PORTRAITS
OF
OPHTHALMOLOGY
AT McGRILL UNIVERSITY
1876-1990

Sean B. Murphy
PORTRAITS

OF

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by

Sean B. Murphy
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Fig. 22 – Dr. Bruce Ramsey. Permission to use photograph given by Dr. Ramsey’s widow, Norah Ramsey. Photograph was taken by George Nakash, Montreal, 1963.

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The specialty of ophthalmology was established in 1876 at McGill University. What follows traces the field’s development for a little over one hundred years. During this time, more advances in ophthalmology were made than in the whole of recorded history - in fact, this statement is equally true of the last fifty years.

One might question the need for a history of a university specialty which focuses upon caring for individuals in the present and the future. In response, I would answer that such a history acts as a record to help explain how the specialty and its practitioners, developed the expertise currently displayed at the university and its affiliated hospitals - expertise which will only be further developed in the future. Such a history can connect the reader, be he or she a doctor, medical student, or merely an interested individual, with the past, and can help one to understand how things have evolved. It may also enrich your knowledge, helping you learn about people, and thus, preserving the traditions of the past by ensuring that they are not forgotten. Furthermore, such a history gives the university and its hospitals a personality which develops loyalty and respect. Hopefully, with this knowledge, we can avoid the mistakes of the past - and deal with the future successfully.

This particular history is a story about people at McGill University and their accomplishments in the field of ophthalmology over a roughly one hundred year period. It portrays their successes and failures, and examines how they reacted to changing times and dealt with difficult issues. More specifically, this is a story of leaders in the Department of Ophthalmology, one of the rare disciplines encompassing medicine and surgery and dealing with all ages from childhood to old age. These leaders had a vision of what they wanted to achieve and they fought to realize their goals with the support of loyal and dedicated colleagues. In fact, without the help of colleagues, the leaders could not have accomplished what they did.

Throughout the years, a most important feature of the Department staff was that, as a group, they respected each other and got along well together within their respective institutions - the Montreal General Hospital (MGH), the Royal Victoria Hospital (RVH), the Montreal Children’s Hospital (MCH) and the Jewish General Hospital (JGH). At times, however, there were
tensions in interhospital relations - inevitable when dealing with all manner of personalities in good and difficult periods. Nonetheless, the leaders had energy and a strong sense of realism which enabled them to advance the Department within the constraints they were faced with at any given time. These advances occurred over several years and alternated with periods of consolidation, coinciding with the appointments and retirements of the various Department heads. It was thus that the Department of Ophthalmology at McGill developed from a single ophthalmologist in 1876 into the flourishing academic and clinical centre, with a staff of 65, that it became in the 1980s and continues to be today.

For over one hundred years the strength and reputation of the Department has been its clinical and surgical excellence, first rate patient care, research, and teaching (which at first mainly involved medical student teaching). Initially, the department was small. However, from the 1940s it grew and its strengths were enhanced. This was especially true of the period stretching from the 1950s and 1960s to the present, during which time residency training, as well as clinical and basic research, came into their own.

While the history of the department includes structural, technical, and clinical developments, it is primarily the story of the individuals who staffed the ophthalmology department. It was those people who were the principal agents of change in the department, and without whom the department would not have been created, let alone developed into the significant centre for training, research, and treatment which it is today. Thus, this book follows the lives, times, and ophthalmological contributions of numerous members of McGill’s Department of Ophthalmology, as well as the various hospital based ophthalmology departments where McGill’s ophthalmology students and residents were trained and the university’s ophthalmologists taught - the MGH, RVH, (MCH) and (JGH).
ACKNOWLEDGEMENTS

In researching the various ophthalmology departments’ records for this project, it was found that the records, especially those from the pre World War II era, were often incomplete. Thus, in order to provide the most complete description of the lives and contributions of McGill's ophthalmologists, the author also made extensive use of existing information concerning the institutions and individuals involved, as well as hospital, government, and university archives. Furthermore, where possible, interviews were conducted with those who were still living, as well as surviving friends, relatives, and colleagues.

Finally, this history is a personal story - the emphasis here and there is the author’s, as is the selection of people involved. Unfortunately, there is not enough space to mention everyone who was and is connected with the Department of Ophthalmology. However, regarding the writing and publication of this text, the author would like to thank Ann Anderman, for her research into the early days of the Department, Victoria Lees for her editorial suggestions, Cristin McCauley for her research at the McCord Museum, and Mary Houde. He also thanks Dr. Miguel Burnier for his support.

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I am also indebted to those whom I was able to interview and to all who responded to letters asking for input into this history.

Great care was taken to gain the permission of the subjects and creators of all of the photographs included in this text. Where the relevant individuals or institutions could not be contacted, the subject and creator are acknowledged.
Initially temporarily located in a house on Craig Street, the Montreal General Hospital was first opened on May 1, 1819. Founded as a result of the efforts of several of Montreal’s influential political and social leaders, as well as a number of charitable organizations, such as the Society for the Relief of Immigrants and the Female Benevolent Society of Montreal, this interim facility of 24 beds and an outpatient department was replaced three years later by a much larger 72 bed, two story, permanent building located on Dorchester Street.

In addition to a new hospital, the 1820s also saw the creation of both a new institution of higher education and a medical school in Montreal. The charter for the creation of the former, McGill University, was granted in 1821. While officially created at the beginning of the 1820s, no classes were held at the university until the end of the decade, when McGill absorbed, and adopted the duties of, the Montreal Medical Institution. The Montreal Medical Institution had been created by Dr. W. Caldwell and his colleagues at the Montreal General Hospital in 1823 to function as a teaching arm of the hospital. Beginning that year, the Medical Institution started offering lectures to medical students, and in 1829 this task was made the function of McGill’s Faculty of Medicine, the university’s first teaching faculty and the first university medical faculty in British North America.

Regardless of the establishment of the Faculty of Medicine early in the century, it was not until 1876, some forty-seven years later, that ophthalmology came to McGill. Dr. Frank Buller, McGill’s first specialist, was also the first academic ophthalmologist at the university, bringing with him the latest developments in European ophthalmology. The university, recognizing the importance of the specialty, appointed him the first Chairman of the new Department of Ophthalmology and Otolaryngology in 1883.

In the 1870s Montreal had a population of 150,000 (today it is almost 3 million). In 1875 William Hingston was the Mayor of the city, and Montreal was beginning to deal with various health and sanitation problems, including a smallpox epidemic.

The city was expanding its railroad network. Train travel to Ottawa, Quebec, and Halifax was being established. The Delaware and Hudson Company began regular service to New York City, and the Laurentian railway to St. Jerome began operating. The transcontinental Canadian Pacific Railway track was not yet in existence. The Windsor Hotel
opened – Canada’s grand hotel – and in 1879 the first flight of an air balloon took place. The port of Montreal was active with numerous sailing vessels to be seen at anchor.

At that time, all clinical teaching was carried out at the MGH. Yet, in 1894, the Royal Victoria Hospital opened its doors, giving McGill two teaching hospitals, since the staff of each held positions at the university. In effect, this left McGill with two autonomous medical faculties. However, over time, control of the different medical faculties was consolidated by the university, and control over each hospital’s residency training, student teaching, and research programs was placed under the management of McGill with the signing of an agreement between the university and the hospitals in 1970. While McGill has always appointed the Chairman of the university’s Department of Ophthalmology, the Chairman, unfortunately, did not hold any significant authority over the hospitals’ ophthalmology departments until the 1970 agreement went into effect. Indeed, it was only in 1970 that McGill was even able to exert control over the running of, and student acceptance to, the residency training program, with the change that residents were now required to apply for acceptance to McGill University rather than to the separate hospitals. However, since the 1970 agreement, the McGill Chairman, in cooperation with the hospitals, has been responsible for the organization of medical student teaching and ensured that the same teaching is given in each hospital. The Ophthalmologist-in-Chief of each hospital is responsible for the activities of that department – clinics and surgery.

In addition, to changes in the organization of ophthalmological teaching at the university, the passage of time also saw many advances in how ophthalmology was practised and taught. Such advances occurred with both changes in the techniques and technology used, as well as an expansion of ophthalmologists’ understanding of the eye. However, while changes in treatment, instrumentation, surgical advances, technological developments and subspecialization all play an important role in our story, this book does not present a history of the scientific developments in ophthalmology. Rather, it primarily offers a history of the people involved, their actions, and how they influenced what McGill’s ophthalmology department has become.
PART I:
HISTORICAL DEVELOPMENT
1876-1970
Chapter 1:  
The establishment of McGill University and medical education in Montreal

On January 8th, 1811 James McGill, the Scottish-born Montreal fur trade merchant had his final will drawn up, dictating to whom and what ends the great wealth he had accumulated in the British North American fur trade would be distributed in the event of his death. One of the stipulations of that will was that his 46 acre estate, named Burnside, located outside of what was then Montreal, as well as a grant of £10,000, would go towards the establishment of a college. The land and money was entrusted to the Royal Institution for the Advancement of Learning, a sort of government education commission for Lower Canada which was headed by the Governor. Formed by the colonial government in 1801, the Royal Institution was created for the purpose of establishing schools, naming school masters, and paying their salaries in a province which was greatly lacking educational facilities, including institutions of higher learning other than religious seminaries. As James McGill stated in his will:

I give and devise all that tract or parcel of land commonly called Burnside, situated near the city of Montreal...unto...John Richardson, James Reid, John Strachan, and James Dunlop... upon condition that the said ‘Royal Institution for the Advancement of Learning’ do and shall, within the space of ten years, to be accounted from the time of my decease, erect and establish, or cause to be erected and established, upon the said last-mentioned tract or parcel of land, an University or College, for the purposes of education, and the advancement of learning in this Province, with a competent number of Professors and Teachers...

McGill passed away almost three years later in December, 1813. True to the conditions of his will, the charter of the University of McGill College was granted by George IV in 1821, within ten years of his death. However, due to protracted legal battles over the manner in which James McGill had intended his fortune to be distributed, the university lacked sufficient funds to hold classes until 1829. Meanwhile, in 1823, the Montreal Medical Institution had been founded as the teaching arm of the MGH. Created by Doctors
Robertson, Stephenson, Caldwell and Holmes, all graduates of the University of Edinburgh, the Montreal Medical Institution began its first session of medical instruction in November 1823. Twenty-five students attended that year, and the numbers increased exponentially up to the turn of the century, at which time there were 425 students “enregistered.” Yet, by century’s end, the Montreal Medical Institution had long since ceased to exist in its original form. Rather, in 1829 it became affiliated with McGill University. Indeed, this affiliation with a university that had previously only existed in law and not in fact, not only made the Montreal Medical Institution McGill’s first teaching faculty, but the first university medical faculty in British North America. At first the university was a very small affair, consisting only of the medical faculty.

Initially, the MGH served as the sole teaching hospital for McGill’s Faculty of Medicine. In 1887 plans were being made to build the RVH, which would also be affiliated with McGill University. At the time a committee was established to consider the question of amalgamating the two hospitals, but difficulties in achieving this prevented any move in that direction. However, it was to be some one hundred years before this idea was seriously considered again.

While McGill’s history of medical education and the university’s affiliation with its teaching hospital began in the 1820s, as mentioned in the introduction, the medical specialty to which this history is devoted did not appear at either McGill or the MGH until the mid-1870s. However, that is not to say that Montreal was completely devoid of individuals with specialized knowledge concerning the eye before that time. Rather, the city’s first well trained ophthalmologist was a French-Canadian, Dr. Louis Edward Desjardins. He graduated from L’École de Médecine et Chirurgie de Montréal in 1864 (founded in 1843), after which he spent seven years in general practice before going to Europe to specialize in ophthalmology. There he worked in London under Bowman and Critchett and in Paris under de Wecker, Galezowski, de Sichel and Meyer. Returning to Montreal in 1873, Desjardins founded the Nazareth Ophthalmic Institute where he practised for over thirty years. In 1882, he was appointed Professor of Ophthalmology at L’École and oculist to the Hôtel Dieu Hospital.

At McGill, during the 1860s and early 1870s, not only was ophthalmology not yet established as a specialty, but the instruction and facilities offered to the medical students have been described as rudimentary. Francis Shepherd, Dean of the Faculty, who later assisted Dr. Buller in establishing himself at McGill in the field of Ophthalmology, reminisced that when he entered the medical faculty as a student in October 1869:
the building of the Faculty, which was a proprietary one, was situated in the lower part of town, on Côté Street, and next door to the old Théâtre Royal. In those days the only laboratory was the dissecting room; there was no physiological, chemical, or biological laboratory. Teaching of the primary subjects, exclusive of anatomy, was entirely by lectures.³

By the mid to late 1870s the form of instruction and the facilities with which Dr. Shepherd had to contend were being modernized. From a medical education which was “scanty and purely theoretical” where “such a thing as a microscope one rarely saw,” medical science was being adopted more fervently and laboratories were being instituted. The first laboratory at McGill was established by William Osler toward the end of the decade.

Building up towards this event, one can observe a shift in the way in which the members of McGill’s medical faculty viewed the study of medicine and the increasing importance of experimentation, the creation of knowledge, physiology, pathology, rational therapeutics and the pursuit of scientific medicine in general. An example which clearly illustrated the change in the university’s medical training focus, was an introductory lecture delivered at the opening of the session of the medical faculty in September 1874 by Duncan Campbell MacCallum, professor of obstetrics and gynaecology at McGill. In his address to the future medical graduates of’78, Dr. MacCallum stated:

Gentlemen: -...For many centuries Medicine remained simply a science of observation. Therapeutics or the knowledge of the treatment of disease during this period was consequently of the most elementary kind. Experimental investigation to determine the laws of life, their operations in maintaining the normal healthful state of the human economy, and the influences which, by disturbing the harmony of their actions, produced disease, was, from the difficulties which attended its prosecution, altogether neglected. The religious element in man, which in his unenlightened state led him to attribute disordered conditions of the system to the malignancy of evil spirits whom he defied and endeavoured to propitiate by rendering them homage; in later years and in the light of Revelation led him to consider that disease was caused by the direct and immediate action of the Divine Being. This theological view of disease coupled with and mainly the result of profound ignorance of physiology, long retarded the advance of the healing art.
The introduction of experimental investigation into the study of the sciences which form the ground work of Medicine, has thrown a flood of light on the true nature of disease, and dispersed forever the superstitious view which had previously obtained, replacing it by the higher and nobler view, that every disordered state is the consequence of definite antecedent conditions, which, under the same circumstances, invariably produce the same results. And it has been by long continued and carefully repeated experiment, that all brilliant discoveries which have made Medicine the noble and elaborate science which it is to-day, have been accomplished. And still the work goes bravely forward. Earnest enquirers are ever questioning the secrets of nature, and striving to penetrate the mysteries of life. So numerous of late years have been the workers in the fields of Physiology, Pathology and Therapeutics, and so extensive and important have been their successes, that the science of Medicine has been in great part revolutionized.4

At the time of MacCallum’s address, the Faculty of Medicine at McGill was joining this scientific revolution in medicine and began to take an active role in contributing to the global pursuit of medical science. An important product of the rapidly growing pursuit of medical science was the emergence of medical specialties. Thus, during the 1870s and 1880s, certain specialties were being introduced at McGill within the burgeoning Montreal milieu.
Chapter 2:
The Early Years: The specialty of ophthalmology at McGill, 1876-1905 – Dr. Frank Buller, founder of the McGill Department of Ophthalmology

Ophthalmology, as a specialty, did not exist at McGill nor at the MGH until 1876. In this era, physicians were not expected to be specialized in a particular area of medicine, but rather, have a general medical knowledge and be able to look after all types of patients. As William Osler recalled, in 1914:

I still shudder at the remembrance of the ‘good old days’ at the MGH, when cases of pneumonia, fractured legs, and cataracts were jumbled in the same ward, under the care of the same man; and it was not without qualms of conscience that the staff consented to the appointment of an ophthalmic surgeon, my friend, the late Dr. Buller.\(^5\)

Likewise, Dr. Francis J. Shepherd reminisced that, “the specialities of eye, ear, nose and throat [and] gynaecology were non-existent in my student days [1869-1873], the surgeon usually doing the eye operations and everybody doing the rest.” He noted that, before specialists were appointed, “everybody did everything and no one could prevent the attending men from performing operations and treating cases for which they were totally unfitted.”

As noted above by Dr. Osler, the employment of doctors at McGill, or its associated hospitals, for their specialized expertise, and not only their general medical knowledge, only began with the appointment of Dr. Frank Buller. Dr. Buller was the first, in Montreal, and probably in Canada, to practice modern ophthalmology. In 1876, with the support of William Osler and Francis J. Shepherd, he established the first Ophthalmic clinic at the MGH.

Dr. Buller was born in Campbellford, Ontario in 1844. At the age of sixteen, he attended high school in Peterborough, Ontario. During his summer holidays, he learned dispensing, and “made himself generally useful” to Dr. Burnham, a leading practitioner in Peterborough. Having decided on a medical career, he attended and then graduated from Rolfe’s Medical
School in Toronto (later the University of Toronto School of Medicine). His further training, although longer than the usual two or three years, reflects what was customary at the time. It involved a year in general practice in the United States, enabling him to earn sufficient funds for seven years training in Europe, where he focused upon ophthalmology and otolaryngology.

In Europe, Dr. Buller sought the best training available. His first destination was Berlin, where he joined Von Graefe's clinic. Von Graefe, had not only established one of Europe's leading eye clinics in 1850, but was also a professor of ophthalmology at the University of Berlin, as well as an innovative eye surgeon, developing new surgical techniques, especially for glaucoma. During the Franco-Prussian War, Dr. Buller worked as a
volunteer assistant in a German military hospital. When the war was over, he was appointed to the staff of the Graefe-Ever Hospital in Berlin, where he pursued work in pathology under the Prussian-born pathologist Dr. Rudolf (Carl) Virchow, as well as in physiologic optics with Hermann Von Helmholtz, the philosopher, scientist and inventor of the ophthalmoscope.

In 1872, Buller moved to London to continue his studies and increase his medical and surgical knowledge. There, he became a member of the Royal College of Surgeons and was appointed Junior House Surgeon at the Royal London Ophthalmic Hospital (Moorfield’s) where he later became Senior House Surgeon. At Moorfield’s, he worked under the leading ophthalmologists and ophthalmic research scientists, Sir William Bowman,
George Critchett, Sir Jonathan Hutchinson, Edward Nettleship, and Marcus Gunn. He acquired an in-depth knowledge of all aspects of operative and postoperative treatment, which he considered essential in ophthalmological training.

While in London, Dr. Buller not only expanded his ophthalmological knowledge, but also helped increase the range of treatments and instruments available to ophthalmologists. At Moorfield’s he imparted his specific ophthalmoscopic knowledge, acquired in Germany, to his English colleagues. He also developed the “Buller Shield,” a device used to protect the good eye when treating conjunctivitis. Before chemotherapeutic drugs and antibiotics were available as treatments for conjunctivitis, the protection of the uninfected eye was a serious problem. Dr. Buller’s device was composed of a watch glass surrounded by rubber, and was fixed in place with adhesive tape. This effectively isolated the infected eye. A small piece of rubber tubing was inserted at the temporal corner to prevent the glass from steaming up and to allow the ophthalmologist to view the eye.6

Following his European training, and having moved to Montreal, it was decided by the governors of the MGH that Dr. Buller’s specialized training in the treatment of the eyes, ears, nose, and throat would make a valuable addition to the services offered by the hospital. Thus, at the annual meeting of the Governors held on Thursday, May 19, 1876, it was moved by Mr. Ogilvy, seconded by Mr. Cleghorn, and carried that “Frank Buller, Esquire M.D. be and is hereby appointed Oculist and Aurist to this institution for the ensuing year.”

Being made the MGH’s first ophthalmologist, Dr. Buller was expected to perform certain duties. At the March 8, 1876 meeting of Governors of the MGH, the duties of the hospital’s oculist and aurist were listed as follows.

1. The oculist and aurist shall attend the outdoor room on such days and at such hours as shall be determined by the medical board.

2. He shall have the right to admit to two beds in the male public ward and to two in the female public ward, patients suffering from ophthalmic or aural complaints.

3. He shall have the privilege of admitting to one private ward when the same happens to be vacant but he shall, at no time, claim the use of more than one private ward.

4. He shall keep a register and case book, including all cases coming under his department.
5. He shall not be ex officio member of the medical board.

Furthermore, in addition to these tasks, as the first specialist in ophthalmology, Dr. Buller was also expected to adopt a teaching role. With his appointment, all clinical teaching of ophthalmology to McGill medical students, a task which had previously been done by lecturers in medicine and surgery, became the responsibility of Dr. Buller and his Ophthalmic clinic.

The value of Dr. Buller’s teaching and the importance of ophthalmology as a specialty rapidly became evident. Already in 1881, 834 eye patients had been seen in the “out-door department.” Of these, there was one case of detached retina, and 36 cataract cases. Consequently, McGill University appointed Dr. Buller to be the first Chairman of Ophthalmology in 1883.

As the first specialist at the MGH and at McGill, Dr. Buller did initially encounter some opposition from other non-specialized physicians who were wary about a new specialist who purported to know more about a particular field than other doctors who had many more years of medical experience. At first, the senior physicians were unwilling to give up their ophthalmic patients. However, as Dr. Buller’s superior training and knowledge in this domain became generally accepted, all such patients were assigned to his care. It was Dr. Buller’s competence that convinced his colleagues that specialization was essential in the medical and surgical care of diseases of the eye.

**Dr. Buller and Sir William Osler**

When considering the introduction and evolution of ophthalmology as a specialty at McGill, it is interesting to note that Dr. Buller was not the only MGH and McGill medical faculty member to consider specializing in this field. Indeed, Sir William Osler, probably the best known physician in the English-speaking world at the beginning of the 20th century, had contemplated a career in ophthalmology early in his medical training. He went to London and met with Sir William Bowman, the most eminent ophthalmologist of the time, who advised him that spending time in the physiological laboratory at University College would provide a scientific background and be the best preparation for his career. However, while in London, upon learning that Buller was already training and excelling in ophthalmology, and that he was intending to come to Montreal, Osler was dissuaded by the then Dean of Medicine, Dr. R. Palmer Howard, from also studying ophthalmology, suggesting instead that he go into general medicine. In this connection, the author recently made a presentation to the American Osler Society entitled “Dr. Buller, the man who saved ophthalmology from Osler.” Osler accepted
all of this with good grace and was always a close and loyal friend to Dr. Buller. In fact, early in his career, Osler both lived and had his office in Dr. Buller’s house when the latter moved to Montreal. Furthermore, the two medical men interacted both socially and professionally. For instance, Dr. Buller wrote an article, “On the use of eserine in Ophthalmic practice,” for the first (1880) volume of *The Montreal General Hospital Reports*, founded and edited by Osler.

It is interesting to speculate about what would have happened should Osler have become an ophthalmologist.

During his time at the MGH, Dr. Buller at first lived relatively close to the hospital at 1351 Ste. Catherine St. In addition to William Osler, his
house had two other “medical boarders” - medical students by the names of Henry Ogden and E.J.A. Rogers. Dr. Buller was known as the “landlord” and the address simply as “1351.” Some tales of life at 1351 are still told today. One anecdote recounts the occasion when Osler asked two or three medical students to remove intact the brain and spinal cord of a horse - not an easy task. The students decided to display the specimen in the bathtub for Osler to see. The brain lay on the sloping end with the spinal cord running the full length of the tub and the spinal nerves spread out on each side. The students left, and Ogden, who had participated in displaying the trophy, went to his room looking forward to Osler’s pleasure at seeing such a perfect dissection. Dr. Buller then returned and stopped speechless at the bathroom door. There followed a scream of profanity and Ogden, upon hearing this, approached his room, put out the gas and hid in a clothes cupboard. When Osler returned, the “landlord” confronted him with the specimen. “Oh look, Buller,” Osler defended, “did you ever see anything so nice? See the spinal nerves and all.” Osler then asked Ogden to help him clean the bathtub and pacified Buller by taking the first bath, and Ogden the second. The next morning, as they all breakfasted rather quickly together, not a word was said about the horse’s brain and life resumed its normal course.

In addition to his fame as a medical specialist and a landlord, Dr. Buller was also known at the hospital and the university for his practical and often unorthodox methods. According to one story, a young girl, complaining of blindness, was brought to his clinic by her clergyman. No organic lesion could be found and it was felt to be an hysterical condition. Buller obtained from the laboratory a large live frog and, hiding it behind his back, went in to see the girl. She assured him that she could not see anything. “Open your mouth” he said, and then held up the frog in front of her. She screamed and admitted that she could see. The clergyman was offended at Dr. Buller’s method and reported him to the hospital authorities!

The 1880s brought changes to both Dr. Buller’s marital and domestic situations. In 1882 he married Mademoiselle Elizabeth Langois of Quebec City and moved to Dorchester Street the following year. His friend and colleague, Dr. Osler soon moved next door. A few years later, Buller relocated to Drummond Street (into a house that has since been torn down to make way for a Concordia University building, later to become a YMCA). Around the same time that Dr. Buller moved to Drummond Street, Dr. Osler started a medical journal article discussion club attended by Buller, Shepherd, Howard, and others. Osler, who had performed 1,000 autopsies, also gave a pathology (autopsy) course in which Buller participated. What
is more, Buller, Osler, Shepherd, and nine other doctors belonged to the Metropolitan Club, dining there once a month.

Throughout the 1880s Dr. Buller’s Eye and Ear department continued to grow. It is recorded in the sixty-sixth MGH Annual Report of 1887-88 that the number of patients being seen in the out-patient clinic had risen to 1149, 29 of which were cataract cases. Furthermore, by 1889, little more than ten years after Dr. Buller instituted the Eye and Ear department at the MGH, significant staffing changes were also occurring at the MGH. Over a decade earlier, in 1878, it was noted in the MGH Medical Board records that ophthalmology had too many patients and, in 1881, it was suggested that a second oculist and aurist be appointed. Dr. Buller, however, disagreed. (It is interesting to note that, in 1884, the Medical Board also discussed the need for champagne to be given to very ill and critical patients - as far as the records indicate, it is not known what Dr. Buller’s attitude was!) However, in 1889 Buller, realizing that there was no second-in-command, began training three physicians as clinical assistants who were looked upon as Senior House Staff.

1889 also marked the beginning of a great debate as to whether or not the MGH and the projected RVH should be combined into one institution. These concerns were precipitated by plans for the erection of the RVH on its current site at the corner of Pine Avenue and University Street. It was noted in the MGH Annual Reports of that year that Dr. Buller felt quite strongly that these two hospitals should be united. Indeed, he was not alone in this belief. Many others, who felt the same way, joined together to form the “Friends of the Union of The Montreal General and Royal Victoria Hospitals.”

Anonymous letters to the editor published in the Montreal Gazette during July and August of 1889 detail the salient points in the amalgamation debate concerning the central, yet crowded, Old Hospital Site (of the MGH), located in the lower grounds on Dorchester Street, “where the air is moist and warm in summer and loaded with noxious effluvia,” versus the remote mountain-top New Hospital Site (of the RVH), surrounded by “pure air free from dust, disease germs, and exhalations from yards and refuse heaps.” The editors of the Gazette considered this timely topic to be “a problem of the highest interest to our city....which touches the prestige, integrity and independence of that time-honoured institution - the General Hospital.” One of the letters reads as follows:

The venerable and justly loved and respected General Hospital has, beyond the remembrance of the present generation of
men, been an institution of which our city has good reason to
be proud, and which has conferred inestimable benefits not
only on our own citizens but also upon strangers. It has been
emphatically the English hospital, managed on the principles
which commend themselves to the practical good sense and
sagacity of the English-speaking portion of our people, attracting
to itself the best medical talent of Canada, and cared for and
supported by the *elite* of our citizens, while it has extended
its benefits to patients of every origin and creed. It has also
been an essential helper to the great medical school which has
given Montreal celebrity as a centre of professional education,
as well as to the rivals which have recently endeavoured to
share its laurels. It has now the prestige of great reputation
and enduring usefulness. Its present governors revere it as an
object of solicitude to good men who have passed away, and
generations of our citizens have looked to it as their resource in
accident or sickness...

The site of the General hospital was selected at a time when
the city of Montreal was almost limited to the ridge occupied at
St. James and Notre Dame streets, when Craig street was in great
part a swamp where a botanist might still collect marsh plants
and where possibly an early sportsman might chance to have a
shot at a snipe. Dorchester street was then nearly as far afield as
the mountain park is now [where the Royal Victoria Hospital
was then under construction]; and if the records of the time
were carefully searched, it would no doubt be found that there
were conservative people then who depreciated a location so far
from the heart of the city, and contrasted it with that of the
older hospitals then near the riverside. Medical doctors at that
time considered the central part of St. James street sufficiently
remote from their patients, and probably regarded a drive to
Dorchester street as something of the nature of a country
visit. Since that time all the large populations occupying the
western and upper parts of the city have grown up, and the
General hospital is nearer to the river than to the rear of the
city, while the part of town surrounding it is becoming more
and more occupied with shops, warehouses and factories, and it
is being more and more enveloped in the increasing smoke of a
manufacturing town.
In the circumstances, the foundation of the Royal Victoria hospital on a site further removed from the lower and less salubrious portion of the city, should be regarded by those interested in the General hospital as a welcome deliverance from a great and increasing difficulty; and if any arrangements can be secured whereby the two hospitals can work together and be mutually helpful, a great advantage to the public will be secured. Besides this, economy is an important object. So long as our French-Canadian fellow citizens prefer the ecclesiastically managed hospitals, which are now being so severely repressed by their brethren beyond the sea, it is evident that the support and management of properly equipped general hospitals must devolve on the comparatively small English element, and this should not be burdened with a duplication of work and expense. It follows that amalgamation of some kind must commend itself to all prudent men, animated by a sincere regard for the public welfare; and the question really is how this may best be effected.  

Letters such as this were reprinted in the form of a 16-page pamphlet by request of the friends of the union of the MGH and RVH. In September of 1889, the pamphlet entitled, “Thoughts on Hospital Sites,” was then “placed in the hands of gentlemen connected with both hospitals...and respectfully commended to the favourable consideration of those interested in either or both of these institutions, and in the great public objects which they are intended to serve.”

Dr. Buller was involved in promoting this cause of uniting the hospitals at the MGH. As a result of his influence a committee was established at the hospital in order to examine the question of amalgamation. However, the committee decided that the logistics were far too complex to allow for such a move at that time. Although Dr. Buller’s desire to combine the two major (English) hospitals in Montreal was never realized, seven years after the initial campaign to merge the two hospitals, in 1896, he did opt to formally connect himself with the RVH. Moving to the new hospital, Dr. Buller immediately became a member of the Medical Board of the RVH, as well as being the hospital’s first Ophthalmologist and Otologist. Thus, once one department had taken root at one hospital, he proceeded to start up a second, parallel department at the other.

In the 1890s, medicine at the MGH was still being practiced in the “traditional” manner whereby there were two disciplines: Medicine and...
Surgery, although the dividing line was not always clear. However, the age of specialization was just beginning at McGill, and the RVH was founded to treat patients from this more “modern” point of view. Thus, the dividing lines between Medicine, Surgery and the specialties became more sharply defined. For the first time in Montreal, interns at the new RVH were appointed solely in Medicine, Surgery or in one of the specialties. Dr. Buller’s move to the RVH was part of a change at McGill’s teaching hospitals. Some of the physicians at the MGH were concerned that the chiefs of a few departments were leaving to take up similar positions at the RVH, thereby reducing department staff at the MGH.

Although Dr. Buller moved, the department he had begun at the MGH continued to grow and to thrive. The continued vitality of the department had been assured in 1890, when Herbert Birkett became Buller’s assistant. In later years Birkett remarked that he had been given much of the work of the department, attending to most of the refractions and generally being assigned older patients, while Buller reserved the younger and better-looking patients for himself! In 1893, the department office was reorganized with Birkett attending to nose and throat cases and Buller handling afflictions of the eye and ear. Before long Dr. Buller limited himself to Ophthalmology, being the first doctor to do so. Dr. Birkett went on to a distinguished military career and then was appointed Dean of the McGill Faculty of Medicine.

When Dr. Buller resigned from the MGH in 1894 to take charge of Ophthalmology at the new RVH he was given six beds on the male surgical ward and six on the female surgical ward, thereby reducing the general surgeon’s beds. This change resulted in friction between Buller and the general surgeons, friction that lasted until more surgical beds were available three years later. However, although disruptive, the reassignment of those twelve beds reflected the fact that, from the beginning, the Eye, Ear, Nose and Throat Department was a distinct separate department of the hospital, not falling under the auspices of surgery or general medicine. Furthermore, it was also a busy new department. During the first six months of operation, the Eye and Ear Department had over 1,300 consultations. The cost, to the hospital, for in-patients was $1.42 per patient per day.

In 1895 the expertise offered by Dr. Buller’s new RVH department was amplified when Dr. F.M. Fry resigned from the position of House Physician at the RVH to become the hospital’s first House Ophthalmologist (analogous to a resident in ophthalmology today). That year Doctors Buller and Fry made 3,086 consultations on 1,200 patients and admitted 185 (104 males and 81 females), upon whom 58 cataract operations were performed. The
average number of days a patient spent in the Eye and Ear Department was 33 days.

Each year there was a different House Ophthalmologist at the RVH whose duties included preparation of the annual report for the Eye, Ear, Nose and Throat Department. In 1898, the department was enlarged by the appointment of Clinical Assistants in Ophthalmology. In addition, one of the new appointees, Dr. Byers, was promoted to Assistant Ophthalmologist and appointed a member of the RVH’s Medical Board in 1899.

During the first decade of the RVH Eye and Ear Department’s existence the number of consultations also grew by about 500 per year, as did the number of operations performed. Furthermore, the average number of days which in-patients spent in the Eye and Ear Department dropped steadily over the years, such that it was 26 days in 1903, 21 days in 1907, 15 days in 1909, and then vacillated around 12 days for many decades thereafter. In 1903, the number of patients and operations were such that the Eye and Ear Department separated from the Nose and Throat Department. There were over 4,000 eye and ear patients seen through the out-patient department, and almost 100 lens and capsule operations were performed each year. Thus, the practice of ophthalmology at the RVH was firmly established and growing only ten years after its inception. So strong was the Eye Department that it separated once again completely from the Ear, Nose and Throat Department in 1905.

Throughout these early decades of the RVH’s Ophthalmology Department until his death in 1905, Dr. Buller maintained his affiliation with the MGH and was considered to be the “consulting staff” of the department. After Dr. Buller left the MGH in 1894 his post as Oculist and Aurist had been taken over by Dr. John J. Gardner, while Dr. A. Proudfoot became the Assistant Oculist and Aurist of the Eye and Ear Department of the MGH. In addition, the number of eye and ear cases seen at the MGH continued to grow to over 1200 “out-door” patients, and by the turn of the century, there was mention in the Annual Reports of operations and “in-door” patients. According to the 74th MGH Annual Report, there were 39 lens surgeries in 1895-96, 23 cataract operations the following year, as well as 145 in-door patients. In the years that followed, the number of in-door and out-door patients oscillated between 130 and 1,000.

In 1898 additional changes were made to the staff at the MGH’s Eye and Ear Department with Dr. J.W. Stirling, a graduate of the University of Edinburgh, succeeding Dr. Proudfoot as the Assistant Oculist and Aurist to Dr. Gardner. Meanwhile, Dr. Buller retained both his position in charge
of ophthalmology at the RVH, the Chairman of McGill’s Department of Ophthalmology, as well as his loose association with the MGH until his death in 1905 of pernicious anemia.

Dr. Buller was Canada’s first modern ophthalmologist and the country’s most outstanding man in the specialty. Having the whole country to himself, he acquired a practice and reputation that would be difficult to attain today. It was not unusual for patients going to Germany for treatment to be told that Dr. Buller’s opinion was equal to any in Europe. Buller was self-reliant, strong, and decisive. He inspired confidence in all who knew his work, and it was obvious that he cared a great deal for his patients. In the early days, when no trained nurses or assistants were available, it was not unusual for

Figure 4: Dr. John J. Gardner
him to stay up all night nursing patients who were threatened with loss of vision - including cases where vitreous was lost and frequent changes of cold compresses were required during the night. Buller was at his best when treating difficult cases and those which others had abandoned. He worked on these problems with great persistence, always looking for new ways of ameliorating the patient's condition.

Regarding Dr. Buller's surgical skills, Dr. Birkett, who joined him in practice in 1890, commented as follows: “During my visits to the leading clinics in Great Britain and Europe, I have seen no one who surpassed him, not only in his operative technique, but also in his wonderful surgical instinct, which served him in great stead in his decision as to the necessity of operating. He was very proud of the steadiness of his hand and would frequently demonstrate it by holding a Graefe knife in each hand so that when they were approached to each other, the points would touch.” Birkett credits Dr. Buller with being the first to realize that, after surgery, infection could come from the lacrimal sac and that, when this was evident, it was necessary to apply a temporary gut suture to the canaliculi. Dr. Buller was also the first to consider nasal conditions as possible causes of eye problems and was advanced in his knowledge of oculoplastics.

In addition to excelling in his surgical work, Frank Buller was also a prolific author of medical articles. He wrote 76 publications primarily oriented towards teaching and clinical practice. His papers may be grouped into three distinct categories: The first is a group of publications which attest to his being the first exponent on this continent (according to Birkett) of the new ophthalmology of Von Helmholtz, the Dutch ophthalmologist Frans Cornelis Donders, and Von Graefe. The second category includes clinical writings produced after prolonged, careful study. Among these are “Anomalies in the Function of the Extrinsic Ocular Muscles” and his last paper, “Methyl Alcohol Blindness” written in collaboration with Dr. Casey Wood. The latter paper was described by the American ophthalmologist George Edmund de Schweinitz as “by far the most important contribution to the subject, and one to which too high praise cannot be given”. The third group of papers can be described as practical efforts to improve ophthalmic practice. Included are papers on skin grafting, suturing the canaliculi (as previously mentioned), the Buller Shield, an improved trial frame, and the modification of Critchett's idea of slitting the lateral canthus in gonorrheal ophthalmia in order to apply silver nitrate to the everted conjunctiva. It is remarkable that he was able to direct the department, attend to a large practice, and author this wealth of papers, all long before full time positions existed.
Dr. Buller’s enthusiasm for ophthalmology knew no bounds. He enjoyed discussing difficult clinical cases and was always interested in innovation - to which he frequently contributed. In one of his addresses he said that:

No one can afford to rely upon the knowledge he has gained at college to carry him through life, hence, the necessity for new books every year, not many, but a few of the best, and also at least two medical journals, these last to be carefully scanned and an index made of all that seems useful and practical as they come in. Such a system of ready reference will prove invaluable in the effort to keep up with the times.

His mind was always open and flexible; it is not surprising that one of his favourite sayings was, “let us pray for an open mind.” Similarly, in his 1903 valedictory address he stated, “Let your first and last endeavour be thoroughness in all that you find to do.”

Outside of his medical career, Dr. Buller delighted in family life, having three daughters and one son who were devoted to him. When his second daughter, at age 18, told him she wanted to study art in Paris, he readily agreed and encouraged her - a broad-minded decision for the time and one which enabled her to go on to a most distinguished career. Respecting her father’s profession, she later made use of her artistic talent and education by learning to use the ophthalmoscope and painting a number of fundus pictures.

In addition to being a devoted father, Dr. Buller was also a gardener, nature lover, and one who enjoyed exploring the country. He became somewhat of an expert on trees, frequently grafting many branches. Summers were spent with his family, going by boat to Rivière-du-Loup and then by horse and buggy to Cacouna. He knew and loved Canada and, on one trip to British Columbia, acquired a massive forty foot totem pole from Masset in the Queen Charlotte Islands. He had it shipped to Montreal via the Canadian Pacific Railway and donated it to McGill University’s McCord Museum, where it can be seen today.

However, as has been shown, Dr. Buller brought more than totem poles to Montreal. Although a man of many interests, and while he is remembered for his important scientific contributions, Dr. Buller’s greatest achievement probably lies in the high standards he set, insisted on, and maintained for the practice of ophthalmology in Canada. He was a leader with a clear vision for the development of Ophthalmology. Modern ophthalmological teaching began at McGill with Dr. Buller, and he brought with him, based
on his experiences in Germany and Britain, the ophthalmoscope, the perimeter, accurate refraction work, a thorough knowledge of muscular defects, pathology, and above all, a modern scientific approach. His work in pathology was the beginning of a tradition at McGill whereby this subject was central to the department for over a hundred years.

The standards and innovations Dr. Buller brought to McGill reflected those of his own teachers. His mentors had been some of the most respected scientists of their day: Von Graefe, Virchow and Helmholtz in Berlin, Bowman, Critchett and Hutchinson in London. It was through Dr. Buller that their medical theory and practice came to McGill. Furthermore, Dr. Buller’s thinking and actions corresponded to the Faculty of Medicine’s shift

Figure 5: Bust of Dr. Frank Buller, Royal Victoria Hospital
towards scientific medicine and had a profound impact upon his colleagues, students, and the development of ophthalmology as a whole. As he stated in one of his addresses, “The real specialist must be evolved by years of patient toil in clinical work after he has become a ripe scholar replete with general experience.” This advice was followed by many of his students, whereby almost all those who asked his advice regarding ophthalmology heeded his recommendation of a four-year medical course and a period of training in general medicine and surgery, followed by a minimum of two years of ophthalmology, a training similar to his own.

The renowned McGill graduate, Dr. Tate McKenzie, an expert in physical education and a first rate sculptor, made an excellent bust of Dr. Buller which can be seen in the Royal Victoria Hospital. (See page 22)

Dr. Buller: Importing Cutting Edge Medical Science to McGill

As has been shown through the discussion of Dr. Buller’s influence upon the field of ophthalmology at McGill, medical knowledge and pursuits at the university were largely influenced by the state of medicine in Europe. Not only did this affect the nature of what was being taught in the classroom, but also the way in which medical men went about their own studies. The prolific European medical men whose ideas found their way into the McGill medical community and onto the curriculum were themselves pursuing a deductive, physiological, scientific approach to medicine, which was then adopted by their followers at home and abroad. In order to keep abreast of the advances in Europe, practitioners from McGill were either fluent in many languages (especially French and German) and well read, spent a certain amount of time training abroad, or both, as was the case with Dr. Buller.

Ophthalmology after Buller

Dr. Buller was highly influential in the development of modern ophthalmology in North America. He established a strong base for ophthalmology at McGill which has been perpetuated to the present day. Under his direction, ophthalmology was firmly established as a separate department – McGill’s Department of Ophthalmology. His tenure at McGill and its teaching hospitals was an active, developing, forward looking period. Furthermore, his activity in the field inspired many others to enter the profession, including his grandson, Dr. Sean Murphy, who joined McGill’s ophthalmology department in 1955.
Following Dr. Buller’s death in 1905, there were two candidates to succeed him: Dr. Gordon Byers and Dr. J.W. Stirling, who are both discussed at length in the next chapter.
Chapter 3:
Building on the Early Years – A Period of Consolidation, 1905-1921

Dr. Casey Wood – 1856-1942

While the focus of this third chapter is those McGill ophthalmologists who succeeded Dr. Buller at the University’s ophthalmology department, mention should first be made of a student of Sir William Osler’s who, although never a member of the staff of the ophthalmology department, did make significant contributions to ophthalmology at McGill.

Born in the United States, Dr. Casey Wood graduated in medicine from Bishop’s College, Montreal in 1872. While there, he attended lectures by Sir William Osler and served as his first clinical clerk at the MGH - the two men remaining life-long friends.

Following graduation from Bishop’s, Dr. Wood practiced general medicine and surgery in Montreal and was Professor of Pathology and Chemistry at Bishop’s for several years. In 1878, most probably after consulting Dr. Buller, he decided to specialize in Ophthalmology and train at the New York Eye and Ear Infirmary and the New York Post Graduate Medical School. He then went on to visit and train in Berlin, Vienna, Paris and London, spending a large part of his time at the Royal London Ophthalmic Hospital (Moorfield’s).

In 1889, he settled in Chicago, quickly establishing himself as a leader in ophthalmology. He held several prestigious positions including Professor and Head of the Departments of Ophthalmology at Northwestern University and the University of Illinois. He wrote extensively, authoring about 345 books, monographs and papers. He edited the eighteen volume American Encyclopaedia and Dictionary of Ophthalmology (1913-1921) and was also editor of the American Journal of Ophthalmology. As discussed on page 20, Dr. Wood collaborated with Dr. Buller on an important paper dealing with methyl alcohol poisoning. In 1909 Casey Wood published a book on ophthalmic therapeutics which he dedicated to Frank Buller, first professor of ophthalmology at McGill.  

An incredibly energetic man, interested in everything, in 1906 Dr. Wood became President of the American Academy of Ophthalmology and Otolaryngology. In 1916 he was one of the first members of the American
Board of Ophthalmology. Dr. Wood also made a significant decision for McGill when he gave his ophthalmological books and manuscripts to the McGill Medical Library. He was also greatly interested in medical history and acquired a large collection of books on the subject. Later, many of his medical historical books and manuscripts were transferred to the Osler Library. This generous donation was of great significance, and second only in importance to Sir William Osler’s gift of his library to McGill.

In 1913 Dr. Wood retired from academic ophthalmology. In his early years, he had shown an interest in natural science, especially in ornithology. It is not surprising, therefore, that in his retirement Dr. Wood became active in comparative ophthalmology research. He travelled the world - India,
Ceylon, Fiji - studying the eyes of birds - becoming an authority and also a first-rate ornithologist, publishing an important monograph on *The Fundus Oculi of Birds* in 1917.\(^\text{13}\) He also collected numerous ornithological books and manuscripts - including many very rare publications and also acquired a superb collection of bird paintings and drawings.\(^\text{14}\) Eventually, Dr. Wood also gave this great ornithological collection to McGill, where it is housed in the Blacker-Wood Library and forms a collection widely known as one of the treasures of McGill.

In 1920 Dr. Wood's thinking about the significance of his ornithological donation and the creation of the Blacker-Wood Library was as follows: “My present intention is to make an ornithological collection for McGill in the hope and belief that some research student or writer may utilize it.... I decided some years ago that this library would be a fine center for research students and historians fifty or a hundred years from now and it is for the next century and not this one that I am expending my humble efforts.” He also wrote that “People recognize energy and devotion to a cause - a good university library is surely a cause worth fighting for.” As a result of this conviction, Casey Wood was successful in finding financial support for his donations.

Casey Wood was a great supporter of McGill and, in recognition of this support, when his Alma Mater, Bishop's Medical College, was amalgamated with McGill in 1905, he was awarded the McGill M.D.C.M. degree. At his death in 1942 the New England Journal of Medicine commented that “The death of Casey A. Wood......brings to an end one of the most remarkable and indeed unique careers in American medicine.....thus passes an American physician, a distinguished scholar, a friend to Canada and a man whose influence, widely felt in his time, will continue in the inspiration he gave so generously to others.”\(^\text{15}\)

**Dr. John William Stirling –1859-1923**

One of Dr. Buller’s eventual successors, and at one time a professor at Dr. Wood’s first medical school, was Dr. John Stirling. Born in Halifax, Nova Scotia in 1859, Stirling completed high school and then proceeded to the University of Edinburgh, Scotland to study medicine. Graduating in 1884 with the degree of M.D.C.M., he went on to become house surgeon in the Royal Infirmary, under Dr. Argyll Robertson and house physician under Dr. T. Granger Stewart. Leaving Edinburgh, as was the accepted pattern of training at the time, he went to continental Europe, spending two years in clinics in Vienna, Heidelberg and Berlin. He later became assistant to Marcus Gunn at the Royal Ophthalmological Hospital in London.
In 1887 Dr. Stirling moved to Montreal, where he established his medical practice and was appointed Professor of Ophthalmology at Bishop’s Medical College in 1893. In 1894, Bishop’s Medical Faculty sent out a circular to the governors of the MGH recommending Stirling and two other staff members for three vacancies at the hospital. However, the Board of Governors would not elect these men unless they agreed to resign from Bishop’s. This matter caused a considerable dispute between the two faculties. In 1899, Dr. Stirling resigned from Bishop’s and became Assistant Oculist and Aurist to Dr. Gardner at the MGH. Following Dr. Buller’s move to the RVH, Dr. J.J. Gardner became Ophthalmologist-in-Chief at the MGH.

Figure 7: Dr. John William Stirling
By that time, McGill University had two large teaching hospitals, and in 1905 Bishop's Medical College was absorbed into the McGill Faculty of Medicine. At the RVH, there was a very promising, ambitious, gifted young ophthalmologist - Dr. W. Gordon Byers. In many ways, he was the logical successor to Dr. Buller both at the RVH and at McGill. Most likely, Dr. Byers expected to be named. It must have been a disappointment to him when Dr. Stirling was chosen as McGill Chairman and head of the Department of Ophthalmology at the RVH. It is likely that Stirling's appointment was connected with the problem of absorbing and properly recognizing the seniority of the faculty members coming to McGill either directly or indirectly from Bishop's. The appointment of Dr. Stirling in 1906 led to a certain tension in the Department of Ophthalmology at the University which persisted for some time to follow.

Dr. Fred Tooke, who was house ophthalmologist in 1899, took charge of the pathology work for the Department of Ophthalmology at the RVH. He became the second Assistant Ophthalmologist (the first being Dr. Byers) in 1910. Doctors A.G. MacAuley and John MacMillan were their Clinical Assistants. The composition of the department remained fairly stable throughout the following decade, only the number of consultations and the costs rose ($2.25 per patient per day in the eye department by the end of the decade).

In 1920, Doctors MacAuley and MacMillan were promoted to Associates in Ophthalmology, with Dr. Rosenbaum as Clinical Assistant and, in the following years, also a fellow Associate. Dr. Stirling became a member of the Consulting Staff in 1922. In turn, Dr. Gordon Byers took over as Ophthalmologist-in-Chief in 1923.

Dr. Stirling had a broad humanitarianism and sympathetic attitude to suffering patients. He was a friendly person with a pleasant outlook on life and was noted for the warm friendship and loyalty displayed by his patients and confrères towards him.

A future Chairman, Dr. John MacMillan, described Dr. Stirling as an excellent ophthalmologist and good teacher who made many useful contributions to the ophthalmic literature. He personally owed much to him as he was his first teacher. When Dr. Stirling was chief of Ophthalmology, Dr. MacMillan had to beat him to the door and carry his bag!

Dr. Stirling occupied a leading position among ophthalmologists of his day in Canada and, in 1911, McGill University granted him the degree of M.D.C.M. About this time Dr. Stirling was appointed Vice-President of the
ophthalmological section of the British Medical Association Congress held in Toronto and was also a member of several societies.

Although not as academic as Dr. Buller or some of his successors, Dr. Stirling made significant contributions on a variety of subjects. These included publications on eye symptoms of intracranial origin, vertigo, the relation of lesions of the eye to constitutional and organic disease, limitations of the visual field of intracranial origin, recurrent paralysis of the oculomotor nerve, ocular traumatism and tuberculosis in eye disease.

While dedicated to his job, Dr. Stirling also had several outside interests. In addition to being an accomplished pianist, his hobbies included botany, photography, horticulture and, in particular, bee keeping. He was a Fellow of the Royal Geographic Society, a member of the Royal Montreal Golf Club and President of the Mattawin Fishing Club.

After teaching at Bishop’s for seven years and at McGill for another twenty four, Dr. Stirling retired in 1920 because of ill health. He died three years later in 1923.

Dr. Stirling, always fully aware of his responsibilities, demonstrated loyalty to McGill and devotion to duty. Under his guidance, the departments of ophthalmology at McGill, the RVH, and the MGH maintained their clinical excellence and continued to grow with the addition of Drs. Tooke and MacMillan to the staff of the RVH. It was a period of consolidation in the Departments of Ophthalmology, and one where clinical excellence was emphasized both at the RVH under Dr. Stirling and at the MGH under Dr. Mathewson.

Dr. George H. Mathewson of the MGH and the McGill Department of Ophthalmology and Otology, 1905-1931

Dr. Mathewson was educated at Montreal High School and McGill University, graduating in Medicine in 1894. Following a year of medical training in Prague and Vienna, he returned to Montreal in 1895 and became clinical assistant to Dr. Buller. Dr. Mathewson spent the next four years at the RVH, after which he was appointed to take charge of the ophthalmology department at the Western Division of the MGH. He also held the position of Professor of Ophthalmology at Bishop’s College following Stirling’s resignation in 1899. In 1905, Dr. Mathewson returned to Prague and Vienna for further study. Later that year, after returning to Montreal, he was appointed Ophthalmologist and Aurist-in-Chief at the MGH. Shortly thereafter, he followed the trend established by Dr. Buller and decided to
confine himself exclusively to Ophthalmology. He became an Associate Professor of Ophthalmology at McGill University and remained in this position and as chief at the MGH until his retirement in 1931.

Throughout Dr. Mathewson’s years as chief of ophthalmology at the MGH, the hospital department continued its excellent clinical work. During this period, Dr. Hanford McKee, the Assistant Oculist and Aurist, also acted as the pathologist to the department, and would prepare the “Eye and Ear Pathological Report.” This report detailed the number and kinds of cases seen by the department and could be used to track changes in the numbers of patients and varieties of disorders diagnosed and treated. For instance, of the 136 in-door and 2,346 out-door cases in 1908, 449 were found to be...
bacteriological and 39 cases were pathological. The following year, there were six cases of active trachoma with Prowazek bodies being found in five. In 48 cases of chronic conjunctivitis, a search for Prowazek bodies proved negative. The Klebs-Loeffler bacillus was obtained from a case of diphtheria of the lid, and the Gonococcus was cultivated from a case of Metastatic Gonorrhreal Conjunctivitis. In 1910, the number of consultations more than doubled and continued to rise from year to year.

In 1914, more changes were made within the MGH’s ophthalmology department. Dr. Mathewson was the Chief of Service, Dr. McKee was promoted to Associate Ophthalmologist and Dr. A. Bramley-Moore took over as Assistant Ophthalmologist. There were also Junior Assistants for the first time that year. These new posts were held by Drs. L.G. Pearce and W.G. Ricker. The additional manpower became necessary as there were over 7,000 out-patient consultations to attend to that year.

Between 1918 and 1921, the number of patients dropped by a couple thousand, and there was no longer any record of there having been Junior Assistants during those years. However, by 1922, the outdoor department was again handling about 7,000 patients, and two new Junior Assistants were appointed: Drs. S.O. McMurtry and G.S. Ramsey.

In the one hundredth MGH Annual Report, it is noted that arrangements were made with Messrs. R.N. Taylor & Company in 1921 to have a representative of their firm attend the ophthalmology department’s Eye Clinic. The physicians felt that prescriptions for eye-glasses given to the patients were not always filled to the patients’ best advantage. The department hoped that this new arrangement would obviate the problem. Although there were many optical firms in Montreal who could have handled such a task, it was considered advisable to hold a single firm (R.N. Taylor) responsible for the quality of glasses given to patients, rather than divide the work amongst several firms. This practice has since been shown to be quite successful and has, therefore, continued up to the present at both hospitals.

The year 1925 marked almost half a century of treatment of diseases of the eye by ophthalmologists at the MGH. The department had grown considerably and there were over 200 indoor and 9,000 outdoor cases annually. Between 1925 and 1955, the department of Ophthalmology and Otology was divided on account of the partial move of the MGH from the original Central Division on Dorchester Street East, to the new Western Division, on the corner of Dorchester Street West and Essex Avenue. The Central Division of the department still handled the majority of the indoor cases and approximately two-thirds of the outdoor cases.
Throughout these transitional years, the number of ophthalmologists on staff expanded. A third Junior Assistant Ophthalmologist, Dr. J.O.S. Gilhooly, was appointed in 1927. Drs. A. Bramley-Moore and S.O. McMurtry remained as the Western Division staff, and they were joined in 1928 by Dr. E.J.O. Walcott as their Junior Assistant.

Dr. J.J. Gardner, the second Consulting Staff member of the department, died in 1929. He had held this position since the death of Dr. Buller, the first Consulting Staff member of the department. Dr. A. Bramley-Moore and Dr. G.S. Ramsey joined Dr. McKee as Associate Ophthalmologists, and Dr. McMurtry was Assistant Ophthalmologist. In 1931, Dr. Mathewson assumed the post of Consulting Staff. Dr. McKee was promoted to Ophthalmologist and, in 1931, he was appointed Ophthalmologist-in-Chief at the MGH. Drs. Bramley-Moore, McMurtry and Ramsey were Associate Ophthalmologists, and Dr. B. Alexander replaced Dr. Gilhooly as Junior Assistant.

The early twentieth century saw considerable development and consolidation at the RVH as well, consolidation which will be described in the next chapter.

**Dr. Samuel Ernest Whitnall - 1876-1950**

In 1919 McGill appointed Dr. Whitnall the Robert Reford Professor of Anatomy and Chairman of the department.

Whitnall’s relationship to ophthalmology was due to his interest in and research on the orbit. His book, the well known *Anatomy of the Orbit*, was published in 1921. He was the first to describe what became known as Whitnall’s ligament – a structure which supports the levator aponeurosis.

Whitnall left a large collection of orbital dissection specimens which were used by the residents in ophthalmology for some 60 years. Unfortunately, they were lost when loaned to another university for teaching purposes.
Chapter 4:
Years of Development, 1921-1941
Dr. W. Gordon Byers – 1872-1957

Dr. W. Gordon Byers – 1872-1957

Dr. W. Gordon Byers succeeded Dr. Stirling as Ophthalmologist-in-Chief at the RVH in 1921 and as Professor and Chairman of the McGill Department of Ophthalmology in 1924. Born in Gananoque, Ontario in 1872, Dr. Byers studied medicine abroad for several years, moving to Montreal in 1899. Upon his return, he was appointed Assistant Ophthalmologist at the RVH. During the last years of Dr. Buller’s life, Dr. Byers helped considerably with running the ophthalmology department. After Dr. Buller’s death in 1905, ophthalmology and otolaryngology were divided into two fully autonomous departments at the hospital level. Within the ophthalmology department at the RVH, Dr. Byers continued his work as a brilliant student, developing an interest in research. Working extremely hard, McGill eventually rewarded Dr. Byers by conferring upon him the degree of Doctor of Science in 1909 – a remarkable achievement at the time.

In addition to his work at McGill and the RVH, in 1920 Dr. Byers founded the Montreal Ophthalmological Society, becoming its first president. Members included both French and English-speaking ophthalmologists. For the first ten years of the society’s existence meetings were held at McGill. Thereafter, they rotated among the various teaching hospitals. At these meetings clinical presentations were offered, and frequently, several patients were also examined. The meetings provided an excellent way for the English and French speaking ophthalmologists to get to know each other.

Outside of practicing and teaching, Dr. Byers also published numerous medical articles. As a boy in Gananoque, he had delivered newspapers and through his job became fascinated with the art of printing. He learned to set type and then went on to write an article on various aspects of Gananoque as seen by a newspaper delivery boy. Setting the type himself, he struck a proof and laid it on the desk of the editor who, impressed, printed it in the next edition of the paper. Dr. Byers admired the editor, Mr. Britton, and studied his style of writing, later crediting this early training with helping him greatly in his professional writing.
In his writing and medical teaching, Dr. Byers emphasized the importance of pathology and stimulated a spirit of investigation and interpretation in his students and colleagues. He authored 40 first rate publications and had a special interest in pathology, contributing several scientific articles on the subject. Many of his publications dealt with clinical experiences, hospital organization, public health, and educational subjects, such as an outline of a curriculum in ophthalmology for undergraduates. An example of his keen interest in public health and education was his survey of the occurrence of trachoma in Canada, which was subsequently identified as having a significant influence upon the later eradication of this disease.

Dr. Byers was a perfectionist, an excellent surgeon with exacting standards and a superb teacher in the operating room. In addition, he was a central
force behind the establishment of the fellowship examination process under the Royal College of Physicians and Surgeons.

Dr. Byers had vigour, zest, ambition and a magnetic, at times, dominating personality. Always a perfectionist, he had a clear and decisive manner which instilled confidence in his colleagues and patients. During Dr. Byers’ tenure, Doctors Kenneth Johnston, A.G. McAuley, and J.J. Rosenbaum were recruited to the RVH department, which Byers led with confidence, maintaining it in an organized fashion and transforming it into a modern and efficient establishment.

As a testament to Dr. Byers’ demands for organization and efficiency, a future resident, Dr. James Jamieson, recalled hearing that when Dr. Byers would line up the ophthalmologists at ward rounds, they would click their heels in military fashion. Possibly, Dr. Kenneth Johnston’s mild demeanour was a result of this. Dr. Jamieson felt that Dr. Byers was a great man and largely responsible for a fine department.

By the mid 1920s, Dr. Byers’ RVH Department of Ophthalmology was becoming increasingly modern in its practices. By that time full use had been made of the new method of microscopy of the living eye for finer diagnosis, and all the members of the staff had been trained in the use of the slit lamp. In addition, cataract extraction was being carried out with iridectomy. In June of 1925, a paper based on the analysis by the staff of all the cases of iridocyclitis was read at the Montreal Meeting of the American Laryngological, Rhinological, and Otological Society. The statistics presented were said to be of scientific value and showed the relative importance of the causes of iridocyclitis in this area. The year 1925 was also a record year for the number of new patients seen by the department - almost one thousand. Yet, regardless of the growing numbers, as chief, Dr. Byers continued to show an interest in all of the department’s cases, believing that it did not matter who admitted the patient - it was always the Chief’s case.

Another important milestone that year was the establishment of the Pathological Laboratory of the Department of Ophthalmology at the RVH. The staff would present their contributions on diverse topics such as thrombosis of the central vein, wound infections of the eye, and sarcoma. The lantern slides used to illustrate these papers were made with their own photographic material. The department also managed to obtain a room vacated by the Orthopaedics Department in order to carry out perimetric studies. In addition, pathological exams of the eyeball were also being performed for outside centres including institutions in British Columbia and New Brunswick. The Department of Ophthalmology at the RVH was entering into a new phase of scientific research activities and novel modes
of therapeutics revolving around diseases of the eye. Included among the new means of treatment was the practice of having all of the hospital’s ophthalmology patients kept in the same ward - an initiative of Dr. Byers and the first of its kind in Canada.

In the years that followed, many more advances were made at the RVH. This accorded with the emphasis Dr. Byers always placed upon academic achievement. In his later years, Dr. Byers became known for his own monograph on gonorrheal ophthalmia. In the domain of therapeutics, striking results were obtained with the use of ultra-violet rays in cases of tuberculosis and phycctenular kerato-conjunctivitis. A number of innovations in cataract surgery were introduced and found to be successful. As well, the use of block anesthesia was extended for many procedures, and a new operation for detachment of the retina (Gonin’s) was also a success.

In addition to the routine work, special studies were carried out in the pathology laboratory, where Dr. Tooke was in charge. He was invited to give an address before the Buffalo Ophthalmological Society on “The Pathological Interpretation of Various Surgical Procedures Adopted for the Relief of Glaucoma.” Dr. Byers also gave an address, to the Ophthalmology Section of the Toronto Academy of Medicine, on “The Pathology of Tuberculosis in the Eye.” Both addresses were based on material collected in the RVH department and illustrated by an extensive series of lantern slides.

Along with their in-hospital work and research, the staff of the McGill department was also very active in the Montreal Ophthalmological Society. At the society’s meetings Dr. Byers presented papers on “Extensive tuberculosis of the eye (pathological series); Multiple papilloma of the lid, plica semilunaris, and carunele; and Operations for the creation of an artificial pupil with Stevenson’s punch.” Dr. Tooke spoke on “sarcoma of the choroid, with recurrence (gross and microscopic specimens); and rupture of the globe over the ciliary body following contusion.” Dr. MacMillan wrote several articles, including “Changes in the pigment epithelium of the iris in a case of diabetes”; “Folds in Descemet’s membrane”; “Late result in transplantation of the lachrymal sac”; and “Result following punch operation.” Dr. McAuley wrote a paper entitled “Large subconjunctival dislocation of the lens,” and co-wrote with Dr. Rosenbaum on an “Unusual course of retinal vein.” Furthermore, Dr. Rosenbaum also wrote an article on “Keratitis with unusual features; Solic detachment of the retina; and Retinitis Proliferans.” Thus, the entire university department was involved in research and the presentation of their clinical, pathological and experimental surgical findings.

In addition to the research being conducted by, and innovations being made in, the department, the late 1920s and early 1930s also witnessed a
continued increase in the number of patients examined and treated. By 1930, the number of out-door patients had risen to over 6,300 and the number of in-door patients to over 400. The number of consultations and operations was ever increasing. The inauguration of the first sight-saving class in Montreal occurred in 1932. That same year, the department began to prescribe contact glasses in suitable cases. They also received a special apparatus for the treatment of detachment of the retina and for operation of the orbit in cases of orbital neoplasm by the new method of electrocoagulation. Dr. Cone of the Montreal Neurological Institute assisted in the adoption of these recent operation methods which yielded good results. What is more, in addition to the growing clinical workload, the members of the department continued to publish scientific papers regularly.

Dr. Byers’ high medical ethics, honesty, and clarity of purpose won the support and loyalty of his colleagues. The staff were devoted, inspired, and encouraged by his leadership in maintaining high standards. Included among these loyal staff members was Miss May Holland, who was recruited as secretary and laboratory technician in 1933. She filled this position of trust with great ability and loyalty for 32 years. There is no doubt that Dr. Byers’ direction and her hard work contributed significantly to McGill’s reputation in ocular pathology. She also worked in these capacities with Dr. MacMillan.

Over the course of his career, Dr. Byers became widely known in ophthalmological circles in Canada, the United States, and Europe, and was held in great respect. In 1934, having been a member since 1906, he became president of the American Ophthalmological Society - the first Canadian to be so honored. In addition, he had been the driving force behind the founding of the Canadian Ophthalmological Society. The society was created in 1937, when Dr. Byers organized a convention of fifty ophthalmologists from across Canada. After several years of discussion, the Canadian Medical Association had finally agreed to allow the Section of Ophthalmology to separate and form a national society. Dr. Byers worked hard in preparing a sound constitution for the new society, and when it was founded he was made its first president. The purpose of the society was defined as the cultivation and promotion of ophthalmology and the study of ophthalmic diseases in relation to public health and welfare. English and French were to be the official languages. Dr. Byers guided the society with distinction in its early years. The initial meeting was held in 1938 in Montreal with Sir Steward Duke-Elder as the first official guest of honour, who in his address said, “…your society should be a clearing-house of new ideas, a marketplace where one’s investigations are displayed, so that on the one hand they can...
be criticized and shaped and moulded, and on the other they can act as a stimulus to others....”

Seventy-eight charter members of the society attended this first meeting. Those from McGill were Drs. Gordon Byers, Kenneth Johnston, John MacMillan, Stuart Ramsey and Fred Tooke.

Apart from his medical work, Dr. Byers had many other interests. He invested much energy in the McGill Medical Library and played an important role in convincing Dr. Casey Wood to leave his outstanding ophthalmic library to McGill University. William Van Horne and others kindled his interest in Chinese and Japanese art and, with a keen eye for excellence, he put together a small pottery collection, several Japanese prints and coloured glass windows which gave an air distinction to his consulting room. In addition, golfing with his fellow physicians was a favourite activity. On Saturday mornings he would have everyone play golf with him so that he knew where they were. Furthermore, Dr. Byers had a keen interest in and liked to discuss ideas in literature, philosophy, education, economics and music. In fact, his musical sensitivity was such that he once said, after hearing a favourite piece, “It is so beautiful I can barely listen to it.”

Dr. Byers resigned as Ophthalmologist-in-Chief of the RVH and Chairman of the McGill Department in 1934 and took up the position of consulting staff. In 1937, he was made Emeritus Professor at McGill University. By this period, Dr. Byers had had five children (two daughters and three sons) and a happy family life. In his later years, he retired to Knowlton, Quebec, where he died in 1957.17

Following his death, it was widely recognized that Dr. Byers greatest contribution to medicine in Canada was the organization of the field of ophthalmology - the founding of the Canadian Ophthalmological Society and the Montreal Ophthalmological Society. The scientific advancement of ophthalmology was his life’s work and he pursued it with great dedication. At McGill, by his insistence on excellence and high standards, he built on the strong early foundation of the department, and with his leadership, left it further developed and its reputation enhanced. We are the heirs and beneficiaries of his achievements and the challenge for us is to follow the example he set. His tenure at the department was a period of growth and development. It is a reasonable assessment that he was Canada’s most noted ophthalmologist of his time.

Dr. Byers had a reputation for being rather autocratic and, at times, irascible, but on other occasions benevolent and paternal. There were some tensions between the hospitals and his manner did not make for a peaceful
life. This was not helped by the fact that the chief at the MGH, Dr. Hanford McKee was equally able, ambitious and, at times, also quick tempered. As a result, feelings ran high when the two men came into contact. In all fairness, though, Dr. McKee was invariably kind and thoughtful to his staff and to that at the RVH.

Still, difficulties between Drs. Byers and McKee arose in particular when the Montreal Women’s Hospital moved from St. Urbain Street to the grounds of the RVH in 1926. Dr. McKee had been Ophthalmic Consultant at the St. Urbain Street Hospital but on its affiliation with the RVH, Dr. Byers laid claim to this position and won out.

Dr. S. Hanford McKee – 1875-1942

Dr. S.H. McKee was also one of Montreal’s most distinguished ophthalmologists. He was born in Fredericton, New Brunswick in 1875 and educated at the University of New Brunswick, obtaining his B.A in 1896. In 1900, he graduated from McGill University’s Faculty of Medicine and for several years was a house doctor at the RVH under Dr. Buller, after which he studied in Freiburg, Germany.

In 1906, he was appointed Assistant Oculist and Aurist at the MGH and Assistant Demonstrator in Ophthalmology at McGill. In the same year, he prepared the MGH’s departmental pathology report and continued to do so over the years. Throughout his career, he was the official pathologist of the MGH department and had an “active interest in the lab aspect of Ophthalmology...[ever] since his graduation in Medicine.” His main areas of research were: disorders of the retina, the pathology of tumours of the eye, the bacteriology of the conjunctiva, and he even carried on some experiments concerning the effect of certain vitamins upon the metabolism of the eye.

During World War I, Dr. McKee, by then Associate Ophthalmologist at the MGH, joined the Medical Corps in the First Canadian Contingent. He saw service in France and later in Salonika, Greece, and was twice mentioned in dispatches. Dr. McKee then returned to England and was given command of the Canadian Eye Hospital at Shorncliffe with the rank of Colonel and awarded the C.M.G. for distinguished services. In 1917, his name was placed on the MGH Roll of Honour.

In the MGH Annual Reports from 1928 to 1930, it was noted that “Dr. McKee has now for a good many years consistently done work along his specialty, the eye. Besides collecting a very fine teaching collection, he has a number of rare and especially interesting specimens.” Similarly, the reports read that “Dr. S. Hanford McKee has, as in the past, not only taken an active
interest in the lab aspect of his specialty, that of ophthalmology, but he has continued to do constructive work as well.”

Dr. McKee was very active in publishing, presenting the results of his extensive research to the medical community. He,

...contributed original works based upon his carefully selected and really excellent material and has another contribution ready for publication on observations from the routine bacteriological examination of a series of conjunctivitis cases. He is presenting, before the Medical Society in Vancouver, Calgary, Regina, and Winnipeg, the result of the pathology of clinical ophthalmology.
This paper embraces the experience of Dr. McKee’s laboratory work.\textsuperscript{20}

Not only did he attend meetings across the country, but Dr. McKee travelled around the world to present his work:

Upon material that he has worked up in the lab, he presented a paper upon blastomycosis of the eye last September before a meeting of the Thirteenth International Ophthalmology Congress in Holland. In the fall, he gave by request an address before the Ophthalmology Section, N.Y. Academy of Medicine in New York. In October by special request he gave a lecture before the American Academy of Ophthalmology and Otolaryngology on recent advances in ophthalmology. He has now almost completed the work for a paper which he will read before the Ophthalmic Society in Chicago[].\textsuperscript{21}

Dr. McKee was appointed Ophthalmologist-in-Chief at the MGH in 1931 and carried on in this position until his retirement in 1941. In 1931, he was also elected President of the American Academy of Ophthalmology and Otolaryngology - a significant honour for a Canadian. Furthermore, 1931 saw Dr. McKee contribute chapters to two textbooks: “Diseases of the Conjunctiva” published in Sajou’s \textit{Cyclopedia of Medicine}, Vol. IV, and “Diseases of the Conjunctiva, except Trachoma” which was to be published in the \textit{Textbook of Ophthalmology}, Saunders & Co., Philadelphia. The following year, Dr. McKee presented the Presidential Address to the meeting of the American Academy of Ophthalmology and Oto-Laryngology which he hosted in Montreal. He was also appointed vice-president of the Pan American Congress.

Over the years Dr. McKee acquired a reputation as an excellent researcher. His academic contributions were of the highest order and he was considered a world authority on bacterial conjunctivitis. Throughout the thirties, Dr. McKee continued to publish an average of four to five papers a year ranging from observations of syphilis in the eye to hypertension retinitis and neuromyelitis optica. In 1932, he published a paper on “Blindness from Methyl Alcohol Successfully Treated by Lumbar Puncture,” carrying on in the tradition of Doctors Frank Buller and Casey Wood’s publications on this subject. In 1933, Dr. McKee presented “Observations of the Fundus Oculi in Diabetes Mellitus” to the American College of Physicians - a report based on the study of 1272 cases. His work on eye tumours was reported to the American Academy in 1936. Other members of the MGH department,
including Drs. Mathewson, Alexander and Ramsey also made contributions to the growing body of literature in ophthalmology over the years.

Throughout Dr. McKee's tenure as Ophthalmologist-in-Chief at the MGH, both the hospital in general, and the hospital's ophthalmology department in particular were undergoing changes. Dr. McKee led his department during a period of advances and by his example contributed to and encouraged clinical research. During the 1930s the number of patients attending the ophthalmology out-patient clinics continued to grow, surpassing 10,000 per year, and even reaching 15,000 in some years. In addition, the number of indoor patients almost doubled to nearly 400. In the ophthalmology department Dr. Alexander was promoted to Assistant Ophthalmologist in 1934, and in 1935, Drs. McMurtry, Ramsey and Alexander were all promoted to Associate Ophthalmologist. Dr. R.J. Viger was the new Junior Assistant and, with a grant, he contributed to the establishment of a glaucoma clinic. In 1937, both Dr. Mathewson and Dr. Bramley-Moore were the consulting staff, with Dr. Mathewson retiring the following year.

During the 1930s Dr. McKee continued to be praised for his contributions to the field of ophthalmology, receiving numerous honours at home and abroad in recognition of his work. In 1938 he was made Secretary of the MGH Medical Board, becoming Chairman the following year. In addition, McGill promoted him to Professor of Ophthalmology and he was on staff at the Children's Memorial and Alexandria Hospitals. At the 1940 Pan American Congress of Ophthalmology, of which he was vice-president, he described a new method of detecting hardening of the arteries in diabetics. It is interesting to note a future McGill Chairman of ophthalmology, Dr. Miguel Bernier, was also to become a vice-president of the Pan American Congress of Ophthalmology (1995). Dr. McKee was in demand as a speaker in the United States and Canada and authored numerous contributions in journals and books.

Outside of his medical work, Dr. McKee had a keen interest in sports. He was not only one of the founders and the first president of the Atwater Badminton and Squash club, but was also President of the Provincial Badminton Association for several terms.

1941 marked Dr. McKee's last year at the MGH. That year he, Dr. Bramley-Moore, and Dr. McMurtry formed the ophthalmology department's consulting staff, with Dr. Ramsey being promoted to Ophthalmologist and Dr. Alexander acting alone as the sole Associate Ophthalmologist since Dr. Viger was away on active military service. In September of that year, Dr. McKee retired, dying just over a year later on November 25, 1942.
Dr. McKee had a life of significant accomplishment in a period when ophthalmology developed along lines of excellence in clinical practice and clinical research. His career coincided with and added to tremendous growth and activity in the field of ophthalmology at the MGH, growth and activity which furthered the department’s international presence. Dr. McKee was a forerunner of the Clinical Scientists of the 1980s and 1990s and it is remarkable that he accomplished so much academically while keeping up a large practice outside the hospital, receiving no salary or remuneration from McGill or the MGH. He carried on the tradition of pathology in the department - a tradition which had started in the nineteenth century with Dr. Buller. Like Dr. Byers before, and Dr. John Nicholls in the 1930s and 1940s, Dr. McKee brought fame and honour to the department of Ophthalmology at McGill. His achievements and contributions were exceptional; he stands as a superb model for future ophthalmologists.

Dr. J.V.V. Nicholls – 1909-1977

Only occasionally is an ophthalmologist held in the very highest esteem by his colleagues. Such a person was John Nicholls.

Dr. Nicholls graduated in Medicine from McGill in 1934 with the Wood Gold Medal (established by Casey Wood in honour of his father and awarded for the highest marks in clinical subjects in the final year). There followed a research year with the renowned Dr. Boris Babkin, Professor of Physiology, McGill University, which resulted in Dr. Nicholls obtaining the MSc degree in 1935 – unusual at the time.

After studies in pathology and internship, Dr. Nicholls enrolled as a resident in Ophthalmology at the RVH in 1936-1937. In the 1930s there was no structured ophthalmology residency at either the RVH or the MGH. Rather, a few individuals, such as Dr. Nicholls were trained for one to two years and then went on to other centres. Thus, awarded a Travers Allan Travelling Fellowship for 1937-1938, Dr. Nicholls went to Moorefield’s Hospital, London for studies in clinical ophthalmology and worked in research at the Department of Physiology, University College, London. India was next for further experience in ophthalmic surgery in Bombay, Calcutta, Hiranpur, and Karachi (with Sir Henry Holland).

In 1939 Dr. Nicholls was appointed a clinical assistant at the RVH and a Demonstrator in ophthalmology at McGill. With the advent of World War II, he joined the medical wing of the RCAF where, as Chief of Ophthalmology, he served with distinction and rose to the rank of Group Captain. He wrote several articles on aviation medicine which covered topics
including: depth perception in aviation, medical examination of air crew, orthoptics in aviation and the effect of goggles on peripheral field of vision.

After the war, Dr. Nicholls returned to Montreal and was appointed Assistant Ophthalmologist at the RVH and Lecturer at McGill. In 1957 he was promoted to Ophthalmologist at the RVH and in 1968 Professor of Ophthalmology at McGill.

In 1951 the annual McGill departmental budget was $1,200. The university felt ophthalmology was a relatively minor specialty. Dr. Nicholls, however, did not agree, believing that the RVH, and specifically the hospital's ophthalmology department, was understaffed. At the time, mandatory

![Dr. John V.V. Nicholls](Figure%2011%3A%20Dr.%20John%20V.V.%20Nicholls)
commitments for each staff member included working three afternoons a week at the hospital (two in the clinic and one assisting a resident in the operating room), time which did not count as teaching responsibilities. Clinic commitments were eleven months per year. Rounds were held once the afternoon clinics were over - with the result that residents and staff were tired and unable to participate fully. This was subsequently changed to mornings by a unanimous vote of the staff. Dr. Nicholls also felt the departments at the RVH and MGH should be combined in one place – an event which did not occur. However, Dr. Nicholls did initiate inter-hospital Grand Rounds on Saturday mornings with local speakers. Unfortunately, this well intentioned initiative did not last long because of poor attendance.

Dr. Nicholls was an inspired teacher - undoubtedly, one of the finest Canada has produced. He had the ability to arouse interest and enthusiasm. To see him showing a small group of students how to perform an eye examination was to experience teaching at its very best. Many will never forget their first observation through the slit lamp with Dr. Nicholls guiding them - patient, accurate, (thorough) always encouraging. He made the wonders of ophthalmology exciting and caused many to think about a career in the field. If the student or resident had a problem, he was always available - never too busy. In his teaching, he stressed the scientific basis of ophthalmology and what he said was stated with clarity, encouraging thought on the part of his audience.

Dr. Nicholls’ scientific contributions covered many areas, including macular edema in association with cataract extraction. In the early 1950s, he was one of the first to write on this subject. The fundi in hypertension and arteriosclerosis, as well as dyslexia, also occupied much of his time, and, in the 1960s, he worked on problems of reading disabilities in the young. Through his ophthalmic work and research, Dr. Nicholls helped establish the beginnings of low vision studies at McGill – this important area will be discussed in a later chapter.

In addition to his work at both McGill and the RVH, Dr. Nicholls was active in a number of medical societies. He was President of the Canadian Ophthalmological Society, President of the Montreal Ophthalmological Society, Vice President of the Association of Ophthalmologists of Quebec, and an elected member of the prestigious American Ophthalmological Society. He always fought for the public’s right to the very best eye care possible.

As a member of the ethics committee of the Canadian Ophthalmological Society between 1960 and 1972, Dr. Nicholls’ wisdom and judgement helped to further high ethical standards for ophthalmology. At this time, the
staff in both hospitals had a high sense of duty, dedicated to doing their best for patients and demonstrating the highest professional morality and ethics. They cared. These traditions, well established, filter down to the present day. Dr. Nicholls further ensured medical standards through his position as Chairman of the Royal College of Physicians and Surgeons Certificate examinations for 1958, 1961, and 1962. In addition, he chaired the weekly rounds that functioned effectively as quality control between 1961 and 1965 at the RVH. In 1965, after 25 years of teaching students and residents at McGill, he received, as was customary, a black and gold McGill chair, suitably inscribed.

Dr. Nicholls chaired a committee (1968-70) appointed by the Chiefs of the Departments of Ophthalmology at the three McGill Teaching Hospitals – the MCH, MGH, and RVH - to study the feasibility and method of integrating the residency training programs at the three hospitals. The committee was made up of Dr. K.W. Adams (MCH), Dr. A. J. McKinna (MCH), Dr. Arthur B. Leith (MGH), Dr. Dario Lorenzetti (MGH), Dr. Peter L. Davis (RVH) and Dr. Nicholls (RVH). The members found that the separate residency training programs in Ophthalmology at the three McGill Teaching Hospitals should indeed be integrated. Previously, the programmes had always been autonomous, a situation which was not only expensive, but limited valuable professional and educational contact between both students and professors. As a result, the committee recommended that the integrated program be a university based residency. With the perspective of the years, it is possible to see that the committee’s work was a defining event in the history of the department.

Another committee in which Dr. Nicholls was involved in the late 1960s was the Quebec Association of Ophthalmology’s Committee on Fee Schedules formed in 1969. Dr. Nicholls was Chairman at this difficult time when medicare was introduced (1970). His mandate was to develop a fee schedule for all ophthalmological acts. In Quebec, many doctors, anxious about the impact of state controlled medicine, left the province in opposition to the Government. Because of the heightened danger to Quebec society, they were ordered back following the murder of the provincial cabinet member, Pierre Laporte, by the Front de Liberation du Québec.

In 1970, John Nicholls, for personal reasons, was interested in moving to southwestern Ontario and accepted a position in London as Clinical Associate Professor of Ophthalmology at the University of Western Ontario. Four years later, he was appointed Clinical Professor of Ophthalmology and Chairman of the University Department.
At Western, Dr. Nicholls’ superb teaching, constant availability and interest in residents led students to develop a special affection for him. He was never too busy to see a resident or colleague and help with any problem. In addition, his patients in London, like those he had treated in Montreal, always held him in great esteem. While he did eventually retire as Chairman of the university’s Department of Ophthalmology in 1975 at the age of 65, Dr. Nicholls maintained his university appointment and continued teaching.

As a man, Dr. Nicholls was naturally curious and interested in many things. The history and geography of the area around London especially attracted him and his wife Adeline. He also had a fondness for his cars. A new Chrysler parked at the hospital told one that he was at work inside.

A true gentleman, John Nicholls radiated excellence and personal integrity. For his coworkers, it was always a pleasure to walk with him in the hospital. His interest in their opinions was demonstrated through the fact that no matter how fast or slowly you walked, he immediately fell in step with you. A thinking leader and a gifted teacher, he touched countless lives and helped mould Canadian ophthalmological thinking during a period of significant change from the 1950s to the mid-1970s.

Dr. Frederick T. Tooke – 1873-1955

Dr. Frederick T. Tooke, who succeeded Dr. Byers as head of ophthalmology at the RVH, was born in Montreal in 1873 and graduated from the McGill Faculty of Medicine in 1899. He spent three years in Europe studying under Axenfeld, Morax, Sir William Lister and Marcus Gunn. Back in Montreal in 1905, he joined the ophthalmology staff at the RVH. An excellent clinician, he rose to become Ophthalmologist-in-chief at the Hospital and Professor and Chairman of the McGill Department in 1935.

Dr. Tooke, in his first annual report, described the department as “in every sense self-sufficient.” From the early 1900’s, Ward M had been occupied jointly by Ophthalmology and the Nose and Throat Services. At last, in 1935, the Department of Ophthalmology received its own quarters, isolated small wards, and two specially trained nurses. A new and completely equipped pathological laboratory was in operation. That year there were 64 operations performed in the Ross Theatre and 265 in the Main Outdoor Theatre. The staff of the Department of Ophthalmology published, on average, five papers a year and presented twelve contributions to the Montreal Ophthalmological Society each year up until World War II.

Dr. Tooke was an active member of Canadian, American, French and British Ophthalmological societies. The American Ophthalmological
Society honoured him by electing him President in 1939. He authored many publications but was probably best known for his invention of the Tooke corneal splitter - a standard ophthalmic instrument widely used, especially in the Elliott trephine operation for glaucoma.

Dr. Tooke retired from his official positions at both McGill and the RVH in 1939. A volunteer at the RVH in the 1920-1930s, Mrs. Anson McKim, gives a picture of Dr. Tooke as a human being. She explains that:

the hospital gave to its lowest form of life, the volunteer, the impression that it was a happy place, that things were right and were going to get better; that people were treasured and helped;
that the welfare of the patient was the important thing; that kindness came right after health......I think of him, a warm, stout, chubby, pink-faced white haired gnome, whom everyone seemed to adore, walking briskly through the corridors, white coat, sides flying, a smile always on his face.....I took great pride in following him through the hospital, to see him greeted happily by everyone, listened to and obviously loved, honoured and admired. There was a feeling of real dedication then.

Dr. Tooke’s tenure was characterized by excellent morale within the department. He was held in high esteem by his Canadian and American colleagues and brought lustre, as well as a warmth of personality to McGill Ophthalmology. Dr. Charles Dyson, a resident at the RVH from 1945 to 1947, recalls assisting Dr. Tooke in the operating room during an attempted dissection. The tip of the needle-knife broke off in the cornea. After a protracted struggle, he recovered the broken tip and said “Save that - it’s a remarkable specimen for the museum!” Unfortunately, Dr. Dyson dropped it and it was never found. Dr. Dyson later went on to study the cornea with Dr. David Cogan in Boston and eventually became Chairman of Ophthalmology at the University of Western Ontario, retiring in 1994.

Beyond his important work at both the RVH and McGill, Dr. Tooke is also remembered for his other actions and interests. In addition to his love of both music and art, he is particularly remembered for the work he did for victims of the Halifax Explosion in 1917. The explosion, caused by the collision of a Belgian relief vessel and a French munitions ship in Halifax harbour, and which was the largest pre-atomic man-made explosion, not only killed over 2000 people, but left many of the survivors with injuries, particularly eye injuries. Dr. Tooke played an important role looking after residents of the city who had sustained eye damage, the majority of such cases having been caused by flying debri, especially shattered window glass.22

Dr. L.S.S. Kirschberg – 1914-2002

Another fine clinician and teacher during these years was Dr. L.S.S. Kirschberg. He graduated in Medicine from McGill in 1939. His uncle also graduated in medicine from McGill (1898) and, influenced by Dr. Buller, went to London and Edinburgh to study ophthalmology, eventually settling permanently in Britain following his studies. Motivated by his uncle's career choice, Dr. Kirschberg applied to the RVH’s ophthalmology program and was given a position by Dr. Tooke.
In 1940, the Ophthalmology programs at both the RVH and MGH lasted one year and consisted chiefly of refraction, surgery and uveitis. It was expected that the would-be ophthalmologist would then go away for further training.

Other future McGill ophthalmologists who took one of the two hospitals’ one year programs prior to Dr. Kirschberg were Drs. John Nicholls, Don McCrae, and Hugh Duncan. In the case of Dr. Duncan, he was accepted in the MGH program and then went to India for one year. During World War II he was in the Royal Canadian Army Medical Corps as an Ophthalmologist. He then joined the RVH’s department of Ophthalmology and McGill. Dr. Duncan was a general ophthalmologist who acquired a large practice. His patients were devoted to him. Always friendly, and a pleasure to work with, he was a strong team player. He enjoyed escaping the Quebec winter for warmer climates, returning fit and ready for work. Dr. Bud Desmond followed Dr. Kirschberg as a resident at the RVH and did one year of Otolaryngology and then a year of Ophthalmology. He settled in Moncton, New Brunswick.

In the case of Dr. Kirschberg, after his year in Ophthalmology, he did one year as an assistant medical resident, which included a rotation to the Montreal Neurological Institute and a locums on the RVH paediatric ward. He then sought advice about what he should do next from Dr. MacMillan, who was greatly respected at the time. As a result of that advice, Dr. Kirschberg next spent one year in London at Moorefield’s and the Central London Ophthalmic Hospital. Dr. Nicholls wrote to Mary Pugh, a well known London orthoptist in England on Dr. Kirschberg’s behalf which led to his studying stereopsis and binocular vision - an interest which continued throughout his career. The staff and residents always sought his opinion on ocular muscle balance problems.

In 1941, while still in Montreal, Dr. Kirschberg joined the RCAF, in which he remained until 1945. In the Air Force he held the rank of Squadron Leader and worked on Regional Command Boards. Later in 1955, when Dr. Nicholls retired as Consultant in ophthalmology to the RCAF, Dr. Kirschberg took over. He dealt with issues of Civil Aviation Standards. Dr. Ken Evelyn (Internal Medicine) had worked on developing the RCAF Color Lantern as a test for colour vision with Dr. Nicholls, and Dr. Kirschberg continued its use.

Towards the end of the war, the ophthalmology programs at both the RVH and MGH were altered. Now each program accepted two residents per year and both programs became two years long. One of the major reasons behind these changes were the residents who wanted their residencies to include more teaching than was available previously.
Dr. Kirschberg was appointed to the RVH and McGill in 1946 as part of the hospital’s desire to increase the amount of time dedicated to teaching their ophthalmology residents. One of the first results of this change was that the staff gave a course of two hour lectures for the RVH and MGH residents every Tuesday evening. Dr. Kirschberg related that “in those days the staff were a very different breed.” The lectures were a real priority and the staff, with no remuneration, gave up other things to do them. He goes on to say “There was a big difference in attitude. They had a sense of responsibility to the hospital and the public. All were very conscientious.” The sense of commitment was strong and great camaraderie existed in the department.

Furthermore, while having been appointed, partially as a result of the hospital’s need for more teachers, Dr. Kirschberg was also influential in even further increasing the amount of time dedicated to teaching ophthalmology residents. In about 1955, during the American Academy Meeting, Drs. Clement McCulloch (University of Toronto), Turnbull and Kirschberg discussed the possibility of extending the residency to three years. Shortly thereafter, under Dr. Locke’s chairmanship, the idea was acted upon, further increasing the amount of resources the hospital needed to dedicate to instructing residents.

In research, a few members of the hospital’s ophthalmology department were expected to present papers each year at the Canadian Ophthalmological Society (COS) meetings. Taking advantage of this, Dr. Kirschberg delivered papers on topics including convergence insufficiency and plasmacytoma of the conjunctiva. He also contributed to and emphasized the importance of providing adequate illumination in schools. In addition, Dr. Kirschberg’s papers assisted in furthering cooperation and understanding between the departments of ophthalmology at the RVH and the MGH. On one occasion, Dr. Stuart Ramsey, Ophthalmologist-in-Chief at the MGH, was so impressed with a Canadian Ophthalmological Society presentation of Dr. Kirschberg’s that he decided to send him his overflow of patients. Dr. Nicholls delivered clinical papers. However, no basic research was going on.

Dr. Cyril James, Principal of McGill, wanted Ophthalmology to be a subdivision of Surgery. The staff, strongly disagreeing, saw Dr. James and departmental autonomy was maintained. From the outset, Ophthalmology was a separate department. The staff was unanimous in feeling that the problems in ophthalmology required the understanding that only ophthalmologists could give. This principle has been maintained through the years and is fundamental to the operation and development of the Department.
Dr. Kirschberg was instantly recognizable when walking down a hall in the hospital, head tilted to the left. He was happy to help everyone in the clinics. His expertise in ocular motility was recognized and sought after. Direct in manner, you knew where you stood with him. Always loyal and willing to pitch in, he was an excellent team player and, besides his knowledge, contributed significantly to the morale of the department.
Chapter 5:
World War II Years and the Early 1950s:
Residency Program Begins

The Second World War marked the end of an era in several ways. Not only had the founding fathers of the department, Doctors Buller, Gardner, Mathewson and McKee at the MGH and Doctors Buller, Stirling, Byers and Tooke at the RVH, either died or retired, but their passing saw the beginning of structural changes in the department and the introduction of new staff. They had shaped the first 70 years of the department’s service to the community, devoting their careers to teaching and fostering the study and care of patients with eye diseases. What they accomplished was made possible by the support of all members of the department. In the years ahead, the McGill department would see remarkable expansion and development.

Dr. John A. MacMillan – 1886-1953

One of the first new ophthalmologists appointed at the beginning of the Second World War was Dr. John A. MacMillan. He replaced Dr. Tooke at the RVH at the outset of the war and to many he was Canada’s most outstanding ophthalmologist of the time. Born in Finch, Ontario in 1886, his early education was completed there and at Cornwall High School. He graduated from McGill with the degree of M.D.C.M. in 1906, after which he interned at the RVH. This was followed by postgraduate studies at the Manhattan Eye Ear Nose and Throat Hospital in New York City. From there he went to Europe for a year of further training in London, Vienna, and Germany.

On returning to Montreal, in 1913, Dr. MacMillan was appointed to the staff of the RVH. However, he soon left again with the outbreak of World War I. During the war he went overseas with no. 3 Canadian General Hospital in France and served as consultant ophthalmologist with the Canadian Corps in 1918 and 1919. After the Great War, Dr. MacMillan came back to Montreal, the RVH and McGill.

Between the wars Dr. MacMillan continued his work at both McGill and the RVH, developing a special interest in ophthalmic pathology. One of his important contributions to the field was a chapter, written with Dr. W.V.
Cone of the Montreal Neurological Institute (MNI) on the optic nerve in Penfield and Cone's "Cytology and Pathology of the Nervous System" (1932).

In addition to teaching and publishing in the 1920s and 30s, Dr. MacMillan also made a start in integrating the residency training programs of the MGH and the RVH. McGill University, however, did not control post graduate training - merely undergraduate training. This left the responsibility for the post graduate programs with the teaching hospitals. Facing this problem, Dr. MacMillan recognized that, while the situation was unsatisfactory, especially in the light of newer developments in post graduate training, a solution would have to wait until new agreements could be reached between the university and the hospitals over educational jurisdiction.

Figure 13: Dr. John A. MacMillan
The present residency training program really started in the 1940s and 1950s. In Dr. MacMillan's day accurate refraction was stressed, especially as it was often noted that patients complained about their glasses following a resident's refraction. On one occasion I heard a staff man taking great pride in pointing out that, in a photograph of a well known person, this individual was wearing a pair of his glasses and was completely satisfied. Also, in Dr. MacMillan's time, surgery training began by assisting in the operating room and doing various procedures under supervision on animal eyes. One resident was responsible for obtaining cat and pig eyes for the group. Pathology was taught by studying microscope slides with a staff man and being asked questions as well as describing what they saw.

Slit lamp design was being perfected in the 1940s and 1950s. Dr. Murphy remembers when the microscope was on a separate stand which could be moved about on a glass surface and coordinated with the light source on a moveable arm. Gradually, new models were developed and, thus, the Haag Streit slit lamp came into widespread use. Doing visual fields, using the tangent screen, was another examination procedure to be learned. Each resident spent many days in the out-patient clinics developing their clinical skills. Because of the work up for glaucoma patients, a special clinic for these patients was instituted.

In 1939, Dr. MacMillan became Ophthalmologist-in-Chief at the RVH and Professor and Chairman of the McGill Department of Ophthalmology. At that time the Consulting Attending Staff consisted of Drs. Byers, McAuley, McKee and Tooke.

During Dr. MacMillan's tenure as Chairman, the residency training was two years in length. Two residents per year were taken on at both the RVH and the MGH. This training was hospital based and, in effect, two distinct programs existed, one at the RVH and another at the MGH. Former resident, Dr. Charles Dyson, comments on his training by stating that "It was a good two years. As well as ophthalmology training, we had good exposure to a strong, ethical background and some could not help but have rubbed off."

It is interesting that, in those days, everyone paused in the afternoon for tea. During the 1940s almost no formal teaching existed and Dr. William Turnbull, who was a resident at the time, remembers the hard life of the residents when they were told by Dr. MacMillan "Here are the books. You'll have plenty of time in the evening to read them." At the time, Sir Stuart Duke Elder's multivolume *Textbook of Ophthalmology* was the major work to study, and one from which residents would frequently quote during their rounds. Furthermore, in addition to memorizing facts and doing their rounds, there were many pathological microscope slides produced which the residents were able to study.
expected to examine and report on at weekly ward rounds. The residents were also responsible for preparing these specimens and working up patients in two large clinics held twice a week. In 1945 the American Academy started a home study course for residents which all McGill residents were encouraged to follow.

In the 1940s there were no Canadian Board Examinations, and as a result, everyone took the American Board Examination. Furthermore, ophthalmology residents were not involved in research – an area where staff activity was limited. This reflected the emphasis and goal of the department, which was to produce competent all round general ophthalmologists, subspecialization being uncommon in ophthalmology at this time.

During the Second World War the RVH’s Ophthalmology Department staff continued to fulfill their hospital and teaching duties, however, their work-load was heavier because of their reduced numbers. Dr. Nicholls, the Associate Ophthalmologist at the RVH, as mentioned earlier, took a leave of absence for Military Service, as did Dr. Kirschberg who joined the RCAF and made valuable contributions to the war effort. Their joining the forces, along with Dr. R.J. Viger of the MGH, meant that the staffs of the two hospitals were greatly overworked and overstressed. To compensate, Drs. MacMillan, Johnston, Tooke, and Rosenbaum, often assisted by Doctors Byers and McAuley, did their best to maintain ophthalmological services in the city. Nevertheless, there were times when they were exhausted.

Between 1942 and 1946 there were no more available Annual Reports from the RVH’s Ophthalmology Department, and yet, during the war years, practice and some research continued. Department staff still in Montreal attended conferences and symposia, gave lectures, published, and took part in the war effort. One of their professional war-time concerns was expressed at the 1939 meeting of the Canadian Ophthalmological Society. The society was concerned with the establishment of standards for visual acuity for members of the Canadian Expeditionary Corps proceeding overseas, and also sought suggestions about how to treat the soldiers during their service abroad, as well as upon their return.

Throughout his tenure at the RVH and at McGill, Dr. MacMillan was much in demand by patients, developing a large practice at his downtown office. An excellent teacher, he was always available for discussion and advice to medical students and residents. He showed a real human interest and sound judgement in dealing with their concerns and problems. Dr. Murphy was grateful to him for his advice in deciding to become an ophthalmologist and recommended sending an application to Dr. John Dunnington’s residency
training program at Columbia University’s Institute of Ophthalmology in New York City.

In addition to his work at both McGill and the RVH, Dr. MacMillan was also involved in a number of external medical organizations. He was a Fellow of the American College of Surgeons and on the Council of the Association of Research in Ophthalmology. For four years, he was Vice-President of the Pan-American Conference of Ophthalmology. In addition, he chaired the council of the American Ophthalmological Society 1949-50, was President of the Montreal Medico-Chirurgical Society, consultant in Ophthalmology to the Physician's Hospital in Plattsburgh, N.Y. and the Jewish General Hospital, and was President of the Canadian Ophthalmological Society 1946-47. Dr. MacMillan retired as Ophthalmologist-in-Chief of the RVH, and Chairman of McGill's, Ophthalmology Department in 1948.

Even after retirement, Dr. MacMillan continued as an honorary consultant to the Royal Victoria Hospital and was always available for service on other boards and committees which found his knowledge and experience invaluable. In 1950, he was selected from among American and Canadian ophthalmologists to act as consultant to the National Association for the Prevention of Blindness.

Dr. Jamieson remembers having dinner at Dr. MacMillan's house with a fellow resident and feeling he had learned much more than Ophthalmology from the doctor. In these early days, the residents were fortunate to work with some superb ophthalmologists and, besides acquiring scientific knowledge, they had role models of ethical behaviour and learned how to handle patients and develop as human beings. After his residency, Dr. Jamieson practiced in North Bay and became known as a violinist in the North Bay Symphony.

Dr. MacMillan was a clinically superb, highly ethical, well respected ophthalmologist who got along well with everybody. He took an active part in organizing ophthalmology in Canada and the United States, and the early steps in the formation and organization of McGill's residency program can be said to have started with him and his associates. When Dr. MacMillan died in 1953 the esteem and affection of his colleagues, patients and friends was reflected by the large numbers of them who attended his funeral. Dr. MacMillan's legacy at McGill was continued through his grand-daughter, Dr. Linda Cooper, who became a resident in ophthalmology at McGill and pursued further training in paediatric ophthalmology.
Dr. William Turnbull – 1917-2005

Dr. William Turnbull, a 1943 McGill medical graduate, was a resident under Dr. MacMillan between 1944 and 1946. Next, Dr. Turnbull spent 1946 to 1947 enrolled in a Diploma course involving one year of research and lectures which had been started by Dr. Nicholls and Dr. McCulloch from the University of Toronto. With Dr. Nicholls as his mentor during this research year, he worked on the retinal and choroidal circulation. At the time, it was unusual for a resident to devote one year to research. However, regardless of the benefits it offered Dr. Turnbull, enrolment in Dr. Nicholls and Dr. McCulloch's program was insufficient, and it was discontinued after only two years.

Figure 14: Dr. William Turnbull
After his year in the short-lived diploma program, there followed a year in California where Dr. Turnbull worked with Dr. Landegger from Vienna and, when invited by Dr. R.A. Irvine, he also gave lectures on diseases of the choroid at the University of California. This was followed by a preceptorship during which he visited other eye clinics in the United States. Finally, in October 1948, Dr. Turnbull returned to Montreal, joining the staff at McGill and the RVH where, over the years, he contributed greatly to the excellence of clinical care and teaching in the department.

When Dr. Turnbull arrived at the RVH, the other resident at the hospital was Dr. McRae, a nose and throat resident, who remained there only one year. Besides Dr. McRae, Dr. Turnbull had been preceded as a resident earlier in the decade by Doctors Hugh Duncan, Ted Craig, and Robb McDonald. The last of these men, who preceded Dr. Turnbull by one year, had gone on to a distinguished career as a retinal surgeon at the Wills Eye Hospital, Philadelphia and the Lankenau Hospital.

With the start of more formal residency training at the RVH in the 1950s Dr. Turnbull began working closely with the residents. In the program, at this time, the residents were accompanied by the staff at ward rounds. They were responsible for working up cases and working in clinics, which were often very large, twice a week. At this time, the residency consisted of two years. Patients coming to rounds would be worked up by a resident and presented to the staff.

In the days of Dr. Turnbull’s residency, the primary goal of the ophthalmology department was to produce competent, well-rounded general ophthalmologists. However, another goal was to encourage a few of the residents to pursue academic careers. If a resident showed a special interest in one area of ophthalmology, he or she was encouraged to develop that interest, which might eventually lead to an area of specialization in which they would pursue academic research. In the late 1940s and early 1950s, when Dr. Turnbull was at the hospital, medical student teaching was essentially unchanged, with the emphasis being placed on the eye examination. Ophthalmology was general with no specialization. In the case of Dr. Turnbull, however, he was persuaded to consider specialization when Dr. MacMillan encouraged him to pursue work in corneal transplants. As a result, in 1951 Dr. Turnbull enrolled in a three-week corneal transplant course at the Manhattan Eye and Ear Hospital (with Doctors Paton and Katzin), after which he performed the transplants for the department. While Dr. Johnston had carried out a few such transplants for the department, after taking the three-week course, Dr. Turnbull performed almost all of them.
Indeed the training and encouragement Dr. Turnbull received from Dr. MacMillan while a resident not only led him to a specialization in corneal surgery, but also served him well in other aspects of his work. When Dr. Turnbull took the American Boards, the examiner, Dr. Theobald said, “You trained with Dr. MacMillan, I don't need to ask you any questions!”

Dr. Turnbull’s specialization in corneal transplants marked the beginning of specialization at the RVH’s ophthalmology department. Later, in the mid 1950s, a glaucoma clinic was started at the hospital also under the supervision of Dr. Turnbull.

Beginning in his residency training, Dr. Turnbull was keen to participate in the development of new knowledge in the field of ophthalmology. While a resident he attended meetings of the Montreal Ophthalmological Society. The society used to gather once a month with all the hospitals (French and English) taking turns at hosting a meeting - as had been initiated in Dr. Byers’ time. The meetings served as a forum where interesting cases would be examined and discussed in an informal environment. The meetings were valuable experiences for both residents and staff.

In addition to participating in the Montreal Ophthalmological Society, Dr. Turnbull’s early academic contributions also included publishing. From early in his career, Dr. Turnbull published articles on several subjects - among them retinal vascular changes in essential hypertension, fibrinolysin, corneal grafts, Behcet’s Disease, and Dacryocystorhinostomy.

As an excellent ophthalmological researcher and writer, Dr. Turnbull read extensively, familiarizing himself with any new developments in the field. He was a curious man, always looking for a better way of doing things surgically. In character, he had a quiet aequanimitiy, excellent judgement, and was rarely phased by unexpected events. Above all, he was a superb surgeon and excellent surgical teacher. Staff and residents sought his opinion frequently. No matter what questions anyone asked him, he was always available to help, always willing to stop and discuss problems. He contributed greatly to the excellent morale of staff and residents.

Dr. Turnbull’s training and research at the RVH gave him a sound scientific background which allowed him to develop great surgical skills; skills which allowed him to contribute enormously to the hospital, the university, and the lives of his patients.

At any given time in a department, great surgical skills make a defining difference - and contributing to that difference was Dr. Turnbull's legacy.
Dr. G. Stuart Ramsey – 1887-1982

Dr. Stuart Ramsey succeeded Dr. MacMillan as Chairman (1947-1950) of the university department. Born in Levis, Quebec, Dr. Ramsey had graduated from McGill University with a B.A. in 1908 and M.D.C.M. in 1912. Following graduation, he travelled to China and worked for a year at the Canton Missionary Hospital. Returning to Montreal in 1913, he interned at the MGH where he began a year of pathology. However, with the start of the First World War Dr. Ramsey was on his way to England by late October 1914. In the war he served with the Black Watch Highlanders and, toward the end of the conflict was transferred to the Indian Medical

Figure 15: Dr. G. Stuart Ramsey
Services where he served for five years. While in India, he married Juliette Pelletier of Quebec City.

After marrying Juliette, Dr. Ramsey became concerned about the potential problems involved in bringing up a family in a foreign country. As well, he noticed that the senior medical officers of the service had developed a distinct lack of zeal. These factors, in addition to a persistent, chronic sinus condition, which was not improving with his stay on the sub-continent, led him to resign from the Indian Medical Services in 1921. Instead, he had decided to pursue a career in Ophthalmology. His decision to study ophthalmology was in large measure related to his experiences in China and India where he saw many avoidable and treatable eye conditions.

Taking his residency at the Manhattan Eye Ear, Nose and Throat Hospital between 1921 and 1923, Dr. Ramsey was appointed assistant ophthalmologist at the MGH and Demonstrator in the Department of Ophthalmology at McGill University following his graduation. Additionally, he gained experience in periodic visits to ophthalmic centres in London, Paris and Vienna.

By 1941 Dr. Ramsey was appointed Ophthalmologist-in-Chief at the MGH, a position which he kept for ten years, stepping down in 1951. Furthermore, from 1947 to 1950 he was Chairman of the McGill Department of Ophthalmology and in 1949 was appointed Professor. Retiring from practice in 1969, he was named Emeritus Professor in 1971.

Outside of his own practice, as well as his hospital and teaching duties, Dr. Ramsey was active within the greater Canadian and international ophthalmology community. In 1951, the Canadian Ophthalmological Society elected Dr. Ramsey as President and, in the early 1950s he served as Canada’s representative on the International Council of Ophthalmology. This council is the organizing body of the International Congress of Ophthalmology, meeting every four years. In 1954 the Congress was held in both New York City and Montreal. The decision to hold the meeting in two cities was because, during the Cold War, visitors from Iron Curtain countries were not welcome in the United States. As the representative from Canada, which, while restrictive, was not so restrictive as to prevent Soviet ophthalmologists from attending an international meeting, Dr. Ramsey organized a second international council meeting in Montreal on very short notice. His exceptional skills and industry greatly helped make the Congress a success.

During Dr. Ramsey’s tenure the MGH saw its first corneal graft performed by Dr. Wyatt Laws in 1948. The chief at the Queen Elizabeth Hospital, Dr.
Laws had first observed the technique in New York. In Montreal, one of his patients was a felon who was in prison for stealing food because his sight was so reduced he could not see. The prisoner was brought out of prison for the corneal transplant surgery, which was a success. Dr. Laws was a meticulous, excellent surgeon and a first rate teacher. He left Montreal in 1970 because he was not comfortable with the idea of socialized medicine and settled in New York.

However, while an influential and effective member of the ophthalmological community, Dr. Ramsey was, above all, a fine clinician and set a superb example as a physician. He was kind and considerate to his patients, encouraging and helpful to residents and younger ophthalmologists. He
guided the Department at a time when clinical excellence and teaching were the priorities. The residency program was gradually being taken in the direction charted by Dr. MacMillan, becoming more formalized. Dr. Ramsey was eventually succeeded by his son, Dr. Bruce Ramsey, who also trained in ophthalmology and joined the Department of Ophthalmology at the MGH and McGill in 1954, where he went on to a distinguished career in ophthalmic plastic surgery.

Beyond his work, Dr. Ramsey was also interested in sports and public affairs, two subjects which he pursued into his final years. While a student, he had captained his hockey and tennis teams, and at the age of 88, as a well known, legendary tennis player, he played his last game at the Montreal Indoor Tennis Club.

Dr. Kenneth B. Johnston

Dr. Kenneth B. Johnston succeeded Dr. Ramsey as Chairman of the McGill Department from 1950-1956. He was also appointed Ophthalmologist-in-Chief at the RVH during this period.

Dr. Johnston was born in 1896, the youngest of eight children, and attended McGill Medical School from 1914 to 1916. He then served overseas in World War I with the 66th Canadian Battery and was awarded the Military Medal in 1918. He returned to graduate in Medicine from McGill.

Between 1922 and 1924 Dr. Johnston was a resident in Ophthalmology at the Peking Union Medical College and from 1925 to 1926 he studied at Moorfield’s Hospital, London and in Vienna with the renowned Dr. Adelbert Fuchs. He then returned to Montreal and joined the ophthalmology department at the RVH. He was especially interested in education and improving the student’s and resident’s knowledge.

Dr. Johnston was active in medical societies, being a founding member of the Canadian Ophthalmological Society and serving as its secretary and then elected president in 1953. His presentations and written contributions to medical journals were clinical and always carefully prepared. He was a consultant to the MCH and the Queen Mary Veterans Hospital.

In appearance Dr. Johnston was lean, fit looking, and possessed a dry sense of humour. He was hard working, and at his best looking after patients in a kindly, considerate manner. Under him, departmental morale was high, with an emphasis being placed on having all of the staff work together as a team. In addition, Dr. Johnston was always available to assist members of the staff, as well as the residents. Indeed, his advice was frequently sought by residents, who were well aware of his good judgment and high ethical
standards. Always careful in making decisions, he took the time to look at all the various aspects of any question.

He retired to Como and his passion was gardening.

**Dr. Benjamin Alexander – 1902-1988**

Following Dr. Ramsey’s retirement as the MGH’s Ophthalmologist-in-Chief in 1951, one of his younger colleagues, Dr. Benjamin Alexander, was appointed to the position in 1952, a post which he held until 1963. Like his predecessor, Dr. Alexander was a graduate of McGill, having grown up in Montreal and graduated from the McGill Faculty of Medicine in
1925. He spent the next two years at the MGH as an intern. Then, in 1927, having decided on a career in Ophthalmology, he left Montreal for London where he studied at Moorfield’s Eye Hospital. After two years at Moorfields, Dr. Alexander obtained the Diploma of Ophthalmic Medicine and Surgery (D.O.M.S.) from the Royal College. This was followed by two years additional specialized training: one year at the Royal Eye Hospital in Manchester and then another in ophthalmic pathology at the University of Vienna.

In 1931 Dr. Alexander finally returned to Montreal where he established a large busy practice in which he received patients for some 40 years. As had been the focus of his training, his interests were mainly in the field of clinical ophthalmology. At times, patients found him gruff but they also knew him to be a conscientious, caring, competent ophthalmologist. His reputation for meticulous surgery was well known. One day, in the operating room, he suddenly felt a draft on his legs - immediately all noticed his trousers had dropped to the floor!

Dr. Ronald Pinkerton, a resident in ophthalmology at the MGH (1958-1960) recalls that the presence of Doctors Sam Adams and Alan Bourne were strong points in the program. However, he felt that generally the teaching program suffered from a lack of well organized instruction. In addition, there was very little contact between the staff and residents of the RVH and MGH. Dr. Adams arranged for him to have an elective at the Howe Laboratories in Boston where he received excellent instruction from Doctors David Cogan, Morton Grant, and Paul Chandler. He completed his residency in the United Kingdom and eventually became Chairman of the Department of Ophthalmology at Queen's University.

‘Benny’, as Dr. Alexander was called, exuded energy, which was obvious when talking to him and watching him in action. He had followed the established route of training, undergoing his preliminary medical training in Canada and then heading to Europe for additional specialized training. At McGill and the MGH he continued the tradition of first rate clinical care with its concern for the patient. His abilities were recognized in 1961 when he was elected President of the Canadian Ophthalmological Society.

Beyond the hospital and the university, he delighted in small boat sailing, both near his summer house on Lake Memphremagog and in the sea off Victoria, his home following retirement in 1972.
Chapter 6:
Basic Science and the Further Development of Residency Program, 1957-1970

Dr. John C. Locke – 1921-2003

Dr. John C. Locke arrived at the RVH and McGill on February 1, 1952. A 1942 McGill medical graduate, he completed a three year residency in ophthalmology at the Institute of Ophthalmology of the Presbyterian Hospital, Columbia University in New York City on December 31, 1950. There followed a Research Fellowship at Columbia in 1951.

Only a few years after his return to Montreal in the early 1950s, Dr. Locke had advanced rapidly in the Department of Ophthalmology at McGill. This was noted in the mid-1950s when, towards the end of Dr. Johnston’s chairmanship, speculation arose about who would be his successor. One apparent successor, Dr. John Nicholls, had established impressive credentials since his arrival at the RVH in 1939 and was being considered for the job. However, earlier in the decade, even in his capacity as a hospital ophthalmologist and a well respected ophthalmology professor at McGill, Dr. Nichols had been unable to persuade the University to provide adequate funding to operate and develop the Department. Dr. Locke, however, had an excellent background in clinical ophthalmology and had contributed in clinical research before and since his arrival in 1952. He accepted the university’s financial limitations, and as a result, was appointed Chairman of the McGill Department, as well as Ophthalmologist-in-Chief at the RVH, in 1956.

When Dr. Locke took up the chairmanship of the Department of Ophthalmology, McGill’s ophthalmology residency program was two years in length, and included four residents, two based at the RVH and two at the MGH. However, ophthalmology was developing as a field, and proper training for its residents required more time than what was offered in a two year program. Thus, Dr. Locke, in an important decision, extended the program from two to three years, with the third year initially spent at the Veterans Hospital. Attempts at rotating residents for parts of their training, so as to ensure that each resident would benefit from training in the different hospital, proved to be a short lived experiment. Instead, residents were trained as well as possible within their respective hospitals. In the case of
paediatric ophthalmology, RVH residents were taught in the paediatric ward of the RVH while MGH residents rotated to the MCH.

As Ophthalmologist-in-Chief at the RVH, Dr. Locke was responsible for selecting residents for the hospital’s program. To do that successfully he enlisted the help of Dr. Nicholls and the two men chose their residents by both interviewing prospective candidates and reviewing their academic files. This procedure was similar to that at the MGH. The first residents chosen by Drs. Locke and Nicholls for the new three year programme were Drs. Keith Edwards and Donald McCunn. Later resident acceptance procedures became more complex, involving interviews by several members of the RVH and MGH staff.

Figure 18: Dr. John C. Locke
With McGill offering insufficient funding for the running of the Department of Ophthalmology, Dr. Locke administered the Department from his downtown office. Indeed, when Dr. Locke was appointed Chairman in 1956 the university only recognized his position as being part-time, offering him a stipend of $10.00 per week. However, the department’s financial problems did not depend entirely upon the Dean of Medicine or the university administration. Rather, McGill’s lack of sufficient departmental funding was also affected by the Union Nationale government of Maurice Duplessis, which would not allow the University to accept federal funds. However, even after the fall of Duplessis’ government in 1960, the university still failed to pay the Chairman a reasonable salary. However, in 1965 he was paid $10,000 per year by the RVH with nothing coming from McGill. Then, finally, in 1967, in addition to the hospital stipend, McGill began to pay him $8,000 per year to chair the department.

The restricted financial position of the department not only affected Dr. Locke’s salary, but also made it practically impossible for the Chairman to make any faculty appointments without the consent of the Dean of the Faculty. During his tenure as Chairman of the department, the Deans of Medicine included Dr. Christie and Dr. Stephenson. In the case of Dr. Christie, he believed that for McGill to be a strong medical school, it had to fully fund the teaching of anatomy, physiology, medicine, and surgery. Any other branches of medicine would have to fend for themselves. Clearly, ophthalmology was not considered a priority by the Dean’s office.

As a result of his frustration with the Dean of the faculty and other parts of university administration, Dr. Locke resigned at least twice over the course of his McGill chairmanship. He found the administrative politics of his hospital and university positions difficult and trying, resigning each time in response to the university’s failure to give his department the level of financial support he demanded.

The future development of the department became an issue and, in 1963, a distinguished visiting committee was invited to make recommendations. The members were Professors David Cogan, Chairman (Harvard), Frank B. Walsh (Johns Hopkins) and A.J. Elliot (University of British Columbia). A lack of coordinated effort between the RVH and the MGH was noted but no recommendation to amalgamate the two departments was made. It was suggested that geographic full time (GFT) appointments be established for the chiefs at the RVH and MGH. With good will, there should be cooperation between the two departments. No precise recommendations were made for research. On the one hand, the committee favored the acquisition of space in the new McIntyre Medical Building as a joint undertaking between the two
hospitals but on the other also favored the development of clinically oriented research areas in close proximity to the hospital departments.

The committee concluded that McGill had a solid core of competent ophthalmologists who gave an unparalleled amount of time and effort to their respective institutions. However, their loyalty to their own hospitals had nevertheless made for a difficult administrative organization at the University level.

Apart from dealing with some of the department's difficult administrative problems of the 1950s and 1960s, Dr. Locke's career also resulted in the development of new and exciting research. For example, in 1954 he reported on retrolental fibroplasia and the need to reduce oxygen to premature babies. His study was based on 327 babies examined in New York City and Montreal. His important contributions to this subject were recognized when he was awarded a medal by the Royal College. Like his work in after image scotometry, his work on retrolental fibroplasias was original and at the forefront of such research. Indeed, it was his research studies that gave Dr. Locke his greatest satisfaction and pleasure.

As an active member of McGill's Department of Ophthalmology and the Canadian Ophthalmological Society, Dr. Locke participated in major events within the national and international ophthalmological community. One significant example was in 1954 when he, along with other members of the Department, assisted Dr. Ramsey in hastily organizing the Montreal half of the International Congress of Ophthalmology. At the congress Dr. Locke filled the role of assistant secretary. In addition, in 1959, Dr. Locke also contributed to the success of the American College of Surgeons meeting in Montreal.

After McGill began partially supporting the Chairman, Dr. Locke's practice was still downtown and almost no funds were made available for the pathology laboratory. At the time, ophthalmology was not considered important enough to have full-time staff appointments. Eventually, there were changes so that if you were full time you could be paid and be given an office in the hospital. If you were part-time, you taught and worked in the clinics, but you were not entitled to salary support.

When Dr. Locke started as Chairman of the department in 1956, he felt that small group teaching for undergraduate and graduate medical students was insufficient. Because of this he decided to personally give thirteen hours of lectures on all major aspects of ophthalmology to the entire third year class. Furthermore, at the time, examinations in ophthalmology did not count for graduation. Dr. Locke believed this explained the lack of effort
students were putting towards studying for their ophthalmology exams. The situation was rectified when the university accepted that it was necessary for students to pass the ophthalmology exam as a requirement for graduation. In addition, Dr. Locke and the attending staff continued to give two hour lectures one night a week to the residents of the RVH and MGH. In the case of incoming residents, an initial crash course in the basics of ophthalmology was offered once a year in July to help them get started; a practice which has been continued to the present day.

Another area in which Dr. Locke excelled was that of specialized treatment. Early in his tenure, the RVH acquired the first Zeiss phachoagulator in Eastern Canada in 1956. This was a complex machine which most of the hospital’s ophthalmology staff found difficult to use. Dr. Locke, however, had become familiar with the machine during his studies in Germany, where he had worked with its inventor, Dr. Meyer Swickerath. As a result of his expertise, Dr. Locke treated most of the patients, especially those with diabetic retinopathy.

Indeed, the acquisition of specialized technology such as the Zeiss phachoagulator and Dr. Locke’s skills as an ophthalmologist were merely one aspect of a hospital department where patient care was excellent overall. During the 1950s not only did everyone practice general ophthalmology, but, as in the case of Dr. Locke, some staff members were also making use of specialized skills. For example, in later years Dr. Nicholls worked increasingly on low vision and Dr. Murphy, starting in 1955, saw consultations from the Montreal Neurological Institute and worked with the residents in this area, encouraging them to make presentations to the staff. Additional examples of such specialization included Dr. John Foreman, a resident at the RVH. He was sent for six months to the Armed Forces Institute of Pathology in Washington, DC, a significant development since there was very little work being done in the pathology laboratory at the time. Furthermore, Dr. John Nicholls pursued studies in retinal vascular and macular conditions while Dr. Turnbull perfected his corneal transplants skills, carrying out the great majority of such transplants performed at the RVH.

In the early 1960s, although clinical excellence and teaching were the department’s priorities, it was decided by Dr. Locke and the staff at the RVH and MGH that the development of research was also essential if ophthalmology at McGill was to progress and make significant contributions to the field. However, it was realized that this new research mission would require a major effort since most staff members in the 1950s and 1960s were not particularly interested in basic research. One of the departmental leaders
in developing new research, however, was Dr. Locke, who had a particular interest in conducting ground-breaking research in the area of blindness.

When Dr. Locke undertook to create a basic eye research centre at McGill in 1968, blindness research in Canada was not only neglected, but almost non-existent. As a vocal proponent of the need for and benefits that could be derived from such research, he criticized the Canadian government for its meagre support of eye research. Ottawa’s lack of financial support was evident when compared to the funding levels offered by the United States government to that country’s research institutions. For example, in 1967 the American federal government contributed in excess of $18,000,000 for eye research. In Canada, the budget of the Department of National Health & Welfare for eye research was $150,000 in 1967, with some additional funds coming from other government sources, although those additional funds were not specifically ear-marked for ophthalmology. Furthermore, Dr. Locke also argued to potential supporters that there were a number of medical schools in the U.S. where, in any one institution, the space for eye research exceeded the combined total space for eye research in all the hospitals and medical schools of Canada.

Given the perceived need for a significant increase in new, cutting-edge Canadian research into blindness and other eye related conditions, Dr. Locke put together a group of professional and lay people to find funds for an eye research centre which would be housed at McGill. While it was not easy to acquire the necessary financial support, he did succeed in raising $500,000, $250,000 of which came from the private sector and $250,000 from grants. Major contributors and supporters were individuals and organizations that were in some way involved with eye disease or blindness. These included the Canadian National Institute for the Blind and the Lions Club. McGill contributed by allocating 2,000 square feet of space on the twelfth floor of the new McIntyre Medical Building. Dr. Locke was unable, however, to secure any long-term funding, and any future monies required for the research centre would depend upon funds secured by the Department of Ophthalmology.

Dr. Locke’s initial fundraising campaign resulted in the McGill Eye Research Centre, which was opened on July 1, 1968 with Dr. Sidney Lerman, Professor of ophthalmology and biochemistry, being made Director of Research. Dr. Lerman was a Montreal native who had graduated in medicine from McGill and underwent his residency training in ophthalmology at the MGH. After the MGH he continued on to post-graduate work at Johns Hopkins University and the Institute of Ophthalmology in London. Furthermore, prior to being appointed a McGill professor and Director of Research at
the new Eye Research Centre, he had been Director of Ophthalmological research at the University of Rochester, New York. From his new position at McGill he recruited two other researchers. Under their direction the centre embarked on studies having to do with biochemistry and cataract, research that resulted in many publications.

With the research centre open, plans were made to seek additional funds for both the creation of a permanent Chairman of eye research, and the construction of additional laboratory facilities. Unfortunately, the raising of additional funds proved difficult and it was not possible to reach these objectives. Furthermore, Dr. Lerman became ill and had to leave after about three years.

While only at McGill a short time, Dr. Lerman made significant contributions to ophthalmology at the university. Clinically, he contributed his expertise and conducted the glaucoma clinic at the RVH. In the classroom his excellent lectures in biochemistry and basic science were a first for the McGill residents. Initially, these lectures were presented as one set of lectures for both the MGH and RVH residents. However, as time passed, some of the lectures were given separately at each hospital. Dr. Lerman’s classes provided the first stimulating exposure to basic science. His method of teaching was to ask the residents thought provoking questions, challenging, and sometimes intimidating them, by asking the residents to explain things in terms of basic science. At times, some would be afraid to answer. In addition, Dr. Lerman, making use of his remarkable memory, further enhanced scientific education at McGill by writing a textbook on basic science to be used by the residents, which he wrote largely by dictating it from memory.

For several years after Dr. Lerman’s departure the MGH residents had a brief exposure to basic science through the Lancaster course at Bowdoin University in Maine while the RVH residents began attending a new course at Stanford University. However, regardless of the university’s attempts to replace Dr. Lerman’s pedagogical talents, these courses did not provide the depth of information which he had offered in his lectures. Furthermore, with his departure, the basic research program instituted by Dr. Locke came to an end. Even though the space in the McIntyre building had been designated for basic ophthalmology research, in the absence of a capable director, the university reallocated the space, a decision which the department was never able to reverse. The loss of both Dr. Locke’s research centre and the space in the McIntyre building was only compensated for much later with the arrival of Robert Hess and his group from England in the early 1990s.

Towards the end of Dr. Locke’s tenure, and illustrating some of the problems from the residents’ point of view, on September 9, 1969, the RVH
residents made recommendations to Dr. Locke and the attending staff. This was an important document giving the residents’ viewpoint with astonishing clarity.

1) The equipment and space in the clinic area must be reorganized to allow more efficient patient care. One should be able to do a complete eye examination without moving the patient.

2) The presence of at least one full-time geographical Staff Ophthalmologist is an absolute necessity.

3) All residents must be allowed to attend the teaching sessions at the MGH.

4) We suggest regular pathology sessions for the residents at the RVH.

5) We suggest institution of a series of lectures by visiting Ophthalmologists who are noted in various fields.

6) One resident should be invited to attend all staff meetings involving matters affecting residents.

7) Saturday is part of the weekend and should therefore be free from lectures and rounds.

8) The dictation of operative reports and discharge summaries of private patients is the responsibility of the attending surgeons.

9) At least one staff man must be present at all clinics, but in an advisory capacity only.

10) Training in contact lenses is absent and should be instituted.

11) We suggest that weekly Staff Rounds consist of one or two cases of interest presented to all the attending staff for active discussion.

12) We suggest that the Attending Staff Man be on call for a period of one week from Monday to the following Sunday and that he make ward rounds at least once a week with the residents.

13) A greater number of journals are required for the library. In addition, the books must be catalogued.

14) A copying facility should be made available to the residents, especially for bound journal duplication.
Dr. Sapp, our elected spokesman, will amplify the above points as necessary.

Respectfully yours,

G.A. Sapp, MD
B. Lennox, MD
P.L. Dawson, MD
James E. Csordas, MD
W.B. Jackson, MD
D. Kaufman, MD

We can see how right and far seeing the residents were. Most of the recommendations were implemented. The department understood the importance of keeping in close touch with the residents. Because their perceptive requests dealt with important issues and was a first of its kind, it is being reproduced in its entirety.

Dr. Locke retired as both Ophthalmologist-in-Chief at the RVH and Chairman of McGill’s Department of Ophthalmology in 1970. In retrospect, his career at McGill and the RVH can be seen as having led not only to advances in research and patient care, but also in the very shape of ophthalmological training at McGill. Under his leadership the residency program had been extended from two to three years and he had made important contributions to ophthalmology clinical research, informing Dr. Murphy personally that some of his happiest moments came when he was working on scientific projects - for example, while pursuing his important retrolental fibroplasia research. While his attempt to establish a basic science program at McGill was discontinued with the loss of Dr. Lerman, it can be seen as having been a forerunner to the research development which eventually occurred in the 1990s. Furthermore, it represented the first major commitment to basic science research in ophthalmology at the university. A lesson learned was that in future such research space and programs must be adequately funded at the time and for the years ahead.

While never enjoying the administrative aspects of his job as departmental Chairman, Dr. Locke had been totally committed to Ophthalmology. With his patients, he was meticulous, accurate, caring, and careful. However, it was only after retiring, and relieved of his administrative duties, that he became much more relaxed and really enjoyed life.
Dr. Peter Rosenbaum – 1926-

Dr. Peter Rosenbaum, the son of Dr. Jacob Rosenbaum (former Chief of Ophthalmology at the JGH) followed in his father’s footsteps, graduating in medicine at McGill in 1954. He became a resident in ophthalmology at the RVH, being appointed in 1956-1959. At this time the MGH and the RVH appointed two residents each year.

Dr. Rosenbaum received an appointment at McGill and the RVH in 1960. His great contribution over the years was his teaching of medical students. He was excellent in introducing them to ophthalmology and taught with enthusiasm. After listening to him there were always some who went on to a residency in ophthalmology.

Dr. Peter Davis – 1966-

In 1966, during Dr. Locke’s tenure as Ophthalmologist-in-Chief at the RVH and Chairman of McGill’s Department of Ophthalmology, the ophthalmology departments at both the hospital and the university were joined by Dr. Peter Davis. Dr. Davis had been a resident in the RVH program from 1962 to 1965. In a communication with the author he described his experience in the residency program as having been:

relatively unstructured with much of the reading self directed using the Academy outlines. The strength of the training was exposure to top notch clinicians combined with the option of taking interesting and difficult patients to the attending surgeon who had the greatest interest in the problem. The quality of work in the clinic attracted a wealth of clinical material. Research was essentially practice based with occasional involvement with an attending with a project underway.

After completing the residency program, Davis obtained a McLaughlin Fellowship and a Percy Hermant Fellowship, which enabled him to spend one year studying cornea with Dr. Phil Thygeson at the Proctor Institute in San Francisco.

Returning to McGill and the RVH in 1966, Dr. Davis became the first clinical scientist from the hospital. He obtained an MRC grant, acquired animals for research, and had residents assist him with his investigations between 1971-1972. In addition, he also established a small diagnostic laboratory for the study of external disease. Furthermore, between 1969 and 1975 he authored a number of publications concerning external disease.
Thereafter, his publications dealt with anterior segment surgery. In that work, he presented innovative ideas based on careful thought. Indeed, Dr. Davis had a knack for coming up with innovative ideas, as was seen through his involvement with the evolution of intraocular lenses at McGill, an area of research in which the university had previously not placed sufficient emphasis. Finally in 1991, Dr. Davis left Montreal to relocate in Kelowna, British Columbia.

Dr. Samuel T. Adams – 1919-1975

Dr. Adams succeeded Dr. Locke as Chairman of the McGill Department in 1971. He began his career by graduating in medicine at McGill in 1943. At that time the standard four year medical course was compressed into three because of the demand for doctors caused by the Second World War. Next, Dr. Adams interned at the MGH while also serving as a Captain in the Royal Canadian Army Medical Corps from 1944-1946. Unfortunately his work was complicated in 1945 when he contracted poliomyelitis, becoming very ill and was unable to walk for over a year. However, regardless of that set-back, he became a senior intern in Ophthalmology at the MGH in 1947-1948. This decision can be partially attributed to Dr. Stuart Ramsey, who, as a friend and mentor to Dr. Adams at that time, was instrumental in Adams’ decision to enter into ophthalmology.

Between 1948 and 1952, Dr. Adams and his family left Montreal for Boston, where he spent his first three months attending a compulsory course at Harvard followed by a three year training program at the Massachusetts Eye and Ear Infirmary. There then followed an unplanned extension of six months studying and operating with Dr. Charles Schepens, a Belgian who had fled to England during the war years and came to Boston. He became known for his contributions to retinal surgery, including devising buckling procedures and developing binocular indirect ophthalmoscopy. In addition, he demonstrated that patients with retinal detachment, instead of lying prone for several weeks with head steadied by sandbags, should be expected to get out of bed the day after surgery.

1952 saw Dr. Adams return to the Eye Department of the MGH where he was the first surgeon in Eastern Canada to perform buckling operations. As such, he was swamped with patients referred from all over the Maritimes and New England. Since such surgeries had to be performed as soon as possible, his patient load continued to be heavy for two or three years, until others could be trained to perform the procedure. Indeed, at the time life was a gruelling existence for both the surgeon and his family. Furthermore, in addition to performing his surgical tasks, Dr. Adams also founded the
first retina clinic in Montreal while at the MGH in the 1950s. His 1959 appointment to the MCH is discussed on page 135.

In 1964 he was appointed Ophthalmologist-in-Chief at the MGH, a position which he would hold until 1975. At the MGH he stressed the importance of providing all encompassing, excellent eye care, while always maintaining the patients’ best interests and welfare as his primary concern. Through his new position at the hospital Dr. Adams worked hard at improving undergraduate and post-graduate teaching and he was one of the first faculty members to recognize the importance of geographic full-time ophthalmologists in the Faculty of Medicine. Appointments to these full-time positions had been made earlier in other McGill departments,

Figure 19: Dr. Samuel T. Adams
as well as at the MGH and RVH. Dr. Adams, as the first geographic full-time ophthalmologist at McGill, helped to create such additional full-time positions in the Departments of Ophthalmology at both McGill and the MGH. Indeed, the fact that appointments to full-time positions in Ophthalmology lagged behind full-time appointments in other departments was a source of considerable frustration for the ophthalmology staff of both hospitals. It also reflected the weakness of the university’s commitment to ophthalmology. As the years went by, it became very clear that the full-time staff played a vital role in the development of the Department at McGill, the MGH and the RVH. These full-time ophthalmologists worked with the Dr. Adams part-time staff as a team and, under his leadership, the Department functioned effectively. A similar development would occur at the RVH.

In 1967 Dr. Adams accepted Dr. Mourad Khalil as a resident at the MGH. Dr. Khalil went on to make important contributions to the MGH and McGill. These are discussed on page 110.

In 1971, Dr. Adams’s responsibilities were further increased when he was appointed Professor and Chairman of the McGill Department of Ophthalmology. Very much a university person, Dr. Adams believed in McGill and was dedicated to developing a first rate department. To him, achieving that goal did not exclude consolidation, and as both Ophthalmologist-in-Chief at the MGH and Chairman of McGill’s Department of Ophthalmology, he worked at bringing the university’s two teaching hospitals’ ophthalmology departments closer together, expressing the hope that one day they might be housed together.

In 1970, Dr. Murphy was appointed Ophthalmologist-in-Chief at the Royal Victoria Hospital. Dr. Adams and he established an excellent working relationship and met frequently to discuss the affairs of the university and hospital departments. He also went out of his way to make himself available to discuss problems with both members of the department and residents.

Significant developments at the time included Dr. Adams’ appointment of a superb organizer and specialist in external disease at McGill and the MGH – Dr. Dario Lorenzetti.

Outside of both the MGH and McGill, Dr. Adams was active in a variety of organizations. He was a founding member, and later President, of the Retina Society (U.S.), as well as a member of the European Retina Society, ‘Club Jules Gonin,’ for three years (1962-65). He served as an Associate Editor of the AMA Archives of Ophthalmology, onetime Chairman of the MGH Medical Advisory Committee, a past President of the Montreal Ophthalmological Society, a former Vice President of the Association of Ophthalmologists
of Quebec, a member of the examining committee and nucleus committee of the Royal College of Physicians and Surgeons of Canada, and a former member of the Council of the Canadian Ophthalmological Society, where he served as Chairman of the Committee on Indians and Eskimos.

Following his chairmanship of the McGill Department, Dr. Adams took a six month sabbatical in Montpelier, France. There he brought the current techniques of modern retinal detachment surgery to the region and established an excellent liaison with the local ophthalmologists. Among other advances, he demonstrated to his French colleagues that it was no longer necessary to keep patients flat in bed for days, but that, when treated using the techniques that he had learned with the renowned Dr. Schepens in Boston in the early 1950s, they could safely get up the day following surgery.

The Arctic was another important chapter in Dr. Adams’ life. In the late 1960’s the Canadian Government began to express an interest in improving the medical services available to the country’s Northern people. At about the same time, Dr. E. Kass in the western Arctic was calling upon government authorities to do more about eye care in the North, suggesting that there was a need for an eye hospital in the region. As a result, the federal government decided to complete a survey of the ophthalmological needs in the North. The area was divided into four districts, with one university being responsible for each. McGill was given the ‘East Baffin Zone’ with twelve settlements under its care.

The first step in completing McGill’s survey was for ophthalmologists from the university to complete an assessment of eye problems in the East Baffin Zone. In December 1970, a team of three - Dr. Adams, Dr. Mourad Khalil, and Doreen Adams, who functioned as clinic clerk/statistician - flew to Cape Dorset to examine all of the inhabitants in the settlement of some 500. As a result of their assessment, they concluded that a Northern eye hospital was not necessary, and that urgent and problem cases should be flown to the MGH.

During the 1970 McGill assessment visit, as on many earlier visits made by medical personnel, the abnormally high incidence of myopia in children and teenagers puzzled the ophthalmologists, especially as most parents and older generations were free of it. This same situation had also been noticed in other countries with northern peoples, and was of such concern that the topic of childhood myopia became one of the main topics at the Third International Symposium on Circumpolar Health held in Yellowknife in July, 1974.
Beyond his accomplishments in ophthalmology and within the ophthalmological community, Dr. Adams is remembered by many for his ability to communicate - make contact - establish rapport with humour, good will, energy and enthusiasm. Although a retina surgeon, professor, arctic pioneer, Dr. Adams also liked to ski, play tennis and hike. He loved being outdoors in contact with nature. Hiking in the Rockies, the Grand Canyon or the Laurentians brought great joy. Walking with him in the woods on a clear crisp day, snow crunching underfoot was a rare pleasure. His enthusiasm for the Arctic was contagious, unbounded and never diminished with his many trips. He was sensitive to the beauty of the Canadian North, was happy there and developed an appreciation and understanding of Inuit art.

Dr. Adams combined a scientific approach with a caring humanitarian outlook. Always enthusiastic about his work, he did his best for patients, the MGH, McGill and Ophthalmology. He understood the importance of interhospital cooperation and appreciated the value of the basic sciences. With the perspective of time, it is clear that he played a significant role in the development of ophthalmology, both at McGill and in Canada. At his funeral, in 1975, the family was overwhelmed and impressed by the variety of the mourners - nurses, residents, patients, doctors from many institutions. One orderly said to his daughter, Jorie, “he was never too busy to talk to me.” A former resident, who had driven some distance from New York State, came to pay tribute to Dr. Adams. He said that:

He taught me something that I have never forgotten. One day in the clinic, we were running late, nearly everyone had gone to lunch, and I was telling my patient that there was still another test to be done - she should come back next week. Dr. Adams was passing by, he asked if he could have a word with me. Drawing me aside, he said “Madame B has four children at home, she has difficulty getting someone to look after them - she has to take three buses to get here. I think we could manage to get that test done now, don’t you?”

Indeed, as such testimonies show, Dr. Adams is remembered fondly. In his memory, the ophthalmological library at the MGH was named the ‘Samuel Adams Library.'
In 1970 the Faculty of Medicine of McGill University was presented with an exciting challenge by the Federal Department of Health and Welfare (now Health Canada). This was to provide medical specialist services to the thirteen Inuit communities in the Baffin Region of the eastern Northwest Territories. They ranged from Grise Fiord on Ellesmere Island to Lake Harbour and Cape Dorset on the south coast of Baffin Island. The area involved was therefore quite extensive, encompassing most of Franklin Territory. No accurate census figures were available at that time but it was estimated that there were perhaps 20,000 Inuit in Canada of which 40% lived in the Baffin Region.

By 1970, some rudiments of a scheduled air service were in place for most of the northern villages. Health and Welfare decided that the best way of obtaining an adequate supply of specialists was to call upon the medical schools to provide specialists to the areas which were north of their location. McGill was given the eastern NWT or Baffin Region. The distances involved when flying to the north from Montreal were quite large. McGill’s most remote village was Grise Fiord, on Ellesmere Island. This is the northernmost community in the western hemisphere, and the airline distance from Montreal is a little over 4000 km.

The McGill program was directed by Dr. Douglas Cameron, Chief of Medicine at the Montreal General Hospital. Dr. Samuel Adams, Chief of Ophthalmology at the MGH, was responsible for the provision of ophthalmologists. When he became ill a few years later, the direction of northern ophthalmology passed to Dr. Leith. Inuit interpreters were placed at the MGH, and funding for equipment and the transport and accommodation of specialist teams and of patients was provided under the terms of the McGill Baffin Project contract.

In the fall of 1970, the first McGill ophthalmologists went to Baffin Island. Dr. Peter Rosenbaum worked in Frobisher Bay for a week while at the same time Dr. Esmond Gordon went to Pangnirtung. In January 1971 Dr. Arthur Leith and Dr. Nabil Saheb went to Frobisher Bay and conducted a survey of 300 randomly selected members of the population. Similar
surveys were carried out in other centres by the other universities involved in the NWT. The purpose of this survey was to find out if the prevalence of ocular conditions was significantly different from that in the south. The eye team normally consisted of two ophthalmologists and an optician. For the first few years the optician was a volunteer from Montreal. However, the NWT government wanted this work to be done by an Inuk, so they sent a young man to Montreal for some very basic training in frame fitting and he became the team “optician.” After a few years the ophthalmologist in Yellowknife began training excellent ophthalmic technicians, and one of them would go with the optician and visit all of the communities regularly, with the ophthalmologist coming along a few weeks later. The technician would screen all of the patients and did all of the refracting. They were very good, and rarely missed a diagnosis. This greatly reduced the workload for the ophthalmologists as they were now needed only for medical ophthalmology. It was thus no longer necessary to send two ophthalmologists, so from the 1980s onward, visits were made by one ophthalmologist.

Throughout the 1970s a steady supply of volunteer specialists was available, and the system worked quite well. Well enough, in fact, that it attracted the attention of groups in other areas. As a result the McGill bailiwick in the north kept expanding. Responsibility for the nine Cree Indian communities in the James Bay region was assumed in 1979. This was followed by the seven Inuit communities on the eastern shore of Hudson’s Bay in 1988, and finally the nine Inuit communities on the Ungava coast in 1990. At its peak, the McGill northern empire consisted of 38 communities spread over an area measuring 2700 km from north to south and 1400 km from east to west. A few years ago Quebec set up a system which formally obliges Quebec’s four medical faculties to provide tertiary level care to defined areas of Quebec. Under this scheme, McGill looks after all of Nunavik and the James Bay area. The Baffin Region is now taken care of by the University of Ottawa.

During the 1970s transport was often a problem. As mentioned above, by then limited scheduled airline service was available, but flights were infrequent, especially to the smaller communities which were often serviced only once per week. This made it impossible to construct efficient tours of four or five communities. As a result, during the 1970s we were largely dependent on charter aircraft which stayed with us as we went from village to village. This was efficient but quite costly.

Accommodation could also be a problem in the 1970s and 1980s. Only the larger communities such as Resolute or Frobisher Bay had hotels. In theory, the clinic nurse in each community was responsible for our accommodation. In practice, at times the nurse could not find anywhere for us to stay. We were
obliged to bring our sleeping bags, and hope for a sofa on which to sleep. Very often we ended up on the floor, which was not the warmest place to be. In one village we slept in a contractor’s plywood shack, which had no heat. In the 1990s, the smaller communities built hotels to service the ever increasing number of visiting government employees and tourists. At present, every community we visit has a hotel, and many of the clinics have apartments for those who visit to work in the clinic.

Ophthalmologists require a lot of instruments with which to do their work. In the early days, the bulk and weight of our equipment was often a problem and sometimes we were refused boarding a flight because of this. We are therefore constantly searching for ways to reduce the weight of our equipment. In the 1970s, we carried around a full-sized slit-lamp. When the Kowa portable slit-lamp became available we bought one and reduced our cargo by 100 pounds. Another heavy item was the lensometer. In the 1980s Pentax came out with a very compact lensometer which used plastic mouldings instead of metal castings and could be held on the palm of one hand. The weight reduction was from 30 to one and a half pounds.

A question which is often asked is, do the Inuit differ from Canadians in southern Canada as regards their ophthalmic status? Reference was made earlier to the northern ophthalmic survey of the Inuit which was carried out in 1970. There were indeed some interesting differences. There was a fair amount of tuberculosis then so we saw lots of phlyctenular disease. Thirty-seven years later, phlyctenular disease is rare as the prevalence of T.B. has been greatly diminished. Before we started in 1970, we knew that the Inuit had the highest incidence on earth of angle-closure glaucoma, and this was borne out by our subsequent experience. What we did not know was that they had virtually no open-angle glaucoma. No certain case of open angle glaucoma (OAG) was ever identified in Inuit of pure blood. Dr. John Speakman, who worked with the Inuit of Keewatin Territory for over 40 years, also noted that there was no OAG in his communities as well. This might have something to do with another interesting observation, which is that many of the Inuit have remarkably low intraocular pressures, often in the 6-10 mm Hg range.

As might be suspected in a population with so much angle closure glaucoma, there was a high prevalence of hypermetropia. However, when our refraction statistics were studied an interesting discovery was made. In Inuit of about 25 years of age and older, there was indeed a large amount of hypermetropia and almost no myopia. In patients under 20, the opposite was true. Ultrasound and keratometry showed that this myopia was axial. Something had happened to the population in the 1950s which had resulted
in a marked change in refraction. There was in fact a great change in the Inuit way of life at that time, and it seems almost certain that this change was related to the shift in refraction.

Prior to 1950, the Inuit were largely nomadic, living entirely by hunting and fishing, often following migrating herds of caribou. Their diet consisted of fat and protein, as no carbohydrates grow in the Arctic. In the 1950s the federal government was anxious to provide the Inuit with health care and education which was impossible so long as they were nomadic. The Inuit were enticed off the land and into villages by offering free houses with heat and electricity provided. By the end of the 1950s, the great majority of Inuit had moved into the villages. In the villages, there was always a Hudson’s Bay Company store which sold goods and bought furs. For the first time, the Inuit had daily access to refined carbohydrates, for which they developed a great fondness. The quantities of soft drinks and candy which they consume is enormous. It seems possible that this major change in diet may have affected collagen synthesis, with reduction in tensile strength of the sclera. However, a second factor came into play at the same time, when all of the children went to school and learned to read. There is a theory that says that prolonged accommodation can induce myopia. However, although the Inuit men spent all of their days outdoors hunting, the women spent much of their days preparing hides, sewing garments and cooking, and so made considerable use of accommodation. According to the reading theory, the women should have been myopic and the men not. This was not the case.

Among the Cree, the distribution of ocular disease seemed similar to that of Caucasians living in southern Canada, with one exception. Among the Cree above 50 years of age, there was a fair amount of Labrador keratopathy. This condition is induced by prolonged exposure to ultraviolet light. There is probably a genetic factor as well, as in Inuit hunters the prevalence was much less. The prevalence of diabetes among the Cree has increased rapidly over the past fifteen years due to obesity, so there is now a significant amount of diabetic retinopathy.

Many McGill ophthalmologists have supported McGill’s commitment to the north, and found the experience very rewarding. It is to be hoped that future generations will continue to meet the challenge of northern ophthalmology.
PART II:
LATER YEARS
1970-1986
What follows in this section is a description of both the important events in the 1970s and 1980s, as well as several of the individuals who were present at McGill and its hospitals during that period. Unfortunately, space prohibits mentioning everybody and the author apologizes for these omissions.

The early 1970s were a difficult period in Quebec. Two challenges presented themselves - socialized medicine and the political separation of Quebec from Canada. In 1967 the federal Liberal government, led by Lester B. Pearson, passed legislation to establish a national medical insurance coverage (medicare) for all Canadians. Although the Quebec government refused to sign on to the federal medicare plan, it did design and implement its own version of medicare. However, in response to the introduction of universal medical insurance, many doctors left the province in protest. Their main problem with the new insurance scheme was that it removed the doctors’ ability to bill patients directly. Instead, doctors were to bill the government, which would offer fixed rates for specific services. This loss of doctors threatened the province with a potential medical crisis.

In October 1970, soon after the introduction of Quebec medicare, the stability of Quebec society was threatened by a second crisis. The French-Canadian nationalist organization, the Front de Liberation du Québec (FLQ), was demanding Quebec independence and was willing to use violence to achieve it. Although the organization had detonated several bombs in Quebec throughout the mid-late 1960s, targeting English-Canadians and symbols of English-Canadian economic and political power, it was their kidnapping of Quebec cabinet minister Pierre Laporte and the British Trade Commissioner James Cross, as well the eventual murder of the former, in October 1970 which presented a major challenge to Quebec society. In response to the kidnappings, the federal Liberal government of Pierre Trudeau imposed the War Measures Act in an attempt to ensure the safety of both the public and the government. Likewise, the provincial government ordered the doctors, who had left the province in protest to the introduction of medicare, to return to Quebec. The government believed that their presence was necessary should a violent insurrection occur.

With the serious social and political challenges facing Quebec and Canada by late 1970, it was becoming increasingly difficult to attract residents to
train in Quebec or trained doctors to come and work in Quebec. At McGill, Drs. Adams and Murphy worked hard at persuading candidates to apply for the residency program. There was considerable concern that trainees might not want to come to McGill because of the political situation. In addition, several staff members resigned. However, Dr. Carolyn Skov, the first female resident at McGill, started her training in 1972.

However, regardless of the recruitment and staffing difficulties caused by the events of the late 1960s and early 1970s, the 1970s saw great advances in ophthalmology at McGill and its hospitals. Such advances included the use of antibiotics and steroids based on solid scientific knowledge, a great increase in the ophthalmologists’ understanding of glaucoma, and increased
medical control over open angle glaucoma. In addition, the operating microscope came into widespread use and cataract surgery began to change from the intracapsular method to the extracapsular with the introduction of intraocular lens implantation. The importance of basic research was also being recognized more and more as, for example, was shown through increased understanding of the vitreous, whereby retinal surgery cases, previously considered inoperable, could now be helped. Lasers, ultrasound, fluorescein angiography and new equipment were all being developed and coming into general use. In this period of extraordinary ophthalmological advances, including the increasingly widespread use of computers, the department remained focused on its original strengths of the 1870s – clinical excellence, teaching and research.

**Dr. Dario Lorenzetti - 1936-1994**

Following Dr. Adams’ retirement from the MGH and McGill in 1975 because of illness, the hospital appointed Dr. Dario Lorenzetti as the new Ophthalmologist-in-Chief, while McGill promoted him to the position of Associate Professor of Ophthalmology.

Dr. Lorenzetti graduated in medicine from McGill in 1960. He then completed the Ophthalmology residency program at the MGH, followed by a fellowship in external disease with Dr. Herbert Kaufman at the University of Florida, Gainsville. In 1967, Dr. Lorenzetti returned to the MGH, and was appointed a GFT ophthalmologist.

As a researcher, teacher, and physician, Dr. Lorenzetti’s contributions to the MGH and McGill Ophthalmology were important. For example, in the 1960s little ophthalmological research was being conducted, either at McGill or at its teaching hospitals. However, one exception to this situation was the work being pursued by Dr. Lorenzetti. After arriving at the MGH, he continued his studies in external disease, worked with several Fellows, and supervised corneal research. His research work, supported by grants, was important, as it signalled the later advent of clinical scientists and furthered the research projects and initiatives previously begun by Dr. Peter Davis at the RVH.

He was a valued member of the departmental executive committee, and could be counted on to come up with better ways of doing things. In his administrative functions, Dr. Lorenzetti was an excellent and reliable administrator; one could always count on him. If he said he would do it, it was done. Indeed his administrative and organizing skills were reflected in his heavy involvement with the MGH project to secure new facilities
for the hospital’s ophthalmology department and clinic on the 6th floor of Livingston Hall. It was a major totally new design, and a project that involved many people, especially Mr. Arthur Mildon.

Although not an ophthalmologist, but a technician and dispensing optician, Arthur Mildon made a unique contribution to the functioning of the McGill Department of Ophthalmology in the 1950s, 60s and 70s. While on military service in the Second World War he received training in naval optical devices and also came in contact with MGH ophthalmologist Roland Viger. After the war he continued his career as a dispensing optician, but his wartime training had made him much more than a dispensing optician. Using his planning, optical, electrical and cabinet-making skills, he designed, built and

Figure 21: Dr. Dario Lorenzetti
installed the examining room desks at which ophthalmologists sat and with which they controlled the instruments they used. Over a period of three decades he carried out such installations at all four of the McGill teaching hospitals, and in dozens of private offices as well. After installation his skills were required for the complicated repair and maintenance of ophthalmic instruments.

Arthur Mildon's rare combination of technical knowledge and varied capabilities kept the Department's clinical facilities functioning at a high level of efficiency. His uniqueness is borne out by the fact that since his departure it has not been possible to find his equal.

The carefully planned new design included a new clinic, excellent GFT doctors' offices, photographer's office, the Samuel Adams Library and administrative offices. A great celebration for the official inauguration took place on June 14, 1979. Ophthalmologists and guests came from all over the city and province to view the superb new facilities which allowed patients to be examined with their dignity intact. No longer were patients ushered into rooms and alleys where every word of their examination could be overheard.

Beyond his research and teaching duties, as well as his official administrative functions, Dr. Lorenzetti held a number of additional university and non-university positions. In 1980 he was appointed Chief Examiner for the Royal College of Physicians and Surgeons. In addition, an interest in medical education led to his chairing the Canadian Ophthalmological Society's Continuing Medical Education Committee for several years.

Also in the late 1980s, Dr. Lorenzetti was a member of the external disease group, composed of himself and Drs. Bruce Jackson and Joel Rosen. The group was trying to obtain greater subspecialty amalgamation between the hospitals, and met for external disease clinics regularly in the different hospitals, where patients were examined and discussed.

At McGill he was Chairman of the Postgraduate Committee (Resident Committee), and in this capacity, as well as being a member of the Executive Committee, he assisted in increasing cooperation between the four different hospital departments.

The position of Chairman of the Postgraduate Committee involved organizing the residents' rotations and their Thursday morning lectures. The teaching offered in the lectures was of high quality and given roughly in parallel with the American Academy of Ophthalmology schedule of subjects. These sessions were instituted in the early 1970s and attended by all the residents. Their attendance was mandatory and they were excused from all other duties to attend. At the conclusion of a series of lectures on a given
subject area, and after discussion with the teachers involved, a distinguished visiting professor in that field was invited to spend time with the residents and give a lecture to the whole department. Most frequently these speakers came from the United States, Canada, and occasionally other countries. Organizing this far-flung training program in four hospitals was complex. However, Dr. Lorenzetti always had everything in good order and submitted on time.

Besides being a good organizer and administrator of medical matters, Dr. Lorenzetti was also renowned for organizing and participating in festive occasions - especially senior resident dinners and more informal events. Dr. Toby Sutcliffe, a former MGH resident, describes his fondest memories of Dr. Lorenzetti as being those of the year end party at Vito’s Restaurant where things started with red wine late in the afternoon, after a long day of work. Everyone, including Dr. Lorenzetti would begin on an empty stomach, leading to a moderate state of inebriation. This was always followed by a great dinner. Finally, the resident roast and caricatures of the geographic full time staff were enjoyed by all, including the victims.

Dr. Lorenzetti was friendly, well liked and his warm hearted support of residents and staff was noticed and appreciated by all. He looked after his staff’s interests admirably, often seeking improved funding and always supporting them. He presented his points of view to others with clarity and conviction. Always logical, and a skilled debater, he fought hard for what he believed. Understandably, both the hospital and university community were greatly saddened by his premature death in 1994 as were his friends and numerous patients. In his honour, the Canadian Ophthalmological Society launched the annual Dario Lorenzetti Lecture. Similarly, the McGill Department of Ophthalmology also established an annual lecture in memory of Dr. Lorenzetti.

Dr. Bruce Ramsey – 1924-2000

Bruce Ramsey was the son of Dr. Stuart Ramsey, a former Ophthalmologist-in-Chief of the MGH. He was a colleague of Dr. Lorenzetti at the MGH and the main reason Dr. Sutcliffe, a resident at McGill, decided to pursue a career in oculoplastic surgery. Dr. Sutcliffe remembers him with his glasses off his nose and hanging from one ear with his eyes closed pontificating on some erudite and obscure oculoplastic factoid. He will also never forget Dr. Ramsey’s handling of the word “tissue” which he has aptly pointed out does not have an “h” in it.
Dr. Ramsey’s teachers were the eminent oculoplastic authorities Drs. Byron Smith and Alston Callahan, who trained him well.

Dr. Ramsey was meticulous in his plastic surgery and devoted much time to each patient and to solving problems. Even with the pressures of medicine, limiting the time he could spend with each patient, he remained dedicated to offering his patients as much of his time as he could. He was McGill’s first ophthalmic plastic surgeon and is remembered for his surgical skills and excellent teaching, as well as for his contributions to plastic surgery.

Dr. Ramsey enjoyed the out of doors, especially skiing. He would invite the residents to his house from time to time and enjoyed entertaining them.
Following Dr. Ramsey, McGill saw the arrival of two excellent ophthalmic plastic surgeons – Drs. François Codere in 1982 and Bryan Arthurs in 1986.

**Dr. François Codere – 1952-**

Dr. Codere’s career illustrates the trend towards specialization in the 1970s and 1980s. He has pursued his goal of being a full-time ophthalmic plastic surgeon with energy and determination from residency to international recognition.

Dr. Codere, a 1976 graduate in medicine at Université de Sherbrooke, also went on to a three-year residency in ophthalmology at Sherbrooke. During 1979-1980 he was a Fellow in ophthalmic pathology with Dr. Seymour Brownstein at McGill University.

His next appointment was crucial in laying a strong foundation for his career. Dr. Richard Anderson, an eminent oculoplastic authority at the University of Iowa, accepted him as a Fellow in 1981. It was a most successful year, and Dr. Codere has remained in touch with Dr. Anderson ever since.

Dr. Codere was one of the first to leave general ophthalmology and specialize. The McGill department of ophthalmology encouraged him and arranged funding to help with the fellowship with Dr. Anderson.

Back in Montreal, Dr. Codere obtained space in the RVH with a cross appointment at Hôpital Maisonneuve-Rosemont. In 1982 he began receiving consultations at Hôpital Sainte-Justine, and then worked in their clinic, which is now one of the busiest oculoplastic centres in Canada.

In 1982 Dr. Codere obtained his own office at the RVH and received secretarial support. His practice was restricted to patients with oculoplastic problems. Most of his time was spent in the operating room. Despite not having GFT support he found time and energy to be president of the Association des médecins ophtalmologistes du Québec for two years. More recently he has taken a two year term as president of the Canadian Ophthalmological Society.

Dr. Codere worked hard, published often and achieved international recognition. He is one of the first French-Canadians to follow this path. Starting in 1984 he began training oculoplastic fellows for one year, and to date he has taught 22 from all over the world. A remarkable career.

**Dr. Bryan Arthurs – 1952 -**

Dr. Arthurs was born in Hamilton, Ontario and graduated in medicine from the University of Western Ontario in 1979. He then moved to Montreal
where he spent one year in internal medicine, followed by a sabbatical year in South East Asia, entering the McGill University ophthalmic training program in 1982.

Residents at this time rotated through two of the three adult hospitals as well as the Montreat Children’s Hospital. The residency program at that time was quite gruelling, with 12-hour days being the norm and first call every third night, as well as second call every other night for the senior resident. However, the collegial atmosphere between the staff and the residents made for a very stimulating and satisfying experience.

After graduating in 1985 Dr. Arthurs decided to pursue subspecialty training in Ophthalmic Plastic and Reconstructive Surgery in New York. He
trained at Manhattan Eye, Ear and Throat Hospital under the legendary Dr. Byron Smith as well as Dr. Richard Lisman and Dr. Murray Meltzer. He also spent a great deal of valuable time with Drs. Robert Della Rocca and John Simonton at the New York Eye and Ear Infirmary.

In 1987 Dr. Arthurs took up a GFT position at the MGH in the Department of Ophthalmology. Although his main focus was at the MGH, he also devoted one full day of service to the Jewish General Hospital. In addition, he made sorties to the Northern Inuit communities with Dr. Lindley.

Besides his regular duties, Dr. Arthurs took on a role with the McGill Ophthalmology Scientific Research Day Committee, which he chaired for nine years (1993-2000). He later became the residency program director for another seven years.

**Dr. Arthur Leith – 1931-**

Dr. Leith graduated in medicine from McGill in 1955 and was accepted as a resident in ophthalmology at the MGH by Dr. Alexander, the Ophthalmologist-in-Chief, in 1956. His residency training included completion of the Harvard Basic Science Course and a research project at Tufts University looking at the induction of cataract by microwave in rabbits. His broad training reflects the fact that, at this time, the McGill residents were trained to do everything in ophthalmology.

Following completion of the residency program in 1959, Dr. Leith spent two years at the renowned Institute of Ophthalmology in London, where he became familiar with research procedures, including the setting up of protocols. While in London, he also had the good fortune to be associated with two great leaders in British ophthalmology, Sir Stewart Duke Elder and Norman Ashton.

In 1961 Dr. Leith returned to Montreal and was appointed a Teaching Fellow at the MGH, supported by a Dominion Provincial grant to the Glaucoma Clinic. He brought to both the MGH and its Glaucoma Clinic his knowledge of applanation tonometry which he gained in London.

The Glaucoma Clinic was founded by Dr. Roland Viger in 1954 and was the first glaucoma clinic supported by the Government of Canada. Dr. Viger, an American, had attended McGill Medical School in the 1930s. During the Second World War he joined the Canadian Navy as a doctor and eventually became an ophthalmology resident at the Massachusetts Eye and Ear Infirmary. Following residency training, Dr. Viger returned to McGill
and supervised the Glaucoma Clinic until 1970 when he left for the United States. He is remembered as a fine surgeon and teacher.

Dr. Leith’s career at the Glaucoma Clinic lasted from 1961 until 1996. His next appointment was as a Teaching Fellow at the MCH. At this time, Dr. S.T. Adams was in charge of ophthalmology at the MCH, and among the staff was Dr. Wyatt Laws, who performed corneal transplants. Next, Dr. Leith joined Doctors Stuart Ramsey and Bruce Ramsey in their downtown office until 1964 when he went into full time practice and became a staff member at the MGH. There he joined other progressive ophthalmologists, such as Dr. Robert Pearman who, in the late 1950s, performed a number of Ridley intraocular lens implants - probably the first examples of the procedure in Canada. His results were similar to Dr. Ridley’s - multiple complications.

Other staff members who Dr. Leith joined at the MGH were several general ophthalmologists - Doctors Ellen Terry, Panos Capombassis,
Esmond Gordon, and Alan Bourne. The last of these, Dr. Bourne, worked with Dr. Adams in the Glaucoma Clinic up until the mid sixties. He was a superb surgeon and had good results with corneal transplants and retinal surgery. In addition, Dr. Bourne was also an excellent clinician and teacher who is remembered as always kind and caring. All his colleagues were greatly saddened at his premature death in 1970.

The McGill department was aware of the importance of general ophthalmologists such as Dr. Bourne, and efforts were made to ensure they were always represented on the staff of both the RVH and the MGH. Their teaching in the clinics and operating rooms was a valuable contribution, as was their referral of patients to the hospitals. Since they received no remuneration, they were less affected by budget cuts than the GFT ophthalmologists who relied upon university and hospital funding.

At the same time that Dr. Leith joined the staff at the MGH, Dr. Adams, the hospital’s newly appointed Ophthalmologist-in-Chief, was recruiting a number of GFT staff. These new recruits included Doctors John Little, Dario Lorenzetti, Howard Tannenbaum, Sekong Luke, as well as Ray Leblanc. Dr. Leblanc came to the MGH from the University of Sherbrooke in 1972. He worked in the Glaucoma Clinic with Drs. Arthur Leith and Nabil Saheb. He commented on the strength of the glaucoma group and the high quality of the teaching program, as well as the fellowship throughout the department. From 1979-2003 he was Department Head at Dalhousie University, where he became well known for his important contributions to glaucoma research.

During the first years of Dr. Leith’s work at the MGH, in the mid-late 1960s, when Dr. Adams was Chief and Dr. Locke was McGill Chairman and Chief at the RVH, relations between the two hospitals’ ophthalmology departments were often complicated by particular tensions. Fortunately, however, this situation slowly improved so that, by the early 1970s, interhospital relations were becoming noticeably more cordial.

A superb surgeon and excellent teacher, Dr. Leith saw the MGH department grow and develop from 1956 until his retirement in 1996. He played a significant role in the teaching and practice of ophthalmology during his tenure at both the MGH Department and McGill. For example, in 1979 he was the first surgeon at the MGH to implant intraocular lenses. Earlier, he spent a week in Holland with Dr. Binkhorst, one of the pioneers in the field, and thereafter began using iris mounted lenses. At about the same time, at the RVH, Doctors Peter Davis and Peter Dawson also began implanting intraocular lenses. Today, in retirement, Dr. Leith still projects a sense of energy. He is optimistic and gifted with a quick special sense of
humour. In his presence, you need to be fully alert. In addition, Dr. Adams asked Dr. Leith to organize McGill’s ophthalmology program in the Arctic. As the leader, Dr. Leith established an excellent program whereby many staff members from different hospitals took turns looking after patients in the north. His account of this program is described in more detail in Chapter 7.

Dr. Nabil Elias Saheb – 1939-

A further MGH co-worker of Dr. Leith’s during the 1960s, 70s, and 80s was Dr. Nabil Saheb. An important member of the MGH and McGill Departments of Ophthalmology, Dr. Saheb was born in Egypt, where he graduated from the University of Cairo in 1964. Upon arriving in Canada, he completed a one year internship at the Hôpital Maisonneuve Rosemont which was followed by a year in general pathology.

After completing these first two years of training, Dr. Adams accepted Dr. Saheb for a three year residency position at the MGH in 1966. In the 1960s a noticeably strong bond was often formed between the residents, one which was not limited to the hospital but extended to their social lives. Among his fellow residents Dr. Saheb, along with Doctors Robert Kelly and Rand Simpson, were known as “the three musketeers.” The kinship the three residents formed were indeed long lasting, with all three of them now distinguished doctors, and maintaining their friendship to this day. Other residents at the time included Ab Tweedie, a fine resident and teacher who was very supportive of Dr. Saheb; Desmond Braithwaite, who was renowned for being constantly besieged by student nurses; Dick Aberga; Bill Baker and Gordon Kuder. In addition, in 1969 Dr. Howard Tanenbaum joined the MGH staff for two to three years. He then moved to the Jewish General Hospital (JGH) where he was appointed Ophthalmologist-in-Chief. Dr. Tanenbaum was a well trained retinal surgeon to whom many difficult cases were referred; cases frequently requiring long hours in the operating room.

In the 1960s a cataract patient was often in hospital for up to a week. 8-0 silk sutures had come into use, and two to three days bed rest was average. At the MGH, Miss Crandall was Head Nurse of the Out Patient Department, ran it well, but was also a dictator. She carried a huge bunch of keys and no one could open anything without her - much frustration.

After his residency Dr. Saheb remained at the MGH acting as a clinical fellow for a year and a half. Then, in 1971-1972, he obtained a Glaucoma Fellowship with Dr. Stephen Drance in Vancouver. In the Montreal hospitals, at the time, a mechanistic view of glaucoma prevailed, a position which stressed things like aqueous outflow, water drinking tests and
pressure. However, in Vancouver, Dr. Saheb and Dr. Drance developed a new outlook and understanding of glaucoma, as well the means to do a visual field for a specific disease. In their approach, obtaining a proper assessment of the optic nerve was important.

Dr. Saheb’s work with Dr. Drance broadened his approach to treating glaucoma, knowledge which he brought back with him to Montreal after his fellowship. Doctors Drance, Armaly and Anderson, all of whom were recognized for their experience in glaucoma, changed understanding of glaucoma treatment from one which focused upon pressure to one which posed the question: ‘Why is it happening?’ Likewise, another McGill resident, Dr. Gordon Balazi, similarly benefited greatly from a Glaucoma Fellowship with Dr. Drance in Vancouver.
Back in Montreal, Dr. Saheb introduced trabeculectomy, laser glaucoma surgery, automated perimetry and stereo disc photos to McGill ophthalmology, while also combining McGill glaucoma rounds between the hospitals.

When Dr. Murphy was appointed Chairman of the McGill Department of Ophthalmology in 1975, it was clear that subspecialization was the future for university ophthalmology. There was an urgent need to recruit and find promising candidates for GFT positions if the department was to move ahead. Since McGill lacked sufficient total resources to fund both Dr. Nabil Saheb and Dr. Bruce Jackson as geographic full time ophthalmologists, funds were raised for half their salaries in the private sector and McGill was persuaded to match these amounts. Sometime later, McGill and the hospitals provided funds for their full salaries.

In 1972, Dr. Saheb received appointments to McGill, MGH and MCH. Over the years, he devoted most of his energies to the study of glaucoma, becoming expert in the field. In recognition of his ability and important contributions to both McGill and its hospitals, Dr. Saheb obtained tenure in 1981. Also, in addition to an active clinical life, he represented all Quebec ophthalmologists with distinction as President of the Quebec Association of Ophthalmologists from 1984-1986.

A true gentleman, Dr. Saheb was respected, always considerate and a vital member of the faculty. The residents and staff doctors enjoyed having a glass of Remi Martin with him at Christmas. He is remembered for being able to join the residents for a glass, and show little pain by the end.

Such social events were indicative of the strong “esprit du corps” and camaraderie which prevailed at the MGH in Dr. Saheb’s days, a situation which was essentially due to the influence of Dr. D. Lorenzetti. Many of the social events were well attended by staff and residents, and these events helped promote a sense of loyalty to the department. Three yearly social events were particularly looked forward to: the Christmas party, the Chez Vito’s party, and the residents’ farewell party.

Dr. Saheb’s opinion was valued and sought by both staff and residents alike. Many colleagues would send him patients in consultation, appreciating his judgment as always being sound and carefully considered, particularly when dealing with difficult glaucoma problems. Meticulous in his attention to detail, he was also outstanding as a teacher. His talent for teaching was recognized by the residents who voted him the first Buller teaching award in 1990-1991, an award given by the residents for excellence in teaching.
Dr. Danny Kaufman

In an interview with the author, Dr. Danny Kaufman recalled that, as a resident at the RVH from 1969 to 1972, it was assumed that an academic approach with high standards, together with a practical approach, was the path he was expected to follow. He spent six months at the MGH during his residency and enjoyed the teaching of many ophthalmologists, all with different backgrounds and interests.

He also recalls that it was a time of change in ophthalmology at McGill and its hospitals, with the introduction of Medicare and the departure of several ophthalmologists. In addition, technology was also changing. During Dr. Kaufman’s residency, use of the microscope in the operating room had not yet become common, although it was being touted as a valuable tool in the United States. In contrast, loupes and local anesthesia had become standard for cataract surgery. Retinal detachments and extra-ocular muscle surgery were performed under general anesthesia.

As a resident at a Quebec hospital, Dr. Kaufman believed strongly that both his career and his ability to aid the public would be enhanced if he could speak French. Thus, he took language lessons and passed the French-language proficiency examination. This allowed him to practice, if he wished, in Quebec as a “French-speaking physician.”

An active resident, Dr. Kaufman not only participated in organizing lectures for ophthalmology nurses, but in 1970 also teamed up with Dr. Ann MacAulay, a McGill internist, and three or four medical students to offer medical services to natives on the Caughnawaga reserve. Dr. MacAulay had already been working at Caughnawaga as a physician on the Indian Service as part of a federal project. Along with Dr. Kaufman and the medical students, she applied for a federal grant to expand the health services available. This was successful, and as a result, Dr. Kaufman had the task of equipping an eye clinic - all on a voluntary basis. At the Caughnawaga clinic he saw patients, some of whom he would refer to the McGill hospitals for further treatment. His leadership role at the reserve was remarkable for a resident, and when he left the reserve clinic in 1972, the tribe leaders showed their appreciation of his efforts by presenting him with a wampun belt and moccasins. Dr. Kaufman went on to become a retinal surgeon and developed a keen interest in the history of ophthalmology. He continues to attend the annual Cogan History of Ophthalmology Society meetings.
Dr. Esmond Gordon – 1928-2008

Dr. Gordon graduated from the University of Geneva Medical School in 1955. He went on to a year of pathology at the Connecticut Meriden Hospital, after which he did his residency at the MGH between 1958 and 1961. In 1961 and 1962 he spent a year in ophthalmic pathology at the Armed Forces Institute of Pathology under Dr. Lorenz Zimmerman, a great friend of McGill ophthalmology, who trained several McGill residents. Following his time with Dr. Zimmerman, Dr. Gordon received appointments at both McGill and the MGH in 1963.

At McGill Dr. Gordon made important contributions to pathology, organizing the first meeting of the Eastern Ophthalmology Pathology Society at McGill in 1968. This meeting was held in the McIntyre Medical Building and the following year in the Bonaventure Hotel. In addition, Dr. Gordon contributed significantly to the teaching of pathology at the university. His teaching method was to project pathological slides and ask the residents to speak. In the late 1960s he was joined at the MGH by another pathology teacher, Dr. Mourad Khalil. Dr. Khalil had joined the MGH Department of Ophthalmology after having gained extensive clinical experience in Egypt. At the MGH and McGill he published several articles on pathology, was well liked and organized the last meeting of the Eastern Ophthalmological Pathology Society in Montreal.

Dr. Gordon remained active in teaching pathology for some ten years, eventually, gradually reducing his teaching load. He was always a caring physician.

Dr. Brian O’Brien

Beginning his residency at the RVH in 1961, about the same time Dr. Gordon completed his at the MGH, Dr. O’Brien next finished a retina year with Dr. Michael Shea in Toronto in 1964. He recalls his three years of residency at the RVH as having been happy ones, working as a close team with his fellow residents Doctors Peter Davis, Paul McCartney and Charlie McMillan. He especially remembers that, when he was a senior resident, this group of young doctors used to see every patient daily and, afterwards, hold a short academic meeting in an effort to teach each other. In addition, Dr. O’Brien has fond memories of the fatherly advice and kindness of Doctors Nicholls and Locke. Dr. Murphy related his experiences in ophthalmology and invited Dr. O’Brien to work in his office. Dr. O’Brien found this experience valuable in comparing the private office with working in the clinic. He found that the surgical skills imparted by Doctors Murphy, Locke and Turnbull
have stood him in good stead over the years. He enjoyed the comradeship of two younger members of the department - Doctors Peter Rosenbaum and John Foreman.

In discussing his three years of residency at the RVH, Dr. O’Brien sums up his experience there as having prepared him well for a life of working with the public. He recalls that: “I think we were a happier group, living and working together in better times.” In contrast, he feels residents are more stressed today. He believes that a lack of funding, government pressures and the need to be more productive are all responsible for this situation. Dr. O’Brien went on to a successful career as a retinal surgeon in Halifax.

Dr. Mervyn Kirker

Dr. Kirker was a McGill resident at the RVH during 1967-1968. To this day he remembers enjoying his time at the hospital and was impressed with the clinical ability of the staff. Following his time at McGill, he completed two additional years of training in Toronto.

In what follows, the author is quoting from a letter by Dr. Kirker in which he gives his impressions of McGill and the RVH.

In particular, Dr. Kirker was impressed with the senior ophthalmologists at both institutions. His recollections of Dr. Turnbull were of a consumate surgeon who provided him with many small details which have proved to be valuable knowledge in surgical situations. In the case of Dr. John Nicholls, Dr. Kirker found him to be a unique individual with a tremendous scope of knowledge and a gentlemanly air - something now lost. One might wonder what he would think of the current advertisements for refractive surgery.

In addition, Dr. Kirker writes that he remembers Dr. John Locke teaching the basics of ophthalmology to the residents - his kindness and courtly manner were much appreciated despite a high level of anxiety. Dr. Murphy, very interested in Neuro-ophthalmology, gave the residents, including Dr. Kirker, the opportunity of presenting cases from the Montreal Neurological Institute. Also, along with Doctors Bruce Jackson and George Sapp, Dr. Kirker provided excellent neuro-ophthalmology rounds. They all believed that it was a first rate teaching experience and provided the basis of all further neuro-ophthalmology that they learned.

All in all, Dr. Kirker remembers the overall tenor of the RVH Department to have been one of a small, warm family, and describes the clinical ophthalmological unit as having been excellent, with a very personal attitude toward resident teaching.
Dr. Sean Murphy – 1924-

A 1943 graduate of Harvard, Dr. Murphy received his medical degree from McGill in 1947. From 1952 to 1955 he served in the Royal Canadian Air Force, where he was in charge of ophthalmological services. Then in 1955 he joined the McGill Department of Ophthalmology and the staff of the RVH. For eighteen years thereafter he saw consultations from the MNI and taught neuro-ophthalmology, at the same time gradually furthering his practice of retinal surgery.

In 1970 Dr. Murphy was appointed Ophthalmologist-in-Chief at the RVH, and Professor and Chairman of the McGill Department of Ophthalmology in 1975. The Dean, Dr. Samuel O. Friedman, gave him
a mandate to unify the department and create a harmonious relationship between the four hospital departments. This was no easy matter as the Chairman had virtually no authority over the hospital departments.

His first initiative was to form a McGill departmental Executive Committee. The four hospital chiefs were invited to be members. They were Dr. Dario Lorenzetti (MGH), Dr. John Little (MCH), Dr. Joel Rosen (JGH), and Dr. Murphy (RVH). The Executive Committee met regularly, once a month, and among the many subjects discussed were: residents, medical students, teaching, staff GFTs, recruitment, subspecialization, research, fund raising, space, amalgamation, and the development of centers of excellence.

The Executive Committee proved to be successful in cementing better interhospital relations. Its creation was an important step in assuring the future development of the department. As a result of its meetings, communication between the hospitals became easier and we all got to know and understand each other better.

Dr. Murphy promoted the training and recruitment of subspecialists and geographic full-time staff. He felt it was a priority to send graduating residents away for further specialized training and, wherever possible, to offer them GFT positions on their return. Supporting departmental research, he emphasized the importance of having basic scientists in the department. He also helped develop a strong McGill Ocular Pathology unit with Drs. Mourad Khalil, Esmond Gordon and Seymour Brownstein, and encouraged the development of the Low Vision Clinic. He participated in the meetings of the Cogan Ophthalmic History Society and the American Osler Society.

Realizing that ophthalmology was under-valued in hospitals and universities across Canada, Dr. Murphy accepted several administrative positions outside of McGill and its teaching hospitals. He became President of the Canadian Ophthalmological Society, President of the Association des médecins ophtalmologistes du Québec, and for two years was Chief Examiner of the Royal College. He was awarded the Order of Canada in 1976, the medal of the Canadian Ophthalmological Society in 1987, and in 2007 received the society’s Lifetime Achievement Award. In 1989 the Department of Ophthalmology established an annual lecture in his honour.

He established the annual Clinical and Scientific Day in 1978 with the help of Dr. Bruce Jackson. It continues to the present day, and provides a forum for the residents to present the results of their research – the research being done with supervision of a member of the staff.

Dr. Murphy believed strongly in community activities and for ten years was President of the Montreal Museum of Fine Arts, which involved
being an active fundraiser for the museum, a position which frequently helped in the search for funds for academic ophthalmology. McGill and the hospitals did not provide sufficient funds for research as well as the resident program with the result that funding became a priority. Dr. Murphy retired as Ophthalmologist-in-Chief at the RVH and Chairman of the McGill Department of Ophthalmology in 1986. In 1991 Dr. Murphy was appointed Interim Chairman of the McGill Department until 1993 when Dr. Miguel Burnier took over the position.

Dr. Mourad Khalil – 1929-2002

Dr. Mourad Khalil was born in Port Said, Egypt in 1929 and graduated from Cairo University Medical School, later obtaining a diploma in ophthalmology. Despite limited resources, he first practiced ophthalmology in small and remote Egyptian villages. These early years of practicing under difficult conditions gave him experiences and surgical skills that were unique.

Dr. Khalil came to Canada in 1967 and was accepted for a three-year residency in ophthalmology by Dr. S.T. Adams at the MGH. During his time at the hospital, he developed a friendship with, as well as lasting gratitude and respect for, Dr. Adams.

Despite his extensive experience and knowledge, Dr. Khalil never showed any feelings of impatience or superiority towards his fellow residents. Rather, he went about his work with modesty, dedication and always wearing a smile. His stories about the volume of surgery, especially cataract surgery, performed in the villages of Egypt were fascinating and entertaining.

While a resident Dr. Khalil became interested in ocular pathology, and after graduation decided to become an expert in the field. He accomplished this the hard way, with almost no financial support and through self-teaching, all the while conducting a very busy ophthalmic practice. He also started publishing scientific papers and became a member of several ocular pathology societies. At the meetings of these societies he would give excellent presentations and eventually became well known to leaders in the field. At the same time he developed long lasting friendships with many of his ocular pathology colleagues.

Over the years Dr. Khalil built up an extensive collection of ocular pathology slides which McGill residents were privileged to see and learn from when attending his popular ocular pathology lectures.

Dr. Khalil liked to participate in, and initiate, various social events – something of a bon vivant with a sense of humour. His warm, caring,
considerate personality brought a special feeling when you were with him. He stood out as a much admired person.

**Dr. Seymour Brownstein – 1940-**

In 1972 Dr. Seymour Brownstein joined the McGill Department of Ophthalmology and was given a university GFT appointment with his office in the RVH. A 1965 graduate of the Faculty of Medicine at McGill and a resident at the New York Eye and Ear Infirmary (1967-1970), he rose to become a McGill Professor of Ophthalmology and Pathology, receiving tenure in 1986.
Dr. Brownstein had arrived at McGill in 1972 after finishing a three-month teaching fellowship at the University of Indonesia in Jakarta. He soon made a positive impression on both his colleagues and students, at his first McGill lecture, by showing a number of rare pathological and clinical specimens he had collected in Indonesia. In addition, Dr. Brownstein remembers “the tremendous support he received from the Department throughout his tenure at McGill.” He states that this support was displayed from the first day after his arrival, when the department had completely filled his appointment book with patients from 8am to 5pm.

By the time Dr. Brownstein joined the McGill ophthalmology department, ophthalmic pathology had begun to develop into a major field at both the university and its hospitals. Indeed, Dr. Brownstein further contributed greatly to the development of this field which had been steadily singled out as

Figure 28: Dr. Seymour Brownstein
important for the department under the leadership of Doctors Buller, Byers and MacMillan. Additional strong academic support from Doctors Locke, Adams and Murphy helped it to flourish. Fellowship training in ocular pathology was offered to students through the Armed Forces Institute of Pathology, which was under the direction of Dr. Lorenz Zimmerman. Doctors who benefited from this training included John Foreman (1958-1959), Esmond Gordon (1961-1962), Seymour Brownstein (1971-1972), and Barry Kattleman (1986). This training of multiple McGill ophthalmologists under Dr. Zimmerman led to his establishing a warm relationship with the university.

The focus placed upon ocular pathology by the university, and the specialized training received by many of its ophthalmologists, has resulted in McGill ophthalmologists contributing significantly to the ophthalmic literature in pathology, as well as their having become members of major pathology societies. In addition, over the years, their expertise in the field has led to the university receiving research grants for work in ocular pathology from the Medical Research Council of Canada, the Baker Foundation and the Oculus Foundation. Moreover, these ophthalmologists have been active in the departmental teaching and in making scientific presentations at other centers, including being invited as visiting professors nationally and internationally.

However, it should also be noted that much of the work of ocular pathology specialists, like Dr. Brownstein, was greatly assisted by the support of the McGill Chairman and the chiefs of the Department of Pathology - Doctors Robert Moore, Bill Duguid, John Richardson and Sean Moore. The Department of Pathology provided the Ophthalmology pathologists with, among other things, equipped laboratories, as well as technical and material assistance.

With the Department of Ophthalmology having focused a great deal of attention upon developing ocular pathology as a field of concentration within the department, a two day symposium was held at the Far Hills Inn in the Laurentian mountains in 1974. Arranged by Dr. Robert Moore of the Department of Pathology, the theme of the symposium was “the role of specialization in an academic department of pathology.” This meeting was important because it led to the establishment of a centralized and universally accepted McGill registry of ophthalmic pathology, housed in the Pathology Institute. There, ocular tissues are processed and consultations are conducted, as are reviews from all the McGill associated teaching hospitals. Additionally, many other centers across Canada submit ocular specimens to the registry.
In addition to the Far Hills Inn symposium, 1974 saw the creation of a one year fellowship program in ocular pathology, established jointly by Drs. Robert Moore and Murphy. Between 1974 and 1996, fifteen one year fellows were trained. At first, this program was funded by the residency program of the Department of Pathology. However, following government cutbacks in the early 1980s, support from the RVH Research Institute and hospital, together with departmental funds, kept the unit going. The plan was for a more stable budgetary situation to be established for the laboratory service, fellowship program and academic unit. Such funding was obtained, and has made it possible to better finance laboratory services for ophthalmologists and other hospitals. These funds also provide better support for the training of fellows and research.

Dr. Brownstein was very hardworking, always having some ten to twelve research projects in progress at one time. He was a prolific researcher and published extensively in the literature, often representing McGill at major pathology meetings, and frequently as an invited guest lecturer. It was not unusual for him to work late in the evening, a fact that was not always easy for his family.

Dr. Brownstein’s scholarly activities were recognized nationally and internationally. While at McGill, he was always active as a teacher, resident education being a priority for him. For example, between 1978 and 1987 he was Chairman of the McGill Annual Clinical and Scientific Day. As Chairman, with his infectious, energetic enthusiasm, this event improved in quality and was established as an important and vital activity of the Department.

In 1992, after twenty years at McGill, Dr. Brownstein left to become Professor of Ophthalmology and Pathology at the University of Ottawa. While at McGill, his contributions were significant. He saw the vital importance of pathology for the Department and carried on in the tradition initiated by Dr. Frank Buller over a hundred years ago. The University is proud of what he accomplished while in Montreal.

Dr. Bruce Jackson

Dr. Bruce Jackson was a graduate in medicine from the University of Western Ontario in the late 1960s. His career at McGill began in 1967 when he was an intern. This was followed by a year of internal medicine at the RVH, as well as three years of ophthalmology residency (1969-1972) at the same hospital. In 1971 he and Dr. Mark Abelson (RVH) took a new basic science course at Stanford University.
At the time, residents from the MGH had attended a basic science course in Maine (the Lancaster course at Bowdoin University) for many years. This course supplemented the McGill program. Yet, there were no further openings in the Maine course and hence Drs. Abelson and Jackson attended the new course at Stanford University. In addition, during his residency Dr. Jackson also worked in haematology and low vision (the latter, with Dr. Nicholls), as well as helping to organize multidisciplinary neuro-ophthalmology rounds (1971-1972) with Dr. Murphy. The neuro-ophthalmology rounds were very popular and were considered a highlight of the program, attracting staff in neurology, neurosurgery and neuroradiology from the MNI. When Dr. Brian
Younge came back to the MNI, he took over the rounds and the neurological consultations from Dr. Murphy.

In 1972, while still an RVH resident, Dr. Jackson helped organize an afternoon meeting at the hospital where both residents and staff presented papers dealing with projects they had been working on during the year. This was most successful and led to the creation of the Annual McGill Clinical and Scientific Day, generally known as “McGill Day”. It became mandatory for every resident to report on a research project he or she had been involved in, where each resident worked with a staff doctor on such a project. In addition, papers were presented by basic scientists and the staff. Over the years, attendance at these McGill Days increased and an outside speaker was invited. In 1988 the Department established the Sean B. Murphy Lecture, which was to be given annually on McGill Day. On alternate years, the lecture would either be given by a distinguished speaker from outside McGill, and on every other year by a member of the staff or a former resident.

Over the years, McGill Day came to be recognized as a valuable major event. In particular, the day is valuable in that it provides an opportunity for the residents to be involved in research projects under supervision. As previously mentioned, Dr. Seymour Brownstein was the first McGill Day Chairman between 1978 and 1987. He was followed by Dr. Bryan Arthurs, and later by others. As Chairman, Dr. Brownstein was the guardian of the time clock. Whenever a speaker went beyond his time, he would let them know by ringing a loud bell and threatening to pull them off the podium with his umbrella.

In addition to helping organize the first McGill Day, 1972 was the year when Dr. Jackson began to cultivate his interest in low vision. As mentioned earlier, Dr. John Nicholls conducted a weekly low vision clinic at the RVH. Successful, this clinic even obtained specialized equipment, for which additional funding was found by the department. Interest among the residents in low vision was created by low vision lectures for them. These specialized lectures were rather unique, placing McGill some twenty years ahead of other Canadian ophthalmology departments.

Dr. Nicholls’ low vision clinic continued until he left in 1970. However, shortly before his departure, Dr. Jackson, who was only starting to develop an interest in the area, attended some of the clinics. Two years later, in 1972, Dr. Jackson left to study low vision with Dr. Eleanor Faye, an expert in the field, at the New York Lighthouse – a centre for low vision activities. Upon his return, Dr. Jackson made use of his new knowledge by providing low vision care to patients at the RVH. Then in 1979, Dr. Olga Overbury, from Concordia University, arrived in the ophthalmology department.
for a doctoral internship supervised by Dr. Jackson. She was trained in experimental psychology, specializing in visual impairment. Her interests in low vision and Dr. Jackson’s meshed and together they created the McGill Low Vision Centre.

Still in operation, the McGill Low Vision Centre, which moved from the RVH to the JGH in the 1980s, sees visually impaired patients and also acts as a research and teaching facility for ophthalmology residents and Concordia psychology students. There the residents obtain practical experience in examining and managing low vision patients. As a department, McGill Ophthalmology became a leader in the field of Low Vision. Dr. Overbury’s careful, excellent studies have been a major factor in bringing this about.

In 1973, after returning from his low vision studies in New York, Dr. Jackson again left the RVH to take up a fellowship in external eye disease at the Francis I. Proctor Foundation in San Francisco. Upon his return to Montreal, he started practice and joined the McGill Department of Ophthalmology with a GFT appointment and an office in the RVH.

Over the next several years Dr. Jackson built up and maintained a large consulting practice in external disease. In addition, he was active in medical ophthalmology and fluorescein angiography. At first, he wondered if there would be sufficient demand for establishing an external disease practice. However, because of his expertise, this concern was unnecessary and patients were referred to him from all over. His timing was excellent as subspecialization was becoming well established.

With his success in the subspecialty of external disease, Dr. Jackson initiated a fellowship program in external disease in 1981. Altogether, eleven fellows were trained. With Doctors Lorenzetti (MGH) and Joel Rosen (JGH), an interhospital external disease group was established and alternated meeting in one of the hospitals.

In Dr. Jackson’s time, the MGH and RVH residents rotated to the MCH. Before, the RVH residents did not go to the MCH as the RVH had a paediatric ward in the medical wing. The MGH staff tended to look upon the MCH as primarily a part of their program. However, in 1973, when the RVH closed its paediatric ward, the RVH residents began rotating to the MCH.

As a teacher, Dr. Jackson was renowned for his detailed knowledge of ophthalmology. He read a great deal and acquired an encyclopaedic knowledge of the ophthalmic literature. Also, as an active clinical researcher, he published regularly. Among both his students and colleagues, he became famous in the late 1970s and early 1980s for his 8-9am external disease
“grilling sessions”. These teaching sessions occurred weekly and involved reviewing external disease slides of cases he had seen in the previous two weeks. The ophthalmic photographer would be present and during the course of the session the quality of the photographs could be assessed. If his work was criticized, a noticeable improvement would be noted over the following months.

While using his grilling sessions as an opportunity to test the residents’ knowledge, Dr. Jackson focused these teaching sessions upon reviewing all aspects of external disease and uveitis. In addition to the external disease sessions, Dr. Jackson conducted fluorescein rounds once a week for residents at the RVH. At the time, similar rounds were also being held in the other McGill teaching hospitals. In 1974, Dr. Brownstein joined Dr. Jackson in these rounds.

In the late 1970s, Dr. Jackson took on the responsibility of overseeing all the clinics at the RVH. In holding this responsibility, he was a first-rate administrator, always extremely well organized and reliable. If he agreed to do something, it was always done and done well. He was accessible and would go out of his way to help the residents. In addition, Dr. Jackson emphasized the importance of the department acquiring up to date equipment and being abreast of new technologies. His opinion and recommendations were important in deciding what new equipment the department should acquire.

In 1989 Dr. Jackson founded the journal McGill Ophthalmology. The concept originated from an alumni suggestion that a newsletter could highlight the Department’s academic activities and alumni news. The journal continued to be published on a yearly basis for five years, providing clinical presentations, historical reviews, hospital reports, items dealing with residents and fellows and alumni news.

From his contributions discussed here, it is clear that Dr. Jackson played an important role at McGill during the 1970s and 1980s. This was recognized by the University and, in 1986, he was appointed Ophthalmologist-in-Chief at the RVH and, in 1987, Chairman of the McGill Department of Ophthalmology. Later, in 1991, after being involved in ophthalmology at McGill for over 20 years, Dr. Jackson left to accept the position of Chairman of Ophthalmology at the University of Ottawa.

**Dr. Jean Deschênes – 1953-**

Dr. Jean Deschênes came to McGill in 1986 following residency training at Laval University and a fellowship at the Francis I. Proctor Foundation in San Francisco. At one of the foundation meetings Dr. Deschênes mentioned
to Dr. Jackson that he was considering coming to McGill, where his wife had obtained an appointment in the Department of Psychiatry. Being interested in treating immune related problems of the eye involving uveitis and the anterior segment, McGill created a position for Dr. Deschênes in the department. He then applied to the “Fonds de Recherche en Santé du Québec” for funds to support his work, and was successful in becoming a Chercheur Boursier - the first in the Department of Ophthalmology at McGill in 1988.

Starting clinical work at the RVH in 1986, Dr. Deschênes also attended clinics at the MGH. However, he soon also began work in ocular immunology, work which saw a burgeoning of the discipline at McGill.
Becoming associated with Dr. Malcolm Baines, Professor in the Department of Microbiology and Immunology, the two men set up a research unit in ocular immunology. Significantly, this occurred at the beginning of the AIDS epidemic, a situation which made the understanding of the immune system in relation to ocular disease even more important. Thus, Dr. Deschênes set up a practice centre for seeing patients in ocular immunology dealing with uveitis, external disease, and AIDS. In teaching, a new section of ophthalmology, concerning ocular immunology and uveitis, was set up, a facility that was unique in Quebec and Canada, and which became well known.

With all of the developments in ocular immunology occurring at McGill, there were many publications and invitations for Dr. Deschênes to write chapters in prominent textbooks. From the research point of view, his and the research unit’s major contribution has been in the understanding of the normal immunology of the eye and the changes occurring in ocular inflammation. In addition, over the years, innovative treatments were developed in the ocular immunology and AIDS clinics.

Beyond the research done and treatments developed at the research ophthalmology immunology unit, it was not long after its creation that the unit began to produce additional ocular immunologists, with fellows and research trainees doing rotations under the direction of Dr. Deschênes. Many of the residents and fellows who worked with Dr. Deschênes are now well established in university centres in Canada, South America and the United States. Ocular immunology has become an important part of the program for teaching clinical care and research. Its international reputation is growing and McGill is known as a centre where treatment of immune diseases of the eye is first rate with excellent research being done.

In addition to his work at McGill and its hospitals, Dr. Deschênes has also found time to be active in many professional associations including, among others, the Canadian Ophthalmological Society, the Association des médecins ophthalmologistes du Québec as president and the International Uveitis Study Group. He has also been an Associate Dean in the Faculty of Medicine and acted as the Residency Training Program Director.

The university’s reputation as a leading centre in immune disease treatment and research can largely be attributed to Dr. Deschênes’ work. He is a first-rate teacher and role model for colleagues and students, combining clinical ophthalmology and research. A prodigious worker, it is fortunate that he is physically strong, a quality that he goes to great lengths to maintain, including having a gymnasium installed in the basement of his house. Despite being incredibly busy and in demand, he always finds time to talk to colleagues and residents. He is indeed a leader in his field and has brought luster to the
Dr. Duncan Anderson

Another McGill resident of the 1970s, who received an appointment in the Department of Ophthalmology was Dr. Duncan Anderson. A graduate of the McGill medical faculty, he completed his residency in Ophthalmology at the MGH between 1970 and 1973. Then from 1973 to 1974 he was in Boston working with Doctors David Cogan and Shirley Wray in neuro-

Figure 31: Dr. Duncan Anderson – President, Canadian Ophthalmological Society, 2002-2004
ophthalmology. In the following year he joined the MGH staff and received a GFT McGill appointment.

A new colleague of Dr. Anderson’s at the MGH during this time was Dr. Sekong Luke. Dr. Luke had completed his residency at Queen’s University, after which he obtained a fellowship in Neuro-Ophthalmology with Dr. Frank Walsh at Johns Hopkins in Baltimore. After finishing his fellowship, Dr. Adams brought him on staff at the MGH. Unfortunately he left after only one year for Toronto because of difficulty with the French language test.

At the MGH, Dr. Anderson was in charge of neuro-ophthalmology from 1975 to 1991. His arrival was significant, in that his office was the first for a full time neuro-ophthalmologist ever held at the MGH. Dr. Donald Baxter, Chief of Neurology, had recognized the importance of both neuro-ophthalmology and Dr. Anderson’s ability back in 1975, and was able to secure him an office and a secretary in the hospital.

Being a “hands-on” neuro-ophthalmologist, Dr. Anderson took the advice of his Boston Chief, Dr. Cogan, who suggested that he examine cases in the intensive care, neurology and neurosurgery areas. He took this to heart and would walk from the sixth floor to the eighteenth floor and down, seeing patients on the way. On these rounds he would not waste any time, even having the residents who accompanied him walk upstairs, as he considered it a complete waste of time to wait for the elevator. Dr. Toby Sutcliffe, a former resident, said that Dr. Anderson was the only person who could do a complete neuro-ophthalmology examination in three minutes at the bedside. Remembering how Dr. Anderson would perform a Goldman visual field, he said that “Dr. Anderson was a time and motion expert who taught us well.” A highly respected and excellent teacher, Dr. Anderson would spend one four-hour morning each week on such rounds seeing neuro-ophthalmology patients. Residents and colleagues alike found that he always had the ability to keep you interested and was able to explain complex problems with clarity.

In addition to being the first full time neuro-ophthalmologist at the MGH in 1975, that year Dr. Anderson was also placed in charge of medical student undergraduate teaching. Then, in 1976, he instituted a series of ten lectures for the medical students covering all aspects of ophthalmology - each one given by a different staff ophthalmologist who had a special interest in the topic under discussion. In addition, Dr. Anderson oversaw an expansion of early morning teaching sessions at all four McGill hospitals. He insisted that this change be made, believing that all academic teaching should take place in the early morning rather than the middle or end of the day when attendance could be poor and the residents fatigued.
In 1988, Dr. Anderson also became Director of the Residency Training Program, a university based program that represented an important shift from hospital based programs. He held this position until his departure to the University of British Columbia in 1991. Development of this new program had been encouraged by significant pressure from the Royal College which wanted to integrate residency training programs across all the McGill hospitals, a development that helped equalize rotations to these hospitals. At first there was some resistance to this when it came to the senior year, where staff and residents felt that resident surgical experience would suffer if they were not at one base hospital for the whole year. However, with the introduction of the program, it was found that resident surgery experience did not suffer.

While at McGill Dr. Anderson was universally liked, enthusiastic, a superb teacher and a pleasure to work with. He did much to make Ophthalmology better known among our medical colleagues and his departure was a serious loss for McGill and the MGH. Leaving for Vancouver in 1991, Dr. Anderson went on to a distinguished career at the University of British Columbia. In addition, living on the west coast, he has been able to further pursue his love of the outdoor life, including mountain climbing and skiing.

**Dr. Brian Younge**

Prior to the arrival of Dr. Anderson, another McGill ophthalmology resident who had shown an interest in neuro-ophthalmology was Dr. Brian Younge. His residency in ophthalmology (1969-1972) preceded three years in the Canadian Forces where he was based in Europe at Baden-Baden. As a resident at the time that the first soft contact lenses were being introduced, Dr. Younge was made one of the first “fitters” of the new “Griffin” lens. With the introduction of these lenses quite a large practice of myopes and aphakes was developed. Unfortunately, as one of the fitters, Dr. Younge claimed the distinction of creating the first pseudomonas ulcer in one of his aphakic patients. Dr. Adams, the Chief, at the MGH at the time, was notably annoyed with him but, nonetheless, stood behind him and the practice flourished.

Another distinction of a similar nature came with the introduction of 10-0 sutures. Dr. Younge was among the first to use them and, later, the first to use continuous sutures for cataracts. However, Dr. Younge also had the first unplanned filtering bleb with 10-0 sutures. In addition, he managed to do a corneal graft with this suture on a patient Dr. Lorenzetti had to follow after he left. Dr. Lorenzetti was not shy in reminding him of this for many years.
Following his residency, Dr. Younge spent one year at the Mayo Clinic. Returning to Montreal in 1973, he soon began work at the MNI as a neuro-ophthalmologist. It had always been Dr. Murphy’s goal to see a strong neuro-ophthalmology unit at the MNI. He believed that the institution’s reputation and its large amount of clinical material made this a priority for McGill. Thus, presented with the opportunity, Dr. Younge was appointed to be the first on-site neuro-ophthalmologist at the MNI. As such, to help get him established, he was provided with an office and a secretary for one year. While there Dr. Younge created a computer-based data system for diagnostic indexing which he later showed his colleagues at the Mayo Clinic with the result that a similar system was introduced there.

Recalling his appointment at the MNI in a letter he wrote to Dr. Murphy, Dr. Younge stated that it was Dr. Murphy who persuaded him to take on the job at the MNI. He wrote that:

Among the people that influenced my career decisions the most were Alf McKinna and Sean Murphy, both of whom encouraged me into neuro-ophthalmology. I was always amazed at the wealth of knowledge Dr. McKinna had in his head and his stories of Frank Walsh were most interesting. Sean had an uncanny ability to listen, lead, and pull together a rather fractious group of ophthalmologists under a single McGill roof, encompassing the MGH, RVH, JGH and MCH.

At the MNI Dr. Younge was received with enthusiasm by Doctors Feindel, Rasmussen, Cosgrove and Murphy. Dr. Rasmussen had trained at the Mayo Clinic where he learned to do visual fields, a technique which he only trusted himself to do or those he had trained. However, when Dr. Younge showed him several temporal lobectomy patients with field defects, he relented and let him do visual fields from then on. He met Dr. Wilder Penfield, the founder of the MNI, on several occasions and looked after his wife when she had a vascular fourth nerve palsy - which cleared spontaneously, much to everyone’s relief! Dr. Frances McNaughton, a remarkable and esteemed neurologist at the MNI, was always most kind and gracious.

In recalling his time at the MNI, Dr. Younge always stated that he was furnished with abundant neurological and ophthalmological consultation and teaching material. For example, Dr. Younge remembers one patient who described his new bifocals as inadequate. On reading the acuity chart, it was clear he was missing the temporal letters with each eye. Visual fields and x-rays revealed the sella to be wiped out by a large pituitary tumour - and the
patient had simply come for refraction. Dr. Younge often used this case in his teaching.

While at the MNI Dr. Younge succeeded in building an excellent neuro-ophthalmological unit. Indeed, within a few years, the quality of the work being done at the unit became well known. As a result of this success Dr. Younge was offered a position in neuro-ophthalmology at the Mayo Clinic. Accepting this new position, he went on to distinguish himself there as well. When he now returns to McGill and sees the accomplishments of his alma mater, he has a feeling of pride, and over the years, he has kept up his interest in McGill.

Dr. Younge was always enthusiastic and a pleasure to work with. Through his success at the MNI he not only gained the respect of his neuro-ophthalmology patients, but he also developed a modest, general ophthalmology following.

**Dr. Susan Lindley**

Dr. Susan Lindley, a 1980 McGill Medical graduate, while pursuing an elective in ophthalmology at the MGH eye clinic with Dr. Lorenzetti, decided on a career in ophthalmology. In 1984 she completed a three-year residency in ophthalmology (with fellow resident Marie-Louise Lapointe) based primarily at the MGH. Of the five residents accepted in 1981 all were female - an indication of the major increase in female ophthalmologists that has since taken place. She became a staff ophthalmologist in 1985 at the MGH and McGill, practicing in an outside office with Dr. Bruce Ramsey, until 1992 when Dr. Lorenzetti persuaded her to move up to the MGH as a GFT instead of moving to Vancouver as she had planned.

Dr. Lindley continued to practice from her full-time office at the MGH after 1992, doing comprehensive ophthalmology, including cataract surgery and resident teaching. In 1987 she had started to develop an expertise in ophthalmic ultrasound, undergoing training with Sandra Frazier Byrne at the Bascom Palmer Eye Institute in Miami, and has been the resident echographer since then. She progressed from Assistant to Senior Ophthalmologist during that time, and her McGill appointment progressed from Lecturer to Associate Professor.

From her MGH home base Dr. Lindley branched out into service with the McGill Northern Eye Program (under Dr. Leith), travelling to Inuit and Cree Communities of Hudson Bay and James Bay. She has also worked for twenty years with the CNIB Eye Van outreach program in Northern Ontario. She was Clinical Director of Ophthalmology at the MGH from
1995-2000, leaving this position when she was elected President of the Canadian Ophthalmological Society for a two-year term. She became Acting Chief of Ophthalmology at St. Mary’s Hospital from 2004-2006 and oversaw the planning and construction of a new Eye Clinic.

**Dr. Mark Gans – 1955-**

Dr. Gans, a 1981 McGill medical graduate, was a McGill resident in ophthalmology based mainly at the MGH (1982 - 1985). Following his residency, he accepted a position at the Bascom Palmer Institute in Miami, Florida (1985-1986) under two well known authorities in neuro-ophthalmology - Doctors Joel Glaser and Lawton Smith. The worlds
of advanced magnetic resonance neuro-imaging and desktop computers were both just emerging, and it was an exciting time to be exposed to new technology concurrently.

Following his fellowship, Dr. Gans returned to McGill as a GFT ophthalmologist at the JGH. His practice involved neuro-ophthalmology, managing an ERG/VER laboratory and general ophthalmology. He also joined Dr. Jack Wise to run the JGH Neuro-ophthalmology service for six years. However, in 1991 Dr. Gans accepted an offer to move to the MGH where he would continue as a GFT neuro-ophthalmologist.
At the MGH Dr. Gans examined patients both in his office and at the bedside. In his teaching he combined the practical aspects, and clinical issues along with the academic side.

In addition to his clinical pursuits at McGill (the MGH, MNI, and JGH), academic work, and participation in the Canadian Ophthalmological Society, the American Academy of Ophthalmology and the North American Neuro-ophthalmology Society, Dr. Gans has proven himself to be an accomplished administrator as Director of Undergraduate Studies and Director of the McGill Residency Training Program. He also assumed the position of clinical director at the MGH and MCH.

Dr. Gans is an innovative capable administrator and an excellent teacher. He is a fair and equitable person who always tries to see both sides of an issue. He contributes substantially to the excellent collegial atmosphere that exists among the staff of the MGH. In 2008 he was appointed interim Chairman of the McGill Department of Ophthalmology.

**Dr. Bruce Lennox**

Two other ophthalmologists who were associated with McGill during the late 1960s and early 1970s were Drs. Bruce Lennox and Frank Buffam. Dr. Lennox was a McGill resident based at the RVH between 1967 and 1970. He was proud to have been a resident at McGill. He recalls that, during a time of extreme cultural tension in Montreal, the hospital and the university were far from being excused from the effects of that tension. He explains that, during the St. Jean Baptiste parade of June 24, 1968, where the soon to be Prime Minister Pierre Elliot Trudeau was in attendance, a riot broke out, and twelve police officers who were charged with protecting Trudeau were attacked with "mace". That night Dr. Lennox was the ophthalmology resident on call. He was urgently summoned to the ER where, the first thing he saw, was six large rumps (six officers bending over scrub sinks) with distraught ER nurses doing their best to irrigate the burned eyes and faces of the groaning officers. Some of them were soaking wet, with their shirts pulled up, their trousers pulled down, water splashing everywhere, and holsters with guns strewn on the floor. Fortunately, all went well and the police department was grateful for the skill and concern of the ER staff and the ophthalmology resident.

Dr. Lennox went on to a successful career in St. Catherines, Ontario. He acquired a large practice and always kept up to date with the latest techniques and equipment.
Dr. Frank Buffam

Like Dr. Lennox, Dr. Buffam was a resident at McGill during times of great changes, both within Quebec and Canada. His residency coincided with the advent of Medicare, the FLQ crisis, Pierre Laporte's murder and the imposition of the War Measures Act. A McGill resident at the MGH from 1969 until 1973, Dr. Buffam worked with Doctors Duncan Anderson, Bruce Smith and David Lewis. The second year of his residency marked a decline in clinic surgery, but also the start of a new opportunity for the residents to gain surgical experience. 1970 was the first year residents were allowed to perform supervised private patient surgery.

In 1970 the MGH's ophthalmology staff consisted of Doctors S.T. Adams (Chief), Dario Lorenzetti, John Little, Sze-Kong Luke (neuro-ophthalmology) as GFTs. Also on staff, were Doctors Arthur Leith, Panos Capombassissi, Graham Little, Roland Viger, Bruce Ramsey, Esmond Gordon and Ken Adams. In subsequent years, however, a number of the staff left. Dr. Alfred McKinna moved to the University of Western Ontario, Dr. Sze-Kong Luke to Ontario, Dr. Ken Adams to New York, Dr. Roland Viger to Virginia and Dr. Graham Little to Belleville. In response, in the following two years, Dr. S.T. Adams recruited Dr. Raymond Leblanc in glaucoma, Dr. Howard Tannenbaum in retina, both of whom worked at the MGH. Later, Dr. Tannenbaum became chief at the Jewish General Hospital and Dr. Mourad Khalil was recruited on a part-time basis in pathology.

During these years of Dr. Buffam’s early career, the clinics were quite large and the residents spent most of their first two years working in them. The partitions between the lanes in the clinic allowed the residents to talk back and forth, and, thus, furthered the development of a constructive esprit de corps between them. Later, more didactic instruction in the form of lectures by subspecialists was introduced into the program.

One of the staff members of whom Dr. Buffam has fond memories was Dr. Adams, “ST” as the then Chief was generally known to the residents. He was seen as a careful clinician who had the goal of doing what was in the best interests of each patient, and who expected no less of the residents. It was a tradition that he assisted each resident with his first cataract (women residents had not yet arrived). Dr. Buffam comments, “I am sure that this was an experience which aged him more than he let on.” Dr. Buffam saw that Dr. Adams was a good clinical role model and stated success in recruiting several GFTs was important. The teaching of these young ophthalmologists provided an important legacy for him.
Dr. Buffam feels that, since his residency, McGill has become a leader in promoting resident research, sponsoring annual clinical days, attracting basic scientists and integrating the hospital departments into a cohesive unit. As for himself, Dr. Buffam settled in Vancouver where he made significant contributions to ophthalmology at the University of British Columbia.

1986 Cyclical Review of the Department of Ophthalmology

In 1986 McGill conducted its regular cyclical review of the Department of Ophthalmology. All members of the review committee visited the clinical teaching units in each of its teaching hospitals and interviewed faculty members and residents.

The committee’s recommendations included that the faculty should strongly support a basic science research unit in one of the teaching hospitals with funding for full-time or GTF appointments. It felt this to be of major importance for the future of the department and recommended an initial effort to recruit an established basic scientist and several younger investigators as soon as possible.

All members of the department of ophthalmology should be assured that the development of a strong basic science research base in ophthalmology is a priority for the faculty of medicine.

The committee noted that the faculty budget available to the Chairman was totally inadequate. It felt that “centres of excellence” in each of the teaching units should be encouraged.

In the early 1980s the concept of developing an Eye Institute was seriously debated in the department, but most staff members who mentioned it felt that it would likely never happen.

The report found the residency training program to be excellent. It also commented on the first-rate interhospital cooperation and collaboration which had been achieved.

Establishment of the McGill Vision Research Unit

The 1986 Departmental Cyclical Review was clear in its recommendation to develop research. Dr. Bruce Jackson made it a priority to develop a strong research base. In this he was supported by Dr. Richard Cruess, the Dean of Medicine.
The opportunity presented itself when Dr. Robert Hess from Cambridge University was visiting Montreal to see Dr. Curtis Baker, who had just moved from Cambridge to the McGill Department of Psychology.

Drs. Jackson and Cruess approached Dr. Hess to see if he would be prepared to move to McGill. Three faculty positions were negotiated and in September 1990 Drs. Hess, Mullen and Kingdom arrived at McGill from Cambridge. With the move of Curtis Baker to ophthalmology, the McGill Vision Research Unit in Ophthalmology was established.

In order to accomplish this, patient negotiations to establish their laboratories with much fundraising were required.

The Vision Research Unit has now grown to five faculty, with more than fifteen fellows and students funded by U.S., U.K. and Canadian grants.

During Dr. Jackson's tenure, a research representative was appointed to the executive committee. Dr. Hess has held this position since 1991 and is currently Director of Research, a position that reflects the importance ophthalmology attaches to research today.

Figure 34: Opening of the McGill Vision Research Unit in Ophthalmology.
Left to right: Dr. Richard Cruess, Dr. Bruce Jackson, Phillip Aspinall, Dr. Robert Hess.
PART III:
OPHTHALMOLOGY AT THE
CHILDREN’S AND THE JEWISH
GENERAL
The Children’s Memorial Hospital (CMH) opened January 30, 1904 in rented premises on Guy Street. It was a bilingual institution, and the first hospital in Montreal with the sole mandate of caring for sick children. In this capacity, the new hospital thrived, and in 1906 a new building was constructed on the south west side of Mount Royal, opening in 1909. However, by 1920 the growing number of patients made it necessary to relocate the hospital to a still larger building on Cedar Avenue.

The CMH eventually became a teaching hospital affiliated with McGill University, with most subspecialties being taught and practiced at the hospital by the 1920s. As a result, over the years a dynamic and successful teaching and research environment was developed at the Children’s.

Hospital care for children had begun years before the opening of the CMH. In the 1870s children were cared for at the Morland Pavilion of the MGH. There had also existed a children’s ward at the RVH from the time of its opening in 1894. In addition, the RVH not only had a paediatric department, which operated between 1905 and 1973, but also offered paediatric ophthalmological facilities. Furthermore, paediatric ophthalmological training was available at the MGH during the same period.

The growth of services and departments required a further expansion of the CMH in 1956 when it moved to its present location on Tupper Street, the site of the Western Division of the MGH. This move also coincided with the hospital changing its name to the Montreal Children’s Hospital (MCH).

The first oculist and aurist appointed to the new MCH in the mid-fifties was Dr. D.A. Kerry. Then, in the late 1950s a subdepartment of ophthalmology was organized as a division of surgery with an ophthalmologist as principal director. The first person to assume this position was Dr. S.T. Adams in 1959. Prior to his appointment there was no record of any director of ophthalmology – it was considered part of surgery. Dr. Adams was the driving force behind establishing an active and complete ophthalmological service at the hospital. He loved working with children and was renowned for his ability to treat and communicate with them. In 1964 Dr. Adams left the MCH to take up his appointment as ophthalmologist in chief at the MGH – a position he held until 1975.
During his tenure at the MCH the ophthalmology residents from the MGH would be rotated to the MCH for their training in paediatric ophthalmology. It was also during this period that Dr. Arthur Leith was appointed to the hospital as a teaching fellow. Later in 1973, after the closing of the paediatric services at the RVH and JGH, all McGill ophthalmology residents were rotated to the MCH.

Dr. Alf McKinna – 1921-2003

Dr. McKinna, a 1952 McGill medical graduate, was a resident in Ophthalmology at the MGH between 1957 and 1959. As a resident, he was on call every other night and every other weekend. In those days, you lived in the hospital when on call and were paid forty dollars per month. Members of the staff were on call about one in three nights and were expected to be called by the resident for all emergency cases. Staff ophthalmologists attended at least two and sometime three clinics per week. These clinics were free and patients appreciated the care they received. Any drugs that were dispensed were offered by the hospital at a nominal cost to the patient.

Following his residency, Dr. McKinna accepted a fellowship in ophthalmology at the University of California, San Francisco in 1959-1960. In 1960-1961 he became a Fellow in neuro-ophthalmology at Johns Hopkins Wilmer Institute, Baltimore. There he worked with the great authority in the field, Dr. Frank B. Walsh, a Canadian from Saskatchewan who wrote the first comprehensive neuro-ophthalmology textbook, Clinical Neuro-ophthalmology – a work all residents studied.

Returning to Montreal, Dr. McKinna was appointed a Teaching Fellow at the MCH in 1961-1962. In addition, he was working in neuro-ophthalmology at the MGH. In 1964 he became Assistant Professor at McGill and Director of the Ophthalmology sub-department at the MCH, succeeding Dr. S.T. Adams. At the MCH, unlike the other teaching hospitals, ophthalmology was considered a sub-department of surgery, falling under the direction of the Chief of Surgery. During Dr. McKinna’s period as Director, his colleagues who rotated through the clinics were Doctors Wyatt Laws, Bruce Ramsey, Allan Bourne, Arnold Katz, and John Little.

Dr. McKinna, while on staff, remembered being frequently on call with Dr. Allan Bourne - one night they performed three enucleations between 11:30pm and 5:30am - a record Dr. McKinna felt would stand for many years. Routinely on Saturday mornings, Dr. McKinna performed five strabismus procedures.
He was possessed of great common sense and had the ability to store an enormous number of facts which never ceased to amaze those who worked with him. If he saw a problem he had an uncanny ability to identify it and promptly solve it. At McGill his appointment at the MCH was essentially part-time. With the large amount of teaching and administrative activity, it was becoming clear that a full-time GFT appointment as Director would be in the best interest of the MCH and the university.

Dr. McKinna continued as the Director until 1972 when he left to work in neuro-ophthalmology at the recently opened University Hospital of the University of Western Ontario (UWO). In 1975 he was appointed Chairman of the Department of Ophthalmology at UWO with the rank of Professor, succeeding Dr. J.V.V. Nichols.
While Dr. McKinna’s clinical and teaching talents were missed at McGill, the staff was proud of his gaining this important new position. He distinguished himself as a leader at McGill and the University of Western Ontario, and working with his peers this resulted in many publications. Invariably he displayed much concern for patients and was always ready to help them. He greatly enjoyed teaching, a fact to which those who were fortunate enough to work with him will attest.

Dr. McKinna’s greatest pleasure at McGill was his association with his peers and the academic atmosphere. He felt comfortable and happy in the McGill of the fifties and sixties. His sudden death in 2003 was a major loss for all his friends and a major loss for Canadian ophthalmology.

Dr. Trevor Kirkham

With Dr. McKinna’s departure, a search committee was convened for the purpose of appointing the first GFT director of ophthalmology at the MCH. In 1973 the committee selected Dr. Trevor Kirkham, who had trained in London, England at Queen Square Hospital. Dr. Kirkham came to the MCH with a strong background in neuro-ophthalmology – a field with many interesting and challenging cases that he took pleasure in both studying and treating. While at the Children’s, he dedicated a significant amount of his time to academic research and publishing several papers, many of which dealt with neuro-ophthalmology. He was a fine teacher, always able to present his subject in a dramatic manner so that you came away remembering what he had said.

Soon after Dr. Kirkham’s arrival at the MCH, it became evident that the ophthalmology service at the hospital was in great need of additional space. However, although Dr. Kirkham began to develop a plan to accommodate for this need, he left the MCH for the MNI in 1975, replacing that institution’s neuro-ophthalmologist, Dr. Brian Younge, who was leaving to take up a position at the Mayo Clinic. Taking Dr. Kirkham’s place at the MCH was Dr. John Little.

Dr. John Little – 1938-

One of the 1964 GFT appointments mentioned above was Dr. John Little, a 1961 McGill graduate in medicine. He maintains a close relationship with his medical school classmates as his class’ permanent president. After graduating, he spent a year in research on lens proteins in the Department of Anatomy under Dr. Jan Langman. The following year Dr. Benny Alexander interviewed Dr. Little for an ophthalmology residency at the MGH. The
interview took place in an informal manner in the hall behind the elevators on 13-East at the hospital. Being accepted, Dr. Little completed a three year residency from 1963 to 1966. In the years that followed the interviewing of resident applicants became more formerly organized with several staff members from all the teaching hospitals participating.

After his residency, Dr. Little spent three and a half years (1966-1970) at the University of Florida, Gainesville in paediatric ophthalmology and retina. There, he was on staff and worked with the well known Doctors Herbert Kaufman and Mel Reubin doing research on immunology of the herpes virus - especially in tears and pharmacology studies.
In 1970, Dr. Little returned to the MGH with a geographic full-time appointment. At the same time, he began his long association with the MCH as a paediatric ophthalmologist and retinal surgeon. In addition, Dr. Little was also active at the MGH, performing retinal surgery there – a position which he has maintained throughout his career. In this field he was filling a need which had arisen as Dr. Adams was operating less and Dr. Howard Tanenbaum had left for the JGH.

In 1975, Dr. Little became Director of Ophthalmology at the MCH, a position he would hold for 22 years. Under his leadership, the department was known for its clinical excellence, first-rate teaching, and, in general, the residents at The Children's were pleased with their experience. Furthermore, Dr. Little worked hard to enhance the image of ophthalmology at the MCH. He saw to it that MCH Ophthalmology was well represented at Canadian and US paediatric meetings and while he was Director, the MCH became a member of the American Association for Paediatric Ophthalmology and Strabismus. During his years as Director the concept of the full-time paediatric ophthalmologist gradually evolved. It was spearheaded in the United States and by the mid-1980s was more formalized.

At the time, research in ophthalmology at the MCH was maturing, with many clinical reports on patient studies, cataract and strabismus. Members of the department, included Doctors Michael Flanders, Robert Polomeno, Arnold Katz, Jack Wise and David Young. With this team of active doctors, the residency program significantly improved with a new level of expertise. In addition, under Dr. Little's direction MCH Ophthalmology gained valuable technical advantages. In an interview with the author Dr. Little explained how he acquired the first ocutome in Canada. While attending a meeting in Colorado, he rode a ski lift with Dr. Patrick O'Mally, the inventor of the ocutome. As a result of this chance twenty minute meeting, Dr. Little was able to upgrade congenital cataract surgery while also improving his skiing.

While the quality of ophthalmology at the MCH advanced under Dr. Little's guidance, the space needed by the ophthalmologists to carry out their work continued to be in short supply. In 1973 Dr. Kirkham had begun working on the problem, and Dr. Little continuing Dr. Kirkham's work was successful in obtaining more space. Eventually, three more rooms, for seeing patients, were constructed within the same area.

Dr. Little is a leader, a skilled surgeon, an exceptional teacher, and a true McGill person, who is always enthusiastic about ophthalmology. He has a genuine feeling and concern for patients and, at the same time, a practical approach to problems.
Besides medicine, Dr. Little has been involved in the McGill Annual Alma Mater Fund for years, acting as Chairman for two years. He has been the ophthalmology consultant to the Canadiens Hockey Team since 1972 as well as the Alouettes Football Team. In addition, he has been a member and president of the Pointe-Claire Old Timers Hockey Club and Vice President of the St. Patrick’s Society of Montreal. Dr. Little continues to play hockey in the senior’s league. In addition, through his connection with the St. Patrick’s Society of Montreal, he assisted in establishing the Irish Studies program at Concordia University. At McGill, he has been the organizer of the McGill Ophthalmological Alumni Association ever since its inception in 1987. This association arranges a much anticipated annual reception at the yearly meeting of the American Academy of Ophthalmology.

**Dr. Robert Polomino – 1941-**

A 1966 graduate of the University of Ottawa medical school, Dr. Robert Polomino came to Montreal for his residency in ophthalmology at the MGH between 1968 and 1971. In 1972-1973 he obtained a Fellowship in Paediatric Ophthalmology with the recognized authority, Dr. Marshall Parks, in Washington. In 1974 Dr. Polomino was appointed to the MCH as the first ophthalmologist to devote himself entirely to paediatric ophthalmology. He has published many papers and is much involved in teaching. The residents recognized this by awarding him the 2004 Buller award.

**Dr. Michael Flanders – 1945-**

A 1970 McGill medical graduate, Dr. Michael Flanders went on to a residency in ophthalmology in the McGill program, 1972-1975.

In 1976 he and Dr. Frank Buffam spent one year at the University of Abidjan, Côte d’Ivoire as visiting staff ophthalmologists in the university hospital. Their work involved teaching and clinics with exposure to a great variety of conditions.

In 1977 he received an appointment in the MGH Department of Ophthalmology where he continues to participate in clinical activities. From 1977-1997 he was consulting ophthalmologist to the Centre Hospitalier Laurentien, Ste-Agathe, which involved driving up to this institution once a week for twenty years!

In 1980-1981 he obtained a strabismus fellowship for six months at the Harkness Institute, Columbia University under the well known authority, Dr. Phillip Knapp.
He was a GFT ophthalmologist at the MCH from 1980-1991 and continues to be active at this hospital.

In 1980 he introduced adjustable sutures for strabismus surgery at the MCH and in 1986, along with Dr. Jack Wise, introduced Botox injections for the treatment of strabismus and facial dyslexia. They both studied this treatment with Dr. Alan Scott in San Francisco.

Over the years (1981-2004) Dr. Flanders has made numerous presentations at the annual McGill Day and the annual COS meetings. He has been equally active in the Canadian Association of Paediatric Ophthalmologists as well as in several other organizations.

Dr. Flanders has made significant contributions in clinical research and paediatric ophthalmology. He is well known in the field, works very hard and
is a superb teacher. In recognition of these achievements, the residents have voted him the Buller award four times.

**Orthoptic Clinic**

In 1955, an orthoptic clinic was established at the hospital – a service which remains an important part of the department. Orthoptists are health professionals specialized in paediatric and adult strabismus. In conjunction with an ophthalmologist, the orthoptist assists in the diagnosis and non-surgical management of visual system dysfunctions involving vision (amblyopia, eye alignment and binocularity).

Over the years numerous orthoptists have worked in the eye clinic rendering valuable services. In discussions with Frances Williams (1967-1991) and
Raquel Beneish (1976) these orthoptists emphasized the important role they played in teaching ophthalmology residents.

**Pierre Lachapelle, PhD – 1951-**

During the late 1970s, McGill’s Department of Ophthalmology was fortunate to have, as one of its affiliated staff members, the university’s first full time basic scientist, Dr. Pierre Lachapelle. He trained with Dr. Jean Real Brunette at Hôpital Maisonneuve-Rosemont. Then, in 1977, when Dr. John Little was interested in creating an electro-retinography laboratory at the MCH, he hired Dr. Lachapelle to set it up. Starting work around May 1977, Dr. Lachapelle was given the task of examining the man who hired him, Dr. Little, as the laboratory’s first volunteer patient, and, in fact, the first person on whom Dr. Lachapelle performed an ERG! (Electrical recording of the retina.) When the MCH’s ERG Clinic opened officially in March 1978 it was only one of three in Canada, the other two being Dr. Brunette’s, in Sherbrooke, and Dr. John Parker’s in Toronto.

In May, 1981 Dr. Lachapelle obtained his PhD and was soon joined by Doctors Stuart Copland (research associate in Dr. Kirkham’s laboratory), Olga Overbury, Norma Lake, and Daniel Guitton, the latter two having their primary affiliation in physiology and neurology. Having obtained his PhD, Dr. Lachapelle’s first MRC operating grant was in the 1983 competition. He was subsequently granted tenure.

Over the years, up until the mid 1990s, Dr Lachapelle trained more than thirty students, including a medical student who went on to an ophthalmology residency (Dr. Devinder Cheema), as well as two who were ophthalmology residents (Doctors John Garfinckel and Michael Quigley). He has become well known for his research teaching and training.
Chapter 10:  
The Jewish General Hospital

The late 19th and early 20th Centuries saw the arrival of thousands of Jewish immigrants from Russia and eastern Europe in Montreal. Unfortunately many of these new arrivals met with both ethnic and religious discrimination when they tried to receive medical care from the existing Montreal hospitals. By the late 1920s the need for a hospital to care for the new Jewish arrivals and their families had become critical. Thus, in 1929 a campaign was launched by Montreal’s Jewish community to establish such an institution, and on August 3, 1931 ground designated for the hospital was officially broken by Canada’s Governor General, Lord Bessborough. In 1933 the Jewish General Hospital was formally incorporated as a healthcare institution, opening in 1934, with the first patient being admitted on October 15.

Dr. Jacob Rosenbaum

At the time of its opening, the hospital’s doctors had already organized a number of departments, including Ophthalmology, which was headed by Dr. Jacob Rosenbaum (1935-1952). Dr. Rosenbaum was born in Austria and graduated in Medicine from McGill in 1912. After McGill, he decided to train in ophthalmology in Europe, especially in Vienna. In the 1920’s he joined the staff of the RVH at the same time as Dr. Bert Macauley. Other fellow staff members included Drs. John MacMillan, Gordon Byers, Fred Tooke and Kenneth Johnston.

While a valuable member of the RVH’s ophthalmological staff, Dr. Rosenbaum’s 1935 decision to head the Department of Ophthalmology at the new hospital would normally have meant that he would have been required to resign from his position at the RVH. However, not wishing to lose Dr. Rosenbaum’s expertise, Dr. Byers created a new category of Honorary Attending at the RVH, which enabled Dr. Rosenbaum to accept the position of Chief of Ophthalmology at the JGH in 1935. The new category similarly allowed Dr. Macauley to become Chief at St. Mary’s Hospital. Dr. Jacob Rosenbaum died in 1952.

From the time of its opening up until 1960, there were no residents or medical students in ophthalmology at the JGH. Rather, the chiefs were completely responsible for both in patients and conducting eye clinics. However, in 1952, with Dr. Rosenbaum working mainly at the RVH, a new
chief, Dr. Aubie Eisenman, was appointed to deal with the demands at the JGH. Dr. Eisenman remained at the new hospital for several years before his death in 1959.

**Dr. Harry Magder**

Dr. Eisenman was soon followed by Dr. Harry Magder. Graduating from the University of Toronto School of Medicine in 1934, Dr. Magder next studied basic science, after which he spent a year of further medical training at Queen's General Hospital, Jamaica, Long Island. There followed ophthalmological training in several centres in Europe, but he stated to the author that he received no formal structured academic training in ophthalmology.

Dr. Magder came to Montreal in 1947 and joined the JGH in 1950. From 1962-1970 he was Ophthalmologist-in-Chief. In 1955 he was joined by Drs. Don Boyaner and Kral. The latter of these two new arrivals came from Czechoslovakia, making a significant contribution to the department by bringing a European point of view to ophthalmology.

As Chief, Dr. Magder’s priority was the further development of ophthalmology at the JGH. He was on the lookout for a dynamic younger ophthalmologist to eventually take over the leadership of the department. He discussed resident training with Dr. S.T. Adams, the McGill Chairman in the early 1960’s. This resulted in a one year Royal College approved residency program, which was established in 1962. Under this program the residents worked in the clinics, assisted in the operating room and worked up the admitted patients. Further training was to be sought elsewhere.

**Dr. Howard Tanenbaum**

Dr. Magder’s successor was Dr. Howard Tanenbaum, a McGill graduate in the early 1960’s. Dr. Tanenbaum first studied medicine at Queen’s University, and then went on to an ophthalmology residency at Queen’s. In 1967 he returned to Montreal, and Dr. Magder encouraged him to go to Boston for further training in retina with the renowned Dr. Schepens. After this further training, Dr. Tanenbaum worked one day a week at the JGH and was on staff at the MGH. Eventually, Dr. Magder approached him to come full time at the JGH, and also offered to step aside in order to allow him to become the JGH’s new Ophthalmologist-in-Chief.

Dr. Tanenbaum assumed his new position as Chief at the JGH in 1970. That same year the Royal College gave provisional approval for a three year resident training program. Five years later the program received full approval after the College found that it fulfilled all of the necessary requirements. As
a result of this approval, the JGH was able to appoint one resident per year. The first resident to finish was Dr. Dragon Svarc, followed by Dr. Eshagian.

As mentioned in a previous chapter, the resident training program became university based rather than hospital based in the early 1970's. With this change, residents now applied to the university and were interviewed by a committee with representatives of the different teaching hospitals. Their preferences were taken into account as much as possible, but it was the committee which made the final decision on which hospital the applicant would be based at. The academic program started at the JGH with Dr. Tanenbaum in 1970-71. In 1975 contracts were signed between the JGH and McGill University, formalizing the hospital's academic connection to

Figure 39: Dr. Howard Tanenbaum
the university, and in 1979 the JGH was designated a fully affiliated McGill University teaching hospital. However, it should be noted that by that time the official name of the JGH had actually changed. In 1978 a very generous bequest had been made to the hospital, and, as a result, the institution's name was officially changed to the Sir Mortimer B. Davis Jewish General Hospital.

Dr. Tanenbaum was a first rate chief. As an excellent organizer, he took charge, assigned responsibilities, was hard-working and respected by all. He brought with him the retinal expertise he had acquired with Dr. Schepens in Boston and developed a large referral practice. As a surgeon, he was admired by patients. For example, he would often come off the ski hill and go straight into the operating room. As a teacher, he was excellent, enthusiastic and forward looking.

In addition, Dr. Tanenbaum's arrival at the JGH initiated a greater connection between the hospital and McGill University. Before his time, McGill had appeared as a distant university to the JGH ophthalmologist. However, he was a true McGill citizen, and pleased to have closer links with the University. Yet, it is fair to say that he wished McGill would give his department greater resources. His contributions to the McGill executive committee were thoughtful, well considered and always helpful. In 1972, the JGH pediatric facility was being phased out and Dr. Tanenbaum, working with Doctors S.T. Adams and A. McKinna, arranged for the JGH residents to rotate to the MCH.

It was department policy to have all McGill residents involved in clinical research and they began to write scientific papers. Ophthalmology was changing with the development of subspecialties but as before, the emphasis remained on strong clinical training.

At the JGH Dr. Tanenbaum was responsible for surgical retina, while Dr. Julius Gomolin dealt with medical retina. Their combined talents made for a good team.

**Dr. Julius Gomolin – 1953-**

A 1977 McGill graduate in medicine, Dr. Julius Gomolin was a McGill ophthalmology resident, based at the JGH from 1978 to 1981. He then received a Retina Fellowship at the University of Wisconsin, Madison, for 1981 to 1982. In 1983 he received a McGill GFT appointment with his office in the Jewish General Hospital. Since that time he has specialized in medical retina, especially dealing most often with diabetes and age-related macular degeneration.
The department conducted large efficient clinics with rapid turnover. For example, in 1979, 20,000 patient visits were recorded. The department's objective was to build the very best department possible and keep abreast of new developments such as intraocular lenses and vitreous surgery (in the mid seventies).

The McGill Chairman was concerned that the various university teaching hospitals could make better use of their ophthalmological staffs and resources by merging all of the different hospital ophthalmology departments under one roof. Dr. Tanenbaum was asked to develop as he saw it arrangements to support this position. He recommended this as the best solution for the development of the McGill department. However, after much discussion at the departmental executive committee and in the various hospitals, it was decided that amalgamation would be too difficult to achieve at the time, and that such a move was somewhat premature.

Instead of amalgamation, it was decided that, for the time being, the best course of action was to develop different centres of excellence in each hospital. From a practical point of view, it was felt important to have as many different specialists as possible at each McGill hospital.

With the JGH an important part of the McGill medical network, Dr. Tanenbaum’s time at the JGH unfortunately came to an end in 1983. That year he and Dr. Marty Kaback, a first rate glaucoma specialist, announced that they had accepted an offer to move to Albany University, New York. Dr. Tanenbaum’s departure left the JGH and McGill short of an excellent retinal surgeon for several years.

With the perspective of time it is clear that Dr. Tanenbaum’s contribution in retinal surgery, teaching and organization of residency training at the JGH was fundamental in placing JGH ophthalmology on a solid academic foundation. He was a leader who led by example and with enthusiasm. Under his guidance the JGH could be proud of the department that had been created – having transformed a fledgling academic program into a flourishing one. With his leadership the JGH had developed a teaching atmosphere which emphasized scientific ophthalmology.

Dr. Joel Rosen – 1943-

In need of a new Chief, the JGH appointed an ophthalmologist from among its own ranks. Dr. Joel Rosen, a 1968 McGill graduate in medicine, had completed the three year residency program at the JGH in 1973. He then trained in corneal diseases with a one year fellowship at Cornell University, New York City. In 1974, Dr. Rosen returned to Montreal and joined the
staff of the JGH. This was also about the time that Doctors Fichman and Solomon came on staff. Then, ten years later, with the departure of Dr. Tanenbaum, Dr. Rosen was appointed Ophthalmologist-in-Chief at the JGH in 1984.

As Ophthalmologist-in-Chief, Dr. Rosen ably represented the JGH on the McGill executive committee and maintained a strong clinical orientation at the hospital. Under his direction, teaching was emphasized and rounds were well attended and animated with vigorous discussions. These discussions were lively with many staff participating, two or three of whom were sometimes talking at once. Indeed, there was an informal free to and fro atmosphere where different points of view were presented and where you had to be prepared to defend what you said.

During Drs. Tanenbaum's and Rosen's tenure as Chief, relations between staff and residents were excellent. Under both the training program had become very popular, with the residents enjoying their time at the JGH. Daily teaching sessions for the residents (7am to 8am) began and a journal club was instituted. In addition, arrangements were made for medical students to attend eye clinics. Indeed, Dr. Rosen is proud of what was accomplished and feels that the McGill program, in the 1980's, had evolved into being among the very best.
Dr. Rosen performed the corneal grafts at both the JGH and the MGH. He was also a member of the external disease group, with Doctors Bruce Jackson and Dario Lorenzetti, which met once a month, alternating their meetings between the JGH, RVH and MGH. These sessions added to the clinical experience of the residents and gave them valuable teaching. During the same period, the JGH’s Dr. Jack Wise was in charge of pediatric ophthalmology and spent a significant amount of time in neuro-ophthalmology, following studies in New York. He was joined in the neuro-ophthalmology clinic by Dr. David Nicolle. As for Dr. Gordon Balazsi and Dr. Elliott Werner, they saw the glaucoma patients while Dr. Svarc conducted a low vision clinic which, in later years was to become an active center in the McGill program. Dr. Tanenbaum had continued to be responsible for surgical retina until he left in 1983.

Dr. Don Boyaner – 1927-2008

As mentioned earlier, another important member of the JGH ophthalmology staff was Dr. Don Boyaner. Born in 1927, Dr. Boyaner had been exposed to individuals preoccupied with the study of the eyes from a very young age. His grandfather had been an itinerant optometrist-optician in St. John, New Brunswick, and his father was also an optometrist-optician. Working in his father’s office as a young man, Dr. Boyaner eventually trained in medicine at McGill, from which he graduated in 1951. Having decided upon a career as an ophthalmologist, he next went to the New York University post-graduate medical school for a didactic year of Ophthalmology. There followed a three year residency under the auspices of New York University at St. Vincent’s, Bellevue and University Hospitals. There, he had the distinction of performing his first cataract extraction with the well-known Dr. Ramon Castroviejo. Returning to Montreal in 1956, Dr. Boyaner joined the JGH’s Department of Ophthalmology, where he was the first staff member to perform corneal transplants in the mid-1950s.

In his New York days, residents were trained to operate with loupes. In the 1970’s the operating microscope came into general use and Dr. Boyaner began using it in 1972. He recalls seeing Drs. Binkhorst and Weiss at the American Academy meetings in 1970-1971 reporting on their results with intraocular lens implants. Their success rate was less than 50% causing him great concern. However, in 1974-75 he decided to begin implant surgery even though the complications could be serious and worrying.

In 1970-71 Dr. Boyaner was joined in his practice by Dr. Leon Solomon (1936-) It was at that time that the two men started doing lens implant surgery. Dr. Tanenbaum, who had been appointed as Ophthalmologist-in-
Chief in 1970, asked Drs. Boyaner and Solomon to keep meticulous records if they were to report their first 100 cases at the Canadian Ophthalmological Society meeting in Quebec City (1978). As a result of their record keeping, in 1978, and at other meetings, viscoelastic was shown to protect the corneal endothelium in implant surgery and in 1980 it became available in Montreal (known as healon). Dr. Boyaner also reported his experiences at other meetings.

It should also be noted that, while Drs. Boyaner and Solomon were performing implant surgery at the JGH, Drs. Peter Davis and Peter Dawson were involved with implant surgery at the RVH and Dr. Arthur Leith at the MGH. In fact, the mid-late 1970s saw the whole field of implant surgery
undergoing rapid changes and the McGill surgeons were attending numerous national and international meetings where they discussed their findings with other colleagues from around the world.

Dr. Boyaner was a very hard-working master surgeon respected by all. His greatest contribution to the JGH and McGill was as a superb surgical teacher. He stated that “Teaching is my connection with the future,” and in 1990 the residents honoured his commitment to teaching by giving him the Frank Buller award for surgical teaching. The residents had created the award, as well as another for medical teaching, in 1990 in honour of the founder of McGill’s Department of Ophthalmology. Respecting Dr. Boyaner’s work, the students again voted to give him the Buller award for surgical teaching in 1995. These awards reflected the view of many residents, that their rotation at the JGH was significantly enhanced by the excellent teaching they received. In addition, the JGH and McGill University established a lectureship in his honour.

Dr. Marvin Kwitko – 1931-2002

Another ophthalmology staff member at the JGH between the 1970s and 1990s, who was also on staff at St. Mary’s Hospital, was Dr. Marvin Kwitko. He was Chief of Ophthalmology at St. Mary’s Hospital and made significant contributions to the work done at that McGill affiliated hospital. The first Chief of Ophthalmology at St. Mary’s had been Dr. John McNally, followed by Doctors Roland Viger, Gaston Duclos, and Kurt Schirmer.

Examples of the significant contributions which Dr. Kwitko made to advancing the reputation of ophthalmology at both McGill and St. Mary’s can be seen in his pioneering achievements in ophthalmological surgery. At St. Mary’s, in 1974, he performed the first intraocular lens implant following cataract surgery at a McGill hospital, and in 1979, the first radial keratotomy procedure at the same hospital.

From 1975 to 1983, he conducted lens implant courses at St. Mary’s for ophthalmic surgeons. Over 300 ophthalmologists attended, including Doctors John Locke and Bruce Jackson from McGill.

With his remarkable energy, Dr. Kwitko was the moving force in organizing well attended, international, ophthalmological meetings in Montreal where the latest ideas, advances and surgical techniques were discussed. In 1975, he organized the first Congress devoted entirely to lens implants. Held at St. Mary’s, the Congress continued on an annual basis in various hotels in Montreal until 1994. In that year, he organized and hosted a cataract and refractive surgery symposium as part of the International Congress of
Ophthalmology. Over 1,800 delegates from 52 countries attended. The former Prime-Minister of Canada, Kim Campbell, opened the meeting and Doctors Charles Kelman, Cornelius Binkhorst, Svyatoslav Fyodorov and José Barraquer attended as the guests of honour.

Dr. Kwitko was also a prolific writer, publishing six books dealing with glaucoma in infants and children, surgery of the infant eye, pseudophakia, current trends and concepts, geriatric ophthalmology and the history of modern cataract surgery.
APPENDIX I

Some defining moments in ophthalmology at McGill.

1. Dr. Buller’s appointment as the first specialist and first ophthalmologist at McGill. His vision of an academic department, identified in 1876, emphasized excellence in patient care, teaching and clinical research.
2. Organization of Canadian ophthalmology. 1930s.
3. Start of the resident training program. 1940s.
4. Development of the training program. 1950s.
8. McGill Clinical and Scientific Day. 1978-.
10. Pathology as a central departmental discipline over the years. 1876-1986.
11. Increasing importance of ophthalmic research. 1985-
APPENDIX II

Chairmen of McGill's Department of Ophthalmology

1883-1905  Dr. Frank Buller
1905-1923  Dr. John W. Stirling
1923-1937  Dr. Gordon Byers
1937-1940  Dr. Frederick T. Tooke
1940-1947  Dr. John Alexander MacMillan
1947-1949  Dr. Stewart Ramsey
1950-1956  Dr. Kenneth B. Johnston
1956-1970  Dr. John Locke
1970-1975  Dr. S.T. Adams
1975-1987  Dr. Sean B. Murphy
1987-1991  Dr. W. Bruce Jackson
APPENDIX III

Ophthalmologists-in-Chief at the Montreal General Hospital

1876-1893  Dr. Frank Buller
1893-1905  Dr. J.J. Gardner
1905-1931  Dr. Matheson
1931-1941  Dr. S.H. McKee
1941-1951  Dr. S. Ramsey
1951-1963  Dr. B. Alexander
1964-1975  Dr. S.T. Adams
1975-1994  Dr. D.W. Lorenzetti
APPENDIX IV

Ophthalmologists-in-Chief at the Royal Victoria Hospital

<table>
<thead>
<tr>
<th>Years</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1896-1905</td>
<td>Dr. Frank Buller</td>
</tr>
<tr>
<td>1906-1921</td>
<td>Dr. John Stirling</td>
</tr>
<tr>
<td>1921-1934</td>
<td>Dr. Gordon Byers</td>
</tr>
<tr>
<td>1934-1939</td>
<td>Dr. Fred Tooke</td>
</tr>
<tr>
<td>1939-1948</td>
<td>Dr. John McMillan</td>
</tr>
<tr>
<td>1950-1956</td>
<td>Dr. Kenneth Johnston</td>
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<tr>
<td>1956-1970</td>
<td>Dr. John Locke</td>
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<tr>
<td>1970-1987</td>
<td>Dr. Sean Murphy</td>
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<tr>
<td>1987-1991</td>
<td>Dr. Bruce Jackson</td>
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</tbody>
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APPENDIX V

Acronyms for Montreal hospitals discussed

Children's Memorial Hospital (1904-1956) = CMH
Montreal Children's Hospital (1956-present) = MCH
Montreal General Hospital = MGH
Jewish General Hospital = JGH
Royal Victoria Hospital = RVH
Montreal Neurological Institute = MNI
ENDNOTES


2 E.M. Renouf, *McGill University Medical Faculty Illustrated.* Montreal 1898.


10 Herbert S. Birkett, “Buller, the Ophthalmologist, Politzer, the Otologist, and Lefferts, the Laryngologist,” *Transactions of the American Academy of Ophthalmology and Oto-Laryngology,* 1927, 3-4.


14 In reflecting upon Dr. Wood’s love of ornithology, it should be noted that he and his wife had a very special parrot, John III, who travelled everywhere with them. When getting on and off ships, they covered him carefully with a large black cloth. John III, without a doubt, was the world’s most travelled parrot and achieved his own fame as many articles were written about him. The Woods considered him a member of the family. For additional information on the life and work of Dr. Casey Wood, see Effie C. Astbury, *Casey A. Wood (1856-1942): A Bio-Bibliography,* Montreal: Graduate School of Library Science, 1981.


16 Bishop’s was the first medical school in Canada to accept women, including Maude Abbot, who went on to a most distinguished career as custodian of the McGill Medical Museum and an authority on congenital cardiac abnormalities.

17 An interesting anecdote was related on how he once overturned his Model-T car on Cote des Neiges Road in Montreal and, thereafter, never drove. Instead, he usually walked everywhere, including to the RVH from Westmount.


21 A.K. Haywood, (1929) 78.
