An interesting life

AOIFE MORRIS spoke to Mr Harold Browne about his career as a surgeon and anatomist.

As a witness to the vast changes in the medical and surgical professions, and indeed the RCSI, there are few who have seen more than Mr Harold Browne. Many will know and remember Mr Browne from their days in the Anatomy Room, where he has been teaching since 1953. His enthusiasm and witty approach has instilled a respect, if not a love, for the subject in many of his students.

When I came here, in late 1953, the teaching of anatomy was somewhat unstructured.

A light approach

Mr Browne has honed his approach to lecturing over the years. "Anatomy is a rather dull subject; basically, you must enlighten the atmosphere with a few risqué stories, if you don't mind me saying so. You need to spice it up, make it interesting by talking about the pathology, the surgical and medical aspects. That's the way I teach anatomy, and did teach it then." Indeed, any RCSI student will know that, "as Moses led the Jews to the Promised Land, the gubernaculum leads the testes to the promised land of the scrotum".

Humour aside, Mr Browne is well aware of the challenges that anatomy can pose to the new medical student, particularly where the modern curriculum is concerned. "I feel, now that I'm at the end of my teaching career, that students are taught too much detailed anatomy. One forgets anatomy very quickly; personally I forget anatomy at times. It is necessary to refer to the books periodically. We often have discussions here [in the Surgeon Prosector's Room] on the finer points of anatomy… no doubt we should make allowances for students learning such detailed material. If one teaches them solid, basic anatomy, they'll remember it."

Teaching anatomy has evolved a great deal while Mr Browne has been at the RCSI. "When I came here, in late 1953, the teaching of anatomy was somewhat unstructured. There were no organised designated tables like today, but we still taught basic anatomy and I used to give lectures on standard and applied anatomy. Of course, we had demonstrations as they exist today, but there weren't as many students as there are today."

A distinguished faculty

Mr Browne has personally witnessed the contribution and legacy of many professors of anatomy. When he first started teaching, Gilbert Marshall Irvine was Professor of Anatomy, assisted by Mr

Tom Garry "who could be quite eccentric at times, and is alleged to have stated that only one person knew more anatomy than him … and that was God!" Professor Irvine was then succeeded by Professor Rooney. "In their time, Professors Irvine and Rooney, and Mr Garry, made great contributions to the progress of anatomy in the RCSI."

"In 1987, Professor [Stanley] Monkhouse reorganised the whole system of teaching. He initiated the table teaching, allotting one demonstrator to each two tables. He wrote the two reference books on anatomy, one for the first and one for the second years, with directions and questions on the day's anatomy, and then specimen questions at the end of each topic. They really are most beneficial. Professor Monkhouse also spent a lot of time in the Anatomy Room and had great empathy with the students. I should also state that Professor Monkhouse wrote an anatomy book for students."

When Professor Monkhouse made a career change, he was succeeded by Professor Clive Lee. "He too has made a marvellous contribution to the Anatomy Department. He has developed and established an extensive research department, with their main research on stress in bones. Not alone has he himself obtained a PhD for his own work in this specialty; he has a large staff and, more recently, three of his graduates have obtained PhDs for their work with him.

Professor Lee has recently introduced a dissection programme for students, and Professor Harold Ellis of Cambridge is a great advocate of this system."

Today, Mr Browne lectures and demonstrates as part of a team of surgeon prosectors. "As a group of retired consultants, we bring a great skill mix to the department, which we understand, going by end-of-term evaluations, is very much appreciated by the students."

"In their time, Professors Irvine and Rooney, and Mr Garry, made great contributions to the progress of anatomy in the RCSI."

Bodies of work

One constant during Mr Browne's teaching tenure has been the use of cadavers for dissection. "I don't believe one can learn anatomy from plastic specimens. One cannot beat hands-on. I presume there may come a time when the supply of cadavers may diminish and we may have to rely on plastic specimens, but as long as the supply lasts, I will be a great advocate of the use of cadavers. It's the same with bones; I dislike these artificial bones – they just don't have the same detail. One sees a lot of congenital abnormalities with the use of cadavers; ductus arteriosus, abnormalities of arteries, the bile ducts, the renal vascular supply, the ureters, horseshoe kidney. Plastic models can never resemble accurately the human body and its great detail."

Changing times

The number of students passing through the Anatomy Room has increased significantly over the years. "When I returned in 1987 [after he retired], there were only about 90 students in a class, as compared to the present when there are about 285. There were also three distinct groups: Irish one-third, Third World countries one-third and a middle group of Americans, Canadians, English and Scandinavians." Similarly, when it comes to the number of women, Mr Browne notes that "it has changed very significantly. In my time, when I qualified from UCD [in 1946], it would have been the same proportion [as it was] here. I think it would have been about 70:30 [male: female], if not more".

"I feel, now that I'm at the end of my teaching career, that students are taught too much detailed anatomy. One forgets anatomy very quickly."

Some of his more fundamentalist mentors and colleagues may have theorised that the growing numbers of women entering surgical specialties will have a negative impact on the previously male-dominated arena, but Mr Browne is convinced otherwise. "A few of my female registrars are now surgeons and I know three, in particular, who are first-class surgeons. They are well able to hold their own, I can tell you. In my time, surgery of all types was purely a male-dominated specialty. I remember there was a famous surgeon I worked with one time and he said to me: 'I shouldn't be stitching this wound, the nurse here beside me is a much better seamstress than I!'"

Career and education

Mr Browne undertook a fellowship in general surgery at the Mayo Clinic, and was awarded an MS degree by the University of Minnesota in 1953. "I spent four years there and my knowledge and technique of surgery was greatly enhanced. During that time I did general surgery and orthopaedics followed by six months of pathology, which was a great advantage to my surgical career. There were 23 operating theatres at St Mary's Hospital (one of the three hospitals which make up the integrated centre that is the Mayo Clinic), and all the specimens following the surgeries of the day were laid out on tables in the pathology department. There was a lunch hour session given by Dr Docherty, who was a Canadian, and he gave expert teaching, grossly and microscopically, on all these various specimens. He was a marvellous teacher. I always remember that 'common diseases are common!'"

Considering the wealth of his own experience, he is a strong advocate of training overseas. "There was a huge volume of patients and the first day I worked with a very urbane man, Dr Gray, he did six partial gastrectomies. You wouldn't see six partial gastrectomies here in 12 weeks. Ireland has a small population and there's just not the volume here to learn all the techniques. It is mandatory that trainees should go abroad to these centres of excellence, not only in

America, but also Australia, Canada, the UK and Europe, and one must spend at least two or three years there." On his return to Ireland, Mr Browne was a consultant surgeon in The Richmond Hospital. He practised there for 32 years, retiring in 1987. Surgery, in practice, was quite different during Mr Browne's career. "There were very few specialists in those days. I did renal surgery, neck surgery, gastric and colon surgery. I had to do a lot of orthopaedic surgery because there would be no orthopaedic surgeon available in our hospital. The interns and students who worked with us got a tremendous all-round experience. Students today are with consultants who are all very specialised; they just don't get that all-round education that the students did in my time."

Surgical challenges

Mr Browne considers the specialisation of surgeons to be one of the greatest challenges to our generation. He is optimistic about the improved patient care pathways that are part of specialist centres or 'centres of excellence', but is cautionary at the same time. "Specialisation has demanded a new population of specialists. In ways, it is good for the profession, because one can't be generalised in everything, one can't be good at everything, and it's certainly better for the patients." Mr Browne does not like the term 'centre of excellence', though, having worked in such centres where patients still died. From his experience, they will improve baseline standards of care because of the large volumes of patients being treated. He does, however, lament the demise of the generalist. "It is better to have specialists, but not too specialised. In those days, we had general surgeons and general physicians; they're now a dying breed. It's a pity really."

The finely-honed clinical skills and surgical techniques that Mr Browne would have used on a daily basis have been largely replaced by more technologically advanced investigations and minimally invasive procedures. "When I was a surgeon, it was purely clinical. One took a very careful history, carried out a hands-on examination of the patient, and ordered the appropriate x-rays. There were none of these CT scans or MRIs until late in my career. One depended on the radiologist to show one barium x-rays of the gastrointestinal tract, or whatever one was concerned with. Laparoscopic surgery came in after my time. I often wonder why one should do laparoscopic hernia operations when it's a beautiful anatomical operation by open surgery. One of the great successes of laparoscopic surgery is the laparoscopic cholecystectomy. Professor David Bouchier Hayes performed the first such operation in Ireland and it has been extended to many other fields of surgery. I can't comment on laparoscopic surgery; I've my own views about it but it certainly is the practice of today."

Other issues

Patients, too, play a different role in healthcare today, becoming more involved in their own management. Patient autonomy, however, is a double-edged sword; Ireland has seen a sharp increase in litigation and malpractice suits in recent years. With increased patient consultation and input, it seems that there are often unrealistic expectations from the patients despite the best efforts of their doctors. Mr Browne observed this trend as his own career progressed. "I was a Governor of the American College of Surgeons for six years, way back in the eighties, and we met every year at the American College of Surgeons Meeting. At one session, there were a hundred governors in the room and they asked anyone who had been sued to put their hands up and 80% put their hands up. I didn't put my hand up and they said: 'Why didn't you put your hand up?' and I said: 'I've never been sued'. To this, another doctor remarked: 'If you haven't been sued at least three times, you're not doing your operations properly!' Now litigation in Ireland has increased markedly, it's caught up with America. Surgeons here are very conscious of the fact. Some people are of the opinion that litigation makes surgeons more accountable. I feel it has potentially destroyed the patient–doctor relationship."

"There were very few specialists in those days. I did renal surgery, neck surgery, gastric and colon surgery. I had to do a lot of orthopaedic surgery because there would be no orthopaedic surgeon available in our hospital."

The administration of hospitals and consultants has been revolutionised but, in Mr Browne's opinion, not for the better: "In the present system, I feel that consultants have lost the influence we had when I was a surgeon. We participated in the boards of the hospital; we had a great input into the running of the hospital. From a satisfaction point of view, I feel that consultants today are not in charge of their own destiny. The system at present, in my opinion, is very unsatisfactory, despite the highly skilled doctors. They just do not have enough resources to care for their patients. For example, accident and emergency remains seriously overcrowded on a daily basis, a percentage of elective surgery is cancelled daily and lengthy waiting lists still exist. Despite the funding of the system, medicine is a well with no bottom to it".

As we sat down to chat in July 2009, 'The System' had just given us the Blasphemy Act, quite the source of bemusement to Mr Browne: "Does it mean we're not allowed curse anymore?" At this stage in the game, Mr Browne has truly seen it all. From UCD to the Mayo Clinic, to the RCSI and the Richmond, a Fellow of the American College of Surgeons, a former president of the Medical Council, an Honorary Fellow of the RCSI, a Recipient of the College Medal, an eponymous lecture theatre in the hallowed halls of the Department of Anatomy … as he says himself, professionally and personally, he's had an interesting life.

Acknowledgements

The author would like to thank Mr Browne for his time and insights, and Ms Amanda Campbell and Mrs Vivienne Nash Browne for their assistance in completing this article.