Editorial

THE ANNUAL GENERAL MEETING - 2005

First the good news, the BAMP dinner was well attended and the guest speaker Sir George Alleyne, gave a memorable address which is reproduced in this edition of the Bulletin; Dr. Carol Jacobs received the BAMP's award for excellence; the CME was well attended and Mr. Kerrie Symmonds address on the CSME excited interest and a number of comments.

The bad news is that the AGM was again unable to raise a quorum and had to be adjourned and held as a special meeting when the quorum could be abandoned. Nevertheless, we must congratulate Mr. Selwyn Ferdinand on being elected as president of the association and wish him and the new council well in tackling the problems that the association faces. Some of the problems seem to surface every year without any apparent change. We must also thank the members of the association who have agreed to serve as members of council in the face of seeming apathy for the task.

BAMP's President 2005 - 6

Mr. Selwyn Ferdinand
MBBS UWI, FRCS
Consultant Surgeon, Queen Elizabeth Hospital

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Sir George's address challenged the association to get involved in issues of medical importance in the community, and not to confine itself to the personal interests of its members. In particular he raised the apparent silence of the association on the 'Walrond Report ' on the Legal, Ethical and Socio-economic issues related to HIV/AIDS in Barbados. It must be recalled that the association has had the report for comment from August 2004 and is yet to respond. Sir George may have tried to pre-empt a possible response by declaring his support for the recommendations in the report and in particular he singled out those areas of controversy such as condoms in prison, decriminalisation of homosexuality, and providing health professionals with the legal cover to treat sexually active children when it is clear that their parents are exercising little responsibility or control.

Sir George is right; BAMP cannot hope to obtain respect within the profession, and certainly not within the community if it is seen as having no view on medical matters of importance. For the council to hide behind a notion that there is no unanimity of view on any issue simply demonstrates weakness and an inability to lead. Leadership involves making decisions and guiding one's members and the public on a path of improvement. This will involve disagreements with some members, even some members of council. To do nothing on important issues is much worse than to disagree or to say when issues need further study or discussion. Meanwhile, BAMP is seen as an effete organisation that will probably continue to be asked for an opinion on issues as a kind of pro-forma, but no response will be expected or taken account of. This is already coming to pass when BAMP was asked for 'an opinion' on a proposal on the internship requirements for doctors that has already been implemented, and was written in late May on a proposal to be implemented in July which would involve doctors working for three years in the public service before being allowed to do 'independent practise'.

The reports from the officers of BAMP reproduced in this issue express some of the frustration that they face. Let us hope that the new council will be able to move systematically to tackle some of the issues expressed and not hear the same negatives expressed year after year, for there is little doubt that for members to pay their dues and to turn up to meetings there needs to be something positive in the life of BAMP.

Justice and the
MEDICAL PROFESSION

There was great unease felt by many in the profession when a charge of murder was brought against a well known member of the profession in a neighboring country, and to recall that other serious charges have been made against members of the profession in various countries. It is of even greater concern when such damning charges are brought and widely publicized, but there is no evidence to support the charges; and in one instance here in Barbados, no evidence was led at all after a member of the profession was arrested on the charge of manslaughter in relation to the death of a patient. Although we cannot say that members of the profession can do no wrong we, like any other citizen, should not be accused capriciously of serious crime, for it is a crime in itself to damage the reputation on which one's livelihood depends.

One is very aware that members of the profession are not immune to committing crime and there have been convictions of doctors abroad and in the region for serious crimes. Indeed there is a concern that we may register doctors to practise in this country who may have committed crimes elsewhere. However, the situation that one sees evolving suggests there is a callousness about the reputation of individuals brought up on such serious charges and by extension callousness about the profession as a whole. In every situation of justice or injustice one must look at both sides, and there is no doubt that in many countries the medical profession, and the surgical disciplines in particular, appear to be on a collision path with the legal system. Thus, we are constantly reminded of the malpractice insurance crisis in the United States, where some doctors in obstetrics, orthopaedics, neurosurgery and in plastic surgery pay more in insurance premiums than the yearly earnings of some of their colleagues. We are told by our professional insurance body here in the Caribbean that the premiums for specialists are higher than they would be because they include the rates of those specialists with higher risks.

Whilst we know some of the malpractice crisis is the result of 'ambulance chasing', and the culture of digging into the perceived deep pockets of doctors and insurance companies, there is also a perception that doctors have become the mere merchants of services and as such the services, like our shirts, should be without flaw when they are bought. But there is also the knowledge in some political and legal circles that in spite of the blows being dealt out to members of the profession that most doctors maintain the trust of most of their patients and they are those in those circles who feel that the profession must be taken down a peg or two. Of course, some of the attacks come from jealousies and rivalries within the profession itself, for some within the profession feel that to enhance their reputation they must pull at that of others.

To combat this dangerous trend our profession must not be seen to be simply self serving, erecting temples for the well to do, one must show whenever possible that selfless service to the public which many members of our profession employ. Such service must be expressed through reasoned judgment, and avoiding cacophony and bombast. But we must not shrink away from the correction of professional misconduct among our colleagues and we should give fair and balanced professional opinions when asked about the conduct of colleagues in matters before the courts or other regulatory bodies. We should not be reluctant to give an opinion on the conduct of a colleague and say when that conduct has been entirely proper or otherwise, for an expert opinion should be based on the facts, not tailored to make a case for one or the other.

Our indemnity insurance company constantly reminds us that the best defense against an accusation is to keep good records, particularly when they are difficult or complicated problems. Your records should not only be in relation to what is found or done but what is said to patients. Do not be reluctant to say to patients that you do not know, or that you are not certain, or that things can go wrong in spite of your best efforts. Do not be afraid to ask for or offer second opinions, for the greatest privilege of the profession is that one is not liable simply because something has gone wrong. Liability comes when one has not explained adequately to the patient what is being done, what problems can occur, and it comes when you stray outside the standards set by your professional group.

Feature Address at the BAMP Dinner May 2005

Sir George A. O. Alleyne
Chancellor, University of the West Indies

The evidence is clear that there is a health benefit to making condoms available to Prisoners; the World Health Organization has gone on record many years ago as endorsing this means of preventing the spread of the disease.

Let me thank you for the invitation to your annual dinner and the opportunity to address you as well. It is not often that one has the opportunity to speak to one's peers in a setting such as this. I enjoy speaking to groups of physicians and have been fortunate enough to do so in many of the Caribbean countries. I confess to being chagrined sometimes that my audience remembers the stories I have told rather than my comments about some of the more important issues of the day. But I suppose as the night goes on- as it tends to do at occasions like these, there is less tolerance for profound reflections if they are not accompanied by comments on some of the less serious aspects of our lives. However, I do regret sometimes that my change in status over the years and the risk that what I say will be recorded and appear in print have very often inhibited my natural tendency to share some of the stories which I would not like to see attributed to a Chancellor of my university. These would be stories that Princess Alice, our first Chancellor would not have even heard of as I doubt that English royalty knows anything about the likes of medical smokers or the markets and bars of Papine.

The tradition of banquets and dinners of the professional guilds is an old one and indeed some of the guilds today exist almost for the sole purpose of banqueting, but I suppose that is normal, because if guilds are like humans, as they get older they and their members are more conscious that food and wine are still two of the very few real pleasures left to man. I admit that I like the idea that our profession still has many of the better characteristics of a guild. The medieval guilds had the notion of equality among their members, pride in their profession and responsibility for self government and regulation.

Guilds thrive on tradition and symbolism. They should therefore be committed to having the lore of the profession transmitted by their own griots and it does not matter that many of these stories are embellished to show the guild in a light that was not evident to the younger members at the time. For these younger members will themselves grow into their own stories and create their part of the ongoing tradition. So it does my heart good to see here tonight a mixture of the veterans and the youngsters and by youngsters I mean all those under the age of fifty. Of course, the ages and stages of man are marked by things other than numbers.

So let me claim the privilege of my advanced stage of membership in this guild to reflect first on the people and places that have made me what I am and then on some of the issues that concern me because of what I now do. This evening

Editor's note: Sir George A. O. Alleyne, Chancellor, University of the West Indies. Former Director of the Pan American Health Organisation.

it is natural to think of the time of my professional life that I spent here in Barbados as a hard working medical officer. When I got married many moons ago, I envisaged that my wife and I would travel to our places of work and study together. That almost fell apart as we prepared to come to Barbados in January 1960. The story of how I almost contributed to her early demise before we reached here is a proof of the motto that the physician who treats himself or his spouse has an ass for a doctor and a fool for a patient.

…governments like all public institutions are very impersonal organizations. They have nothing against you, but they have nothing for you".

We did get to Barbados a month late and I recall vividly reporting for work to Dr. Maurice Byer, who was then Chief Medical Officer and is probably the father of public health in Barbados. He greeted me, sat me down and listened to my ideas of what I would like to do and the role I thought the Government of Barbados might play in my further development. He wished me well during what he hoped would be a long stay in the government service and then gave me a piece of advice that has stuck with me and whose salience I have appreciated more and more over the years. He said, "Dr. Alleyne, remember this, governments like all public institutions are very impersonal organizations. They have nothing against you, but they have nothing for you". I have spent all my life in public institutions and as over the years I got to learn more about organizational theory and behavior, the more I have appreciated the wisdom of that advice. I recall it when I hear individuals rail against the government or the University for not addressing some personal want.

I remember with fondness the tutelage of Harold Forde who for me was one of the kindest and gentlest of physicians, who taught me more about medicine than the elucidation of physical signs and symptoms. He had an uncanny sense of the nature of illness and the meaning of what it was to be well. He was firm in his principles, he would not be disrespected and let his displeasure be known when that occurred, but none of this dimmed his adherence to the finest canons of medical ethics in the Hippocratic tradition. Sometimes his caring elicited unsuspected responses, but that is another story.

No one who worked here in the old Barbados General Hospital could have survived without the help of an incredibly competent nursing staff. Ladies such as Sisters Crane, Hamblyn, Husbands and Matron Walters were as much teachers of doctors as they were of nurses. Sister Crane who was my ward sister, could draw blood from a stone if it had a vein.

Those were days when there were only six medical officers for the whole hospital and when your turn came to work in Casualty at night, it was almost literally you alone and God. You will of course realize that what I now look back upon with fondness and nostalgia could not have been ideal for patient care, and there are several incidents that on reflection should not have occurred. This makes the point that the good old days were perhaps not so good after all. But on the positive side, I accumulated a wealth of experience that put me way ahead of many of my peers when I went to London for postgraduate study.

…the guild should concentrate not only on the betterment of and protection of the profession, but should also assume the responsibility to improve the systems of health care.

But let me return to the concept of the medical professional guild. In reading about the medieval guilds, I came across a description of the "Death of the Guilds" in which the author describes the four elements that were crucial to guild power. These were control over who could become and remain a craftsman, control over the work place, control over the market and control over the state itself in that it almost exacted from the state its really vast powers. It was partly because the professional guilds sought to maintain these powers to the detriment of the public good that they fell somewhat into disrepute. I also read an interesting paper by the President of the Institute for Healthcare Improvement who raised the question

whether medical associations were guilds or leaders. He put forward the view that the guild should concentrate not only on the betterment of and protection of the profession, but should also assume the responsibility to improve the systems of health care. He refers to medical associations leading socially responsive improvements in health care and insisting on strategies to improve quality.

I wish to take this further and posit that the guild has to take responsibility not only for individual care, not only for the sick individual but also for the sick populations; not only for the health of individuals, but also for the health of populations. The guild should accept some responsibility for the public good. These are concerns that might be considered as falling within the realm of public health.

I confess that at the time I worked here I thought little about public health. The image I had of the ideal physician was one who cured or cared for the individual. My good friend Kenneth Standard, who had completed his training in public health with distinction, was then Medical Officer at the Six Cross Roads Health Center and was making a name for himself in terms of outreach to the community. We would discuss the two branches of medicine as if they were separate and never the twain should meet.

Because of the Scottish tradition of the first Professor of Medicine, Eric Cruickshank, we were taught of the influence of the environmental and social factors on individual health and illness. But I had no real concept of public health in the sense of the health of the population as a whole. After all one could not elicit a Babinski reflex from a population; populations did not have disturbances of electrolyte metabolism or abnormal urea to creatinine ratios. And it was not that I did not have inducements to change my opinion.

The idea or opportunity to affect the lives of more than one person and the belief that health had to have a role beyond medicine were perhaps the factors that led me to join the Pan American Health Organization. But it was Geoffrey Rose who really crystallized for me the importance of the difference between sick individuals and sick populations. His 1985 classic by that name has to be one of the most important papers ever published. He showed how the cause of cases differed from the determinants of incidence in a population. The most ambitious application of the second concept is in the attempts to change societal norms of behavior.

There is no doubt at all that the major problems that affect and will affect medical thinking and practice in Barbados and the Caribbean have to be seen not only in terms of the sick individual, but also in terms of the health of the populations. I have been privileged to chair the Commission on Health and Development that was established by the Heads of Government recently and we are clear that the Caribbean has to face squarely the mega problems that are a product of three factors. The first is the health transition that results from the demographic shift; the second is the result of globalization which brings with it the influence of vectors of various kinds. The vector of propaganda is inducing our people into life styles that are fairly new to us. Another vector is the human one which brings new infectious diseases. The third factor is the social fracture or the decline of our social capital. Thus we have to confront the modern epidemic of obesity and its co-morbidities such as cardiovascular disease and diabetes. The infectious disease that concerns us most now is HIV/AIDS. The result of the social fracturing is the epidemic of injuries and violence. Perhaps for completeness I should add the mental illnesses, but these do not represent a new phenomenon or an escalating problem-at least I do not have evidence of such.

We have a responsibility to address the issue of AIDS, and not only from the point of view of the individual case.

If we are faithful to the basic tenets of our guild and have progressed conceptually to care for the public good, then we must be concerned about the societal conditions that influence the public's health. If we are true professionals then we owe it to the public to be concerned for its health. I will not dispute the claim of those who say that the body public is made up of individuals and the personal care physician is therefore doing his or her part to care for the public's health. But I believe that as a

group, our responsibility goes beyond that and we should articulate a position on how those societal influences on the public's health should be addressed. For example, we have the responsibility to say that the epidemic of obesity must be confronted and dealt with aggressively and of course we should set an example ourselves.

We have a responsibility to address the issue of AIDS, and not only from the point of view of the individual case. I have become very involved in the issue of AIDS in the Caribbean and wish to see more hands on deck and involved in the struggle. The situation locally and globally is a serious one and men and women of good will as well as their associations cannot stand aside and watch. As Dante wrote "The hottest place in hell is reserved for those who remain neutral in times of great moral crisis".

It is hedged around with a fence of political, legal, ethical and social thorns and I have been impressed by the depth and quality of the report prepared by Professor Walrond to address some of these.

There is considerable debate and discussion over how this epidemic should be addressed and indeed Barbados is often cited as an example of a vigorous, successful program. Those who are involved should feel proud of the success to date. Perhaps this is one of the reasons, in addition to her own considerable professional and personal qualities that led to Dr. Carol Jacobs' election as Chair of the Global Fund for AIDS, Tuberculosis and Malaria. I congratulate her here publicly and I should hope that your Association has recognized the significance of her preferment.

The cocktail of sex, religion, blood and money is a potent brew for stirring emotions around this epidemic that is like no other of modern times. It is hedged around with a fence of political, legal, ethical and social thorns and I have been impressed by the depth and quality of the report prepared by Professor Walrond to address some of these. I wish to congratulate him, as it has taken a considerable amount of courage to write objectively about many of these sensitive matters. I have followed some of the debate in the press and read some of the correspondence that seeks to vilify him. I may have missed it, but I have yet to see the position that your Association has taken on this Report. I would have thought for reasons of solidarity if nothing else, but more importantly because of professional responsibility you would have entered the lists. If there are differences of opinion, as there must be, then let the thousand flowers of opinion bloom, but be not silent.

Silence cannot be caused by doubt about the evidence adduced to buttress the positions he takes. This is not the place to expand on the Report, but I believe that it can evoke a reaction at the level of the individual and at the level of the Association as such. I recognize that individuals will have the right to express their own free conscience that is enshrined in our constitution and hold views that are a result of their religious and moral value systems. But I believe that as a guild with the public good at heart, there is room for a corporate position, and of course you will have to judge whether the individual preferences, if there are minority ones should determine the corporate public persona.

…is it too much to hope that the notion of fairness and abhorrence for discrimination might stir a good guild to support the need for these issues to be addressed by legislation?

I will refer briefly to some of the main issues addressed in Professor Walrond's Report. There can be no debate about the responsibility of the individual physician to offer care and support to ill patients without discrimination. This has been one of the canons of our profession that must have been laid down by Iminotep our father. The issue of encouraging testing for HIV is patently in the public interest and every professional body should support it. There can be no debate about the sacred nature of the pact of confidentiality that must exist between the physician and those who come to seek our

help. It is possible that a medical professional body might recuse itself from giving an opinion about the issues of testing for immigration purposes and screening for employment. But is it too much to hope that the notion of fairness and abhorrence for discrimination might stir a good guild to support the need for these issues to be addressed by legislation?

But the part of the Report that seems to have attracted most of the public debate, especially recently, is on HIV transmission in criminal settings and especially the notion of making condoms available in prisons. Let me clear that I support fully his position that condoms should be made available to persons in correctional facilities. I appreciate that there may be legal reasons that seem to prevent this. But given the clear and present danger to the public's health I cannot imagine that it should be beyond our genius to find a way through or around this apparent impediment. The evidence is clear that there is a health benefit to making condoms available to this population; the World Health Organization has gone on record many years ago as endorsing this means of preventing the spread of the disease. Why should there be acceptance of the ABC of AIDS prevention that has been shown to be effective and deny any population access to the C part of that trio.

I wish King Charles II were with us today. It was he who asked the Earl of Condom to find a method to prevent him from contracting syphilis. The story goes that the Earl used sheep intestine to prepare the condom that therefore has a royal pedigree. History does not record if the monarch avoided the spirochete, but we do know that he had 14 illegitimate children. Perhaps he was selective in its use.

…if we believe that popular perception is inimical to the good of the public's health, then there is a responsibility to enter the debate and try to change it.

It is not only on the use of condoms that men and women of good will should speak up if they do see themselves having some responsibility for the good of the public's health. Everyone here knows that the stain of stigma and the consequent discrimination are driving the AIDS epidemic underground and making a genuine population health approach difficult. We need individuals of influence to enter the debate and invoke the spirit of charity in dealing with others who are different by way of sexual orientation. We in health today have viewed with repulsion the atrocities committed against other human beings because they were perceived as being different. Surely that same spirit should inform our position on the stigma and discrimination that attends HIV/AIDS and is especially vicious against those who are homosexual. There is a feeling in some quarters that these matters should be legislated by the state and Professor Walrond points out the possible changes in the legislation. This is all well and good, but in many matters the state or rather the executive and legislative branches of the state follow the popular perceptions. Thus, if we believe that popular perception is inimical to the good of the public's health, then there is a responsibility to enter the debate and try to change it. There are numerous examples in history of the extent to which popular perception was not in the interest of all the people.

Mr. President, I know I have touched on sensitive issues, but I claim the privilege of age, a fairly intimate knowledge of the health problems of our part of the world and a firm and unshakeable conviction of the nobility of our profession. It is our professionalism that calls on us to be concerned about the public that has accorded us the status of professionals and rewards us for it. That nobility been expressed in many ways and in many places over the years and I have no doubt that it will continue to be expressed in the Barbados Association of Medical Practitioners for generations to come. You will have your griots speak of these as the good old days and the problems will be seen through lenses that are increasingly rose tinted and I am sure that neither you nor the members of your Association will find yourselves in those hot places to which Dante referred.

I wish you and your Association well.

The Annual General Meeting

BUSINESS 2005

THE COUNCIL 2005-6

Mr. Selwyn Ferdinand	President
Dr. Adrian Waterman	1st Vice President
Dr. Opal Gibson	2nd Vice President
Dr. Geoffrey Lafond	General Secretary
Dr. Vikash Chatrani	Assistant General Secretary
Mr. Haresh Thani	Treasurer
Dr. Anne Carter	Public Relations Officer
Dr. Bamidele Babalola	Floor Member
Dr. Michael Hoyos	Floor Member
Dr. Karen Springer	Floor Member
Prof. the Hon. Errol R. Walrond	Floor Member

CHAIRMEN OF STANDING COMMITTEES

Building and Maintenance:	*Mr Haresh Thani*
Bulletin:	*Prof the Hon Errol Walrond*
Ethics and Complaints:	*Prof the Hon Errol Walrond*
Finance and Membership:	*Mr Haresh Thani*
Public Relations & Health Education:	*Dr Anne Carter*
Web Page:	*Dr Geoffrey Lafond*

President's

REPORT

Dr. Dave Padmore

Colleagues, thank you for the honour and privilege of serving for another year as President of this esteemed organization. Sadly, for largely personal reasons, I must decline to seek re-election. I say sadly, because there is still much to be done. In any case, I plan to continue serving the cause of BAMP, as long as I am here in Barbados and God gives me the strength – a little less intensely; but no less loyally.

I believe I learnt a lot during the past two years. That was in no small part to the excellent Executive Council. All very busy people, they found time to attend Council meetings, helped me represent this body at meetings with Government and Civil Society, and made some tough decisions. The presence of a well-balanced mix of ages and genders, helped illuminate issues from all sides, personally enhancing my learning experience. I want to specially thank those senior members who return to serve on Council, and who continue to pass on the knowledge derived from the experiences you have gained.

However, all is not rosy in our little world. BAMP is at a serious crossroads, if not at the top of a cliff. As noted by our previous treasurer in his 2004 address, the inter-related problems of a shrinking membership and a further decline in our revenue streams continue to plague us and threaten to strangle BAMP. Since the accusation noted in previous business reports that BAMP is a 'crisis' organization, I believe the likely diagnosis is apathy. Either we are too comfortable to respond to calls to meet or give input via correspondence, or we are so beaten that we have given up the fight. I believe that Barbados needs us to revitalize ourselves as it sails into uncertain waters.

I will report my perspective on our activities this past year. As is customary, I will delineate and itemize for clarity.

MEMBERS' GROUP BENEFITS

In the face of rising premiums, Council opted to 'shop around' in the market place in hopes of getting a better deal. In my continued efforts to utilize external service providers to lighten our burden, I turned to Insurance brokers. A process was started by Field Insurance Brokers, who made a partial presentation in February 2005, after having the project in hand since June/July 2004.

The main result was an offer by Sagicor to split our group into higher cost/higher benefit and lower cost/lower benefit strata. It is hoped that this might stimulate interest amongst our younger members to join the plan. An offer by NemCare (now Brydens) for a competing plan was presented by their Manager, Mr Derrick Garrett, which matched in some areas, but overall did not beat our old plan. We requested a two-tier plan from him to allow us to compare apples to apples. If this is not done, then Sagicor's two-tier plan will be circulated for members' opinion/approval.

Our relationship with MPS continues to be good. In fact, as other income sources diminish, our handling fees from MPS increase in relative importance to our bottom line.

Disability Insurance Plans and Funds were considered during this year as well. No real progress was made. Our group is too small to make a group disability plan worthwhile. Council would need further direction as to whether or not a group fund is suitable, what type and fund governance systems to be used.

BAMP BULLETIN

After a year of renewed life and hope for the Bulletin, in 2004-2005 its vital signs deteriorated to now critical levels. The editor, Prof Walrond, and Council have pleaded for contributions to no effect. Without material

to publish, the editorial committee cannot meet its obligations to advertisers and publishers. This has lead to a drying up of advertising dollars, a previously steady source of income for BAMP.

We need to decide as a group here today – are we going to have a journal or not? Can we find 8 or 10 or 12 persons - members or non-members, bi-monthly, to contribute? Should the editor solicit specific subject areas like we do for CME meets or some GP magazines do in some developed countries, or should we scrap the idea altogether?

TRADE UNION MATTERS

BAMP went ahead with its plan to join CTUSAB. Yours truly in fact was elected in September to be it's 3rd Vice President. This facilitated the 1st part of the process of changing over to our new employers – allowing them to set rules of employment for all employees to replace the Civil Service General Orders.

This document – the so-called "Draft Terms and Conditions of Service for Employees of the Queen Elizabeth Hospital", has gone through countless revisions. Despite it's constantly changing nature, BAMP attempted to come to consensus. This was difficult since special meetings have been poorly attended in the past, input was sought through QEH departments, by conventional mail and electronically, with limited success. Eventually, the negotiating committee, with assistance from the Director of Medical Services at the QEH, Prof Hassell, prepared a list of comments but generally supported the document. It is to be noted that the document does not directly address the specifics of doctors' unique working conditions (the 24-hr nature of our work, training opportunity etc). It has been agreed in meetings with the QEH Board and Management, that our specific issues are to be addressed separately in another form (e.g. contracts).

The process has been a long and slow one. It appears as though the general introduction is coming to an end, and the time to address our specific requirements is approaching. We need to decide how long we are willing to wait.

WEB SITE

www.bamp.org.bb is functioning once again, this time under the able management of Mr Deepak Thani of Caribyte Inc. Unfortunately, there have been only a handful of members registered to enter the members area. I plead with you all to register, send items for posting and send your email address to BAMP by phone, snail mail or email (info@bamp.org.bb). We must utilize technology to a far greater degree. No business or organization can afford to move at the pace that comes from having to meet fact-to-face and communicate solely by letter. Worse when you are busy as we are? Why can we use email in our private and professional lives, but can't use it as BAMP members effectively. I look forward to the day when Council can seek the opinion of the membership and get greater than 75 answers.

CSME

I understand from reading the recent newspaper headlines that Barbados is supposed to be CSME ready. Although our freedom of movement was in place pre – CSME, other issues remain to be addressed.

- Higher cost of business inputs in our private sector versus other regional economies
- Planning for a potentially higher health care system burden from worker influx
- Cost sharing across economies for health care

I hope our meeting with the Minister of State for Foreign Affairs, The Hon. Kerrie D. Symmonds MP, will be the beginning of a dialogue with Government on this issue.

CME

Having been given the mandate to move towards mandatory CME for continued licensing, I consulted with the chairman of Medical Council. He informed me that legislation needs to be put in place first to allow for this. He believed drafts have been prepared that also include a specialist register. To my knowledge no new legislation has yet been tabled.

From our end, our CME meetings have been a resounding success. Our pleas for better attendance have

not fallen on deaf ears. The organizing committees have also stepped up and are now consistently producing excellent weekend conferences semi-annually, that provide excellent reviews/updates for Family Physicians. The quality is such that I believe the fee should be increased for certain attendees, and more regional marketing needs to be done. This may be a future revenue stream for BAMP.

Members were asked to comment on the report (preferably electronically) in order to facilitate a response. Two separate and thorough treatises were received but represent the stated views of a total of three members. As suggested by our guest speaker, our silence is not acceptable. We need to state publicly where we stand as a group, understanding we will need to be calm, cool and open to come to a consensus position.

OTHER MATTERS

Some 'interesting' issues confronted Council this year. I will leave discussion of our financial matters and real estate holdings to the Treasurer and General Secretary, but there is need for some discussion of those issues. We also were faced with the controversy surrounding the report one of our own Council members' as a consultant to the Attorney General's office, on the Legal, Ethical and Socio-Economic issues relevant to HIV/AIDS in Barbados.

CONCLUSION

Thanks once again to all who supported me, taught me, guided me and constructively criticized me during this past year. I feel that I am better for it. Thanks to the Council members and to Shirley and Angela for all their help and for putting up with me – you'll still hear me – just not as often. I want to wish the incoming President and Council a successful tenure and pledge my fullest support.

General Secretary's REPORT

G. Lafond

I started this job as General Secretary after much coercion at the last AGM. With no formal handover, I embarked upon this mission like a fish out of water. I was wisely advised by our last Office Manager/ Secretary, Mrs Margot Symmonds, that an organization will survive with a bad President and a good General Secretary, but not necessarily with a good President and a bad General Secretary. I hope the Association survived this General Secretary.

At present BAMP's financial membership stands at 212.The year under review began with the instant resignation of the duly elected Treasurer, Dr Margaret O'Shea, citing academic studies as her reason. Council invoked a section of the BAMP's Constitution to appoint Mr Haresh Thani as the new Treasurer for the Association.

MEDICAL INSURANCE

Sagicor continues to provide group health insurance for BAMP members. Council pursued other insurance brokers to provide alternative quotations for group health insurance. Mr Martin Field of Field Insurance Brokers Inc., was able to provide figures for the Association. However, the quotations provided were thought to be slightly higher than Sagicor's, hence members would be disadvantaged. Consequently, Field Insurance Brokers Inc., were asked to review their figures and return with a competitive proposal, for which we are still awaiting.

ADMINISTRATION/STAFF

The Council has hired Ms Shirley Jones as Office Manager, after the resignation of Mrs Margot Symmonds (who served BAMP very well) for the last two (2) years. Ms Jones came highly recommended, having previously served at the Heart Foundation of Barbados. Council decided that the restructuring of staff was necessary and as a consequence, Ms Philomena Delice (BAMP's long serving cleaner/messenger) was made redundant. Ms Delice worked with BAMP for more than ten (10) years. At present, the Association hired a cleaner, Ms Millicent Brathwaite, on a twice weekly basis, for two hours each visit.

Ms Angela Philips continues as our stalwart Accounts Officer. Heartfelt thanks must go out to both Ms Philips and Ms Jones for their dedicate, hard work throughout the year. Their assistance and initiative have made the job of General Secretary easier than I first thought it would be.

CME/BANQUET

BAMP continues to play a role in the UWI/BAMP November CME conference and the UWI Medical Alumni Association welcoming ceremony & banquet for new medical graduates.For the just concluded CME/Banquet/Conference, the Association hired the services of Premier Event Services Inc., to take charge of the planning and coordination of the weekend of activities. This was as a result of the dissatisfaction expressed, of the organization of the previous conference.

We sincerely hope that this year's event was of a higher standard. It is Council's wish to make the dinner a 'black tie' affair in the future.

BULLETIN/WEB PAGE

These two areas have been the bug bear for Council and the Association. The bulletin survives on the shoulders of Prof Walrond. He has admitted on several occasions that due to the dearth of articles submitted for publication, that soon the bulletin may be out of

circulation. Council on several occasions, have appealed to members for submissions/views towards sustaining the BAMP bulletin, but with very little success. Council has taken the decision to arrange yearly contracts with prospective sponsors. These contracts would facilitate the publication of four (4) issues of the BAMP bulletin per year.

BAMP has a fledging Web Page. The BAMP Website is maintained by Mr Deepak Thani of Caribyte Inc. Like the bulletin, it is dependent on BAMP members for ideas/articles to keep it fuelled.

UNION MATTERS

BAMP continues to be the official registered Trade Union for medical doctors, The Association has been reinstated as a member of CTUSAB (Congress of Trade Union and Staff Association of Barbados). There were no major industrial disputes in the last year to be resolved. However, the Association's representation of its members' negotiations regarding the new Terms and Conditions of Service for employees of the Queen Elizabeth Hospital, must be deemed as appalling. BAMP has not, up to present, made a written submission to the negotiations. It has been left to the President, Dr Padmore, to represent the Association at most of those meetings. All the other unions who represent workers at QEH have already made proposals on behalf of their members. In this regard, BAMP's Council has failed its constituents, especially as it is the first time in many years that doctors at the QEH have an opportunity to make recommendations, and institute changes with regards to their terms of employment.

Council was made aware of a draft memorandum of understanding between the Government of Barbados, and the University of the West Indies, in relation to the conduct of Clinical teaching and Research in Medicine at the Queen Elizabeth Hospital, which would make teaching mandatory for Consultants and Senior Registrars. This piece of correspondence was circulated to members for a response. To date only two BAMP members have responded.

NEW PROJECTS/IDEAS

Council has started a Continuing Medical Education (CME) fund to assist doctors in attending medical conferences overseas. This was the treasurer's (Mr Haresh Thani) idea, as a means of the Association giving back to its members. To date no one has applied for the use of those funds.

CONCLUSION

The past year has been a relatively quiet year in BAMP's existence. BAMP has been almost silent on major health issues, especially on the Walrond report on HIV/AIDS.

I must thank the lay staff and members of Council for their assistance throughout the year, and I wish the next Council every success.

Treasurer's REPORT

Mr. Haresh Thani

Mr President, members of council ladies and gentlemen, as the only member of council not elected by the general body, I feel I must explain how I got here. At the last AGM, the general body elected Dr M. O'Shea as treasurer. Due to pressures of her work/studies, she found it difficult to continue in the post due to the pressure of her work, and resigned. I was then asked by council to fill the vacant post for the remaining term. I accepted, but little did I know what I was getting myself into. I soon realized that BAMP's account was more complicated than I thought.

After spending the year in office, I am now beginning to get the hang of these accounts. This is mainly due to the excellent assistance from Mrs. Angela Phillips who was very patient, for the most part. For this I am forever grateful to her and to the office manager Ms Shirley Jones.

In discussing the financial report, I will try to take you through the various parts of this corporation. Please understand this, accountants after their calculations and various permutations, will come up with the rosy figure and tell us that we are healthy. But, as the one who has to decide what to spend and where, my bottom line is cash. Do we have any?

BAMP THE LANDLORD

There are essentially two parts of BAMP. The trade union, and the landlord. In 1995, BAMP purchased the property at Spring Garden for $500,000. This was done with the help of a mortgage from The Mutual. The amount secured was $300,000 to be paid at $3,800 per month for 180 months. The mortgage runs to 2008. The amount was recently reduced to $3400 per month. The latest estimate shows the value of the property as follows:

Estimated current construction cost	$ 705,000.00
Estimated current mortgage value	$ 984,500.00
Estimated current market value	$1,055,000.00

Rent (from two of three offices) was collected and used to service this loan. The income from the offices amounted to $4500 per month. Of note, BAMP is not paying rent for the office it presently occupies. Unfortunately, one tenant defaulted on his rent for the last six months of the year giving a short fall of over $12,000. With the total collected, $40.000, we were supposed to pay $40,000 plus on mortgage, $ 5000 for Insurance and $4000 for land tax. (These figures are all rounded off; the actual figures can be found on page 4 of the report. To this must be added maintenance.

After repeated promises to pay, we eventually decided to evict the errant tenant and sought a judgment against him. Unfortunately, by the time he moved out, his debt had climbed to $17,000. The latest news we have is that the Bailiffs are looking to seize his property for an auction so we do not know how long this will take.

After he moved, we had to repair the office before renting again. The choice was to borrow again or do the repairs in house. We decided to do the latter. Council also agreed to raise the rent from $1.75 per sq foot to $3 per sq foot. The repairs are now over and we are now looking for a tenant. As a matter of interest, repairs are needed to the other offices but we cannot afford it at the moment.

As mentioned in the last Treasurer's report, there is no rental agreement in force. The draft agreement was drawn up by our attorneys but Council never approved it until late 2004. We are now finalising this agreement.

It is hoped that BAMP will have a comfortable surplus when the offices are rented at the price we are asking. We have contacted two Real Estate agents with no luck so far. One realtor did suggest we spruce up the property as the prospective clients will prefer more pleasant surroundings. I agree whole heartedly with this,

but we are in a catch 22 situation. Hopefully, the next council will be able to make the necessary improvements.

BAMP THE UNION

Income:

BAMP essentially has five sources of funds available:

1. Subscriptions
2. The Bulletin
3. MPS/Sagicor Commissions
4. A Government Subvention
5. CME / AGM

Subscriptions:

Of the over 300 members, the income generated depends on the level of the doctor. The subs range from $125 for interns (17 in number), $350 for doctors with less than 4 years post graduation (36 in number) and $450 for Consultants and GP's (197 in number). There are 55 members who, because of their more than 25-years in BAMP do not have to pay dues.

The figures in the report show that we generated $101,054 for the year 2004, but this is not the true story. This includes the subscriptions receivable which have now risen to $90, 451. Actually, early in 2004 this figure was over $100,000.This problem continues to dominate the financial woes of BAMP. Most doctors are delinquent for more than one year and somehow are reluctant to pay when asked. Some are new members who join and may pay for one year then nothing!

The usual response to a request for subs is "what has BAMP done for us?" and this is the crux of the problem. Taken as individual groups, it is difficult to explain the result of BAMP's activities taken on their behalf. There are times I find it difficult to justify my membership of BAMP. Honestly, how can we approach a doctor in the polyclinic or a GP and tell them this is how BAMP made your life /work better. But we continue to have meetings and discuss issues which, to the SHO at the Hospital, mean nothing.

The Bulletin:

In the past we had contracts with our advertisers for six bulletins to be published a year. We were lucky if we had six issues in two years. Thanks mainly to Professor Walrond and his committee, we have been getting the bulletin out quicker. But they cannot do this alone. We make between $20,000 and $30,000 in profits per contract, and to fulfill this contract we need articles.

For the new contract, started this year, I changed the conditions to four issues per year and recalculated the charges on a per issue basis. Also, we invited other companies to submit half and quarter page ads. The advertisers, however, are becoming reluctant to advertise in a bulletin that reaches a small number of readers. I am hoping to send copies, to all the Medical Associations across the Caribbean. This hopefully will increase the coverage for their products.

***Commissions on MPS/Sagicor*:**

This item earned us $47,475. It is merely a handling fee for the companies. Recently, MPS reduced the amount paid from 10% of the amount collected to a flat rate of ?45 per member. Recently the QEH board concluded a contract with the MPS to provide malpractice coverage for its doctors. This will remove some of the doctors from our list if it is restricted to non-consultant staff or a lot more if it includes consultants. Not something to look forward to.

Sagicor Health Insurance covers only 95 of the 310 members in BAMP. The younger doctors and some of older ones refused the coverage as they believe that it is too expensive and they will not need insurance coverage. Maybe they should speak to the four or five doctors who had to travel overseas for themselves, spouse or child, for medical treatment costing over $250,000 US each. The complaint is the cost. Based on the claims experience, the costs are adjusted accordingly. We approached other companies but we are yet to get a better quote. We even tried negotiating a smaller version of the present policy, but so far we are still waiting.

***Government Subvention*:**

This amounts to $10,000 per year and is appreciated.

***CME/AGM*:**

We always try to keep the cost of the CME/AGM down. This year council decided to do it in grand style but, to cover the costs, we have to charge a subsidized rate for members and their spouses. At the time of writing this, we only had 35 confirmed members for the dinner.

Expenses:

The expenses for the year are covered on page 3 of the report.

The figure that stands out is that of the secretarial services. This is half of the total expenses for the year $83,803. This is way too much for an Association of this size. The past treasurer in his report suggested that something be done to cut this down to a reasonable figure. For this I must take the blame for I was so busy trying to understand the intricacies of the accounts that I neglected to advise council on this matter.

We have two persons working it the office, an office manager and an accounts officer. From the mere volume of the work involved, I think they are equal. But if you look at the importance, I would prefer to have a capable accounts officer who can oversee a receptionist/typist. I do not believe we are being well served by an office manager to justify the salary we are paying. If used judiciously, we can cut the expenses by $18,000 per year. But, as I believe that the Accounts clerk is indispensable to the Treasurer, the General Secretary will have to decide if the Office Manager is just as indispensable.

Other expenses we have been trimming gradually. We were paying a cleaner $12,000 per year to work two hours a day. We severed her and are now paying $2400 per year. We have been trying to separate the two accounts and was succeeding until the rental income dried up.

For BAMP to survive, we need to look past the loyalties of the Association by the older members, like myself, and listen to the younger generation. In the past council established a sub-committee for non-consultant hospital (QEH, Psychiatric and Geriatric) staff, polyclinic staff and a sub-committee for GP's. These lasted only two terms. If we are a union, then let us act as a union if we are an old boys club then we should act like one. We should not sit back while administrations walk over our members and wait for a formal letter from someone before we act. We need to be proactive! We either do this or BAMP will die.

I am sure there are other areas we could improve our financial position but without an increase in the membership, we will still come to a standstill. We need to encourage greater participation of all our members. We need to improve communications between the council and the members; a simple weekly or monthly newsletter via the webpage is one way. But the real thrust must be our union activities. Money talks for everyone! Here are but a few suggestions:

1. Renegotiate allowances for the staff of the Hospitals.
2. Negotiate better working conditions for the polyclinic doctors
3. Negotiate for better allowances, like Tax deductions for CME activities for all doctors.
4. Negotiate tax deductions for equipment in order to better perform our medical duties.
5. Stop the Hospital from issuing conditions to the staff without our prior knowledge and approval like the recently negotiated deal with the MPS.

I am sure you can think of others and I hope those of you who can see a progressive path for BAMP would decide to stand for posts in Council.

In closing, I must thank you for your patience while I tried to vent my spleen, that's how I think BAMP can better serve the members of the medical fraternity. I must also again thank Mrs. Angela Phillips for her patience in trying to take me though the maze that is BAMP's account. I must also thank Ms Shirley Jones for bearing with my constant queries regarding the bulletin and the AGM. The Auditor, Mr Carter, who prepared the report, I must say that I had to run to my daughter, an auditor for an accounting firm, for an explanation of some of the entries, thank you Payal. And finally, I would like to thank the Council for giving me the opportunity to serve, as the treasurer of BAMP, although my wife would disagree with this. I hope as you deliberate the future of BAMP, you will try to be more positive than I was.
Thank you.

The Barbados Association of Medical Practitioner's Award for Excellence

CAROL ELIZABETH JACOBS

Mrs. Carol Elizabeth Jacobs receiving her award.

Sir George Alleyne, Chancellor of the University of the West Indies and our honoured guest, Dr. David Padmore, President of the Barbados Association of Medical Practitioners, Sir Richard Haynes, members of the council of BAMP, colleagues, members of the press, it is my pleasant duty to introduce Lady Carol Elizabeth Haynes nee Jacobs for the BAMP's award of Excellence for contribution to medicine in Barbados. I know if I were to look I would see a little frown on her face, for introducing her as Lady Haynes. However, I will like her to know that she has been referred to as Lady Haynes or Lady Jacobs, depending on who it was, by many of her admirers well before her husband became Sir Richard.

Mr. President, when you called and asked me to do this introduction, or suggest someone else, you said that I was chosen because your organisers thought that I knew her best. Although flattered by that thought I still requested her CV in case there was some detail that I was not sure about. Well after perusing the CV, I am afraid that when I was the dean I would have had to send it back for further particulars. Most CV's start off with a date of birth and gives you some details about the schools attended and when. For all of you ladies and gentlemen who might have come here hoping to hear some detail of that sort, I am sorry to tell you that all of that detail was missing so that you will have to continue guessing. The CV simply states born and educated in Jamaica, a medical graduate of the University of the West Indies

I first met Carol as a medical student in Jamaica. I was doing my first teaching round as a staff member and I suspect that the three students who appeared were having their first encounter with the surgeons. She was part of a formidable trio, one of whom looked at me through very shiny glasses and corrected my mispronunciation of her name, there was this tall imposing one who pretended to be shy, and there was a short quiet one from a famous campus family who turned out to know everything from day one. Little did I know that I was meeting someone who would marry a friend of mine in Barbados, and who was a contemporary and schoolmate of the woman I would meet and marry many years later. For those of you who are still trying to calculate I will just tell you that my wife always reminds me that I married a young woman and that I still have a young wife.

Carol came to Barbados for her final year as a medical student and as you can imagine threw some confusion into the heads of some of the young men about town. One of them managed to convince her to marry

him, and many of his friends still congratulate him and possibly even envy him. They have reared two children, exceptional in their own ways, and they are proud grandparents. In spite of these continually growing family obligations, Carol threw herself into the professional life of Barbados for which she is being honoured tonight. But she also participated in the political career of her husband and I have it on good authority that Carol had significant influence in the area of Martindales and Halls road, part of the constituency which her husband held with such great distinction. Indeed Carol had become one of those women immortalised in calypso as 'No Bajan'.

Her influence in the area did not come from her looks, it was from the rapport established with the patients in the area by her work in Casualty, as it was then called, and before that in the intensive care unit. I understand that many of those patients would follow her up to Golf Club Gap when she eventually opened her private general practise, and I suspect some of them still pay little or no fees as well as getting the excellent and empathetic care for which she is well known.

As regards HIV/AIDS her involvement began around 1988 with her serving on BAMP's AIDS Task Force. She became its chairman from 1998 to 2000, and was instrumental in producing a video for the association in 1998. She had also produced videos on AIDS for the Optimist Club, of which she has been a governor. As regards other service with the Association she has served on the Executive Committee in several positions.

From 1995–1998 she was appointed the Chairman of the National Advisory Committee on AIDS**,** and represented Barbados and the Caribbean on the Management committee of the Global Program on AIDS, and subsequently on the coordinating board of the UNAIDS Program.

With the formation of the National HIV/AIDS Commission, under the Office of the Prime Minister, she was appointed its chairman and subsequently a Special Envoy of the Prime Minister for HIV/AIDS, for which she is well qualified with her diplomatic and political skills. In this position she has presided over a much-enlarged bureaucracy and has forged great dedication, pride and loyalty among the staff of the Commission. Amongst the programmes the commission coordinates is the HAART treatment programme that is looked upon as one of the areas of best practice in the Caribbean. She plays both a national as well as a regional and international role in the field of HIV/AIDS and in 2004 was appointed the Board member for Latin America and the Caribbean on the Global Fund for AIDS, Tuberculosis and Malaria, and has just been elected as chairman of that body for 2005 to 2006.

Mr. President I know that you would like me to state that Dr. Jacobs was selected for this award before she was elected to the chair of the Global Fund, lest it be seen as if BAMP is merely following the wide public acclaim that her election has brought. It is indeed so and you may well wonder how she will be able to carry on with additional duties and still be able to keep her practice going, as well as her family commitments, especially to her grand children and her several other commitments on boards etc; and no doubt we all wish her the strength to achieve all her goals.

Some of you may also wonder where how she came by this exceptional motivation to public service. The answer is that she has simply joined the family business, for both her late father and her mother were renowned in the field in public service in Jamaica and internationally, particularly in the area of Family Planning and the International Planned Parenthood Federation. Her contribution to public service has been acknowledged by many organisations with awards and they include the award of the Barbados Centennial Honour in 2001.

Mr. President, Colleagues and friends I present to you Dr. Carol Jacobs for the Barbados Association of Medical Practitioner's award for Excellence for her contribution in the field of Medicine and in particular her work in HIV/AIDS.

Citation given by Prof. E. R. Walrond
28/06/2005

The CSME

- CARIBBEAN SINGLE MARKET AND ECONOMY

The Hon. Kerrie Symmonds MP

Moreover, as the single market evolves it will become far easier to make much needed financial investments in the health sectors of our sister states.

Since the signing of the Revised Treaty of Chaguaramas in February 2001, CARICOM member states have made substantial progress towards the implementation of the Single Market, the major provisions of which are contained in Chapter Three of the Revised Treaty. Of particular note is the fact that Barbados, Jamaica and Trinidad & Tobago have met their obligations under this Chapter, one year ahead of schedule, while the rest of CARICOM is scheduled to be compliant by the end of this calendar year.

The single market, with the removal of the restrictions on the free movement of goods and services, skills and capital and on the freedom of establishment, has laid a solid platform for the next phase of our integrated development. That is, the progression to the single economy. With the evolution of the single economy, the expectation is that the region in its single space will operate as a country does within the space of its national jurisdiction.

In both of these dimensions, the single market and the single economy, there is, I suggest a critical role for medical practitioners to play as stakeholders in the process. The fullest understanding of your capacity and potential in this process is perhaps best grasped by beginning with an overview of the role of the health sector in international trade negotiations.

The lessons of the last decade of globalization and the implications for small developing countries like ours can be applied to issues of trade in health services. All of the countries of CARICOM are considered small developing countries with only four having populations of over 700, 000 people and of the remaining eleven, ten have populations of less than 300, 000. Small developing economies differ from other economies in terms of structural characteristics. These are manifested in 3 major ways:

(1) Economic vulnerability due to export concentration on a few primary commodities.

(2) Income volatility due to our susceptibility to natural disasters, our traditional export instability and higher risk ratings for foreign direct investment. And finally,

(3) A lack of international competitiveness due to constraints on material and labour inputs along with higher transportation costs, all of which lead to overall higher production costs.

For such economies, the way forward has to lie in the exploitation of our adaptive capacity and ability to seize opportunities to maximize and develop our human resource potential. The area of services therefore becomes critically

Editor's note: The Hon. Kerrie D. Symmonds MP, is the Minister of State in the Ministry of Foreign Affairs and Foreign Trade.

important and not least among these must rank health services. In international trade, trade negotiations in the health sector are primarily governed under the WTO by the GATS, a still largely uncompleted exercise whose built-in agenda seeks to create a rules-based fully liberalized internationally binding agreement for trade in all services. That agreement when concluded will be the standard against which all other international or regional trade agreements must comply. Happily for us, the health sector is not at this time one of the most dynamic areas affected by GATS. Negotiations in health services are continuing and are not moving rapidly. A bold proactive and visionary CARICOM health services sector can capitalise on the opportunities created by this work in progress.

Specifically, for WTO purposes in the area of health services, CARICOM member states would want to try to more adequately cover the existing and potential activities in this area. We would for example wish to create opportunities for activities that require significant inflows of foreign investment and which would also facilitate the movement of our skilled natural persons. Additionally, we would be seeking to tackle fundamentals such as the non-portability of health insurance and the cross border supply of healthcare via use of cutting edge technologies involving tele-diagnosis and tele-medicine.

Once we are able to achieve the requisite framework for our optimal capacity at the level of global trade rules, we would better be able to capitalize on opportunities at the hemispheric level, for example under the Free Trade Area of the Americas and at the regional level under the CARICOM Single Market and Economy.

As health professionals it is important for you to be on the same page as the national policymakers. It is the view of the government of Barbados that our country has a substantial competitive and comparative advantage in the services sector. In particular, health services provide an excellent case study in the possibilities for sectoral linkages. The government sees these sectoral linkages as being critical to our national development strategy. I give you one example. There is much feasibility in the concept of health tourism. I say this against the background of a recognition that health is now big business with estimated annual global healthcare expenditure being in excess of 3 trillion US dollars. In Barbados, the area of health tourism would see a well established, competitive, domestic hospitality industry complete with an ambient environment and proximity to target markets being paired with the strong intellectual capital and internationally respected skills to be found in our medical profession. I suggest to you that this would be a win-win situation for both the tourism and the health sectors. With specific reference to your profession, opportunities would arise in the areas of convalescent care, rehabilitation, curative care, and new impetus would be given to specialist treatments including elective surgery.

From a national perspective, we see several benefits to such a trade linkage. Foremost among these of course would be the foreign exchange earning potential, the reduction in the need for public resources to drive the process and the consumer gains associated with an evolving health management sub-sector. As policymakers, we must of course, be conscious of the need to ensure that equity continues to exist in public health services. Government is therefore cognizant of the possibility that by providing health services to visitors and capitalizing on new regional markets that scarce public resources, primarily personnel, will be diverted from much needed public health programmes. In practice however, other jurisdictional experience has indicated that private health service initiatives do in fact reduce pressure on public sector financial resources by supplementing existing healthcare. Since much of this innovation depends on private sector entrepreneurship and investment, this reduces the demand for public resources which can then be redirected to improve access to and overall quality of healthcare. In this sense trade in health services does result in positive redistribution of scarce public health funds and domestic consumers make gains in terms of better access to affordable care. Further, I would say to you, that these opportunities are so significant that it is in my view necessary for us to have a national development strategy involving all stakeholders so that we might best evaluate the various interests, resource constraints and potential problems associated with trade in health tourism.

Such a strategic analysis on the part of our stakeholders will help us prepare for the ultimate insertion of our health sector into the hemispheric economy and beyond. But what of our own single market? In some measure the immediate benefits of the single market are already being enjoyed by members of your profession. Consultants enjoy free movement across this region and junior doctors who have been certified in this region can select their hospital of choice. Under the new arrangements however, the practitioner can now, as of right, establish a physical presence in the market in which he or she wishes to operate. Under the rights of establishment he or she can also bring in their managerial and supervisory staff in order to service the clinic even in that practitioner's absence. Moreover, as the single market evolves it will become far easier to make much needed financial investments in the health sectors of our sister states. Your professional skills must now be merged with business acumen. Now is the time to determine for example, the level of investment that might be required to replicate a Bayview hospital in a capacity-diminished St. Kitts or an FMH emergency services facility in Dominica. Equally, this is the time to determine which segments of the region's population have certain health needs which cannot be serviced within their country and would therefore cause them to seek care outside of their territories. In servicing such needs, the investment necessary would therefore be domestic as opposed to cross-border. To some extent of course, this is already happening, but I suggest to you that this is the time to exploit the greater sophistication of our market and to recognize that beyond the lack of certain services in CARICOM, a major attraction of Barbados is the greater confidence in our local providers and the confidentiality, privacy and speed of service which is associated with a more developed country.

As is the case in my own profession, many regulatory policies and practices in health services do not favour the generation of business from foreign markets as generally doctors are not allowed by the rules of the profession to actively market themselves or solicit business. This must however be the time to enforce across the region an acceptance of the fact that healthcare, if it is to be seen as a business, should be promoted by informed and knowledgeable purchasers. Your task must be to determine whether the time-honoured system of referrals ought not to be augmented

by advertising and public promotion of specialties. In practice, for example, when a specialist intervenes in the quality of care by investing in a new piece of equipment does he not deserve the right to speedily maximise the returns on that investment by fullest possible disclosure in the marketplace? If the progressive junior brings net value added by being multi-lingual, should the discerning public consuming from abroad not know of this when considering issues of comfort levels and emotional security involved in seeking healthcare in unfamiliar surroundings.

Because of our comparatively higher standards and accompanying support systems in terms of nursing and paramedic care and telecommunications infrastructure, the single market and economy provides a platform from which to consolidate specialty practices at home with a view to ultimately attracting health service consumption from the wider hemisphere and beyond - the relatively successful experience of Island Dialysis provides a case in point. Your profession must however now build linkages with the insurance industry in order to advance the removal of barriers to such progressive development. In most cases, private health insurance policies and public systems do not cover treatment abroad except in the case of emergency. The portability of health insurance is primarily an issue in the US market which would obviously be one of our key focal points. Americans older than 65, are eligible for a government sponsored programme (Medicare) to cover hospitalization and other costs. Medicare does not however cover any care received outside of the country. This absence of insurance portability needs to be weighed against the fact that in the year 2000, 29% of Barbados' tourist arrivals were 65 years and over and over 55% of our visitors to the region were German, British or American aged 60 years and over. We must now therefore decide as a matter of national strategy whether there is merit in an intense lobbying effort to bring about a change of perspective in the way in which these matters of health insurance are handled.

Equally Barbados' strategic advantages in telecommunications and electronic commerce lend themselves to usefully developing cross border health service delivery through the use of computer-based technology. It also provides an excellent basis for continuing education and training for health care professionals.

I return to the observation that emotional security is often a consideration of ill persons when seeking healthcare in unfamiliar surroundings away from friends and family. The inhabitant of rural St. Vincent or Suriname may think long and hard about leaving hearth and home in search of elective health care. Such technologies are now used effectively in the developed world to treat patients in rural areas at cost effective suburban standards. There is no reason, therefore, why such technology ought not to provide similar benefits for inter-island consultation and care.

The single market will of course bring not only opportunities but substantial challenges. For a country like Barbados with high levels of access to pharmaceuticals through the national drug service, a high influx of consumers can potentially place great strain on the capacity of the service and lead to a consequential shortage of drugs. Additionally, there will continue to be a need to balance the social costs of an expanded access to our domestic health system with the potential cost to the public, especially in terms of the introduction to our society of communicable diseases which have otherwise been eradicated. In this regard government will of necessity have to continue to adopt the most guarded approach to negotiating contingent rights of automatic access to public health care for CARICOM nationals who take up work in Barbados under the provisions of the Revised Treaty.

It is important to recognize that the Caribbean Community and Single Market and Economy are not built on purely economic principles alone. In fact our integration project represents a quest to ensure both the social and economic development of our region's citizenry. In this regard, the process has led to the evolution of an ethos of collective action for enhanced results. The Pan-Caribbean Partnership against HIV/AIDS represents one such effort. As you know the Caribbean is second only to sub-Saharan Africa in terms of HIV prevalence. As in other regions of the world, the epidemic is more than a health problem - it is an unprecedented threat to social and economic development. The partnership is an incomparable initiative designed to engage a network of stakeholders

in the fight against this disease. It is in fact a model of functional cooperation that has spared the small countries of the region from having to duplicate efforts and has enabled the rationalization of scarce resources. More importantly however this approach has ensured that all member states of the Caribbean Community are developing and implementing HIV/AIDS responses at the same time so that the extent of vastly differing infection rates is reduced over time.

Ventures such of these will form the spirit of our single market and single economy endeavour. It is expected that by the first week in July of this year, the Heads of Government of the three lead countries – Barbados, Trinidad & Tobago and Jamaica, will sign declarations of compliance in order to formally launch this massive undertaking. There will of course be ongoing negotiations with sister states with a view to defining key issues such as the extent of public health access under the rights of establishment contemplated by the treaty, the pace and extent of implementation of the full movement of labour and the evolution of an electronic commerce protocol. These considerations will all impact to some extent on the carrying capacity of Barbados' health sector and I therefore reiterate my earlier invitation that this is the time for the fullest possible evaluation of the various interests and potential problems, which you as stakeholders and members of the medical profession would see taken into account as we proceed towards deeper regional and ultimately hemispheric integration.

Continuing Medical Education Conference, May 2005
Ophthalmology
1 Article and 11 Abstracts

Certifying the Elderly
TO DRIVE

Peter Adams

International data suggests that the crash rate per mile driven begins to increase from age 65-years. After controlling for distance driven, older drivers[1] have a higher rate of motor vehicle accidents than any other age group, except for those younger than 24-years, and when they are involved in an accident they are more likely to be seriously injured or killed.

According to the Road Traffic Act of Barbados [L.R.O. 1987 ss.76 (5)] a person of 70-years and over needs a medical certificate certifying him or her as being fit to drive, and a licence cannot be issued for a period greater than one-year for such a person. The act states "*Where the holder of a driving licence is 70-years of age or over, the licence of the holder shall not be renewed unless he produces to the Licensing Authority a medical certificate signed by a medical practitioner as to his physical fitness*".

Mandatory reporting of conditions that might affect an individual's ability to drive safely is not legislated, and hence protection of doctors doing so without the patient's permission is not specifically provided. *See Editor's endnote*

The elderly are a heterogeneous group with a wide range of functional ability, and there is often not a clear distinction between aging and the onset of disease. General Practitioners see patients over the course of time and quite often they see the early stages of disease. Decisions as to whether a person is fit or unfit to drive can understandably be difficult. This difficulty is compounded by the fact that the road traffic act does not provide any guidance as to what might constitute an adequate assessment, and what are the medical criteria for being fit or unfit to drive. Even in other jurisdictions where guidance is provided by the law or the medical association, doctors often realise that they have a limited ability to judge whether someone is fit to drive. Complicating the issue is that losing a driver's licence could drastically change the life of the elderly patient. Driving cessation can greatly decrease mobility, limiting out of home activities such as access to the supermarket, social and religious activities, health care, and employment opportunities. Social isolation and worsening depression might be the result. Caregiver stress may be increased, as they[2,3] may now have to be responsible for transport. The medical practitioner has to weigh the public's concern over safety against the autonomy of the elderly person.

Editor's note: Dr. Adams is a Lecturer in Family Practice in the School of Clinical Medicine and Research.

Requirements for safe driving

Driving is a complex activity, which requires the integration of many functions. These can be categorised as follows:[4]

- Operational skills: Motor, sensory, perceptual and cognitive abilities required to control a vehicle.
- Tactical skills: Choice of speed, distance from the car in front.
- Strategic skills: Planning and preparing for trips.

Causes of accidents

Older drivers are less likely than younger drivers to drive at night, speed, tailgate, consume alcohol before driving and engage in other risky behaviours. Young drivers crash mainly because of lack of experience and risk taking. Reducing the risk of crashes in younger drivers is not usually a medical issue, but a law enforcing one. In the case of older drivers inattention, or slowed perception and response are often the cause. Accidents often occur at intersections and involve right hand turns. The driver may not heed signs or grant the right of way. As a driver ages the cumulative effect of several factors can combine to make them eventually unfit to drive. These include:

- ***Ageing***
  - Slower reaction times
  - Diminished cognition
- ***Chronic diseases***

Diabetes, glaucoma, Parkinson's disease, osteoarthritis, dementia

- ***Medication side effects***

Many older drivers self-regulate their driving, but this is not so in all cases. Healthy older adults and those with mild cognitive impairment (dementia) often lack insight and tend to over-estimate their functional ability, whereas depressed older adults under-estimate their abilities. Peripheral vision loss may occur so insidiously that the driver only becomes aware of it on becoming involved in a motor vehicle accident.[5]

ASSESSMENT

Doctors assess operational skills, but do not generally assess tactical decisions and strategic approaches that can determine if early minimal loss of operational skills can be effectively compensated for.[6]

Three key functions for safe driving which need to be assessed are:

(1) Vision
(2) Cognition
(3) Motor function.

It should be noted that these functions do not directly predict crash risk. Vision is important, and while a certain amount of vision is needed for a person to drive safely, this is often not the overriding issue. Mobility, reflexes/ reaction time and cognition are equally important. There might be some problem with matching the results of office tests for vision to driving performance in the real world, as some persons with significant visual loss function well while others with minor loss have great difficulty with motor activities requiring vision. There is considerable difference between someone's ability to perform a visual acuity test under optimal office conditions, and the ability to walk without falling, drive a vehicle, or to recognise a friend in a crowd. However, standardized and reproducible visual tests do exist.[5] Tests to determine cognitive and motor skills are unfortunately not always standardized and reproducible.

History

Assessment should begin with a history. The doctor should note whether a family member (or the patient) has shown concern about whether it is safe for the patient to drive. The history should include medical conditions and medications that may affect driving. UK regulations for common health problems are listed in table 1.[7]

Table 1:
UK regulations re common health conditions[7, 8]

Condition	Recommended action
Transient ischaemic attacks (TIA) One TIA Multiple TIA's	 1-month ban 3-month ban
Cerebrovascular accident	1 month ban
Epilepsy	Should not drive during and for 6-months after medication withdrawal* Ban 12 months until seizure free awake Ban until 3 years of only night time seizures

Myocardial infarction	4-week ban
Angioplasty	1-week ban
Pacemaker	1-week ban
Anxiety/depression Mild Severe	 No ban Stop driving until stable or controlled
Diabetes on insulin patient hypoglycaemic	No ban if controlled, visual standards achieved and can recognise episodes
Diabetes on diet/tablets	No ban if controlled and visual standards achieved
Dementia	In early dementia when sufficient skills are retained and progression is slow, a licence may be issued subject to annual review. A formal driving assessment may be necessary.**

*40% increased associated risk of seizure in the first year of withdrawal of medication compared with those who continued on treatment.

**It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive. The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause impairment. A decision regarding fitness to drive is usually based on medical reports.

EXAMINATION

Observe the patient carefully as they walk into the room for:

- Poor hygiene and grooming
- Difficulty walking and getting in and out of chairs
- Difficulty with vision
- Difficulty with attention, memory and comprehension

Vision

Visual acuity and visual field defects can be assessed in a doctor's office.

Important defects are (1) decreased central acuity, (2) binocular visual field defects and (3) double vision.

Central visual acuity

The UK has a number plate standard. This test requires that a person is able to read with the aid of glasses if needed a registration number (79.4 mm high) at a distance of 20.5m. As it is an outdoor test, glare and contrast sensitivity might impact the results. While there is no exact equivalent for an indoor test this standard roughly is equivalent to a visual acuity of 6/9 or 6/12 on a Snellen chart. However, there is no scientific basis to this cut-off. Studies undertaken in the USA suggest there is no increased crash risk between 20/40 (or 6/12) and 20/70 (or 6/21).[9]

Persons with a visual acuity less than 6/12 should have any underlying cause of vision loss treated. Appropriate glasses should be worn. The patient can restrict driving to familiar areas, daytime, non-rush hour times. For acuity less than 20/70 (or 6/21) on-road assessment is recommended by the American Medical Association (AMA).[9] For acuity less than 20/100 (or 6/30) driving should not be allowed unless safe driving can be demonstrated by an on-road assessment performed by a driver rehabilitation specialist.

Visual field defects

For driving in the UK the minimum uninterrupted field of vision required (with both eyes open) is a rectangle 120 degrees wide and 40 degrees high.[7] This is achievable with one eye. Patients with visual field defects such as bitemporal hemianopia, homonymous hemianopia will not achieve this standard.

The AMA's Physician's Guide to Assessing and Counselling Older Drivers[9] states that visual fields can be tested on each eye by confrontation. The examiner is positioned 1 m in front of the patient at eye level. The patient is asked to close the right eye while the examiner closes the left eye. Both fixate on each other's nose. The examiner holds up a random number of fingers in the four quadrants, and the patient is asked to state the number. The fingers are held slightly closer to the examiner. The process is repeated for the other eye. Further assessment is needed if any defect is found. This approach might be inadequate as it has been shown to lack sensitivity.[10] The more sensitive visual field analyser is of course usually absent from a GP's office.

Glaucoma affects the visual field, and in its later stages visual acuity as well. Pan retinal photocoagulation for diabetic retinopathy can reduce the visual fields. Upper visual fields can be affected by ptosis.

Even if the visual field is accurately measured and is found to be normal it may not necessarily translate well as far as real world functional ability is concerned. Ball [5] has postulated that age related changes in performance can occur because of

(1) reduced speed of visual processing,

(2) reduced ability to divide attention, and

(3) greater susceptibility to distractors.

Drivers with excellent scanning ability might compensate for some visual field loss, and drive as safely as another patient with normal peripheral vision, but restricted neck rotation.

In addition the doctor should be aware that in the real world, glare, contrast sensitivity, and accommodation to changes to illumination could affect vision. This might be the reason why static visual acuity has consistently been found to have an extremely weak relationship to traffic accidents. Unlike real visual scenes that vary in complexity, contrast and illumination, visual acuity is measured small, high contrast and low complexity images.

Glare

Even with early stage cataracts glare can be a problem. This would be particularly problematic at night with oncoming headlights. Many elderly persons restrict their night driving for this reason. Difficulty with driving can be a valid indication for cataract surgery. The number plate test can be useful in this circumstance.

Contrast sensitivity

Older adults require about 3-times more contrast than young adults to distinguish targets against a background. This problem is exacerbated at low light levels. This can result in difficulty in distinguishing cars and pedestrians from background scenery, and is particularly acute at night. Contrast sensitivity has been found to be a valid predictor [9] of crash risk, but research is needed to produce validated cut-off points. Vision care specialists are usually unfamiliar with measuring contrast sensitivity.

Accommodation to changes in illumination

Older adults require more time than younger adults to adjust to abrupt changes in the level of illumination. Bright lights of an oncoming car on a dark road might be a problem.

Cognition

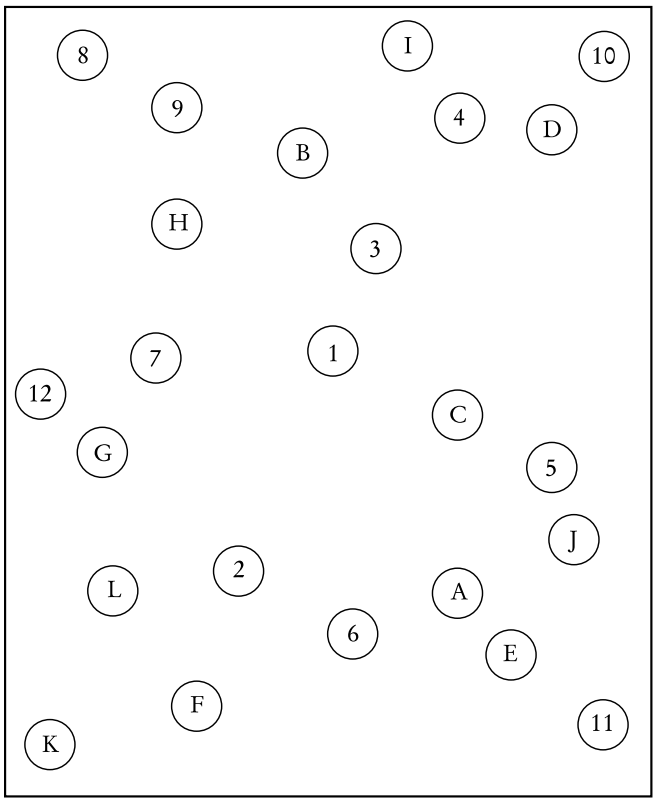
Accidents involving older persons often occur in complex situations in which cognitive overload may occur. This suggests that cognitive overload may have a role in causing accidents.

Cognitive skills required for driving include, memory, visual perception, visual processing and visuospatial skills, selective and divided attention, and executive skills.

While many doctors assess cognition with the Mini Mental State Examination (MMSE), the cut-off point for safe driving is unclear. A Canadian review of driving and dementia states that the MMSE "is inadequate as a predictor of on the road driving performance because it was not designed to assess cognitive function with respect to driving". [11]

The UK's DVLA position is stated in table 1. The AMA guide [5] says the diagnosis of dementia does not necessarily mean that driving should not be allowed, and recommends that the *Trail-making part B test* (figure 1) be routinely used. This requires a special form and most doctors are not familiar [9] with it. Further assessment is required if more than 180 seconds are required for completion. There is some limited evidence that the results of this test correlate with crash risk. The AMA also recommends the use of the *clock-drawing test*. There is limited evidence for its benefit with regards to driving. Further assessment is required if there are any incorrect or incomplete elements.

Figure 1: Trail-Making Test Part B



Starting with 1 draw a line to A then to 2 then to B and so on

MOTOR FUNCTION

The AMA guide[9] suggests the following:

1. Rapid-pace walking - the patient is asked to walk 3m, turn and come back as quickly as possible. A walking aid can be used. This task should be completed in 9 seconds. There is some evidence that the performance on this test correlates with crash risk but the cut-off point is arbitrary.

2. Range of motion - the active range of motion of the neck, shoulders, elbows, fingers and ankles are tested. Further assessment is needed if there is excessive pain, hesitation, or a very limited range of motion. The scoring for range of motion was left deliberately vague as the impact of diminished range may vary with other factors including vehicle design. A vehicle with automatic transmission, and power steering and brakes might help.

3. Strength is tested (both shoulders, wrists, hands, hips, and ankles) and graded 0 to 5. Further assessment is needed if strength is less than 4/5 (movement against gravity and some resistance).

Osteoarthritis which is common in the elderly may impact on motor function.

ON-ROAD TESTS

Some advocate the use of on-the-road tests. Ideally the test should be standardized, designed for those with impaired cognition, and include a complex traffic situation. It would not be possible to test every driver every year by this method, because of the time and cost involved.

COUNSELLING THE UNSAFE DRIVER

Using the term "driving retirement" may help to normalise the situation, as retirement may be looked on more favourably than giving up. Review the pros and cons of driving with the patient.[9] Do not only examine the negatives, such as loss of independence. Point out that this will improve the safety of the patient and of others. There may be other benefits of not owning a car including costs. Savings on car maintenance could pay for a fair amount of taxi fares.

Involve the patient in the decision making process. Explain the results of your tests in simple language. Describe the likely effects on function of any impairment discovered. Demonstrate to the patient that you are listening by acknowledging concerns over retiring from driving, and use empathetic statements when addressing them. It may be useful to ask the patient to identify peers whose driving they consider unsafe, and to give the reasons why they think so. The patient may be able to recognise similarities in their own driving. Remember driving cessation result in a feeling of loss, and possibly perceived poor health status. A sudden unexpected decision can increase this sense of loss. A general practitioner who may have been seeing the patient over many years can anticipate this and start introducing the idea of retirement well in advance of the actual time so the patient can start to make adjustments. Help the patient to identify alternatives. These can include relatives, neighbours, friends, and church groups. The patient may

have to plan their transport in advance to maintain social contact. A weekly schedule can be worked out with family to run errands. Unnecessary trips can be avoided, and it may be possible to schedule several appointments in the same area for the same day. It may be possible to have groceries and newspapers delivered.

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Editor's note: *A doctor is protected in issuing all relevant information in issuing certificates. This includes prevention of activities in the interest of the public's health, as in the famous Typhoid Mary case. Preventing a person from injuring the public is perfectly defensible. See the Medical Registration Regulations Part V, Professional conduct and General Fitness to Practise Medicine 21.(2) (e) (m).*

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1. ABC of Poor Vision

D.C. Gibbons FRCP, FRCS, FRCOpth.
Consultant, Queen Elizabeth Hospital

The myriad causes of poor vision present a diagnostic challenge for the non-ophthalmologist confronted with such a patient. It can be difficult to arrive at a diagnosis, which can result in inefficiency and frustration both for the patient and the clinician. A simplistic pathogenetic classification of the causes of poor vision forms the nidus for a reasoned approach to the problem. The analogy between the camera and the eye provides the basis for this classification. Three aetiological groups are recognised – the refractive error (errors of focus), the commonest cause of poor vision, are myopia, hypermetropia, astigmatism and presbyopia (loss of accommodation). The opacities in the media affect four areas. Corneal lesions include dystrophies, post-inflammatory scarring and degenerative lesions. Aqueous opacification include chronic inflammation and haemorrhage. Cataract, an opacity of the lens, is the commonest cause of blindness in the world. The vitreous clarity may be impaired by chronic inflammation, or haemorrhage. The receptive defects, involving the retina and its connections with the brain, encompass retinal lesions e.g. retinal detachment and retinal vascular lesions e.g. diabetic retinopathy. Diseases of the optic nerve include optic neuritis and terminal open angle glaucoma. Using this classification a simple scheme can be devised to pigeon hole the particular cause to one of the three groups and go a long way to defining the diagnosis. The key to the assessment hinges on the understanding of and the practical method of determining visual acuity. This not only quantitates the visual deficit, but is the first step in approaching the diagnosis.

2. The Barbados Eye Studies: an Overview

Anselm Hennis FRCP, Ph.D;
Chronic Disease Research Centre; UWI

The Barbados Eye Studies (1987-2002) were developed to provide the first population-based data on major eye diseases affecting persons of African descent, including open-angle glaucoma, age-related cataract, diabetic retinopathy and age-related macular degeneration. Their objective was to document the prevalence, incidence, and risk factors for ocular conditions, thus providing essential information to develop strategies to prevent or control blindness.

The studies were based on a cohort of over 4,700 Barbadians, aged 40-84 years, or 84% of a randomly selected sample of the general population of the country. After baseline examinations that ended in 1992, the cohort was re-examined to obtain 4-year and 9-year incidence data. An additional study included over 1,000 relatives of persons with glaucoma, with the intent of determining the mechanisms of disease transmission among families.

Results have substantiated the unusually high frequency of open-angle glaucoma and its importance as a cause of visual loss in the black Barbadian population. Considerable information was also obtained on associated risk factors, such as intraocular pressure and family history, providing better knowledge about the disease and assisting the identification of high-risk groups. The studies also determined that cortical cataract was the major type of lens opacity in this population and identified various risk factors, some being potentially modifiable. These factors include diabetes, hypertension and obesity, which the studies also linked to other major eye diseases. Analyses of the long-term follow-up data are providing information on the risk and progression of all major blinding eye diseases. These data are essential to develop sound prevention and health delivery policies in our population and similar groups.

3. Ophthalmic Manifestation of Systemic Disease

David Callender,
Consultant Ophthalmologist,
Queen Elizabeth Hospital

The eye is a very complex organ, with a mixed embryological origin. It houses the only part of the body, the retina, where direct visualization of brain tissue and blood vessels can occur without the need for any invasive procedure. For this reason, medical conditions which affect the nervous system, the vascular system, and the circulation in general, may show changes in the eyes, sometimes before there are any systemic signs. In addition, as some parts of the eye and the skin share a common origin, some connective tissue disorders also show ophthalmic features.

Utilizing a systematic approach based on anatomical landmarks, ophthalmic manifestations of systemic disease can be grouped according to the affected structures in the eye. This presentation serves to highlight the ophthalmic features of some of the more common conditions seen in general practice.

4. The Eye in General Practice

Dr. C.V. Alert MBBS, DM.
Family Physician.

"Some eyes are born dysfunctional,
Some achieve the dysfunctional state,
And some have dysfunction thrust upon them".

Family physicians should be aware of guidelines for the appropriate evaluation of visual function from birth to old age, and be available to guide on the prevention of eye injuries and visual loss.

Family physicians should be committed to helping patients and their family members adjust to illnesses that may significantly affect daily life and family function – dysfunction of the eyes fall into this category. In general there are three presenting symptoms of eye disease – pain, loss of vision, and discoloration. Since there are often subtle differences between non-serious and serious eye conditions, family physicians are urged to appreciate these differences, so that appropriate decisions can be made as regards 'when to treat', and 'when to refer'.

5. Failing Vision in the Elderly

Michael D. Hoyos, CBE,
Hon. Distinguished Fellow UWI

Failing vision in the elderly is a common problem, being present without symptoms and sometimes in denial, in many senior citizens who attend their doctors. This presentation highlights its prevalence, and the need for physicians to be proactive by uncovering failing vision with Snellen's charts or the pin hole method. It stresses the need to examine the eyes of the elderly for early diagnosis and referral of lens opacities, glaucoma, and diabetic retinopathy.

Failing vision is more than a problem of ophthalmology, for its impact compromises quality of life with significant personal, family and social consequences. Poor vision and falls in the elderly, with resultant morbidity, mortality and loss of confidence and mobility result in dependency, pressure on carers and eventually, in some cases abandonment.

The impact on self-care is discussed, difficulties with compliance with medication and with foot care in diabetes. The conclusion is that all who care for the elderly, regardless of specialty must be involved in diagnosis and care of seniors with failing vision.

6. HIV Ophthalmology

Mr. John Pitts,
Oculoplastic Surgeon, UK

In 1981, a new disease appeared in the USA, characterized by Pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma in gay men. In 1983, the virus responsible was discovered and named LAV by Montagnier at the Institut Pasteur in Paris. In 1984 the virus was designated as HTLV-3 by Gallo in the USA. The resulting professional sparring match culminated in law suits between the governments of those countries. To restore order, the virus was renamed as HIV.

Retroviruses use reverse transcriptase to transcribe DNA from RNA. There are 36,000,000 HIV carriers worldwide, 12% of whom are women. Spread is vertical (in-utero, at birth or during breast feeding) and horizontal (during sexual intercourse, with contaminated needles, or during blood transfusion or organ donation).

AIDS is anti-body confirmed HIV infection with CD4 T- lymphocyte count less than 200 (CDC Atlantic definition) or is based on indicator diseases of fevers, weight loss of 10%, and diarrhoea for 1 month (WHO definition for use in sub-Saharan Africa).

Clinically, it includes wasting syndrome and constitutional disease, encephalopathy and neurological disease, opportunistic infections (PCP, TB, Tinea, Candida, HSV, molluscum) or cancers (Kaposi's sarcoma, non-Hodgkins lymphoma, primary CNS lymphoma, Hodgkin's disease, and testicular tumours). The eye conditions seen in HIV include kerato-conjunctivitis sicca, Herpes zoster ophthalmicus, Kaposi's sarcoma of lid or conjunctiva, molluscum contagiosum, infectious keratitis, iritis, anaemic retinpathy, HIV retinopathy, Toxoplasmosis, acute retinal necrosis and CMV retinitis.

HIV retinopathy causes cotton wool spots, intra-retinal haemorrhages and microaneurysms.

CMV retinitis has been nicknamed "Cheese and tomato pizza retinopathy". It consists of pale retinal necrosis with or without haemorrhage, spreading along and occluding vessels. It affects 1 in 3 patients with a CD4 count below 100. Patients with HIV and low CD4 counts should be screened regularly.

Previously, patients with CMV retinitis died within 9 months of diagnosis. Since 1996 HAART (Highly Active Anti-Retroviral Therapy or "triple therapy") has revolutionised the management of AIDS, and survival times of 10-15 years are not unusual now.

While CMV can be treated with ganciclovir, foscarnet or cidofovir, the ideal option is to boost the CD4 count rather than continue long term anti-CMV drugs.

Further reading

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7. Indications and Correct Use of Contact Lenses

Christopher King,
BSc(Hons) MCOPtom, Opthometrist

Contact lenses, when indicated, offer a viable alternative to spectacle correction for common refractive errors including myopia, hyperopia, astigmatism and presbyopia. Patients with more severe refractive conditions such as severe myopia, aphakia and anisometropia often have enhanced visual performance when corrected with contact lenses as compared to spectacles. Indeed, the use of rigid gas permeable (RGP) lenses is the mainstay of treatment for keratoconus and

other ectatic dystrophies in which irregular corneal astigmatism, induced by corneal thinning and distortion, causes a progressive loss of visual acuity. Contact lenses offer visual improvement which could not be achieved with spectacles.

However, this is not the only indication for contact lens use. Contacts are also indicated in certain conditions where the benefit is therapeutic and simply not visual. Soft lenses are often used as a mechanical barrier to prevent further corneal compromise and enhanced ocular comfort in cases of trichiasis, recurrent corneal erosions, corneal abrasions and post PRK surgery.

The use of specially tinted soft lenses offers improved cosmesis in persons with corneal scarring or pigmentary defects of the iris. Visual benefit may also be derived in cases of aniridia and iris coloboma.

All contact lenses, no matter what the indication, should be considered as medical devices. A comprehensive preliminary assessment of patient suitability and a rigorous routine of aftercare is required to prevent the possibility of sight-threatening complications.

8. Diabetes and the Eye - A practical approach for GP's

Dr. Cyril Reifer,
Consultant Ophthalmologist,
Queen Elizabeth Hospital

This presentation outlines the importance of having a good working knowledge of the natural history of the disease, its effects on the eye as well as an appreciation of the optimum time for seeking an ophthalmic consultation for the patient.

Because diabetics are living longer, the incidence of diabetic retinopathy has greatly increased. This is the biggest single case of registered blindness worldwide. Diabetes also affects the eyes in other ways and the ocular manifestations of the disease should be known to all General Practitioners, because as the primary care providers, they can influence the long-term visual outcome of patients.

It is my opinion that the GP's should assume a more active role in the early prevention diabetic retinopathy and the education of the diabetic patient.

9. Strabismus: A Common Eye problem in Children

Dr. Kirk Miller,
Queen Elizabeth Hospital

Strabismus (squint) refers to a misalignment of the eyes in which the visual axes deviate from bifocal (normal) fixation as a result of extraocular muscle imbalance. This abnormal ocular alignment is one of the most common eye problems encountered in children. Ocular deviations occurring during the first 3-months of life does not necessarily indicate an abnormality. Oculomotor instability is expected during this time and therefore alignment assessment is not usually made until the patient is approximately 3-months of age. The mean prevalence of strabismus in the Western hemisphere is approximately 5% and is an important cause of visual and psychological disability in pre-school children.

Strabismus may be congenital (<6 months) or acquired and may be unilateral or alternating. Strabismus can be essentially classified as follows: Esotropia (convergent squint), Exotropia (divergent squint), Hypertropia (upgaze squint), Hypotropia (down gaze squint). These may be further classified according to whether they are comitant; that is, equal misalignment in all directions of gaze with no muscle paralysis or incomitant (non-comitant) in which the misalignment is varied because of extraocular muscle paresis or paralysis. Of note, pseudo-squints are a common entity and are characterized by the false appearance of a squint when in fact the visual axes are accurately aligned.

There are certain risk factors known that play a contributing role to squint development. For instance, approximately 30% of children born to a strabismic parent will themselves develop strabismus. In addition, infants who suffer from cerebral maldevelopment; for example, occipito-parietal and intraventricular haemorrhages, have a 50-100 fold increase of squint development. Also, infants with very low birth weights, with treated or regressed retinopathy of prematurity,

ocular or oculocutaneous albinism and Down's syndrome are also at increased risk. Cranial nerve palsies (CN 3, 4 & 6) and certain strabismus or restrictive syndromes; such as, Duane Refraction syndrome, Mobius syndrome, Brown syndrome and general fibrosis syndrome are also causes of strabismus.

The management of strabismus may be conservative or surgical but depends on several factors; such as, the age of presentation, the type of squint, the size of the deviation, the refractive error and the visual acuity (presence or absence of amblyopia). The common goal is to permit the development of binocular function where possible. Conservative management usually involves the use of spectacles, patching, prisms or cycloplegic penalizations. Surgical treatment and its timing remain controversial; however, it usually involves extra-ocular muscle recession (posterior re-insertion) and or resection (shortening of muscle length) of the horizontal recti muscles at varying distances according to the extent and type of deviation of the squint. Other extra-ocular muscle manipulations are also performed surgically depending on the characteristics of the strabismus and muscle involvement.

10. Diabetic Retinopathy

Narendra Armogan, MD, FRCSC,
Mount Sinai Hospital;
– Clinical Instructor, University of Toronto

Diabetes and its related complications remain one of the more difficult diseases of our times affecting both affluent (through obesity and poor dietary management) and emerging (poor access to drugs, lack of education and poor diets) populations.

Diabetic retinopathy remains as one of the principal causes of irreversible blindness in the world (other include cataracts, glaucoma and macular degeneration) with a spectrum of findings in the eyes all of which affect vision in different ways; including, ischemia secondary to non-perfusion of the capillary bed, oedema leading to photoreceptor disorganization, bleeding into the vitreous cavity and complicated tractional fibro-vascular changes in the retina which can lead to detachments and permanent visual loss. The classification of diabetic retinopathy while not related directly to the severity of the systemic disease is based on the risk of progression and allows one a ready appreciation of a patients risk for progressive visual loss and blindness.

Current management strategies for diabetic retinopathy include systemic control, management of hypertension, renal disease management and overall health management. Unfortunately even with the best intentions patients continue to deteriorate leading to further treatments which include the use of photocoagulation (lasers), injections into the vitreous cavity and surgical interventions. The goal of this presentation is to introduce the classification for diabetic retinopathy, its clinical correlates and the related therapeutic management for this difficult disease.

11. Orbital Cellulitis

Mr. Christopher Maynard,
ENT Surgeon,
Queen Elizabeth Hospital

From an ENT perspective, orbital cellulitis is usually a complication of acute bacterial sinusitis. Other less common causes include, penetrating injuries and post-surgical sepsis.

In Barbados, less than seven cases are admitted to the Queen Elizabeth Hospital annually and more than fifty percent of these require some form of surgical intervention. The anatomical proximity of the orbital cavity to the paranasal sinuses lends itself to the direct spread of sepsis from the sinuses to the orbit and beyond.

Anticipation of this complication along with early referral for evaluation and investigation with aggressive anti-biotic treatment with timed appropriate surgical intervention can prevent loss of vision and more life-threatening complications.

Ethical Practice

IN EVERYDAY HEALTH CARE *By E. R. Walrond*

Published by the University of the West Indies Press (2005)
ISBN: 976-640-164-0

BOOK REVIEW

By Professor Henry Fraser
Dean, School of Clinical Medicine and Research, UWI Cave Hill

Every so often one comes across a text book that is as engrossing as any thriller. ***Ethical Practice in Everyday Health Care*** is just such a book. From the very first paragraph, in which Professor Walrond introduces the first of many moral / religious issues (the Roman Catholic Church and contraception), to the very last, which throws out the challenges of the HIV affected orphan, this book is compulsive and enjoyable reading.

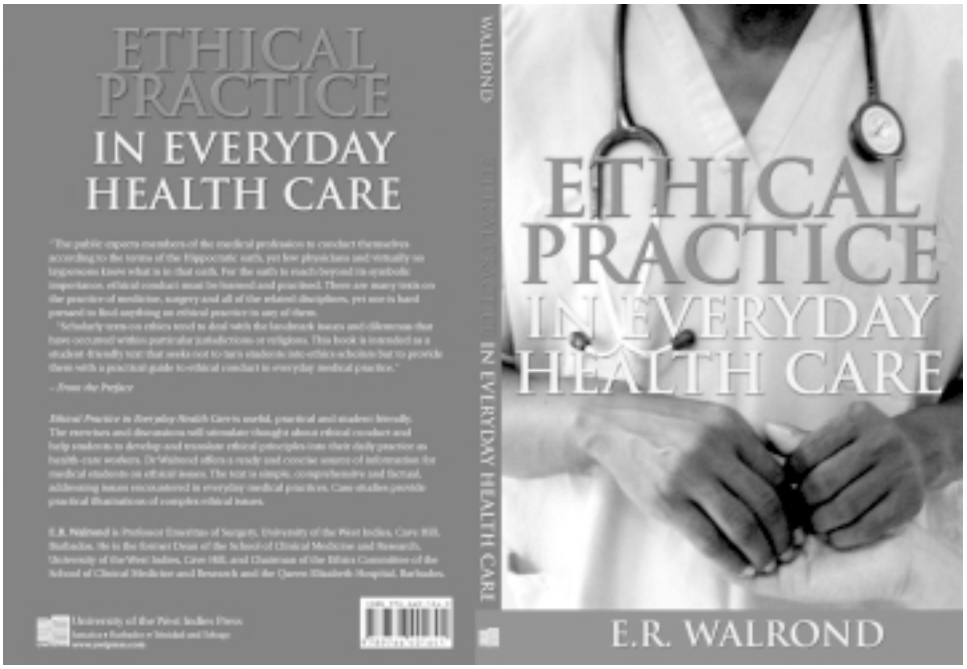
The jacket blurb describes it as "*useful, practical and student friendly … the text is simple, comprehensive and factual, addressing issues encountered in everyday medical practices. Case studies provide practical illustrations of complex ethical issues.*" Professor Emeritus the Honourable "Mickey" Walrond himself describes it modestly as "*intended as a student-friendly text that seeks not to turn students into ethics scholars but to provide them with a practical guide to ethical conduct in everyday medical practice.*" He intends it to fill a gap left by most medical textbooks and by the more scholarly texts on ethics.

I think the book succeeds wonderfully. In his acknowledge-ments Professor Walrond thanks the colleague who suggested that some student exercises should be added. In fact he added some 86 exercises! While the main text is outstanding for its clarity and logical trains of thought, and the major theoretical aspects of ethical practice are covered (starting with definitions and the Hippocratic oath), the exercises, to my mind, are the real riches of the book. Many of them sound familiar, as if recalled from the monthly Saturday morning Ethics Conferences in the QEH Auditorium, coordinated for so many years by the author and now by Dr. Harley Moseley. They are invariably "true to life" and intriguing, and it's great fun to read the exercise, speculate on the issues and "best ethical practice", and then consult the discussion. The issues are objectively discussed, and when they are muddy this is acknowledged. The importance of seeking second or more senior opinions, or legal advice, is constantly emphasised.

But ***Ethical Practice in Everyday Health Care*** should not for a moment be considered just a textbook for students. **While every medical student should acquire it, read it from cover to cover and return to it for patient after patient, I believe every registered medical and health care practitioner should do the same.** The fact is that most of us have graduated with minimal teaching on ethical problems and solutions, and we often flounder when faced with difficult ethical decisions. The Terry Schiavo fiasco, played out over many years and finally becoming an international tragi-comedy, indicates the complexities and the difficulty of these issues. We all need to know more, to think about the problems more, and to have ready access to a useful guide.

As ERW says "*One is hard pressed to find anything on ethical practice in medical texts*". The School of

Clinical Medicine and Research at Cave Hill / QEH and the programme of the Medical Faculty at Mona have recently introduced a formal course in Medical Humanities, in which Medical Ethics is a major component. This book will of course be the recommended text for the course and for all medical students. As a major medical text it is a first for Professor Walrond, a first for the School of Clinical Medicine and Research and a first for the UWI Press, which has finally entered, with great success, the arena of medical publishing!



The Book - Ethical Practice in Everyday Health Care by Prof. E. R. Walrond

Get your copy quickly or you may have to wait for a reprint!

History' Page

25 Years Ago

BAMP Bulletin July 1980

COUNCIL MATTERS

Discussion between BAMP and the JHMSA have been continuing with the aim of getting a larger membership among hospital staff.

The general feeling of Council could be summarised as follows:-
(1) We need maximum membership, including junior hospital staff.
(2) We need money in order to continue performing even as well as we have so far; we need a lot more money to produce the kind of work necessary to deal with the problems looming on the horizon.

To illustrate how badly this may be necessary just look at the amount of paper work that has to be done.

Council is working frantically to work out a response to Government's latest NHS pamphlet. This work is not done on scraps of paper. Drafts, re-drafts, and re-redrafts are being typed and circulated almost daily. This is all without any proper employment of secretarial staff.

Council has discussed taking on a part-time secretary, which will cost $400 per month = $4800 per annum. This at present Subscription rates represents fees for 48 members (50% of our membership) or 134 annual membership fee from junior hospital staff within three years of qualification!!!

In summary the JHMSA position is as follows:-
(l) Junior medical staff of all grades, being salaried cannot afford to pay the full membership fee - currently $100.
(2) JHMSA does not basically feel that BAMP Council will have their interests at heart and is not therefore prepared to become a sub-committee of BAMP.

JHMSA therefore requests:-
(a) Reduced membership fee for all doctors who are not entitled to private practice (currently available under our Constitution, for three years after qualification at a third = $34.
(b) JHMSA to continue to exist as a separate entity, collecting its own membership fees (currently $30 per annum).

In response to this the JHMSA position one would have to consider .....

Editor's Note

The more things change the more they remain the same. Members are aware of some of the sentiments expressed here remain the same. By its very nature the leadership and expertise of a JHMSA remains inexperienced and what has happened over the 25 years since this was being discussed bears looking at carefully. In comparison with staff in the rest of the Caribbean how would the junior staff consider their current position.

The financial problems of BAMP remain precarious and there is continuing debate about how to secure more paying members. For although we have advanced on the secretarial staffing and being able to afford paper, there are still a number of problems to be addressed.

20 Years Ago

BAMP Bulletin July 1985

COUNCIL NEWS

ETHICS AND THE MEDICAL PROFESSION IN BARBADOS
FROM THE ETHICAL COMMITTEE OF COUNCIL

Ethics as part of the professional activity of medical practitioners can be defined as a framework of principles and laws which allow the profession to interact with patients, the society in general, and most importantly with members of the other professions without unnecessary recourse to the Courts. The Ethical Code which is derived from such principles should be seen primarily to benefit and patients whom the profession serves. However, there are also elements in an ethical code which will serve to promote and protect the interests of the profession itself.

The Ethical Committee of the Barbados Association of Medical Practitioners, currently chaired by Sir Maurice Byer, was specifically constituted to advise members on ethical problems in general, however, in some instances, specific advice is also given. The Committee is not a replacement for the semi-judicial body, the Medical Council, which is empowered to regulate the conduct of the profession and to discipline it when necessary. BAMP's Ethical Committee therefore advises members on what are the acceptable practices they should follow. Adherence to the Committee's advice will keep members from coming before the Medical council, but will also ensure that members maintain a harmonious relationship with colleagues, their patients, and the community in which they practice.

The ancient Hippocratic oath which the public thinks the professions adheres to is somewhat outdated.

Editor's Note

The aims of the ethical committee of BAMP and the need for it remains the same. The late Sir Maurice Byer was always pointing out to his students the 'paradox of the absurd' in STD control, for he said that in spite of curative antibiotics and contact tracing the STD's continued unabated. He would have been fascinated by the vigour of debate on the control of the spread of HIV, and perhaps would have found some views even more absurd.
There have always been complaints that practitioners do not know how to conduct themselves ethically and this is usually laid at the door of the youngsters, although one must admit that they probably pick up most of what they know from their elders. It is difficult to find easily readable material on the ethical issues that faces one in everyday practice. A book that tries to fill that void is reviewed in this issue of the Bulletin, and as the reviewer notes the book has exercises that can be used by students but is intended for every practitioner.

15 Years Ago

BAMP Bulletin July 1990

Happy Anniversary Barbados Drug Service

One often hears reference to the past as the "good old days", but prior to April 1980, prescribing in general practice could not be described as good. The doctor was never certain that the medication prescribed for a sick child would be taken, for some parents could not afford to pay the doctor's fee and buy the medicine. In other cases the medicine was bought, but at the expense of not being able to afford milk for the child. Poor compliance was a problem in the treatment of chronic diseases such as diabetes and hypertension. But the lack of compliance was not related to the inconvenience of taking medication or to the side effects of the drugs, but to the cost. The patient simply the could not afford the treatment. Old age pensioners suffered the most, they often could not afford their medication on their small pension.

All of this has changed since the introduction of the Barbados Drug Service on April 1st, 1980. The service has grown from initially providing medication free at the point of delivery to old age pensioners and those patients suffering from hypertension, diabetes and cancer, to the present, where children under sixteen have been included, and the special benefit groups now include asthmatics and epileptics.

All Barbadians should be proud of the achievements of the Barbados Drug Service as it celebrates its tenth anniversary this year. It is second to none. Even in a wealthier and more developed country like U.K. there is a charge of three pounds and five pence per prescription. We don't have to look far to see how fortunate we are in Barbados. Basic essential drugs are often not available in Guyana.

There was a recent case of a young lady from Trinidad who lost her sight in one eye as a result of macular haemorrhage secondary to her hypertension. She could not afford to buy the medication because her husband was at law school and things were financially tight.

The introduction of the Drug Service must rank as a major mile-stone in the development of Barbados. The goal of "health for all by the year two thousand" cannot be achieved without the introduction of the service.

However, there are a number of areas within the service that continue to be of concern to the medical profession. Cost has to be contained. No country can afford to have an open ended drug service, and no government

would be re-elected if taxes have to be increased continuously to offset health care costs.

Editor's note

It is now the 25th anniversary of the drug service, and it is still going strong. In fact it now has the additional burden of providing the drugs for the treatment of the AIDS patients. It has spawned a number of imitators, not clones, around the Caribbean. The OECS, Trinidad and now Jamaica are all trying to have some kind of service and this is well in advance of that being attempted in the USA.

There is no doubt that the control of diabetes and hypertension have improved since the introduction of the drug service, but not as satisfactorily as one would like. There is a need for a major thrust in life style management to avoid the increasing numbers of new diabetics and hypertensives. Such Life style changes are primarily related to diet and exercise. Unfortunately, these are increasingly looked at as a prescription, and government will have to take the lead in providing places where those getting on in years can feel safe to be out before and after work, we could start with lighting our beaches. Changing our diets is going to be a lot more difficult but the hand has to be put to the plough.

As regards the drug service it needs to eliminate waste and fraud and modern computer technology should be able to assist in this. BAMP again wishes the Drug service a Happy Anniversary and looks forward to working with it for further improvements for the benefit of the people of Barbados.