The first Spanish account of abortion in the New World was in 1502 among the Taino women. This practice was undertaken as a last resort in the face of unimaginable cruelty and torture. Bartolomé de las Casas' account of the Spanish cruelty included vicious attacks by dogs, disembowelment and "hacking off of women's breasts". He noted that this drove Taino women to drown their children and take "*herbs to abort, so that [the fruit]*

was expelled Stillborn"⁶.

Abortion was also used among the free Amerindian people along the Orinoco River as a method of family planning. It was reported by Alexander von Humboldt that these women were able to delay the start of a family to prolong the years of "freshness and beauty." At this time very little was known about the plants used to procure abortion among these native Amerindian people.

With the introduction of African slaves into the West Indies, this practice was undertaken as a form of resistance by the slaves who were "*bred (slaves) like cattle*"⁷. In a society where there was a lack of control in all aspects of life, this afforded a modicum of freedom. The issue of the seemingly suppressed fertility among slave women was a grave concern around 1770 when there were threats to end the slave trade⁸. The slave owners, doctors and legislators were concerned because they still needed to import slaves to maintain populations due to the sub-fertility imparted partially due to abortion. Edward Bancroft, a plantation medic from British Guiana wrote "*this unnatural practice is very frequent, and of highest detriment to the planters...*"⁹. This tradition thus had harsh financial implications for slave owners who would be unable to "grow their own slaves" if these successful abortive remedies continued. Slave women were also used to fuel the sexual economy of the region and it was reported that abortion was sometimes used to prevent the birth of offspring resulting from such unions with European men.

Some remedies for abortion had been known long before the slaves reached West Indian shores and this knowledge was passed from generation to generation. There were also suggestions that the abortifacients used by the slaves were smuggled across the Atlantic in their hair, clothing etc. The practice of abortion was carried out to "*abort offspring who would have otherwise been born into bondage*"¹⁰. In an excerpt from *Metamorphosis of the Insects of Suriname*, written by Maria Sibylla Merian¹¹ she explores the use of abortion in the liberation of the unborn

The Indians and Africans, who are not treated well by their Dutch masters, use the seed [of this plant] to abort children, so that their children will not become slaves like they are... They told me this themselves.¹²

The plant to which the author was referring was discussed extensively in her book. She referred to the plant as the *flos pavonis* which translates to peacock flower. The seeds of this flower were used by the native Amerindian and African women to induce abortion.

This flower was just one of the many plants used as abortifacients. The use of the peacock flower was also described in other Caribbean territories such as Jamaica, Barbados and Saint Domingue. In Jamaica this plant's abortifacient properties were first described by Hans Sloane: "*It provokes the Menstrua extremely, causes Abortion, etc. and does whatever Savin and powerful Emmenagogues will do.*"¹³ This drug was used effectively and was found to be surprisingly safe; it worked by inducing uterine contractions. In later research the abortifacient properties were attributed to the presence of garlic acids, tannins and hydrocyanic acids.¹⁴ This peacock flower is known as the *Caesalpinia pulcherrima*, which is surprisingly revealed to be The Pride of Barbados - the national flower of Barbados! [Ed: Also surprisingly, it is thought to have been introduced to Barbados from the Cape Verde Islands by Richard Ligon, in 1647; see A - Z of Barbados Heritage, by

Carrington *et al.*] Other exotic abortifacients used in this era among slaves in the Caribbean included gully root (*Petiveira alliaceae*), Ram Goat Bush (polypodium phyllitidis), penguins plant (*Bromelia plumieri*), wild cassava, cotton plant seed (*Gossypium herbaceum*) and green pineapple among others¹⁵.

Primitive surgical methods of abortion were also performed during this era of slavery. The plantation doctor was called in only if there was an immediate threat to the life of the mother after the third month of pregnancy as an alternative to herbal remedies. Sloane stated that "the hand" was the preferred method after this time: "The doctor pressed down on the abdomen with one hand while pushing through the cervix with a finger of the other; pulling out the embryo from the womb."¹⁶

In the early 20th century some methods used by women of the Caribbean still mimicked those of their slave ancestors. In territories such as Belize, Jamaica, Costa Rica, Martinique, Guadelope, Dominica and the Dominican Republic the traditional abortifacients still remain in use today, although in the predominantly Catholic territories such as Dominica they are done so in utmost secrecy.

In Barbados, in particular, "back alley" abortions were rampant especially prior to the 1980's. These illegal procedures were mostly carried out by untrained persons in unhygienic surroundings. The methods used included the insertion of wire hangers into the vagina in an attempt to rupture the amniotic sac. Also, disinfectants such as Dettol and Savlon were injected into the uterus¹⁷. These primitive methods resulted in an obscene number of deaths and injuries due to hemorrhage, sepsis and renal failure. These botched abortions flooded the Accident & Emergency Department of Barbados's General Hospital and later Queen Elizabeth Hospital, especially during the weekends. Significant numbers of women never reached the hospital and succumbed to the complications. This was due to overwhelming embarrassment over what had transpired and the fear of the repercussions of their actions. These unnecessary deaths prompted the Barbadian government to implement the Medical Termination of Pregnancy Act (Act No. 4 of 11 February 1983) (*Appendix A*).

The Act was the first of its kind in the English speaking Caribbean as it sought to liberalize abortion regulations. Prior to this, the laws governing abortion were based on the *Offences against the Person Act* of 1868 which allowed termination only to save a woman's life or to protect her physical or mental health. Additional grounds upon which abortion could be obtained under the 1983 Act include: pregnancy as a result of rape or incest, foetal impairment, and social & economic reasons. This resulted in a 70% decline in septic abortions and a 53% decline in abortion complications seen at the hospital between 1982 and 1992; this was according to Dr Frederick Nunes and Dr Yvette Delph, in their study on *Contraceptive Knowledge And Practice Among Women Seeking Legal Abortions in Barbados*²⁰.

At present in Barbados, the hushed back rooms of the past have been replaced by sterile doctor's offices and operating theatres. The abortion procedures now offered include surgical methods such as dilatation and evacuation. In this method the anaesthetized cervix is progressively dilated with the insertion of dilators. A sterile cannula is then inserted into the uterus and connected to a pump which creates a vacuum to suction the contents of the uterus (dilatation and suction

curettage). This procedure is conducted by trained professionals and the patients are required to remain in recovery area briefly to ensure there are no immediate complications. Also, as a mandatory component of the Act clients are required to undergo counseling prior to the procedure to discuss matters such as: alternatives to abortion, contraception and the procedure itself.

In some other Caribbean regions and other regions worldwide, abortion laws have not yet been liberalized and the practice of abortion continues to be taboo. This practice that may be as old as time itself, is - and always will be - carried out by women throughout the globe, from the richest countries to the poorest remote villages. It has always been a source of secrecy and shame even in places where the laws are liberalized. Today, thousands of abortions are carried out world wide by legitimate professionals, back-alley abortionists, herbalists and the women themselves; we will never be able to put a definite figure to the number carried out but we can continue to count the deaths that arise from botched procedures.

In conclusion, abortion has been practiced by women from pre-historic times until now. The development of modern abortifacients and surgical methods has made this practice one of the most widely used gynaecological procedures. The debate will continue to rage between pro-choice groups, pro-life organizations, religious factions, politicians, doctors, scientists etc., as each tries to justify their own view. The only fact that remains is that abortion will continue - legally or illegally - as long as human beings continue to indulge in the innate act of coitus.

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- ⁵ **Bartolomé de las Casas**, (1484 – 1566), was a 16th-century Spanish Dominican priest, writer and the first resident Bishop of Chiapas. As a settler in the New World he witnessed, and was driven to oppose, the torture and genocide of the Native Americans by the Spanish colonists.
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- ¹¹ Anna Maria Sibylla Merian (1647 – 1717) was a naturalist and scientific illustrator who studied plants and insects. Her detailed observations and documentation of the metamorphosis of the

butterfly make her a significant contributor to entomology.

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¹⁸ Dr. Frederick Nunes is a Jamaican social scientist at the University of the West Indies, Mona Campus.

¹⁹ Yvette Delph, MBBS (Hons.), DA was a Member of the Department of Anaesthesia, Queen Elizabeth Hospital, St. Michael, Barbados, West Indies. She also chaired the AIDS Task Force and other Committees of the Barbados Association of Medical Practitioners (BAMP).

²⁰ Fred Nunes, Yvette Delph. *Contraceptive knowledge and practice among women seeking abortions in Barbados*, (1996) (unpublished)

APPENDIX A

Barbados Medical Termination of Pregnancy Act (Act No. 4 of 1983), 11 February 1983. (Official Gazette, Supplement, 17 February 1983.)

Section 3. Notwithstanding sections 61 and 62 of the Offences against the Person Act, the treatment for the termination of pregnancy is lawful if administered in accordance with this Act.

Section 4. (1) The treatment for the termination of a pregnancy of not more than 12 weeks' duration may be administered by a medical practitioner if he is of the opinion, formed in good faith,

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman or grave injury to her physical or mental health; or

(b) that there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped.

(2) The written statement of a pregnant woman stating that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute the element of grave injury to mental health required by subsection (1)(a).

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health of the pregnant woman as is required by subsection (1)(a), the medical practitioner must take into account the pregnant woman's social and economic environment, whether actual or foreseeable.

Section 5. The treatment for the termination of a pregnancy of more than 12 weeks' duration and of not more than 20 weeks' duration may be administered by a medical practitioner, if two medical practitioners are of the opinion, formed in good faith, of the matters specified in paragraph (a) or (b) of section 4(1).

Section 6. the treatment for the termination of a pregnancy of more than 20 weeks' duration may be administered by a medical practitioner, if three medical practitioners are of the opinion, formed in good faith, that the treatment to terminate the pregnancy is immediately necessary to save the life of the pregnant woman or to prevent grave permanent injury to the physical and mental health of the woman or her unborn child.

Section 7. For the purposes of sections 4 to 6, the duration of a pregnancy must be determined

(a) by calculating from the first day of the last normal menstruation of the pregnant woman ending on the last day of the relevant week; and

(b) by clinical examination.

Section 8. (1) Subject to this section and to section 11, a medical practitioner may require the written consent of the pregnant woman before administering treatment for the termination of a pregnancy.

(2) The treatment for the termination of the pregnancy of a female under the age of 16 years or of a person of unsound mind of any age shall not be administered except with the written consent of her parent or guardian.

(3) "Person of unsound mind" has the meaning assigned to it by section 2 of the Mental Health Act.

Section 9. The treatment for the termination of a pregnancy of more than 12 weeks' duration shall be administered in a hospital approved by the Minister for this purpose.

Section 10. (1) Subject to subsection (4), no person is under any legal duty to participate in any treatment for the termination of a pregnancy to which he has a conscientious objection.

(2) In legal proceedings, the burden of proving the conscientious objection lies on the person making the allegation.

(3) The burden of proof referred to in subsection (2) may be discharged by the person testifying on oath or affirmation to the fact of his conscientious objection.

(4) Subsection (1) does not affect the duty of a person to participate in treatment for the termination of a pregnancy that is immediately necessary to save the life of the pregnant woman or to prevent grave permanent injury to her physical or mental health.

Section 11. The following sections do not apply where the treatment to terminate the pregnancy is immediately necessary to save the life of the pregnant woman or to prevent grave permanent injury to her physical or mental health, namely:

(a) sections 5 and 6 relating to the number of medical opinions required; and

(b) sections 8 and 9.

Section 12. The Minister may make regulations

(a) with respect to the counselling services to be provided;

(b) with respect to the requirement as to residence that a pregnant

woman must possess in order to qualify for treatment under this Act; (c) in respect of the records to be kept by medical practitioners or other persons of the pregnancies terminated and in respect of the submission of the records to the Chief Medical Officer, together with other prescribed information;

(d) prohibiting the disclosure, except to such persons and for such purposes as may be prescribed, of any information required to be contained in records kept by virtue of paragraph (c); and (e) in respect of the form of consents required by Section 8.

Section 13. The Chief Medical Officer or other person authorized by him in writing, may at all reasonable times enter any premises for the purpose of ascertaining whether there has been any contravention of this Act or the regulations.

Section 14. (1) Subject to section 10, a person who contravenes sections 8 and 9 is guilty of an offence and is liable on summary conviction to a fine of \$2,500 or imprisonment for 12 months.

(2) A person who unlawfully discloses information obtained by virtue of paragraph (d) of section 12 is guilty of an offence and liable on summary jurisdiction to a fine of \$2,500 or to imprisonment for 12 months.

Section 15. This Act comes into operation on a date to be fixed by proclamation.

Medical Termination of Pregnancy Regulations, 1983.
(Official Gazette, Supplement, No. 41, 19 May 1983.)

Section 1. These regulations may be cited as the Medical Termination of Pregnancy Regulations, 1983.

Section 2. A medical practitioner who carries out the treatment for the termination of a pregnancy shall

- (a) keep a record of the treatment in the form specified in the Schedule; and
- (b) forward the record to the Chief Medical Officer within 30 days of the treatment.

Section 3. Any information given to the Chief Medical Officer in pursuance of these regulations shall not be disclosed except

- (a) by the Chief Medical Officer in the performance of his functions under the Act and the regulations;
- (b) to a member of the police force for the purpose of instituting criminal proceedings under the Act;
- (c) for the purpose of carrying out scientific research; and
- (d) to a medical practitioner, or other person, with the consent in writing of the woman whose pregnancy was terminated.

Section 4. (1) A medical practitioner who carries out the treatment for the termination of a pregnancy must be familiar with counselling functions with particular reference to family life education and child-birth.

(2) Before carrying out the treatment for the termination of a pregnancy, a medical practitioner must

- (a) counsel the woman requesting the termination of her pregnancy; or
- (b) ensure that the woman has been counselled by a person authorized by the Minister.

(3) A person who counsels a woman requesting the termination of her pregnancy must

(a) advise her on courses of action that are available as alternatives to the termination of the pregnancy;

(b) inform her of the operative procedures and the possible immediate and long-term effects of the termination of her pregnancy;

(c) advise her of methods of contraception and the availability of family planning services;

(d) give such advice as to enable her to deal with the social and psychological consequences of the termination of her pregnancy; and

(e) in the case of a woman who decides to continue her pregnancy, advise her on the availability of adoption, fostering or other services.

Faculty of Medical Sciences, Cave Hill - Report

Professor Mike Branday, MBBS, MD, MSc

Along with the other campuses, the Faculty is currently preparing for the second formal visit from the Caribbean Accreditation Authority (CAAM-HP) which is scheduled for March 2012. Preparation commenced in February with a cross-campus institutional self-study. The study examines performance under seven categories set by the Authority and must meet more than 130 standards for continued accreditation.

The first cohort of students to enter the full 5-year programme has now commenced their fourth year and, along with their counterparts from Mona and St. Augustine, they are expected to graduate in May/June 2013. Meanwhile, work is finally starting on the restoration and conversion of the splendid old Nightingale Home (c. 1936) into the Faculty's new Clinical Teaching Complex, with Clinical Skills Lab, Medical Library, Dr. Cecil Cyrus Museum, offices and other facilities, which will upgrade the Phase 2 programme's facilities to match the state of the art facilities at Cave Hill.

The Faculty also welcomed another two full-time members of staff: Dr. Charles Taylor, internist and endocrinologist, who has returned from a distinguished postgraduate spell in the UK, to join the faculty as Senior Lecturer in Medicine and Endocrinology and the QEHS as Consultant Physician in the Department of Medicine; and Dr. Keerti Singh, who previously taught at the Mona Campus has also recently joined the Faculty as Lecturer in Anatomy, and will strengthen teaching in the Section of Basic Medical Sciences.

Sadly, the entire Faculty mourns the recent passing of Margarita Greaves, senior secretary in the office of Student Affairs. Maggie was loved by the students and will be sorely missed by all who worked with her.

Mrs. Brathwaite was in the QEHS recovering from an operation when the nurse on duty took a call from a lady asking how Mrs. Brathwaite was doing.
"Oh, quite well. We expect she'll be going home tomorrow."
"Very good - thank you very much."
"May I ask who's calling so I can tell Mrs. Brathwaite?" asked the nurse.
"This IS Mrs. Brathwaite."
The doctors don't tell me a damn thing!"

Anonymous
(maybe Mrs. Brathwaite, maybe the nurse!)

History Corner - Old General Hospital Staff



BACK ROW L–R: Dr. “Sincks” Ashby”; Nurse Fishlock; Dr. (later Sir) Arnott Cato; Dr. Will Kerr; Nurse Marion Fletcher (later married Capt. Bruce Austin); Dr. Rene Charles (brother of Dame Eugenia Charles)

FRONT ROW L – R: Dr. Herbert St. John, Eye Specialist/ENT Surgeon; Nurse (name unknown); Dr. Grey Massiah; Matron Veacock; Dr. Glyne Bancroft; Nurse (name unknown); Dr. Gerald Manning (father of Dr. Charlie Manning)

SEATED FRONT L: Dr. Hal Shepherd? or Dr. Lindsay Hutson? **FRONT R:** Dr. Harold Skeete

Ed: Dr. (Later Sir) Arnott Cato, Dr. Will Kerr, and Dr. Lionel Stuart and Dr. (Later Sir) Maurice Byer all graduated from Edinburgh in 1935 and returned home after their internships. Drs Cato, Kerr and Stuart returned on the same ship to Barbados, where Dr. Stuart invited Dr. Cato (a Vincentian scholar) and Dr. Kerr (a Grenadian scholar) to stay over and spend a holiday with him in Barbados. They loved it and remained, making a huge contribution to health care in Barbados. Sir Arnott was one of three general practitioner / general surgeons who supported Sir Jack Leacock and Mr. Frank Ward, the qualified surgeons at the old General Hospital, and briefly at the QEH after it opened in 1964. He became Chairman of the Medical Staff Committee, President of the Senate of Barbados, and was a famous turfite and bridge player. The Sir Arnott Cato Foundation is his legacy and supports medical initiatives in Barbados and St. Vincent. Dr. Will Kerr was a hugely popular family practitioner, practising at his home, Harmony Hall, previously the home of two other

distinguished doctors – Dr. Nathan Lewis, nearly 300 years ago, and Dr. Sir John Hutson. It is now known as Solidarity House, home of the BWU. Dr. Grey Massiah became Sir Grey Massiah, President of the old Legislative Council. Dr. Hal Shepherd was a surgeon (FRCS) who practiced at Barrow’s in St. Lucy. Dr. Lindsay Hutson was the Parochial Medical Officer for St. Philip under the old Vestry system. Dr. Harold Skeete was a general practitioner living and practising at The Grotto, Culloden Road. He delivered my wife, Dr. Maureen Skeete-Fraser!

The mark of a good doctor is usually illegible
(John Kelly)

The Silent Voice: biblio-hedonism

'Reading outside or your discipline...for pleasure as well as productivity, is one of the best things you can do to improve your work'—R. Toor (1)



Summer is swiftly elapsing and it is often time for fun. Usually time is limited and work schedules have their own abundance of stress. But do you revel in the simple pleasures of life? Do you make time for meaningful recreation? Reading is one activity which can be quite relaxing. This does not refer to mulling over tedious technical reports, research notes or conference proceedings. Rather, magazines, newspapers, science fiction, romance, thrillers, biographies and other genres.

Many studies have been conducted on reading proficiency and academic achievement in children and adolescents but there needs to be more comment on reading for pleasure by adults in the Caribbean. Much of the international literature refers to reading done by adults engaged in remedial or adult literacy encounters (2). But what about devoting time to reading for just enjoyment?

Humans innately use their senses but have to be taught to read. It is a by-product of our culture. Reading is the ultimate cerebral workout. At the heart of reading lies the recognition of symbols. Symbols have to be recognized as letters, then they are congregated to form words, words build sentences and sentences construct paragraphs. This serial decoding process causes neuro-circuits to get fired up as individuals actively journey through the world of text. The skill of reading requires use of multiple areas of the brain. Each part executes its own function. Its magnificent architecture is in fact a highly complex network of signals and reactions, a 'cerebral internet'.

Intrinsically, pleasure is not a sensation but a positive reaction to stimuli and it can be classified as fundamental or higher-order (3). Reading serves as a source of higher-order pleasure, like music, money or art.

It has been suggested that regular hedonic reading builds greater powers of concentration and it even affects our socio-economic, cultural and civic lives. In other words, research suggests that poor or passive readers are less likely to vote, volunteer time to charitable events or be qualified for advanced professional engagement. These issues contribute largely to social exclusion. Former Dean of the Faculty of Medical Sciences, Prof. Henry Fraser notes "...those who can't read are at an enormous social, mental, emotional, spiritual, cultural and economic disadvantage, and those who choose NOT to read are almost 'in the same boat'" (4).

E-Readers, such as the Kindle or the Nook have become very popular and have attracted a younger legion of readers. Audio books invite us to 'read with our ears' and ensure the accessibility of literature to those willing to embrace technology. 'Lit on the move' is an attractive feature of these devices. It should be noted that while

some readers endorse these wonderful innovations, others stick close to the traditional print media.

Many studies have been done on the merits of recreational reading using different methodologies, strengthening the argument in favour of reading as a leisure pursuit. Not only does recreational reading spur literacy development and allow individuals to absorb complex stimuli better but it has been shown to promote emotional stability (5). Furthermore it ignites imagination and the individual develops empathy.

Language has its own trajectory. The whole notion of new realities being created each time we read is well discussed. As the reader travels through another person's different time and space they build empathy. According to Gambrell (6) 'we are no longer limited by the confines of our lives, our perceptions, our thinking'. Voracious readers interweave textual material into their own lives (7). The 'silent voice' has spoken. While the text has intrinsic value its effects are felt beyond the initial reading experience. As the layers of the story unfold the text resonates with the reader; there's no disconnect.

The reader constructs the imaginary space of the passage. The issue of serendipitous knowledge through reading is important since its effects often increase passion for reading and a sense of empowerment. The reader's eyes are 'awakened' to new situations. Furthermore, this intrinsic value differs depending on the individual's values and their stage in life. How read-y are you?

Written by Jillian L. Husbands, MSc.(Econ.)

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Should I really join Facebook?

(Sent by an over 70 year old! I know some of you are not 70 yet, but thought you would enjoy the message below anyway.)

When I bought my Blackberry, I thought about the 30-year business I ran with 1800 employees, all without a cell phone that plays music, takes videos, pictures and communicates with Facebook and Twitter. I signed up under duress for Twitter and Facebook, so my seven kids, their spouses, 13 grand kids and 2 great grand kids could communicate with me in the modern way. I figured I could handle something as simple as Twitter with only 140 characters of space.

That was before one of my grand kids hooked me up for Tweeter, Tweetree, Twirl, Twitterfon, Tweetie and Twitterific Tweetdeck, Twitpix and something that sends every message to my cell phone and every other program within the texting world..

My phone was beeping every three minutes with the details of everything except the bowel movements of the entire next generation. I am not ready to live like this. I now keep my cell phone in the garage in my golf bag.

The kids bought me a GPS for my last birthday, because they say I get lost every now and then going over to the grocery store or library. I keep that in a box under my tool bench with the Blue tooth [it's red] phone I am supposed to use when I drive. I wore it once and was standing in line at Barnes and Noble talking to my wife and everyone in the nearest 50 yards was glaring at me. I had to take my hearing aid out to use it, and I got a little loud.

I mean, the GPS looked pretty smart on my dash board, but the lady inside that gadget was the most annoying, rudest person I had run into in a long time. Every 10 minutes, she would sarcastically say, "Re-calc-u-lating." You would think that she could be nicer.

It was like she could barely tolerate me. She would let go with a deep sigh and then tell me to make a U-turn at the next light. Then if I made a right turn instead. Well, it was not a good relationship.

When I get really lost now, I call my wife and tell her the name of the cross streets and while she is starting to develop the same tone as Gypsy, the GPS lady, at least she loves me.

To be perfectly frank, I am still trying to learn how to use the cordless phones in our house. We have had them for 4 years, but I still haven't figured out how I can lose three phones all at once and have to run around digging under chair cushions and checking bathrooms and the dirty laundry baskets when the phone rings ...

The world is just getting too complex for me. They even mess me up every time I go to the grocery store. You would think they could settle on something themselves, but this sudden "Paper or Plastic?" every time I check out just knocks me for a loop. I bought some of those cloth reusable bags to avoid looking confused, but I never remember to take them in with me.

Now I toss it back to them. When they ask me, "Paper or Plastic?" I just say "Doesn't matter to me. I'm bi-sacksual." Then it's their turn to stare at me with a blank look. I was recently asked if I tweet. I answered, No, but I do toot a lot.

P.S. I know some of you are not over 70. I sent it to you to allow you to forward it to those who are. We senior citizens don't need any more gadgets. The TV remote and the garage door remote are about all we can handle.

A Bad Case Of Medical Ethics

Artist: How am I selling?

Gallery owner: Well, there's good news and bad news. A nice man came in this morning and asked if you were an artist whose work would become more valuable after your death. When I told him I thought you definitely were, he bought everything in the show.

Artist: Wow! That's terrific. Then what's the bad news?

Gallery owner: He was your doctor.

(Adapted from Plato and a platypus walk into a bar, by Thomas Cathcart and Daniel Klein)

A Great Golf Game

A doctor who is passionate about golf asks a fortune teller at a charity fair what Heaven is like. The fortune teller gazes into her crystal ball and says: "Hmm, I see some good news and some bad news. The good news is that there are many golf courses in Heaven, and they are all incredibly beautiful."

"Wow! That's terrific! Then what's the bad news?"

"You have an 8:30 tee time tomorrow morning at Sandy Lane in Paradise."

The desire to take medicine is perhaps the greatest feature which distinguishes man from animals."

Sir William Osler

Certifying Fitness to Drive in Barbados – Are We Doing Enough?



Dear Sir

In Barbados, only drivers over 65 years of age are obligated to obtain a certificate of fitness to drive annually. Stopping a patient from driving is a major life change and should never be taken lightly. Unfortunately, there are many cases when the decision is not clear-cut and, in the absence of guidelines from the Barbados Licensing Authority, the doctor is forced to rely on their clinical judgment alone. In such

instances, if one refuses to issue the certificate, some patients will continue to search for a physician who is willing and too often they will find one. Such an inconsistency is potentially damaging to the doctor-patient relationship. How much easier it would be if we could apply a standardized and more reproducible assessment that would assure both doctor and patient that the correct decision has been made!

What is more concerning though is our impotence as it relates to protecting the public from those whom we deem unfit to drive but are not required to seek certification. I recently saw a thirty four year old epileptic who continues work as an ice cream truck driver despite having his last generalized seizure less than nine months prior and admits to recent non-adherence to his medication. Clearly this gentleman should not be driving a large commercial vehicle around children all day! On expressing this concern to the patient he agreed with me but said that he could not afford to look for a new job. I strongly considered breaking confidentiality and reporting this gentleman to the Licensing Authority. To my dismay, even after calling two senior officials there to ask for advice, none was forthcoming and I am still waiting for them to “get back to me”.

As it turns out, there is no legal obligation in our jurisdiction for such individuals or their doctors to report a condition that may significantly impair the ability to drive (and there are many such conditions). In fact, a doctor making such a report without the patient’s permission is exposed to a significant risk of litigation. Meanwhile, in many countries this gentleman would have never been allowed to drive a commercial vehicle again and we would both have been prosecuted for not disclosing his epilepsy to the relevant authorities.

Perhaps most bizarre is our country’s lack of motivation to adopt a zero-tolerance approach to driving under the influence of alcohol. It is well documented that strategies such as blood alcohol concentration laws, minimum legal drinking age laws, and sobriety check points lead to significant reductions in morbidity and mortality. With drinking being touted as our national pastime, we cannot afford to be so laid-back!

If there is enough support within the membership of BAMP, and Dr. Hoyos’s article “Certifying the elderly to drive” in the January / February issue of the Bulletin suggests that there is, I propose that we release a public statement expressing these concerns and calling for the appropriate legislation. Barbados does not need to re-invent the

wheel – there are many well-established guidelines and laws around the world that we can borrow from. Given that it took several decades of lobbying before the introduction of seatbelt laws only underlines the importance of our role in pressuring government for such changes!

Dr. Joseph Herbert

Dr. Harry Bayley

The Editor, BMAP Bulletin

The biography of my father, Dr. Harry Bayley, in the recent issue of the Bulletin, has jogged my memory for many amazing stories about my amazing father. For instance, the breadfruit coma story.

The breadfruit story is true and here is the complete story, because I was there . . .

We were having lunch one Sunday at the Clinic (the famous Diagnostic Clinic, precursor of the Bayview Hospital of today). This was unusual because we were usually at Andromeda on Sundays. In any event, in the Clinic was a Norwegian sailor who had gotten sick and had to be hospitalized. His boat continued, but he had to stay.

Daddy used to eat very fast because he always had to rush back to the patients and so he got up from the table and on his way back up to the Clinic Lab (Remember that the Clinic dining room & kitchen were on the first floor) he ran into the Norwegian sitting under the breadfruit tree reading and getting some sun. (There was a big breadfruit tree planted outside in the middle of a type of square.)

Anyway, Daddy – who could speak or at least communicate in about 7 languages, stopped to talk to the Norwegian patient and while he was talking, a breadfruit fell from the tree and hit him on the side of his neck and down he went – completely passed out!

In the meantime, the Norwegian, who could speak no English, ran for help – he found us and we all rushed up to see what was going on. There was Daddy passed out cold, and the Norwegian was trying to indicate that the breadfruit had “done it”. Everyone thought he had had a heart attack, but not so.

Daddy soon recovered and did not know what the hell had hit him until the Norwegian told him the story.

The reason that Daddy could speak so many languages was because he was so allergic to the pollen in England when he was studying Medicine. So he would take off in the spring and travel North, and as Spring would break out in one Country he would leave there and keep going further North – when Spring pollen was gone from England, he would return. Daddy continued studying languages and taught himself Spanish – he was fluent – so that he could speak to the many Venezuelan patients, our first medical tourists. When he died he was studying Russian, as he swore that they would take us over.

LETTERS TO THE EDITOR... cont'd

Hydroponics was another Harry Bayley passion and he got all caught up in that for a while – this is where he discovered that the water in Barbados needed Molybdenum and a few other trace elements to grow watermelon sized tomatoes.

And on and on it goes – one brilliant idea after another!

I tell people here in America that if I really wanted to see my parents – I would have to go to the Clinic Lab in the evenings – that was Daddy's play pen and he loved it. Always some research project going on. At Andromeda, now Andromeda Botanical Gardens, Iris's gift to Barbados through the National Trust, it was downstairs where he kept his lathe. I remember the research on the whistling frogs and the bats and the bush teas and so many, many other things.

May his memory live long among the medical profession of Barbados.

Sincerely
Patti Mull.

[Ed: Patti Mull is the third daughter of Dr. Harry Bayley, who is commemorated in the Dr. Harry Bayley and Dr. Anne Bayley Memorial Prize, for the best student in the UWI Medical Final Exams, Clinical Exam in Medicine. Patti is herself, like her mother Iris Bannochie, an eminent horticulturist, and Chairman, Foundation Board, and Director, Operating Board of Mariners Hospital, Florida Keys; and Director, Executive Board, Baptist Hospital System, Florida.]

BOOK REVIEW

Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis

By Lisa Sanders, MD

Published by Broadway Books, NY, (2009) in paperback, at US \$ 14.99 (but used from Amazon at \$6.63, and on Kindle at \$11.99)

I came across this book in Barnes and Noble, one of my favourite places over and away – a treasure house of a million books or more! I've been a fan since early school days of Sherlock Holmes's diagnostic methods, and since medical school of Berton Roueche and his medical mysteries, so this title intrigued, as well as the marketing ploy in the star on the cover: "The New York Times Bestseller". Then the bit at the bottom caught my eye "Technical Adviser to HOUSE, M.D." So was this going to be a trite, TV drama approach, or a medical treasure?

Well it IS a medical treasure. The author is an internist at Yale University School of Medicine and writes a monthly column "Diagnosis" for the New York Times Magazine. She writes beautifully – lucidly, to the point, and with enough sense of drama to keep you reading and reading. But before I get to the point – her point – I was puzzled by some of the wise words written and chosen for the back cover blurbs and the praise at the front, which seemed to miss her main point.

Hugh Laurie, star of House, M.D., wrote: "If you need to be reminded that there are still diseases that can't be cured in an hour – then Every Patient Tells a Story is for you. Fantastic stuff!"

Atul Gawande, author of Better: A surgeon's notes on Performance: "Lisa Sanders is a paragon of the modern medical detective storyteller. The tales here crackle with suspense..."

Pauline Chen, author of the brilliant Final Exam: "Every Patient Tells a Story is a must-read for anyone who has ever been a patient or is a doctor. Written by a physician I respect and a writer I love, the book is filled with intriguing diagnostic dilemmas that will draw you in, and with human stories that will linger in your mind – and heart – long after you are done." All these praises tell you what a great story teller Lisa Sanders is, and what a great read. And there are many

absolutely fascinating stories of patients with sometimes exotic and sometimes simple problems, solved when clinical skills and "directed thought" replaced a knee jerk battery of sophisticated tests. But running through the book, acknowledged, inferred and lucidly spelt out, but not mentioned in most of the sound bites used for marketing, is the really important issue ... it's the great deficiency in much modern medicine, but ESPECIALLY in the great USA, where the detailed history taking process and the physical examination have been almost entirely replaced by a routine battery of costly tests, unguided by clues from the history or the physical examination. The results, as we know only too well from the literature and occasional reports on our patients who holiday up north, are horrendous costs and sometimes horrendous mistakes that seem incongruous in the context of such sophisticated and advanced medical and surgical systems.

It is widely known that more than 70 % of medical diagnoses are made on a good history alone, and another 15 – 20 % on the physical examination, which usually confirms the tentative diagnosis made on the history. Laboratory tests, imaging et cetera confirm or refine the diagnosis in most cases, and make the diagnosis exclusively on the tests in perhaps less than 10 %.

Dr. Sanders is eloquent on the value of the physical exam, and its story teller Lisa Sanders is, and what a great read. And there are "Physicians and even patients have seemed willing, even eager, to abandon the physical exam, painstakingly developed over the past two centuries, and allow its erosion to advance unchecked." And again: "In residency, it often seems that no one cares if the patient is examined or not. Small wonder that many of the finer points of the exam simply slip away. And once they're gone, it practically takes a miracle to get them back."

There are positive suggestions to correct the problem. One missionary for change is Dr. Eric Holmboe, who has developed a rigorous resident training programme on clinical skills at Bethesda. He is quoted, realistically, as saying: "There's a tendency to think that back in some previous golden era things were better. I call that Nostalgialitis imperfecta. But there's plenty of evidence that there were significant inadequacies in the way doctors took a history and performed a physical exam starting as early as the 1970s." And what happened in the 1970s? The CAT scan arrived. Developed at Amersham in the UK, within five years they were all over the USA!

There are hugely important lessons to be learned here, and Dr. Sanders does a splendid job of bringing them to global medical attention. Our own situation in the Caribbean, in the UWI faculties of medical sciences, at the QEH and across our health care system may be a little better than in the USA, because as teachers we lay

enormous emphasis on the history and exam, and in our final examination in the UWI system passing the Clinical Exam component is mandatory. But we all have ample evidence that we're getting closer to being "in a similar boat". With the retirement of the "old hands", those legendary consultants with inspired clinical skills and clinical teaching skills, all of the young changing guard or those from different cultures are not always as focused and emphatic in teaching these clinical skills as the UWI old brigade. It requires a concerted effort on everyone's part. We must first recognise the incontrovertible value of good history taking and examination, and have the good sense and good conscience to learn, do it conscientiously and "teach it right!"

Every Patient Tells a Story is a fascinating read for every physician, and it carries a hugely important message. I can't recommend it too highly.

Professor Henry Fraser

Book Preview - A Personal View

Hillary's Barbados: *"Observations on the Changes of the Air and the Concomitant Epidemical Diseases in the Island of Barbados"* William Hillary 1766.

Fourth Edition.

Editors: Edward Hutson and Henry Fraser.

Publishers UWI Press – forthcoming, October 2011.

Dr. William Hillary was a Yorkshire born physician and a Quaker, who came to Barbados in 1757 because of the strength of the Quaker brethren in Barbados at that time. He was to have a profound and serendipitous influence on my professional life.

In 1972, while a Registrar in the Department of Medicine at the University Hospital of the West Indies, I wrote to Professor (later Sir) Christopher Booth, Professor of Medicine at the Royal Postgraduate Medical School, Hammersmith Hospital, asking for a resident's post, to train in gastroenterology. To my great relief, Sir Christopher invited me to London for an interview, where we spent most of the time with him telling me the story of Dr. Hillary in Barbados. He had written a splendid biography of this brilliant physician who was born close to his own birthplace, and on his way back from a lecture in Trinidad he had actually stopped in Barbados a few months before our interview just to see the Barbados Museum's copy of Dr. Hillary's famous book! I felt that Hillary had "God-fathered" me into Sir Christopher's good graces, and got me a job with him . . . which led to his positive reference for my next job at the Institute of Neurology (Queen Square) and then support for Sir George Alleyne's submission for a Wellcome Fellowship for me, for a PhD and training in Clinical Pharmacology back at Hammersmith Hospital. So to these three great men, Dr. William Hillary, Sir Christopher Booth and Sir George Alleyne, I owe a great deal, and this new edition repays some of my debt to Dr. Hillary!

Without Dr. Hillary and the doors he opened for me, I would have spent my life as a gastroenterologist. But read the very powerful last words of Hillary's own Preface. He wrote: "And as for those who will neither read, nor yet know how to reason on the causes . . . of diseases, and yet will boldly practise by rote, and prescribe by guess at a venture, though the life of the patient depends on the right or wrong method of prescribing; I must, with the learned and judicious Dr. Huxam, seriously advise them, at least to peruse the Sixth Commandment." What could have been a better omen for me as a clinical pharmacologist with a mission!

Hillary's book went through two editions in London and one nearly 50 years later in Philadelphia, in 1812. This edition had notes and annotations by the most famous American physician of the 19th century, Dr. Benjamin Rush, but his notes add little of value to Hillary's work. Sir Christopher Booth, in his biography of Hillary, points out the excellent clinical description – the first accurate one – of tropical sprue, then apparently endemic in Barbados. In that era miasmas related to climate and weather were implicated in many diseases, and Hillary made rigorous observations of rainfall, temperatures, humidity and the occurrences of both the common illnesses, e.g. the fluxes or diarrhoeal diseases and the serious and life threatening pneumonias, jaundices and tetanus.

He is impressively accurate in his clinical descriptions, and his observations were often "right on". He noted, for example that malaria was only seen in visitors to the island, and not in residents!

This was quite extraordinary, since it was common across the Caribbean, but uniquely absent from Barbados until a brief period between the 1920s and 1940a. It is of great interest that he recognised a type of jaundice that he distinguished from yellow fever, and which was later labelled “Barbados Jaundice” by the 19th and early 20th century physicians here. It was, of course, our own brilliant Dr. Harry Bayley, with his own approach of laboratory diagnosis, in his own garage-located laboratory and autopsies at the old General Hospital, who recognised it as leptospirosis, or Weil’s Disease – then, like HIV / AIDS today, a relatively newly recognised disease. Ironically, although Hillary could tell the difference, an English expert, Sir Rubert Boyle, was sent to Barbados in 1911 to assess the high incidence of jaundiced deaths, and thought it was yellow fever. Dr. Harry Bayley reviewed the addresses of the victims 25 years later

BOOK PREVIEW . . . cont’d

and showed that they came from the slums of Bridgetown and the sugar cane fields.

Why a fourth edition, with notes? Well, when I recently showed my precious second edition to Dr. Edward Hutson, Bajan anaesthetist working at QEH when I was an intern, and now retired in Alaberta, Canada, his reaction was “This calls for a new edition.”

“Without history, nothing has a full meaning.” “The history of medicine is the history of humanity itself.” These and other words of the medical greats point out the value of knowing something of the past and how medicine has developed. The notes of Hillary’s original manuscript are retained, as well as new notes, with translations, explanations and comparisons. We hope that the book will be of interest both to physicians, students and medical historians.

Professor Henry Fraser

INSTRUCTIONS TO AUTHORS

BAMP Bulletin is the journal of the Barbados Association of Medical Practitioners (BAMP). It is now effectively in its 35th year, having replaced the initial Newsletter of the Association, begun in 1976.

The Editor is assisted by members of an Editorial Committee, chaired by the Public Relations Officer of BAMP Council, and comprising a cross section of BAMP membership, from Professor Emeritus to medical resident. There is also an Advisory Board of seven senior members of the profession (See page 3) and since the beginning of 2011, with the publication of the new Bulletin, submitted papers are peer reviewed, usually by members of the Advisory Board or other local specialists in the relevant area. Expansion of the Advisory Board and of our reviewers to include international experts is planned.

Manuscripts should be clear, concise, accurate, and where appropriate, evidence-based, but written, in the words of the Royal College of Physicians, “with a style that retains the warmth, excitement and colour of clinical and medical sciences”. Content may range from letters to the editor and clinical case reports to short Commentary articles, clinical or epidemiological studies, CME review articles or historical articles. Good items of medical humour are accepted, and quality photographs or paintings may be submitted to adorn the cover, which will have the new, dramatic masthead above a photograph or painting. Historic photos, such as that of the General Hospital senior medical and nursing staff in 1938 in the issue July / August, 2011, are welcome.

Authors are asked to indicate with their submission any competing interest, including any funding for a study. They are asked to submit in Word, to edit their work carefully, and to provide full name and qualifications, address (email address optional), a word count, a portrait photograph, and an abstract of not more than 200 words. References should be indicated in the text with an Arabic numeral in brackets, e.g. (1) or (6,7), numbered in order of appearance and listed at the end, using the style of “Uniform Requirements” in the New England Journal of Medicine

and as referenced here: (New Engl J Med 1997; 336: 309-15).

They should give the names of up to four authors. If more than four, they should give the first three followed by et al. The title should be followed by the journal title (abbreviated as in Index Medicus), year of publication, volume number, first and last pages. References to books should give the names of authors (&/or editors), title, place of publication and publisher, and year of publication.

Other examples, taken from the instructions in the Journal of the Royal College of Physicians, are:

1. Abbasi K, Smith R. No more free lunches. BMJ 2003;326:1155–6.
2. Hewitt P. Trust, assurance and safety – the regulation of health professionals in the 21st century. London: Stationery Office, 2007.

www.officialdocuments.gov.uk/document/cm70/7013/7013.pdf

Accuracy of references is the responsibility of the author.

Photographs and illustrations should be submitted as separate attachments and not embedded in the text.

Submission of an article implies that it represents original work or writing and is not submitted elsewhere. However relevant articles of interest that have been published elsewhere may be accepted if clearance is obtained from the first journal and republication is stated, or may be abstracted for airing in the BAMP Bulletin, with appropriate reference.

Articles, letters and all items should be submitted to BAMP Office (info@bamp.org.bb) and to the Editor at henryfraser@gmail.com

The secretary buzzed the doctor on the intercom and said: "There's a patient on the phone who wants to know if you make house calls - whatever THEY are!"
(Anonymous)

Lifestyle-related diseases such as heart disease, cancer, diabetes, hypertension, stroke and obesity are spreading through our region, and continue to create serious social and economic challenges. We must all seriously commit to doing our part in promoting increased physical activity and healthy eating to live longer, healthier lives.

Sagicor also supports the regional goal that, by 2012, 80 percent of people with non-communicable chronic diseases will receive quality health care and have access to preventative education.

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HEALTH IS A STATE OF COMPLETE HARMONY OF THE BODY, MIND AND SPIRIT.



For relief of coughs that are ...

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- *irritating* • *non productive*

BroHex



*Liquifies mucus
to ease
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Bromhexine Hydrochloride Elixir 4mg/5ml

Dosage:

Adults and children over 12 years: Two teaspoonfuls three times daily
Children 6-12 years: One teaspoonful three times daily
Children 2-6 years: Half teaspoonful three times daily
Children under 2 years: Quarter teaspoonful three times daily