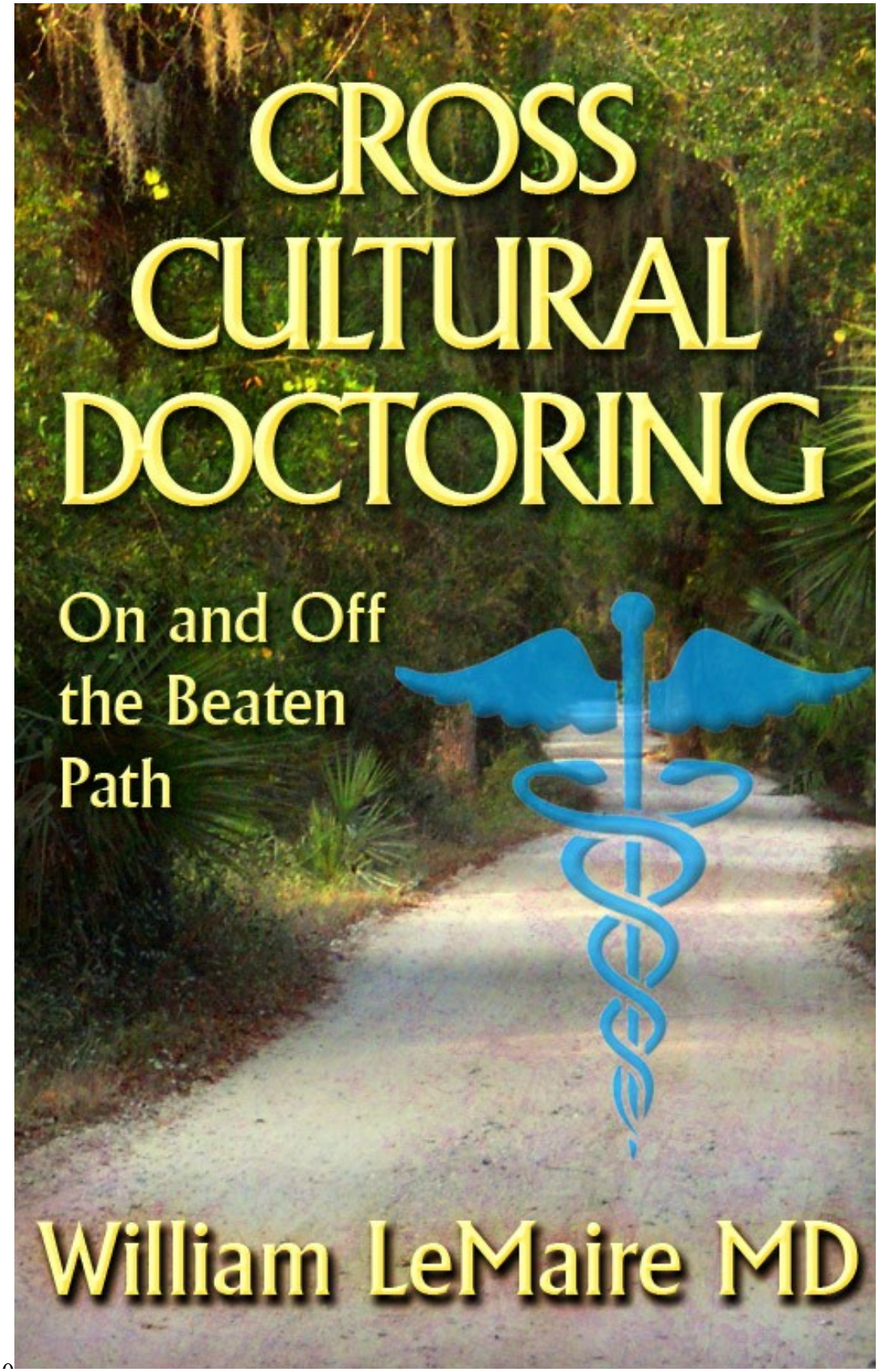
CROSS
CULTURAL
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William LeMaire MD

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ON AND OFF THE BEATEN PATH

William J. LeMaire MD

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To Anne and our kids, Ingrid, Elke, Tom and Frank. Without Anne I would never have done what we ended up doing. The kids were independent and supportive enough to allow us to leave the beaten path without worries.

Special dedication: I am dedicating this book to the group of Catholic nuns who run Hospital San Carlos in Altamirano, Chiapas Mexico. Our experience at that hospital is described in Chapter thirteen. We were most impressed with their superior effort to provide medical care to the destitute Mayan population in that area under difficult circumstances and with minimal resources. Thus, rather than selling this book on line I am making it available for free and suggest that anyone downloading the book, make a donation to that hospital in lieu of the usual downloading fee. Their website is: http://www.hospitalsancarlos.org/

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PROLOGUE

The turning point in my career as an academic Obstetrician and Gynecologist came in 1980 when my best friend died from a complication of cardiac bypass surgery. He and I were in our late forties, at the top of our academic careers and doing well but working hard, maybe too hard. He, his wife, my wife and I had often talked about our retirement that lay still far ahead. We were already making plans, vague of course at that stage, for our post-retirement activities. His sudden death put an end to these dreams. It did however induce my wife and me to think more about values in life other than work and career. Over the ensuing year or so, a more concrete idea began to crystallize in our minds. I was going to continue with my career until age 55 and then retire from my position as professor in obstetrics and gynecology at the University of Miami and pursue different interests. But I am getting ahead of myself. Let me first tell you what led up to the time that we actually put our plan in effect and then give you an account of how we accomplished it.

Right from the beginning let me say that we never regretted the decision to leave my academic career and we have never looked back, even though we have kept in contact with our friends and colleagues. In fact, it is at the prodding and encouragement of many of these friends and colleagues that I am finally sitting down to write this book. It was never my intent to do this but invariably these friends would tell me: “Wim, why don’t you write a book about your experiences?” They would tell me that every time my wife Anne and I came back from one of our “adventures” and after they had listened to an account of some of our experiences.

I had been reluctant to write a book mainly because I felt that not many people would be interested, but they kept saying how wrong I was. Nevertheless I resisted, maybe out of laziness or maybe because I had no idea on how to write a book, and more likely because of both of these reasons. Then, in the spring of 2008, I was asked to give a presentation at one of the weekly grand rounds, for an audience of medical students, residents and faculty at the University of Miami, where I had spent most of my professional career. My initial reaction was to say no, because I had really nothing scientific to offer, besides I had been out of academic medicine for close to 20 years and had not given a formal presentation in years. When the person asking me kept insisting that nothing scientific was expected but that they wanted to hear about our travels and experiences in different cultural settings, I accepted. That presentation was well received and seemed to be a success. The preparatory work for the presentation put me in the right frame of mind and gave me enough impetus to actually go ahead and start writing. Voila! Here it is.

”The first part of the title of the book reflects a major aspect of my “post retirement” activities as I have kept working off and on as an obstetrician and gynecologist in a variety of cultural settings in different parts of the world. Hence the title: *Cross Cultural Doctoring.* The second part of the title of this book reflects the fact that during my entire career I have followed some traditional and expected paths but at times, also have deviated quite a bit and followed a much more unconventional path, leading up to my retirement and thereafter. Hence the subtitle: *On and Off the Beaten Path.*

The book is written as a series of rather loosely connected anecdotes and I hope that you will enjoy reading them. While many of these anecdotes are medical in nature, I sincerely hope that they will appeal not only to people in the medical field, but also to the non-medical reader and inspire others in different fields of work to get off the beaten path. I am writing this book in a chronologic fashion, starting with medical school and progressing through the various stages of my career. Many of the earlier anecdotes happened more than 50 years ago, and as I never took notes, this book is written from the collective memory of my wife Anne and me. We have often talked about many of these events and related them to family and friends over the years. While I can assure the reader that these anecdotes are real, I cannot vouch for their exact sequence and timing, as time and places may have become blurred over the years. I apologize for any minor inconsistencies or inaccuracies.

CHAPTER ONE: ON THE BEATEN PATH

I grew up in Antwerp in the Flemish part of Belgium and my mother always wanted me to become a Jesuit priest. She didn't say that to me directly, but that was the hidden message I perceived. I certainly was in the right environment to follow that direction as from grade school through high school I was educated by the Jesuits; and a great education I received from them! Thus it came as somewhat of a shock to my parents when I announced towards the end of high school, that I wanted to go to medical school.

At age 17, I entered medical school at the University of Louvain in Belgium. This was a seven year program, where the first six years were entirely theoretical, followed by a one year rotating internship before one actually could graduate with an MD degree. During these first six years, I was the proverbial good student. This gave my mother a glimmer of hope that even after finishing medical school, I might still join the Jesuits. Such a career path is not entirely unusual in that religious order as a number of their priests have advanced degrees in other fields.

However this was not to be, as I met Anne on the swimming team in Antwerp. This first meeting was somewhat of a unusual experience. I had never met her before, but we were swimming laps and we were both in the same lane with at least five or six other swimmers diligently trying to keep on their own side of the lane. When swimming free style, it is not always easy to swim straight and as it turned out Anne deviated into my path and bumped into me. Without realizing who ran into me I yelled, "Get out of my way!" Probably not a good start for any relationship, but we soon started dating and towards the end of the sixth year of medical school we decided to get married. Announcing this to my parents shattered my mother's hope for a more spiritual career for me. Thus I was made to understand that I was going to be on my own and that my parents were not going to support me during my upcoming year of internship.

As I wrote earlier, in these days (1957) a Belgian internship was an integral part of medical school, to be completed before the MD degree was awarded. In fact that internship was part of the curriculum and required the payment of tuition, however small. It was invariably completed in a Belgian hospital affiliated with the university. Anne and I now faced the prospect of being without income during my year of internship. The question was what to do, especially because Anne's parents had told her that she needed to first finish her degree in medical technology at the university. While Anne's parents finally relented as they realized that we were determined to get married, my parents certainly did not. They did everything they could to dissuade us. One rather amusing (in retrospect) incident occurred when my mother came to the University. Unbeknownst to me she had made an appointment to see the professor in obstetrics and gynecology. She knew that I had befriended him and she thought that he might be helpful in her plan to dissuade me. When she told him the reason for her visit, he immediately thought, as he related later to me, that my mother was worried because I was going to marry some "floozy." So he asked her who the girl was that I was so intent on marrying. She told him that she was the daughter of a medical doctor in Antwerp. He immediately asked her what this doctor's name was. When my mother told him he smiled and said: "The daughter of Marcel Voet? Well I do know him quite well; he was a classmate of mine in

medical school. He is a great guy and has a nice family. Great catch for your son! I would let them go ahead." That was certainly not what my mother expected. While I resisted some other attempts by family members to make me call off our plans, Anne and I started thinking on how to manage for a year without much financial support.

I knew that in the USA, internships were completed after medical school and that interns received a stipend (rather small). This certainly appealed to us and the idea was born of going to the USA to complete the year of internship. That was easier said than done as such a move was, at that time, unheard of in Louvain. However, it turned out that seven of my colleagues out of a class of about 150 students had similar ideas. Together we petitioned the dean of the medical school to allow us to do that year of internship in the USA. After initial refusal and considerable discussion he finally relented. There was one condition however; we were required upon returning to Belgium to do an additional three months of internship in a University hospital in Louvain. I suppose that was meant to allow the professors there to assure themselves that we had learned "something" in the USA. The result of that condition was that we would miss graduation and officially be awarded the MD degree three months after all the others. That was a small price to pay. The eight of us were thrilled and searched for a suitable internship in the US, which we readily found.

But first we needed to plan for our wedding. My parents were not going to attend and thus Anne's parents decided to move the ceremony and the reception to a small village near Antwerp, where Anne's father had a cousin to whom he was very close and who was the parish priest there. Normally the wedding ceremony would have been held in Anne's parish, an old beautiful, large baroque church. As Anne's father was a well known and well liked family doctor, many of his patients would have been likely to attend the wedding. Having the ceremony in this church but without my family attending at all, would have been awkward and would certainly have raised eyebrows in the community. Moving the wedding to the small village could easily be justified by the fact that Anne wanted her father's cousin to preside over the ceremony. To everyone's surprise, my parents and sisters decided at the last moment to attend anyway. On June 25th 1957 Anne and I became husband and wife, and after an all too brief honeymoon on the Belgian coast, we started our first adventure together off the beaten path.

CHAPTER TWO: FOR THE FIRST TIME OFF THE BEATEN PATH

My choice for internship was Ellis Hospital, a small hospital in Schenectady in upstate New York. What an initial culture shock that was! The first problem was the language. I knew enough "school" English to get by, or so I thought. Talking on the phone was the hardest. Initially, the nurses in the hospital thought that I was the most conscientious intern they had ever worked with. When I was on duty and the nurses called me on the phone at night, I would always go to the ward, look over the chart, see the patient and then write a note and orders, rather than just handle things over the phone like all the other interns did when called for rather minor matters. Little did the nurses realize that the reason I would get up in the middle of the night and physically go to the ward was due to the fact that I had no idea what they were talking about. I did not understand a word of what the nurses were telling or asking me on the telephone, especially not when they were using even common American abbreviations, like PRN, QID, LMP etc. [PRN (Latin) means as needed; QID (Latin) means four times a day and LMP means last menstrual period]. That problem rapidly resolved as I began to understand more and more of the English medical terms. However, there is a major difference between understanding day-to-day common English and grasping all the idioms and sayings. A rather amusing anecdote will illustrate that.

About two months into my internship, I was on call at night when one of the nurses telephoned me in the early evening. A patient was having a bad headache and wanted something for it. I was proud that I had understood the problem over the phone and was even more proud that I managed to order something for her headache without having to walk over to the ward. An hour or so later, the same nurse called me for the same patient because she had been constipated and wanted something for it. Again I understood and again I was able to prescribe a laxative over the phone without having to go to see the patient. A while later the same nurse called to let me know that this same patient was agitated and wanted something for sleep. Once again I understood and prescribed a sleeping pill. Close to the 11pm shift change the same nurse called me once more: "Dr. LeMaire, I am so sorry to bother you again about my patient, but she is really a pain in the neck." Immediately some horrible thought occurred to me. Here is a patient who has a bad headache, is constipated and agitated and now has a pain in her neck. These could all be symptoms of meningitis and here I have been ordering medications over the phone for a potentially serious condition. I broke out in a cold sweat and I told the nurse "I am coming." I ran over to the ward where that patient was hospitalized, went to her room and after introducing myself said "Mrs. X, the nurse tells me that you have a pain in your neck." The patient lodged a complaint about the nurse and me, but we both got off with a minor reprimand and in fact somewhat of a chuckle by the administrator handling the complaint.

The teaching in medical school in Belgium was mostly theoretical, with little, if any, of the hands-on type of experiences that the medical students in the US routinely receive. That undoubtedly has now changed in Belgium. Thus, when I started my internship I was rather inexperienced in practice compared to the interns in the hospital who came from American medical schools. This may seem ridiculous now, but I had never started an

intravenous drip, had never read an ECG (electrocardiogram) at the patient's bedside, nor placed a stomach tube, nor sutured a laceration, nor delivered a baby. Also, while I had been able to observe surgery from distance, I had never actually assisted in an operation. All this I had to learn on the job. As it stands, practical hands-on skills are quickly learned, once the basics have been learned. Thank God, the residents and attendings I worked with were understanding and helpful, without ever making me feel inferior. They went out of their way to give me confidence.

One such confidence-building episode I remember vividly. Sometime in the middle part of the one-year internship, I was on call in the emergency room and was called to see a woman who was obviously in active labor. She was in her thirties and had already delivered several babies before. The problem was that she had had no prenatal care at all and there was no record of her in the hospital. I began by asking her some standard questions, like when her last menstrual period had been and when she thought her due date was. I did not get far with my questioning as she had one contraction after another and she was not interested in answering. Soon the bag of waters broke and she said that she had to push. The only obvious action for me at that point was to get ready for a delivery in the emergency room. There was no time to transport the woman to the labor and delivery room. There was an emergency delivery "pack" in the ER, which the nurses opened for me while I quickly washed my hands and put on gloves. Soon after, a healthy, screaming, but rather small baby was delivered and handed to the pediatric resident who had been called. At that point it became obvious that there was one more baby inside the uterus. Realizing that I was dealing with a twin pregnancy, I panicked as in my limited experience during my obstetrical rotation some months earlier I had never performed or even seen a twin delivery. I asked the nurses to summon the chief resident, who promptly arrived to my great relief. I immediately started peeling off my gloves to make room for the resident to take my place and deliver this twin baby. However, he calmly stood by and, over my objections, bluntly told me "you can do it" even though I kept telling him that this was a first for me. I delivered this healthy, screaming twin baby in front of a large number of nurses and doctors crowding the room, only to realize that this was not the end of it and that indeed there was a third baby. Now I was really ready to step aside and let the chief resident take over. However he remained calm and again, stood by and assured me that I could handle this situation. I am not even sure how many triplets he had delivered himself as they are not common. Baby number three appeared quickly and also was healthy and vigorous. What a boost to my self-confidence that was! I only delivered one other set of triplets later in my career and that was by C-Section.

What I will never forget is the implied lesson in confidence building the chief resident gave me. I have always remembered that. In fact I have put this approach in practice numerous times when the roles were reversed later in my career as teacher. Often in a somewhat difficult situation at the bedside or in the operating room, a student or more junior doctor would refer to me to take over and finish a procedure he or she did not feel qualified to do. Most of the time I would reassure and encourage that person to continue while I talked him or her through it. Many of these junior doctors have told me afterwards how they appreciated this confidence building. Of course one has to be careful to balance this approach with patient safety and I have never delegated responsibility in critical situations and have often taken over when a junior doctor was having trouble.

Schenectady, in 1958, was one of the main headquarters of General Electric and its population had a large number of all sorts of engineers working for GE. I am not sure if that fact plays a role in the story I am about to relate but at the time I did think so.

One of the surgical nurses in the hospital felt that her family was complete and was thinking about some form of sterilization. Sterilization in that era was only permitted under strict regulations. She and her electrical engineer husband thought that the best approach was a vasectomy, but that was not commonly performed in the hospital. A vasectomy is a rather simple outpatient procedure. The nurse had some surgical knowledge and access to minor surgical instruments and to local anesthetic as well. She and her husband decided that they were going to perform the vasectomy at home with the equipment and anesthetic she brought home from the hospital. One evening they started the procedure and everything went well until after making the small incision in the scrotal skin, she ran into a minor blood vessel that she had apparently overlooked when studying the anatomy of that area. When she injured that blood vessel it started bleeding profusely and she was unable to stop it. When they came to the emergency room, her husband's underwear was soaked with blood and so was the gauze pad that they had applied over the area. I happened to be on call in the emergency room and tended to this man right away. As it turned out the problem was rather minor and the bleeding stopped promptly after tying off the small vessel that was the culprit. The only proper action for me at that point was to suture the small cut, place a gauze dressing over it and send the couple home. I can assure you that they were rather disappointed that I did not finish the job they had started.

During that internship I witnessed and participated in a number of rather dramatic cases for which medical school does not prepare the student. The saddest case and probably the saddest of my entire career was the case of a little two or three year old girl who was admitted after inhaling a peanut. That peanut had crumbled into multiple smaller pieces upon the attempt to remove it from one of her bronchi by bronchoscopy. As a result the little pieces had lodged further down in the bronchial system. She became progressively sicker and sicker and ultimately died from lipid pneumonitis. I was the intern on the pediatric ward and took care of her for a number of days. She was the nicest and most adorable little girl and it was just heartbreaking to see her slowly deteriorate and die.

Qualifying as the most dramatic case of my internship was the case of an elderly man who had an alleged tumor eroding into one of is bronchi. His private specialist was going to biopsy this tumor via the bronchoscope. Remember that this was many years ago and before the availability of CAT scan, MRI and other modern sophisticated diagnostic methods. I was assigned to assist him, which consisted of supporting the patient's head and move it slightly on directions of the operator, so that he would have better visualization. As it turned out this tumor was an unrecognized aneurism of the aorta eroding into a bronchus and upon biopsy a major gush of blood emerged that continued while the patient exsanguinated within a short period of time practically in my lap, while frantic attempts were being made to staunch the bleeding.

Anne and I lived in a small apartment close to the hospital and got by on a small, very small, salary. So did all the other interns. Therefore our entertainment consisted of pot-luck weekend evenings at each other's apartments on a rotating basis. When it was our turn to host the get together we had told our friends to come around 8:00 pm. In Belgium

this means arrival at the earliest around 8:15 or even later. Of course this is quite different in the punctual American culture. That evening the bell rang at 8:01 with the arrival of the first guests. I opened the door, sat them down, started the background music and offered them a drink, as other guests arrived. While they all were sipping their wine, whiskey, or soft drink, someone asked where Anne was. She was still getting ready, not expecting any one until sometime after 8 pm. I told them "Anne is taking a douche." Now, a douche is actually the French word for shower and is also commonly used in the Dutch language, but of course in the English language that word has quite a different meaning. When I told everyone quite innocently, that Anne was taking a douche, people's mouths fell open and I could see on their faces the disbelief and hidden thoughts …"what kind of party is this going to be?"

A similar confusion occurred toward the end of our stay in Schenectady, when the student nurses, many of whom had befriended Anne, who was now in her first pregnancy, told me that they were planning to give her a baby shower. They asked me not to say anything and keep it as a surprise. However, I felt compelled to warn Anne that she was going to receive a gift of a shower for the baby, rather than a bath. I felt that I needed to prepare her for this unusual gift, as I knew that babies in Belgium are washed in a small bath and not in a shower. Of course we had a good laugh when we realized our misunderstanding.

Anne had befriended some of the other interns' wives. Several lived in the same apartment complex and one at least was also pregnant. One evening towards the end of her pregnancy and while I was on call in the hospital, Anne received a frantic call from one of the other pregnant women, asking Anne if she could come over right away as she had begun labor and needed to go to the hospital immediately. She had a two-year-old toddler at home and her husband was also on call. Of course, Anne walked over immediately, but not before telling her friend that she, too, had felt some stirrings in her pregnant belly earlier in the day. Somewhat later that evening, while babysitting for her friend, Anne's contractions started. She called me and I rushed over to get her, while Anne made arrangements for one of the other women to come and take over her babysitting duties. In the hospital, Anne had a rather fast labor and three or four hours later our first child, Ingrid, was born on April first. When Anne called her family in Belgium they would not believe her at first. They figured that it was an April fool's story.

Before the end of our internship we had a week vacation. We borrowed a car from one of the other interns and explored the surroundings of Schenectady. We drove to the Niagara Falls and carried our little Ingrid with us everywhere we went; restaurants, musea and even movie theaters.

Our trip back to Belgium was by ship and we had a bit of amusing interaction with some American students going to Belgium. At that time it was rather common for prospective medical students who had not been accepted in an American medical school, to go to Europe for their studies. On the ship were several such students whom we befriended. Two of them showed us one of their suit cases which to our amusement were filled with toilet paper. They explained to us that their mother had wanted them to take this along, as they had heard that toilet paper in post-war Belgium was scarce. Remember this was 1958 and 14 years after the end of the war. Of course we were able to reassure them that they were not going to run out of this item, even though during the war itself toilet paper

was indeed scarce. I remember well that as a ten year old boy growing up during the war in Belgium with four sisters, I was the one that had to fold and cut old newspapers in neat squares to be used as a replacement. There are many such stories from the Nazi occupation era of Belgium to be told, but that is beyond the scope of this book.

Our one year in the US was a great experience. We learned a lot about the "American way" and about American medicine as well and liked it enough so that we wanted to come back. But first we needed to return to Belgium to complete the additional three months of internship prior to actually graduating and receiving the MD degree, the condition imposed by the dean of the medical school in Louvain for allowing us to complete the US internship**.**

CHAPTER THREE: OFF THE BEATEN PATH IN AFRICA

At the time I graduated in 1958, Belgium still had a compulsory military service of 18 months. However, I had no desire to join the army. First of all, the Belgian government paid the conscripts barely enough to buy a pack of cigarettes a day; I did not smoke and needed more money than that to support Anne and our daughter. Secondly, from all I knew about a doctor's service in the army, it was boring and I wanted some more excitement. There was a way out though and that was to sign up for three years of duty as a civilian with the Belgian Colonial Health Service. The former Belgian Congo was at that time a Colony of Belgium in Central Africa and was maintaining and staffing a number of health care facilities around that vast country. After making sure that Anne was up to it and ready to travel far to an unknown place in the developing world with a ten month old baby, I signed up for a tour of duty there. But first I needed to complete a required four month course in tropical medicine at the then famous Tropical Institute in Antwerp. There I learned all about malaria, sleeping sickness, leprosy, and many other mean and ugly insects, worms, and parasites and their related diseases. Then we were ready to start our tropical adventure.

Anne and I and our daughter, Ingrid, boarded a Belgian motor ship in Antwerp and sailed to Lobito, a harbor on the Atlantic Ocean in Angola. We had a stopover in Tenerife in the Canary Islands and the entire trip took about two weeks. In Lobito we boarded a train to take us through Angola into the Belgian Congo to Albertville, which is now called Kalemie, a town on the western shore of Lake Tanganyika. We were on that train for several days. The train was pulled by a wood fired steam engine and we stopped every few hundred kilometers to load up on wood. The nasty aspect about that wood-fired engine was that the red hot cinders from the burning wood would blow out of the chimney and drop down on the train behind. There was a flat bed wagon right behind the engine, where the autos that the train transported were located. You can imagine that many of these autos were completely pockmarked with cinder burns on arrival at destination. We also often wondered why there were not more forest fires along the route of the train, as we traveled through dense forests and grass plains.

Anne was bottle feeding our daughter with powdered milk that was dissolved in water. Of course one could not trust the water on the train and she would prepare the milk with bottled soda water (the only bottled water available). We would take turns shaking the opened bottle to get rid of the bubbles before feeding it to the baby, who never turned a hair.

After three nights on the train we arrived in Albertville, and boarded an airplane to fly us north to Bukavu the capital of the Kivu province. Bukavu is situated on the south eastern shores of beautiful Lake Kivu, at an elevation of about 1500 meter or more than 5000 feet. Its climate is temperate, with mostly warm days and cool nights. It was then really a rather beautiful and peaceful city. But after the genocide in neighboring Rwanda in 1994, Bukavu and its surroundings became a center for Hutu refugees and witnessed fierce and nasty fighting. In 2004 the city fell to the Rwanda backed rebels and was the scene of indescribable atrocities and rape. I have no idea what the current status is of this once beautiful city, but from the reports in the press it seems that its infrastructure is in dire

straits. A recent book by the British author Tim Butcher, called *Blood River. A Journey to Africa's Broken Hear*t gives an account of his epic travel along the Congo River in 2004. He retraced the exploration by Henry Stanley of the Congo River from its origin to the sea more than a century ago. In his book, Tim Butcher describes the heartbreaking decay and collapse not only of all infra-structure, but also of human communication and interaction in this once beautiful and prosperous region of Africa. The book is well worth reading.

I was scheduled to be in Bukavu for six weeks to get an orientation to the job that was awaiting me in Shabunda, a village in the middle of the jungle, west of Bukavu. At the hospital in Bukavu I shadowed the doctors there and went with them to outlying clinics. I saw cases which I had heard off and learned about in my tropical medicine course, but had never seen firsthand. I learned the practical aspects of treating these cases and about the medications that were available. I was also indoctrinated in the running of a rural hospital and was shown how to order medicine and equipment, how to write monthly reports, and how to interact with the local administration, the hospital staff, and the natives in the village.

When we were ready to go to our hospital in Shabunda, I purchased a second hand Ford Taunus. I was to drive by car with our belongings over the Kimbili Mountains down into the Maniema area where Shabunda is located. This was going to be a full day drive over rugged mountainous terrain and unpaved, often muddy and winding roads. The head of the medical service for that territory felt that it was unsafe for my pregnant wife and our baby daughter to go along in the car and arranged for her to fly there by small plane. On the day of our departure I drove both of them to the local airport where they boarded a small two seater airplane. There was barely room in the jump seat for Anne and the baby. The steering yoke pushed into her protruding pregnant stomach especially on takeoff and while climbing. After seeing them off, I began my trip to Shabunda by car. I had a rather uneventful drive and expected to find Anne with Ingrid already in Shabunda, awaiting my arrival. When I arrived in the late afternoon, I asked where she was. The local authorities were surprised however that I had a family. They had expected their new doctor to be single. Something apparently was missed in the communication. After some back and forth telegrams (no direct phone connection at that time), we found that Anne and Ingrid were sound and safe back in Bukavu. Here is what happened:

The small plane with Anne, Ingrid, and the pilot took off from Bukavu. After about two hours of flying the pilot turned to Anne and said:"I have never been to Shabunda, but I know that I am supposed to follow this brown looking river below us, till it meets up with a blue looking river. At that confluence I am supposed to make a sharp turn towards Shabunda. But I cannot find this confluence and if I keep looking too long I am going to run out of gas. We are turning back." They ended up back in Bukavu. Arrangements were then made for her to fly commercially to Kindu, a larger town north of Shabunda, where I would pick her up by car. This was several hours driving on unpaved roads. The next day we were reunited and were assigned a house close to the hospital. There were five families and a few bachelors, all Belgian, living in similar houses spread throughout the post, which was located a short distance from the actual village.

I started work right away and met all the Belgian administrative people of the village and the medical personnel in the hospital. The hospital was rather primitive, serving a large

area. It had close to one hundred beds in various divisions. One doctor was in charge (soon to be me). There was one Belgian nurse and the rest of the staff was the equivalent of health aides. As I soon found out these health aides were competent and able to deal with the usual cases of malaria, pneumonia, malnutrition, parasitic infestations, diarrhea, and minor trauma. Assisting the medical doctor was a Belgian "Agent Sanitaire" which translates in English into Health Agent. Many of these professionals were employed throughout the Congolese health care system. They were specially trained for these positions. Our "Agent Sanitaire," his first name was Freddy, was truly god sent as he was able to handle a million large and small tasks in the hospital, besides taking care of sick people. He would literally keep the hospital running, by making sure that the native employees were working on schedule, wages were paid on time, the pharmacy was stocked at all times, the generator was running, instruments were in working order, the X ray machine was running, clinics scheduled and a lot more. As he had been at the post for some time before I arrived he was also instrumental in getting me oriented and staying on the right track on this new and, for me, somewhat daunting job, fresh out of training. Needless to say, he and I became close friends.

After my first few days in the hospital and village, I learned that a rumor had made the rounds that the new doctor is "muganga mtoto kabissa," meaning: "The new doctor looks like a child." I was then, at age 25, very young looking indeed. During my internship, patients would often respond when they first saw me with "Are you a doctor?" or "I would really like to see the doctor."

In the Belgian Colonial system, like in many other administrations of that era, the efficiency was such that by the time a replacement doctor arrived, the doctor to be replaced was already gone for several weeks. Of course that did not allow for good continuity. I was lucky, as the doctor I was to replace, was scheduled to remain with me for several more months. It is likely that the administration in Bukavu had decided that the new doctor for the hospital (me) was too inexperienced to strike out on his own right away. This was good decision indeed and certainly good for me as the reader will see later.

However, when I arrived, the doctor had been on vacation and was planning to return in a couple of weeks. Thus the hospital had been without a doctor for a while. Soon after arriving in Shabunda I asked the health aides if there were any urgent or difficult cases for me to see. Their response was that everything was under control; except for one case of a rather elderly man who was admitted with what they thought was an amoebic abscess of the liver. An amoeba is an intestinal parasite that can lodge in the liver and cause an abscess. I went to see the patient right away. He looked rather moribund and had a large swelling in the right side of his abdomen. I had never seen an amoebic liver abscess, but knew about it from my course in tropical medicine. The patient had already received the usual medication to kill the parasites in his body, but I knew that the abscess needed to be drained. I had the health aide explain this to his "entourage." I say entourage, because patients in this area, and in other developing areas in the world, often come to the hospital after traveling, sometimes walking, for long distances. If they are very sick they may need to be carried and frequently they would come with their entire family and even with many villagers. This particular man had about twenty people around him. So he was placed on a gurney and wheeled to the operating room followed

by a procession of his family and friends. They all sat down silently and solemnly on the floor outside the operating room.

Inside a male health aide was getting the patient ready on the operating table, while I was scrubbing my hands. I was still doing this when the health aide came over and told me not to bother as the patient seemed to have expired. Indeed he had, and was beyond resuscitation. We needed to go outside and tell his family and friends. As I did not speak any Murega, one of the local languages, I asked the health aide to do the talking by my side. The twenty or so people who had accompanied this man were still sitting solemnly and silently on the floor outside the operating room. I did not understand what was being said, but after about the second sentence this entire group of people that had been so subdued till just before, jumped up shouting and crying, beating their chests and some even their heads against the wall. To me this was a most frightening scene as I was sure that they thought that I had killed their friend, father, or husband. I was also sure that, from the way it looked, they were going to come after me. My cowardly reaction was to run back in the operating room, jump out of the back window and drive home to tell my wife: ”Let’s get out of here, they are going to kill me.” This demonstration outside the operating room had been very frightening to me, but I quickly realized that in fact it was a normal cultural reaction. I did witness similar reactions several times since, not only in the Belgian Congo but also in several other countries where I have worked.

After about two weeks working alone, the doctor whom I was eventually going to replace, returned from his vacation and we worked together for about two months. I was lucky in that regard because he was a board certified and accomplished surgeon and his fame was wide spread in the area. Many surgical patients came from long distances to be operated by him. Some had to walk or be carried from their village in the bush, along dirt roads for days to arrive in the hospital. I assisted him in the operating room almost daily and progressively he gave me more and more responsibility. That helped a great deal to build up my confidence in this new and daunting environment. The hospital was a rather good hospital by Congolese standards but in many ways primitive by contemporary standards. Electricity depended completely on the water levels in the reservoir built up stream by the catholic missionaries and more often than not we were without power. We had a generator but we could only use it sparingly in order to conserve fuel. Many times operations were carried out right next to a window, without the benefit of overhead light and of course no electrical powered instruments, such as suction, electrical coagulation, etc. As we did not have an anesthesiologist most operations were carried out under spinal anesthesia, administered by ourselves, or under local anesthesia and yes, even anesthesia by drop ether or chloroform, neither of which are used anymore these days.

Ectopic pregnancy, or pregnancy in the tube, is a rather common occurrence, especially in areas where infection with a venereal disease is common, such as in this and other areas of Africa, Such infection often lead to damage of the fallopian tube, which then may result in an ectopic pregnancy. If a patient were bleeding inside the abdomen, like for instance from a ruptured ectopic pregnancy, blood transfusion with donor blood was out of the question. In such a case we would have ready on the operating table a sterilized ladle. After quickly stopping the ongoing bleeding, we used the ladle to scoop out the blood from the abdomen and poor it over gauze to filter out the clots. The gauze was stretched over a porcelain bowl, with some citrate solution in the bottom. The citrate

prevented any further clotting of the blood in the porcelain bowl. We would then aspirate the liquid blood in large syringes and inject it directly into the patient's veins. This may seem rather primitive, but it worked. A similar method these days uses a sophisticated machine called a cell saver.

I assisted my colleague in many interesting procedures for such problems as huge groin hernias; large vaginal fistulas in women following prolonged and complicated child birth; enormous enlargement of the penis due to elephantiasis, which is a parasite infestation resulting in a blockage of the lymphatic system; very large goiters, which is an enlargement of the thyroid gland and was common there due to lack of iodine in the food and water. A few months later, when my "mentor" had left for good and patients with these problems kept coming to the hospital I had to deal with these all by myself. It made me appreciate how lucky I was to have been able to work with an accomplished surgeon, before being "thrown to the wolves by myself," so to speak.

Before he left Shabunda he wrote an article about a surgical procedure that he had developed for the correction of elephantiasis of the penis. It was an ingenious procedure involving a full thickness pedicle skin graft from the upper thigh. I assisted him in several such procedures and the outcome was invariable very impressive and very satisfying to the patients who were extremely grateful to have regained the function of their penis. He was a generous man and he made me co-author of the article that was published in a Belgian medical journal (Annales de la Societe Belge de Medicine Tropicale. 34:781, 1959), even though I only assisted him on some of these procedures. This was my first publication of many more to come much later.

A curious custom I needed to get used to was, that any tissue removed from a patient during surgery, such as gallbladder, uterus, amputated limbs, etc. was placed at the end of the day in big basins outside the operating room, for anyone to come and see, no matter how bloody or "disgusting" it might be. By inspecting the removed tissue, the natives were reassured that the treatment of their family member or friend had not involved merely some witchcraft. Much later on, I witnessed a similar practice when I worked in a hospital in a remote area of Mexico among the Mayan people. The difference, however, was that in Mexico, the removed tissue was shown only to the nearest relatives and not to everyone who cared to come and look, as it was in the Congo. In the USA and many other countries, all tissues removed in surgery are sent to a laboratory for microscopic analysis. Such a luxury was not available to us in these remote areas. So after the tissues had been inspected by the family and friends they were destroyed.

We had an old fashioned X-ray machine which we mostly used to diagnose fractures of bones. We needed to fire up our diesel generator to use the machine, as any power coming from the hydroelectric generator of the missionaries was insufficient to run it. Our "Agent Sanitaire" was most helpful with running the machine, keeping the generator in working order and developing the X-ray films. Now days of course, X-ray pictures are digital and do not require a lengthy development in chemicals, followed by drying

The hospital, and also our houses had running cold and even hot water, but not the kind of running water you may think. The way it worked was like this. Outside the buildings there were two large empty oil drums positioned on an elevated platform and connected to a plumbing system inside the building. These drums would be filled every morning.

One had a wood fire under it, which was lit every day to heat the water; the other was for cold water. The way these drums were filled every day is a story by itself.

The village had a prison system and the prisoners would perform many menial jobs, like mowing the grass. This was done by hand with a machete. They would work on the roads (no paved roads) and keep the water tanks in the hospital and the houses filled. Each morning they would make the rounds carrying large containers suspended on a pole and lifted on the shoulders between two people. They would then fill the water drums at each building and tend to the wood fires. The remarkable thing about these prisoners was that even though some of them were hardened and violent criminals, they were housed in a minimum security environment and worked during the day around the village supervised only by unarmed guards. At night they were glad to go back voluntarily to their quarters. The background for such loose security lay in the fact that the vast territory of the Belgian Congo was inhabited by many different tribes. Criminals arrested and convicted in one part of the Congo and belonging to one tribe, would be sent to live out their prison term in another part of the country inhabited by another tribe. As these tribes were often hostile to each other an inmate in a prison far removed from his own tribe would think twice before trying to escape and having to travel into and through a hostile environment. At best they would risk being turned in and at worst they might not survive. I have no idea if this prison system still works in this now independent country.

As electricity was scarce we had to improvise often. One example was the care of premature babies. We did not have incubators and yet these small infants needed to be kept warm. We used a large fish tank with a smaller one inside. We would poor warm water between the two tanks and an aide would then sit next to this “incubator” with a thermometer. She would keep the temperature at predetermined level by pouring more warm water in the space between the tanks. The water was heated in a kettle on a wood fire outside.

The hospital did not have a kitchen and there was no need for one. Patients would come to the hospital with family and friends who would cook for them outside in the hospital compound. Within the hospital compound there were a series of huts to house the patients from remote villages who were not acutely ill but needed to be close by. These huts were for women awaiting delivery, men or women awaiting surgery, or recovering from surgery and for those patients needing prolonged outpatient treatment. The patients themselves or their family and friends could cook their meals or do their laundry there.

To check if a woman was pregnant we used a rather ancient method as the modern pregnancy test had not been developed yet. The test utilized male frogs of the species Xenopus Laevis. These frogs were ubiquitous in the woods around the hospital. If we needed to do a pregnancy test we would send out one of the workers to trap some male frogs. We would then inject a small amount of the patient’s urine into the dorsal lymph sac of the frog, which was easy to do, and then a few hours later with a medicine dropper collect some urine from the “cloaca,” which is the common posterior excretory opening of birds, reptiles, and amphibians, also called the vent, and examine it under the microscope. If the woman was indeed pregnant she would be secreting a pregnancy hormone, called Human Chorionic Gonadotropin (HCG) in her urine. That hormone was similar to a frog hormone that causes sperm to be released in the urine of the male frog. Thus, if the test on the woman’s urine was positive, there would be sperm seen in that

urine sample. This is certainly not a very rapid, sensitive or quantitative test, but it was simple and it worked for us. The male frog could then be released or kept to be used again sometime later. We usually kept a few of them in a small glass cage and before using them we checked their urine of course to make sure that there was no sperm prior to injecting them with the woman's urine. The excretion of this HCG in a pregnant woman's urine is the basis also for the modern pregnancy test, using immunoassays. This test now, is of course much more rapid, precise, and sensitive and can be carried out quantitatively to follow an early pregnancy over time.

We had no possibility of evacuating a patient who needed more expert care to a larger facility. Any patient arriving in our facility was "ours" and was taken care of, to the best of our abilities. This resulted in me doing some procedures that I did not really feel qualified for, but that had to be done as there was no one else to do them and there was no possibility to send the patient elsewhere. I could not even call a colleague in another town to obtain a consultation or advice. I did a lot of reading in the many textbooks which I had brought with me, and even did some surgery with an open anatomy book on a stand next to the operating table. Some of the procedures I ended up performing, included a thyroidectomy under local anesthesia for an enormous goiter; an incarcerated inguinal hernias with partial bowel resection; suturing of a ruptured Achilles tendon; stabilizing bone fractures with screws; amputation of gangrenous limbs.

Vesico-vaginal fistulas are a common occurrence in Africa and other places in the world, where women have no or little medical help available during childbirth. They often will have their labor and delivery in a remote village, attended only by family or an unskilled birth attendant. If a labor does not progress well, a woman may be in labor and pushing for many hours without progress and sometimes even resulting in the baby's death. As a result of this prolonged pressure of the baby's head on the pelvis and the compression of the bladder wall between the bony pelvis and the head of the infant, the bladder wall can be deprived of blood supply for extended periods of time. This may result in extensive avascular necrosis and sloughing of part of the bladder and vaginal wall, creating an opening between the bladder and the vagina that will not heal spontaneously. These poor women are often young and will leak urine continuously. As a result they will have great difficulty with body hygiene and body odor and tend to become complete outcasts from their community. Nowadays these women can undergo a sometimes difficult surgical procedure to close the defect. There are now several centers in African countries specializing in this kind of surgery. But during my time in the Congo such specialized centers did not exist yet and even if they did exist, a referral was not possible. I certainly was not qualified to do these more complicated procedures. Sometimes the best thing to do for these poor women under the circumstances was to perform an operation whereby the ureters, small tubes that carry the urine from the kidneys to the bladder, are disconnected from the urinary bladder and then re-implanted in the sigmoid colon. I had been thought by my surgeon mentor to do this procedure, which is relatively easy, but carries with it a risk of urinary tract infection at a later time. Following the procedure the patients would be dry, but would have relatively frequent loose stools as long as they still had good anal sphincter control. No wonder that these women were extremely grateful and appreciative, even though I did not carry out the best possible procedure, which would have been a difficult repair.

In any case, while I often felt way over my head, I had almost no serious complication and only one surgical death and had the satisfaction that I was able to help these people. The surgical death occurred following a C-Section done under spinal anesthesia. The procedure itself went well, but several hours later the patient developed symptoms that I thought were due to intra abdominal bleeding. An abdominal tap yielded non clotting blood and I thought that I had no choice but to re-operate, find the source of bleeding, and stop it. A second spinal anesthesia was necessary. Upon reopening the abdomen and after a thorough exploration we did not find a major source of bleeding and closed the abdomen again. The patient developed an infection in the spinal canal, probably from the second spinal anesthesia and succumbed several days later.

I can think of a number of memorable events during our stay there. Some of these events may seem hilarious now, but they seemed rather serious at the time. One such occasion was when the native village police chief came to see me requesting that I have the body of a deceased man exhumed and perform an autopsy. The man had died some weeks before and a complaint had been lodged with the police department, claiming that the man had not died from natural causes. Hence the request for an autopsy. I was not too keen on complying with that request because I had never even done an autopsy, although during my training I had witnessed several. Also, the prospect of working on a several week old corpse in a tropical climate was far from appealing; I thought that I might escape by going to the Belgian "chef de poste." I was hoping that he would override the request by his chief of police. However he told me: "Wim, you have to comply with his request. It is the law. However, I will give you some advice. It is also within the law that you may request the chief of police to be present during the entire process of exhumation and autopsy and I can guarantee that you will never receive another similar request." I followed his advice, had the body dug up, and I performed the autopsy as best I could. And indeed over the duration of my term there, I was never asked to do another autopsy. As it turned out this one and only autopsy of my career was useful for the police as I discovered definite evidence of foul play in the form of a probably fatal stab wound to the chest.

Soft tissue infections and abscesses were rather common in this tropical climate, but at one time there seemed to be virtual epidemic of abscesses on the buttocks or upper arms. It seemed that patients with these abscesses were all coming from one area of the territory. That seemed rather odd and we started investigating. By way of background let me say that the hospital was also serving several outlying clinics or dispensaries in the territory. Health aides were assigned to a specific dispensary on a periodic basis. Patients would know his schedule and come to the dispensary for their treatments. Now this was the era of "penicillin." As the reader may know, penicillin was discovered in 1928 by Ian Fleming for which he shared the Nobel Prize in Physiology and Medicine in 1945 with Howard Walter Florey and Ernst Boris Chain. The natives were convinced that this wonder drug would cure all their ailments from malaria and dysentery, to headaches, infertility, and impotence. You name it and penicillin was thought to be the cure-all. No wonder they would like to get an injection of penicillin. As our investigation demonstrated, the particular health aide assigned to the dispensary from where most of the abscesses came, would swipe a vial of penicillin and a bottle of saline (physiologic salt solution) from the hospital's pharmacy on his way out to his assigned dispensary. When he arrived at his dispensary there was usually already a long line of patients

waiting with various ailments. He would get out his vial of the “magic” penicillin, show the label to the patients and pour it in the liter bottle of saline; shake it up and then proceed to give anyone, who paid five Belgian Francs (at that time equivalent to 10 US cents), which he pocketed, an injection of the penicillin, now much diluted in the large bottle of physiologic solution. To make matters worse, he used only one syringe and one needle. No wonder there were so many abscesses in the area of injection. Of course we quickly put a stop to that.

The Agent Sanitaire and I frequently made unannounced visits to the various wards to make sure that all established procedures were being followed and that the patients were well taken care of. We made these rounds during the day, but at one time we had received an anonymous suggestion that we should make evening rounds as well. That we did, and upon coming to the women’s ward we found to our horror that several of the beds had two occupants. One was the woman patient and the other a man. These “couples” were engaged in various non-medical activities, which I will not describe here. Upon investigation of this rather shocking finding we found how it came about. The village nearby was on a travel road and travelers passing by would often spend the night in the village. The male health aide responsible for the female ward would sell tickets for a price I cannot remember, to eager male travelers. The ticket had a number on it of one of the beds in the woman’s ward. He would select women who were not very ill or were well on the way to recovery. The traveler had then bought himself the right to spend the night with that woman and the woman would not object, as refusal would mean that treatment for her illness might be withheld the next day. No need to elaborate here, but of course this horrible racket was stopped quickly. We could hardly believe that this practice had been going on for some time right under our noses. Of course we felt terrible for these poor women, especially because there was no social worker or counselor available to help them cope with their traumatic experience.

At the domestic level we were doing well indeed. Anne, Ingrid, and I and later our new daughter Elke, lived in a rather nice house close to the hospital. Even though there was sporadic electricity in the village, we mostly worked with Coleman lamps at night. The house itself stayed rather cool in this tropical climate, because it was built with a large veranda all around it, providing excellent air circulation. Most of the houses for the “white” Belgians were constructed that way. We had two male servants (they were called “boys” at that time). Their names were Jean and Sabuni. They were responsible for a number of daily chores including the laundry which was all done by hand. The drying of the laundry was done outside on a clothes line in the sun. There was one problem however. In the tropics there is a fly, called botfly which seemed to be attracted to the color white and likes to lay its eggs on white surfaces, like bed sheets or cloth diapers hanging on a line in the sun. If the eggs would come in contact with human skin they would hatch and the larvae would burrow into the skin where they could cause painful and unsightly abscesses. Thus all the dried laundry had to be ironed to kill these eggs before they could do their awful deed. One of our servants was also in charge of the ironing, and because we did not have electricity most of the time, this was done with a charcoal heated iron. Anne would get rather irritated with him as he would take most of the afternoons to do the ironing which she herself could probably have done in an hour or two. He was moving the iron in a very slow (too slow for her liking) motion, up and down over the surface to be ironed. One day the servant was sick or for some other

reason did not show up. As a result Anne did the ironing herself. She got the charcoal lighted and the iron filled. She was ready to polish off this job in no time. As soon as she started with rapid and brisk motion, as she was used to at home with the usual electric iron, she quickly realized why the servant was moving the iron so slowly. With her rapid motion the cinders of the glowing charcoal flew all over the place, burning holes in the sheet or diaper that she was ironing. After that, of course she lost her irritation with the servant's slow process.

Most Belgian families in Shabunda had three servants. One extra one to do the cooking, but Anne preferred to do most of her own cooking on a gas stove. Jean however would bake the bread in a wood fired oven and from time to time one of the delicious local dishes, called mwambe or moambe. This is the national dish of the Congo. It is made usually as a stew, with chicken simmered in a sauce made from the African palm nuts and made spicy, sometimes too spicy, with pilipili. The correct spelling of pilipili is actually piripiri, but we knew it always as pilipili. It is just a very hot pepper, native to this area. The natives usually eat it by dipping a manioc (cassava) paste into a bowl of this moambe dish, but we usually ate it with rice. It is truly delicious and we developed a real taste for it, and Jean made the best mwambe. Many years later when we would occasionally be able to attend in Belgium the annual reunion of the old timers from Shabunda ("les anciens" we called them), the dinner on the evening of the get together was always a mwambe. Even though it was always excellent and somewhat nostalgic, the mwambe made by Jean in Shabunda was still just a little bit better, a little bit more flavorful, a little bit spicier.

Anne was pregnant with our second child when we came to Shabunda in mid April and at the end of June she delivered our second girl, Elke. The general surgeon was still there and he delivered Anne after a short labor. The delivery was done in a separate building from the main hospital. That building was called "Hopital des Blancs" or hospital for the white people. It was rather small, with only one room and seldom used (thankfully). While Anne stayed in that hospital at night after the delivery, I needed to go home to be with Ingrid, so Anne was all alone, without telephone and no attendant anywhere near. That was a bit of an awkward situation and in retrospect somewhat risky, as one never can anticipate any potential post-partum problems. The delivery went well, but the surgeon needed to perform an episiotomy and when he was ready to suture the cut, there was no suture material at all in the hospital. So he ended up putting in metal skin clips. It worked well and did not cause Anne too much discomfort. The staples were removed after a few days with excellent healing. I have never heard of or seen a reference about the use of skin clips to close an episiotomy. That may have been a first.

Both our servants were really good with the children. Besides, some cooking, laundry, and ironing they would clean, tend to the fire under the hot water drum outside the house, and in general look after the house. Every evening Jean would climb a papaya tree and get us a fresh papaya which he would put in the refrigerator (run on diesel fuel) for breakfast the next morning.

There was a tendency among the natives who were working for a Belgian family to try to imitate some of the things white folks did or wore. I wore glasses and so did Anne. So one day Jean showed up wearing a pair of glasses. We asked him how come his eye sight had deteriorated. He said his eyes were fine and the lenses he had in his glasses were just

plain glass. I used to ride a bicycle around, so one day Jean showed up at the house, walking next to a brand new bicycle. He could not ride it, but at least he had one just like "bwana," which is the Swahili word for boss. We also found out that domestic workers or natives working for the government, hospital or around a village, would often combine part of their weekly salary, so that one of the group could buy a "big ticket" item, such as a watch or bike (like Jean's bike). They gladly gave up part of their wages as they knew that their turn would come so that they then could buy something "big." However, what about providing for their families on the weeks that they put a good part of their salary in the "common pot? We never found the answer to that question.

We had started out by taking oral malaria prophylaxis but stopped after several months because of the side effect, mainly ringing in the ears. We slept under a mosquito net, which neither Anne nor I liked. But it is probably the best protection against malaria, short of the prophylaxis with medication. Both of us however contracted malaria as did our oldest daughter. Fortunately we recovered quickly with treatment and never had another episode. Malaria is of course the number one killer in Africa, especially of young children. Great strides have been made in subsequent years in the prophylaxis and treatment of this deadly, mosquito borne illness.

Most of our food, like rice, flour, potatoes, powdered milk, meat, some fruit, and many other necessities were trucked in from Bukavu the capital of the Kivu Province or from Kindu, another big city in the province. What was locally available was not too attractive to us, except for the chicken used for the mwambe, some fresh fruit, and dried fish which we prepared in a similar way as the mwambe, but with boiled potatoes (also very delicious, but we cannot remember the name of this dish). In the rainy season the dirt roads would turn into mud, which the local people called "potopot." Trucks would sometimes get stuck for days. If that happened we would not have any fresh produce, milk, meat etc. for days. We kept fresh food in a refrigerator powered by diesel fuel. Milk for the baby (my wife was unable to nurse as she had had a serious mastitis in the past) was powdered milk, dissolved in boiled water. Of course all drinking water was boiled and filtered to kill the bad germs that could cause diarrhea or worse.

In the village there were five other Belgian families and a few bachelors. These bachelors were "Agents Agronomes" (Agricultural Agents). They would go for prolonged times out into the bush and work with villagers in remote areas to help them with agriculture. In the vicinity there were also several plantations owned by "colons" as the locals called the colonials. They would grow a number of different crops and import a variety of items from the city. If one needed something, like fabric, soap, sewing supplies, diapers, canned food, etc., one would send in an order to these "colons" and with some luck the items would arrive in reasonable time with the hope that the shipment would not be delayed by the "potopot."

The missionaries had their own compound some distance away and we did not socialize with them much. There were two other physicians in charge of a sanatorium nearby. One of them was Italian and the other Polish. We saw them sporadically at the "cabana". The cabana was really the major social gathering place. There was a small swimming pool to the delight of all the children and a covered area with a bar and some tables, including a ping-pong table. All the Belgians would meet almost every day after work for a drink, a game of cards (like bridge) chess or darts and exchange of "news." That is where we

would also celebrate birthdays, Christmas and New Year and hold any other social activities. There were two brands of local beer, which were pretty good. By local, I mean of course from the Congo and brought in from the "big" city. It came in liter bottles and one was called Simba and the other Primus. Of course there was no TV, only some radio and the daily telegrams coming in from the "city," to keep us informed of any important news.

Besides my work at the hospital itself, I also needed to periodically inspect the various outlying "dispensaires," which would consist of a day trip together with my "agent sanitaire." Typically, we would leave early in the morning by car and return late in the afternoon. While driving along the dirt roads through the rain forest we would hear and see much wildlife. We looked out for monkeys high up in the trees. I cannot remember what kind of monkeys they were, but I do remember that the natives thought that their meat was a delicacy. So, on our trips we took along a .22 long rifle and occasionally on our way to a dispensary we would shoot and kill a monkey and give it to the health aide running the clinic we were going to visit. They really appreciated that. That is the only hunting I have done in my whole life and I did not like it.

Close by, but independent of the hospital, was a Leper Colony. I visited it occasionally and became acquainted first hand with the horrible disfigurement and mutilations these poor people suffer. I had however no direct responsibility for their medical care.

We arrived in the Shabunda in mid-1959 and the natives in this rather remote area of the Central Kivu Province were calm and friendly towards the Belgians, but in other more urban parts of the colony, political trouble was brewing which would eventually lead to the independence from Belgium. That actually occurred in the summer of 1960, a bit over a year after we arrived in Shabunda. While our area remained calm, hostilities broke out in other parts of this vast country and the Belgian government deemed it necessary to recommend that Belgians should leave.

While we were somewhat oblivious to what was happening in other parts of the country and had not felt threatened at all in our area, one day in July of 1960 word came via telegram from the government in Bukavu that all the Belgians needed to evacuate Shabunda. By that time Anne was now pregnant with our third child and was already past her due date. Realizing that there was a pregnant woman in Shabunda ready to have her baby, the government sent a plane to evacuate her. The airstrip in Shabunda was a large grass field which was overgrown most of the time even though the goats had free rein on it. When a telegram came from Bukavu that a plane was on the way to pick up Anne, the airstrip needed to be readied. That meant cutting the overgrown grass in a hurry. So a detachment of prisoners showed up to cut a landing path. They used machetes and worked efficiently so that when the DC 3 plane started circling an hour or so later, the strip was ready. We certainly were not ready. When I had gotten the word while at work in the hospital, I drove home and helped Anne pack (stuff would be a better word) some suitcases and foot lockers with our most precious belongings. When the plane was on the ground the pilot wanted to leave right away, so we ended up leaving most of our belongings behind and drove to the airstrip with whatever we had been able to pack. This was a strange feeling as everything had been so calm and friendly where we were in Shabunda and we could not really grasp the urgency. Later of course we did, as the violence quickly spread to the rest of the country. My intention had been that I would

take Anne to the plane with our two kids and that I would stay behind to take care of the hospital and if necessary join her later by car. I had actually promised this to the hospital staff, as there was no other doctor to take care of the sick. I had been able to say this as neither I nor the other Belgians in Shabunda had felt threatened at all up till then. When I got Anne and the kids and whatever luggage we had in the plane and was ready to say good bye, the pilot ordered the door of the plane shut. When I objected and told him that I was planning to stay behind, he told me in no uncertain terms: "No you are not; you are going with us." The plane took off and flew us to Usumbura in then Ruanda-Urundi, which was at that time a Belgian Protectorate under mandate from the United Nations. That city is now called Bujumbura and is the capital of Burundi.

To this day, I feel that in some ways I betrayed the local Shabunda people as I broke my promise to them, but of course in hindsight that was the right decision as only days later the remainder of the Belgians in Shabunda were ordered to evacuate and left in a convoy of cars in time to avoid the violence that broke out shortly thereafter. I sometimes wonder if that violence might not have reached the area around Shabunda so soon if we Belgians had stayed behind to continue to work with the local people. I always felt that, at least in our little remote place in the Congo, we had a good working relationship with the local people, based on mutual respect. Within the larger picture of the tense situation, this is probably a rather naive feeling on my part as later events in the uprising in that area of Africa have demonstrated.

In Usumbura we went straight to the hospital as Anne was overdue in her third pregnancy and could deliver any moment, even though she was not in labor yet. The Catholic hospital was run by nuns. Anne was seen there by the only obstetrician and she took an immediate dislike to him. He came in to examine her with a cigar in his mouth and dropped ashes right on her bare pregnant belly when he was trying to listen to the baby's heartbeat. A day or two later she went into labor and the nun in charge of the labor room told Anne that it was time for the delivery and that she was going to call the doctor. Anne told the nun: "No you are not. My husband is going to do the delivery" and she told the nun why she did not want the doctor to come in. She understood and I ended up doing the delivery of our third child, our first son. Anne did a great job and went real fast through her labor and delivery. Delivering my own child was an exciting experience and a piece of cake. Not so however for sewing up the episiotomy. At that time episiotomies were still commonly performed but not so much anymore now. I was trying to do a meticulous job and was sewing under local anesthesia. Anne however kept asking me why it was taking so long. "Hurry up….!" That made me nervous but I still did a good job. After the delivery we went back to our room where a nurse's aide was watching the two other children who were 13 and 27 months by then. As it turned out we stayed in that hospital room for over 10 days until Anne and the three children went back to Belgium. There was no room elsewhere in the city because of the influx of the many refugees from the Belgian Congo.

During our stay in the hospital our new baby, Tom, was in the nursery among a fairly large number of newly delivered babies. Many of these were white. The babies were all lying in individual cribs. The cribs were identified with name and birth dates, but the babies themselves were not. They did not have an identifying bracelet like they do nowadays. When it was time for feeding, the native nurse's aides brought the babies to

their respective mothers and after the feeding was over, put them back in their cribs. Hopefully in the right crib. Anne kept worrying whether she received the right baby. She said that African or Asian babies often look much alike to us Europeans. Would not European white babies look alike to an African native nurse's aide? It would be so easy to make a mistake and put a baby, not wearing any identification, back in the wrong crib and thereby inadvertently switch babies. Fortunately that did not seem to have happened.

When we left Shabunda in such a hurry we had to leave most of our belongings behind including our car. There was little or no hope of getting any of these back, except that I managed to contact one of the male nurse's aides in the hospital in Shabunda by telegram and convince him to drive our car to Usumbura, a rather long and tiring trip. I met him in town and he handed the car over to me and I paid his way back by bus to Shabunda, and gave him a decent reward for doing this. I was then able to sell the car in Usumbura.

While I was out and about arranging flights back to Belgium, selling the car and buying some souvenirs, Anne stayed in the room in the hospital with the two toddlers. The room was on the ground floor and had sort of a balcony with a railing and bars and looking out over a grass field surrounded by some woods. One day soon after the delivery and while I was gone, the two little girls decided to go for a walk and wiggled through the balcony bars. Before Anne realized what was happening she saw them trotting off on the grass toward the nearby woods. She panicked as there was no way of knowing what could be awaiting in the woods beyond the hospital confines. The girls would not listen to her calling them back and they kept going. There was no way she could climb over the balcony and go after them and there was no one around to go get them. Fortunately they eventually listened and trotted back.

The Government's plan was to send us back to Belgium. However all planes from Bujumbura to Brussels were booked solid for days to come. So we stayed in our hospital room until some seats opened up on a plane. However it was women and children first, so Anne left for Belgium with the two toddlers and a newborn baby, while I stayed behind to await my turn. This was the late summer of 1960. This deal about "women and children first" was a farce. When Anne got on the plane she was the only woman on board. One would think that the stewardesses would pay some extra attention to a woman with two toddlers and a new born baby and give her some assistance. But no, they were busy serving the men and paid scarcely any attention to her. The plane was a propeller plane and it took more than 12 hours to reach Brussels with a stopover in Athens. On arrival in Brussels, Anne and the kids were met by people from the Red Cross and received as refugees, given cloths, diapers, milk etc., and transported to Antwerp where Anne's family lived.

I followed Anne a week or so later back to Belgium. By that time I had made up my mind that I wanted to specialize in obstetrics and gynecology and definitely wanted to do it in the US. The idea of specializing in O&G, as it is commonly called in the USA, had already occurred to me in medical school and had led to my close contact with the professor in that specialty. That idea became more of a decision while delivering babies and doing C-Sections, hysterectomies, and other related procedures in Shabunda. I like to think that the clincher came from the delivery of my own son in Usumbura. My earlier exposure to American medicine during internship in Schenectady and Anne's and my exposure to the American way of living as well as my lack of closeness to my family in

Europe made it rather natural that we would select the USA to pursue my goals. However, I first needed to pass an exam, called Educational Council for Foreign Medical Graduates (ECFMG), the entry exam for all foreign graduates who wanted to come to the US for post- graduate medical education and medical practice. Now the requirements and examinations for foreign trained doctors or medical students have changed and have become considerably more difficult. This ECFMG exam was a Multiple Choice Question Exam and was held periodically in different countries. American medical graduates are used to this type of multiple choice exams. But for a Belgian medical graduate this was very new. Throughout my entire medical school I had never been exposed to this kind of testing as all our exams were oral during a face to face meeting with the various professors, Thus I needed to study and prepare for this. I also needed a job to make enough money to support my wife and three children.

A solution to these two problems, namely the need for time to study and the need to have an income, came to us rather unexpectedly. A distant relative of Anne was working in Antwerp for a Belgian shipping company, called Agence Maritime Internationale or AMI. I do not know if this company still exists under the same name. This company had regular shipping service to and from the Belgian Congo. Their main base in the Congo was the port of Matadi on the mouth of the Congo River. AMI found itself without a physician in Matadi and was looking for someone temporary. That suited me fine. The job was going to be relatively easy with plenty of free time to study and a relatively decent salary for someone like me, fairly recently out of medical school. Remember that I was not an obstetrician/gynecologist yet and was functioning as a general practitioner. Importantly also, the position was going to be relatively safe as the Belgian army still had a base there to protect Belgian interests during the stormy transition to independence. So we rented an apartment in Antwerp for Anne and the kids and I took off to Matadi by ship (of the AMI of course) for a three to four month's contract. My job was to tend to the seamen on the ships as they arrived in Matadi and look after the harbor workers of the company. I had regular office hours and took care of mostly minor injuries and illnesses and went on board the ships if needed. I had plenty of time to prepare for the upcoming examination for entry in the USA and I also needed to begin to look for a place in the US to enter specialty training.

The process of applications to different hospitals involved choosing various training programs in O&G from a catalogue and listing them in order of preference. Resumes and letters of recommendation needed to be sent (this was of course way before the now common use of the internet) to the various places I selected. The places that one applied to would then also list the various applicants in their order of preference. All this would go to a central pool called the Residency Matching Program. After a lengthy process the candidates would then receive, usually in March or April of a year, notification of what position they were matched to. That was then the position an applicant went to. The problem was at that time that none of the institutions to which I applied would even consider my application until I had received the certificate from the ECFMG that I had passed the exam. Furthermore that certificate would not be forthcoming before the deadline for entering the selection process with the Matching Program. So this was a no win situation. The only thing I could hope for was that after the "match" there would be some unfilled position in a desirable program to begin residency training in July 1961. After I heard the good news in April 1961 that I had received a passing score on the

ECFMG exam, I frantically searched for available positions. One must know that this late in the game the available positions were “leftovers” from the Matching Program. However, I found a hospital in Cleveland Ohio that needed a position filled and they accepted me. And so Anne and I started back on the beaten path.

CHAPTER FOUR: ON THE BEATEN PATH IN THE US

The hospital in Cleveland where I had signed up for my residency in O&G was not our first choice. When I signed the contract, while still in Belgium, I was promised that the training program would be approved for three years by the American College of Obstetricians and Gynecologists (ACOG). Soon after my arrival there, it was clear that the program was not approved and probably never would be. Therefore I ended up staying only 10 months instead of the contractual 12 months and left by May 1961. Of all the places we have been over all the years up till now, Cleveland was probably the only place we did not like at all. In any case, we ended up in the early summer of 1961 in Miami, Florida at Jackson Memorial Hospital, the teaching Hospital of the University of Miami, where I started a formal three year residency in O&G. The drive from Cleveland to Miami was rather uneventful but somewhat stressful. Anne was seven months pregnant with our fourth child, Ingrid was just four, and Elke and Tom not yet three and two. We were all packed in our station wagon and took several days to drive down. We had shipped most our sparse belongings separately. In Miami I was back on the traditional "beaten path," doing what residents did. I was going to use the wording "… what residents do…" but that has changed so much since I was a resident that it is appropriate to use the past tense here. I was working hard with hardly enough pay to keep the family fed. In addition our fourth baby was on the way. Frank our fourth child was born at Jackson memorial Hospital in July of 1962. My income then was US $ 220.00 per month and our rent was $ 107.00. One can imagine that we had a hard time getting by.

The nurses on the Labor and Delivery ward were aware of the financial hardship of the residents and would often save the untouched food trays of the laboring patients for us. What woman in active labor would want to eat anyway? Thanks to these thoughtful nurses we did not have to go down to the cafeteria and pay for our food.

Many of my fellow residents did some moonlighting by working in other small hospitals during some of their time off from the residency. With a schedule of usually 36 hours on and 12 hours off there was not a lot of free time. Thus I decided not to moonlight. If I had done that, I would not have seen my family at all. So we scraped by as best as we could. Remember, this was more than 50 years ago, so one cannot compare this to modern standards, which are quite different. In order to supplement our income something came our way unexpectedly. I will tell this story later, even though what I did might have gotten us in some trouble at the time.

There are many stories to be told about these memorable years of training as future obstetrician/gynecologists. Some are medical, others are more social. The first one occurred in fact before the actual start of my residency in Miami. I had come to the University of Miami for an interview prior to accepting a position there. The chief resident was giving me a tour of the hospital when he was called to the operating room to assist a junior resident with a Cesarean Section. Rather than abandoning me for a while he invited me to come with him and watch. What I ended up watching was rather dramatic. When the chief resident arrived in the OR with me in tow, the patient was already on the table and all prepared and draped ready to start the operation. The junior resident gave his senior resident a brief account of the patient's history, which boiled

down to the fact that the patient had been in the second stage of labor for a prolonged period of time and had failed to make progress. The senior resident agreed that a C Section was indicated and they proceeded with the surgery. Rather than the usual rapid incision of the skin, exposure of the lower part of the uterus and incision of the uterine muscle, followed by delivery of the baby's head, there was a brief delay after the skin incision. Then there was a rapid verbal interaction between the two residents followed by a somewhat frantic instruction to the personnel in the OR to remove all the drapes and put the patient's legs up. It was immediately obvious that the baby's head was about to be delivered the natural way. And so it did with a screaming and healthy baby making it into the world. Of course after the vaginal delivery the skin incision still needed to be closed. This was a great learning experience for me. Since then I have made it a rule for myself and other residents under my supervision, to always do a last vaginal exam on a patient, just prior to beginning the C Section for failure to progress in labor. This way, one can be assured that a C Section was still necessary and that there had been no significant progress towards a vaginal delivery, from the time that the decision for an operative delivery was made and the actual time that the patient was on the operating table ready for the surgery. Indeed in rare situations there might have been enough progress towards normal vaginal delivery during that time interval, especially if that interval is somewhat prolonged for one reason or another.

I also remember one day when I was on call as the junior resident in charge of the labor ward when I was urgently called to a patient's room because of a "prolapsed cord," This is a situation where the umbilical cord of the baby protrudes first and is compressed by the fetal head. If this pressure is not relieved within minutes the baby will die. This emergency situation requires the doctor or nurse to place a hand in the vagina and push the head up so that the umbilical cord will no longer be compressed, while preparations are made for an immediate C-Section. After rushing to the patient's room I knelt on the bed, pushed the head up and away from the umbilical cord and directed the nurse to notify the chief resident and the operating room that we were on our way for an emergency C-Section. Just as we were rolling the bed out of the room, I heard the intern working with me yell from the admitting room, where he was examining a newly arrived patient, "prolapsed cord!" While we were rolling down the hall on our way to the operating room, with me kneeling on the bed and my fingers in the patient's vagina, I shouted instructions to the intern to push the head of the baby up, call another resident for help and notify the operating room that a second prolapsed cord was coming for an emergency C-Section. As it turned out, both C-Sections were done almost simultaneously in adjacent rooms and both babies survived. That was an on call shift to remember.

Another night later in my training, when I was already senior resident, I was called to help one of the other residents doing an emergency abdominal hysterectomy on a woman with a ruptured tubo-ovarian abscess. That is a serious infection of the fallopian tube and ovary which, if left untreated surgically, carries a high mortality. When the procedure was nearly finished, I was examining on a side table the specimen that had been removed. In the process of doing that I inadvertently nicked my hand with a scalpel. The wound in my hand was minor but I had penetrated the skin with a knife that was covered in purulent material from the abscess. As it turned out, the patient was a prostitute and a drug addict, therefore likely to carry some bad infections such as syphilis, gonorrhea, or hepatitis. AIDS was not yet known at that time. I could have been infected with one or

more of these bad germs. Hence a series of tests were done on the patient and me as well and, thank God, they were all negative. But it was a scary few days awaiting the test results.

Early in my residency, I realized that the more senior and experienced nurses in the hospital were an invaluable source of practical knowledge, and by having an open mind and listening to their suggestions, one could often make the right decision. I noticed that some of my fellow residents did not have that willingness to accept advice from "nurses" and they often did not fare as well. On a philosophical note, taking care of sick people requires team work and humility.

When we were on call at night we were assigned a room in an old two story building hidden and surrounded by more modern and taller hospital buildings. That old building was in fact the very first building when Miami City Hospital moved to its new location in 1918. It was called the Alamo, because it's structure somewhat resembled the more famous Alamo in Texas. Later the hospital was named the Jackson Memorial Hospital and over the years, many new buildings were added around it. When in the late sixties, early seventies, major hospital expansion was needed, the old Alamo building was slated for demolition to make room for new, more modern structures. Thanks to the efforts of conservation minded citizens that plan was scrapped and the building was moved and restored to a new location only a few hundred yards away. It now stands as a prominent and beautiful landmark in the middle of the medical campus in front of modern Jackson Memorial Hospital. In December of 1979 the building was added to the National Registry of Historic Places. I am very proud to have spent many, mostly sleepless nights in that building.

The workload of a first or second year resident in O&G included the performance of the circumcisions requested by the parents of the baby boys delivered the day before. Every morning, after making ward rounds the resident assigned to that floor ended up in the newborn nursery. The nurses lined up the babies in need of circumcision. Sometimes there were none, sometimes one, sometimes three or four. Jackson Memorial was a busy hospital with at one time more than 10.000 deliveries a year and circumcision was often requested at that time, much more so than now. Because there were so many, we became skilled in doing them. No need to describe the details of the procedure here, but at the end, we were left with a piece of foreskin that was discarded appropriately. As it happened at that time there was a graduate student in biochemistry at the University of Miami who was doing his thesis research on the effect of testosterone, the male hormone, on sexually receptive tissue. Foreskin is of course one such tissue and the graduate student knew that the foreskin removed at the time of circumcision was being discarded. This tissue would be useful to him for his research. He asked us residents in obstetrics if we would be so kind to save the tissue for his research. The only thing we needed to do instead of disposing of the tissue is to place it in a test tube and store it in the freezer in the nursery. He would then periodically pick up the rack with tubes. Of course we got him a few, but in a busy resident's schedule it was easy to "forget" to do this, as it required a few extra steps. The graduate student did not nearly receive as many specimens as he had hoped for and needed. He decided that there was enough money in his research grant to actually pay the resident for the collection of the tissue. He promised to pay us $ 5.00 per foreskin that we saved for him. Of course that got our attention right

away. Five dollar multiplied by maybe 10 or 15 circumcisions a week amounted to almost doubling our monthly salary. That was great news and I can assure you that not a single circumcision specimen was disposed of. They all ended up in the freezer in their little test tube. The graduate student came by once a week or so to collect his tubes and gave us our money. Soon however we realized that these little pieces of foreskin, when frozen in the test tube, appeared to shrivel down considerably. We figured out that if we cut the piece of foreskin in half and put it in two test tubes instead of one, no one would notice and we would get paid double. Now that may sound dishonest, and I admit that in some ways it was, but it did not mess up the graduate student's research, as he would take all the test tubes from one week to the laboratory, put them all together and make a homogenate (mixture) of all of them to do his studies. What it did, was to make it possible for us residents and our families to eat something other than ground meat, or chicken necks and backs.

One frightening experience at Jackson Memorial Hospital occurred during my second or third year of residency. I was called to the emergency room to see a patient with an obvious ruptured ectopic pregnancy. When I examined her it was clear that she had a belly full of blood from the internal rupture. Indeed, she was approaching a state of hemorrhagic shock. She needed urgent surgery. The operating room and the anesthesiologist were alerted that we were on our way with the patient, while a blood transfusion had already been started. The patient had to be wheeled on a stretcher down a long corridor to the elevator. Someone was holding the elevator door open and as soon as we got in we pushed the button for the third floor, where the operating rooms were located. When the elevator stopped, the door did not open and we realized that the patient, an orderly and I were trapped. We activated the alarm and luckily someone was able to open the doors, only to realize that the elevator had stopped short of the third floor and that there was an opening of three or four feet between the roof of the elevator cab and the third floor. We were able to lift the stretcher with the patient above our heads and slide it through the opening to the floor, where she was immediately brought to surgery. The patient ended up doing well, but it was a tense situation for a while. The orderly and I remained in the elevator until technicians were able to get it moving again and let us out.

These three years as resident in Miami were memorable. I learned a lot about pregnancy and its complications, about delivering babies, and about gynecologic problems. I spent a lot of time in the operating room and became skilled in the usual gynecologic operations. Our chairman was a real task master. He would hold ward rounds on Saturday mornings and even on Sunday noon time. Everyone was expected to attend even if it was a day off. Anyone not there better had a good reason to be absent! Also, the chief resident on duty was supposed to call the chairman every evening at 10 P.M. to give him a report, even if there was nothing going on. If we were busy with sick patients or working in the operating room and unable to call at 10 pm, we would not want to wake him up by calling at 11 or midnight when we were free. But we knew we would be called on the carpet the next morning and asked to explain why we did not call. Any unusual case or event had to be presented to him in addition to the attending on call. It was a stressful time, but learning we did. What I remember the most from this time is the chairman's philosophy of medical practice. Stated simply, it goes like this. "It is all right to make a mistake by error of judgment, but it is not all right to make a mistake by omission." Let

me try to illustrate this with a hypothetical example.

A resident is called at two o'clock in the morning by the nurse in the emergency room about a patient who is pregnant, has pain and is bleeding. The resident gets up and goes down to the emergency room. After the interview and examination of the patient, and after discussion with the senior resident an ectopic pregnancy is ruled out. A decision is made that the patient has nothing serious going on and sent home, with the instruction to return if her bleeding and/or pain continues or increases. It should be remembered that ultrasound and precise quantitative pregnancy tests had not yet been developed and one had to rely heavily on clinical signs and findings at the time of examination. If, however, this patient comes back later with worsening complaints and turns out to have an ectopic pregnancy anyway, an error of judgment was made and a lesson was learned. The resident would have been called by the chairman to explain the case but would never have been scolded. With a similar scenario, the nurse calls the resident, who does not get up and go down to examine the patient, but over the phone tells the nurse: "tell the patient to go home and rest and give her some pain medication." The next day the patient comes back with an ectopic pregnancy. Again the resident would be called by the chairman to explain, but this time he or she would get a dressing down he or she would not easily forget, because an error by omission was made. This philosophy has stuck by me for the rest of my career and I wish that every doctor would be exposed to that philosophy early in his or her career.

Almost three years of residency passed by quickly, and I was ready to decide what to do at the end of my training: Should we go back to Europe or stay in the US? We had come to appreciate the USA, which seemed to offer many more opportunities and freedom to do what one likes, and we decided quickly that we were going to stay in America. The first decision we needed to make then was to either go into private practice or stay in academic medicine. Anne and I opted for academics but first I wanted to have some subspecialty training. I picked reproductive endocrinology and infertility and joined the Endocrine Laboratory at the University of Miami to do two years of research. Initially, I did research on cow ovaries. To get these ovaries we would periodically go to the local slaughterhouse and collect what we could get. Later, I switched to rabbits and rats. Our rabbits would be treated for several days with hormone injections to prepare their ovaries for our experiments. We would then anesthetize them and remove their ovaries. I remember one day one of the rabbits stopped breathing while being anesthetized. Those were valuable animals as they had received expensive hormone injections and if she died our experiment for that day would be ruined. So my immediate reaction was to try to get the animal to breathe again by doing mouth to mouth resuscitation. And it worked. Our experiment and the rabbit were saved. Of course I was teased quite a bit by my colleagues. Not too many people have done CPR on a rabbit.

Doctor Savard, the director of the laboratory where I did my research during that time, had previously worked for a large pharmaceutical company that had been involved in the development and marketing of one of the first oral contraceptive pills. While the company and its headquarters were located on the US west coast, they had a factory in the Bahamas. The basic material for the steroid hormones in the birth control pills came from a yam harvested in Mexico. These yams were then transported to a factory in the Bahamas, where the yams were processed for the extraction of the female steroids.

Something seemed to have gone wrong as there had been demonstrations and petitions by the wives of the factory workers. The basis for the complaints by these women was that a number of their husbands had developed gynecomastia (a development and enlargement of the breasts in males) and on top of that had become impotent. This of course worried the direction of the company and they wanted to investigate. As the director of our laboratory was close to the Bahamas they asked him to go there, visit the factory and report back to the headquarters. He accepted, but as he was a scientist with a PhD degree he wanted a clinician to go with him to examine the affected men.

So it happened that he and I flew to the Bahamas on a weekend. Very soon into the guided tour of the factory, it became obvious to both of us what the cause of the problem was. The yam extract was dried on big trays in an oven and when dry, the trays were dumped in large vats for transport to the main factory on the US west coast, Most of the powder of course ended up in the vats, but a large cloud of fine powder was generated that settled everywhere including on the workers that handled the trays. Provisions had been made to prevent this to happen by the installation of large fans over the work area. These fans were designed to suck away the excess powder. They had however been turned off as they blew the excess powder into the atmosphere, thereby creating a potential environmental hazard in the surroundings of the factory. The workers wore a protective suit, hat, gloves and masks covering their entire body. As it was very hot in the factory and there was no air conditioning the workers were perspiring heavily. The sweat from their foreheads and faces would slowly seep into their masks and thus into their mouths as well. They ended up swallowing every day small quantities of this powder containing hormones, including female hormones. Over the months and years this became accumulative, hence their symptoms of gynecomastia and impotence.

Following our tour of the factory and our realization about the root cause of the problem, Doctor Savard continued the inspection of the facility and its records, while I proceeded to examine the dozen or so men that had been affected. This examination included a detailed history taking, measurement and photography of the breasts, and measurement of the testicles with a caliper (not bad for gynecologist). When we were done and all observations had been recorded we were ready to leave, but not before taking possession of a dozen or so gallon bottles of urine. As part of our investigation we needed of course to measure the hormone levels in these men and by prior agreement they all had collected 24 hours worth of urine for this purpose. One should be reminded that this was an era before the very sensitive and accurate hormone measurements by radio-immuno assay allowing hormone determinations in small blood samples. The only way at that time to obtain these measurements was by analysis of a 24 hour urine sample which was available in the laboratory of Dr. Savard.

So he and I left by plane to Miami with our dozen gallon bottles. Arriving at customs at the airport in Miami with a number of plastic bottles filled with liquid which we declared as urine raised some eyebrows from the agents. Even if we were not lying and indeed the bottles contained urine and not some other illegal substance, it still was a biological material that could not be simply allowed into the country. After considerable discussion and phone calling, we found an infrequently used license to the University of Miami, permitting the importation of certain biological materials for medical and research purposes. Thus we were allowed to leave customs with our bottles.

Doctor Savard and I wrote our separate reports to the company. Weeks later the result of the urine testing was available and was also submitted to the company. As of this date I am completely in the dark about what happened to our reports and what actions were taken, as I never received any further information, either directly from the company or from Doctor Savard, in spite of my repeated inquiries.

During these two years in the laboratory there were times of disappointment when time consuming and costly experiments did not work out as expected. But there were also many times of exhilaration when we discovered something new. I had many publications in scientific journals and oral presentations at national and international conventions, initially as co-author, but later, as I became more independent, as first author. I learned all about the rigors of scientific experimentation. We had many lively discussions about the meaning of the results of our experiments and often stayed late at night to finish experiments, prepare and practice oral presentations of our results, and review manuscripts. Many students and fellows rotated through our laboratory. It was a marvelous time and very rewarding.

At the end of my fellowship in the laboratory the plan was to join the faculty of the Department of O&G at the University of Miami. In fact, the chairman had offered me a job as instructor at a yearly salary of $ 12,000.00. However, during my fellowship the chairman resigned and when the newly appointed chairman offered me a position as assistant professor at almost double that salary we were elated. Thus I joined the faculty there and continued on the beaten path. Before actually joining the faculty, my chairman, Dr.William Little, suggested that I take a three month rotation with a well-known reproductive endocrinologist, Dr Raymond Vande Wiele, at Columbia Presbyterian Medical Center in New York. My two years spend in the Endocrine Laboratory in Miami were mostly dedicated to bench research, thus the clinical exposure under Dr. Vande Wiele's guidance were invaluable for my future clinical practice in reproductive endocrinology and infertility. As an aside, I will mention that Dr. Vande Wiele was original Belgian, as I was also. We got along well and he taught me a lot. We also played some indoor tennis (it was winter then) and to my dismay I have to admit that he beat me every time, even though he was my senior by many years. He had me running all over the court, while he seemed to just stand there effortlessly in the right place to return my ball every time.

It was going to be a bit hard on me and my family to be separated for 3 months. This, Dr. Little realized and without me asking, he send me prepaid return tickets to come home for two weekends during my time in New York. That was extremely thoughtful of him and much appreciated by me and my family.

In academic medicine, a faculty member is classically expected to wear three proverbial hats. The first one is of patient care; the second one is of teaching; and the third one is of research, not necessarily in that order. One is expected to balance these to the satisfaction of promotion committees, the chairman of the department, and the dean of the medical school. Sometimes one is even expected to wear those hats simultaneously. So I did a lot of teaching, a lot of patient care and in the time left over, a lot of research. It also required a fair amount of travel to meetings, conventions and symposia, and later in my academic career to various committee meetings of national and international organizations. All of this took up a considerable amount of time far beyond the 40 hour work week and I am

sure that my family suffered from some neglect on my part. They never complained. And in looking back and reflecting with them, they never resented me for frequently not being there for their birthday parties, PTA meetings, sports, or various other events. I do admire Anne and am grateful to her for having put up with me during those years. She complained not even once and in fact was always very supportive and encouraging.

Most physicians have been sued at one time or another during their career. I am happy to be able to say that I have only once seen the inside of a court room, and that was as a witness for the defense. The case involved a woman in her thirties who had had a total hysterectomy and removal of her ovaries elsewhere. She consulted the gynecology clinic at Jackson Memorial Hospital because she had developed menopausal symptoms. One of our fellows counseled her and started her on hormone replacement with oral estrogen. A year or more later she sued the fellow and the university because her breast had enlarged to the point that she needed a breast reduction operation. and blamed the estrogen that was given to her. When I was called to the witness stand I pointed to the patient's medical record and demonstrated without doubt that the patient had had a consultation some years prior to being placed on estrogen by our fellow. That consultation was with plastic surgery to request a breast reduction operation, which was denied. It was thus obvious that this woman's breast enlargement antedated the administration of estrogen by a considerable length of time. The judge immediately called the opposing lawyers to the bench and threw the case out of court. To me it was incomprehensible that the judge then charged the defense (which was the University of Miami and thus a deep pocket) with the court costs, instead of the prosecuting lawyer and reprimanding him for not doing his homework and filing a frivolous law suit.

In any case, I enjoyed my academic career and was rather successful. I quickly rose through the academic ranks and was promoted to full professor at the age of 41. I was able to build a sizable clinical practice, mainly in reproductive endocrinology and infertility. I participated actively in teaching 3rd and 4th year medical students as well as residents and fellows at all levels both in the classroom and at the bedside and operating room. I also continued an active program of basic research. This research was well funded by various NIH grants and took place in the Reproductive Science and Endocrinology Laboratory on the medical campus. The director of the Endocrine Laboratory (later to be renamed as REPSCEND, meaning Reproductive Sciences and Endocrinology) was a Ph.D. in Biochemistry and he taught me most of what I know in basic research. He and his wife and Anne and I became friends. We shared many scientific and extracurricular activities. Over the years we talked often about our future retirements and our plans for our "old" age. When he died unexpectedly, our lives began to change as I alluded to in the prologue of this book.

There are many memorable stories to be told. I remember one that occurred during one of my teaching classes. But first I have to give some background. As part of the research which I continued to do in the Endocrine Laboratory, a number of members of the group traveled together periodically to attend scientific meetings and present the results of our research. One such meeting was held in Utica, New York. One free afternoon without a scheduled session, a group of us (all male) went for a hike along a river. It was beastly warm and after a while we were all pretty sweaty and ready for a swim in the river. However none of us had thought to bring a bathing suit or towel. The eight of us were the

only people in this rather remote area, and we decided to go in the water in our birthday suits. After a most refreshing dip we all needed to dry off and we sat together on a huge tree branch hanging low over the river. The leader of our group, who was the director of the laboratory at that time, took a picture of this naked group. Nothing was said or done about it anymore and in fact none of us got to see the picture. That is until some months later. The director of the laboratory, who had taken the picture, was also in charge of the course in Biochemistry for the freshmen medical students. As had been customary for several years I was to give a lecture in that course on the biochemistry of female reproduction. On the appointed day I showed up at the lecture hall where one hundred or more students filled the auditorium. The director of the laboratory was there to introduce me, as this was my one and only lecture to the freshmen in biochemistry. He started his introduction by saying: "You may all know Dr. LeMaire as a prominent obstetrician/gynecologist and an accomplished researcher, but I want you to know about one aspect of Dr. LeMaire that is not obvious…" and then he put the slide on the screen of me and my seven colleagues sitting naked on the branch over the river. You can image the roar of laughter in the auditorium, even though the photo was not at all revealing or indecent.

On another occasion, when I was to give a lecture in the physiology curriculum this time, also to the freshmen, about the physiology of human female reproduction, I showed a very excellent movie by a famous reproductive biologist documenting the female cycle of rats and their reproductive behavior, including actual scenes of ovulation and also copulation. Of course rats are different from humans, but I thought that it was useful to point out some of the similarities. After the movie of about 20 minutes or so was over, I began my lecture by saying: "As you can see, and I will try to point out, women, in some ways, may be very similar to rats…." This was, on my part, meant to be an innocent statement, but it was perceived by some of the female students as sexist and offensive. Thus I was called on the carpet by the dean after a contingent of female students lodged a complaint. I was supposed to apologize, but never did. Instead I met with some of the female students and explained to them what I had meant. They accepted my explanation.

During my time as a faculty member at the University of Miami, I had one scary experience related to my health. One day I was preparing to go to the operating room for a procedure on one of the clinic patients. In the locker room I was bending over to put on shoe covers when I had a sudden severe pain in my back. I managed to get into my scrub suit and after sitting down for a few minutes the pain subsided somewhat. I thought that I was going to be all right and able to proceed with the planned surgery. I did not mention anything to the other doctors and nurses in the OR, but soon after beginning the procedure, the pain returned in full force and I was not sure if I was going to be able to continue. The next thing that I remember is opening my eyes and staring into a bright light while lying on the operating table in the adjoining OR, while nurses and doctors were scurrying around me, taking blood pressure and pulse, administering oxygen, taking an electrocardiogram, and drawing blood samples. I had apparently fainted during the surgery in the adjoining room and a heart attack needed to be ruled out. After some further testing and X rays it was decided that my fainting was secondary to the severe pain in my back and I was discharged home to a week of bed rest, anti-inflammatory drugs, and pain medication. The diagnosis: slipped disk in the lumbar area. In retrospect I can relate the occurrence to some strenuous physical activity the previous day.

Most of the practicing obstetricians and gynecologists in the Miami area belonged to the Miami OB & GYN Society. This Society used to meet four times a year between October and April. These evening meetings were held in various hotels and were rather formal, with most male members dressed in tuxedos. In fact, I had to buy one especially for these meetings. At that early time there were only two or three female members who would come dressed in evening gowns. Spouses were never invited. The meeting started usually with a cocktail party followed by a dinner and then a formal presentation by an invited speaker. Some of the members invited one or more guests. I usually invited one or two of the residents or sometimes medical students to be my guests. A few weeks prior to each meeting a flyer was sent out announcing the date, time, and location as well as the speaker and the topic. One year one such an announcement arrived on my desk and as I recognized the envelope I did not bother to read the details of the announcement. I asked my secretary to put the date on my calendar and invite one of the female medical students, who had been working with me on a research project, to be my guest. I also asked her to tell the student that it was necessary to wear an evening gown and that she probably would be only one of a small number of women present. When the evening came, I drove to her house to pick her up. She lived with her family close to our house, and our children had been babysitters for her children on several occasions. In the car, on the way to the meeting I told her again about the nature of the meeting and not to be embarrassed if she happened to be one of only two or three women present. When we arrived at the hotel, the cocktail party was already in full swing as I walked in with the female student. To my horror the room was packed not only with my male colleagues but also all the wives were there. I do not need to tell you that I must have turned red as a cooked lobster. What was happening? The explanation was simple. When the invitation had arrived on my desk, I had failed to open it and look at what it actually said. After entering the meeting, and when I had gotten over my initial shock, I picked up an announcement and there it was. The preamble by the then president said something like this "… because of the nature of this evening's topic, the society is making a onetime exception and urges all members to bring their *significant other* to the meeting as their guest. …" So what was the topic of that night's meeting? It said in bold letters "Postmenopausal Sexual Activity." And here I was with my significant other. Several of my colleagues came up to me and took me aside, "Wim, what is going on with you and Anne? Are you two splitting up?" While I was utterly embarrassed I must say to the credit of my guest that she did not flinch a bit. I was fearfully anticipating the end of the dinner, when during dessert, the president of the society traditionally asked each member in turn to stand up and introduce their guest(s). Thankfully the president this time omitted that custom and I did not have to get up and introduce my *significant other*.

One other time I had received a last minute verbal invitation for a cocktail evening at the home of one of my colleagues, to greet a visiting professor. When I came home that evening after work I told Anne to get dressed and that we were invited for a party. When we arrived at the house at the determined time there were only men. In fact, my colleague told me that his wife had already gone to bed with a book. Of course I had failed to tell Anne that the invitation was for a stag party. This is another one of these idioms which I had failed to learn and did not think of as being important enough to mention to Anne. Gracefully, his wife came out and she and my wife had a nice chat while we men socialized and had our cocktails. Needless to say that Anne was somewhat exasperated

with me and became suspicious of any invitation that I brought home.

Early on in my career as a faculty member I had invited a visiting professor from another university to come and give a lecture in reproductive endocrinology. We had arranged for a dinner at our house the evening of his talk and invited the chairman of our department as well as several other faculty members. This was the first time we hosted such a rather formal dinner and we had decided to serve stone carbs which is a typical south Florida delicacy but which we had never tasted before. When Anne went to buy them she was asked if she wanted them cracked or not. She had no idea what they were talking about and said: "Not cracked". That of course in retrospect was a big mistake as these crab claws have extremely hard shells. So at dinner everyone put several crab claws on their plate, but then everyone was stuck as there was no way to open the shells without some help. Out came a hammer, pliers, and the only nut cracker we possessed. Pieces of shell were flying everywhere; everyone was laughing and having a good time. The crabs were delicious and of course we have had them many times after that; cracked of course. Years later when we decided to change our flooring from carpet to tile we still found pieces of crab shell in the corners and under the carpet.

In my clinical practice, which was eventually mainly devoted to infertility and reproductive endocrinology, I had more and more contact with patients who only spoke Spanish. Many of these patients were Cuban refugees, but also many patients from South American countries who were seeking consultation. A number of these patients were referred to me by a physician in one of the South American countries for evaluation and treatment of infertility or some other endocrine problem. When my secretary received their phone calls to set up an appointment, she would give them a date and time within the time frame of their travel to the USA. Not infrequently the response would be: "Oh no, no es possible, en esta fecha seramos en Disney World." We called these referrals the Mickey Mouse connection.

My understanding and speaking of Spanish was initially almost zero. I needed my secretary to be present to translate during my interview with Spanish speaking patients. That often turned out to be time consuming and also frustrating. An example would be a patient consulting because she was not having her menstrual periods. I would turn to my secretary and ask her to ask the patient: "When was your last period?" My secretary would then ask the patient in Spanish. A discussion would ensue between my secretary and the patient, lasting 20 to 30 seconds. At the end my secretary would turn to me and give me the patient's reply e.g.: "May fifth last year." This short reply after a considerable discussion between my secretary and the patient left me wondering about what had transpired during these 20 to 30 seconds of Spanish discussion. Clearly I was missing something. So I decided that it was time for me to learn enough Spanish so that I could communicate with my patients. I set out on my own, using books and tapes to learn the language. As it turns out that was not so difficult, especially as I was already fluent in French, which is somewhat similar in terms of conjugation of verbs and gender of inanimate items. I received a big help from my secretary and other members of the laboratory, in which I continued my research. One of the Cuban technicians would actually stand me up in front of a blackboard during lunch breaks and rehearse various topics with me. One day it would be "la cocina" another "la familia" or another yet "la casa y la officina" etc. I became not fluent but conversant in Spanish so that I could

interview my patients without help. When it came to important instructions and explanations, I would still have my secretary present to make sure that I was conveying the message correctly.

One rather amusing anecdote had to do with one of my patient's perfume. I have no allergies but I had noted that I would react violently with sneezing, eye watering and congestion to a perfume, that some of my patients were wearing. You can imagine the embarrassment to both me and my patient when I was getting ready for my gynecologic exam and I suddenly had this allergic reaction. This happened several times and after my secretary had pinpointed the culprit (Shalimar), she would be alerted when a patient came to check in and if she smelled Shalimar she would reschedule the patient after telling her the reason: "Doctor LeMaire is allergic to your perfume I need to reschedule your appointment without perfume.

Much of my practice had to do with infertility and over the years I had a fair number of successes. My daughter Elke remembers a funny incident that happened while she was working as an occupational therapist in the clinic of a hand surgeon in Miami. One day she had just started working with a woman who had undergone an intricate procedure by this surgeon. She noticed Elke's last name (this was before her marriage) and became rather excited and animated when she found out that she was in fact my daughter. She let Elke know that she had been seeing me for infertility and that the end result had been a beautiful baby. She expressed extreme gratitude. Elke and the other therapist enjoyed her enthusiasm which she vocalized rather loudly. This caused the doctor in the adjoining room some concern and he came to the door to inquire if there had been a problem with the surgical repair. The patient immediately and loudly stated that her hand was just fine but that she was so happy because: "Doctor, it was Elke's father who finally got me pregnant." The doctor, not knowing anything about Elke's father and being a reserved gentleman (Pakistani descent), looked at Elke with open mouth and an expression of shock. The other therapist in the room and Elke remained speechless for a second and then burst out laughing. The surgeon listened to their explanation but then left in a hurry, quite red in the face.

One other time Elke was at a party and ran into a classmate from high school who was very happy to see her and let her know that she had had a successful infertility experience with me. She stated: "I wanted a baby for so long and then your father finally got me pregnant." She was so excited that she did not realize how loud she was speaking. Several small groups of guests stopped their conversation and turned to her. She then realized what her statement must have sounded like and became quite embarrassed.

In 1979, I was offered the opportunity to do a year of sabbatical research in Goteborg, Sweden. I accepted and worked in the Department of Physiology at the University of Goteborg, Salhlgrenska Universitetssjukhuset (Salhlgrenska University Hospital). To do this I received a rather prestigious Senior Fogarty International Fellowship. In Goteborg I worked with several obstetricians and also several scientists on a project that was aimed at reproducing ovulation outside the body in an artificial milieu. Our ultimate aim was to be able to do this in human ovaries but we started off with laboratory animals. First we used rabbits and later rats. It was an incredibly successful year. Not only were we able to

induce ovulation in an artificial perfusion medium but we were able to manipulate the process in various biochemical ways. As a bonus, we were also able to record a film of ovulation occurring in this artificial setting. The movie was recorded by none other than the world famous Swedish photographers Lennart Nillsen and Carl O. Lofman. All this research resulted in a large number of publications in scientific journals and many presentations at national and international meetings. It also resulted in continuing collaboration over many years between the Miami and Goteborg Laboratories, with exchange of several graduate and post graduate students.

When we went to Sweden our three oldest children, Ingrid, Elke and Tom were already in college. Frank went with us and finished his senior year at the local high school. While initially he had not wanted to go and wanted to stay with his group of friends in Miami, he ended up having a ball in Sweden. He learned enough of the language to get by and joined the local wrestling team. During the summer vacation of that year the three older ones joined Frank and bummed around all of Europe on a Eurail pass.

Besides the work aspects, we also enjoyed the many social activities in Sweden with skiing in the winter, hiking and boating in the summer. While we enjoyed our year in Sweden and made many friends among our colleagues at the University, we found that "the people on the street" were not as friendly or outgoing. I will give a few examples. We lived in a large apartment building and Anne went down to the basement laundry room on a frequent basis and ran into other women in the building doing their laundry. She repeatedly tried to engage these women in conversation, hoping to get some insight in the Swedish way of living or maybe even to find some common area of interest while waiting for the dryer to finish. Anne was not looking for any lasting relationship, just some light conversation. The only responses she would get were a polite yes or no. Another example is from the time we went cross country skiing. The trail was absolutely beautiful with stunning country sights and un-crowded. In fact, for the first hour or so we did not encounter anyone. Finally we heard some voices coming our way and we went off the trail to let a group of four or five skiers pass. We waved at them and said "hey" and something to the effect of "What a beautiful day..." They did not acknowledge our presence, did not say anything to us, did not skip a beat in their skiing rhythm, continued their conversation, and went on.

At the end of our stay in Scandinavia Anne and I traveled around Sweden, Finland, and Norway for two weeks and went as far as Nordkapp, which is a 307 m. high cliff, usually referred to as the northernmost point of Europe. Standing on these cliffs and looking in the distance towards the North Pole was an incredible experience. Watching from atop a cliff the midnight sun dipping down to the horizon, going down into the water as it seemed, and then rising again, without completely disappearing, was a sight never to be forgotten.

Upon our return to Miami in 1980, I was ready to pick up my clinical practice and teaching duties again. Shortly after, my best friend, the director of the Endocrine Laboratory became ill and needed a bypass operation, which initially was successful. However, a few days after the surgery he developed a complication and suddenly died. He was 49. Of course that was a tragedy for everyone and foremost for his wife and three daughters. For my wife and me it was the real beginning of our future incredible adventures off the beaten path which I will relate in the next chapters. At the time of my

friend's death I was 47 and while I was to continue for some time in my academic career, we began to plan for an early retirement. We certainly did not want to wait till sickness or even early death would wipe out our many plans for "life after academia," as it happened so unfortunately for my best friend and his family. After much soul searching Anne and I decided that I would retire from the university when I reached the age of 55

CHAPTER FIVE: OFF THE BEATEN PATH AFTER RETIREMENT

I was 51 years old when I told my chairman about our decision to resign from the University when I was going to turn 55 in four years. He immediately pooh poohed the idea. He told me that he understood my concern about having more time to spend with my family and that when the time came he would offer me a half time job in the department. Now that was being a good businessman as I saw it. He would be paying me half of my salary and I would still be working full-time. Once one has been fully emerged in patient care, teaching and research, it would, in my view, almost be impossible to cut the workload in half without compromising the quality. We stuck to our decision and when I turned 55 I handed in my resignation, which was not accepted by my chairman. He told me "Wim, you are going to regret this. Why don't you apply for a non-paid leave of absence? You may change your mind and this way you will still be part of the faculty." I told him that our decision was firm and that I had no intention of coming back to academic medicine. I made that decision even though I was happy in the department and in fact was at the top of my career with a big and successful clinical practice, well-funded research, and a good name as a teacher amongst the students. At the chairman's insistence, I ended up applying for a leave of absence anyway. That request was granted by the dean.

Now came the difficulty of deciding what to do. I certainly was not ready to retire and do nothing. We could pretty much do what we wanted as our children were independent by that time. Ingrid was married and working as an MBA at DuPont in Wilmington, Delaware. Elke was engaged and working as an occupational therapist in Miami. Tom was married and working as a physical therapist in Gainesville, Florida. Our youngest son, Frank was working freelance for the movie and advertising business in Miami. He was ready to rent the house from us (at a good price of course). We ended up eventually selling the house to him.

We considered two options. The first one was to go do something entirely different, like farming, raising horses, or buying an orchard. We considered many possibilities but kept coming back to option number two which was to continue working in some sort of capacity as an O&G. Then came the next question: what and where? Our first idea was to look for a job in a developing country and maybe work in a mission hospital. My first contact in that regard, came via a letter in the New England Journal of Medicine, written by a physician who was working in internal medicine in a mission hospital in Katmandu, Nepal. In that open letter he described in some detail his experiences and his satisfaction with the work he was doing. That letter caught my eye, and I immediately wrote him a short letter asking for more details and for suggestions on how to pursue my own plans. Some weeks later I received a handwritten reply that started something like this: "Doctor LeMaire, you may not remember me but I remember you very well as my senior resident during my O&G rotation as a third year medical student at the UM." He then continued by giving me a vivid description of his career and a list of various leads for me to pursue. Following his advice, I contacted many different religious denominations who were also running medical hospitals in various parts of the world. Remember that this was back in 1988 - 89 and websites were not yet as sophisticated and ubiquitous as they are now. So

there were many written applications and responses and the search was a bit frustrating. I certainly could not afford working entirely for free at this point in my career and many of the missions would only pay for travel to the location in Africa or Asia and give us housing, but no stipend or salary. Some of the missions suggested that a yearly vacation back to the USA could be used to go around the various congregations and give slide shows and talks with the idea to raise enough money to sustain us for the next year. In addition, a number of the missions required some prior indoctrination in the particular religion with the requirement to participate in proselytizing once on location. We were not interested in either requirement. Thus our attention turned away from "voluntary" work in mission hospitals.

As it turned out I came across an advertisement in one of our O&G journals. This ad was for a position for six months to a year at the University of Hawaii teaching program in Okinawa, Japan. They were looking for a senior academician at the level of associate or full professor, to come and work in the Department of O&G at Chubu Hospital in Gushikawa City, Okinawa, Japan.

First I need to give some background about how the University of Hawaii came to have a teaching program in Japan. Postgraduate medical training in Japan has always been different from that in many other countries like Great Britain and the USA. It essentially lacked a structured progression in the training of specialists. There were neither rigorous requirements nor strict evaluations of the meeting of these requirements, prior to moving on to the next level of training. At the end of World War II, Okinawa was exposed to heavy American presence, not only military but also medical, with the establishment of a US Naval Hospital there. This allowed the Japanese there to become exposed to the US system of medical education and post graduate training and prompted them to attempt to emulate the US system. They decided to set up a medical training program at the local Government Hospital, called Chubu Hospital, modeled along the US system. To do so they contracted with the University of Hawaii Medical School to help them to get started. By the time that I was looking to join them in 1989, their program had been well established and had received attention and recognition throughout Japan. The program consisted of one permanent faculty member from the University of Hawaii, stationed at Chubu Hospital to oversee and direct the training program for medical students, interns, and residents in various specialties. The respective heads of the different departments all were Japanese and had previous exposure to, and experience in, the US postgraduate education system. All applicants, medical students, interns, residents, and faculty, were required to provide proof of basic knowledge in communication in the English language prior to acceptance. The director of the program would arrange throughout the year, for many short or longer term visits by US visiting professors in various specialties according to perceived needs by the Japanese department heads. At the time I was considering leaving the University of Miami, the chairman of O&G at Chubu Hospital had resigned to enter private practice. His successor was an excellent specialist but he had never had any direct exposure to American post graduate education. Therefore the director of the program in Okinawa deemed it necessary to bring in an experienced academic O&G from the US for a period of six to twelve months, to assist this new chairman at Chubu Hospital in continuing to implement American standards. This was the basis for the advertisement that I saw in our trade journal.

I sent in my curriculum vitae and was contacted by the director of the program in Okinawa with an offer to join them for six months. During that time I was to be appointed as professor at the University of Hawaii. I was to receive travel for my wife and myself, housing, the use of a car, and a reasonable salary, to be paid half in the US dollars and half in Japanese Yen. Even though I had not planned for this type of post-retirement activity, the position in Okinawa seemed almost tailor made for me. So we enthusiastically accepted and in January of 1989, I entered the first year of a leave of absence from the University of Miami and travelled to Okinawa, sight unseen.

CHAPTER SIX: OFF THE BEATEN PATH IN JAPAN

Our travel to Okinawa led us first to Honolulu to meet with the dean of the medical school there and to receive some briefing about the position at Chubu Hospital. Not only was that useful and instructive, but the stop over for a few days in Hawaii allowed us to break up the long trip from Miami to Okinawa.

Upon arrival in Okinawa, we were met by the director of the Hawaii Program at Chubu Hospital. He was a pediatric nephrologist and helpful in getting us situated and oriented. He and his wife became our good friends.

My work at Chubu hospital mainly consisted of several informal teaching sessions each week. These were supposed to be small group sessions for a mixture of medical students, interns, residents, and faculty. These sessions were to be held in English as I obviously knew zero Japanese and the audience, luckily, was supposed to be conversant in English. I was naturally completely unfamiliar with Japanese medical and postgraduate education, but knew that I was expected to reinforce and facilitate an American type of educational and training system. As I did not have a good feeling at that time for the level of knowledge of the students and doctors at Chubu Hospital, I thought that it would be a good idea to start off by asking everyone to complete a written test. This would enable me to spot strengths and deficiencies, which would make it easier for me to direct my teaching. I had prepared ahead of time a comprehensive multiple choice type of test, covering the entire field of O&G. To do this I had borrowed heavily from previous exams of the American Board of OB &GYN and of medical student exams at the University of Miami. At the beginning of my first meeting with a mixed group of perhaps 25 students and doctors, I introduced my idea and gave each one a copy of the test. Knowing about the Japanese sensitivity to the notion of "losing face" I told them that they could take the test home, complete it "open book" style and return it to me in one week. I emphasized that there was no requirement to identify the test with either name or any other type of matriculation. I told them my purpose, namely to have some idea about their general level of knowledge and to better serve their needs. Well, if the reader thinks that this was a good idea and that it would have met with general approval, think twice. Two weeks, three weeks went by and not a single test was returned. I spoke to the chairman of the department about it and he seemed enthusiastic about the idea and promised to talk to students and staff and have the completed tests back to me in a week. "Very good idea sensei LeMaire... Very good idea..." Sensei is Japanese for teacher and a title of respect. As the reader has probably guessed by now, I never received one single test back. So much for that bright idea, but this reaction reinforced my perception of the extreme importance of the Japanese notion of "not losing face."

This notion was brought home to me again forcefully during my numerous teaching sessions. The American method of teaching is an interactive one. All students are supposed to take part in discussions, especially in small group sessions as we were supposed to have at Chubu hospital. The Japanese system, I was told, and found out, is much more "ex cathedra," namely from the seat of authority. During my teaching sessions I sometimes had the feeling that if I had pointed to the sun in mid-day and stated: "that is the moon," the whole group would have bowed and said. "Yes, the moon,"

while of course thinking, “sensei LeMaire is crazy.” Such a profound feeling about losing face came to haunt me also during these sessions. In an attempt to make the teaching interactive I would begin a session, let’s say about infertility, with: “Today we will talk about infertility. There are two types of infertility, what are these two types?” I would then turn to one of the students with the question, expecting that he would know that the two types are primary and secondary infertility. That student would then first stare at me for several seconds, then turn to the person on his right and look at him or her for several more seconds, repeat the process on his left, all without uttering a word and then turn to me again and stare some more. At that point I was not sure if the student had not understood my question, even though they were supposed to be conversant in English. Perhaps he or she did understand the question but did not know the answer, or perhaps knew the answer but was offended by the very basic nature of such an easy question. Well, I had to work my way around this problem and gradually was able to gain their confidence by making them understand that I was not out to get them. With time, the teaching sessions became much smoother and informative.

Besides the teaching sessions, I also made rounds on the in-patients with the team and consulted with them in the outpatient clinic and emergency room. These encounters were carried out in Japanese, as few of the patients could understand or speak English and everything was translated for me. Thank God, I never needed to be the primary contact with patients. I also worked with the doctors in the operating room, and taught them various techniques and approaches, but also learned from them as they were rather sophisticated and in many ways at the forefront of technical developments. In their clinics I came across an unfamiliar situation, at least for Americans. In the USA, when a gynecologic patient needs to be examined, she is placed in stirrups on an exam table and during the manual vaginal examination the doctor has eye contact with the patient, which can be helpful in eliciting reactions to such things as sore spots. At Chubu Hospital, however there was a curtain over the patient’s abdomen, thereby hiding the patient’s face and making eye contact impossible. If during my exam for instance I was pressing on an area of concern, I had no idea if it was painful or not by just simply observing the patient’s expressions, but needed to repeatedly ask via an interpreter to let me know if it did hurt and where.

One incident in the hospital was particularly memorable. Even though it did not have anything to do with patient care, it brings out the wonderful contrast between the afore mentioned “losing face” consideration and the absolute sense of honesty of the Japanese. I wear a platinum wedding ring and in preparation for surgery take it off and place it over my watchband which I then put in a pocket of my surgical scrub suit. One day I came home and Anne noticed that my wedding ring was missing. I immediately considered the possibility that it had slipped off my watch band in the pocket of my scrub suit which I had thrown in the laundry hamper at the end of surgery. I considered the ring lost but nevertheless the next morning I went to see the operating room nurse supervisor, who told me she would see what she could do. I had no hope of seeing the ring again. In the US, under similar circumstances, the ring would either be lost in the laundry, or if recovered, might not find its way back to me. However, towards the end of the day I was paged to the operating room, to be met by a diminutive old lady, who apparently was a laundry room worker. It is difficult to describe the scene, but she came shuffling up to me in slippers and a traditional Japanese kimono. Her hands were out in front of her with the

palms turned up. On her hands was a folded towel and in the middle of the towel was my ring. When she was near me she stopped and stretched her hands out, bowed deeply and the only thing she said was “Sensei.” I took the ring, also bowed and said “domo arrigatou gozaimasu..” This is one of the few things I learned in the Japanese language and it means: thank you very much. So I got my ring back.

Social life in Gushikawa was wonderful. We made many acquaintances among the Japanese doctors but only one real friend. We had many dinner parties at restaurants with delicious Japanese food (miso soup, sushi, sashimi, yakisoba, udon, teriyaki, shabu-shabu, yakitori etc.) and much sake, beer, and wine. However we were never invited to any of the homes of Japanese colleagues and at the dinners in various restaurants with the male colleagues, their wives were almost never present. This brings me to a story about incredible Japanese hospitality.

The Japanese are most gracious hosts as we had found out already much earlier, when I was still at the faculty of the University of Miami. During my two years of fellowship doing research in the Endocrine Laboratory, we had a visiting fellow from Japan. He came for a year of research. He came with his Japanese wife, who was pregnant. We became friends and I ended up delivering his first baby. Many years after he had returned to Japan, I received an invitation to visit his department of O&G in Kyoto, where he now was the chairman. I was going to Japan at that time to attend an international meeting of endocrinology. He wanted me to come a week earlier and bring Anne. He was going to make all the arrangements and take care of our expenses and in return, I was asked to give a scientific presentation at his medical school department.

When we arrived in Kyoto, we were met at the airport by his wife. She escorted us in a chauffeured limousine to our American style hotel in the center of Kyoto. She went up with us to our room and went in first, while we were asked to wait outside. Apparently she wanted to be sure that the room was in perfect order. She told us that she would be waiting for us in the lobby and to come down in about 30 minutes, so that she could show us the town. By then we were dead tired and suffering from jet lag, but could not refuse this gracious proposal.

The next morning at the appointed time she picked us up again at the hotel and drove me to the medical school, where I was to meet her husband and give my presentation, while she and Anne went sightseeing. At night they took us to a most fabulous restaurant for some sumptuous Japanese food. We sat on tatami mats on the floor at a low table Japanese style. Food and drinks were served by Japanese ladies dressed in traditional kimonos and obis, while another lady was playing traditional music on a stringed instrument and singing Japanese songs.

Later in the week, I attended the international meeting and afterwards his wife took us on a three day trip to several places around Kyoto, again in a chauffeured limousine. First we went to a place, whose name I cannot remember, in the shadow of Mount Fuji, and the next day to Nara, the holy city. Each night we stayed in traditional Japanese inns, called Ryokans. Before entering shoes come off and slippers are put on. This is followed by a mini tea ceremony as a welcome gesture. The rooms have tatami mats on the floor and in the evening a Japanese lady comes to roll out the futons and prepare them for bed. Before retiring there is the opportunity for a traditional bath. This consists of first a

shower and soap and then the wooden community tub. Meals are again taken on a low table while sitting on the tatami-covered floor. Some places make allowance for people with stiff joints and provide a shallow depression in the floor for one's legs. Often the walls of the dining area are made up of beautifully decorated paper sliding panels.

In Nara, we visited a number of Buddhist temples and strolled among the tame, free roaming deer. One of the temples we visited gave us a most wonderful snapshot of the proverbial Japanese discipline. A number of school buses had dropped off at least a hundred school children, boys and girls around 10 to 11 years old. By the time we arrived, they were all sitting next to each other on a low retaining wall on both sides of the path leading up to the entrance of the temple. They were all talking excitedly to each other, but were perfectly behaved, while a few adults, teachers we presumed, were organizing their entry to the shrine. Further up and closer to the entrance, lining each side of the path were a hundred pairs of shoes, all neatly arranged next to each other. Imagine the same circumstance in the US: one hundred fourth graders, visiting a museum, where shoes need to be taken off before entry. The scene would likely be one of utter chaos, with shoes all piled up in heaps and kids running around, yelling and playing tag, with at least five or more teachers frantically trying to calm down their kids and organizing their entry. We wish that we had taken a photo at the scene of this temple.

When time came for us to leave Okinawa, we were invited to a large farewell party at a local restaurant. When I told Anne about it, she stated that she was not going to go as she had grown tired of going along with me to parties and almost always being the only woman there among all my male colleagues. When the evening came, I showed up alone, only to find out that this time around not only were my male colleagues there but also many of the female operating room, clinic, and ward nurses, as well as the wives of some of the doctors. When asked where my wife was, the best I could do was to tell them that she was going to come later. So I went quickly home to get her and correct my social "faux pas." It was a nice party with great food and drinks and many speeches and some wonderful farewell gifts.

On returning to the USA at the end of June 1989, we wanted to travel a bit in the USA, which we did, but we also needed to start considering our future activities. By that time I felt that I wanted to continue to do general O&G. During my last years at the University of Miami, my practice was almost entirely limited to gynecology and especially reproductive endocrinology and infertility. I had not done or seen a delivery for many years and in Japan all the deliveries were done by the residents. Thus I felt that I needed to refresh my knowledge and practice of obstetrics. As I was still a faculty member on leave of absence, it was easy for me to join the obstetrical group at the University of Miami for about six weeks and work along with the faculty and residents, doing deliveries, C-Sections, and taking care of complicated obstetrical cases. For me this was a great way of getting my hands in the business of delivering babies again, and for the obstetrical group it was helpful as well as I was another pair of hands to help out on this busy service at Jackson Memorial Hospital. I was able to update my obstetrical skills and knowledge during these six weeks and realized that during my years of absence from the practice of delivering babies, there had been great strides in technology, such as ultrasound and fetal monitoring. It was nevertheless, comforting to me to realize that babies still came out the same way and that in fact taking care of pregnant women had

not changed all that much. More than two years later, after my next assignments, I also felt that I needed to refresh my knowledge and practice of gynecologic oncology, even though my intent would be to refer women with more advanced types of gynecologic cancer to a sub specialist. I was again able to join the gynecologic oncology group at the University of Miami for a month or so. I received updated training in taking care of women with abnormal cervical cancer smears (PAP smears), which as I knew, are a frequent occurrence in many places in the world. I was especially interested in sharpening my skills in colposcopy, which is a procedure whereby one looks at the mouth of the uterus (cervix) with a magnifying instrument or colposcope to decide where the abnormal tissue is, so that that piece of tissue can be removed for microscopic examination. I also assisted in cancer surgery and learned more about caring for sick patients with gynecologic cancer. These few weeks or months of "retraining" helped me in my later assignments elsewhere. I must again thank my former chairman, Doctor Little, for having convinced me earlier to retain my faculty appointment at the University of Miami, first while on leave of absence and later as a clinical professor, in absentia. That continuing relationship with the medical school allowed me to take this time for "retraining" without any hassle or need to obtain medical malpractice coverage and also enabled my continuing interaction with academic medicine.

CHAPTER SEVEN: OFF THE BEATEN PATH IN PAKISTAN.

While traveling in the USA and relaxing, I needed to start looking for my next activity. Again I came across an ad in our O&G journal, this time by the Aga Khan Medical School in Karachi, Pakistan. The dean of the medical school there was looking for a senior academic obstetrician and gynecologist for their faculty. I sent in my curriculum vitae and promptly received an invitation to go to Boston for an interview with the dean, an American, who happened to be visiting the USA on business. I flew to Boston and had my interview there. When I returned home the following day, there was a message for me offering me a two year contract. After considerable discussion with Anne we decided to accept and prepared for our new adventure. We did not really know what to expect as we were going sight unseen, but we were quite excited.

The Aga Khan University is part of a large Development Network established and directed by Prince Karim, the current Aga Khan and spiritual leader of the Ismaili sect of the Shia Muslims. Shah Karim al-Hussayni, the Aga Khan IV, is the 49th and current Imam of the Ismailis. He has been in this position, and has held the title of Aga Khan, since July 11, 1957. He lives in Paris and uses his enormous wealth to promote the wellbeing and education of Muslims throughout the world, including the Aga Khan University. The University is spread over a number of countries including Pakistan, Kenya, Tanzania, Uganda, the United Kingdom, Afghanistan, Syria and Egypt. The crown jewel of this organization is the Medical School in Karachi. Established in 1983, it is by far the most modern of the nine or so medical schools in Karachi. When we first saw the sprawling facility we were absolutely awed by the magnificence of the architecture and later by the excellence of its modern medical facility and its first rate care to the poor and the rich alike. But more about that later.

At the end of December 1989, we flew to Karachi. We were put up in a modern hotel in the center of the city and spent New Year's Eve and New Year's Day exploring the city. Our first excitement came soon after we arrived when a minor (as it became clear later) altercation took place around the hotel with gun shots being fired for several hours. We never found out precisely what happened. Whether we made the wrong decision was certainly our major concern at that moment. We had several more scary episodes during our two years in Pakistan, which I will relate later.

When we first arrived in Karachi we noticed that rather often one could see boys and young men walking in the streets holding hands. This seemed to us rather odd and raised the question about sexual orientation. Later we learned that this behavior is common in this part of the world and has nothing to do with sexual orientation. Initially however we certainly wondered.

The medical school gave us the use of a car. Thank God (Allah), the car came with a driver. Traffic was something to be seen to be believed. Driving is on the left, but that was not really a problem for me, as I had already experienced that in Japan. But the streets and major thoroughfares in Karachi were packed with not only small cars, trucks, buses, taxis, motorcycles, bicycles, and motorized rickshaws, but also horse or camel drawn carts, wandering camels, cows, sheep, and goats all mingling around in absolute

chaos. So we were happy that every morning our assigned driver would come to the hotel to pick us up and drive us wherever we needed to go. The plan was for us to look for a suitable house that the hospital then would rent for us. We saw many houses relatively close to the hospital and settled on one in a somewhat secluded neighborhood. It was much too big for the two of us, but that was what was available at the price range we were given. The house, like all the others we saw, was unfurnished, and the hospital gave us a budget to buy furniture. So we spent days shopping around for suitable furniture. Once this was done we needed to wait for the furniture to be delivered, which took a long time. As a consequence, we stayed in the hotel for nearly a month. In the meantime I had started work and every day I was driven to the hospital by our driver, who would then return to pick up Anne and take her shopping or on other errands.

After being driven through the chaotic traffic a number of times, I realized that there probably was some order to the chaos and that it was time for me to start driving. So I did, and in fact had no problem. The thing to remember when one drives on the left is "right wide," meaning that in order to make a right hand turn from the left hand lane, one has to make a wide turn, lest one ends up in the oncoming traffic. There were no lines demarcating the lanes, even on four or five lane highways, and all traffic, cars, buses, rickshaws etc. would just weave through all the invisible lanes. All this at breakneck speed and deafening noise from the backfiring bus engines (many without mufflers), the tuk tuk from the rickshaws, and above all the continuous sounding of all kinds of horns and whistles. It seemed that a horn was probably the most important part of any motorized vehicle. One day, Anne was being driven to a local market and in the middle of a five lane highway the motor conked out and the car stopped dead in its tracks with traffic whizzing by on all sides. That must have been a frightening experience even for an experienced driver. Anne's driver turned to her in the back seat and excitedly announced to her "Memsa, Memsa, no horn!" Memsa was his way of addressing Anne respectfully. That he was stuck in busy traffic with a conked out car was less important to him, than the fact that he could not blow the car's horn.

While I eventually drove myself, Anne never did. The main reason was that there was nowhere to park a car if one was going to, let's say, the market. The driver would let Anne off at a specific location and then stay with the car and move it as needed, until she came back.

Driving around town became less problematic for me as time went by and I learned the "rules of the road." One had to be constantly on the alert for unexpected obstacles, such as people or animals suddenly crossing the car's path or unexpectedly changing directions. One of the dangerous obstacles was the manholes in the streets. These were supposed to be covered by cast iron lids. But iron was valuable, so sometimes these covers were stolen. The holes would then be re-covered with concrete lids. The concrete was more often than not of poor quality and would crack under the weight of the heavy trucks or buses. This would then leave a gaping hole in the middle of the pavement and be a major hazard for the cars. Many a car ended up with a broken axle in these uncovered holes. Some good soul would drive by, find a wooden stick and place it in the hole with a piece of cloth tied to the top, so that unsuspecting motorist would be warned about such a hazard. Of course wood is also scarce in this desert like area and such a "warning pole" would never last long, again leaving a major hazard.

Even so, we felt mostly relatively safe driving in Karachi within the city. We had been advised not drive too far outside the city limits. One day I was invited to give a lecture at a hospital in Hyderabad, the second largest city in the Sindh Province, located on the banks of the Indus River about 150 km north of Karachi. The university provided us with a mini bus and driver. Once we reached the outskirts of Karachi there was a road block, and Anne, the other people accompanying us and I, were required to show identification. The bus was then allowed to continue but an armed policeman boarded the bus and rode shotgun with his weapon at the ready. You can imagine that we did not feel very safe, but it was too late to change our minds.

One other time we felt insecure driving around the town was during the first Gulf War in January of 1991, a year after we arrived in Pakistan. As soon as the war started and even somewhat before that, the people in the streets of Karachi were demonstrating. It seems that Sadam Hussein had dispatched some agitators and the mobs were stopping cars and blocking traffic while shouting anti coalition and pro Sadam slogans, waving placards with inflammatory threats. While the Pakistani government was openly pro coalition, the people in the street certainly were not. It was definitely not a good time for a Westerner to be out on the streets, whether in a car or on foot. Many Americans and Europeans, including the Peace Corps volunteers and the Fulbright scholars left Pakistan and the American consulate in Karachi had mostly evacuated their personnel except for their essential people. We considered leaving also, but in the end we and a number of our European colleagues from the Aga Khan University decided to stay. However, we did not venture far from home or the medical school. The men would go to the hospital and back home while the women stayed together at each other's houses, listening to the radio and playing Scrabble. As our friends were from Belgium, the Netherlands, or France the women played Scrabble in three different languages at once, which seemed to work all right. We had our suitcases packed and our passports ready in case we would need to leave in a hurry. As it turned out the war did not last long and as soon as it was over we resumed our usual activities. It was interesting to see the reaction in the streets. Presumably the same people who were sometimes violently demonstrating against westerners when the war started, were now dancing and celebrating in the street with pro coalition and anti Sadam demonstrations. So much for their sincerity.

Anne and I have one other impression which is somewhat hypothetical and entirely our own, and emphasizes this ambiguity and the two-facedness of some of the people in that culture. If, in the middle of the anti-American demonstrations which we witnessed, one of us would have been standing at a street corner waving American passports or visas to be given out to the first ten comers, these passports would have been be snapped up in no time even by those waving an anti-American placard minutes before.

After the end of the Gulf War, in February of 1991 we resumed our usual activities, but not before taking a much needed break. We flew to Sri Lanka and spent a week or so traveling around this fascinating country by bus and by train. One of the highlights was our visit to Kandy, the former Capital and a most picturesque city. Back in Karachi, life went on as before. Anne would regularly go to the market and if possible I would accompany her. One market in Karachi that was our favorite, the Empress Market, was enormous and one could buy anything and everything there. The vendors did their best to make their stalls look attractive. Characteristic of this area of the world is that almost all

vendors were male. What was curious to us however was that even the shoppers were mostly male. Of course the few female shoppers all were dressed traditionally in burka or head scarf and long robe. It was definitely not a pleasant place to stroll around for a western woman alone and Anne received numerous stares, whistles, and unwelcome contacts, even though she was always dressed very conservatively, with skirts below the knees or pants and long sleeves. However she also managed to ride a bike and attracted some curiosity there, as not many Pakistani women would ride a bike.

Talking about bikes, small motor bikes were a common method of transportation and it was an astounding sight to sometimes see a whole family, all on one such a small motorbike. The husband would be driving and his wife would sit sideways behind him, often with a baby in her arms. A small child would often sit somewhere between the driver and the handlebars and one other child between him and his wife and frequently there would be one or even two children sitting behind the woman in the back. The largest number of individuals that we saw on one such small bike was seven. These bikes would then weave in and out of traffic with apparently no fear whatsoever. I have always been surprised that there were no more serious accidents or fatalities. Of course no one wore helmets. Motorized three wheel scooters with a small covered cab in the back are a popular method of transportation all over Pakistan as in many other developing countries. They are called rickshaws, or more commonly tuk-tuk, imitating the sounds made by their muffler-less two stroke engines. These tuk-tuk are meant for at most four people in the cab in the back, in addition to the driver up front. We often saw them crammed with not just people, but also all sorts of luggage and animals. We have counted as many as seven people and one or two sheep or goats in one rickshaw. Just incredible! One day we were driving in town and were following a small taxi cab with at least seven people in it, but what was so amusing, was that the trunk lid was open and in the trunk were four more children, laughing and waving at us. This certainly was worth the picture which we managed to take.

Public transportation in a city like Karachi is mainly by bus. The bus system is extensive but unreliable and the buses are poorly marked, at least for us westerners, unable to read the local language which is Urdu. These buses were often so overcrowded that people were hanging out from the doors like a bunch of grapes. There was always a driver and a fee collector. How the collector got around was often on top and over seats. Most buses have a somewhat flat area on top with a shallow railing meant for luggage, but often had people and animals crouched on top if the bus was too full. At a later time while on vacation and traveling by bus in the northern part of Pakistan we often bought three seats for the two of us. The third seat was meant for our backpacks, so that they did not have to end up on top and risk to be lost in the shuffle. Invariably however some kid or kids would end up sitting on top of our backpacks anyway.

The buses and trucks in Pakistan are almost all elaborately painted, decorated with wooden panels, reflective tape and tinsel, and are most colorful. Many trucks have an unusual sloping compartment above the driver's cab, called a viewing compartment, and we have been told that that is where the driver sleeps at night. The owners or drivers must have spent a lot of money to get these decorations and so they take good care of them, keeping them polished and shiny. It was an incredible sight in downtown Karachi to see all these hundreds and yes, thousands of most colorful trucks and buses working their

way noisily trough the narrow streets, passing each other, stopping in the middle of traffic, belching exhaust with backfiring mufflers, blaring horns and avoiding pedestrians, camels, cows, and sheep.

We heard about the corruption of local police. One day we were stopped for a minor traffic violation of which we were indeed guilty. We decided to test the system. When the policeman approached the car, I rolled down the window with 100 rupee bill in my hand. No words were said; he took the bill and waved us on. Of course this is probably just the tip of the proverbial iceberg.

The housing rented for us was on the second floor (top) of a large stone house. The house was too big for the two of us but comfortable. The owner and his family lived on the ground floor and we rented the second floor. We had access to a large flat roof from where we had an almost 360 degree view of the surroundings. We were also within earshot of at least three mosques, so that five times a day we would hear the call to prayer in triplicate, broadcasted loudly from the mosque's minarets. Our house was located in a somewhat secluded community with limited access. After having spent almost a full month living in a downtown hotel, the first night we slept in the house was memorable. We had just gone to bed and we were awoken by a loud whistle somewhere in the neighborhood. The whistle was repeated every few minutes. Some seemed close by the house, almost under our window, while others were further away and seemed to come from different directions. We did not know what all this meant and were thinking that maybe the police was looking for someone or investigating something. When we inquired the next day, our landlord explained with a big smile that these were the chowkidars or night watchmen, hired by the various houses to keep an eye on the property. To prove to the owner that they had not fallen asleep they needed to blow a whistle every so often. Hence the multitudes of various whistles, blown close by or further away, all through the night.

Shortly after we moved in, we got a little kitten which we called Chowkidar. That little cat was extremely unusual. In the morning when my alarm would go off and I would get out of bed, Chowkidar would come trotting in our bedroom from the room where she was sleeping and precede me into the bathroom. She would then jump in the bathtub and sit there looking up at the shower head, waiting for it to be turned on. I always thought that cats hated water, but Chowkidar loved it and would sit in the water stream, waiting for me to pick her up and soap her off. The problem afterwards was that she would often jump out of my arms before I could dry her and on her way out leave a trail of water all over the house. I had never heard of, or seen a cat like that and I have no idea how she came to like water so much. Later I learned that there is a cat breed that likes water. They are called the Turkish Van cats. I doubt however that our Chowkidar was of that breed. Years later after we had left Pakistan and were working in Sitka, Alaska we also got a kitten and called her Chowkidar as well, but she hated water as any normal cat would.

Our house was located in an upscale neighborhood, but nevertheless there was no garbage collection. In each neighborhood there were designated areas for garbage dumping in the streets. People would dump whatever they needed to get rid of. What was amazing was that these dump areas never seemed to overflow, even though there was no scheduled pick up of garbage The reason for that was that one could see little kids, teenagers, and older men rummaging through the piles and salvaging anything usable.

That included anything metal or wood, all paper, cardboard and cloth, you name it and if it had any use at all it was gone. Anything edible, such as potato, vegetables and fruit peels or leftovers was dug up and consumed by the multitude of free roaming animals (sheep, goats, cows, pigs, or birds). The only remains were the brown plastic bags that had been used to carry the groceries home. There was apparently no use for them and they were blown around by the wind. This resulted, especially in the winter, in a rather eerie sight with the bare, leafless trees "decorated" with hundreds of these empty bags flapping in the wind high up in the branches. Talk about recycling! Anne and I often reflected about this. What we, Americans discard, lets say at one single construction site, would probably provide enough material, like wood, nails, plastic, tubing, etc. to build one or more small shacks for a poor family in Pakistan or many other developing countries.

Driving or walking through this sprawling city one would encounter enormous contrasts. There were beautiful tree lined boulevards with magnificent houses and some old colonial architecture and little traffic, then there were the busy noisy thoroughfares just jam packed with people, vehicles of all sorts and a variety of animals all going in any direction. These streets were lined with a multitude of small and large shops and stalls. A must see for any one visiting Karachi, is the magnificent Tooba Mosque with its all white marble construction and giant white dome. One curious sight throughout the city's larger roadways was the numerous workers, clad in salwar kameez, which is the traditional, pajama like trousers and tunic worn by men as well as women, bending over on the side of the road and sweeping with large brushes. In doing so they would raise a cloud of dust which promptly settled elsewhere. We often wondered what the purpose was of "rearranging the dust." Another interesting sight along one of the main tree-lined boulevards in downtown Karachi were the road-side dentists. For several blocks there were numerous stands preceded by huge billboards advertising their trade with pictures of huge dentures, people-size molars with cavities before and after filling and underscored with text in Urdu, presumably advocating this or that special treatment. Next to these advertisements, one could see on the pavement dental chairs often with a patient in the seat and the "dentist" at work, surrounded by his paraphernalia, and using a foot pedal operated drill, as of course there was no electricity on the sidewalk. A bit farther up the same boulevard there was a whole block or more of barber stands, also with appropriate advertisement boards and barbers busy cutting hair and shaving. I must admit that I never took advantage of these curbside opportunities.

One other totally unexpected sight in Karachi and elsewhere in Pakistan, were the movie billboards over the theaters. Knowing the Muslim's extremely conservative attitude towards the role and position of women in their society, it is not surprising that many western movies and publications were censored and more revealing photos in magazines and passages in movies removed prior to release to the public. This censuring however did not apply to the billboards advertising the movies that were being shown. These billboards are enormous pieces of painted art and often depicted violence and surprisingly also, women in various provocative poses and often showing lots of skin, which in real life in Pakistan would be totally unacceptable. Another contradiction!

Selling and consuming alcohol in various forms is certainly frowned upon in this largely Muslim country, but for a westerner, obtaining beer or hard liquor was no problem. It was

available for westerners and their Pakistani friends or guests, at the embassies and consulates as well as at large multinational companies with an established presence in Pakistan. There also were local stores where one could go with a special permit, and buy locally produced alcoholic beverages, which to my taste were awful. Many of the local Pakistanis would also have access to alcohol and freely consume it at their parties. One more contradiction! Although beer and hard liquor were relatively easy to come by, wine was not so plentiful. So we set out to make our own wine. Initially we did this from a kit which was easily obtainable, but later we moved to making wine from the local fruits which were plentiful and cheap. We made wine from oranges, apples, mangoes and yes even onions. All of these came out pretty good and very drinkable, even the onion one.

In terms of entertainment for westerners, there was really not much to do. On weekends we would often be invited to the beach. Karachi has many beautiful beaches on the Arabian Sea, but I understand that these have recently become more and more polluted because of practically unrestricted industrial waste and raw sewage dumping. In any case when we were there in the early nineties, some of these beaches farther away from the town, were still rather unspoiled and not crowded. We would go along with one of our friends whose company owned a hut on one of the beaches north of Karachi. A hut meant a rather large concrete structure with running water, bathroom, cooking and sleeping facilities but no electricity. Spread out along the beaches would be many of these huts owned by affluent Pakistanis or by foreign companies, The beach we would usually go to was quite a ways from the city and in a remote area with no villages around. Most of the time there was not a soul to be seen anywhere when we arrived early in the morning, but as soon as the women in our party got into their bathing suits and on the beach or in the water, one by one Pakistani men in their traditional salwar-kameez would appear from out of nowhere and sit on the dunes next to the beach. They would sit there and watch the women. They did not ever bother us, but in the beginning it was a rather uncomfortable feeling for the women, being stared at. Sometimes one of our Pakistani colleagues and family would accompany us. Their women would also go in the water, but they would never put on a bathing suit and would go in with their baggy salwar pants and ample kameez tops. We would often see them trip in the water and have a hard time keeping afloat with their heavy clothes impeding their movements. I understand that this may be one of the reasons that so many people drown along the Karachi beaches.

We would go often on the weekends early in the mornings when the beaches were deserted, but later in the day various vendors would come by with cold drinks and snacks for sale. One could also pay for a ride on horses or even camels. We tried the camels once, and that was quite an experience. They had elaborate and colorful saddles and the guide would make the camels lie down so that we could get on the saddle. The camel would then be prodded to get up which he did by first getting on his front legs which would bring the saddle with the rider on top in a rather precarious and scary position leaning extremely far back. Hold on for dear life! After the stroll or run (rather uncomfortable) the process was reversed to get off with the camel dropping on its knees first, resulting in the rider leaning dangerously forward. We had noticed a local Pakistani man walking along the beach with an animal on a leash and a large burlap bag over his shoulders. From a distance the animal seemed like it was a small dog but one day he came up to us and it looked more like a large rat, until the man asked us if we wanted to see the animal fight his snake that he had in his bag. Only then did we realize that the

“dog or rat” was actually a mongoose and the bag contained a cobra. For a price one could watch the fight. Knowing that either one or the other was going to get hurt or die (most of the time it was the snake), we declined.

One memorable experience from our two years in Karachi was the festival of Eid al-Adha which is held each year to commemorate the willingness of Abraham to sacrifice his son to god. This festival lasts several days and any Muslim who can afford it, is supposed to slaughter an animal and share the meat with the poor. Several weeks before the start of the festival, farmers from surrounding villages would bring their herds of cattle, goats, sheep, and camels into town and sell their livestock to the local citizens. The people would go to the market to select and buy the animal they could afford and take it home to await the beginning of the festival. As the festival drew near it was quite a sight to walk through neighborhoods where the people had the animals they had bought days or weeks earlier, tied up in front of their house on the sidewalk, where they kept, fed and cared for it until the morning of Eid. That day special crews of butchers would drive around the neighborhoods and slaughter these animals right there in the streets. The carcasses would be tied up against garage doors or the side of the houses to be dressed so that the meat could be distributed. Ample pools of blood could be seen in the streets and the guts were placed in heaps on the streets to await pickup a day or some times more than one day later by special crews (remember there was no routine garbage collection in Karachi). As the climate in this area of Pakistan is hot and arid and these piles of guts often lay for a few days in the blazing sun, one does not need too much imagination to realize the scenery and the olfactory stimuli.

We attended the Pakistani wedding of one of my female colleagues from the medical school. It was quite an elaborate event in a large outdoor facility of one of the upscale hotels. The wedding was supposed to start at 8 pm, so we arrived a few minutes after eight only to find the place completely empty, except for the ushers. Anne and I entered and were immediately separated. Anne was directed to the right side and I was ushered to the left side. There we sat, kind of uncomfortably, waiting for a trickle of other guests to come in. I was lucky that I knew a few of the other guests and could have some conversation, but poor Anne did not know anyone. By 10 pm, the place was packed. Everyone was milling around with some soft drink or juice. When finally the bride and groom were announced they proceeded to an elevated podium where they sat down in their most beautiful and elaborate outfits. Everyone then walked up the steps to pay their respects to the pair. This consisted of shaking hands with the groom and bowing to the bride. I went up as well. I knew the bride quite well and was good friends with her. When standing on the podium in front of the couple I did something that would have been quite acceptable and even expected in the western culture, but in this Muslim culture was definitely a no-no. The bride and groom were seated in their lavishly decorated chairs (one could have called them thrones), and after shaking hands with the groom, whom I had never met (and as it turns out the bride had met him only twice before) I bent over and gave the bride a kiss. I did this on impulse, but later realized that this might have gotten me in trouble. I suppose that I got away with it because, by then, I had enough gray hair and the bride herself was younger than my own daughters.

Once everyone had a chance to go up and pay their respects to the couple, there was apparently some subtle sign (which neither I nor Anne recognized) and all of a sudden

everyone rushed to the tables under the large tents, loaded with plates of wonderful food. Everyone helped themselves, sat down, ate rather quickly, and then within a short while (certainly not longer than an hour), everyone was gone. While I had not seen Anne in the "female" crowd across from the "male" crowd during the whole time, I had no trouble finding her on her side of the party once almost everyone was gone.

My work at the Aga Khan University was similar to my work at the University of Miami, except that I did not conduct any research. I taught medical students and residents in small group seminars, made rounds with them, attended clinics, taught them in the operating room, and consulted with them on cases they would see in the emergency room. As everyone knows, the interaction between women and men in the Muslim world is different from the western world. The reader can well imagine that it would be rather difficult for a man to examine a woman in a Muslim country like Pakistan, Therefore the majority of obstetricians and gynecologists in a that country are females. The chairperson at the Aga Khan University was an exception. He was a male and I was the only other male in the department. It worked out reasonably well for me, as by that time I was old enough, so that most (not all) women would accept my interview, exam, and treatment. It did not work out so well for the young male medical students doing their required rotation through the department of O&G. I do not know if the reader knows what a "kick chart" is. Counting and recording the number of times a baby kicks inside the uterus of a pregnant woman, is one way that obstetricians try to keep track of the well being of a fetus, especially in difficult pregnancies. We ask a woman to keep a log of the number of times she feels the baby kick over a specified number of hours each day. That log is called a kick chart. Well, the male medical students kept comparing their own kick charts. In their case however it was a record of the number of times they were kicked out of the room by female patients. This happened to be quite often and the students would be frustrated, but came to accept this aspect of their culture and kept their kick charts as a light hearted way of dealing with that frustration.

In the Muslim culture men have the right of unilateral divorce. A divorce is effective when the man tells his wife that he is divorcing her in front of the required number of male witnesses. Apparently the word used is "Talaq" and is pronounced three times. I personally witnessed such an on the spot divorce. One day in the outpatient clinic a gynecologic patient was being seen by one of the female faculty members. A male medical student sat in during the interview, but left the room when the patient was being examined. After the exam and after the patient was again fully dressed the male medical student came back into the room and was present during the post exam briefing of the patient. When the husband came into the room to be present during the discussion, he became enraged when he saw a male medical student in the room. He proceeded to divorce his wife right then and there by pronouncing the required words. He then left the clinic and his wife or rather ex-wife stayed behind. It is often not the women who object to the examination by a male, but rather the husband. The following experience I had will underscore this.

One day I was sitting in my office next to the labor and delivery suite and one of the more junior female residents came running into my office, quite excited. "Doctor Le Maire, could you please come quickly? One of the laboring patients has some very major drop in the baby's heartbeat. I am worried but cannot reach her private doctor and the

doctor on call is in the operating room." I ran over to the delivery suite with the resident and into the patient's room. She was obviously in much discomfort and her husband was at her side. One of the first things an obstetrician may do when a woman in labor shows signs of some problem with the undelivered baby as evidenced by a drop in the baby's heart rate, is to examine the woman vaginally. In doing so, the doctor can determine if the baby can be quickly delivered or if there is a reason for the drop in the baby's heart rate, such as a loop of the umbilical cord being compressed by the head, in which case an immediate C- Section might be necessary. So I immediately put on a pair of sterile gloves and got ready to examine the woman. She herself was perfectly ready to let me do this, but her husband stopped me and told me that he objected to his wife being examined by a male. This was even in the face of a serious situation with potential for harm to his unborn baby. There was no time to be lost trying to reach one of the female attendings, so I did the next best thing and told the very junior resident to take the patient into the operating room and examine her there and let me know the findings, while I was getting the operating room organized to do a C-Section, if called for. The strange thing is that the husband would have let me do a C- Section on his wife, but not a vaginal exam. As it turned out, by the time the patient ended up in the operating room, her private doctor had been located and was in attendance. The outcome was good and a healthy baby was delivered soon after. However the situation could have been quite different and catastrophic. Even stranger to me was that the woman's husband was not a lay person but actually a chief resident in anesthesiology in the same hospital. I would never have thought that an educated person and a medically educated person at that, would jeopardize the well being of his unborn child and wife, based on cultural and religious beliefs. Later on in the year this same anesthesiology resident came to ask me for a letter of recommendation as he wanted to apply for a specialized fellowship in the USA. I hope that the reader can understand why I politely (perhaps not so politely) refused.

As we spent two years in Pakistan we were there twice during the month of Ramadan, which is the Islamic month of fasting during which participating Muslims do not eat or drink from dawn until sunset. The day before the start of our second Ramadan in Karachi, I was sitting in the cafeteria and I had a heated discussion with some medical students and one of the female assistant professors in the department of O&G whom I will call Nadia (not her real name). I was telling the group that I did understand the requirement for Muslims to abstain from eating during the daylight hours, and if nothing else, that was probably healthy for the body. What I could not understand was that God (Allah) would require the people to do something harmful to their bodies, like not drinking any fluids during the day. Dehydration could not be good, especially not in the arid and hot climate of southern Pakistan. Not taking in enough fluids might be harmful, as was demonstrated, I argued, by the fact that during Ramadan workers in Karachi became lethargic in the later part of the day, and in fact were often seen just lounging around waiting for sunset, so they could start eating and drinking again. Another argument for my point that not drinking in this hot climate was unhealthy was the observation that the number of cases of kidney stones seen in the emergency room of our hospital increased markedly during the later part of the month of Ramadan.

Around the table we batted this back and forth. But the most vocal person in favor of the strict observation of the no eating and no drinking rule during Ramadan was Nadia. She pontificated that this was what the Prophet wanted them to do; therefore they should

strictly adhere to this rule. We left the discussion at that, and even if I did not agree, I respected their, and especially Nadia's, dedication until a few weeks later. But first let me backtrack a bit. Karachi has many slum areas called Katchi Abadis and the Aga Khan University had outlying clinics in these areas served by members of its faculty. The staff members in O&G would go out to one of these clinics in the Katchi Abadis on a regular basis. One day during the month of Ramadan following the discussion about eating and drinking which I described earlier, it was Nadia's turn to go out for the whole day to one of these clinics. Late in the afternoon of that day I was sitting in my office, finishing some paperwork and in came Nadia, looking disheveled and tired. She closed the door and plopped in a chair in front of my desk. Here is the essence of the conversation that ensued.: "Oh Wim, I am so tired. I was so busy and it was so hot and dusty in the clinic. I am so very thirsty and I really need something to drink. I know that you have some coke in your refrigerator, could I please have one?" I was astonished, as this was the same Nadia who a few weeks earlier had been so adamant in public that she and all the Muslims needed to abstain from drinking during the day in the month of Ramadan. So I said, "Nadia, do you remember our earlier discussion about this? No you cannot have a coke," And then I did something rather mean and later kind of regretted it, but I had to do it as I was so taken back by this lack of sincerity. I went to my refrigerator and had a nice cold coke myself. I think she understood as she left without saying much and we stayed the best of friends afterwards.

The Aga Khan hospital is a modern hospital with all the up to date facilities. It is also an excellent medical school and has great medical students. Teaching them either in the classroom or in clinical settings was a pleasure and similar to our American system. There was certainly no problem getting the students to respond to questioning and actively participate in the teaching sessions. This was much different from my experience in Okinawa as I discussed in a previous chapter.

One of the difficulties I saw with medical education was similar to what we were already experiencing in the USA. To explain that I need to first elaborate a bit. Over the years many excellent, new, and rather sophisticated technologies have been developed to aid in diagnosis and treatment of a large number of conditions in medicine. In my own specialty of O&G we have seen the development of ultra-sonography to diagnose various pelvic problems and to aid in the visualization of the unborn baby in the womb and even make treatment of an unborn baby possible; fetal monitors have been introduced to follow the heart rate of the unborn baby before delivery and make it possible to intervene before any damage occurs; highly sophisticated instruments have been developed to visualize the abdominal organs and carry out surgery through small incisions (laparoscopy); specialized laboratory tests have been developed to aid in quick diagnoses, where in the past, days and sometimes weeks were necessary to obtain results. While I certainly welcome these new developments and use them every day, the drawback has been that young students and trainees come to rely on these "adjuncts" in diagnosis and treatment sometimes to the exclusion of clinical acumen. I will try to give a few examples. One day, I received a call from the resident in the emergency room about a woman who had come in because of some abdominal pain and vaginal bleeding. While the resident told me these two symptoms her next sentence was: "… and the pelvic ultrasound showed…" I stopped her right in her tracks before she could tell me the result of the ultrasound scan. I told her: "First tell me more about this patient. Does she look ill? Is she bleeding

heavily? Is she in a lot of pain and where is the pain? What are her blood pressure and pulse rate? How long has she been having these symptoms? When was her last menstrual period? What are your findings when you examined her ? What is the result of the pregnancy test?" The resident could not answer most of these basic clinical questions and findings. She had proceeded straight to a test which might or might not have been necessary or even indicated and she was not using her clinical skills or judgment.

Another example that comes to mind is the time when the resident called me to the emergency room about a patient with a ruptured ectopic pregnancy. This is a pregnancy in the fallopian tube which, when ruptured, can cause massive bleeding in the abdominal cavity and requires urgent surgery. The resident told me that the patient was pale, and obviously bleeding inside her abdomen and on the verge of going into shock. The resident had accurately made the diagnosis, based on the patient's history and examination, but when I ran down to see the patient, the resident was wheeling the patient into the radiology department for an ultrasound. "Why an ultrasound?" I asked. "You already have made the correct diagnosis and she needs an urgent operation not another diagnostic procedure that will take up precious time before we can stop the internal bleeding." Instead of having the needless ultrasound, the patient was wheeled into the operating room. What I am trying to point out is that advances in technology are great but they need to be used judiciously and young medical students need to be taught to use their clinical skills first and then apply new technologies, if needed, to help them to come to the right diagnosis and treatment.

Termination of unwanted pregnancy was of course out of the question in the Aga Khan hospital in Karachi and in other hospitals in the city as well. However abortions were being carried out unofficially by doctors who might have felt that an abortion was in the best interest of the woman, or who were unscrupulous enough that they would do abortions for whatever reason even knowing that it was against the law. Or worse yet, these procedures may be done by unqualified persons in sometimes rather unhygienic and primitive conditions. One day, I recall being called to the emergency room by one of the residents who was seeing a young woman who was rather ill, with a high fever and severe abdominal pain. She gave the story that she had had an abortion several days earlier by a non-medical person and had been sent home after the procedure. That person had told her that a packing had been placed in the vagina and that she was to leave that packing in for several days. In the ensuing days she became progressively more ill and finally decided to come to the emergency room. What I saw was a very ill woman who had an "acute abdomen." This is a condition of sudden onset of severe abdominal pain associated with spilling of pus, intestinal contents or blood and/or infection in the abdominal cavity. It requires urgent medical and often surgical intervention. One example would be a ruptured appendix. We transported this patient to the operating room, where we removed the packing in her vagina. To our horror we were presented with several feet of necrotic and infected intestine filling her vagina and spilling out onto the operating table. To make a long story short, the general surgeons were called in and the patient underwent a laparotomy. This is a procedure whereby a cut is made in the abdominal wall to gain access to the abdominal cavity. In this woman's case she underwent resection of the dead intestine and removal of her damaged uterus. Ultimately she recovered nicely, but of course minus her uterus. What had obviously happened was that whoever did the abortion on this woman had perforated the uterus and in doing so

had brought forward through the uterus and into the vagina some loops of bowel. When this complication was recognized, rather than sending the woman right away to the hospital for surgical repair, the abortionist must have panicked and tried to hide the problem by placing a packing in the vagina, thereby seriously jeopardizing the woman's life. This story reminded me of my early resident days in Miami, when abortions were illegal. As a result we saw many similar cases of botched abortions performed by unqualified people, mostly for monetary gain. Some of the extreme cases then ended up dying. Since abortions were legalized in the United States, such serious complications are rarely seen anymore.

The Pakistani medial students and residents were much like their American counterparts and mostly well trained and dedicated. Many wanted to go on to the United States after completing their formal education and obtain additional experience and training in a specialized field. I interviewed a number of them and wrote several recommendation letters. While I was convinced that they were sincere at the time when they told me that they wanted to get this extra training so that they could come back to Pakistan afterwards and be of service to their people, the reality turned out to be somewhat different. Of those going to the States, a number of them ended up staying in America, for whatever reason, and they seemed to have forgotten their professed intention of returning to, and working in, Pakistan. However I do not think that this is unique to Pakistanis.

In a similar vein, I noted several deserving candidates receiving grants and fellowships to travel to the USA for additional training. These grants and fellowships then turn up in the US statistics as proof that we in the USA are supporting developing countries. In a sense that is true, but I did note several of these awards being given to applicants with extremely wealthy backgrounds. These candidates were capable of supporting themselves even for several years in the US without any additional aid. Equally deserving students from poor backgrounds might not be able to afford to go medical school in the first place. Such is the irony in many ways of our (USA) beneficence.

One of the highlights of our stay at the Aga Khan University was the graduation ceremony which was attended by His Highness, Prince Ali Khan himself. That ceremony was quite an elaborate and impressive affair with everyone in full regalia. I even had my picture taken with the Aga Khan.

While I was working in the hospital, Anne was busy working as a volunteer assistant swimming coach at the American School, formerly called the International School of Karachi. This School is an independent, coeducational and multinational day school. Anne's swimming team had 23 kids of different age groups. There were 17 nationalities speaking 11 different languages. Of course everyone also spoke English as the official language of the school. Her coaching job allowed her to travel with the team to Lahore, the second largest city in Pakistan after Karachi, located about 650 miles NE of Karachi. It is the capital of the Punjab province while Karachi is the capital of the Sindh province. I was a bit jealous that I did not get to go, as Lahore is a beautiful city, I hear.

Towards the end of our two year contract at the Aga Khan University we were able to take an extended vacation and travel north to Islamabad. From there we first flew by small propeller plane from Islamabad to Gilgit and then on by local bus transportation all the way along the Karakoram highway to the border of Pakistan with China. The flight

from Islamabad was a most breathtaking experience, as the plane was not equipped to fly high enough to be able to pass over the high peaks of the Himalayan mountain range. Therefore we zigzagged around various peaks banking sharply over snow fields and glaciers and skirting towering rock walls. In Gilgit we were lucky to arrive there when there was a big Polo tournament. Players with their ponies arrived from everywhere and we attended a big match between local teams. We did not know much about Polo, but it seemed that the game in Gilgit was played almost without rules, at least so it seemed. It was exciting to us and apparently to the local people as well. The entire atmosphere in and around the town was festive. From Gilgit we continued our trip north along the Karakoram highway and passed through many picturesque towns and villages. One of these towns was Karimabad in the Hunza valley.

Before we left Karachi for our trip to the Karakoram, some people had told us that we should try the local water there, which apparently is famous for supposedly promoting longevity. It is called Hunza water. When we checked in a hotel in Karimabad, we asked the owner who served us dinner that night if we could taste some Hunza water. He had a big smile and said: “Sure but later.” As we were the only guests in the restaurant that evening, the owner came to sit at our table when we were finished with the meal and asked us if we were ready to taste some Hunza water. To our surprise he brought some glasses and a bottle of something that did not look like water at all. It turned out to be a locally brewed apricot wine. It was rather good, very strong, and euphemistically called Hunza water. Naively, we had assumed that we were going to drink their famous water.

The northern area in Pakistan is well known for its large apricot orchards. This is made possible by an extensive and sophisticated system of irrigation installed and developed by the British during the colonial years. The area is rugged and starkly beautiful. We did several day hikes and on one of these days we had an experience we will not soon forget. We came to the edge of a ravine with a hanging rope bridge spanning the ravine for at least 200 yards. We crossed by stepping on the wooden slats between two ropes. The slats had about a foot between them but on several occasions one or two slats were missing, so that one had to almost jump from one to the next, with only a rope at shoulder level on both sides to grab onto and a roaring torrent a hundred feet below. It was scary. What was most amazing was, that we watched a bunch of cows walking across this bridge as if it was just a stroll in the pasture.

We also noted that the people in this northern area were more open and friendly than we knew the Pakistanis to be from our stay in the Karachi area. We wanted to travel all the way into China but when we got to the border it was temporarily closed because of some unrest in a nearby Muslim enclave within China. In any case it was a most memorable trip. Years later, both Anne and I had the good fortune of reading a marvelous book by Greg Mortenson, called *Three Cups of Tea.* The descriptions in that book reminded us of some of our experiences years earlier in the same area of the Karakoram Mountains in Northern Pakistan.

Upon our return to Karachi, our contract was at its end and we went back to the USA. In the meantime the program in Okinawa, where we had spent six months before our Pakistani adventure had contacted me and wanted me to return for another six months. We readily accepted and after a short visit to Miami for Christmas with our family we traveled back to Okinawa.

CHAPTER EIGHT: RETURN TO OKINAWA

On return to Okinawa my work there was similar to the previous six months, even though it was a bit easier, probably because the Japanese doctors now knew me and I knew them. We also traveled extensively in this most beautiful area of many islands called the Ryukyu Islands in the South China Sea. We tried as much as possible to stay in the local Japanese inns, called Ryokans, or the budget version called Minshukus where one is welcomed with a tea ceremony, sleeps on tatami mats and is served most delicious Japanese food. The only meal of the day we usually did not like was breakfast. We would often have preferred a nice slice of bread or bagel with an egg or jam over the traditional rice with dried or grilled salty fish, pickled vegetables, miso soup, and dried seaweed served for breakfast. We often decided to forgo that breakfast fare and pulled out a jar of jam of some sorts and to the amazement of the locals put that on white rice for our breakfast.

Our weekends were free. So we would go to the harbor and see which ferry was going to which island and we would just hop on and get off at a place we had not been before. It was a most marvelous way of exploring this "paradise." Among other islands, we visited Iriomote where there is a rare species of a wild cat, not found anywhere else, but we did not get to see any. We were also in Kuroshima, where there are more cows than people on the island, and we snorkeled in Tokashiki in the Kerama group of Islands, famous as one of the great diving spots. On Ishigaki Island we saw the famous blue coral and learned that that reef was being threatened by destruction to make way for an airport runway extension. I do not know at this time if that construction went through, as there had been a lot of opposition. Our travels in and around Okinawa exposed us some more to the Japanese life style and behavior. On one of our trips we were sitting on the deck of a ferry taking us to one of the islands. Next to us was a young girl of may be eight or nine years of age with her mother. It seemed that they were heading for a weekend vacation. However the mother was making her daughter do some homework. It looked like it was a math test and she had to do it while her mother was timing her. She had to do it over and over again as she did not complete the test within the required time. This illustrates the well-known extreme competitiveness of the Japanese educational system.

One day we went snorkeling on one of the most beautiful beaches and on the edge of the water was a group of may be ten Japanese men being instructed about the use of their snorkeling equipment. They were obvious novices and had never snorkeled before, but each one was equipped to the hilt, even with knifes strapped to their legs, cameras and strobe lights. All that for their first time out snorkeling in shallow water. It illustrates the Japanese quest for perfection under any circumstance. The disturbing observation was that some of them ended up standing shoulder deep in the water with their flippers on and trampling on the underlying coral.

At the end of these six months in Okinawa we had planned to relax and travel, which we did. But we also began to think about our next assignment. While still in Pakistan we had established contact with the Department of Obstetrics and Gynecology at the College of Medicine and Health Sciences of the United Arab Emirates University in Al Ain (Abu Dhabi). The dean there knew about my previous two years at the Aga Khan University in Karachi, and he was interested in me joining their faculty. We had kept that as a possibility. So we paid a site visit, while still in Okinawa. We flew to Dubai and then

traveled by car through the desert to Al Ain, which is called the garden city of the United Arab Emirates. And indeed it is. The streets are tree-lined and there is grass everywhere, even though the city is surrounded by desert. The site visit went well, but it was somewhat unusual. I learned that both men and women were admitted to the medical school, but stayed segregated throughout their classes. This meant that all lectures and clinical rounds had to be done twice, once for the men and once for the women. The library for instance had two entrances, with a central administrative core. Women would come in on one side and the men on the other. They were completely segregated. To us this was a bit unexpected as some of the other rules which we had come to expect in a Muslim country like Pakistan seemed to be more relaxed here in Al-Ain. For instance, as a non-Muslim one could order an alcoholic beverage in any restaurant or hotel, which had been impossible in Karachi. In any case, I was offered the position which came with a generous salary and benefits, but after returning to Okinawa, we decided that this was not for us and I respectfully declined the offer.

On our way back to the US, after completing our six months in Okinawa, we stopped over in Saipan, an Island in the Mariana group in the Pacific, north of Guam, where there was a position available in the government Hospital. The site visit was interesting and the island was beautiful, but again we decided that it was not for us. In any case we were not in a hurry and wanted to relax for six months or so. In fact we had planned a camping trip to Alaska. While planning the trip to Anchorage, I came across an ad from the Indian Health Service Hospital in Sitka, Alaska. The position that was being offered seemed attractive, even though it was certainly not an academic position. We contacted the medical director there and made arrangements for a side trip to Sitka while we were in Alaska. Our itinerary called for a flight from Miami to Seattle and then on to Anchorage. From there we would visit Denali and other sites by rental car. On our way back to Miami we had a stop in Seattle and as this was an “open jaw” ticket we could interrupt our trip and fly to Sitka. This we did. The job there seemed just right for us, except for the fact that as a new hire I would only have two weeks of vacation a year and one week of CME leave (Continuing Medical Education). At my age and seniority that was not acceptable and I told the medical director so. She was apologetic but stated that the organization’s rules precluded her from giving me more vacation. So we left Sitka still undecided about our next assignment.

Our plan was to take the ferry from Sitka to Prince Rupert in British Columbia and then by another ferry to Port Hardy at the northern tip of Vancouver Island. From there we would bike all the length of Vancouver Island to Victoria at the southern tip. We had brought our panniers with us and had left the majority of our luggage in Seattle with friends before flying to Sitka. The problem was that we did not have any bikes. So we first took the ferry to Juneau which is a much bigger city than Sitka in the hope to be able to buy there two secondhand bikes. We would then try to sell the bikes again on our arrival in Seattle. As it turned out we were lucky and readily found what we wanted by looking through the posted ads in a grocery store in downtown Juneau. We bought two used bikes, attached our panniers to the bikes, stuffed them with our camping gear, and boarded the ferry for Prince Rupert and then on to Port Hardy. We arrived there in the middle of the night in the driving rain and were soaked to the bone when we found a campground and set up our tent. The next morning was a beautiful sunny day when we set out on our biking trip. We never had any more rain. We had no specific time table,

other than meeting in Seattle our return flight to Miami, so we took our time and made numerous side trips to surrounding islands such as Quadra, Denman and Hornby. We camped wherever we found a nice spot and we found plenty of those. Our intent was to bike all the way to Victoria in the south of the island and from there take a ferry to Seattle to retrieve our luggage and fly back to Miami. But when we got closer to the south end of the island the road became rather busy with many large logging trucks whizzing by us while we kept to our narrow biking lane. This became a bit nerve racking after a while and we decided to forgo Victoria and took a turn off the main highway to Nanaimo, a port on the east side of Vancouver Island. From there we took a ferry to Vancouver in British Columbia.

Vancouver is a beautiful city and we enjoyed roaming around there, but we had a problem as we were with our bikes and needed to get to Seattle. Biking from Vancouver to Seattle was out of the question. It was too far and there were no good biking roads. So we decided to go with our bikes on the Greyhound bus. We found out however that the bus would only take our bikes if they were disassembled and boxed. What to do? We found a nice bike store in Vancouver close to the Greyhound bus station. They had some empty bike boxes which they gave us. They even helped us disassemble and pack the bikes. On arrival in Seattle we needed to reassemble the bikes so that we could get around for the next few days until our scheduled flight. We had no tools to do the assembling but borrowed some from a gas station nearby the bus station. That done, we set off to our Youth Hostel where we planned to stay. On our way we passed by the REI Company store. This is a famous sports and recreation equipment store where we wanted to buy some equipment. Close by REI we passed a second hand sport store with a sign "we buy and sell any sport equipment." As we needed to get rid of our bikes before returning to Miami, we stopped there. The owner of the store was interested in buying our bikes. He offered us $ 125.00 for both bikes. We had paid $ 175.00 for them back in Juneau two weeks earlier. That deal seemed good to us. However we had a problem as we wanted to spend two more days in the Seattle area and go to our friend's house to pick up our luggage that we had left behind there before we flew off to Sitka. The store owner agreed to let us keep the bikes until we were ready to leave. On the day of our departure we pedaled back to the secondhand store, sold our bikes, transferred our luggage from the panniers to the suitcases, and took the bus to the airport. It all worked out so beautifully.

Back to our plans for our next assignment. As stated earlier we did not want to accept the offer in Sitka because it did not give us enough vacation time. The medical director had asked us to call about a week after we had left Sitka. While on our bike trip we made the phone call. The medical director in Sitka again apologized that she was unable to give us more vacation time, and I felt immediately disappointed as we wanted to go there. But then she added, "What I can do is give you in addition to the two weeks' vacation to which you are entitled, two more weeks of unpaid leave of absence and I will increase your salary by two weeks." I thought that was imaginative and creative administration at its best, and I jumped at the opportunity and verbally agreed on a two year contract. So when we arrived back in Miami we were in high spirits. We started to get ready for our move to Sitka where we were to begin work in February 1993.

CHAPTER NINE: OFF (OR IS IT BACK ON?) THE BEATEN PATH IN SITKA

Sitka is a relatively small town on the Island of Baranof in Southeast Alaska. It can be reached only by air or sea. Even though its population is only about 9,000 it apparently is the largest city in the USA by area. Although this number varies, about 1500 Native Americans live in Sitka. These are about 80% Tlingit Indians and the remainder are Haida or Tsimshian. These natives have organized their medical care under an organization called SEARHC (South East Alaska Regional Health Consortium). This is a non-profit tribal health organization and is one of the oldest and largest native-run health organizations in the USA. It was established in 1975 under the provisions of the Indian Self-Determination Act. The intent of this legislation was to have Indian Health Service programs and facilities turned over to tribal management. The hospital of SEARHC is called Mount Edgecumbe Hospital and is located in Sitka. The hospital is named after the dormant volcano, called Mount Edgecumbe, which is located right across Sitka on another island (Kruzof Island). The hospital's catchment area includes 18 native communities on surrounding islands, including Juneau, the capital of Alaska. My job in Sitka was to be the one and only O&G for SEARHC. Natives from other communities, who needed O&G hospital care needed to travel to Sitka. If they had private insurance they could obtain their care from specialist in Juneau and Ketchikan or elsewhere, but most would come to Sitka. As Juneau had a private hospital, some of the uncomplicated deliveries for native women could be attended by the family practitioners who were employed by the SEARHC clinic in Juneau and who had privileges at the Juneau Hospital. However, many pregnant women would travel from their village to Sitka at about 37 week's pregnancy and await delivery.

A number of the family practitioners at Mount Edgecumbe Hospital had obstetrical privileges and they loved doing deliveries. I shared call with them and if I was not on call, but in town, and not hiking, fishing or kayaking, I would keep my beeper on in case of an emergency, like a problematic labor or a C-Section. This sounds like a busy job, but in reality it was not. First of all the family practitioners were very keen and also very competent and would only contact me if they really had a problem. Many times they would just call to give me heads up about a potential problem or call to get my advice. If I was not on first call and wanted to get away, I would phone the MD on call and find out if anything was brewing and if not I would contact the general surgeon and sign out to him. He was very versatile and perfectly capable of handling emergency obstetrical and gynecologic problems. I always felt a bit guilty, because I could not reciprocate the courtesy and have him sign out to me, as my skills did not include general surgery. But the surgeon was always very gracious about this and he and I were friends. From time to time I would bring him some fresh fish I had caught while he was "minding the store." The obstetrical service was not very busy in any case. The number of deliveries at Mount Edgecumbe Hospital when I arrived in Sitka in 1993 hovered about 100 per year and since has declined to about 70.

There was one incident in the labor and delivery ward that set me up for a bit of teasing by colleagues and nurses. The background of the story is that the uni-sex locker room was supposed to have an ample supply at all times of the blue scrub suits that everyone working in this area wore while on duty. Frequently the right size for the right person was missing and I had complained many times to the charge nurse about this without the problem being corrected. One night I was called by the nurses for an urgent delivery. There was no real problem but the woman was progressing rapidly and a delivery seemed imminent. When I arrived I went straight to the locker room, got out of my street cloths and looked on the shelves for a scrub suit. Not only was there no scrub suit of my size, there were none at all on the shelves. Here I was standing in my underwear with the nurses yelling at me: "Doctor LeMaire, hurry up, she is pushing!" The only thing I could think of at that time is to grab whatever I could find on the shelves. That happened to be a scrub dress, almost never used anymore nowadays by the nurses. I put it on, hurried into the adjacent delivery room, and was welcomed with great laughter while I prepared to complete the delivery. Everything went fine and after some more laughing and joking about my "outfit" I went back into the locker room to change. There it dawned on me that I probably should get angry about this persistent lack of proper supplies in the locker room. So I swept everything else that was on the shelves on the floor. That included towels, masks, head covers and shoe covers. The next morning I confronted the charge nurse, told him to have the mess in the locker room cleaned up, and scolded him about his failure to follow up on my multiple earlier requests to have the locker room properly stocked. The next morning I was summoned to the office of the head nurse, who apologized about the incident. She then pulled out a catalogue of hospital wear and uniforms and asked me to pick out the specific style of scrub suits I preferred. I told her that that was not the issue but that I wanted an ample supply of all the right sizes for all the providers available in the locker room at all times. I picked a simple design blue scrub suit. The head nurse then proceeded to ask me how I wanted my name embroidered on the scrub suit. I told her that that did not matter either. The next thing I knew was that shortly thereafter all the doctors doing obstetrics (at least six of them) were provided with four sets of blue scrub suits with names embroidered both on the top and on the bottom of the suit. A few days later I was called into the office of the charge nurse of the operating room who apparently did not want to be outdone by "*obstetrics*" and she had me go through the same routine. As a result all surgery providers also received their own green scrub suits with embroidered names on them. Nowadays, years later I often ask new staff members if they know why they have their own labeled scrub suits, and then tell them the story.

When on duty at night, I would be able to stay home and would come into the hospital when needed for any obstetrical or gynecologic cases. There were often calls from outlying villages. Except for Juneau, Ketchikan and a few other larger communities, the clinics in the villages did not have a physician and were staffed by health aides who were well trained by SEARHC, but had limited obstetrical or gynecological knowledge and skills. Therefore I would often receive calls from the health aides in the villages, or the physicians in the larger communities about cases. If possible, I would give over the phone advice, but if I sensed any hesitation or discomfort on the part of the caller, I would tell them to send the patient to Sitka. For non-urgent cases that was rather simple as they could come by ferry or by commercial flight. From the villages, commercial flights often

meant float planes, as many of these villages did not have a landing strip. Of course Juneau, Ketchikan and a few larger communities are exceptions.

If the case was an emergency and a commercial flight was not available or not appropriate, a medevac (medical evacuation) team needed to be dispatched to go and retrieve the patient and bring her to Mount Edgecumbe Hospital. Although there was a well-organized medical evacuation system in place and things usually went very smoothly, on occasion a plane was not readily available, or the weather was such that a medevac plane could not fly. Also at night no medevac planes could go out because these villages did not have a navigation system. It was then time to call the US Coast guard who would fly their rescue helicopter to the village. The US Coast guard has a big presence in Sitka, with both an air and sea station and responsibility for search and rescue operations for the entire area of South East Alaska. On occasion even the Coast Guard helicopter could not go out because of bad weather, in which case the doctors at Mount Edgecumbe Hospital would just have to do their best by advising the health aides to take care of the patient as best they could with their limited skills and limited facilities and transfer the patient as soon as conditions permitted.

I vividly recall one case in particular. I received a call from a health aide from one of the smaller villages. It was in the middle of a stormy and foggy winter night. The call was about a woman who was at term in her pregnancy and apparently in labor. The woman had failed to follow the instructions and travel to Sitka at 37 weeks and now was going to have her baby. A medevac flight was not possible at night and the Coast Guard was not flying because of dense fog. So it seemed that the woman was going to have her baby in the village. The health aide had never done or even seen a delivery. I told her to get some help from other health aides in the village and I asked her a few basic questions about the patient. The baby's heart tones were good. She had apparently ruptured her membranes and was having strong contractions every two to three minutes. Her vital signs were all right, but the health aide could not tell me about the dilatation of the cervix or the station of the head of the baby as she had not done an internal exam. In fact she had never done an internal exam before. Hopefully it was not a breech presentation. I stayed on the telephone and tried to talk her through it. However I never found out what the dilatation was as the next thing the health aide excitedly told me: "She is pushing and I can see the baby's head." I stayed on the phone and waited until the baby and placenta had been delivered and all was well. That was certainly an exciting call night. The next morning the mother with her baby could be transported to the hospital, where we made sure that all was well with both.

Our hospital was not set up to take care of complicated obstetrics and especially not of premature babies. So if we had such a problem we would consult with one of the obstetrician-gynecologist at Alaska Native Medical Center (ANMC) in Anchorage. If appropriate we would transfer the patient by commercial flight if not urgent or by medevac if urgent. In fact if there was a real danger of preterm delivery ANMC would dispatch a special team from Providence Hospital in Anchorage. The team would come with all the necessary equipment and with a nurse from the neonatal intensive care unit to take care of a preterm baby. When that team arrived in Sitka they would take over and transport the patient if she was not delivered yet and delivery did not seem imminent (one does not want to deliver a baby in the air if one can avoid it) or transport the baby if she

was already delivered. It was really comforting to have this back up from the doctors and nurses in Anchorage. They had a similar philosophy with us as we had in Sitka with the villages. If we felt in any way uncomfortable having the patient stay in Sitka they would not hesitate to say "send her!" and would help us organize the transfer. For non-native patients, medevac referrals would sometimes be made to Seattle.

Early on during my stay in Sitka, I would periodically visit some of the outlying clinics and spend one or two days there, seeing patients with obstetrical and gynecological problems. I would fly by jet to the bigger cities, but getting to the smaller villages was different. I could go by ferry but most of the time I went by float plane. When the weather was bad, and it could turn bad in a hurry, that could be quite exciting and sometimes a bit scary. I remember one such float plane flight. We left Sitka to go to Kake, a small village SE of Sitka. The weather was passable, but as soon as we left Sitka the fog rolled in and the pilot decided to fly as low as possible under the clouds, so that we ended up practically skimming over the waves and winding our way through the mountain passes. I had to close my eyes a couple of times and say a prayer. One other time, flying back by float plane from Angoon, another village east of Sitka, the weather was gorgeous and the pilot climbed as high as he could and we had an incredible bird's eye view of Baranof Island, where Sitka is located on the west coast of the Island. Also one was not always sure to make it back as planned. Bad weather could really mess up schedules. After a while I realized that going to the smaller villages was not very productive. I could really not do anything diagnostic, like biopsies or colposcopies, as these small villages did not have the necessary equipment. What I ended up doing was deciding that such and such patients needed something done and arrange for that patient to come to Sitka anyway. This I could easily have done over the telephone, or the family doctors who periodically came to visit these villages anyway, could have made arrangements for the referral to Sitka. So I stopped going to the smaller villages, even though I liked to go. I would of course continue to go to the bigger clinics in Juneau and Ketchikan, where I could do such things as biopsies and colposcopies.

Even flying by commercial jet to the bigger cities in SE Alaska can be challenging, especially in the winter. Sometimes airports are fogged in for days on end, with no planes making it in or out. This is especially true for Juneau. The airport there is located in a bowl that often fogs in completely, even when the weather is relatively clear in the city itself, only a few miles away. All the commercial jet flying in SE Alaska is via Alaska Airlines, which has a virtual monopoly here and the pilots are well trained and skillful.

I remember one winter day when I was supposed to fly to Juneau to do a two day clinic there. We left Sitka in the early morning but circled the Juneau airport for a while and even had an aborted landing before the pilot finally decided to fly on to the next destination, which was Seattle. When we landed in Seattle, there was another plane on the ground there, scheduled to take off for Anchorage with a stop in Juneau. We were told that the weather in Juneau had cleared and we could board that flight. So we did and retraced our steps, about two hours flying. Alas, Juneau airport was fogged in again and after some circling we flew on to Anchorage. Alaska Airlines put us up in a hotel and scheduled us on an early morning flight that left for Seattle, via Juneau and Sitka. To make a long story short, Juneau was fogged in again. We overflew it and the plane landed in Sitka on its way to Seattle. So I got back to Sitka twenty four hours after leaving

without ever making it to Juneau, even though three times we were so close that we could almost see the outskirts of the town, but not the airport. One other time in a somewhat similar situation, the pilot attempted a landing in Juneau in a dense fog. I was sitting on the left side of the plane and could not see anything but fog and clouds. The pilot aborted the landing and announced that he was going to try again. On our next approach it was apparent to any one sitting on the left hand side that the fog had cleared as we could see the lights on the shore along the landing approach. Everyone was sure that this time we were going to make it, only to be disappointed as at the last minute the pilot revved the engines and climbed out of the approach. He came on the public address system and apologized: " …I know that the people on the left hand side of the plane thought for sure that we were going to make it in as the lights on the left were clearly visible. But I have to see up front and I tell you I could see diddly-squat (sic). " He tried a third time and made it all right. My kudos to the Alaska Airline pilots.

Life in Sitka was different from what we had been used to. We lived in rental houses. In fact during the first two years we lived in three different furnished places until we eventually moved to one of the big unfurnished houses owned by the hospital. Most, if not all, of the furniture we had, came either from a garage sale or was given to us by people who moved. It ended up being a bit of a mismatch, but it would do just fine. By the time we moved in the hospital-owned house we had decided that we would extend our two year contact for two more years. In fact we ended up extending twice for a total of six years. I guess that qualifies it for being on the beaten path, even though it was a bit of an unusual path. Each time we renewed the contract, we did not think that it would be economical to buy a house for two years so we ended up renting. In retrospect, we should have bought a house right from the beginning, but of course we did not know that we were going to be there that long.

Our hospital-owned house was within walking distance from the hospital, which was convenient. It also was right on the water and we ended up buying three sea kayaks from a couple that just moved out of Sitka. We bought the kayaks with another couple and had great fun with them. When we wanted to go out, we would just slide the kayaks down a small slope from our house right to the beach and take off. This we did as often as we could, because kayaking around Sitka Sound was just incredibly nice. Not only was the scenery breath taking, but the wildlife all around was exciting.

Sitka sound is the permanent home for a pod of humpback whales and when we would go out in the kayaks we often could spot the waterspouts from the whales in the distance. If they were not too far we would paddle in that direction and when we got closer we would just sit there and watch without moving. On several occasions we would find ourselves surrounded by these huge animals. We never felt in danger as they seemed to know our whereabouts. One time one of these huge animals came right under our kayaks and we could clearly see it through the crystal clear water. One surfaced close to Anne's kayak. So close in fact that if she had wanted to, she could have touched it with her paddle. The amazing thing was that it came up so gently and barely made a ripple or a wave. In retrospect, we may have been a bit too adventurous as we have heard of whales tipping over boats. In fact it is illegal to get to within a certain distance of the whales. We really never did approach them, but they approached us. We would not get closer than several hundred feet as is legally require and then just float and watch them. Often they gave

quite a show, surfacing, blowing, diving, and breeching and on rare occasions bubble netting. One day a friend of ours was watching the whales from his motor boat, floating with the engine off. Our kayaks were about half way between his boat and a pod of whales that was putting on quite a performance. This friend took a photo of a breeching whale in the distance. Because of the angle and depth of the picture, this photo seemed as if the whale was breeching right over our kayaks, even though we were physically still quite far away from the whales.

Otters were also wonderful animals and we would just sit back and watch their frolicking. Diving birds were always all around us. Especially cute are the puffins. We did not particularly like to get too close to the sea lions. They always seemed more aggressive and one had the feeling that they were coming right to the kayak and would have tried to climb aboard while making loud and aggressive barking like noises. We would stay as far away from them as possible. Frequently we would sight brown bears on the shoreline or encounter them on hiking trails. Of course we always kept our distance as they can become quite aggressive, especially a sow with cubs.

Living so close to the sea was just wonderful, but without a boat one is kind of lost. So, soon after we arrived in Sitka, I got together with one of my colleagues at the hospital and bought a used 16 foot aluminum skiff on a trailer. It cost us $ 2,000.00 each, but we had our water transportation. We would go out either together, alone, or with other friends. We never seemed to have a conflict. We split all the cost of maintenance and repairs. We fished, went crabbing, and used it to go hiking in places where one only could get by boat, or took the boat overnight to remote cabins. In one word we had so much fun with that skiff that to me it seemed like it was one of the best investments I ever made. In the summer when there are 18 hours of light, we would get up at 4 am and go out trolling for salmon and be back at work at 8 am with our limit of salmon all cleaned and ready for the smoker. After work, we would have dinner of freshly caught salmon and afterwards we would go out again and fish for our limit up to 11pm when it finally started to get dark. The morning and evening catch would then go in the brine overnight (we experimented with many different kinds of brine) and then the fish would go in the smoker. Mostly we smoked with alder chips. We gave a lot of fish to friends and family, either fresh or smoked and of course ate a lot of fish ourselves.

We also had several crab pots and would go out to put them down where we knew we might find either Dungeness or less often Alaska king crab. The pots were baited with leftover fish heads or herring which we caught (that is another story). We let the pots soak for a day or two and then went back and pulled them up by hand. We could only keep the male crabs. These were easy to recognize by their underbelly. Many times we had nothing, but the times that we had crabs we had a feast. To recognize one's pots, there was a buoy attached by a line and marked with the license number of the boat. From our depth meter we would figure out how far the bottom was and measure out that much line so that the buoy would just be at the surface at high tide. We would then loop the line several feet and tie the loops with a piece of zinc. When the crab pot was then dropped overboard it would carry the line with buoy attached down under water. The buoy would now be several feet below the surface and only visible if one knew where exactly to look in the crystal clear water. Importantly it would be out of harm's way from propellers of passing boats and be mostly undetectable by poachers. The purpose of the zinc was to

allow this zinc to dissolve in the sea water over time. When the zinc was completely dissolved the loops of line which were held together by the zinc would be released and if everything worked out right, the buoy would now float on the surface and be readily visible when we came back to retrieve the pots. One could buy zincs with different times of release, from a few hours to several days. It was not always possible for us to get back when we knew that the buoy was going to be released either because of the weather or because we were working. Needless to say we still lost a few pots. They were either taken by poachers who passed by before we did or the line got tangled in some way and the buoy never made it to the surface. We would also know that our pots had been raided if there were no crabs in it and all the bait was gone. That made us really mad, but there was not much we could do about it. On one of our retrieving trips we found our pots and the first one we started pulling up was really heavy and required two of us to pull. We were elated as we thought that we had hit the jackpot with a big load of crabs. We were disappointed however when we got the pot in the boat. There were no crabs, all the bait was gone but there was a six pack of beer in the pot. Poachers had raided our pots but at least had the decency and humor to leave us something. We were raving mad anyway.

Another water-related activity was clam digging. There were several beaches where there were oodles of little neck and butter clams. We would go clam digging at a particular low tide and fill a bucket in no time. We had been warned that there always was the possibility that the clams would harbor a toxin from the red tide, especially in the summer. The toxin was not destroyed by cooking. This toxin could be lethal as it would paralyze muscles so that an affected person could not breathe. Artificial respiration could keep the person alive while the toxin was being metabolized and dissipated from the organism. So by eating the clams we knew that we were taking a chance, but the clams were tasty. As a precaution we did something that will sound very bad and could have attracted the wrath of the Animal Protection Agency. We had a house cat also called Showkidar, the same as our cat in Pakistan, except that this one did not like water at all. She loved raw clams and when we had a bucketful we would make sure the cat stayed in the house and feed her a few clams. For the next several minutes we would watch her closely for any sign of toxicity. We would be ready to take her to the local vet for treatment. Luckily we never had any problem. This danger of the toxin is not imaginary as apparently in 1799 there was an incident where Alexander Baranov, who was the manager of the influential Russian American Company, lost 100 or more Aleut warriors when they ate clams or mussels from a beach which was later called Poison Cove. The story goes that they collected the clams or mussels in Poison Cove and ate them on a beach across from there which is now called Death Man's Reach. There is a story that about 200 years later there were some local entrepreneurs planning to start a micro-brewery in Sitka. They had planned to call one of their beers "Poison Cove "and another "Death Man's Reach." However the brewery never got off the ground.

Another delicacy from the sea would come to us each year in early spring when the herring started running in Sitka Sound and the Sitka Sound Herring Sac Roe Fishery was about to begin. More about that later. When the herring run, millions of fish congregate in Sitka Sound, a relatively small area of the North Pacific Ocean. They come there to spawn. Once they spawn whole areas of the crystal clear water surrounding the multiple little islands in Sitka Sound turn milky white with the milt (sperm) of the male herring. One needs to have hiked up on one of the surrounding mountains and looked down on the

water to appreciate this incredible sight. The fertilized herring eggs are a delicacy for the native Alaskans and are actively harvested. One of the ways they collect these eggs is by placing large branches of western hemlock in the water close to shore, where the herring are expected to spawn. These fertilized eggs are sticky and will adhere to the needles of the branches. One can see some of these branches covered with double, triple, and yes, quadruple layers of eggs which are then collected, processed, and frozen for later consumption. When eaten, they are often mixed with seal oil and are served at parties and celebrations by the local natives. We tasted them but did not particularly like them like that. The way we liked to prepare them is to collect whole sheets of them from the hemlock branches or from the kelp where they also adhere. We first blanched them in boiling water for a few seconds and then peeled them off the branches or kelp. Next we marinated them in soy sauce and vodka overnight and froze them in zip lock baggies. When needed, we would thaw them, pour off the extra fluid, and pile them high on crackers with cream cheese. Delicious! Before we decided on vodka and soy sauce we tried several other ways of marinating them, white wine, soy sauce alone, vodka or gin alone, and a few other mixtures, but settled on soy sauce and vodka. Another way of preparing these herring eggs was on the kelp itself, without peeling them off. The kelp turns a bright green in the boiling water and one can then cut strips of kelp with the eggs on it and marinate them the same way. The kelp will give a little crunch to the eggs when consumed on crackers with cream cheese.

Herring eggs are also considered a delicacy in Japan and Korea and when the herring begin to show up in Sitka Sound, the town gears up for the impending Sitka Sound Herring Sac Roe Fishery. Seiners move into the town harbors ahead of the opening to stock up on supplies and equipment, prepare their nets and skiffs and await the signal to start fishing for herring. This fishery is well regulated by the Fish and Game Department. They calculate the yearly allowable tonnage so that the fishery will keep being sustained and they organize test fishing to see when the ratio of the weight of herring roe sac to the weight of the fish is optimal. When the optimal weight is reached they put the fishing fleet on alert and when the time nears they announce over the radio the exact time of the opening of the fishery and then start a countdown. Everyone with a radio can hear this and the excitement builds up. All 50 seiners with a permit go out to the assigned area of Sitka Sound and mill around, awaiting the signal for the opening. The trick for each seiner is to find the spot where there is a congregation of herring so that they can maximize their catch. We are talking now about a multimillion dollar fishery and no one wants to miss the big catch. To optimize their chances, the boats contract with float planes that start flying around the target area to detect schools of fish from the air and direct their respective seiners to the best areas. So here we have 50 boats milling around in a rather restricted space and a large number of float planes flying around, thank God, in organized circles. It is mayhem and people from town drive out on the road system along the sound to get a good look. Sometimes the designated area is close to shore and everyone gets a great look and one can hear, smell, and almost taste the excitement. Other times the area is farther off shore and the view is not so close.

When the time comes, the countdown actually goes like this: 10, 9, 8 ...3, 2, 1, and then the opening. No boat can have its nets in the water until that opening signal is given. At that moment all 50 boats drop their nets and their powerful skiffs pull the nets in a big circle which they will then close before winching them in, hopefully loaded with herring.

The millions of herring in the net are then transferred to the boats hold or to a nearby tender. This transfer is done by a large hose and suction with the water flowing out and the herring guided into the hold along a slide. During the process of pulling the net in, the weight of the loaded net tends to pull the seiner over to the side of the net. To prevent accidental capsizing and drifting, the powerful skiff that every seiner has and that helped in setting out the big circle of the net, now has a cable attached to the boat at the opposite site of the net and pulls hard to keep the seiner upright. During this time the skiff of the Fish and Game Department goes around trying to estimate the size of the catch in tons and when they think that the day's quota will be met, they call for a closure of that day's opening and another countdown starts to get the nets out of the water at the determined time or risk a fine.

Because of the often restricted space in the sound for the fishery, boats can be close to each other, sometimes too close, resulting not infrequently in collisions, or fouling of nets in propellers etc. As you can imagine tempers are on edge and this may occasionally result in foul language and rarely in violence. Hundreds of thousands of dollars are at stake and if nets get fouled or a seiner comes up with empty nets, all can be lost. There may however be a second and third chance as the herring is weighed at the end of that day's opening and if that year's quota is not met there may be a second and even a third opening a few days later. The herring is then processed and shipped to Japan and Korea. This is an exciting time in Sitka, not the least because it heralds the end of winter (even though there may still be snow on the ground) and the beginning of spring.

One additional aspect of this fishery, which I did not know at that time, is that the fish are not caught for their meat, but exclusively for their roe sacs. There is actually a delegation of the buyers from Japan to gauge the quality of the roe sacs which will be the basis for the price they negotiate for that year's catch. What happens to the fish carcass once the roe sac is removed, I do not know.

Besides the commercial value of the Sitka Sound yearly herring run and all its excitement, there is a fun part too for the ordinary Sitkan. When the herring run they are all around. Near shore, in the harbor, around docks, and they are easy to catch to the great delight of kids who, with almost every cast pull up one or several herring on their light line with tiny, multiple, shiny, unbaited hooks. Adults too catch them with rods and nets and will use them either as bait for salmon or halibut or for their crab pots. During our first herring season in Sitka I was on a dock with many neighbor kids all fishing for the herring. When I caught my first one from that dock, I was reminded of the Dutch tradition of eating young raw herring. These are often sold during the Dutch herring season from stalls right next to the roads and eaten raw right there, after dipping them in chopped onion. These are called "maatjes haring" and are considered a delicacy. I used to love eating them and when I caught my first herring in Sitka, I took my knife, filleted the herring, skinned it and started eating it right there at the dock, to the amazement of the many kids on the dock. Some of them ran home yelling: "Dad, Mom, come and look. Doctor LeMaire is eating raw herring!" As it turned out these were not nearly as good as I was used to in Europe, probably because the herring in Sitka are "spawners" and older than the young herring used for "maatjes haring" in Holland

When the pink salmon run in the summer, some areas of the bay close to shore and next to the mouth of a stream absolutely teem with fish and it becomes quite easy to catch

them with rod and lures from shore. While pink salmon are not considered as good tasting as king salmon, silver salmon, or sockeye salmon, we still liked them fresh, smoked, or canned.

Water-related activities are big in Sitka, but there are still many other activities to enjoy. There are some incredibly beautiful hiking trails. I remember one vividly as on that particular hike I performed a medical procedure for which, as a gynecologist, I was not really qualified. It was a beautiful summer day and actually quite warm and we hiked along the Indian River to a waterfall. There were four of us. One of the female staff doctors, who was a good friend of ours, a female medical student, who was doing a four week elective rotation in our hospital and Anne and I. The medical student was a delightful young woman originally from India and while outgoing, somewhat shy. It took about a five hour leisurely hike to the falls and back. On the return we all felt quite warm and sweaty and a dip in the river seemed attractive. We looked for a hole where we could actually swim. As we had not planned on going into the water, none of us had a bathing suit or towel. That did not seem to be a problem for us as there were no people around and when we found a suitable place in the river Anne and I took off our clothes and went into the water, while the medical student kept on her underwear and joined us for a splash. The water was refreshing but cold and we did not stay in long. Anne and I came out first and were off to the side somewhere between the trees to dry off and get dressed, when we heard this scream of pain apparently coming from our medical student, who was still in the water and had been pulling herself up on the bank by holding on to a tree branch. We immediately ran over even though we were still buck naked. Here was the medical student still standing in her underwear in the water, holding her left arm which appeared to be at an odd angle. She was obviously in great pain and our initial fear was that she had broken her arm. In between sobs of pain she told us “Wim, oh please help me, I have dislocated my shoulder, and have done this a number of times before. If it does not get reduced right away, swelling is going to set in and the reduction might have to be done in an operating room. If we can reduce it right away it will be all right.” We were still at least an hour hiking away from the trail head and our car. So the pressure was on me to reduce this dislocation. When I was an intern many years before, I had been taught to do this and in fact had done several myself. But that was eons ago. I did remember the principles however and was prepared to try. One picture would be worth the proverbial 1000 words but let me try to explain the principle. With a dislocated shoulder the head of the upper arm bone is out of it socket and to reduce it one has to first pull the head away from the surrounding soft tissue where it had lodged and then rotate the head back in the socket. The easiest way for the “reducer” in a situation like this is to take hold of the lower arm and elbow, while the patient is either sitting or standing, and have an assistant hold the patient’s shoulder back. The “reducer” then places his foot in the axilla (armpit), pulls on the arm until he feels the head of the humerus, which is the large bone in the upper arm, coming free. He then flexes the arm so that the head pops back in the socket. This is what I did, and as soon as I felt the head pop back in place, the patient, our medical student, gave a sigh of relief and said “Oh thank you so much, Wim. This saves me a trip to the operating room.” One could say: Not bad for a gynecologist. But remember the circumstances. Here is a diminutive young woman from India, standing in the river in her underwear, unable to get out of the water because of a dislocated shoulder, and here is the “doctor” standing on the river bank, buck naked,

putting his foot in the poor woman's axilla and pulling on her arm. Nobody managed to take a photograph though. The medical student was fine afterwards. She had an X ray taken when back in the civilized world to make sure that there was no fracture and she planned surgery sometime in the future as she had had several dislocations in the past and needed surgery to prevent these recurrences. As I knew how sensitive and shy our Indian medical student was, I never said a word to anyone about this event. She stayed in Sitka for another few weeks to finish her rotation. It was only after she had been gone for a few weeks that I started to get inquiries at parties from several of my friends. People would come up to me with a knowing smile and ask "Say, where did a gynecologist learn to do orthopedic work in the buff?" Apparently, while I had not said a word out of respect for her privacy, she had gone around and told everyone. You can imagine the ribbing I took.

One of the local veterinarians was a real character. He and I were good friends despite the fact that he would say anything that came to his mind. On one occasion he would introduce me to some friends of his with: "Hi, I want you to meet a friend of mine, he is a crotch doctor." On another occasions I would be the guy who looks up women's skirts.

Sitka has a wonderful Raptor Center, where injured birds, mainly bald eagles, but also any other sick or injured birds are taken care of. Some of them are able to be released in the wild after they had recovered from their ailment; others either became permanent residents at the Raptor Center or were farmed out to zoos or animal parks. Several people volunteered in the center and I signed up for this. My task was limited to Sundays when I would go for a couple of hours and clean the mews (cages) and feed the animals. It was exciting and rewarding. One had to wear a leather hat, leather jacket and gloves as the eagles have very sharp talons and if one is not careful one can get badly injured. They would not attack their caregivers, but inadvertently might land on one's arm or shoulder. I also helped capture eagles from their mews when it was time to give them a check up or treatment. That was also quite an undertaking as we needed to corner a particular bird in the large, walk-in mews, throw a blanket over it and grab its feet so that it could no longer do damage with its talons. One of the attendants would then slowly move the blanket from the bird's head and slip a leather hood over the eyes. Once these eagles were blinded this way, they would become docile and be ready for the vet's activity. When an eagle was deemed to be well enough to be released in the wild, this is the way we would manage to get them ready. The person handling the bird would have the eagles legs firmly immobilized and the bird's body tightly against the handler's chest. The bird would be hooded and thus remain perfectly still. When the moment came to release it, an assistant would slip off the hood and the handler would then let go of the legs with a little upward push and the bird would be off to the applause of those attending. These releases were always well advertised ahead of time. For the volunteers it was a great honor and quite exciting to be chosen to release a particular eagle. I had that opportunity once and I will never forget the sensation of this magnificent bird soaring away from my arms.

While I was working at the Raptor Center one Sunday morning, someone brought in their dog with a fish hook imbedded in its jaw. They had been unable to locate the veterinarian and decided to come to the Raptor Center. While I had never removed a fish hook from any animal, I knew the principles and went ahead and managed to remove the hook without much trouble to the great relief of the owner and apparently also of the dog.

Although Sitka is a rather small town, there are many opportunities for all kinds of

activities: physical, intellectual, and cultural. One of the great cultural activities is the Sitka Summer Music Festival. When we first heard about this yearly event we were rather skeptical and thought: "...how good can that be in such a small town?" Boy, were we wrong. During the entire month of June there are evening performances of chamber music three or four times per week with world class, and I do mean world class, artists. They are invited from all over the world and regale the community with fantastic performances. This is chamber music of the highest quality. The performances take place in an auditorium called Harrigan Centennial Hall. The entire front wall of this auditorium is of glass. During the performance one listens and has a full view of the mountains in the distance, some still snow capped, surrounding Sitka Sound. Not infrequently one or more bald eagles would soar by, gulls would fly past, or fishing boats coming in or out of the harbor would pass, only their masts showing. All these visual and auditory impressions are just incredible. During this month the invited musicians would also give impromptu performances at various venues, like a brown bag lunch concert in open air, a performance over cocktails on a tour boat plying Sitka Sound, or at a church function. Music students at the various schools would have the opportunity for one on one teaching by some of the best known violinists, cellists, or pianist. Another very exciting time in Sitka!

In the summer a large variety of wild berries become plentiful and we enjoyed picking and eating them. Many types of them made great jellies and jams. We also made so many different great wines from blueberries, huckleberries, salmonberries crowberries, dandelion, rosehips and even Sitka rose petals. Our wine label was "Chateau LeMaire." These bottles were much appreciated by our friends at parties and we even won several first prizes at the South East Alaska fair in Haines. Our favored was salmon berry wine.

As may be expected from this enthusiastic account of my professional as well as our social life in Sitka, we readily signed on for a second two year contract and even a third one. We negotiated a three month leave of absence without pay between the first and second contract. That gave us time to travel a bit and also do some volunteer work in the Caribbean. More about that in one of the following chapters.

The medical work was relatively easy and while sometimes busy, was never really hectic. I had been there, done that and seen that, as they say, and I was not out to prove myself. This was just right for me at this stage of my career. For a younger professional just out of training, this pace might prove not only a bit boring, but also insufficient to collect the necessary number and spread of cases to qualify for medical board examination and licensing.

The one and only case where a complaint was lodged against me was in Sitka. The case was a straight forward abdominal hysterectomy for uterine fibroids. The case went well and at the end the nurses reported a complete needle, sponge and instrument count as is required after every surgical case. An hour or so later I received a call from the head nurse of the operating room to tell me that the person cleaning the instruments had noted that one of the instruments, a self-retaining retractor used during the procedure, had a part missing. They had looked everywhere and could not find it. We obtained an x ray of the patient's abdomen and saw that the metal piece was still in her abdomen. It had apparently broken off, and while the entire instrument was counted, the fact that a piece was missing was not noted. Of course the piece needed to be removed and the patient was

taken back to the operating room, the surgical wound reopened, and the piece easily removed. In the following days the patient developed a hematoma (blood collection) in the abdominal incision that needed to be drained surgically. Following that she had a bit of a stormy course with an ileus (condition where the intestines are temporary paralyzed). Eventually she did well and recovered completely, without any lasting effects, but she was hospitalized considerably longer than for an uncomplicated hysterectomy. The case was reviewed by a small committee in the hospital and that committee decided that I was to blame. The case was then forwarded to a review committee at the Indian Health Service. The then hospital director went to bat for me as she felt that I was not to blame. She went out of her way and wrote several letters in my behalf with photos attached of the faulty instrument and a very detailed description of the occurrence. To make a long story short, the final decision after several years was that the incident was labeled as a system failure. The complaint was dismissed, the patient received a small compensation for her additional unscheduled procedures and the extended hospital stay, and I was not named in the settlement. I am grateful to the medical director for having supported me and going out of her way to have the case resolved in my favor, even after I had already left Sitka.

By now I had been in the USA for many years. While my knowledge of the English language had become nearly perfect, I still had an accent that most people found difficult to place. When I was asked where my accent was from (a frequent occurrence), I often would give the person asking, a riddle that goes like this:

-I speak Dutch and I speak French

-But I am neither Dutch nor French

-What am I?

Most of the time, the person asking would not be able to come up with the right answer. I would then give a clue: “chocolates.” Almost invariably the response then would be Switzerland, well known for its excellent chocolates. But of course, Dutch is not spoken in Switzerland.

I would then give the second clue: “beer.” This would almost always result in Germany as the response. Germany is of course known for its October beer fest, but no French is spoken in Germany. My last clue would be: “waffles” leading almost 100% of the time to the correct response of Belgium.

While my command of the English language had become nearly perfect, I would occasionally still have a problem with idioms. Even as recent as in Sitka, I can remember a somewhat embarrassing mix-up as a result of me not recognizing the double meaning of an English word.

This occurred when I was examining a patient and needed to perform a biopsy of the mouth of the womb in a middle aged woman. The patient was in the usual gynecologic position on the examining table and in stirrups. The cervix was exposed with a speculum and I usually anesthetize the biopsy area with the injection of a small amount of local numbing medicine, much like a dentist would before working on teeth. I always warn the patient just before the injection that she will feel the needle stick, so that she would not be startled and move. This particular biopsy went without problem and the nurse and I left

the room so that the patient could get dressed. No sooner than the door was closed the nurse suddenly bent over laughing. Of course I inquired what the matter was. Her response was a question: “Doctor LeMaire, do you realize what you just said in there?” I told her that I had no idea what she was talking about and asked her what was so funny. Then she explained this to me: “You know Doctor LeMaire, when you were about to stick the needle with the anesthetic into the cervix, you told the patient….. Mrs. X, you are going to feel a little prick up here. Mrs. X in a calm and matter of fact voice said… I hope not.” We had a good laugh about this “double entendre” and the patient’s response which, while in the room, had completely bypassed me.

While we thoroughly enjoyed the professional and social life in Sitka, we still had the urge to explore other parts of the world. We were not getting any younger and if we wanted to pursue this dream, Anne and I both felt by 1999 (I was then 65 years old) that we should get on with it. My ideal was to find an O&G who would want to share the job with me on a 50/50 basis. That way we would keep our ties with Sitka and at the same time have six months each year to pursue other interests. The medical director gave me permission to start looking for someone to split the job with.

I was pretty confident that I would have no trouble finding someone amongst my colleagues and friends from the University of Miami, who would jump at that opportunity. Over the years many of these friends and colleagues had told me, when they heard about all our experiences: “Wim, this is so nice what you are doing, I wish I could do it.” I called a number of these people of about the my age and told them: “...well here is your chance to do it.” As it turned out, I was a bit naïve as none of them seemed ready. Most of them were interested, at least that is what they told me, but they all had some excuse why they could not. Here are some of the excuses I heard: “I play golf every Friday and I cannot disappoint my golf buddies;” “my wife has her bridge club that meets every Thursday, and she cannot get out of that;” “we would not know what to do with our dogs and cats;” “we have a house full of art collections (or carpets) and cannot really leave these;” etc. To make a long story short, we never found any serious interest. So we decided to retire from our position in Sitka. We gave the medical director at least six months’ notice and tried to help her find a permanent replacement, which we did not have by the time we left Sitka.

We left Sitka, after shedding some tears and emotional farewells and promised to be back as we had made many friends there. Our plan was to travel around Alaska for a bit. We wanted to camp and had looked around for a van that we could use as a camper. We found a second hand Chevy van in White Horse, British Columbia and drove up there to retrieve it. We sold our other vehicle to a couple in Sitka and when our van arrived in Sitka, the husband of one of the nurses in the hospital, built us a nice folding bed in the back of van.

We took the ferry from Sitka to Haines where we hit the road, without any definite plans other than seeing as much as possible of Alaska. It was the month of May and our first campground in Haines was still closed because of heaps of snow. Many campgrounds in Alaska are located in state parks and are invariably nice and not crowded. For the next six months or so we stayed in campgrounds except for the occasional motel when we felt the need for a bit more luxury and for the times we were on ferries. In the camp-grounds we spent most of our time outside: hiking, exploring, picking berries, and reading. Our van

was mainly for sleeping, even though if needed we could sit in it and play cards, dominos or boggle, when it rained. What struck us often is that some of the big rigs, like fifth wheelers, would back into a camping spot and as soon as they were situated the occupants would come out, walk their little dog on a leash around the campground and then go back in. The TV antenna would come out and we would never see the people again until next morning when they would walk the dog again and drive off. They completely missed all the wonderful outdoor activities around the campgrounds.

At night both Anne and I started worked on sewing a quilt which Anne had designed. Anne did the needle point and I would stitch the pieces together. We often attracted visitors who came to look at what we were doing, sitting around a campfire and sewing. Making this quilt was a big job. We worked on it intermittently, entirely by hand, and only finished it completely several years later. It is a piece of art.

We did not keep a log, and as we camped in Alaska one other time for several months, the many places we visited have turned into a blur of wonderful experiences one after the other. Thus my accounting of these experiences has lost some of its exact chronology. The reader must forgive me for being inaccurate as to time, but we were in all these places at one time or another, but maybe not in that exact sequence.

From Haines we worked our way to Anchorage, where we stayed for a number of days. The unusual thing about Alaska is that big stores such as Fred Meyers and Walmart will allow campers to stay overnight in their parking lots for free. Now and then we took advantage of that generosity. This was in 1999 and I have been told that they no longer allow this. From Anchorage we drove south into the Kenai Peninsula along Turn Again Arm of Cook Inlet, where we watched the Bore Tide come in. Then on to Seward and Homer, camping, hiking, fishing, and clam digging all along the way and stopping wherever we felt like it. In Homer we left our van with a colleague and took a ferry to Kodiak, where we stayed with friends and did some incredible fishing. From there we took the ferry to Dutch Harbor in the Aleutian chain. That ferry was the Tustumena of the Alaska Marine Highway system and one had to make reservations long ahead of time as the ferry ran only once a month. The trip one way takes three nights and the ferry stops in a number of places like Sand Point, Cold Harbor, King Cove, and False Pass. These are remote places and look quite desolate. We had a calm journey, but unfortunately the fog was rather thick and except for a lot of activity on the water from birds, whales etc, we did not see much of the coast line, except for an occasional fleeting glimpse. That coast line had been described to us as breathtaking with many volcanoes, some recently active. Maybe we will do the trip again another time.

On arrival to Dutch Harbor, also called Unalaska, we explored the place for a day. We arrived on a Saturday and on Sunday morning we went to Catholic Mass, which was held in the hall of a local hotel as there was no proper church at that time. There also was no resident priest in Unalaska and for that day's mass the priest flew into town in his own twin engine plane. That was quite an accomplishment as for the previous several days the scheduled flights of Alaska Airlines in and out of Unalaska had been cancelled because of the dense fog. After mass we had lunch with the priest and took him back to the airport for his flight to a nearby village for mass as well. His was the only flight that took off that day. That priest was quite a character and he had had several close calls with his airplane. Some years later we learned that he had crashed and had died. The next day the weather

had cleared and we flew back to Homer to retrieve our van and continue our camping trip. We took our time driving back to Anchorage and then on to Denali, where we camped hiked and did the usual full day bus ride all the way towards the end of the park and Wonder Lake. What a trip that was. We saw so much wild life: grizzly bears with their cubs, caribou, moose, ptarmigan, foxes, Dall sheep, goats, and marmots.

At another time in Denali, we obtained a back country permit and hiked into our assigned wilderness area without anyone else in sight. It was a rainy day but fortunately when we found a nice area to put up camp, the rain had stopped. The tundra where we set up our tent was just absolutely covered with low bush blueberries. After cooking our dinner we deposited our mandatory bear proof canister away from our tent and sat on a knoll overlooking a little stream and pond where a beaver was actively building its lodge. We experienced firsthand the expression "eager beaver." In the early morning (like 4 am) Anne called me out of the tent as she had spotted a huge bull moose standing on a rise in the tundra several hundred yards or more from our tent. After watching him and him watching us for a while, we went back in the tent and when we got up around 6 am Anne called me out again with an urgent pitch in her voice to come and look quickly. Here was this (I assume it was the same) bull moose standing not 30 yards from our tent. This was quite exciting, but rather reassuring to watch him slowly walk away from us. We had planned to spend another night in the wilderness, but it started raining again and it looked like there was no relief in sight. We packed up and hiked out back to the road. There we waited for the camper bus to come by and pick us up and bring us back to our van. We have been back to Denali on a number of other occasions and every time we had a great outdoor experience.

At one of our trips we drove further north to Fairbanks and wanted to drive to Prudhoe Bay on the North Slope along the famous Dalton Highway. We had been discouraged by many people to attempt that drive in our little van. We had been told that this gravel road was dangerous and required all kinds of emergency equipment, like extra gas, extra tires etc. The main danger apparently was broken windshields from flying gravel, kicked up by the big rig trucks barreling down to and from the oil fields on the North Slope. Then we met a friend of ours who had just done it with his family in a Winnebago. He told us that it was a piece of cake. So we set out on our northbound trip. As it turned out our friend was right and we had no trouble at all. We had followed his advice and every time there was a big truck in sight, we just went off to the far side of the road and waited for it to pass. We took our time, camped everywhere and fished the streams and lakes for Arctic Grayling. We drove through the Brooks Range and over the Atigun Pass without any problem. Just over the pass we camped on the side of a lake all by ourselves. When we woke up in the morning there was about a foot of snow on the ground and on the van. This was in the middle of August and it surprised us a bit. We could deal with the snow on the ground and van but it was still snowing fiercely and the visibility was severely limited. So reluctantly we decided to turn back. We were glad that we did, as it started raining later on and the road got washed out in several places north of our camping spot on the lake. Due to the washouts several big rigs got stuck for days until the road could be cleared. We imagined ourselves in our little camper van stuck between two washouts and we were happy with our decision to turn back. Someday we might still make it to the North Slope.

One other memorable trip was to the old Kennecott Copper Mine in McCarthy. We drove into Chitna on the Glenellen highway. We had been warned not to drive ourselves on the McCarthy road to Kennecott as that road was treacherous. It took five hours then, but apparently it has been vastly improved and the 60 miles or so to the mine now only takes about two hours. In any case we found someone who was willing to drive us for a fee to McCarthy in his van. He was going anyway to participate in a big party for the local workers and guides. So we left our van in a parking lot in Chitna and were picked up at the appointed time by our driver. When we were already on the way, he told us that he needed to make a little detour to pick up one of his friends. His friend turned out to be a character. He was dressed in army fatigues, was full of tattoos, and had a handgun in his belt as well as a rubber club. He was a rather unsavory character and to tell the truth, a bit scary, not only the way he looked, but also the way he talked. We were not too keen on continuing with them, but could not really go back as we were already a number of miles on our way on the McCarthy Highway. After about half an hour, he asked his friend the driver to stop. They both got out and told us they needed to take some “pitchers” (sic). They walked over the side of the road and disappeared carrying a bag. We thought this was kind of strange as we did not see any cameras and they certainly did not look like camera buffs, even though the scenery was fantastic. Anyway we stayed in the van and waited for at least 20 minutes before they returned. Then we drove off and about an hour later he wanted to stop again to take some more “pitchers” (sic). The same thing occurred, but this time, when they returned it was clear to us what was happening. They had stopped to go drink a few beers. I told the driver in no uncertain terms that we could not interfere with what his friend was doing, but that it was out of the question for a driver of a van on this treacherous and difficult road to get stoned and that there were to be no further stops for “pictures” or anything else. While the driver seemed to be quite sober his friend promptly fell asleep in the back seat and started snoring loudly. He had several episodes of sleep apnea and at one point I was not sure he was going to come out of it. The whole situation was a bit scary, especially because in his stupor he kept grabbing for his gun. In any case we made it safely to McCarthy. It is a beautiful place and the remains of the copper mine which are well maintained for the most part, are well worth a visit. We had our backpacks with us and all the camping gear. After visiting the mine we hiked up a trail along the Kennecott glacier and found ourselves a beautiful secluded spot to put our tent right along the glacier. We had a minor grizzly bear encounter on the trail, but nothing too close or exciting. The next day we made plans to fly back to Chitna and forgo the ride back with our driver.

From Chitna we worked our way to Valdez on Prince William Sound. At one point we took a side trip by ferry to Cordova, a town at the mouth of the Copper River. We had left our van in Valdez and when in Cordova we rented a car and explored the area. There I had, what in my mind was probably the scariest experience of my adult life. There is an old railroad bridge, called the million dollar bridge, spanning the raging Copper River. It was used in the old days by the trains bringing the copper ore from the Kennecott mine to the coast for shipping. With the Alaska earthquake on Good Friday of 1964, the bridge had severely buckled and had never been restored (it is apparently restored now, but not in 1999 when we were there). It was however made passable for cars by planks fastened to the trestles. When we approached the bridge it did not seem too difficult at first. It was going to be one way, with no room for an oncoming car to pass, but fortunately there was

no traffic. But once on the planks which were laid out about the width of the cars on either side, with not a whole lot of room to spare, it quickly became obvious that this was going to be a trip from hell. What from a distance seemed to be a gentle slope became a steep incline. In between the planks and between the trestles one could catch terrifying glimpses of the raging torrent tens of feet below. Thank God we did not meet any oncoming traffic as there was no way one could have backed up, without risking having the tires slip off the planks and …. The scariest part came at the top of the bridge where it had buckled. The steep incline seemed to end in the sky. We knew of course (or did we) that the planks continued once over the hump, but there was nothing to see but a clear sky and the only thing to do was to have great faith and slowly ease over the rim. My knuckles were completely white and I could not speak, but I had to press on. On the other side the descent was still scary but not nearly as bad as on the way up. Just to think that we had to go back the same way made us rather nervous. In any case the trip turned out to be every bit worth it. We had a great viewing close-up of the Childs Glacier which ends at a bend of the Copper River. The raging river undercuts the face of the glacier, resulting in frequent calving. We stood on the opposite shore and watched in awe. Standing on that shore could actually be somewhat dangerous as people have been swept away by huge waves generated when a big chunk of ice from the glacier tumbles down in the river on the opposite side.

On our way north from Valdez we drove for many miles along the Alaska Pipeline. Sometimes the pipe line was far away, and at other times it was close. One can even walk up to it and almost touch it. We often wondered about security.

On one of our camping trips we left our car in Anchorage and flew via Kotzebue to Nome on the Seward Peninsula. Nome is situated on Norton Sound in the Bering Sea and once was a busy gold mining town. The gold mining is all but gone now and enormous pieces of rusting mining equipment can still be seen along some of the rivers. While walking along one of the beaches we noticed several small, what looked like homemade rafts or boats, several hundred yards off shore. These were not moving and were attached to shore by sturdy ropes. They had no one visible on board, yet one could hear a motor running. We inquired about this and were told that these were gold miner's crafts. Apparently the sea is quite shallow close to shore and there is still gold to be found. To get to this gold, the adventurous miners build themselves a platform with an air compressor and a pump. They then go out a few hundred yards off shore and with their diving gear they go down to the sea bottom. The air compressor provides their life support and a powerful pump will bring up the sand from the sea bottom through a hose to their platform and into a sluice box ,where the water runs off and sand, and hopefully some gold sediments down. When their sluice box is full, they come up and maneuver their craft back to shore where they then sift through the collected sediment looking for the gold. We were lucky enough to meet one of these people coming on shore with his "catch" of the day. He told us that, while he will not get rich from his finds, he collects enough gold to supply his jewelry making business. We watched him pull several small nuggets out of his sluice box. We could see at least 10 or 12 similar small private operations along a mile or so of beach. Obviously there is not enough gold there to warrant a big mining company to come in, but for private entrepreneurs, it provided a livelihood. We were told that some diehards would even go out in the winter and operate through a hole in the ice.

We had so many wonderful experiences in Alaska, but time came to head back to Miami. By now it was the end of September and we headed back to Haines to take the ferry to Sitka, pick up some of the stuff we had left behind there and take off to Prince Rupert in British Columbia, by ferry. We had been on that ferry several times and I do not remember if it was this or another time, but we put up our tent on the deck instead of renting a stateroom. It is about a two and one half day trip with stops at many ports, like Juneau, Petersburg, Wrangell, and Ketchikan. One takes all meals on board, and spends a lot of time looking at the beautiful scenery, reading, talking, and playing cards, or just reflecting. It is a relaxing passage. As I said, we have done this voyage along the inside passage a number of times and I think that it was during this return from Sitka in September that we had an absolutely clear sky during the entire trip and the nightly display of the Northern Lights was so intense that we just could not go to sleep and had to stay awake staring into the sky and admiring the ever changing patterns and colors. It was truly magical.

We got off the ferry at Prince Rupert and began our return to Miami. We took our time and stopped along the way wherever we felt like. We drove through so many wonderful places in British Columbia, Montana, the Dakotas, Minnesota, Michigan, all the way to northern part of New York. We kept following the fall change of the colors of the trees. It was again magical. Once in Pennsylvania we spent a few days with our daughter and her family, who live in that area, and then headed south to Miami. Our plan was to get back to Miami in only a few days but once we were on the Blue Ridge Parkway and were driving South through the Shenandoah National Park, it was so beautiful, with the fall color change, that we had to slow down and take our time getting it all in. It took us more than a week to get back to Miami.

What was going to be our next adventure? I had read about the need in New Zealand and Australia for locums practitioners and had been in contact with an agency in Utah, called Global Medical Staffing. Through them I had arranged to do six months locums in Townsville, Australia and the process of getting the registration and visa requirements out of the way began.

CHAPTER TEN: OFF THE BEATEN PATH IN AUSTRALIA

Obtaining a temporary medical license and working visa for Australia was relatively easy, but required a lot of paper work which was thankfully mostly handled by Global Medical Staffing. So in February 2000 we were off to Down Under and on to a new adventure. We interrupted the long flight from Miami to Sydney with a night stopover in Honolulu. Our destination was Townsville in North Queensland which lies about one thousand miles north of Sydney. There I was to work for six months at Kirwan Hospital, the Hospital for Women affiliated with Townsville Hospital. It was unique in that it was separated physically by a rather long drive from the main hospital and was devoted exclusively to women and newborns. Townsville Hospital together with Kirwan Hospital was the major clinical teaching facilities for the James Cook University Medical School. Later, after our term there, the two separate hospitals were combined in a brand new facility which was already under construction when we were in Townsville.

My work there was similar to my work at the University of Miami but without research. I would make daily rounds with the medical students, interns, residents and registrars (more about that later), attend clinics, assist the registrars in surgery, and organize tutorial sessions with the students and trainees. I would also share night and week-end call with the senior staff.

Medical training in Australia and New Zealand is similar to the education in Great Britain, but somewhat different from the USA. After finishing high school, a medical student completes five years of formal medical education, followed by a year of internship and then several years of training as a house officer, assigned to different departments in rotation. During this time the trainees are often referred to as RMO or Resident Medical Officer. This is not to be confused with a resident in the USA. In America a resident is a doctor in training in a specific specialty, like internal medicine, surgery, ophthalmology, radiology, obstetrics and gynecology and so on. In Australia and New Zealand, as in the United Kingdom, a doctor who wishes to become a specialist applies for a position as registrar (equivalent to resident in the USA) after completing his required years as house officer. Once accepted into a specialty the registrar then advances through the required number of years of specialty training (different for each specialty) and becomes senior registrar for his last year. After that he has a choice, just like in the USA, of going into practice as a general obstetrician and gynecologist, or continuing further training in a sub-specialty. That would be a choice between maternal-fetal medicine (taking care of complicated pregnancies), oncology (taking care of women with gynecologic cancer, such as ovarian, uterine, cervical cancer), uro-gynecology (caring for women with various problems with their bladder and vagina) or reproductive endocrinology (helping women with hormonal problems and women and or couples who have difficulty conceiving, including in vitro fertilization). If sub-specialty training is not chosen then the doctor has a choice of either entering practice or accepting an appointment as a consultant in a government or private hospital. Much of this is similar to the US training, except for the period of time spent as a RMO prior to entering specialty training.

Medical care is also nationalized in these countries. I can only comment on my own

specialty of O&G but I suspect that it would be similar in other specialties. As a result of this nationalized system, public hospitals have a chronic shortage of operating room time. Of course women needing urgent surgery are taken care of expeditiously. But for less urgent problems, such as uterine fibroids (a benign enlargement of the muscle of the womb) or sterilization, women are placed on a waiting list and given a classification according to the relative urgency of the case. They may then have to wait weeks or sometimes months before they are called in. If they cannot make it for one reason or the other at the time they are called, they are placed back on the waiting list. When a patient is then finally given a new date for her operation, the specialist, who examined her in the first instance, and who placed her on the operating room list maybe months earlier, may or may not be at that hospital anymore. That patient might therefor have her surgery performed by a different specialist, whom she may have never seen before. For me that presented certainly a problem to which I was completely unaccustomed. As a newcomer, without a waiting list, I was assigned backlog cases to be placed on my operating room list. After my initial shock of meeting a patient and her family for the first time in the waiting area, only hours before I was scheduled to operate on her, I quickly made it a policy for any of my cases, that I wanted to meet her at least a day before the surgery, and not with one foot already almost in the operating room.

There seems to be a chronic shortage of medical doctors and specialists in various fields in Australia and New Zealand. I really do not know the ins and outs of this shortage, but it made it easy for me to find this job in Townsville and for my other later assignments in Tasmania and New Zealand.

Kirwan Hospital serves a large area and some remote outposts. There is a great system in place there and in many other areas throughout Australia and New Zealand for evacuating seriously ill patients from these remote areas to the hospital by fixed wing aircraft or helicopter. This efficient system is organized by the Australian Royal Flying Doctors Service.

While at Kirwan Hospital, and for the first time in my career, I started working closely with midwives. I learned to appreciate them. They would see the pregnant women throughout their pregnancy and follow them through labor and do the deliveries. They were mostly skilled and knew when problems exceeded their expertise and they needed to call for help. These were the midwives who were attached to the hospital, but then there were also the independent midwives. These often had a mind and agenda of their own. They would also call for help when they were in trouble, but sometimes (often) would not follow the advice from the consultants, who would then have to bail them out when things got worse.

When I was on call, most of the time there was also a senior registrar on duty. These were highly trained and skilled doctors, towards the end of their formal training. They would phone me with problems but, after discussion, often were able to care for the patients themselves. They would only ask me to come in if they thought that they were in over their heads and needed help. Therefore my on call nights and week-ends were often rather easy.

There was another, and in my opinion, a rather negative aspect of this government-run hospital care. I will illustrate this with an example of one case I did experience

personally. The woman was scheduled for a hysterectomy because of fibroids of the uterus. She had been on the waiting list for several months and was finally scheduled for a particular day. She came to the hospital the morning of surgery and was prepared for the procedure; she was seen by me and by the anesthesiologist and had laboratory work done, such as a blood count and cross matching for blood in case she needed a transfusion. She was number three on the schedule for the day. The surgery schedule started at eight o'clock that morning and case one was finished by ten am. There was a delay with starting case number two which finally got underway by 11:30. It turns out that that second case was more complicated than expected and took three hours instead of the planned two hours. This got us now to 2:30 pm and the operating room still needed to be cleaned before my case could get underway. That cleaning usually required at least one half hour. Three o'clock is the latest a new case was allowed to start (administrative and union decision). Therefore I received a phone call from the head nurse in the operating room a bit before 3 pm that my case had been cancelled for lack of time. I now needed to go see my patient who has already been readied for the surgery and was together with her husband, anxiously awaiting the start of the procedure, and tell her that her case had been cancelled and needed to be rescheduled. Placing her on the schedule for the next day, or next week or even next month was impossible because that schedule was already made up months in advance. She now needed to go to her home, rather far away, and await rescheduling. Of course she was mentally prepared for the surgery, had made the necessary arrangements to be off work for some time, and her husband and other family members had done likewise. This was of course totally frustrating for the patient and it could have easily been avoided if the policy would be (as it is in many other places) that the day's surgery schedule is finished, no matter what. This policy is also quite inefficient and costly. The patient has to spend time and money traveling to the hospital. The nurses and ancillary personnel waste time getting the patient ready and doing laboratory studies and the operating doctor (in this case me) wastes the time he had blocked off for the procedure. As a consequence, waiting lists get longer and longer. There is a mandate that waiting lists have to be kept to a certain length and if they exceed a predetermined number of weeks or months for non-urgent procedures, a regulatory agency may step in. To avoid that, I have witnessed the waiting list essentially being wiped clean and started all over. All this seems quite unfair to both the patients and the medical staff. But I suppose that is the price one pays for government subsidized free health care. Of course the patient has the option to seek private care if she has purchased separate medical insurance or is able to pay out of pocket. In such cases she can go to a private hospital where the limitations encountered in the public hospitals do not exist.

The care that the patients receive however was excellent and second to none. The fact that Kirwan Hospital for Women was free standing and quite a distance from the general hospital resulted in the fact that not all services were available directly at Kirwan Hospital and for more sophisticated tests like a CAT scan, the patient had to be transported back and forth to the general hospital by ambulance. That was certainly a not very efficient system. Now that the Women's Hospital has been incorporated in a new facility together with the general hospital, that problem no longer exists.

Townsville is located in the Northern part of Queensland, one of the six states of Australia. It is a large town on the shores of the Indian Ocean and facing the Great Barrier Reef. Our apartment there was on a beautiful promenade (called The Strand)

along the beach. In the distance we could see Magnetic Island. On one end of the promenade was a state of the art Olympic swimming pool within walking distance from our apartment. I went swimming there as often as possible early in the morning, before work, while Anne usually went at some other time during the day.

Swimming is a major sport for us, and certainly a major sport in Australia. Anne and I met on a swimming team in Belgium and we have continued to swim competitively. In fact Anne held the record in her age group in North Queensland in the 100 meter freestyle, and I hold the record in Tasmania of the 50, 100, and 200 meter breaststroke in my age group. One day while in Townsville, Anne had heard about an upcoming open ocean swim on one of the following weekends. She wanted to enter the two kilometer race and she tried to convince me to enter too. I kept resisting but finally relented and said I would swim the one K race. On the day of the races we arrived at the beach a bit late. Apparently all the swimmers in the different distances (5K, 2K and 1K) were already at their respective starting points some distance away at the water's edge. We actually thought that we were too late, but were assured that if we hurried we would be OK. So we entered, paid our fee, got a number written on our upper arm, and a bathing cap (different colors for each distance), and were pointed to the different starting points. Anne ran over to the start of her 2K race and I to mine (1K). When I got to the starting point my self-esteem immediately dropped to near zero. I was surrounded by 20 or 30 young kids, none older than 14 years. And none was coming up to higher than my shoulder. I was totally embarrassed and my first impulse was to withdraw. But here I was, already entered with a number and the appropriate swimming cap. So I swam 500 meters out into the ocean, around a buoy and 500 meters back to the beach. I came in third. I guess I felt good about the fact that I had done it anyway, until Anne later overheard one of the mothers of a participating kid tell another Mom: " It was so nice this year that they had this older gentleman looking out for the kids." The results of the races were published in the local newspaper with the times and names of all the participants in the three different distances. When I came to the hospital on Monday morning, one of the nurses came up to me and excitedly told me: "You know, Doctor LeMaire there is a little boy in Townsville with the same name as you." As you can imagine, my embarrassment was now complete.

Swimming at the beach in the summer had to be in a restricted area, surrounded by huge nets to keep the box jellyfish out. These jellyfish have long tentacles that can be poisonous, and cause painful stings, occasionally resulting in death. Swimming far out in the sea is also dangerous because of sharks in the deeper water off shore. Once a year there is a famous swimming race from Magnetic Island to Townsville, a distance of about eight km. The swimmers are in individual steel cages, pulled by a motor boat, so that they are protected from the sharks. That race was quite a sight. I understand that since 2008 the cages have been omitted and I have not read or heard about any shark attacks.

While in Townsville for the six months of our contract we had many memorable outings. The first one occurred the day after we arrived. The doctor who had met us at the airport on arrival and had driven us to our apartment was a pilot and took us on a small Cessna plane ride the following day. We flew around Magnetic Island and had a magnificent view of this beautiful island and also a bird's eye view of Townsville. Every free week-end we did something exciting, like driving to Cairns, a large town north of Townsville,

with a snorkeling trip to the Great Barrier Reef; a visit to the Atherton Tablelands NNW of Townsville, with a early morning exhilarating hot air balloon ride; of course a visit by ferry to Magnetic Island. There we stayed in a youth hostel that sported a large flock of small green parrots. These squawking birds were all over the surrounding woods and were fed in the evening. They were so used to the exact timing of this feeding that they congregated several minutes before the appointed time in the surrounding trees. Guests in the hostel were allowed to feed them and the parrots would come flying in droves and sit on one's arms, shoulders, and head and anywhere else they could find a place. At one point Anne and I must have had at least twenty parrots each sitting on some part of our anatomy eagerly waiting their turn to pick at the seeds in our hands. Quite exciting!

One interesting trip was to the Lava Tubes in the Undara Volcanic National Park, some 250 km northwest of Townsville. Lava tubes are unusual geological formations. As their name implies, they are formed from volcanic outflow (lava). We had never heard of them, but as explained to us, they form as lava from a volcanic eruption flows down the path of least resistance. That path is often a dry river bed. The upper part of the lava flow cools and consolidates to form a crust. Underneath the still hot and liquid lava continues to flow downstream. When the lava flow eventually stops, what remains is a thick tubular crust of consolidated lava with an empty inner core. Hence the name of Lava Tubes. These tubes can be of enormous diameter and can branch off just like the river bed did eons ago. Others are much smaller. Many have now collapsed, but the remaining ones can be visited with a guide. This is quite interesting as many human artifacts can be found in some of these cave-like structures; evidence that the lava lubes were once used by the local natives for shelter. These days one can find all kinds of animal activity especially large colonies of bats. Such lava tubes can be found in many areas in the world with existing or past volcanic activity.

The drive from Townsville to Cairns is memorable as one drives along through miles and miles of sugar cane fields. Sugar is one of the main export commodities from this area. Along the coast there is an island called Hinchinbrook Island. It is a national park and except for a small resort at the northern tip there are no buildings on the island and it is completely unspoiled. A famous hiking trail runs on the eastern side of the island. We did this most wonderful trail. It is called the Thorsborne trail and it has restrictions as to the number of hikers allowed on it at any given time. Reservations are a necessity. Boat operators bring the hikers to the north end of the trail and pick them up at the south end at a predetermined day and time. We did the trail in four nights and five days. One hikes through luscious rainforest, over high mountains, through swamps, past waterfalls with inviting pools and along unspoiled sandy beaches (watch out for the crocodiles). There are many incredible places to pitch a tent and we only encountered one other couple in the entire five days and yes, our boat was waiting for us at the determined time. We have done some other magnificent short and long, day and multiple night hikes in many different places during our many travels, but the hike on Hinchinbrook Island stands out as one of, if not the, most beautiful of all.

We visited many other places in Australia either during our first six months in Townsville or at a later time when I was doing a locums job in Tasmania, which is part of Australia. Tasmania is an island south across the Bass Straight which separates it from Australia's mainland. The first such visit from Tasmania to the Australian mainland was an

incredible journey bringing us to many places in this vast and starkly beautiful country. As part of this excursion we took a camping trip with a small group of mostly young people all piled into a large van. We went from campsite to campsite with set up tents and cots, but sometimes we slept under the stars in a traditional “swag” or bedroll, cooked on open fires, and sat around campfires, telling stories and singing. We flew to Alice Springs and drove to Uluru or Ayers Rock. Ayers Rock is located in the middle of Australia and is a sacred site for the Aboriginals. Seeing it and walking around it is an incredible experience. Visitors are requested not to climb the rock as it is a sacred site and holds major significance to the natives. We observed that request and just walked around the rock (a beautiful experience of its own), but were dismayed to note that several tourist ignored that request and climbed the rock anyway.

From Uluru we also drove to nearby Kings Canyon and hiked around there. Another breathtaking experience! After this camping trip we flew to Darwin on the north coast of Australia and camped in Litchfield National Park. We had wanted to also visit the famous Kakadu National Park, but ran out of time. From the Northern Territory we flew to Perth, where we explored some of the coastline by rental car. There are many stories to be told about all these beautiful places. Suffice it to say that we had a most fantastic trip. We even learned some history. In Darwin we learned that that city was actually bombed heavily by the Japanese during World War II. Something we had not realized before.

At a much later time, when we were in Tasmania we flew from Tasmania to Melbourne, rented a car, and did the famous Great Ocean Drive, south and west along the shore. A magnificent drive indeed. We then turned inland and visited The Grampians National Park, a beautiful national park. Years later we learned that a major wildfire in 2006 had destroyed much of that park.

In any case, our Australian experience came to an end and we headed back to the US, ready to see our kids and grandkids, with whom we had only sporadic phone and e-mail contact over these six months plus. What next?

CHAPTER ELEVEN: NEW ZEALAND / TASMANIA.

It was August 2000 when we returned to the United States and our plan was to travel, including a trip to our native Belgium and relax a bit before starting another adventure. In fact, we did not begin to look actively for a new locums position but stayed in touch with our agency, Global Medical Staffing. In early 2001, they contacted us to find out if we were interested in going to New Zealand. There was a position for an O&G in a government hospital in Whangarei. This is the most northern city in the north island of New Zealand and has about 50.000 inhabitants. The hospital serves a much bigger area and about three times that many people. This position appealed to us and so began the paper work to prepare for our next assignment, to begin in June of 2001.

We flew first to Auckland where we had the required interview with the representative of the Medical Council. That interview, and the one we had in Townsville the year before, seemed to be just a formality. I was only required to present the original of my medical school, internship and residency diplomas and sign some documents. As I will relate later, the paper work and interview became much more formal and complicated for a later assignment to Tasmania.

Whangarei Hospital was not a teaching hospital, even though there were RMO's (resident medical officers like in Australia). There were no registrars (residents). Therefore my "on call" schedule was more intense than at Kirwan Hospital in Townsville. Patients would first be seen by the midwifes and/or RMO's and if there was a problem I would invariably need to go into the hospital at night or on weekends for procedures, such as a difficult delivery, a C-Section, a gynecologic operation, or to see any sick patient. When on call I also needed to communicate by telephone with the outlying village clinics. This involved advising the midwives and family practitioners regarding complicated pregnancies and emergencies. Not infrequently I needed to arrange and coordinate an ambulance transport to our hospital. I remember one night when I was called by one of the midwifes in a town about 100 kilometers away from Whangarei. There was a pregnant patient who had come into the local small hospital in active labor and the midwife diagnosed a breech presentation. Breech deliveries may present somewhat of a problem as the biggest diameter of the baby is the head and in a breech delivery it comes last and may get stuck, while the remainder of the body is already delivered. This may become an urgent situation as the blood flow to the baby is cut off by compression of the umbilical cord. Now days breech deliveries are often done by C-Section in the USA, especially for a first baby, where the bony pelvic passage has not been tested before. If a vaginal delivery of a breech baby is to be done, it is best performed in a hospital with a skilled obstetrician in attendance. In this particular case there was no time to transport this undelivered woman to the hospital as she was quite advanced in her labor. There would be nothing worse than having to do a complicated delivery in the cramped space of an ambulance, airplane, or helicopter. That is to be avoided at all costs. So it was clear that this woman was going to deliver a breech in that local hospital.

While the nurse, calling me, was an experienced midwife, she could not remember the last time she had been involved in a breech delivery, so I stayed on the telephone and coached her along until the baby was actually delivered and all was well. As it turned out,

all that this midwife needed was some support and encouragement as it all came back to her as the delivery progressed.

There were no medical students in Whangarei Hospital, so I did not have formal teaching duties, even though I did a lot of bedside teaching for the RMOs and instructed them in the operating room and clinics as well. Every morning there was a meeting of the entire staff to discuss any new and any difficult cases. That was usually followed by a brief presentation of a specific topic, assigned by the department head to one of the RMOs. While there, I introduced a new tradition, by starting each meeting with a very brief *word of the day,* or *question of the day.* This was very much liked by everyone. Years later when I was going back periodically to Sitka and Mount Edgecumbe hospital as a locum specialist I introduced that tradition as well. Nowadays, when I am there (Sitka) every Friday morning meeting starts with the director turning to me and asking: "Wim, do you have a word of the day?" My most famous word of the day was probably "callipygian." Look it up!

Periodically I needed to attend a clinic at one of the smaller towns away from Whangarei. I would drive there for the day and occasionally take one of the RMOs with me. On one such trip, I remember driving along on cruise control and mentally reviewing some of the cases I was going to be seeing in the clinic that day. I paid little attention to the direction as I had driven this road many times before. When I arrived at the hospital about an hour and a half later, I only then realized that I was at the wrong hospital and must have taken a wrong turn somewhere without realizing it. I needed to drive almost all the way back and then make a turn in an entirely different direction to get where I was supposed to be. That was at least another hour and a half and I was going to be late for my clinic. So I called the hospital and the nurses did some quick rescheduling so that at the end all turned out all right. But you can image the ribbing I got from my colleagues about this rather flagrant absentmindedness.

In the town of Kawakawa, where I had to go for the clinic, there is a famous and unusual tourist attraction. An Austrian artist by the name of Hundertwasser decorated a public toilet with some fascinating designs, well worth visiting. The public toilet has inside and outside some colorful columns, mosaics, tiles, and inlays, and is frequently visited and photographed by tourists, who actually will come on a scheduled stop to see this unusual place. These are the only restrooms I know off where men will be allowed freely in the women's restroom (of course when not in use) and vice versa, to inspect the amusing and clever artwork and take photos. On our travels in the area we also came through a Kauri forest. The Kauri tree is a special conifer growing in large stands, some of the fallen trees have been buried under swamps for many millennia and local landowners periodically find such well-preserved trees which are then used for some beautiful wood carvings.

The local native people are the Maori who make up about one third of the total population of the Northland area. So my activities at the hospital involved a great deal of interaction with the Maori women for their deliveries and gynecologic problems. Many of their medical problems are not any different from those encountered in other places I have worked at, but such problems as obesity, diabetes, smoking, substance abuse, unemployment, and domestic violence seemed much exaggerated. This was similar to the problems of the aboriginals in Townsville, and the Alaska natives I worked with. I do not want to speculate on the reasons for these problems developing over the years for these

native people. There are undoubtedly many scholarly studies covering this problem, but most certainly the arrival of the “white people” and their subsequent oppression (or worse) of the native population and the introduction of alcohol, drugs, and fast food have played a major role in this development.

I saw many interesting cases during my six months at Whangarei Hospital. One stands out in particular. This was a middle aged native woman who had been seeing her family doctor for several years because she was gaining too much weight and her abdomen was getting bigger and she was constipated. Each time the family doctor saw her, he did not examine her but patted her on the back and encouraged her to eat less, eat more fruit and vegetables and be more active so that she would lose weight. When much later he finally examined her, he noticed a large tumor in her abdomen and referred her to the hospital. To make a long story short, we operated on her and removed a large ovarian cyst weighing more than 18 kilograms (about 40 pounds). This cyst fortunately turned out to be benign and the woman did well. The operation itself was something else as we needed an extra assistant to hold the tumor in her arms while we removed it without breaking it. Even though this large tumor was certainly not a record, we ended up publishing the case in the national medical journal of family practice. Not so much for the nature of the tumor itself as for pointing out to family doctors that examining patients before giving them advice is most important.

We lived in a rather large house directly across from the hospital, which made it convenient when I was on call and needed to go into the hospital. We had a fairly big yard with a hedge along the fence of kiwifruit, but they were not as tasty and juicy as we were used to.

I learned that there are at least five meanings to the word Kiwi. One is the kiwifruit; then there is the kiwi bird (exclusively found in New Zealand); the New Zealanders themselves are often called Kiwis and their currency, the New Zealand dollar is often called the Kiwi, as there is a reproduction of the Kiwi bird on their one dollar coin, just like the Canadian dollar is often called the Loon; and finally there is a shoe polish brand called Kiwi.

In 2005, more than four years later we returned to Whangarei Hospital for another six months of locums work at the same hospital. That time we lived also in a rented, house which was smaller and further away from the hospital, probably at least 15 minutes driving. This made it a bit less convenient when I was on call. That house also had a large yard with several fruit trees. One tree in the front yard had an enormous amount of green egg shape fruit, we had never seen before. We were told that the local name was Feijoa and later found out that they are also called pineapple guava. That explained why they tasted like guavas. At first we did not particularly like them but it became an acquired taste. To have the fruit at its best one needed to let them fall off the tree and then collect them. We would eat them raw, but also juice them and sometimes made a cocktail with them by adding lime juice and rum. These cocktails were delicious and much appreciated by our visitors. There was one problem: they had a rather unappetizing green color. Anne overcame that problem by adding a small amount of beet juice, which now gave these cocktails a much more attractive color.

On weekends off duty we would make wonderful trips to tourist attractions and also to

remote places and hike or tramp, some fantastic trails, or tracks as they are often called. The weather in this part of New Zealand is incredibly good and the area is often called the winterless north and is ideal for all kinds of outdoor activities. We sure took advantage of that. The area north of Whangarei on the east coast is called the Bay of Islands and is a favorite area for boating and fishing. It is a paradise for sail boats. Much farther north is Cape Reinga. While not exactly the northern most point of New Zealand, it sure looks like it. When one stands there at the foot of a towering lighthouse and looks out north over the ocean one is impressed with the tremendous churning of the sea. This is where the Tasman Sea and the Pacific Ocean meet and their currents clash. Cape Reinga has an important significance for the Maori people, as it is here they believe the spirits of the dead leap off the cliff to enter the underworld. On the North West coast of the peninsula is a stretch of beach, called Ninety Mile Beach. The name is a misnomer as the entire length is only about 55 miles, but it is a deserted beach and popular among the locals. The sand is packed hard and suitable for four wheel drive vehicles. However, one should not drive a personal or rental vehicle on it. Unless the driver knows what he/she is doing, the car is likely to get stuck in the sand, as incoming fast-moving waves wash the packed sand from under the car which immobilizes it. There is no towing service to come to the rescue. One can get on a special tour bus that will drive along the entire length of the beach. But even our tour bus got stuck as the driver had trouble with his gears and could not get fast enough in lower gear to get out of the way of a wave. Luckily for us and the driver, there was another tour bus just behind us, who towed us out of the sand. Cars that get stuck may never get out, in fact on our trip we spotted several roof tops and antennas sticking out of the sand. These were cars that had been stuck and over time had almost completely been covered by the sand. On the way to Ninety Mile Beach we passed some tall and steep dunes, ideal for sliding down on a rented plastic board. After a tedious climb up to the top, a fast and exhilarating ride down awaits the climber.

We went to some other beautiful and deserted beaches and learned about finding and collecting tasty shell fish. One in particular stands out as great fun collecting and incredibly good eating. It is the Tuatua clam. If one thinks about the traditional clam digging, forget it. No rake or shovel is required. At incoming tide one wades into knee-deep water and feels the clams with one's feet in the sand or gravel and then picks them up. There is a limit to how many one can catch, but they are plentiful. We also collected small oysters right from the rocks in the surf. They were small but abundant. We would carry a zip lock bag with us and take the small oysters out of the shell after prying them from the rocks and put them in the bag with lime juice until we had enough to have a feast right there on the beach. We had such a great time.

Our six month contract at Whangarei Hospital went by so fast that our time to leave came before we realized it. At the end of 2001 we were back in the US to see our family, travel (in fact we drove cross country to Alaska and back) and do a short stint as a specialist in a small catholic hospital in St Lucia. But more about that later.

By mid-2002 we were contacted about a six month locums job in Tasmania, one of the six states of Australia. The job was in Launceston General Hospital in the city of Launceston in the north part of the island. It seemed attractive to us, so we set out preparing for our move to Tasmania. That included getting a temporary Australian license again (we had one before for our six months of locums in Townsville) as well as a

working visa. Our first application for Townsville was a piece of cake in comparison to the hoops we had to jump through this time around. Luckily the Global Medical Staffing people were most helpful and understanding and helped us through the process every step of the way.

The reason for this increased complexity of the application for a temporary license in Australia was apparently the fact that there had been some "bad apples" coming through the pipeline and the Australian College of O&G wanted to avoid such problems in the future by tightening their screening process. This we found out later, but at the time some of the road blocks we ran into seemed rather ridiculous. As I was apparently one of the first applicants going through this new and "improved" applications process, it seemed that some of the administrators running this new program were not too sure about all the details themselves and did not quite know how to make the process work smoothly.

The hospital in Launceston wanted us as soon as possible. It was now late summer 2002 and we figured that we would fly to Tasmania in the early fall, so we cut our travels short and drove back to Miami to take care of all the formalities and prepare to leave for six months. We filled in the appropriate forms and sent them off to Global Medical Staffing. They made sure that these forms were completed properly and forwarded them to the Australian College of O&G. A piece of cake, we thought based on our earlier experience with that college, prior to the change in their policy.

This time around, however it was much different. The entire application was sent back and forth a number of times because of minor (from my view point) technicalities. Some of these technicalities seemed ridiculous and unnecessary. To give just one example I needed to prove that I spoke English in an acceptable fashion. The questionnaire gave three possibilities to prove this. One was that I was born in an English speaking country, the second that I had graduated from an English high school, or finally that I had passed the English exam given in Australia. As I could not mark the box next to any of these possibilities, some considerable time passed with correspondence and phone calls, to try to resolve this "problem." There was no "box" to mark that I had worked as an O&G for the majority of my life in an English speaking country (USA) and in fact had worked earlier for six months in Townsville, Australia. I finally suggested that someone at the board pick up the telephone and call the chairman of the O&G department in Townsville, who in fact was a member of the Australian College himself, and ask him " Hey, does Dr. LeMaire, who worked with you less than two years ago, speak reasonable English?" Someone with common sense heeded my suggestion, and after some other delays my application was finally accepted and conditionally approved..

By the time the initial approval from the Australian College came through it was now late fall. The earliest we could hope for was a beginning date of late December rather than the fall as we had expected. But first now we needed to apply for a work visa. However, a working visa would only be granted after the "final" approval by the board which, according to the new guidelines, required a formal interview in person by the board in Adelaide, a nice city but far from Tasmania. As it was getting close to the Christmas holidays even an interview in December would probably not result in the "final approval" before early January. Therefore I was informed that I would need to travel to Adelaide, have the interview and then return to the USA while awaiting this final decision before departing for Launceston in Tasmania. All this did not make a whole lot of sense to us,

and apparently it did not make sense to the hospital director in Launceston either. Through the intercession of Global Medical Staffing it was decided that we (my wife and I) would fly to Adelaide via Sydney just before Christmas, have our interview in Adelaide, relax a bit there and then fly to Launceston at the end of December and await the "final" documents of approval. At least someone was thinking clearly!

Thus we applied for, and quickly received, a visitor's visa and off we went to Australia with a stopover in Hawaii, to break up the long flight. In Adelaide, I went to the designated place a few days before Christmas, expecting a pro forma interview as I had done before in Townsville and New Zealand. I was met by the president of the board and ushered in a large conference room with long tables behind which were sitting two additional doctors and two secretaries. To my surprise and shall I say shock, I was informed that the interview would consist of an hour long oral medical exam. I sat on a lonely chair in front of the table and the examiners asked me questions related to the specialty of O&G. As it turned out the questions were straightforward and I thought that I answered them just fine. However there was no feedback from these doctors and I was informed that the final decision would not come until after the holidays. There was one other "applicant". He was a gynecologist from Belgium and he had been told to go back to Belgium while waiting for the results. That seemed like a waste of time and money but as it turned out he did not pass the test. The test, in fact, was quite reasonable. The questions had to do more with policy and procedure than with actual medical care. For instance, I was presented with a hypothetical case of a teenage, mentally retarded, and sexually active women brought in by her mother requesting a permanent sterilization for her daughter. As her daughter would not take her birth control pills in a consistent fashion, the mother was worried that she might inadvertently become pregnant. I was asked how I would handle that problem. While the question might seem straightforward and the request by the mother reasonable, the answer, of course, depends on the legality in Australia of a sterilization procedure, especially as regards to under aged women. My answer was that I would first need to formally establish the level of competence and degree of retardation of her daughter and then would enquire from the department head and the hospital administrator about the official policy in Australia. I also would give the mother some alternative possibilities which were equally effective but less drastic than permanent sterilization. I would then get back to her with an answer. I think that my response was exactly what the panel wanted to hear. They wanted to be sure that a locums doctor, coming from a foreign country would find out about and adhere to Australian law. The next two questions were in a similar vein. One question was regarding my approach to a woman requesting an abortion and the other regarding informed consent for surgical procedures. My answers to these two were straightforward also. I told the panel that I would inquire about the local regulations and policies first. Again, that was exactly what they wanted to hear.

After the exam Anne and I enjoyed a few days in beautiful Adelaide, the largest city in South Australia and flew off to Launceston in Tasmania, where we celebrated Christmas and the New Year by ourselves in our new home there, about 10 minutes from the hospital up on the surrounding hills.

The final approval of my application for a temporary medical license came in early January. Now I needed to change my visitor's visa which had brought me to the country,

into a working visa. For that a whole new application needed to be submitted to the government authorities in Hobart, the capital of Tasmania. It required amongst other formalities, a repeat (I had already done these in the USA in anticipation of my working visa, which was not granted) of my chest X ray and test for MRSA (methcyllin resistant staphylococcus aureus carrier state) as well as an interview in person in Hobart, this time with the immigration authorities. When a week or so later, the word came through that my working visa was granted I needed to travel again to Hobart (a two to three hour trip by car) to sign all the final documents and receive the visa.

While waiting in Launceston for the conclusion of this administrative morass, I was not allowed to see any patients. Thus I spent my time teaching the medical students and doing administrative work. Finally in mid-January I could start the real thing.

The real thing was much as it had been in Townsville. There were registrars who made my work load much simpler as they were advanced in their training and were competent. The patient load was similar as before in New Zealand and Queensland, but the major difference was that there were few aboriginal patients. In fact there are few aboriginal people left in Tasmania, period.

The only medical school in Tasmania is in Hobart, but medical students come to Launceston Hospital to complete some of their clinical rotations. Thus part of my work there consisted of teaching the medical students, which I loved to do. Daily seminars for medical students started at 8 am and lasted one hour. Therefore the students were often torn between the choice of attending the seminars or to be present at the beginning of ward rounds or operating room cases; both of which started at 8 am also. To remedy that dilemma I proposed to the students to start the seminars at 7 am. That proposal was summarily nixed as the student's union (yes they were unionized) only required them to start "work" at 8 am. So much for my effort to improve their teaching. All in all though these students were a good bunch and eager to learn, but apparently not eager enough to get out of bed an hour earlier.

Tasmania is a wonderful place. There is a great variety of geology, with beautiful deserted sandy beaches, steep cliffs and rocky beaches, towering mountains, rain forests, rolling hills, and farmland with many sheep (not as many as in New Zealand though). It is a hiker's paradise and it is all well within a day's driving, as opposed to mainland Australia, where there is also much variety and many beautiful areas but one has to drive long ways or fly to get there. We certainly took advantage of the many activities Tasmania has to offer. We hiked to Wineglass Bay, which is an incredibly beautiful bay with a most gorgeous deserted white sandy beach. We climbed Craddle Mountain in Lake St. Clair National Park. It is a 1500 meter rocky peak that from distance seems unreachable, but once climbed by jumping from bolder to bolder, affords a breathtaking 360 degree view of the surrounding park. We took a ferry to Maria Island, which is an old penal colony, and stayed in the old convict's bunkhouse, now converted into a primitive hostel. We went to Bicheno on the east coast, and took a guided tour to see the little blue penguins, also called fairy penguins, come ashore at dusk. They walk in small groups along narrow paths to their nests in the nearby bushes in the dunes. Our guide gave us red flashlights (so not to disturb the penguins) and positioned each one of our small group on a different place along the path the penguins would take. On their way to their nest they completely ignored us and in the semi dark practically walked over our

shoes. They were noisy and there was a distinct unpleasant fishy odor.

In July of 2003 our six months at Launceston General Hospital were up and we left with the idea of returning someday if they still needed us. In fact that came in August of 2004 and we stayed till February 2005. In January of 2006 the Hospital in Whangarei, New Zealand where we had been in 2001 wanted us back. So we were in New Zealand and Tasmania twice for six months. Our plans were to return again in the future but other opportunities arose and we never went back.

CHAPTER TWELVE: WORKING IN ST LUCIA

Between our assignments in N. Queensland, Tasmania (twice) and New Zealand (twice) we had plenty of free time and used it well to travel but also did a number of stints as volunteer O&G.

One of the places we went to, was St. Lucia in the West Indies. Over the years we have been there five or six times for short periods of time (four to six weeks each). St Jude Hospital is situated at the south end of this most beautiful and lush island. The hospital was run by the Sisters of the Sorrowful Mother, a USA-based order of catholic nuns, and was using volunteers from all over the world. I understand that nowadays the hospital is operated by the government of St Lucia, but volunteers continue to play an important part in the function of the hospital. The volunteers included family doctors, specialists, residents, and medical students in training, and also some nurses. The patients came mostly from the rather poor area of the nearby town of Vieux Fort. While the hospital only had the bare essentials, medical care for the patients was adequate under the circumstances, but certainly without any luxuries. The pregnant women labored and delivered in a rather cramped room with two delivery tables separated only by a flimsy curtain. Nurse midwives (very competent indeed) followed the women in labor and attended their deliveries but without any niceties such as even local anesthesia to repair the inevitable occasional small lacerations of the perineum or vagina. Bigger lacerations were taken to the operating room. The volunteer obstetrician was only called for problems. When I first began to volunteer there, only one O&G was available at any one time (with some exceptions) and that person was always on call and could not leave the premises at all, or at most go to a nearby beach two kilometers away, where there was a telephone for emergencies (no beepers, at least not at first). Later, there were times that there were two and even three O&Gs so that we could take turns for time off and explore this beautiful island. The workload was never heavy but the cases we saw were interesting and the work rewarding. There was practically no opportunity to transfer any complicated patients to a higher level of care facility, so we did the best we could.

I remember one case of early stage cancer of the cervix. The patient was a young woman in her thirties. She needed a surgical procedure called a radical hysterectomy. This is a more complicated procedure than a simple hysterectomy for benign disease and in the USA is usually performed by a gynecologist with special training in such procedures (Gynecologic Oncologist). There was no Gynecologic Oncologist in St Lucia or in any of the nearby islands. Sending the patient to the USA was out of the question, as that would have been far too expensive. The other option would have been to send the woman to the nearby island of St Vincent, where radiotherapy was available. Radiotherapy would have been an acceptable approach for a more advanced cancer, but for this relatively young woman with early stage cervical cancer, a surgical procedure was much to be preferred. I ended up calling one of my friends in the Department of Gynecologic Oncology at one of the medical schools in Florida. He agreed right away to come on the next Friday. St Jude hospital had funds to pay his trip and provide room and board together with the other volunteers. He came as planned and on Saturday and Sunday he operated on the patient with the cervical cancer and one other complicated case we had saved for him. He left on

Sunday night, so that he was not away from his own duties at his medical school for too long. The patient did well and recovered completely. As it turned out this whirlwind visit by a gynecologic cancer specialist was the beginning of a longstanding relationship between him and St Jude Hospital. He has been back a number of times to operate on cancer cases that were saved for him.

There was another benefit of this impromptu visit by the cancer specialist. At the time of his first visit, there was a young gynecologist at St Jude who had just finished his residency and was working as a volunteer for several months. He was happy to be able to assist the oncologist with this radical hysterectomy and in doing so became interested in furthering his career by doing a fellowship in gynecologic oncology. The visiting specialist offered him a position in the training program at his medical school and after completing his required three year fellowship, he himself became a gynecologic oncologist. I understand that he too has been back several times to consult and operate on gynecologic cancer cases in St Lucia. What a success story!

As patients at St Jude Hospital were mostly poor, they could not always come up with the fee for their care (small as it was) and often ended up settling their debt "in species" by bringing in fruit, eggs, and even chickens as a method of payment. Talking about poverty, I never understood how these proud people managed to always look very decently dressed and groomed. We would walk through the poorest area of town where people seemed to live in shacks, without running water or toilets (these were located in a common area). At around five 'o clock in the afternoon one could see neatly dressed women in high heels, impeccable clothes, and with perfect hairdos, walking home from their jobs as store clerks or bank tellers. We would see them entering their "home" (shack), and we could never understand how they managed to look so good under these rather primitive conditions. Similarly on Sunday mornings we would see whole families leaving these "houses" for church, all neatly dressed, young boys in bright white, perfectly ironed shirts and slacks, girls in flowery dresses and Sunday hats. How did they do this without some of the barest essentials in their house?

There was a small gift shop on the premises. Patients and their family or companions would often come from far away and they sometimes needed to stay the whole day. They would take advantage of a canteen attached to the gift shop, called the Tuck Shop There these people could buy snacks and drinks. Anne would volunteer and help out with serving these customers and tending the gift shop. She would also go periodically to the pediatric floor and entertain the children there.

Transport from and to town was mostly by jitney. These were mini vans in which as many people as possible would crowd in, packed shoulder to shoulder. There were no body odors or unpleasant smells as we had experienced in other developing countries under such crowded conditions. We admired those people's resilience and resourcefulness.

The cases I saw and treated in St Lucia were similar to the O&G cases I had encountered elsewhere, but one case stands out in my memory. A young woman in her first pregnancy came in with pain in her abdomen. She was about 16 weeks pregnant and had obvious signs of some major intra-abdominal problem. We ended up operating on her and found a ruptured uterus with the dead fetus in its amniotic sac partially extruded. The only thing

to do was a quick hysterectomy as the uterus was too badly damaged to warrant a repair. A ruptured uterus is not such an unusual condition in later pregnancy, but what was unusual was that this rupture happened in completely unscarred uterus (no previous damage by C-Section, perforation or surgery) and that she was only about 16 weeks along in her pregnancy. As this was so unusual we ended up publishing the case in the obstetrical literature.

During one of the times we were there, the staff had found an abandoned baby on the premises and the hospital ended up adopting (not officially) the baby and raising it for several years until a suitable home was found for the little girl. Everyone took turns to watch and feed the baby, who undoubtedly was badly spoiled.

One Saturday morning we received a phone call from the police that there had been an accident. A British woman in a group of tourists climbing one of the more treacherous mountains in St. Lucia ("Le Petit Piton") had fallen off the steep trail and was badly injured. The police and the rescue team were going to bring her to our hospital. Surgeons, laboratory and x ray staff were called in and we all were waiting and ready for major trauma. We waited for many hours and when finally the helicopter with the victim approached we were treated to an incredible sight. The helicopter was a small sightseeing one and not equipped for transportation of injured people. In fact there was no room for a stretcher. As a consequence the resourceful emergency team had opened the helicopter doors on either side and secured the stretcher with the patient strapped down at right angles to the helicopter. Thus on one side her head was outside and on the other end her feet. As it turned out her injuries were not as serious as we had expected and she did well. But the whole event was rather curious.

Driving in St Lucia is on the left hand side of the road and for tourists, used to driving on the right hand side, this is rather dangerous, especially as the roads in the hills are narrow and the local drivers go about it speedily and take risks No wonder there were many accidents, some serious and even fatal. The hospital took care of many gravely injured patients and some fatalities. On a number of occasions I helped the general surgeons by scrubbing in on the trauma cases.

During one of our stays there Anne suddenly became very dizzy and started vomiting. She became rapidly dehydrated and needed to be hospitalized with a diagnosis of acute labyrinthitis (a viral inflammation of the inner ear affecting equilibrium). She was well taken care of and was discharged after two days. It was remarkable that the total bill for two days in the hospital, intravenous feeding, medications, and medical attention came to 150.00 US $. Imagine the bill for a similar case in the USA. Not unexpectedly, our Medicare and Medicare supplement insurance refused to pay the bill as it was generated outside the USA.

While on the subject of medical insurance, one of our main concerns when abroad was, and still is, medical insurance coverage. What if one of us would have a serious illness or accident while abroad (St. Lucia, New Zealand, etc.)? During one of our stays in St Lucia we learned about one of the radiologists who had suffered an unexpected seizure while volunteering at St Jude Hospital. In addition to his usual medical insurance he also had a policy called MedJet. This policy was quite inexpensive but guaranteed repatriation by medevac for any serious medical condition for which transport back to the USA was

recommended. This radiologist was repatriated at no cost to him and we learned later that he had died from a brain tumor. This encouraged us to obtain a similar insurance policy which we have kept current up to this day. It certainly gives us extra peace of mind. We would recommend this or a similar policy to anyone working or traveling for extended periods of time. Fortunately we have not had to use this insurance.

One of the attractive aspects of volunteering at St Jude was the fact that all the volunteers (doctors, nurses, students) were housed together in a building on the premises. The rooms were rather primitive and the facilities shared, but the ambience was incredible. Game nights, parties, and outings to nearby restaurants were frequently organized and there was a great deal of socializing amongst young and old from all parts of the world. This was definitely a big bonus for the volunteers. During one of our visits the volunteers would all go down to our compound at dusk to watch a most interesting action. The compound was rather old and certainly in need of some major repairs. The eaves had many holes and a colony of bats had taken up residence under the roof. Every evening they would swarm out at dusk to look for insects. Hundreds of them would come out in batches to the apparent delight of a pair of hawks that had taken up residence nearby. These hawks would also come out and start hovering high in the sky above our compound a few minutes before the bats were expected. As soon as the bats started to come out they would dive down and swoop up a bat for their evening meal. Sometimes they missed and would try again, but they always got something. That was quite a spectacle that repeated itself every evening at the same time.

I recall one humorous incident. One late Saturday afternoon a bunch of volunteers decided to walk to the nearby town. As it was the weekend, the gate to the road was locked and we called the security guard to come and open the gate. While waiting for him we all started walking towards the gate. The sun was still out and Anne urged me to put on some suntan lotion. While slowly walking towards the gate, I took off my glasses and rubbed the lotion on my face. As there was no mirror to ensure that I had rubbed the lotion in completely, I turned over my left shoulder to ask my wife (or so I thought) about it. Turning around without my glasses on, I asked “am I still white?” only to realize too late that it was not my wife on my left side but the rather tall native, black security guard who had caught up with us on the way to the gate. Quite calmly and obviously fully conscious of the hilarious situation, he looked down at me and said: “Of course, Dr. LeMaire you are still white and you will always be white.” All this of course produced a big laugh from the volunteers in the party.

One beautiful cloudless evening a group of us decided to drive up a high hill where there was a lighthouse and watch the sun set over the water. We had brought some snacks and a bit of rum and coke and sat down to await the sun set. Our local guide who had driven us up the hill asked if we had ever seen the “green flash” just as the top of the sun disappears under the horizon. Sure enough as the last of the sun disappeared there was a fraction of a second that the area turned green. We were all quite skeptical as we were sure that the rum was responsible for the “green flash.” As it turns out we have seen this phenomenon a number of other times from different locations (once actually in Alaska) and without the rum or gin. Some years later I actually read a short blurb in Time Magazine offering a physical explanation for the phenomenon. I am now quite convinced that it is real. One needs to be high up and looking towards the sun setting over water in

the absence of a cloud cover. Believe me it is real and I take pleasure in showing it to friends if the conditions are right. I have made a number of believers. Look it up!

St Lucia is a beautiful island with much variety. There are incredibly luxurious resorts all over the island but the contrast between the rich, mostly foreign, and the poor, mostly native, is disconcerting. One is left to ponder whether all the generated wealth leaves the island. To make matters worse we learned that two years ago there was a major fire in St Jude Hospital, destroying an entire wing and killing a number of people. We have not been back since (but are planning to) and have heard that the hospital has been relocated for the time being to the nearby cricket stadium until the construction of a new hospital is completed.

Before the fire and probably more so since, the hospital relied on donations of equipment and medications from abroad. After one of our visits to St Lucia I was back at my job in Sitka, when there was going to be an inspection of Mount Edgecumbe Hospital by the regulatory agency. This is serious business as hospital accreditation can depend on such an inspection. Thus began an intense preparation and cleaning. Part of the preparation consisted of emptying out store rooms and disposing of all outdated equipment and medications. I learned that there was a truckload of items that were going to be disposed off. Naturally I thought about St Jude Hospital in St Lucia and obtained permission to take possession of all this material. I made a couple of trips with our van and stored all this equipment and supplies in our basement, where it occupied a good part of one basement room. Included in all this were at least 30 stainless steel bed pans and emesis basins (now replaced in most hospitals by plastic); boxes full of glass syringes of all sizes with needles; at least 50 wooden crutches of all kinds; boxes full of rubber catheters; colostomy bags; birth control pills; boxes of antiseptic solutions and more. I was ecstatic as I was sure the hospital in St Lucia would be happy with all this. I obtained a verbal agreement with one of the local barge companies who promised to put these supplies in one of their containers if there was room, and ship it to Miami at no cost. From there I would need to make arrangements to get this all to St Lucia. I thought that that would not present a big problem, but first I needed to let the hospital in St Lucia know what was coming. They asked me to make an inventory and call them with the various items. So I did and when I called them to tell them that I was planning to ship X number of stainless steel bed pans and emesis basins the response was “Oh please Dr. LeMaire, do not send these; we have a supply of these to last us for years and have no room to store them.” As it turns out almost all hospitals in the USA have switched to plastic disposable bed pans and emesis basins and many hospitals had donated their stainless steel ones to St Jude or other third world hospitals. I got the same response about a number of other items including the crutches. The glass syringes were not wanted either as the hospital had also switched to plastic. Any outdated items could not be accepted either even if they were still perfectly good, such as plastic or rubber catheters or tubing.

We ended up sending nothing and were stuck with the dilemma of what to do with all these materials in our basement. When we had people over for dinner we would ask them at the end of the evening and to the amusement of everyone, if they wanted a stainless steel bedpan. As it turned out they were gobbled up and used for planters. The emesis basins I gave to the local raptor center where I volunteered on Sunday mornings, to feed the bald eagles. The stainless steel basins were durable and would outlast the plastic

containers they had been using at the center (these were destroyed in short order by the sharp beaks of the birds). The crutches we took with us on a trip to Juneau and donated them to the local Salvation Army. Some of the rubber and plastic tubing we donated to the preschool where they cut them up in pieces that could be used by the kids for some craft. I cannot remember what we did with the other materials, but as it turned out we were able to get rid of everything, but of course without achieving our initial intent.

CHAPTER THIRTEEN: VOLUNTEERING IN CHIAPAS

At one point at the end of 2002 and beginning of 2003 we had some time and volunteered to work in Mexico in the province of Chiapas. At first we were a bit nervous as this area was rather volatile for a while due to the uprising of the Zapatistas, but by the time we arrived there, things were mostly settled and safe. We were assigned by Doctors of the World (DOW) to Hospital San Carlos in Altamirano in the mountains of south Chiapas. The hospital is a catholic hospital run by nuns. It was a rather primitive hospital but under the circumstances was well run by the nuns. It is staffed by Mexican doctors who have to complete two years of duty in underserved areas and by a number of volunteers from different countries and sponsored by different non-government organizations (NGOs) such as the DOW that sponsored me. Parenthetically DOW is now called HealthRight International

One of the problems we noted with several NGOs who would provide short time specialists to the hospital (and this is certainly not meant as a criticism of these organizations) is the fact that these organizations did not seem to coordinate their activities. For instance two organizations would provide a doctor in the same specialty for a number of months at the same time when there was only need for one. Then for a next period of time they did not provide one at all. If they just would communicate with each other and coordinate their efforts, consistent staffing would work out so much better.

Altamirano, and the surrounding areas, for some reason, has a large number of cases of hare lip and cleft palate. These cases require specialized surgery which certainly is not locally available. Once a year a team from the USA consisting of a plastic surgeon, an oral surgeon, and an anesthesiologist volunteer an entire week of their time and fly to Hospital San Carlos to operate on these cases. They arrive with all the necessary equipment and take over the operating room during the entire week. They usually manage to operate on at least twenty cases during the week that they are there. In preparation for their surgery, children and sometimes young adults with harelip or cleft palate from the surrounding area are called to the hospital at least a week before the planned surgery. They would be prepared for the surgery by the nuns and often placed on prophylactic antibiotics to prevent them from developing an infection (ear infection, tonsillitis, bronchitis etc.) which might have led to cancellation of their planned surgery and forced these poor patients to wait another year. The outcome of all this was phenomenal. That particular surgery team was not supported by any NGO and they were entirely volunteers. They changed the lives of many. One can only hope that they will be able to continue their work. Of course one of the burning questions is “why are there so many cases of cleft lip and palate in this area?” I have no answer for that question.

Most, if not all, patients were Mayan, living in and around Altamirano, some in remote villages, in the mountains where they led a harsh life, working their small coffee or corn (maize) fields. Sick patients from these villages had a difficult time getting to the hospital. Many had to travel first on foot over mountain trails to a road where they had to flag down a transport, mostly minivans, to drive them to the hospital. One can see why they would not make this journey lightly and would wait until their condition seemed serious and sometimes they would wait too long. One case I remember clearly, as I had

not seen such a complication since my Congo days. A pregnant woman at term was brought in by her family (they had to carry her part of the way). She had started labor and had partially delivered a breech baby, but the head had been stuck in the pelvis. By the time she got to the hospital the baby had been dead for many hours. The sad part of it was that the baby delivered promptly after I catheterized her full urinary bladder (more than a liter of urine). This full bladder obviously had prevented the baby's head from descending down the birth canal. If this had been recognized earlier on in the village the baby would almost certainly have survived. But of course no medical help was available in their remote village.

I remember another case. It was also a pregnant woman about a month before her due date who was brought in with painless vaginal bleeding of several days duration. She also had to be carried part of the way and when she arrived she looked very anemic. She was not in labor and the baby luckily was alive. She probably had a placenta previa (a condition where the afterbirth or placenta lays in front of the baby's head) and needed an urgent C-Section. Her blood count was low (I do not recall the exact number, but around 5 gm. of Hemoglobin, the normal being way above 10 gm.) and she was desperately in need of a blood transfusion. Of course the hospital had no blood bank and there was no family or friends willing to donate blood. I went to the laboratory and quickly donated a pint of blood (I am blood group O and RH negative and thus a universal donor). I then rushed to the operating room and started the C-Section while the patient was being transfused with my blood and that of my wife who is also O RH negative and had followed me to the laboratory to also donated a pint of blood. The operation turned out well and mother and baby did all right. I had no ill effects at all of the bloodletting followed by the performance of the surgery. Probably the rushing adrenaline kept me going. It was a satisfying experience.

The operating room was a rather small room and not well equipped. It had a low ceiling and the large operating room light (obviously donated by an NGO) came so low over the operating table that it was close over the surgeon's head and the heat generated by the powerful light was almost unbearable on the surgeon's bent neck. One thing we constantly needed to remember is not to suddenly stand up straight to avoid hitting one's head against the light fixture. Also the light could be tilted but not moved so that for vaginal operations, such as a dilatation and curettage (D&C), for instance for a miscarriage, one needed to use either a gooseneck lamp or a head light to be able to direct the light beam into the vaginal area. It is amazing how one can improvise if needed and make do with the minimum of equipment.

Talking about equipment, I have noted that a number of hospitals in the developing world receive donated pieces of equipment. Some of this equipment is at times rather sophisticated. In my area of specialization I am talking about ultrasound machines, fetal monitors, electrical cautery instruments, laparoscopic equipment etc. These instruments arrive at the hospital to the great joy and anticipation of the staff. More often than not, however, either there is no one around who knows the details of working the instrument, or after a short while it breaks down. This breakdown may be simple to remedy but there is often no one around or close by with enough know-how to make the repair. Bringing a repair person in from the "big city" or in many cases from abroad is financially prohibitive. Thus the instrument ends up in a storeroom gathering dust. This was indeed

the case at Hospital San Carlos. When we were there we found a rather good ultrasound machine that was not being used because no one knew how to operate it. The volunteer surgeon and I got it to work and used it frequently on our patients; I used it for pregnant and gynecologic patients and the surgeon for his cases of gall stones or appendicitis etc. A similar thing happened with a fetal monitor that was not being used at all.

Communication presented a bit of a problem. Anne and I have a working knowledge of Spanish, but that did not help me in communicating with the female patients at San Carlos Hospital as many did not speak Spanish but only one or another of the many Mayan dialects (Tzeltal, Tojolabal, Chol etc.). I talked to the patients through one of the nurse's aides who happened to speak a particular dialect in addition to Spanish. As for these aides, Spanish was not their native language and when they translated for me they spoke Spanish slowly and articulately, and easy for me to understand. Where both Anne and I often got lost was at the dinner table with all the Mexican doctors and students. They would be holding a lively discussion in rapid fire Spanish. Often we were completely lost and left to concentrate on enjoying our tortillas for breakfast, tortillas for lunch, and tortillas for dinner. Overall we were well fed and what came with the tortillas was usually tasty.

At that time in 2003, there were few living quarters for the doctors in the hospital compound itself. Anne and I were housed in a building about a kilometer away. The house was a two story building and four or five single Mexican doctors occupied the bedrooms. We were given a free standing garage where there was a single bed. In order to accommodate us as a married couple they had widened the bed with a wooden board supported by a couple of stools and on top had placed a double mattress. The place was rather cramped and above all there was no bathroom. So at night we needed to get out and cross a small courtyard to get to the bathroom in the main house. We learned quickly to use a pail to pee in and dispose of its contents in the morning. Showers, especially hot ones were sporadic. We did not have a telephone in our garage so at night if there was an O&G emergency, the hospital would send the night watchman on his bicycle to come and get me. He would bang on the garage door and shout: "Doctor LeMaire… urgencia … urgencia!) I would quickly get dressed and jump on his bike to get to the hospital. The watchman would then walk back.

In addition to the usual O&G cases I helped in a lot of other cases. For one, I assisted the general surgeon (who was from Spain) on most of his major cases (gall bladders, appendicitis, bowel cases, trauma etc.). He in turn would assist me in my surgical cases (C-Sections, hysterectomies etc.). One weekend day there was a political rally in a town nearby and many people traveled to it. One group of about twenty men was crammed in the back of a small pickup truck. The truck missed a turn on a bridge and overturned into the river, injuring many. They all came to San Carlos Hospital. One patient was dead on arrival, another had major head trauma and was loaded into the only ambulance in town and sent to the hospital in a bigger city 100 km or so away. While the surgeon was tending to some major injuries, I participated as best I could. I ended up suturing an older man with a horrendous scalp laceration (he did well) and amputated a couple of fingers that were too badly mangled to be saved (at least under these conditions).

The hospital had one nurse anesthetist. She was one of the nuns and in her late seventies. She was excellent in what she did, whether it be general or regional (like a spinal or an

epidural) anesthesia. She was so good at it that a common joke around the hospital was that Sister Celeste (not her real name) could start an epidural anesthesia in a cockroach. Often she was called upon to start an intravenous access in a pediatric patient with tiny veins or an adult with fragile or collapsed veins, where everyone else had failed. The problem was that this nun also had a chronic illness herself and on occasion would have a flare-up and be out for several days. During the time she was not available, most elective surgery was halted unless it could be done under local anesthesia. Any major emergency, that could not wait and needed general or regional anesthesia, needed to be sent to a nearby town where there was a bigger hospital. As there was also a government hospital in Altamirano it would have been logical to refer any patient who could not be helped at San Carlos Hospital to the nearby government hospital, rather than being transported out of town by either ambulance or local transportation (jitney). However the local people (Mayans) had such a distrust of anything governmental that they would refuse to go to the government hospital. This distrust was based on the mistreatment the Chiapas people received from the government soldiers during the Zapatista uprising that started in 1994. By the time we arrived in Chiapas, the uprising had settled and we never felt in any danger, but the mistrust of the people remained and I would venture to say, probably is still there and will always be. To understand this conflict one needs to turn to the political history of Mexico during that time, which is certainly not within the scope of this book.

The Mayans from that area are sincere, hardworking, and also very poor. When they came to the hospital for care they would receive a bill, but the nuns would always give them credit and allow them to pay their bill in small installments. That was of course generous of the hospital administration, but this generosity had a rather serious drawback. As these people were also proud, they wanted to pay off their debt and if someone else in the family became ill before their earlier debt was paid off, they would often delay coming back to the hospital with the newly sick child or woman until they were very sick and sometimes even moribund. They felt that they could not impose on the hospital again before their earlier debt had been paid off.

Anne kept busy during our time there. There were always several malnourished kids in the pediatric ward, who were not really sick, but majorly underfed. Anne took it upon herself to play with these kids, take them out for walks and teach them some basic skills like writing their names, recognizing colors etc. One big success with these kids were the building blocks Anne got for them. A new hospital was being constructed nearby and all the wood work was being done by hand. There was much scrap wood and Anne found many pieces with geometric design, squares, rectangles and cubes of all sizes. All the doctors helped sanding these numerous pieces and Anne had the kids build all kinds of constructions with them. What was amazing was that some of the older children managed to use the wooden blocks to construct buildings that resembled the old Mayan ruins. And they did this without any drawings or pictures of these Mayan ruins. They loved it. Most of Anne's time was spent with two orphans. One was a boy called Paco. He was 18 months old and majorly underweight. His mother had died from a snake bite and while his father was at work in a remote village he was being cared for and looked after by an eight or nine year old brother. Because he was malnourished he was brought to the hospital and left there with his four year old sister, also malnourished. The nuns, and in fact the whole hospital kind of adopted these two kids. Anne's work with these children was much appreciated by the nuns and when we left and a farewell party was organized,

it appeared to me that the party was more for Anne than for me.

One problem we encountered was with obtaining a working visa allowing me to work as a doctor in the hospital. When we were dispatched to Mexico by Doctors of the World, we entered the country on a visitor's visa good for three months but not allowing me to work. I was supposed to pass by a government office in Tuxtla Gutierrez, the capital of Chiapas, present a letter of introduction from DOW, and have my visitor's visa instantly converted into a working visa. As it turned out that was more complicated than we and the administrators at DOW had envisioned. In fact, we never received that working visa. We found out that none of the other volunteers who worked at San Carlos had a working visa and thus we did not bother pursuing the matter. The only problem was that our visitor's visa would expire after three months and we were going to stay at San Carlos for four months. Thus we needed to get our visitor's visa extended, which apparently was easy, but of course we could not go through the normal channels as we had never obtained our working visa as was formally required. The way around that was to travel to the border with Guatemala, which was relatively close by, cross the border, and return the same day. At the custom post at the time of reentry the visitor's visa would be extended without any problem. That is what we did. Probably, or most certainly, this was somewhat illegal but effective.

Chiapas is located in the middle of an incredible area rich in Mayan culture and ruins. These were all located within an easy day trip by either jitney or bus. We sure took advantage of all these opportunities on our weekends off. Beautiful places like San Cristobal de las Casas, Comitan, Palenque, and Ococingo are just a few cities we visited. The landscape is stunning and the ruins of the Mayan structures are impressive. As Chiapas is the southernmost state in Mexico it borders Guatemala and towards the end of our four months at Altamirano we traveled by bus and visited many beautiful and interesting places in that country as well.

CHAPTER 14: ONTO THE MARSHALL ISLANDS

One other interesting assignment off the beaten path occurred some years before we decided to leave the University of Miami. I was contacted by someone at the Brookhaven National Laboratory asking me if I was interested in joining a group of physicians, nurses, and technicians on a two week trip to the Marshall Islands. That laboratory had a contract with the United States Government to do a yearly medical checkup of the native people in this region. The background is as follows: from mid-1940 to well into the 50s the US had been testing nuclear devices on Bikini, one of the atolls, in this large group of islands in the middle of the Pacific Ocean. Without going into details here, there was a good deal of nuclear exposure to the natives and a periodic medical survey was initiated. Each year the Brookhaven Laboratory would assemble a medical team and organize a survey of all the people living on these islands. The survey would include medical exams, x rays, and laboratory tests. As part of the medical exam the women would receive pelvic exams and a pap smears in addition to other tests if indicated. The laboratory had acquired an old garbage barge and transformed it in a well-equipped clinic with laboratory, x ray facility, and exam rooms. This vessel was called EGABRAG, which, when read from right to left obviously spells GARBAGE.

The ship would sail to several predetermined locations in this vast island group and the natives would come for their check-up. While the ship was underway to a new location, the medical team was flown to the next location. At these locations we were busy with the clinic, but during the interval that the ship was sailing to the next location and the staff had already been flown there, we had plenty of time to explore the islands and get to know the local people.

Obesity and diabetes were pervasive, probably due to rather poor dietary habits as in many developing areas in the world. A telling piece of information is that the most successful company in the Marshall Islands, we were told, was the Coca Cola Company. Another problem we saw that impacts heavily on the area's environment was the introduction of disposables, such as diapers. Any generated waste needs to be shipped out of these atolls and that is expensive. As a result, we noted innumerable plastic containers and disposable diapers littering these otherwise pristine beaches, and floating in the lagoons.

Flying into the Marshall Islands provided a rather unusual experience. These islands are located west of the International Date Line. I flew from the US west coast on a Tuesday morning to Kwajalein, my final destination that day. I had a short stopover in Majuro and as we crossed the date line I arrived there on Wednesday. The continuation of the flight to Majuro took us farther west, but when we arrive in Kwajalein we were back on Tuesday.

The explanation for that oddity lies in the fact that Kwajalein has served as a tracking station for US missiles launched from the US west coast and therefore had synchronized its time zone with the US west coast, remaining on the east side of the time zone, while the rest of the Marshall Islands remained west of it. In 1993 this anomaly was corrected and Kwajalein is now on the same time zone as the rest of the Marshall Islands. As

Kwajalein had military significance, Anne who was not an American citizen yet, was not given clearance to fly into Kwajalein. She joined me later when the ship was in Majuro. One of the reasons that Anne did not become US citizen at the same time as I did, was the fact that our children then could retain the choice to become Belgian citizens at age 18. That was especially important for our sons, in case they would be drafted to the military during the Vietnam War. Much later, when our kids were independent, Anne opted to become US citizen and did so in Sitka. There is a photo in the Sitka Sentinel of the ceremony when about nine other people were sworn in. Anne was the only Caucasian. That program for Brookhaven laboratories in the Marshall Islands ended in 1998.

At this point I am a bit out of the chronology of our adventures, but that is not so important. In 2005, during one of our "off" and travel times I was contacted by the director of the Alaska native Medical Center (ANMC) in Anchorage. This is the major hospital exclusively for all natives in Alaska. The hospital needed a locums O&G. I knew most of the doctors in that department as I had frequently consulted with them during my time in Sitka. The director knew that I might be available and contacted me. As I was in my "off" time and was actually beginning to think about "what next?" the timing of this contact was just perfect. After consulting with my wife, I accepted a position at ANMC for four months. The work there was quite different from what I had been used to until then. Instead of doing the usual outpatient clinics with on call rotations on nights and weekends, and surgeries, either scheduled or urgent when needed, the position was more like a "hospitalist." I would come on for instance at 7:30 in the evening and be responsible for the entire obstetrical floor with laboring women, do deliveries and C-Sections if needed, and make evening ward rounds on all the in-patients. I would also be available for any emergency room visits and/or admissions, including emergency surgery. Calls from the outlying villages would often come in to discuss problems or arrange a medevac. On a somewhat ironic note, I would sometimes receive calls from the doctors in Sitka about a problem there. Remember, sometime back I was the one in Sitka, calling the O&G on call at ANMC for my problems in Sitka. This night call would last till 7:30 am when the day staff would come in, I would spend another half hour or so with the doctor, the midwife, and the nurses taking over the duty and hand over all the patients so that there would be a continuity of care. Some nights I would get some sleep in a rather spartan "on call" room, but other nights would be too busy to lie down at all. Coming home I would be ready for breakfast and then sleep. Sleeping during the day was a bit of a problem, not so much because of the light, especially in the summer, but because it was usually quite noisy around our apartment. One of the neighbors would mow his lawn, another would use a chain saw to cut up some wood, another would be hammering at some new roof tiles, or the garbage collectors would come by and noisily empty the dumpsters of the apartment complex.

This night call was alternated with similar day calls, where I would come in the morning and work for 12 hours. During the day time I would also assist in surgery and attend meetings if there was time. The hospital would typically have around 1500 deliveries a year, but most if not all these were attended to by the midwives. These midwifes were competent and would consult with me and ask for help when needed, During the day I would also be responsible for making rounds on all the obstetrical patients and discharge the ones who were ready. Circumcisions were also part of the "deal." I indirectly benefitted from these as well, not from money received from saved foreskins (as I did

during my residency in Miami), but because the instrument package used for these procedures contained small scissors and “hemostats” which are little clamps used to secure small blood vessels. These were all disposable, and would be discarded at the end of the procedure. However these were perfect for fly fishing, to remove small hooks from the fish’s mouth. Thus I made a number of my fisherman friends in Anchorage and elsewhere pretty happy. There was a great demand for them. A typical week would consist of three twelve hours shifts and the rest of the time I was completely free to go fishing, camping, hiking, berry picking (in the right season) and just hanging around.

Alaska Native Medical Center is a relatively new hospital. The old one was close to downtown Anchorage and the new one was built a bit farther away. And a beautiful building it is. Not only is the architecture stunning but the inside is incredible. Every main landing of the five floors of the hospital has a large show case of Native, Alaskan artifacts and crafts, each with its own theme. The hospital is well worth visiting even if one is not a patient. Tourists in fact do. The thing to do is to take the elevator to the 5th floor and then walk down the stairs from landing to landing. The walk down the stairs is also worthwhile, as the side walls of the staircase are lined by small glass-covered recessions with incredible small pieces of jewelry, bead work, weaving, and other crafts. On the first floor there is a gift shop that probably has the most and best Alaska Native arts and craft pieces. While in Anchorage, another place worth visiting is the native arts and crafts museum of Wells Fargo Bank. It is located in the main bank building on Northern Lights Boulevard. It has incredible historical pieces. And the entrance is free.

Our contract at ANMC was for four months and since that first time we have been back two more times, once in the middle of the winter. Besides the great time I had working there, it allowed us also to explore not only Anchorage as a town, but also the immediate and distant surroundings. It is a paradise for outdoor type of people. In the winter it is not uncommon to run into a moose or two on the snow covered hiking or cross country skiing trails. I remember one time that I was arriving at the hospital in the morning and could not get into the building as a bull moose was lying down comfortably in the snow in front of the entrance. The police had cordoned off the area until Mr. Moose decided later in the morning that it was time to get going. Avoiding getting inadvertently in between a female moose and one of her calves is most important as these “mothers” can get quite aggressive if they feel that they need to protect their young.

EPILOGUE

After our last episode in Anchorage we were not quite sure what we would be doing next. Returning to Anchorage for short episodes, or returning to Tasmania or New Zealand were all options. However I received a call or an e-mail (I cannot remember) from the Medical Director at Mount Edgecumbe Hospital in Sitka, where I had worked earlier (see Chapter Nine). The O&G, who had replaced me, had given short notice that he was leaving as his wife was ill. The hospital needed a replacement and wanted to know if I would consider coming back. This came as a pleasant surprise to us as we loved Sitka and had only left there because we wanted to have some other experiences. No surprise thus that we accepted readily, however I did not want to work full time and told the medical director so. All he wanted to know is when we could come and for how long. It was a bit like I was going to be able to write my own ticket. So we agreed on starting in January 2008 for three months at a time and continue until they no longer needed me and found a permanent replacement. As of this writing we have been back numerous times, mostly for about three months each time. The hospital has now finally been able to appoint a permanent O&G and thus my return visits to work in Sitka will only be when the permanent doctor is either on vacation or away for other reasons. My visits will also be shorter. The work and lifestyle in Sitka is much the same as I described it in Chapter nine and we still love all of it.

Having had those wonderful experiences over the last 20 years or more, I come to the point where I have to ask myself when to actually quit. I am now 78 years old and I still feel physically and mentally fit. Although I have drastically cut down on the scope of my surgical procedures, I have no problem with the “bread and butter” type of practice of O&G. For instance, I no longer do complex and advanced laparoscopic procedures or major vaginal repairs and refer such cases to Alaska Native Medical Center if the patient is Alaska Native, or to the private sector in Seattle or elsewhere if they are not. The time will come however, when I will need to stop doing even the more mundane procedures, and I hope that I will be humble and realistic enough to know when to make that decision. I have seen a number of my older colleagues resist the inevitable and when they are finally confronted by their chairman or supervisor they are deeply hurt and angry. I do not want that to happen to me and have recruited a number of my colleagues and friends in Sitka and asked them to be blunt and tell me to my face: “Wim, it is time to quit.”

In reflecting back on my career as an obstetrician gynecologist, the first thing that comes to mind is that I have no regrets and neither does my wife. A good 29 years were spent on the beaten path at the University of Miami, where I had a productive and satisfying career. The next 22 years or so (and maybe several more years) were spent off the beaten path and in these pages I have attempted to impart to the reader the enthusiasm and satisfaction we have felt and still feel about this part of my career. While I was happy at the University of Miami, the decision to leave was the best decision both Anne and I ever made. We have never looked back. If given the opportunity, I would do almost exactly the same. That includes entering medical school, marrying young to Anne (with whom I have a fantastic relationship), going abroad (USA) to do an internship, signing up for the Congo, specializing in O&G, sub-specializing in reproductive endocrinology and

entering an academic career, and ultimately getting off the beaten path. The only thing I might have done differently during my time at the University of Miami, when my kids were still young, is to spend more time with them. At eight, ten, or twelve or so they really would have needed me to be around more, and I was not. Later when they were in their teens, I had more time but then it was kind of too late, they wanted more to be with their friends and did not need me as much. That time never returns. In discussing this with Anne, she reminded me that if I had indeed spent more time at home in the early part of my career, that career might have turned out differently and I might not have reached the status that allowed me to switch as I did.

Anne herself has also no regrets. While she interrupted her university studies in Belgium to get married, travel with me, and have our children, she managed much later to start taking college courses again at the University of Miami. She ended up receiving a Bachelor's degree in 1983. One of her interesting classes she took was religion, thought by one of the priests of St Augustine University center at the UM. This was known to be a rather easy class and thus also taken by many of the football players of the UM. Our son Frank, who was attending the UM also at that time, learned from some of his friends that his mom was sometimes seen to be drinking coffee in between classes with some of these players.

While I am writing this, I am reflecting on the fact that even now with our eight grandchildren we have limited contact as we are away so much. All eight of them were born after we had left the University of Miami and we were only there for the birth of two of them. Our oldest daughter, Ingrid has two sons. Both of them are in College at Penn State. Nick, the oldest is a mechanical engineering major and a member of the NCAA Championship wrestling team and Matt is a marketing major is a long distance runner and competing on the national level. Elke, our second daughter has three girls. The oldest, Kaley is majoring in psychology at the University of Florida. She will be spending a semester in Spain to become fluent in Spanish, which is somewhat of a necessity in South Florida. Kristine is graduating in the top 5% of her class and is going to college at Chapel Hill in North Carolina. Her youngest girl, Kourtney is still in high school and competing on the varsity volley ball team. As the names of Elke's girls all three begin with a K, we call them the K girls. Our son Tom has two teen age girls. Murielle is a high school freshman and plays on the varsity tennis team. Emilee is in seventh grade and is an accomplished violinist. Both are on their church choir. Our youngest son Frank has an eight year old daughter who loves to draw and is real good at it, especially fashion type drawing and has a knack for drama and theater. All those kids are doing well academically, and it is fun for us to see them grow up, even from some distance. Without being a 100% sure, I think that eight grand kids is going to be it for us. Of course I could be writing an entire chapter on each one of the kids and also the grand kids, without it ever seeming to be boring. However that would go way beyond the purpose and the title of this book.

In the process of pursuing our diverse assignments we have traveled extensively and many of our friends remind us of this. However a fair number of my colleagues and of our friends have traveled much more extensively than we have. They however were passing through as tourists or on short medical missions, while we stayed put in each place we visited for three, four and six months and even two years (Pakistan) or seven

years in Sitka. Assignments for such lengths of time allow for some integration in communities, so that we got to know the area inside out, learned to appreciate the diversity of cultures as well as the differences in medical care and in the process developed an incredible network of friends and colleagues. The loose, continued attachment to the University of Miami has been beneficial, if only to allow me to fill the gaps in my curriculum vitae each time we were not on an assignment and just relaxing or traveling. For this I am much indebted to the insight of Dr. William Little who was my chairman at the time we made our decision to step off the beaten path. He was the one who encouraged me not to sever the connection with the University and appointed me as voluntary faculty. As a result, today I am an Emeritus Professor at the University with the status and benefits that go with this position and with connections to a major medical center.

Getting off the beaten path relatively early at age 55 allowed me to step away from academics relatively easily and transit from "sub specialist" in a highly specialized area of reproductive endocrinology to being a generalist in O&G. I believe that the longer one waits, the more difficult such a transition becomes. To do what I did, I believe that it is necessary to be a generalist, as there would have been little demand in the various locations we went to, for a reproductive endocrinologist or for any other sub-specialist for that matter. An example in point comes from our experience in Chiapas, Mexico. There we met an internal medicine specialist who was volunteering in the catholic hospital there. He was prominent and well known in the specialized field of liver diseases (hepatologist) at a university. He was in his late sixties or early seventies and this was his first volunteer job. While he was brilliant in diagnosing and treating liver diseases he felt much like a fish out of the water when he had to deal with the far more common, run of the mill internal medicine problems (like anemia, infectious diseases, pulmonary and cardiac problems etc.), seen at the hospital in Chiapas. In his role as a hepatologist for many years he had not had any hands-on practice in these common medical problems. Reversing from a highly specialized field to a more general area is, in my opinion, much more difficult at a more advance age and this colleague agreed with me.

As I look back on my earliest experience off the beaten path in Africa about 50 years ago, I must admit that I am saddened by one realization. While working in other similar underserved areas in various parts of the world many years later, I have come to acknowledge that in spite of so many major technical advances, little has changed for the large number of people living in these underserved areas. I have seen and experienced the many unfulfilled needs of these places and I have come to realize how difficult it actually is to fill these needs.

One of the major unfulfilled needs in developing areas of the world is the overwhelming need for safe and effective family planning with contraception and sterilization readily available. Anne and I consider ourselves relatively good Roman Catholics, but to us it is indeed sad to see the Catholic Church continuing to oppose such effective measures. In my opinion many of the world's troubles are due to overpopulation. Poverty, pollution, crime, joblessness, wars, illiteracy, and depletion of natural resources are in some measure aggravated, if not caused, by overpopulation. Continuing opposition by the Church, and also by many politicians, to effective methods for curbing this overpopulation seems shortsighted or worse. I have worked as an O&G in a number of

hospitals in the developing world and several of these hospitals were operated by Catholic nuns. They do an excellent job. In one of the places (which I shall not name, lest these nuns get into trouble) I saw a real ray of hope in regard to the need for family planning in a Catholic setting. Let me relate the incident.

I was about to do a scheduled repeat C-Section on a relatively young woman (in her early thirties). She had five or six children, all delivered by C-Section. After she had signed a consent form (or rather placed a cross in the appropriate place of the form as she could not write), I was about to have her wheeled into the operating room. One of the nuns came up to me and took me aside and said something like this: "Dr. LeMaire you know that this woman has already five children, her husband is out of work and they are very poor. Do you not think that it would be a good idea to tie her fallopian tubes so that she would be permanently sterilized? Please go and talk to her." I did talk to the patient and she practically embraced me and thanked me profusely in her own native language. Of course I had to have her sign the consent for a tubal ligation which I thought might have presented a problem. However the nun was prepared for this and pulled out a separate form which the patient also marked with an X and instead of putting that form into the patient's file it went into a bottom drawer of the nun's office. I thought that this was humane and compassionate. These devout religious women (the nuns) were realistic and saw the need of the people clearly. If only there would be more clear thinking people in the hierarchy of the Catholic Church, and more politicians who would recognize the real problems in the world.

We are often asked how it is that we have been able to have these many off the beaten path experiences while many of my colleagues don't seem to be able to bring themselves to do likewise even though they express great interest. The answer is not a simple one.

First I do think that our early decision to get married right after medical school and do the unusual, like go to the USA for internship and serve in Africa instead of military service, put us in the right frame of mind to take more unusual steps later. Then the fact that we had our children at an early age allowed us to feel free to do the unconventional on our own at a later time, when we were still at our prime but the kids grown and independent enough so that we could leave them. Our kids often refer jokingly to this by saying that we (the parents) ran away from home, while most of the time it is the reverse. A third major factor is that Anne and I are detached from "stuff" and have always been. We had no problem leaving that "stuff" behind. In a broad sense one can classify as "stuff" such things as pets, plants, hobbies, carpets, art work, bridge club, golf buddies etc. In fact we ended up selling our house to our son. The fourth factor is that we both love traveling. Many of my colleagues tell me that they would do the same thing we are doing if it was not for their spouse, who does not want to travel. By travel I mean not just a few weeks away from home on a cruise or a brief medical mission, but extended periods of time away from home in a foreign environment. The final and probably most important factor is that something rather shocking might need to happen to shake one out of his/her comfort zone, so that one begins to question the importance of what one is doing and where one is going. To us that was the sudden death of our best friend.

In any case all these factors came together for us and allowed us to live this very exciting "second career." As I stated earlier we would do it all over again.

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