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Editorial

The Johnston – Kennedy Era.
A Quarter of a Century of Change

The paper by McConville and Crookes[1] in this issue of the Journal highlights the contribution of many Ulster surgeons to gastric surgery. The era of Professor George Johnston and Mr Terence Kennedy produced some of the most dramatic changes in surgery of benign upper GI disease.

I was a medical student, House Officer, Senior House Officer and then Senior Registrar to these giants of Ulster surgery – these questioning surgeons participated in some of the most important trials of that time in gastric surgery, and assessed scientifically (and independently) the benefits of a logical progression in surgical vagotomy from truncal to selective (with the various drainage procedures) to the highly selective procedure. I would like to take you on a thirty year journey of reflection.

THE SURGEONS

I first met Mr (as he was then) George Johnston and Mr Terence Kennedy in the old Wards 15 and 16 in the Royal Victoria Hospital (now demolished)[2] when I was a student. They had strikingly different personalities - Mr Kennedy was more than a little daunting but both were constantly stimulating and renowned teachers. The teaching ward rounds revealed surgical cases in the true sense of the word 'general', ranging from open cholecystectomy to various vagotomies (both de novo and re-do), fundoplications, colectomies, trauma, breast cancer and much more. In terms of trauma, it was the height of 'The Troubles', a curious euphemism for the times. Trauma of every description was present in the ward, but most common were gunshot wounds of the abdomen accompanied, not infrequently, by a police and army guard outside the ward.

Other cases involved jaundiced patients, some having undergone hepatico-jejunostomy for bile duct problems. There was the frequent presence of patients with oesophageal varices with their dramatic haematemeses. The Registrars of the day were held in high esteem and always seemed to be "around". I cannot recall many rotas and certainly no European Directives on working hours! I next met Mr Kennedy when he examined me in Finals. I had a nervous moment or two until we got past the first few minor cases.

Subsequently, I returned as House Officer, Senior House Officer and Senior Registrar and I enjoyed all of these times enormously. At that time, Sister Cherry ran the ward with firmness (and fairness) and the mid-morning cup of tea with the Registrars was a golden opportunity to hear the stories about Consultants of yesteryear and in particular their previous chiefs. Perhaps we have lost something with the new shift systems and less time available for getting to know junior staff, particularly the House Officers.

I recall Mr Kennedy (I still cannot call him by his first name!) permitting me as a Senior Registrar, to do four consecutive highly selective vagotomies on one of his lists. 'The Troubles' were ongoing and, each night, there were several gunshot wounds, usually managed by the Senior Registrars. During this era, Senior Registrars worked a virtual one-in-one rota and gained an enormous amount of experience. Many from this era are now retiring or have already retired!!

In the 1970s and 1980s, honours fell upon these two surgeons, ranging from the Hunterian Professorship (Mr Johnston), to Presidency of the Association of Surgeons (Mr Kennedy). Both men undertook lectures across the world, travelled extensively and became very well known in the surgical fraternity. They each had differing personalities,[1] but worked closely together. Despite frequent leg-pulling and the occasional good humoured "come, come George!" from Mr Kennedy, I never heard a cross word.

Despite their already formidable reputations in portal hypertension, complex biliary surgery, ulcer surgery and revisional gastric surgery, they were innovative and would tackle new procedures. In particular, I recall them working together to do one of the first restorative 'pouch' procedures in Northern Ireland. One compares that new procedure then with the pre-requisite nowadays of intensive courses and prolonged mentoring!

From my student days in Ward 15 and 16, some thirty years ago, my clear recollection is that the students were not a nuisance. Both consultants personally taught junior and final year students, unless either one was on leave. The variety of cases was enormous, encompassing all of general surgery. Being a final year student in the Unit meant being in the ward at night time. Indeed, junior students on their clerkship were also expected to attend the ward at night time to see the incoming emergency cases. At their worst, these cases involved several gunshot wounds per night, in addition to the usual general surgery cases, such as bowel obstruction and the quite common perforated ulcer (usually one per night in this era before Cimetidine).

With the passage of thirty years, there have been many changes. The wide variety of surgery done by one team is gone; units and surgeons are now super-specialised. "General surgery has gone" goes the lament, although there is an

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increasing realism that we still need general and take-in surgeons and the 'wheel' may yet turn full circle.

The European Working Time Directive has brought in shift work, and decreased hours on-call are now the norm, with the corollary of the demise of the 'Senior' Senior (highly experienced) Registrar, who could handle most general surgery, when appointed as a young Consultant.

While the Consultants then also did seem to lament administration, I doubt that there was the volume of paperwork which is part of daily work in 2007. Malpractice work was present in the 1970s, but the volume in the 21st century is clearly enormously increased.

There seemed to be less talk of budgets then. In fact, I remember the notion that one must spend the budget before 31st March each year. GMC inquiries were virtually unheard of. The words "plagiarism in examinations" were never mentioned. A Patient Complaints Officer seemed not to exist.

So was it all better in1970s surgery? (like the warm summer holidays of childhood that one remembers nostalgically through the mists of time?) As Senior Registrars, there was no doubt we gained enormous experience and, in hindsight, (perhaps through the mists of time), it seemed enjoyable, despite the hours on-call. We had continuity of care and continuity of patient experience. However, the training programme was long and there was an excess of junior surgeons whose average age to be appointed a Consultant was late thirties.

And finally, perhaps the biggest change of all is that the Province is now a quiet and better place, as 'The Troubles' are fading.

Furthermore, many lessons have been learned from the 1970s, such as titanium plates in neurosurgery following gunshot wounds to the head, vascular trauma repairs using stents to maintain blood flow and the fact that we now work in multidisciplinary teams. These are but some of the lessons. There are many more.

In conclusion, a generation of surgeons, myself included, consider it a privilege to have been taught by two giants of Ulster surgery, one a home-grown star, Professor George Johnston, and one an adopted Ulsterman, Mr (I still cannot call him Terence!) Kennedy. Both were world-renowned surgeons but I think both would agree with John Hood[3] in his oration who quoted from Sir Isaac Newton: "If I have seen further, it is because I stand on the shoulders of those giants who have gone before."

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3. Hood J. If I can see so far. *Ulster Med J* 2005;**74(1)**:33-42.

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