

No. 165 Dec 2007

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Communications are preferred in electronic as well as written formats.

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Editorial...

What should we expect of THE HOSPITAL BOARD?

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The establishment of a Board of Management for The Queen Elizabeth Hospital provides a means of ensuring that it acts on behalf of the government and people of Barbados.

Following its creation, and in the eyes of many, the concept and implementation of such a 'body with a difference' appeared to be the answer to, and the resolution of many of the longstanding challenges faced by the staff, patients and users of the QEH during its four decades of existence.

But does the installation of a Board make sure that management and medical staff function in ways that further the mission and goals of the institution, or does it mandate that the Board assumes responsibility for its own effective and efficient performance?

A board is ultimately accountable for everything it does and everything that goes on inside of it, and whereas it assumes the role of full accountability although unable to perform the actual work of the hospital, it must nonetheless oversee that such work is done. In this regard, the tasks and authority delegated to management and the medical staff hold them in turn directly accountable to the board for their decisions and actions, or lack thereof.

To govern effectively, the board must fulfill certain responsibilities and perform certain roles. Responsibilities being the "what" aspects of governance or specific matters to which the board must attend, and roles being the "how" aspects of governance or the activities that the board must undertake to fulfill its responsibilities. Together, they define the work of a board.

The Board must formulate a mission and vision for the hospital, specify key goals that if accomplished result in mission accomplishment and vision actualization, and ensure that strategies devised by management lead to fruition.

The Board must assume responsibility for ensuring high levels of executive management performance and the quality of patient care. The Board must also be responsible for ensuring the hospital's financial health, and must assume responsibility for itself – its own effective and efficient performance.

The Board must fulfill its responsibility through its policy formulation, decision making and oversight roles.

Policies formulated by the Board provide direction, and are the means by which authority and tasks are delegated to management and the medical staff. In so far that policies also provide a framework for execution of the decision-making role, they should be formulated with great care, written, explicit, brief, and should be reviewed periodically.

Decision making is often considered to be the central and most important role of governance, since much of what boards do eventually comes down to making choices.

Decisions must be made by the Board in each of its area of responsibility and with regard to recommendations forwarded to the Board by management and the medical staff. The Board must then engage in oversight by monitoring decisions and actions to ensure they conform to set policies and produce intended results.

Oversight entails three functions – monitoring, assessment and feedback, with monitoring and assessment functions as the guarantee that delegated tasks and authority are being executed in ways that meet board expectations as expressed in its policies and decisions.

Execution of the oversight role closes the loop with respect to a board’s ultimate responsibilities. Management and medical staff alike are accountable to the board for decisions they make and the actions they undertake. Proper oversight ensures this accountability.

Feedback provides the information the board needs to modify existing policies and to formulate new ones. In order to effectively and efficiently execute its oversight role, a board must put in place a governance information system. The Board has different responsibilities and executes different roles than management and the medical staff and therefore needs governance, not management or clinical information. The Board therefore, in consultation with management and medical staff leaders, specifies the information it needs.

Active participation by the Chief Executive Officer (CEO) and the Hospital Board members is essential to major hospital quality improvement initiatives.

Boards are often impaired because they are either unaware or unable to practice the fundamentals of governance, their ultimate responsibilities, and their core roles. To enhance their performance, improve their effectiveness, and make the contributions they could, boards must have a precise, clear and shared understanding of the type of work they could and should be doing – and they must “just do it.”

Following the installation of an Interim Management Team to ensure a smooth transition, the current QEH Board officially assumed the reigns for operations in September 2005. It should not be presumptuous to assume that the Board has been in full control of operations since that time and that the honeymoon is over. To the contrary, feedback from members of our professional body indicates that a litany of complaints which adversely affect the delivery of an acceptable level of patient care continues with unacceptable frequency while others remain unresolved. Recurrent “stock-outs” of supplies, out of service equipment, unavailability of previously available patient services for delivery of basic care, and Human Resources matters are but a few.

Governing a hospital is a difficult and demanding job. If done properly, the hospital can function well. If the board is inept or incompetent, the institution will suffer. The real test is seemingly one of individual capabilities against a backdrop of institutional pathology of immense proportions.



Letter to the Editor

The Non Communicable Chronic Disease Summit 2007 – Some thoughts.

On Saturday 15th September 2007 15 Heads of Government of Caricom States met in Trinidad to discuss chronic non-communicable diseases, to find solutions to tackle ‘the striking and alarming increase’ in heart disease, strokes and diabetes affecting the region’s population. But is this just another episode of ‘talking loud and saying nothing’ by our leaders? Would the ‘lotta long talk’ be converted to action this time?

The cynics could have a field day! They would point out, for example, that the Caricom Ministers responsible for Health adopted, at a special meeting held in Jamaica in 1986, the Caribbean Co-operation in Health (CCH) Initiative, in which special programs would be put in place **by 1995** to tackle a number of priority areas. Chronic non-communicable chronic diseases (cncds) were one of the six priority areas identified. The goals of the CCH were to meet the felt needs of the countries to mobilize additional resources for health, to concentrate upon priorities and to promote greater technical cooperation among Caribbean countries.

In 1988, AIDS was added as a seventh priority by the Caribbean Ministers responsible for Health, after considering its medical, social and environmental consequences of this disease. Since then AIDS (or HIV/AIDS as it is commonly called these days) gained the attention of the Prime Ministers (and Ministers of Finance), leapfrogging the other priority areas previously identified, and gaining financial commitment from the Prime Ministers. The optimists hope that the cncds would get the same level of national attention afforded to HIV/AIDS.

At the review meeting in 1995, **there seemed to be little evidence that most countries had actually gotten programs off the ground to tackle the cncd priorities previously identified.** So much for the 10 year plan. In true Caribbean style, this was met by a “No problem, man” approach – CCH (1) was followed by CCH (2), and the Ministers responsible for Health proposed a plan called “20/20 vision”, whereby ‘centers of excellence’ would be established in each Caribbean country by the year 2020, to effectively manage the priority health areas previously identified. [This “20/20 vision” should not to be confused with 20/20 cricket, although the recent performances of the West Indies cricket team can have

an equally negative health effect on West Indian peoples as the cncds.] Thus the 10 year plan of CCH 1 gave way to a 25 year plan of CCH 2: we are currently at a point 12 years after this plan was proposed, and we are still waiting to see the emergence of these ‘centers of excellence’. “(Don’t worry man, we have 13 more years)”.

Then the 2007 summit was announced, where the Prime Ministers were to take over from the Caricom Ministers responsible for Health (“moving from the House of Commons to the House of Lords”) in the task of charting a course for dealing with the cncds. The optimists were elated – surely the men who control the national purse would probably be in a better position to commit funds to the programs needed to tackle these deadly lifestyle diseases.

Indeed, the Caribbean is noted to have lost quite a few of these same leaders while in office to heart diseases, strokes, and diabetes, i.e. these same cncds; they are not immune to the effects of these silent killers. [In other parts of the world bullets, the sword or other forms of violent persuasion are used about as often to interrupt the courses of leaders while leading their countries]. But the cynics would once again point out that these same leaders have a track-record of leaving Caribbean shores for treatment overseas when personally affected by the cncds, while suggesting that their people have access to the ‘best affordable’ health care locally.

Caribbean people have become accustomed over the last two decades of promises from our Ministers responsible for Health of ‘improved health provision’. The optimists can suggest that a 21 year wait between identifying health areas for priority consideration and finally getting some action is ‘reasonable’. The weeks, months and years ahead will determine whether the cynics, accustomed to the No Action Talk Only (NATO) approach by our Ministers responsible for Health to many health issues that wreck havoc in our populations, or the optimists, will be forced to keep their mouths shut.

*Dr. C.V.Alert, MBBS, DM (UWI)
Family Physician.*

President's Report

BAMP has been very active over the past year and I take this opportunity to update you, our members on the current state of affairs of the Barbados Association of Medical Practitioners.

- CTUSAB - Proposed Bills: Employment Rights, Metrology, Public Service Bill, Minimum Wage, Income Tax Reform
- QEH - Resignation of the Board, Chairman's letter, Funding, Stockouts and shortages, DMS, Medical directorates, QEH redevelopment-\$700Million
- Terms and Conditions of Service Negotiations
- Extended Hours at the Polyclinics
- Medical Registration Bill
- CME May 2008

CTUSAB

The Congress of Trade Unions and Staff Associations of Barbados has grown into a strong body representing the workforce in Barbados and as part of the Social partnership with the private sector has made great strides for the greater good of Barbadians.

Several draft legislation bills have been sent to CTUSAB by the government for comment and negotiation; the more well known were the Employment Rights Bill and The Public Service Bill.

The Employment Rights Bill is in its final stages of consultation and talks are scheduled to conclude in early December 2007.

The Public Service Bill was the most contentious with CTUSAB taking a firm position on the proposal to amend the constitution, and its firm stand supported by the Private Sector persuaded the government to review and reverse its proposed decision to amend the constitution.

Queen Elizabeth Hospital

The Queen Elizabeth Hospital has been at the forefront of our focus and it still continues to take up the majority of time, effort and resources at BAMP.

After our meeting with the Chairman of the Board, Minister and QEH top management, there has been some improvement in the situation of stock outs. This has been inadequate to completely reverse the trend and shortages of basic supplies still continue on a daily basis.

Archaic management processes, procedures, ancient working timetables and ineffectual leadership have led to breakdown at all levels at the QEH and a new, modern approach is necessary to resuscitate the QEH.

The QEH needs to urgently restructure its management style and shift to a true 24 hour institution if it is to transition into the 21st century. Areas such as the Laundry and Laboratory should be functioning full time 24 hours a day as evidenced by the increase in the sheer volume of work to be done caused by the rapid expansion in services offered by the QEH.

We however, still tinker along with a process developed over 40 years ago with an inadequate emergency service offered by the lab after hours.

BAMP supports the proposed Clinical Directorate with its inherent support staff and integrated approach which would bring accountability and transparency to all areas of the QEH. This would also cut out wastage, duplicity of effort and would blend in with the newly implemented accrual accounting system by the Government and the proposed performance indicators linked to funding.

A recent exercise to ascertain the operational costs of the QEH department by department was an eye opening exercise. It showed the many flaws in the current system and supported the need for a fundamental management change to bring accountability and financial prudence to the QEH.

BAMP has maintained that that QEH has been chronically underfunded to the tune of BDS\$192 million and notes with interest the recent articles in both Sunday Newspapers of Nation and Advocate of November 25, 2007 which stated Government's intention to build a new \$700 million dollar facility over 4 years.

BAMP needs to know the projected annual operational cost of the proposed new facility, included in this would be equipment maintenance contracts, warranty on equipment and building maintenance.

Promises

BAMP was told that a centrifuge would arrive two weeks ago. This was over 2 months AFTER the Chairman wrote about it.

When asked, we were then told that there were some problems and that another supplier was being contacted.

This in an URGENT situation where people are dying in an epidemic of Dengue Fever, to compound the usual leukemia patients' care, with the current centrifuge deemed unsafe by the Head of Haematology Department.

At our most recent meeting of December 4th 2007, the centrifuge had still NOT been installed and we were told again that the Director of Engineering Services (Ag) had flown out to acquire and return with a centrifuge weighing over 100 tons.

The cafeteria and the elevators remain to be fixed after several years and after promises to have the matter resolved by month end. All the things promised by the Chairman are coming to a head.

Terms and Conditions of service negotiations

BAMP has engaged the Ministry of the Civil Service in negotiations on the terms and conditions of service of doctors in the public service. We have had one meeting so far and have made some progress and have already negotiated some terms. We are awaiting a response from the Ministry to our other proposals. Due to the fast tracking of the Public Service Bill, the Ministry of Civil Service had asked for an extension for them to respond to our proposals and BAMP agreed. The CEO has engaged BAMP on the terms and conditions of service of doctors at the QEH and we are awaiting his written response to our proposals.

Extended Hours at the Polyclinics

The Ministry has started an after-hours service at some polyclinics and there has been an especially great and overwhelming response at the Maurice-Byer Polyclinic, suggesting the need for a greater expansion of the service in the North of the island.

Medical Registration Act 2007

BAMP received a copy of the draft Bill and circularized its members in electronic format. Not ONE member replied with any comments on the proposed bill. BAMP council went through the act and made recommendations and again circularized our members. It was noteworthy that such a proposed bill with such far reaching consequences did not seem to evoke any response from our members on an issue that would impact on our livelihood.

CME

CME continues to suffer from lack of interest and poor attendance. The coming of the Medical Registration Act will make CME mandatory and while one may argue about its appropriateness to assess doctors etc., the fact remains that it is coming.

The next CME in May 2008 will feature an Abridged Business of Medicine Conference and Nutrition.

Timelines

The time is fast approaching that BAMP will be forced to take action at the QEH as the slow pace of change for the better is tied up in bureaucracy, the very thing that the Board was meant to cut out.

The apparent incompetence in the procurement of vital pieces of equipment, of the provision of basic services and supplies speaks to the need for a change.

The Barbados Association of Medical Practitioners holds the Chairman of the QEH Board and the CEO of the QEH accountable for the state of the QEH.

One can only assume that the slow ineffectual pace means that we are waiting for Christmas. Christmas and thereafter will be a deciding time; please stand ready to be called on early in the New Year.

Christmas is the time of giving, of good will and cheer, of remembering our fellow man and central to the theme, the celebration of the birth of Christ.

A Merry Christmas to all.

Dr. Carlos A. Chase
President



Allergies and Sick Buildings

Dr. Euclid Morris MBBS, MSC, MRCP

The basic functions of the immune system involve protection of the body from agents of external intrusion and contribution to the maintenance of internal homeostasis and surveillance. **The primary organs are the thymus and bone marrow** whilst the spleen, lymph nodes and lymphoid tissue along the oropharynx, bronchial walls, gastrointestinal and urogenital systems are referred to as the secondary organs.

The cellular elements of the immune system arise from a common bone marrow-derived pluripotent stem cell which gives rise to lymphoid and myeloid series. Some lymphoid cells develop into T lymphocytes and some into B lymphocytes. On antigenic stimulation B lymphocytes transform into Plasma cells which produce specific antibodies. **Lymphocytes have specialised but sometimes inter-related functions.** For example, B cells make antibodies; cytotoxic T cells kill virally infected cells; helper T cells coordinate the immune response by direct cell-cell interactions and the release of cytokines, which in turn help to stimulate B cells to produce antibodies.

An immune response consists of two phases. In the first phase, antigen activates specific lymphocytes that recognise it and in the second or effector phase, these lymphocytes coordinate an immune response that eliminates the source of the antigens. Hence, specificity and memory are two essential features of adaptive immune responses and the immune system mounts a more effective response on second and subsequent encounters with a particular antigen. When an adaptive immune response occurs in an exaggerated or inappropriate form, the term hypersensitivity is applied and results in inflammatory reactions and tissue damage.

There are four types of immune hypersensitivity described in the Gell and Coombs classification (Types I to IV). In practice these do not necessarily occur in isolation and more recently a Type V or “secretory” type has been described.

Type I, immediate hypersensitivity reactions are commonly referred to as allergic reactions and occur when an immunoglobulin E is directed against innocuous environmental antigens such as pollen, house-dust mites or animal dander. The IgE antibodies are attached to

mast cell receptors and the recognition of antigen triggers the release of histamine, serotonin and other vasoactive amines from the mast cell. These chemical mediators induce the allergic reaction seen in allergic rhinitis, asthma and anaphylaxis.

Atopy is an umbrella term used to describe a set of clinical conditions such as asthma, eczema, urticaria, hay fever and food allergy. It describes the clinical presentations of Type I hypersensitivity and usually occurs in patients with a family history. Atopic individuals typically show immediate wheal-and-flare skin reactions to common environmental allergens when tested.

Type II reactions require complement fixation, type III are associated with autoimmune disease and type IV are referred to as delayed type hypersensitivity. The main type of hypersensitivity seen in relation to building exposures is postulated to be Type I and to a lesser degree, Type IV.

Over the years there have been multiple terms used to describe illness thought to be related to conditions that exist within buildings or dwelling places. In the nineteen-seventies and eighties reports of building associated illness from developed countries such as in North America and Europe were emerging with labels such as “building sickness”, “tight building syndrome”, “office eye syndrome”, “sick office syndrome” and “sick building syndrome”. These titles, in the main, attempted to describe the environment believed to be associated with developing symptoms rather than describing the symptoms themselves. In 1982, a group of experts within the World Health Organisation (WHO) described a list of symptoms and perceptions as sick building syndrome. This typically involves symptoms from mucous membranes i.e. nose, throat and airways; the central nervous system, headache, fatigue and difficulty concentrating; and symptoms of the eyes and skin. In more recent years, there have been reports of the sick building syndrome from countries around the world including the UK, most European countries, USA, Canada, Australia and Japan.

An early classification of building associated illness divided conditions thought to be associated with buildings

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into short latency and long latency illness. The short latency illnesses so described were:

- building associated infections,
- building associated hypersensitivity pneumonitis,
- illnesses associated with specific contaminants,
- mass psychogenic illness and
- the sick building syndrome.

The long-latency illnesses included cancer and chronic pulmonary diseases but because of the long induction and latency periods for these conditions and their multi-factorial origin, it is much more difficult to establish a causal link to specific building exposure.

In 1987 in the USA, a committee on indoor air quality for the National Research Council defined building related illness as those specific clinical syndromes that result from exposure to indoor air contaminants (e.g. hypersensitivity pneumonitis or Legionnaire's disease). In contrast, the sick building syndrome referred to the occurrence of a variety of non-specific symptoms wherein it was not possible to make a specific diagnosis. It is thought that a significant proportion of these symptoms, such as irritation of the eyes, skin and airways may be related to allergic (or Type I hypersensitivity) phenomenon.

A more contemporary classification considers building-associated illness to be further divided into **specific** building-related illness and **non-specific** building related illness.

There are several categories of **specific** building related pathology such as allergic or hypersensitivity conditions, infectious diseases, intoxication diseases and irritant conditions. The allergic conditions are thought to be the group most commonly related to indoor air quality; affecting the upper airway, lungs and skin. Symptoms are usually caused by exposure to biological or chemical agents to which an individual has been previously sensitized and may present within the range of atopic symptoms such as rhinitis, urticaria, allergic dermatitis and asthma symptoms. Hypersensitivity pneumonitis and humidifier fever represent extreme examples of pulmonary hypersensitivity reactions for which atopy is not thought to be a predisposing factor.

Examples of building related infectious diseases are Pontiac fever and Legionnaire's disease. These two conditions are caused by the same bacterium *Legionella pneumophila* and occur as two distinct clinical diseases; the former a self-limiting flu like illness and the latter a potentially fatal pneumonia and multisystem disease.

Other more common infections such as bacterial pharyngitis, chickenpox and tuberculosis are thought to be more easily spread under conditions of overcrowding and are therefore indirectly linked to building factors. Opportunistic fungal pathogens such as *Pseudomonas* and *Acinetobacter* are generally not thought to be a threat to normal, healthy individuals but may pose a risk to immunocompromised hosts.

The case of Legionnaire's disease requires special elaboration as its first recognition represented a significant event in building related illness. In 1976, members of the American Legion convening in a Philadelphia hotel were struck by a pneumonia epidemic resulting in 182 cases and 29 deaths. Epidemiological investigation linked the deaths to the contamination of a ventilation system with *Legionella pneumophila*. With the colonisation of the ventilation system, the organisms became aerosolized in droplets of water and the infection was spread by inhalation of the aerosolized *Legionella*-contaminated water. *Legionella* exists freely in the natural environment without causing any apparent disease to non-immunocompromised individuals and no person-to-person spread from those infected has ever been observed or reported. It can be inferred therefore, that without the suitable environmental or building related conditions, Legionnaire's disease as a human pathological condition would not exist. Legionnaire's disease thus represents the very severe and significant end of the spectrum of building related illness where the building plays a clearly defined role in the aetiology and spread of the disease.

The intoxication diseases arise from exposure to indoor pollutants such as carbon monoxide, heavy metals, pesticides and volatile organic compounds and the severity of the symptoms depends on the degree of exposure. Carbon monoxide is a product of combustion devices and is a particular threat in temperate countries where artificial heating is utilised during the colder months. High level exposure can result in cardiovascular events and fatality whereas low level exposure may present with headache and flu-like symptoms.

Mass psychogenic illness is a phenomenon where individuals present with symptoms compatible with hyperventilation, features not readily explained by organic mechanisms and a visual or verbal chain of transmission. Onset is usually abrupt and explosive and the symptoms resolve without any measurable physical sequelae.

As stated earlier, the sick building syndrome is not classified under specific building related illness but

rather refers to the occurrence, in a growing percentage of the modern working population, of a variety of non-specific symptoms without an easily identifiable diagnosis. These conditions are characterised by a relatively acute onset closely related in time to the individual's presence within the building and relieved by removal from further exposure. Hence the sick building syndrome is now classified as **non-specific** building related illness and the newer terminology suggested for non-specific building related illness is **building related occupant complaint syndrome (BROCS)**.

The main symptoms comprising the sick building syndrome relate to the eyes, nose, throat and skin, together with what are often called general symptoms of headache and lethargy. All these symptoms are common in the general population and it is thought that the distinguishing feature which makes them part of the sick building syndrome is their temporal relationship with a particular building. Symptoms commonly described are rhinitis, pharyngitis, nausea, headache, dizziness and fatigue and are reported to improve after leaving a problem building. There is thought to be an allergic component to some of the symptoms of the sick building syndrome particularly those associated with mucous membrane irritation. Over the years, more than 50 different symptoms have been attributed to the sick building syndrome and this has contributed to the considerable on-going debate over the existence of the syndrome and the possible psycho-physiologic nature of some of the symptoms.

There has been a list of factors, environmental and otherwise postulated to be related to the sick building syndrome or BROCS and these include:

- Building factors such as the type of ventilation and ventilation rate, temperature, humidity and the presence of cigarette smoke
- Personal and organisational factors
- Biological factors such as Bacteria and fungi
- Degree of freshness of the ambient air, among others.

It is beyond the scope of this report to go into detail the various hypotheses and technical aspects of the relationship between the individual factors and the emergence of symptoms but it is believed that there is an "ideal environment" outside of which symptoms are more likely to occur.

The approach to classifying and treating so-called problem buildings is therefore very complex. A healthy

building is one that is designed, maintained and operated to minimise environmental risk factors and maximise comfort, well-being and productivity. By convention, a problem building is one in which either greater than 20% of the occupants have building-related health complaints or specific environmental contaminants have been linked with building related illness. A crisis building is one in which complaints and public concerns have reached the point that normal activities have been severely disrupted. A meta-analysis of epidemiological studies indicated that sealed, mechanically ventilated, humidified and air-conditioned buildings are more likely to generate complaints than naturally ventilated buildings.

The clinical evaluation of building associated illness involves the assessment of the individual patient or patients and an assessment if necessary of the building. Patients may present with health complaints or with anxiety about future health effects caused by indoor environmental contaminants. Most building associated illnesses resemble common clinical problems seen by primary care physicians. With this in mind, clinicians must therefore balance having a high index of suspicion to identify occult environmental contributors to a patient's illness and wariness of accepting too readily the patient's self-assessment of the building-relatedness of their complaints. The clinical evaluation involves taking a detailed history from the individual as well as clinical examination of the relevant systems. Further investigation is determined by clinical suspicion of specific pathology e.g. asthma but in the management of the sick building syndrome or BROCS laboratory investigations are usually normal.

The evaluation of the building is dependent on the level of reported symptoms and the investigators' suspicions of the building-relatedness of the symptoms. The first phase facilitates the collection of general information about the building and about the occupants' complaints. Surveys and structured or semi-structured questionnaires of the occupants are particularly useful at this stage and can contribute significant useful information. Investigations should be carried with awareness and analysis of the psychosocial dynamics of building complaints and these should not be omitted or ignored, as the investigators' activities are likely to impact on social dynamics. Confrontation can easily result with particular interest groups having varying environmental and psychological explanations for the origins of the problems. If not adequately managed, organisational crisis may result, with decreased productivity and even

evacuation whilst, as one author put it: “occupants clamour for repeated investigations of ephemeral odorants and phantom toxicants.”

A step-wise, coordinated, multi-disciplinary team approach is therefore favoured with a strategy to minimise speculation and distrust by keeping the building occupants informed of the progress and conclusions of the investigation. The recommended make up of one such team would include physicians, industrial hygienists, engineers, epidemiologists and microbiologists. It is suggested that the further phases of the investigation not be entered into unless there is sufficient suspicion of a building associated cause in the initial stage and should proceed only with specific environmental or medical hypotheses in mind. If identifiable causative environmental factors are found then the remediation of the building should be carried out in accordance with existing, established guidelines. These guidelines however vary from country to country and from jurisdiction to jurisdiction. In the final analysis, what the process tries to achieve is the elimination of any potentially harmful factors whilst bearing in mind the economic and psychological impact of large-scale and intrusive investigations for relatively minor or poorly correlated symptoms to the building environment.

In conclusion, there is significant merit in taking a proactive approach to addressing specific and non-specific building related illness and this is analogous to the primary and secondary prevention of any medical condition. Ideally, for new buildings, steps should be taken in the design and planning stages to optimise indoor environmental quality. This should be done in conjunction with other desirable goals such as energy efficiency, structural integrity, safety, spatial utility and aesthetics. The relevant input of expertise from occupational health personnel, architects, engineers, building contractors etc has to be allowed at every stage of the building’s life cycle; from its siting and design, to its construction, commissioning, operation, maintenance and remodelling. For older and existing buildings, routine preventative maintenance for the early identification and elimination of potential environmental risk factors is recommended. Schedules for cleaning and maintaining air conditioning and ventilation systems exist and should be adhered to, as well as addressing sources of damp incursion or indoor pollution. Paying attention to these issues as well as the general up-keep of the building should go a long way

towards achieving a healthy building, preventing specific building related illness and removing some likely targets of occupants’ concerns.

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Chronic Low Back Pain

More than a biomedical disease - Part 1

Dr. C. Malcolm A. Grant, MBBS (UWI)

According to the internationally endorsed definition of Chronic Low Back Pain, the patient often reports a muscle tension, stiffness or pain that is continuously or intermittently present for more than twelve weeks. This pain is located between the costal margins and the inferior gluteal folds. The pain may or may not radiate into either leg. It is also assumed that a specific cause or pathology has been excluded.

While there is a number of Classification schemes used for low back pain, classification (Spitzer et al 1987) into acute pain as that of less six weeks duration, sub-acute pain lasting six to twelve weeks, and chronic LBP lasting more than twelve weeks, is perhaps the most useful.

Strict application of the biomedical model chronic low back pain does not lend itself to a specific diagnosis and while acute pain is a “messenger of harm, nature’s poignant alarm”, chronic low back pain seems to serve no biologic purpose. However, within the context of the biopsychosocial model chronic pain is letting us know that there is something wrong within the patient’s life.

Although in well over 80% of chronic low back pain cases there is no identifiable pathology, after a while, Chronic Low Back Pain essentially takes on a life of its own where it evolves from being a symptom into an independent and distressingly self-sustaining entity.

It must also be noted that it is by far the most expensive benign disease known-accounting for reduced productivity, a drain on the social security services, astronomical medical and legal

cost and the disproportionate over utilization of scarce medical resources. In many western countries it accounts for over 1% of their Gross Domestic Product.

The interaction between the physical and the mental deconditioning is a reciprocal process. Negative emotional reactions, such as depression in turn reinforce the disuse and the atrophy of the injured area. For example, someone suffering from depression is less inclined to participate in work and recreational activities, which leads to a further loss of physical capacity.

Thus, the interplay between physical and mental deconditioning results in a vicious cycle that leads to increased pathology and psychological sequelae. The end result is a combination of physical, psychological, occupational and social impairment.

While there is little to no local statistical evidence regarding the contemporary prevalence or incidence of chronic lower back pain here in Barbados, the General Household Survey in Britain (1988-89) found that chronic low back pain (CLBP) is one of the most common causes on chronic sickness in the British. Anywhere from 3-7% of British population ages 16-64 report CLBP.

CLBP – New Evidence

In 1987, Gordon Waddell recommended that Chronic Low Back Pain not be treated like an injury and not be considered surgical, as a matter of fact he presented evidence to support discouraging rest while encouraging activity and exercise. What is distressing is the fact that

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in the ensuing twenty years his recommendations have been for the most part ignored and borne out by the fact that reported disability and the surgery rates have skyrocketed internationally.

In 1994 the US Agency for Health Care Policy and Research published evidence-based guidelines for the management of back pain. Once again for the most part most of these recommendations have been ignored.

Over the last 200-300 years there has been no change in CLBP pathology and neither has there been an increase in the incidence of CLBP, however, what has changed dramatically is the increase in Sick Certification and Permanent Disability Claims attributed to CLBP.

There are a number of physical risk factors that seem to predispose to the reporting of CLBP. Many of the early studies suggest that heavy manual work increases the likelihood of the reporting of CLBP. However, this association seems to be independent of the radiological degenerative changes noted in the lumbar spine.

From biomedical studies it seems as though concomitant and repetitive lifting and twisting in an awkward manner are more likely to damage the lumbar spine.

Some studies have suggested that prolonged sitting in one position increases the reporting of CLBP.

Jobs that involve driving often expose the driver to 4-6 Hz of total body vibration. It must be noted that this is the resonating frequency of the spine. Many studies show a higher incidence of spinal degeneration, lumbar disc prolapse and CLBP in drivers.

It is not uncommon for persons here in Barbados to complain of CLBP following a motor vehicle accident, however, it is somewhat difficult to determine whether such lower back pain is a primary symptom of a whiplash or just a secondary or tertiary byproduct as a result of prolonged bed rest, poor posture, pre-existing lower back pathology, etc. Lumbar disc herniation is not an established complication of flexion/extension MVA injuries. Slip-And-Fall accidents often result in the protracted and even life-long reporting of CLBP.

Contrary to popular belief, most studies show that obesity does not result in the increased reporting of CLBP. There is also no evidence that weight loss is an effective treatment for CLBP.

Several early Scandinavian studies from the 1970s suggested that the psychosocial aspects of work played a pivotal role in the development of CLBP. Such studies establish links between monotonous work, lack of personal control, low job satisfaction, social class, and CLBP.

There seems to be a correlation between social class and the reporting of CLBP, all things being equal. Most surveys on CLBP in the UK use this simple classification as follows;

- I. Professionals – doctors, lawyers, etc.
- II. Intermediate – teachers, nurses, self-employed
- III. Skilled occupations
- IV. Partially skilled
 - i. Non-manual – e.g. clerical workers
 - ii. Manual – e.g. tradesmen
- V. Unskilled – laborers, cleaners, etc.

This classification is twofold (1) It is partly occupational, with a major distinction between manual and non-manual work and it is also (2) socio-economic and serves to proxy results into social disadvantage such as education, housing and income.

Studies show that CLBP is more prevalent and tends to take on a more protracted course in unskilled manual males when compared to professionals, teachers and self-employed.

Women in the lowest income bracket were more likely to suffer from CLBP when compared to women at the other end of the spectrum re income bracket.

Manson et al (1994) found that Men and Women in manual class took more time off work. A higher proportion of men and women in the lower social classes were more likely to blame their CLBP on work and they were more likely to use bed rest as a primary means of treating their CLBP. It was also found that the more highly educated you were the less likely you were to take time off as a result of CLBP.

The reporting of disability was more likely to be transient with higher the education. The average male was more likely to take time off or report long term disability as a result of CLBP.

Leino et al showed that poor physical fitness and Cady et al proved that inadequate trunk strength correlated with an increased incidence in the reporting of CLBP.

Burton et al showed that CLBP peaks in persons who are in their late 40s.

Battie found that those that smoked were more likely to report CLBP. It was found that smoking may be linked to certain demographics, social class, behavior, coughing, physical fitness, body weight, etc.

A number of iatrogenic factors often lead to the reporting of CLBP. Here are some reasons for our shortcomings re the management of CLBP: Often patients are provided with the wrong advice. Patients are often to

take it easy – they are told “rest your back”, “don’t do too much” and patients take such advice to heart and take to their beds or just sit around their homes doing little to nothing in terms of physical activity.

Advice like “Let pain be your guide” promotes fear avoidance whereby the patient fears that he or she will become a cripple if they stir up their pain too much.

The longer a person stays away from work, the less likely that person will ever return to work. This is true not only for persons who are ill, it also holds for persons who may have won a lottery, taken time off to be with a sick relative, someone who has decided to stay home with the children, etc. In someone out of work for 6 months there is a 25% chance that they will never return to work, where that period is twelve months the chances of never returning to work approaches 50%, whereas if they are out of work for 18 months there is a 100% chance for no return.

Often there is an incentive on the patient’s part for reporting CLBP. This incentive is referred to as secondary gain.

Fishbain (1994) defined secondary gain as the means whereby a person is rewarded economically, physically or emotionally as a result of their illness or injury.

All illnesses to some extent can lead to secondary gain. When an individual becomes ill he/ she may be relieved from work, chores, certain social obligations and even civic duties – the classic e.g. being jury duty. The person who adopts the sick role may also benefit from increased social support.

Studies have shown that comparatively speaking, work injuries have a 60% greater chance of resulting in CLBP when compared to non-work injuries.

1. There is strong evidence that psychological variables are strongly linked to the transition from acute to chronic pain disability: (Level A evidence.)
2. There is strong evidence that psychological factors can be associated with the reporting of the onset of back pain: (Level A evidence.)
3. There is strong evidence that psychological variables generally have a greater impact than biomedical or biomechanical factors on back pain disability: (Level A evidence.)
4. There is strong evidence that attitudes, cognitions, and fear avoidance beliefs are strongly related to the development of pain and disability: (Level A evidence.)

- There is strong evidence that passive coping is strongly related to pain and disability: (Level A evidence.)
 - There is strong evidence that pain cognitions such as catastrophizing are strongly related to pain and disability: (Level A evidence.)
 - There is little evidence concerning acute pain: (Level C evidence.)
5. There is strong evidence that depression, anxiety, distress, and related emotions are strongly related to chronic pain and disability: (Level A evidence.)
 6. There is evidence that poor self-perceived health is moderately related to pain and disability: (Level A evidence.)
 7. There is evidence that psychological factors are moderate predictors for long-term pain and disability: (Level A/B evidence.)

In managing CLBP there is first-hand need for the determination of deficiencies in the management at the individual level and thereafter there must be a commitment to a change and an upgrade in current practice patterns. Unfortunately studies have shown that not only does Evidence Based Medicine take forever to make it into the mainstream of medicine, however, when such ideas are presented as a pragmatic alternative to the current practice less than 10% of doctors comply with such recommendations and changes.

It was no less than one of the founding fathers of modern medicine William Osler who observed that “The Greater the Ignorance, the Greater the Dogmatism”

Tertiary Gain was first proposed by Dansak in 1973 as an important factor in modulating and motivating illness behavior. Tertiary gain is defined as a gain sought or attained from a patient’s illness by someone other than the patient. Often the caregiver may benefit from the doctor-patient relationship by: fulfilling altruistic needs, representing the “little man” against Goliath (big corporation/ government), withdrawing from confronting the patient with the truth, establishing oneself as a patient advocate, avoiding intellectual honesty, and attacking professional detractors.

- Both the Opiates and Diazepam have the distinct potential for dependency
- Often unnecessary MRIs/ CT Scans/ X-rays are performed. While these tests each have varying

sensitivities they all have low specificities. And we have to be mindful that a patient may take a “False Positive” result and hold onto such as being the cause of their CLBP

- Up to 35% of patients undergoing low back surgery may end up with the Failed Low Back Surgery Syndrome. This percentage increases when cases are not properly selected.
- Many doctors conclude that if B follows A then B is a consequence of A. This argument essentially holds no water. However, when an authority like a physician suggests that the accident that you had last year is responsible for the pain

in your back that you have been experiencing for the last two weeks – there is almost no patient that would question such a spurious linkage.

- Often the doctor and the patient become “Partners in Pain”. It is not unusual for a symbiotic relationship develop between the patient and the caregiver... In that the patient expects a “good medical report”, sick leave on demand, disability certification, etc in return for being an unyielding and faithful supporter of the physician’s practice over a number of months/ years and sadly it is not unusual for the physician to comply with the patient’s implied or often stated desires.



Sick Leave Certification

P. Abdon DaSilva M.B.B.S. (UWI)

Whenever we advise our patients on fitness to work, a fundamental principle of this arrangement is that such advice is provided as an integral part of the clinical management of a patient's condition. In so doing, the certifying physician has to consider whether advising the patient to return to an important entity called work, or whether prescribing sick leave represents the most appropriate clinical management.

To a greater or lesser extent work provides an income, an activity, an occupation, a structure of time, creativity, mastery, social interaction, and a sense of identity and purpose, and whatever the cause, the effects of loss of work can include poverty, social deprivation and social isolation, poor physical and mental health, and increased mortality.

Against this backdrop however is the ever increasing patient expectation of what the financial benefit and health care systems should provide.

The sick role

It is relevant for certifying doctors to have an understanding of the sick role and the factors which influence its development in patients.

The sick role is not itself a medical diagnosis, but rather a status accorded to the individual by other members of the society that may be variably associated with a medical condition.

Patients may be physically, psychologically or socially unable to return to work, and the person's beliefs and behaviour are often part of the problem; the individual will accept and adopt the sick role, and particularly in relationship to work loss or obtaining financial benefits there is often medical certification to legitimize this role.

There is some evidence that a person is more likely to refrain from work in the short term when they fall ill where there is no or little economic loss owing to continuing pay or good replacement wages. Realistically, income maintenance payments of this sort can be disincentives to resuming work.

Other factors include little disapproval from fellow workers and managers, little perceived risk of job loss, and employees aged 50 years or over.

Whether and how often the employee has recourse to certification depends on a number of factors.

Absence proneness - a well defined personality trait leading to repeated absences (the patient we all encounter sooner or later and wish we hadn't). Another well recognized entity is workplace phobia where anxiety engendered by the work place leads to an inability to work, and simply giving the patient sick leave may do more harm than good.

Others include poor working conditions, lack of group cohesiveness (smaller groups tend to be more cohesive and result in less sickness absence), quality of leadership and organizational behavior, job satisfaction, and market-place conditions (supply and demand).

Sickness certification provides access to financial benefits, and as we can see from figures from the National Insurance Scheme - somewhere in the region of sixty thousand claims provided for over eight hundred and fifty thousand days paid to the tune of some twenty-eight million dollars in 2003.

In effect, as doctors we are custodians of the NIS sick benefits scheme, and most of us would remember recent accusations of being agents of "wastery".

What do we know?

- The cost of sickness absence is high.
- Objective clinical findings are present in only a few instances of sickness certification, hence only a proportion of people certified as sick can truly be regarded as unfit for work due to medical reasons.
- No formal training obtains in sickness certification and as a result doctors may be learning this aspect of their work by trial and error.
- Sick leave is often generated by the patient with the individual seeking validation for his or her perceived illness from the physician who often feels coerced into writing certificates.

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- General practitioners develop individual ways of operating sickness certification, and in practice most operate a “sick-certificate on demand” system.
- All stakeholders, including general practitioners may seriously misuse the system.
- General practitioners are unhappy with their certification role

No one seems to have a monopoly on misuse of the system and it should come as no surprise that straight forward sickness certification is not a problem, however where difficult decisions exist, any or all of the stakeholders may substantially misuse the system.

WHAT THEN IS A SICKNESS CERTIFICATE?

A sickness certificate is a major instrument for establishing contact and conveying information between two authorities that have a substantial impact on the life situation and work situation of patients as well as the economic costs of the society.

HOW TO WRITE A SICK-LEAVE CERTIFICATE

The certificate should be legible, written on the doctor’s letterhead, and should not contain abbreviations or medical jargon.

It should be based on facts known to the doctor and on the doctor’s own observations, or must indicate the factual basis of those statements.

The certificate should indicate the date on which the examination took place and the date on which the doctor considers the patient likely to be able to return to work.

Patients’ rights to confidentiality must be respected; a diagnosis should not be included in a certificate without the patient’s consent, however certain employers may insist on this information and patients may request doctors to with-hold information regarding their diagnosis.

In such cases it should be made clear to the patient that the information provided on the certificate may not be sufficient to attract sick-leave and that the employer has the ultimate right to accept or reject a certificate.

A certificate may be issued by a doctor subsequent to a patient taking sick leave, however the certificate must state the date of the examination and must be based on observation of symptoms during the examination, or upon information provided by the patient which the doctor deems to be true and cover the period during which the doctor believes the illness would have incapacitated the patient.

Sick leave certificates are legal documents and under no circumstances should the examination date be back dated or dated forward to correspond with an existing or proposed absence from work.

Under no circumstances should the examination date be other than the date on which the patient attended the doctor and at which time a genuine medical condition was considered in the doctor’s judgment to have existed.

In a similar vein, a physician should never cater for days off work for holiday or special needs.

Signing a false certificate may result in the doctor facing a charge of negligence or fraud. Furthermore, the issuing of a deliberately false, incorrect or misleading certificate may lead to a complaint of unsatisfactory professional conduct or professional misconduct under the relevant Medical act.

THE MEDICAL REGISTRATION ACT.

The Medical Registration Regulations, 1972. Part V. Professional Conduct and General Fitness to Practise Medicine. 21. (2).

For the purposes of the Act and these regulations professional misconduct includes –

(c) knowingly giving a certificate with respect to birth, death, state of health, vaccination, or disinfection or with respect to any matter relating to life, health or accidents, which the medical practitioner knows or ought to know is untrue, misleading or otherwise improper.

(For those of us who are not yet acquainted with the act. Here, the underlining has been done solely for the purpose of this presentation and clearly spells out professional misconduct in the local setting.)

Among the reasons for misuse are patient confidentiality, stress, demands on time, avoiding conflict in the doctor –patient relationship, disillusionment with the system, and undermining of decisions.

Documenting sick leave.

While there are no rules requiring you to retain work or school excuses, it is good practice to keep copies of them to answer future inquiries by the patients or by others legally authorized to obtain that information.

It may be convenient to file them in the patients' charts so that all documents related to the patients' conditions remain together. However, they may be filed separately in a location where their confidentiality will be maintained.

Patient's rights and responsibilities.

The sick person is not responsible for the original disease or injury, and is entitled to support and attention over and above that given to a fit person, but must at least share the responsibility for his/her own health and disability and accept obligations either to try to get well or to reduce illness behaviour and disability as much as possible.

The physician's role is to treat the condition, to fulfill the appropriate role of patient advocate, to facilitate health (including resumption of activity), to offer proactive advice on the basis of prognosis, to be familiar with the patient's social obligations and resources, and to provide education about the therapeutic benefits of returning to optimal function.

In short, the physician's role is to manage the patient's condition and expectations in a way that produces the best overall outcome for the patient. . Work often helps in regaining health, and since many factors are involved in a return to work outcome, as physicians we need to know how to identify and track the factors that facilitate or impede return to work.

What we must avoid is the justification of the "healthy worker absence" from work.

It is essential however that in order to implement these strategies effectively, the physician should recognize that the most effective tools must be compassion and understanding combined with firm therapeutic goals

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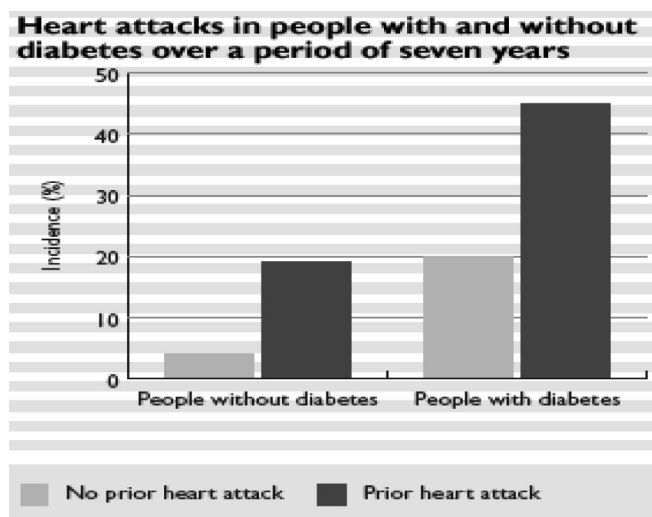


Linking Diabetes and Cardiovascular Disease

Dr. C. V. Alert MBBS, DM(UWI)
Family Physician

Type 2 diabetes has reached epidemic proportions worldwide, and is still rising. And if this is not bad enough, it is complicated by the growing burden of diabetes-associated cardiovascular disease. More than 75% of type 2 diabetes patients die from cardiovascular disease ⁽¹⁾, and the risk of death from a myocardial infarction is the same in patients with type 2 diabetes as in individuals who have suffered a previous MI ⁽²⁾, Graph 1.

Graph 1.



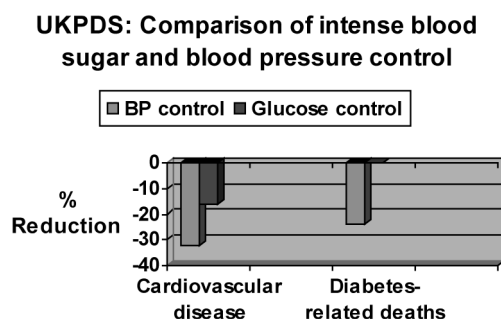
Further, in diabetics, the risk of sudden death is more than three times greater than it is for non-diabetics ⁽³⁾.

The United Kingdom Prospective Diabetes Study (UKPDS) was one of the largest studies that explored this relationship between diabetes and cardiovascular disease. Between 1977 and 1997, 5102 newly diagnosed diabetics were enrolled into the study, randomized into one of two groups which offered either conventional or intensive blood glucose control. These newly diagnosed diabetic patients were followed for a median of ten years,

and their clinical course with respect to the development of diabetes related complications closely monitored.

The results showed that, in the intense blood glucose control arm, there was a 16% reduction in cardiovascular end points, which was of borderline statistical significance, and there was no reduction in diabetes-related deaths.

One sub-study within the UKPDS looked at the effects of intense blood pressure control when compared to the conventional blood pressure control. 1148 of the newly-diagnosed diabetic patients were randomized into one of these arms. The results here showed that there was a 32% reduction (statistically significant) in cardiovascular end points, and a 24% reduction in diabetes related deaths, in patients offered the intense blood pressure control therapy.



The graph above shows this relationship, showing that intense blood pressure control had a more significant impact on cardiovascular end-points and diabetes related deaths than did intense blood sugar control. In patients with type 2 diabetes, there is thus a direct relationship between the risk of complications of diabetes and systolic blood pressure. The lower the systolic blood pressure the lower the risk of complications. Any reduction in blood pressure is likely to reduce the risk of complications, with the lowest risk being in those with systolic blood pressure less than 120 mm Hg ⁽⁴⁾.

While intensive glycaemic control did not significantly reduce the risk of cardiovascular complications in the UKPDS, other studies report that a multifactorial regimen targeting hyperglycemia, hypertension and dyslipidemia reduced the risk of cardiovascular complications by about 50% ⁽⁵⁾.

Numerous studies have shown that the risk of cardiovascular morbidity and mortality is increased at glycaemic levels well below the current thresholds for the diagnosis of diabetes ⁽⁶⁾.

In Barbados, cardiovascular disease has been our leading cause of death over the last 3 decades, since the Ministry of Health began keeping official statistics. Our most recent 'national' audit of diabetes and hypertension management, conducted about 2 years ago by Dr. P. Adams, and presented at the most recent UWI/BAMP CME, identified multiple deficiencies in the care offered to patients. Many of the deficiencies mirrored the problems identified in a previous 'national' audit about 15 years ago; unfortunately no sustained efforts were put in place to correct these deficiencies, hence their persistence. Since the management of the long-term complications of diabetes is associated with substantial cost and resource consumption, diabetes will continue to cause human suffering as well as being a significant financial burden on the national budget.

Perhaps the best way to reduce the risk of diabetes-associated cardiovascular disease is to prevent the development of type 2 diabetes in the first place. This will require the implementation of educational strategies directed at the community, in addition to pharmacological interventions in those at high risk.

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Our Members say - From “The Horspittle”

Members of BAMP are concerned re the QEH services and environment:

*** “Stockouts”...**

Frequently reported of standard materials, reagents for tests and supplies for patient care. The “in funds exception” response for supplies long requisitioned, has become a standard response.

*** Cluttered corridors...**

The unsightly accumulation of no less than 20 large card board and wooden boxes [marked Phillips for the X-ray department] remain stacked outside the entrances of the Radiology, Pathology and Social Workers Department, boxes which arrived on the island close to 3 years ago and have been waiting to be installed for over 1 year. How much longer before installation of the much needed equipment?

*** Services and tests unavailable...**

After 3 years, when will patients be able to have tests which require an operational machine to perform radiological screening e.g Bariums, IVPs, ERCP’s and other such machine dependent studies? EEG services are virtually unavailable.

The options are: no study, “funds exception” or pay one’s way.

Appointment dates for some tests e.g ECHO’s are in 2009.

*** Elevators...**

Patients, staff and visitors continue to experience a struggle with 2 functioning (occasionally 3) of 6 elevators, *which access general wards of the hospital* (not the Lions Eye Care Centre building) despite the empty words of Board members in the media. Disused furniture blocks the out of service elevator doors.

What about when only one elevator is functional and poses a great risk in transporting patients?

*** Cafeteria...**

After near 4 years closure of the hospital cafeteria, BAMP members and other hospital staff who are compelled to remain on the premises for more than 24 hours at work, cannot access or purchase a warm meal during their working time. Is the non-facilitation of this service for staff not on the agenda of the hospital Board?

*** Adequate security....**

Still Continues to be lacking for staff. When oh when will the new system be installed? Until then, who watches over us as we walk on the long lonely corridors at night?

*** Parking...**

It has become a sprint to the finish to obtain any sliver of asphalt or grass on which to park at the hospital. (The decorative green spaces are standard slots now!) If snooze you lose, if it rains you are flooded and when the arm frequently malfunctions you are definitely lost.

See the next issue of BAMP Bulletin.....

3rd International Aids Conference

- Washington, June 1-5 1987

The actual Conference was preceded on the night before by a speech by the US President, in which he announced mandatory testing for a number of groups including prisoners and immigrants. There was some hostile reaction to the announcement, including booing at the fund raising event for AIDS research at which the speech was made.

At the opening of the Conference, the Surgeon General who had been clear in his opposition to mandatory testing was given a long ovation by many of the 4000 participants, but did not in anyway challenge the President's announcement. On the other hand, the Vice-president who gave an opening address and rationalised the president's announcement was also booed, by an organised gay group. It was felt that the resources expended on such testing would be put to better use in research and education. This was the somewhat emotive beginning to a very large but successful and informative conference.

Scientific advances have continued particularly by those looking at the behaviour of the HIV virus. Thus it is now known that after the virus enters the T4 helper blood cell, it multiplies, but may lay dormant in the cell for a variable period of time before it exits and infects other cells. It is when it exits from the cell that the cell dies. It appears that this moment of viral exit and cell death is stimulated when the cell gets an immune challenge, in other words, when there is another infection around. The implications are clear for the asymptomatic patient who has the virus – stay away from situations where you can get any infection. Good hygiene, clean sex, and the avoidance of pets and insect bites may well prolong the interval when the carrier may become ill.

The development of illness has been followed in a large group of San Francisco gays who were asymptomatic at the time of the time of the initial finding of sero-positivity. After 7 years (the serum had obtained to look at hepatitis B) 35% of the sero-positives had progressed to AIDS.

In addition it is now known that patients may progress to full blown AIDS without going through the milder ARC.

The development of symptoms appears to be best predicted by the count of the number of T4 helper lymphocytes. In addition the antibodies which are used for detection in screening patients at the moment, and which may be somewhat protective can be cleared by new antigens. In other words persons who are reinfected by continued exposure to the virus are at increased risk for the development of the illness of AIDS.

THE ROLE OF THE MEDIA

In a group largely drawn from the American national press, it was confessed that the media had only used what they had considered acceptable to publish. They had avoided other matters which they had considered taboo, or not newsworthy. The situation is rapidly changing however with taboos of a year or so ago now being acceptable, and a definite attempt to be more balanced.

On the other hand, the media feels that scientists, who hardly ever reflect certainty, are not giving the right messages to the public who wish certainty. It was brought out into the open that the recent media treatment of the possible infection of health personnel through the skin was handled very unprofessionally by the media, for they had not stressed that the practices described were very poor health care practices and should never have occurred even in ordinary care.

In Brazil, it appears that the media had taken the lead in describing 'safer sex', a situation which Government and the church had been reluctant to do, particularly in a predominantly Catholic country and which the American press certainly thought was taboo for them.

Red Cross 'promotions' shown used a good combination of dramatic sequence as well as the information

BASE. However, it was pointed out that much of the material was not geared to ethnic minorities, which indeed had proportionately more infection with HIV.

1987 Epidemiology - The present published figures are as follows:

36,000 cases in North America

5,000 cases in Europe

4,000 cases in Africa

With the large number of researchers in Africa at present, it appears that the figures may not be under reported in any significant way.

AIDS LEGISLATION

Many countries have made the disease notifiable, but there is no evidence that any better control has been achieved by that measure. The debate was certainly stimulated by the announcement by the US administration of mandatory testing for some groups, and this was not well received at the conference.

Justice Kirby from Australia outlined the following principles in looking to any legislation in relation to AIDS. He felt that the law should be used with the following principles in mind:-

- [1] In the interest of prevention (including the use of needles and regulation of sexual activity where appropriate).
- [2] Avoid laws that lead no where
- [3] Design laws that are not discriminatory
- [4] Laws should address local situations
- [5] Avoid the overreach of the criminal law (detention etc.,)

These principles were emphasized in one way or the other by other speakers - thus one quoted a Law Lord in England. "The more the private life is involved, the less the legislator should interfere". There was stress laid on

the point that any testing should be accompanied by laws that ensure confidentiality and prohibit discrimination. It was stressed that in many judicial systems, confidentiality could be overtaken by the use of "laws of necessity", whilst in others there are fiduciary duties that allow third parties to be warned of risks, whilst 'violence' may be interpreted in law as anything doing harm.

Thus it is clear that there are existing legal avenues to protect the unwary and to punish those who would deliberately seek to spread the virus, without adopting new measures which may contravene the principles above.

E. Walrond
Chairman, BAMP TASK FORCE

Attendance at this conference was sponsored by USAID

***Editor's note:** Prof. Walrond was the first Chairman of the BAMP Task Force and was clearly trying to keep members up to date with what was going on. Since then the numbers in the epidemic exploded in Sub-Saharan Africa, and to a lesser extent in the Caribbean. This international conference was not held again in the USA because of the discriminatory travel laws passed by the then USA administration. It is interesting that the phrases 'mandatory' and 'routine testing' are re-emerging with the thinly disguised intent to test persons without their consent. Disguised because we hear the rationale that the person could opt out but that is not what most health care workers understand by mandatory or routine, for these are clearly associated with the idea of doing tests without explicit consent. This is no little matter because we have refused to put non-discriminatory legislation on the books leaving us hamstrung as to how we persuade those who are not yet diagnosed to come anywhere near the health sector. Let us ask ourselves why there is a gap between those known to have AIDS and those who are availing themselves of the treatment available.*



History's Pages

25 years Ago

BARBADOS ASSOCIATION OF MEDICAL PRACTITIONERS

1982.

C/o THE QUEEN ELIZABETH HOSPITAL, MARTINDALES ROAD, ST. MICHAEL.

NEWSLETTER

NO. 40

EDITORIAL

"All You Ever to Wanted To Know About Sex, But Didn't Dare Ask"

It is unfortunate that the "sexual revolution" of the past two decades did little to induce a sense of responsibility about sexual intercourse among those whom it affected. While the distasteful hypocrisy of Victorian sexual mores had to go, the progressive abandonment of restraints has led to a license for sexual activity which, in previous centuries was enjoyed almost exclusively by males.

In those days the number of women involved in multiple sexual liaisons must have been vanishingly small when compared with their male counterparts. With the coming of the "revolution"¹¹ the number of those women has increased dramatically to include the daughters of all social classes as well as the "professionals". Both the potential pool and the opportunity for transmission of the venereal diseases have increased beyond recognition in the past 20 years and their increase certainly explains the greater part of the current epidemics of sexually transmitted diseases.

Homosexuality did not, of course, commence with the "Gay Revolution" of the 1970's. The old Turkish soldiers' song ran "there's a boy across the river with a bottom like a peach; alas, I cannot swim:". Unfortunately, those homosexuals who attempted to learn "all they ever wanted to know about sex" have discovered more than they could possibly have conceived and recent medical publications are just beginning to highlight the frightening complications of this long established practice.

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In the 10 December, 1981, issue of the New England Journal of Medicine two articles reported on the development of acquired cellular immunodeficiency in previously healthy homosexual men who developed pneumocystis carinii pneumonia, mucosal candidiasis and chronic perianal ulcerative herpes simplex lesions.

Further, the June, 1982 issue of the Annals of Internal Medicine carries no less than four articles on medical complications in homosexual men. In addition to the above opportunistic infections, infection with cryptococcus neoformans and cytomegalovirus was recorded. Worse still, Morris et al reported 11 cases of severe autoimmune thrombocytopenic purpura while Triedman-Kien et al reported 19 cases from an "epidemic" of disseminated Kaposits sarcoma in homosexual men. This latter 19 also had an impressive past history of sexually transmitted disease with one or more episodes, of gonorrhea in 16; hepatitis B, 15; syphilis, 14; amebiasis, 12; condyloma acuminata, 8; 'herpes simplex progenitalis, 5; giardia lamblia, 4; and lymphogranuloma, 1. That's more than anyone wants to know about sex!

Morris et al ask "why are sexually active homosexual men developing these disorders of immune regulation?" They answer themselves as follows: "The lifestyle of these persons has changed in the last 10 years leading to greater promiscuity and use of drugs. A long latent period of perhaps, 5 to 10 years many occur before they develop impairment of immune regulation with consequent disease complications, possibly secondary to known or mutant viruses or latent viruses. If true, then physicians will begin to see increasing numbers and forms of clinical disorders developing from impairment of immune regulation in this group of homosexual men.

Clinicians should be alert to the possibility of such epidemics. If one thinks carefully about it, one can explain many of the proscriptions on social behaviour in the Old Testament (from dietary to sexual taboos) in terms of survival value. It has taken modern societies thousands of years first to unlearn and then to relearn the value of those caveats.

Editor's note:

BAMP was certainly on top of the emergent pandemic that would later become familiar as AIDS from the primarily sexually transmitted HIV. Whilst the original articles and the author's views were prescient they fell into the trap of thinking that a clearly sexually transmitted disease would remain confined to homosexual men. BAMP's editor also ensnared himself by going back to the Old Testament for the answers. Religious 'caveats' have never proven effective except for the few, whether it has been not eating the pig to the various sexual 'proscriptions'. Unfortunately, the 'distasteful hypocrisy of Victorian sexual mores' has not gone and is probably the primary reason why a lot of sexually active persons do not heed the advice being given by those they view as hypocritical, for they see the sexual scandals of those in the church revealed on a daily basis. It is even more unfortunate when colleagues who should be dispassionate in their profession, proselytize these Old Testament values leaving in doubt whether our profession is not being hypocritical in its Oath of Professional Fidelity – 'I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient'



THE RIGHT TO DIE

While major political and other battles are currently being fought over the right to life of a developing foetus, there may be an equally strong case to be made for the right of each individual to the most dignified pain free death possible.

All religions have some concept of heaven, although there is no general agreement on the concept of hell. This acknowledges the fact that to date at least, all that lives must die. It is not surprising therefore that modern medical science has concentrated its efforts on prolonging the life of an individual for as long as possible.

The great technological advances of this century have made it necessary to carefully examine the “spinal reflex” of modern medicine to regard every case as a challenge to the available medical and technical skills and the death of the patient to be viewed as a failure of the application of these skills. It is the rather astounding success of our efforts and the rate at which progress is being made, that has combined to provide us with some very difficult ethical problems. Central to the problem is the freedom of the individual or his agents to choose the time and manner of his death.

The problem can be said to follow the King’s instructions to the White Rabbit, and “begin at the beginning” with the birth of a child. The progress made in the relatively new specialty of neonatology has greatly improved the survival rates for the most premature lowest birth weight babies. However, our ability to assess and report the physical and mental outcome of these very low birth weight babies has lagged far behind our ability to resuscitate them.

There is evidence that even premature babies as old as 32 weeks, may develop learning and behavioural problems unless they and the parents are exposed to special, expensive programmes. The lower the birth weight, the higher the possibility of a severe neurological deficit, and there have been few if any studies on the long term outcome of very premature infants, even if they overcome all the attendant severe medical problems and survive into childhood.

Given then the costs of specialised medical care in such infants and the further costs of special care following discharge from hospital, to say nothing of the disruption of family life in the family unit to which these infants are discharged, is there not a strong case to be made for choosing which of these cases should be actively resuscitated? What if the infant should survive despite the absence of resuscitative efforts has not the prognosis been worsened by the absence of early medical intervention?

What about the wishes of the parents? There are indications that doctors perhaps driven by the developing technology are becoming less sensitive to the wishes of the parents. It may not be coincidence that Paediatric Wards the world over have some cases of premature and severely malformed infants who have been abandoned by their parents and have had to be looked after by the state.

At the other end of the age scale, the problem takes on a different face. In the highly industrialised countries the ethics of the decision to die has been brought into prominence with the decline of the nuclear family. The

problem of what to do with the elderly patient who has a terminal illness or has lost touch with the reality of their environment is perhaps just a little more personal as we can all perhaps see ourselves fulfilling that role.

In what could be viewed as an enlightened move, some states in the USA have now permitted doctors to follow the instructions of patients if they are rendered unable to convey them themselves. These instructions, called “Living Wills” as durable power of attorney constitute a legal framework by which the expressed wishes of the patient can be carried out if they are unable to otherwise convey them. The patient’s wishes as regards hospitalization, iv therapy, artificial ventilation, artificial nutrition etc. and the willingness or not to donate their organs and tissues may be quickly carried out. However for these to be effective, they must be readily available and recognized by the appropriate authorities and interpreted as intended by all concerned. Any options detailed in the documents must not be interpreted broadly but in such a manner that always give the patient the benefit of any doubt. Opportunities should be given for patients to suspend the orders if they so desire.

Some states in the USA have also passed a “do not resuscitate” law (DNR) and allowed surrogate choice. A physician can write a DNR order at the surrogate’s request, only when the patient has a terminal condition, is permanently unconscious, resuscitation would be medically futile and where Cardio Pulmonary Resuscitation (CPR) would impose an extraordinary burden on the patient in view of their medical condition and expected outcome. It is of interest that in one study, it is reported that the main reason given by surrogates for choosing DNR was “not to prolong the process of dying”. Further those factors rated “not at all important”, were money, age, fear of pain, fear of residual illness following resuscitation and burden to family. Of interest was that in this study, neither age nor apparent disability appeared to have a major effect in choosing DNR. This reinforces the fact that ‘quality of life’ is an individual sentiment and cannot be predicted by any scientific means.

The very ill are another group of patients who do not necessarily fall into the extremes of age. Illness may arise from severe trauma or other disease process and the issues in these patients relate to the diagnosis of death or irreversible, non recoverable illness and the ethics of the harvesting of organs for transplantation.

As far as the diagnosis of death is concerned, there are two pathophysiological states germane to this condition. They are Brain Death, which is irreversible brain damage where the body can no longer maintain its internal homeostatic function. Such patients are considered legally dead in many countries in the world, and a Persistent Vegetative State. This latter condition results from prolonged hypoxia from cardiac or respiratory arrest for several minutes and results in loss of brain activity at a level higher than the brain stem. The patients’ eyes may open but they are unaware of their environment.

This state takes some time to develop and cannot be diagnosed at the time of the incident. It is these latter patients who provide us with the greatest challenge as they can live for many years in ICU settings with proper care. Considerations then arise as to what is unreasonable medical support. Is the provision of nutrition and hydration through a gastrostomy tube a medical treatment akin to artificial ventilation?

Faced with these problems, physicians may find themselves asking is there an ethical distinction between not starting therapy and withdrawing that therapy once started? Is it better to start a potentially beneficial therapy to assess its real benefit than not to start a therapy for fear of having to remove it?

In Barbados the legal framework to deal with the problems which we have outlined is not yet in place. The matter is however acquiring an increasing need for urgent solutions is becoming more evident daily. When legislation is considered some of the questions that may arise are:

Is there a legal difference between PVS and Brain death?

Has the state a right to assert an unqualified interest in the preservation of human life?

Is not the choice between life and death an extremely personal matter?

How can the state prevent abuse when incompetent patients don't have loved ones to serve as surrogate decision-makers?

Is the state more interested in your life than you or your family? Should families not have the right to decide with the burden of proof be on the state to show that the family is not acting in the best interest of the patient?

Lastly anyone interested in debating the subject of the prolongation of life should be aware of the following:

Sophisticated technology is expensive and reduces available resources.

Where space is finite, priorities must be perused.

Experimentation and experience are a major part of scientific method and therefore scientific progress.

If the goal is the greatest good for the majority, is all life precious?

Editor's note: The principles described in this editorial remain sound. However, from time to time they are challenged, the latest and most egregious example was the Shavaiao case in the United States where extremists under the cloak of 'faith' went to extraordinary lengths to push frightened politicians to deny the right to die in peace and dignity. What is most extraordinary is that such 'life' extremists are prepared to threaten and even take other people's lives in the process of satisfying their 'beliefs'. As mentioned in the editorial, the Laws of Barbados need updating to reflect the human rights accords we are signatory to as well the scientific definition of death that would allow cadaveric transplantation. Unfortunately, there appears to be no political will to drag us into the 21st century.



May 30, 1996

OFFICIAL PRESS RELEASE FOR B.A.M.P.

The Barbados Association of Medical Practitioners feels compelled to respond to two recent articles which appeared in The Nation Newspaper.

The first appeared in the Sunday Sun of May 26, 1996 under the headline, "BLAME THE DOCTORS" - Report on Q.E.H sees Medics as the biggest problem. In our opinion this article constitutes an example of poor and irresponsible journalism. As the article itself, seemed to have hardly any relationship to the headline, yet a cursory glance at it portrayed the impression that the Doctors were responsible for all or the majority of the problems at the Q.E.H.

Indeed we were not as privileged as The Nation, to receive a copy of this "Confidential Report," and certainly thus far, no one has thought it necessary to discuss their findings or concerns with BAMP. Therefore we were very interested in what was said about our members who are employed at the Q.E.H. However our hunger for information was not satiated by a lame front page article that made mention of some nebulous "doctors' hospital," whatever that is? Followed by a paragraph which accused doctors of circumventing and not complying with systems and procedures, but then went on to state that; "it was difficult to identify a single area in the Q.E.H. not plagued with problems of inefficiencies and lack of systems." We can only ask how can one circumvent that which does not exist.

The second article being responded to, appeared in The Daily Nation of May 27, 1996, under the headline; "BACKDOOR PATIENTS." This article was more informative.

Indeed BAMP was of the opinion that since the implementation of the

new Central Admissions System, just over one year ago, that it would be impossible for a patient to be admitted to a ward with nothing more than a letter from a Doctor's private practice.

Certainly the overwhelming evidence is to the contrary.

- Private patients in labour have to submit their slips before admission.
- Patients for minor operations and day-surgery are sent from the Operating Theater Suite to Central Admissions prior to being prepared for their surgery.
- Patients being admitted to the PRIVATE Wards, or their relatives are sent to Central Admissions and the Accounts Department prior to admission.
- Indeed all admissions are required to be registered at the Central Admissions Department, before they are admitted to the relevant wards.
- Ward clerks check daily for private and Category C patients.

As far as the Category C patients are concerned, these pay their doctors but opt to be admitted to the public wards, where they are required to pay \$40.00 a day. Certainly the patient is in the best position to determine if he can pay a doctor's fee and \$40.00 or \$150.00 per day for his hospital bed.

In finding a solution the following will have to be answered:-

1. Are all Barbadians entitled to free hospitalisation if they so desire?
2. Who determines if an individual should use health insurance or not?

3. Who is responsible for ensuring that hospital fees are collected?

In reference to the final paragraph of the article which reads, "such patients are usually admitted to the wards on the basis of a referral letter from their private doctors." We refer you to the Q.E.H. brochure on Referral of Patients (Revised February 1991). Paragraph C, reads as follows - "where admission is being requested the medical practitioner can telephone the relevant duty Registrar, discuss the problem, and if admission is agreed on, the patient can be sent directly to the appropriate ward." Of course the patient or relative is first sent to Central Admission. Indeed BAMP has in its possession a letter from a G.P. who followed this procedure and the patients' relative were told they had to pay, - obviously a misunderstanding of the admission policy.

In closing we hope that the "Confidential Report," has sought also to address the shortage of basic supplies, e.g. hydrogen peroxide solution which some patients are being asked to buy for their dressings even now. There is also the recurring and continued late payment of on-call, overtime and travelling allowances to medical staff, which still needs to be addressed.

We find it distasteful to be discussing the problems of the Q.E.H. in the press, but this is obviously the wish of some person or persons. The Q.E.H. in spite of its shortcomings is still the most important health-care facility in the island and indeed in the Eastern Caribbean, we should therefore try to improve it and not tear it down.

Jerome Walcott MBBS, FRCS
P.R.O. of B.A.M.P.

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IN MEMORIAM

RONALD WILSON – 15 March 1931 to 2 October 2007

After a long illness and one month of hospitalisation, Ronald Wilson, a former member of BAMP died on October 2, 2007 at age seventy-six (76) in the Queen Elizabeth Hospital.

After receiving his secondary school education at the Combermere School and later Harrison College, Ronald travelled to Canada where he was a professional part-time singer, while financing his studies at the Mount Allison University, Nova Scotia where he attained a BSc Degree.

After commencing studies in architecture in Montreal, he changed his career direction and enrolled in the Faculty of Medicine in the University of Montpellier in South France, later transferring to the University of Paris. He spent rotations at the University of Paris Campus in Morocco, including internship and also completed training in surgery at Rabat in Morocco. He subsequently returned to Paris and graduated in Medicine in 1962 and completed his thesis.

Between 1962 and 1965 Ronald worked in London in an effort to gain equivalence for his medical degree and training. He gained further experience in general surgery and especially trauma surgery. After returning to Barbados, he was subsequently employed as a registrar in the department of surgery of the QEH for three (3) years. He then commenced private practice and did surgery at the St Joseph Hospital.

Ronald was also qualified in acupuncture and studied herbal medicine. He had a special interest in sport and sports medicine and served as Chairperson of both the Barbados and Caribbean Amateur Boxing Associations. He also travelled overseas as the team physician for athletes who were on tour representing Barbados. Ronald also qualified in Reiki and completed a diploma in regression therapy.

The Barbados Association of Medical Practitioners extends sincere condolences to Ronald's family and loved ones.

Farewell Ronald and may you Rest In Peace.

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