GREEN LANE HOSPITAL

The First Hundred Years

Edited by

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HISTORY OF CARDIOLOGY

Looking back it would now seem inevitable that cardiology would develop into a major specialty at Green Lane Hospital the moment Sir Douglas Robb was appointed as a visiting surgeon to begin thoracic surgery - where thoracic surgery goes, cardiology usually follows. It was a very modest start with the appointment of Dr E.H. Roche, as visiting physician with a strong interest in cardiology in 1944, that marked the beginning of cardiology at Green Lane. Who at that time could have foreseen the enormous developments that were to take place in cardiac surgery and cardiology in the subsequent 45 years? In 1947 the Green Lane Medical Committee asked the Auckland Hospital Board to set up a cardiology department at Green Lane Hospital. This was opposed by physicians from other hospitals in the Auckland area. A cardiosurgical clinic, however, was approved by the Hospital Board with the emphasis on cardiac surgery, which at that time had nothing to offer patients with ischaemic heart disease. The members of the first cardiosurgical clinic were:

Chairman	Dr C.B. Gilberd (Medical Superintendent)
Physicians:	Drs K.H. Holdgate, J.L. Reynolds, E.H. Roche
Surgeons:	Mr G.D. Robb, G.R. Nicks
Radiologist:	Dr N. Klein
Anaesthetist:	Dr G.F.V. Anson
Registrar:	Dr A.F. Coombes

All patients presenting to the physicians with heart disease were presented to the cardiosurgical clinic on a weekly basis and discussed by all members of the clinic. This method of patient management has proven a very important part in the development of cardiology at Green Lane Hospital and continues at present. It allows close integration of the viewpoints of the various disciplines involved with the patients. Over the years, many of the management decisions of patients with heart disease with respect to cardiac surgery, have been very difficult, particularly during the development of new procedures and the pros and cons of surgical versus conservative management have been fully discussed at these clinics. This clinic still serves a valuable purpose, but in recent years has been overwhelmed by the number of patients being presented.

Investigation of patients by means of cardiac catheterisation, was begun in 1948 with very primitive methods. The catheters were ureteric catheters and pressure measurements were by water manometers which were quite unsatisfactory. These initial efforts were a co-operative effort involving a surgeon, Rowan Nicks, a cardiologist, Edward Roche and a radiologist, Dr N. Klein. As the surgical workload

increased, the surgeon left the team but the development of cardiac catheterisation, cardiac angiography and subsequently interventional procedures has always been a very happy co-operative venture with very strong and cordial relationships between cardiologists and cardiac radiologists, and this has been a major factor in the success and development of cardiology at Green Lane. Early in the development of cardiology, a major event was the visit to Green Lane Hospital by Dr Paul Wood in 1951. His visit was arranged by the Post Graduate Medical Committee, and his teachings on clinical cardiology and techniques for cardiac catheterisation were to prove very valuable.

In 1953, Dr James B. Lowe was appointed as Cardiologist. Looking back, it is of interest to note that one of the terms of his contract was that he would not treat patients with coronary artery disease. This was entirely understandable at the time as patients with myocardial infarction and angina were managed by general physicians. No surgery for coronary disease was available at that time, no Coronary Care Units were available and cardiology had little to offer such patients. Despite this restriction, which became progressively overlooked as the years went by, Jim Lowe was to prove one of the dominant forces in the development of cardiology at Green Lane. All of the current cardiologists at Green Lane owe much to his teachings.

A paediatric ward was established in 1959 to house the children with cardiac disease. This was in association with Dr Jack Matthews, paediatrician, and the paediatric cardiologists Dr Jim Lowe, Dr Dick Rowe and subsequently Dr John Neutze, Dr Louise Calder and Dr Patricia Clarkson. It is interesting to reflect that much of the early development of cardiology was based in buildings that were single storey wooden prefabs in close proximity to One Tree Hill park, where at times auscultation was made difficult by the noise of the nearby sheep! The route to the catheter laboratory was outside by way of a carpark and catheter procedures were never cancelled because of weather conditions. In 1970 the new seven storey building housing adult and paediatric cardiology wards, cardiac surgical wards, cardiac catheter laboratories, pathology laboratories and radiology department, was opened.

The Coronary Care Unit was opened in 1967. This was opened following the initiative of Dr J.L. Reynolds, a cardiologist in charge of one of the general medical wards at Green Lane Hospital and the unit was set up under the direction of Dr Robin Norris. Initially, the Coronary Care Unit was not part of what had become known as the Cardiology Unit, but over the years the functions of the two departments have been much more closely involved.

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The first coronary vein graft operation at Green Lane Hospital was undertaken in 1969. A small number of patients were operated on over the next few years, but subsequently there has been an enormous increase in both coronary arteriograms and coronary vein graft operations. The number of coronary arteriograms rose from 112 in 1972 to 727 in 1980. The number of coronary vein graft operations between 1969 and 1971 was 62 patients increasing to 404 in 1980. The enormous increase in this one operation taxed the resources of the unit to the limit and created very long waiting lists which persist in the year 1990. Coronary angioplasty as an alternative to coronary surgery in suitable cases was commenced in 1981 and after a cautious beginning, the numbers have progressively increased to almost 400 during 1989. The first coronary atherectomies were undertaken in February 1990.

The investigation of patients with congenital and rheumatic heart disease has been greatly facilitated by the development of cardiac ultrasound. The initial M-mode studies were undertaken in the early 1970's with subsequently 2D echocardiography, Doppler echocardiography and colour flow mapping facilities. Approximately 2,700 cardiac echo studies have been performed annually in recent years. The development of 2D imaging and Doppler studies was greatly assisted by Professor David Sahn and Professor Dick Green, both of whom spent a year's sabbatical at this hospital and subsequently by Dr Warwick Jaffe who made a major contribution in establishing the accuracy of Doppler studies in valvular heart disease.

Two very successful echocardiographic courses were organised with the assistance of Professor David Sahn. The first, in association with Antony De Maria from Kentucky and the second, in association with Richard Popp from Stanford and Harvey Feigenbaum from Indianapolis.

Dr Warren Smith has been responsible for the development of electrophysiology and surgery for cardiac arrhythmias. The first operations were undertaken in June 1986 with the assistance of Mr David Ross and Mr Warren Johnson, surgeons from Westmead Hospital, Sydney. Since then, surgery for cardiac arrhythmias has been undertaken on a regular basis by Mr Clive Robinson. A research programme by Margaret Hood in 1988-1989 made excellent progress in studies towards the development of a reliable surface mapping system for ventricular arrhythmias, undertaken in association with staff members from the Auckland University School of Engineering.

One of the developments to receive the most publicity was the introduction of heart transplantation at Green Lane Hospital. Before the development of this service, patients requiring heart transplantation travelled either to Sydney or London. It was

eventually agreed that one unit in New Zealand should be responsible for heart transplantation and Green Lane Hospital was selected as this unit. The first transplantation was undertaken in December 1987 and as at November 1989, fifteen transplants have been undertaken. The surgical team has been led by Mr Ken Graham and Clive Robinson on the surgical side and Drs Trevor Agnew and Arthur Coverdale on the medical side.

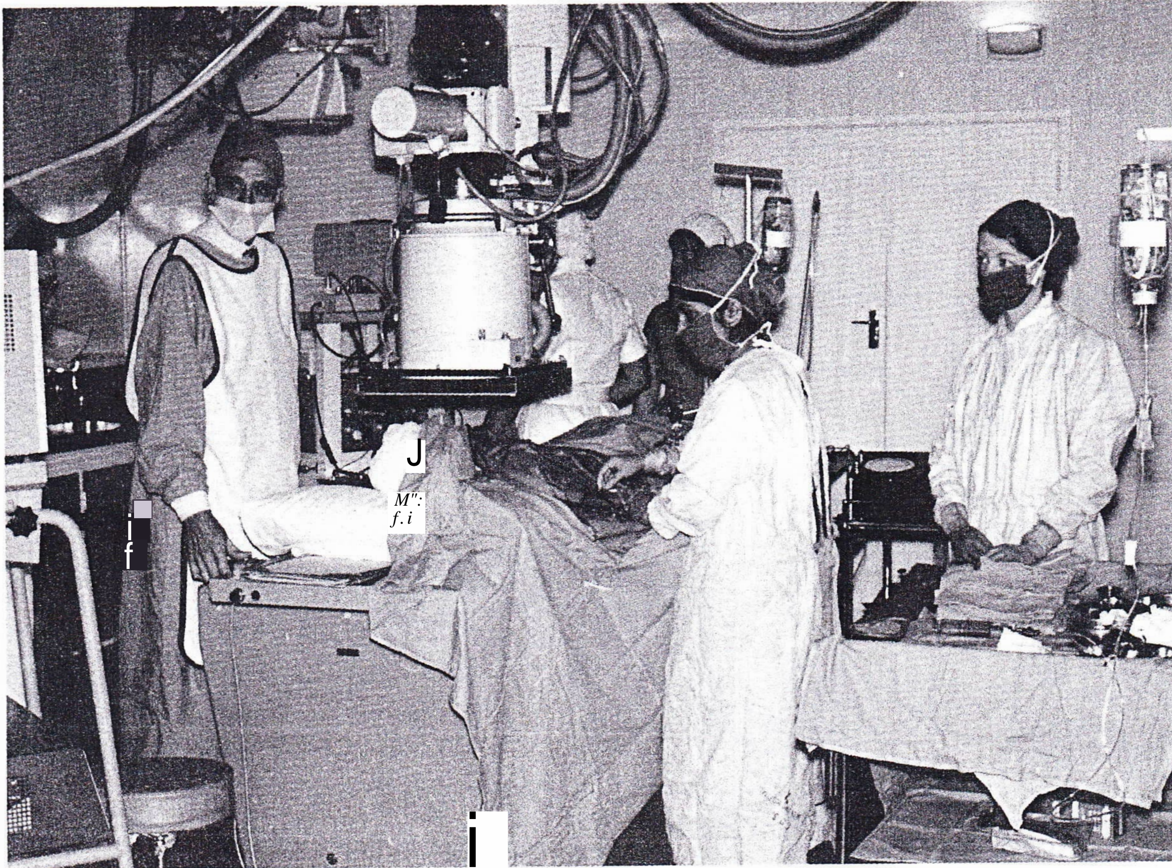
New appointments have been John Neutze to the Chairmanship of the Cardiology Department following Jim Lowe's retirement, Dr John Rutherford from 1981-84, Dr Arthur Coverdale, Dr Warren Smith and Dr Harvey White. Dr Wilhelm Lubbe was appointed to the Chair of Cardiovascular Studies in 1986.

Research programmes have continued and Dr Robin Norris has continued productive studies based on the care of patients admitted to the Coronary Care Unit. Harvey White has undertaken extensive investigations into the use of thrombolysis during a four year term as Senior Heart Foundation Fellow. A very successful heart appeal was mounted in 1988 to help fund continuing research, and despite the economic downturn at that time, donations exceeded one million dollars at the end of the appeal period. The first appointment from this fund was made late in 1988, with Harvey White becoming the first specialist in cardiovascular research.

1989 has seen major changes in the establishment at Green Lane Hospital with the disappearance of most of the general medical and surgical services, a move which has been long opposed by members of the cardiology unit. Green Lane Hospital is therefore now almost a purely specialist hospital. Management systems have changed and Susan Belsham has become the Hospital Manager. In 1990, Terry Stanbridge took up the position as Manager of the Cardiovascular Group.

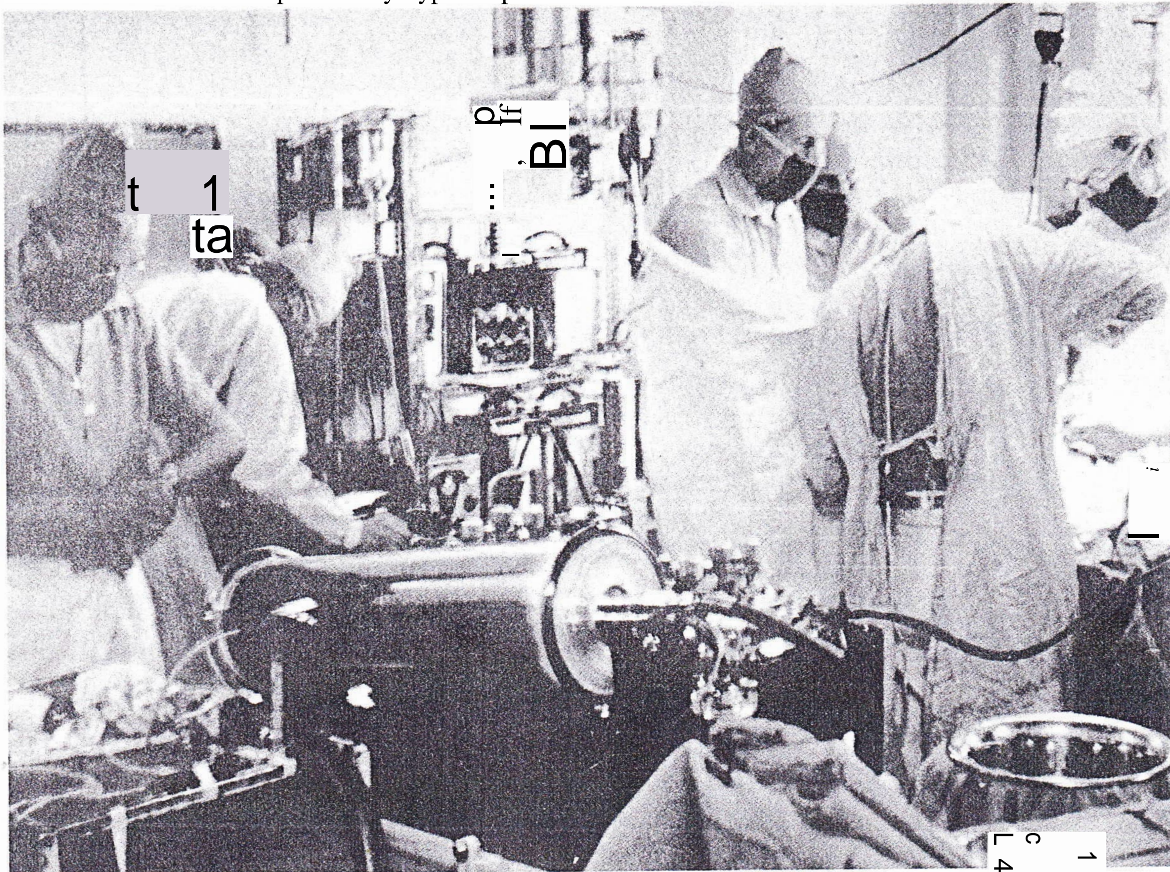
The transforming of Green Lane Hospital into a specialist hospital has had the effect of weakening the speciality of cardiology at Green Lane. Acute cardiological cases will always go where general medical cases go. In the 1990's, acute cardiological cases will increasingly require urgent investigations and treatment which is only possible at Green Lane. The diversion of these patients from Green Lane, may prove to be ah unfortunate development.

Tony Roche



Above : A 1960's scene in the cardiac investigation room - the teamwork required in a catheter study is shown by radiology, cardiology, nursing and physiology staff.

Below : The first cardiopulmonary bypass operation in 1958.



THE DEVELOPMENT OF THE CARDIOTHORACIC SURGICAL UNIT

The national and international recognition and acclaim enjoyed by the Green Lane Cardiothoracic Unit has, in the minds of the public, been largely identified with two outstanding surgeons - the founder of the Unit, Sir Douglas Robb, and his brilliant successor Sir Brian Barratt-Boyes. Perhaps the unique feature of the department, however, which led to its early leadership in cardiac surgery was the teamwork which developed within the department, and the outstanding co-operation and support of the associated medical specialists both in cardiology and in respiratory medicine.

It is therefore appropriate to record that thoracic surgery at Green Lane, had its real foundation with the appointment of Dr Chisholm McDowell as visiting medical tuberculosis officer in 1933. Dr McDowell had worked as a physician with the founder of British thoracic surgery, Tudor Edwards, and had learned that surgery could play an important role in the management of tuberculosis in that era when no chemotherapy was available. It was he who urged his patient and neighbour, G.D. Robb (later Sir Douglas) to take an interest in this work and he persuaded the Auckland Hospital Board to appoint him as the first thoracic surgeon in 1942. Robb had been an outstanding student whose Presbyterian upbringing inspired much of his thinking. He himself suffered from pulmonary tuberculosis through his early adult years. Early in the 1930's he had been appointed as assistant surgeon at Auckland Hospital but had incurred the wrath of his senior colleagues following publication of a report on several of their number. His problems were compounded further when he was forced to admit authorship, under a pseudonym, of articles in the New Zealand Herald which were scathingly critical of the Hospital Board. His application for re-appointment was refused in 1935 and he did not work in the Board's hospitals again until his appointment to Green Lane in 1942.

In the early years, surgery was almost exclusively for tuberculosis, and Douglas Robb was assisted by Chisholm McDowell and John Hinds, assistant tuberculosis officer. In 1946 Frederick Furkert was seconded from Auckland Hospital as assistant thoracic surgeon. This appointment was quickly followed by that of Rowan Nicks who had had formal training in thoracic surgery in Britain following service in World War 1 and whose dedication, imagination and enthusiasm contributed greatly to the development of the new unit until his resignation in 1956 to take up a position as head of cardiothoracic surgery at the Royal Prince Alfred Hospital in Sydney. The group was further strengthened in 1955 by the appointment of David Cole, fully trained in British thoracic surgery, whose subsequent distinguished career culminated in his service as Dean of the Auckland Medical School.

During this early period there was a rapid development of surgical techniques for treatment of pulmonary disease; predominantly tuberculosis and later lung cancer. Staple operations were thoracoplasty, drainage and decortication of empyemas and

pulmonary resections including lobectomies, pneumonectomies, and later segmental resections. During this period cardiac surgery was in its infancy, but techniques for treatment of patent ductus arteriosus and coarctation were already being perfected overseas. A patent ductus had already been successfully ligated in Wellington in May 1944 and later that year Robb attempted ligation of a ductus complicated by infective endocarditis. The operation was subsequently investigated by the Hospital Board's Complaints Committee. The operation was regarded as experimental and referred to by one member as "cold-blooded murder". Fortunately, the next operation performed in 1946 proved successful, and subsequently aortic coarctation was also successfully repaired.

In 1944, Alfred Blalock successfully palliated tetralogy of Fallot by anastomosis of the subclavian to the pulmonary artery at Johns Hopkins Hospital at Baltimore. Robb studied in Baltimore in 1948 and preparations were made at Green Lane for the investigation and surgical management of cardiac patients on a wider scale. A Cardiosurgical Unit was established, chaired by the then Superintendent, Dr Carl Gilberd, and consisting of physicians, surgeons, radiologists, and anaesthetists. In the developmental years of cardiac surgery which followed, this committee provided an invaluable platform for the exchange of ideas and for decision-making. Techniques of electrocardiography and cardiac catheterisation were introduced by Dr Edward Roche with close co-operation from Mr A.W. Melville of the Department of Scientific and Industrial Research. Further impetus was provided by a visit from world-famed London cardiologist, Dr Paul Wood in 1951. The Blalock operation was successfully established, and in 1951 the first open mitral valvotomy was performed with the assistance of Dr Gordon Murray from Toronto. Cardiology was greatly strengthened by the appointment of Dr James Lowe as full-time cardiologist in 1953, and he assumed chairmanship of the Cardiosurgical Clinic.

In 1954 Green Lane vascular surgery had its beginnings with the first operations for abdominal aortic aneurysms. Fresh and later freeze-dried aortic homografts were initially used for aortic replacement, and these were followed by locally made synthetic grafts (Terylene, Holeproof) before dacron and teflon grafts became commercially available.

In the mid 1950's intense interest in the correction of intracardiac defects developed. Overseas, hypothermia was already in use to allow correction of atrial septal defects and relief of pulmonary stenosis during brief periods of circulatory arrest and this technique was first used at Green Lane in 1958. The first successful human use of cardiopulmonary bypass was in Philadelphia in 1953. In 1956 a surgical laboratory was developed with Sidney Yarrow as its first technician, and research on a bypass machine was commenced. Progress was initially slow but received enormous impetus when in 1957 Brian Barratt-Boyes was appointed to the position vacated by Rowan Nicks. Barratt-Boyes was a New Zealand trained surgeon who had spent two years working with John Kirklin at the Mayo Clinic where he witnessed the early successful

development of open-heart surgery. After further experience in Bristol, England, while on a Nuffield Fellowship, he returned to Green Lane. A heart-lung machine designed by Denis Melrose in London, was purchased and refined by Sid Yarrow and Alfred Melville and after thorough testing in the animal laboratory, was first used in September 1958 for closure of a ventricular septal defect. Cardiac surgery as a major specialty in New Zealand was truly under way.

The first patient, a 10 year old with a ventricular septal defect, proved a considerable trial. The initial repair broke open and a second repair with a prosthetic patch was required two months later. She has subsequently required further surgery for her aortic valve. This operation, however, heralded a highly productive, sometimes traumatic but always exciting period during which, surgical procedures for correction of initially congenital and later valvular heart disease, were introduced and refined. Some techniques were imported from overseas and others were initiated at Green Lane. Particularly noteworthy was a large and successful series of primary complete corrective operations for tetralogy of Fallot and the development of surgical treatment of aortic valve disease; first decalcification and valvotomy for calcific aortic stenosis, and later aortic valve replacement using valve allografts. This later procedure was first performed in August 1962. The patient was a 14 year old girl whose aortic valve had been completely destroyed by infective endocarditis and who was terminally ill. A freshly taken homograft valve was used and has performed remarkably well, having only recently been replaced after almost 25 years of service. At the time, this procedure had never been reported in the medical literature and was thought to have been a world "first", although it was subsequently found that Donald Ross working at Guy's Hospital, London, had independently performed a similar procedure 30 days earlier. It is interesting that the technical difficulties of insertion and uncertain durability of homograft valves, deterred surgeons in most overseas centres from adopting this technique. The valve has been in continuous use at Green Lane, however, with gradual development of improved techniques of sterilisation and preservation. These improvements, together with the widespread availability of allograft tissue provided by transplant procurement, has led to a recent resurgence in interest in the technique in North America.

Throughout the 1960's, the Unit functioned as a closely knit team with invaluable support from the cardiologists, led by Dr Lowe and also by Dr Richard Rowe, an outstanding New Zealand paediatric cardiologist who later returned to America to head departments of paediatric cardiology, first at Johns Hopkins in Baltimore and later at the Toronto Children's Hospital. Among other anaesthetists, Drs Marie Simpson and Eve Seelye provided meticulous and continuous care both in the operating theatres and in the intensive care room. Dr Peter Brandt quickly gained an international reputation in both paediatric and adult cardiac radiology and physiological support in both clinical and research areas was provided by Drs J.D. Sinclair, E.A. Harris and R.M.L. Whitlock. Sir Douglas Robb, who was kjiighted in 1960, continued to play an active role in thoracic and vascular surgery and to provide

leadership and inspiration for younger members of the team. He had the foresight and wisdom, however, not to involve himself with the development of open heart surgery, and during this period was heavily committed to the formation of the Auckland Medical School. He later became Chancellor of the Auckland University.

Dedicated nursing services through these difficult times were led by Gloria Grattan, subsequently Principal Nurse at Wellington Hospital. A postgraduate training course for nurses was developed. This still continues and has proved invaluable in maintaining high standards within the Unit. Many graduates now occupy prominent positions within New Zealand's nursing services.

Sir Douglas Robb's Farewell, July 1964. From left : Dr Chisholm McDowell, Sir Douglas, Dr Jun Lowe, Mr David Cole, Mr Brian Barratt-Boyes and Dr John Hinds.

By 1968, most forms of valvular and congenital heart disease in adults and older children, could be treated fairly safely and adequately. There were persistent problems in infants in whom the rather crude bypass techniques available proved too traumatic, allowing only palliative non-bypass procedures to be performed. At about this time, Barratt-Boyes refined a Japanese technique using profound hypothermia with circulatory arrest with only minimal periods of perfusion cooling and rewarming. This technique allowed a dramatic improvement in the results of corrective procedures early in infancy and was quickly adopted internationally. By this time, the outstanding results achieved by the Unit and their articulate presentation at overseas

forums by Barratt-Boyes, had brought Green Lane widespread recognition among cardiologists and surgeons. Many overseas patients were referred to the hospital and many surgeons visited to observe techniques first-hand. Successful international meetings were held at the hospital in 1965 and 1972.

By 1970, the weekly cardiac surgical case load had increased from two per week in the early 1960's to six per week. Coronary artery bypass grafting had first been performed at the Cleveland Clinic in 1967 and was introduced at Green Lane in 1969. In parallel with all cardiac surgical departments, this operation gradually assumed a major place on the weekly operating lists and by 1980 had become about 60% of the total case load which steadily increased to its present 18-20 cardiac operations weekly.

During the 1970's and 1980's, fewer new procedures were introduced and existing techniques were modified and refined for increased effectiveness and safety. Sir Brian Barratt-Boyes was knighted in 1971. David Cole left the Unit in 1974 to become the second Dean of the Auckland Medical School. Of the surgeons who had worked in the Unit in the late 1960's, Geoffrey Allen and Peter Clarke left to take up posts in Hamilton and Melbourne respectively. The Unit was joined by a series of surgeons, all of whom received their early registrar training at Green Lane; Alan Kerr in 1969, Ken Graham in 1972, David Hill in 1975, Clive Robinson in 1984 and Peter Raudkivi in 1988.

Superb support has been provided by our nurses, led in the ward and intensive care by, among others, Margaret Rickard, Olwyn Young, Rachel Ronaldson, Wendy Benjamin and Sylvia Hilton, and in the operating theatre by Moira McDonald, Rachel Ronaldson, Gill Crawford, Carol Fox, Elizabeth Lee and Robin Lines.

Our office, organised since 1974 by Doreen Gibson, has been the envy of other departments; and physiotherapists Sheila Glendining and Sue Webb have provided sterling service. A valve bank was developed by Peter Philpotts and later Philip Whiting with microbiology help from Anne Strickett. Perfusion developed rapidly, initially under Sid Yarrow and has become a strong department under Ron Bentley, Cathy Perkins, Tim Willcox and Jan Ruygrok.

During the 1960's the New Zealand economy was buoyant and the developing Unit enjoyed a high profile as a "centre of excellence" and as such was generously supported by the then Hospital Board chaired by Sir Harcourt Caughey. The downturn in the New Zealand economy in the 1970's and 1980's, combined with the increased caseload and consequent expense, delayed expansion of sendees and introduction of new technology and impeded research. Despite these restrictions, surgical treatment for cardiac arrhythmias has been introduced successfully by Mr Clive Robinson working in conjunction with Dr Warren Smith, cardiologist, and more recently, an active cardiac transplantation programme has been developed, headed

surgically by Ken Graham with support from Clive Robinson and cardiologists Dr Trevor Agnew and Dr Arthur Coverdale.

Events of the past two years, with the loss of general services from Green Lane, radical management changes and altered public perception of medical services, have combined to disrupt the day-to-day running of the service and to change referral patterns. The cohesion of our department, which has been its greatest asset, has been seriously threatened and it is vital that this should be preserved in the long period of restructuring which must lie ahead.

Alan Kerr

NURSING

Green Lane Hospital was founded on April 24th 1890, firstly as a hospital for the care of the elderly and then to include chest diseases, particularly tuberculosis. The "New Building" was built and opened in 1943 and these new wards were used as general medical and surgical wards, with the present ward 1 later becoming Main Theatre. The hospital itself is in a lovely setting with magnificent views of One Tree Hill and Cornwall Park. Looking north there is the War Memorial Museum and the Domain and some of the volcanic cones, and west the Waitakeres - few parts of the hospital do not have a view of some kind and this must be of therapeutic value to the patients. "The Cottage" in front of the present Ward 1, added to the charm of Green Lane and housed Nursing Administration, Managers and some of the Clerical Staff. In the early stages, the hospital was staffed entirely by "Pinkies" because of their pink uniform; these nurses were untrained but were of invaluable assistance to the few registered nurses. When I first started at Green Lane in 1959 there were registered nurses employed who were proud to have been "Pinkies" before they started their training.

A general nursing training for Green Lane was first started in the early forties and there were regular intakes of female students at six week intervals. The Preliminary Nursing School was then at Market Road and all students throughout the main Auckland Hospitals commenced their training there before being allocated to their appropriate hospitals. As a small general hospital for student nurses, Green Lane was renowned throughout New Zealand for being a very happy and friendly hospital. Students applied for Green Lane in abundance and there was always a waiting list for applicants. Being small, everyone knew one another but there was no lack of respect, junior nurses held open doors for more senior ones, even if they were only six weeks ahead. Wards were staffed by a ward sister and staff nurse and student nurses. Nurses did a lot of the work which is now performed by the domestic staff. When I first started in Ward 5 (E.N.T.), I shared the one staff nurse with Ward 14 (Infectious Diseases). Uniforms were supplied; there were dress uniforms for when staff left the ward for meals etc. For student nurses, these were a light blue with long sleeves and for ward work they wore white uniforms with short sleeves. Staff nurses also had two types of uniform, green with long and short sleeves. A lot of the time each day was spent changing from one uniform to another. Sisters wore long-sleeved white uniforms. Sometime during the early sixties, these were scrapped and everyone wore white uniforms with white or red epaulettes with various stripes denoting rank. White shoes and stockings were part of our uniform, but during the seventies we changed to brown pantihose and white sandals became optional, while going without pantihose during the summer, made working conditions more pleasant. Two referendums were held during the late 1970's and early 1980's and caps were abolished. It took a long time for clients to get used to this.

Student nurses took time off ward work for study days and study blocks and when I first arrived, they were transferring to Middlemore Hospital for orthopaedics, to Cornwall Hospital for gynaecology and to Auckland Hospital for infectious diseases, eye and paediatric experience. Students had to move all their belongings to the respective hospitals and it was quite a business arranging rosters so that all these moves could be effected. Students from other hospitals came to Green Lane to get their Tb and chest nursing experience, for in those days there were many Tb patients and consequently more wards were allocated to them. Registered nurses were able to live out but students were resident until about 1970; meals were free for everyone until the last few years and even available for night nurses. As trainee nurses, all students worked four to six weeks at a time on night duty, gradually decreasing over the years. Over the years the nursing curriculum has been altered, changed and improved and nowadays most of the nursing training is done at Technical Institutes. The last hospital based students are completing their training shortly. With the opening of the new cardiothoracic block in 1970 and the projected changeover to Technical Institute trainees, part-time staff were employed. The opening of the creche has enabled all staff to patronise it whether they be nursing, domestic, medical or other employees and it has been fully utilised. What a long time it took to get that off the ground. A few male nurses started training about 1970, their course being of two years, as some areas of the female nursing training were not included. Later, they were able to do the third year. During the seventies, obstetrics was included in the general training.

The one nurse who can truly be identified with Green Lane was Miss Tilly White who started as a "Pinky" before doing her general training at the Waikato Hospital in Hamilton. Her whole life revolved around Green Lane; she was dedicated to her patients in Ward 16 and concerned for her nurses. Everyone knew Tilly and she knew everything that went on in the hospital. She was always the first to spot the flag flying at half mast. There were various cups, the McCormick Rose Bowl being competed for annually between hospitals. Nurses were at first given a theme to act out, but later they could choose their own subject and these were judged on their ability and other aspects. Sport was encouraged and there were interhospital basketball matches. At one time, Green Lane had a highly successful hockey side which reached Senior B level.

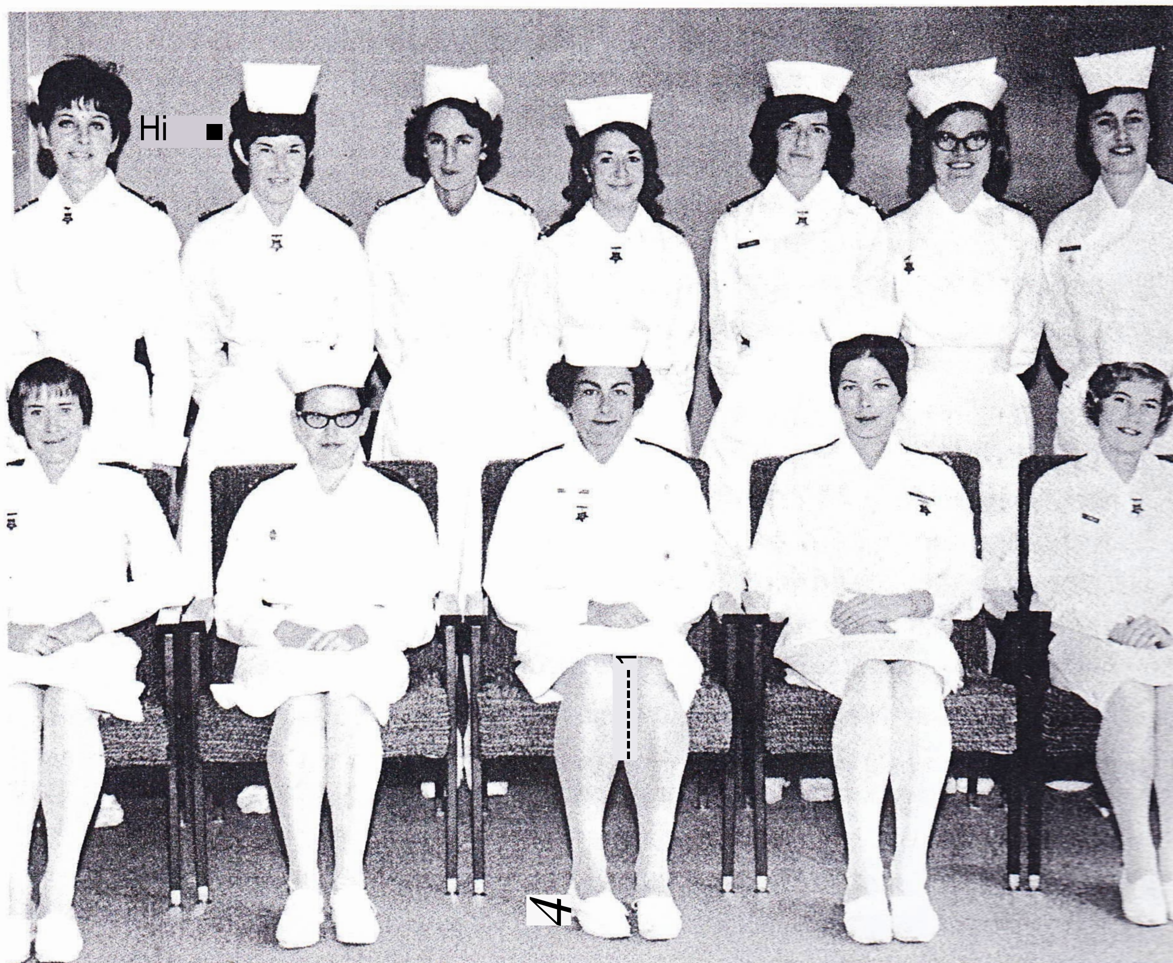
Pantomimes were started in 1966, organised by medical and nursing staff. These were written and choreographed by staff; Jack and the Beanstalk and Cinderella were great favourites and the ballet performed by the menfolk was always a tremendous success. These were real family affairs, not overly ambitious but great fun to be in. A dress rehearsal was held for patients and then it was put on once and then twice for friends and anyone else who wanted to come. In those days, a stage was erected firstly in the dining room and then in the live-in staff lounge, afterwards transferring to the Hall when that was erected. Over the years the pantomime was an annual

event and has become very professional, giving several performances and has always been a great success.

Last year, three geriatric, two medical, two surgical wards and the Accident and Emergency Department, were transferred to other hospitals or closed, causing a great deal of anxiety amongst all staff at Green Lane. Everyone was redeployed either at Green Lane or at one of the other hospitals, and some went with their wards. At the same time, management structure changed and there is now no Principal Nurse, nor Assistant Principal Nurse. The hospital is now divided into five, each division having a nurse manager with a non-nursing manager at the top. All supervisors are now nurse managers or clinicians and charge nurses are now charge nurse managers.

I wish to thank Ellison Johnson, Margaret Harvey, Ruth Woollett (Beale) and Rachel Ronaldson in helping me to compile this article.

Anne Carter



A cardiothoracic postgraduate nursing class of the late 1960's. Sister Margaret Taylor, Charge Nurse for the cardiothoracic wards (and, later, Principal Nurse) is in the centre of the front row.

THE OCCUPATIONAL THERAPY DEPARTMENT

The Occupational Therapy Service commenced at Green Lane Hospital in the early 1950's. The Department was accommodated in the rear section of an old double ward near the porter's recreation area. The Occupational Therapy team of Miss Joy Farrell and two staff occupational therapists, carried out a programme of adapted craft activity for the sick and disabled.

In the beginning, most of the work was carried out with the tuberculosis patients at Green Lane Hospital. From 1955-59 under the guidance of charge occupational therapist Mrs Patricia Dunn, staff and students visited some tuberculosis patients in their homes as well as treating in and outpatients, catering for many differing disabilities. Mrs Dunn organised an art programme for tuberculosis patients which was run by volunteers. She also compiled a booklet on practical adaptations to equipment for the disabled.

Mrs Hilda Moodie who was charge occupational therapist from 1959-68 was responsible for the design of the present department which was opened in March 1967. The previous Occupational Therapy Department was evacuated on an emergency basis when large cracks appeared in the wall during the drilling of the foundations for the new cardiothoracic area of the hospital. Occupational therapy staff were temporarily housed in the "White House" until the opening of the new department. In 1964 Mrs Moodie was granted a year's overseas study leave to observe the latest treatments in occupational therapy in both Britain and U.S.A, with special emphasis on the facilities available for carrying out activities of daily living and the area of housing alterations for the disabled.

Following Mrs Moodie's resignation in 1968, Miss Raewyn Davies was in charge until 1969. The department was well staffed with both therapists and assistants and was a valuable learning situation for students. The emphasis for treatment was on activities of daily living for patients from all areas of the hospital. Some home visits were carried out to assess the needs for home alterations. Occupational therapy was a valuable part of the rehabilitation process. Miss Alison McKay who was charge occupational therapist from 1969 to 1972, appointed the first woodwork instructor who trained tuberculosis patients in the techniques of woodwork.

From 1973 until the present time, Mrs Wendy Davies has been charge occupational therapist, initially with a staff of three occupational therapists and one assistant and a woodwork instructor. Soon after her appointment, Ward 23, the geriatric assessment and rehabilitation ward, was commissioned as was the geriatric day ward. Long-stay patients were transferred to Wards 17 and 18 from Cornwall Hospital when it closed and the occupational therapy staff numbers were boosted to cope with the high involvement of staff in this area.