SBNS Caribbean Training Fellowship Report

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Neurosurgery ST7
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Most of my neurosurgical experience has been in the NHS, and the SBNS Caribbean Training Fellowship was an unprecedented opportunity to experience neurosurgery in a different setting. Jamaica is a beautiful country with a rich cultural history I have always been interested in, so I was excited to get to know the place better.

There are three neurosurgical units in Jamaica, serving a population of nearly 3 million. The University Hospital of the West Indies, Mona (UHWI) receives referrals for all neurosurgical conditions from across the island, and is the regional neurovascular surgery centre. Kingston Public Hospital (KPH) is the default referral centre for all neurotrauma cases, and also cares for neurosurgical patients with non-traumatic pathology. The third centre is at the Cornwall Regional Hospital in West Jamaica.

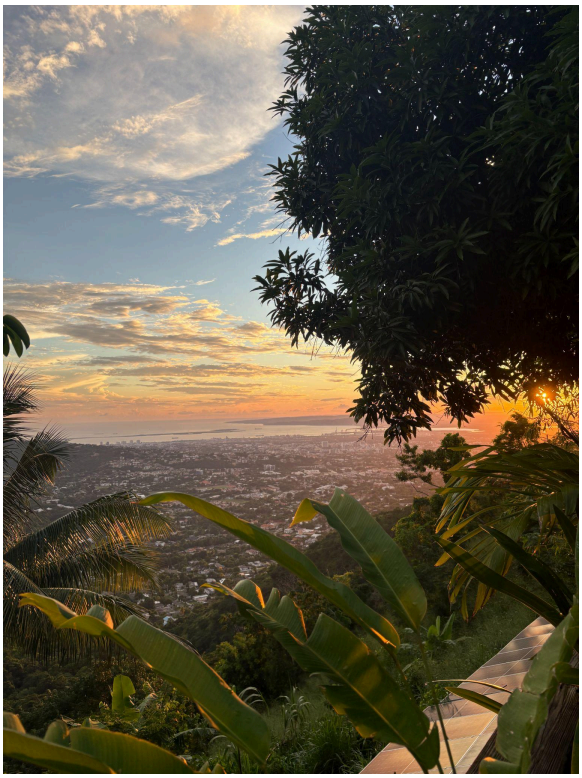
I arrived in Kingston in November 2024 as the second SBNS fellow in the unit. After a handover with my departing colleague I began work in Firm B at the University Hospital of the West of Indies (UHWI), Mona. The hospital is set in a fertile valley at the foothills of the Blue Mountains on the former

UHWI grounds with Blue Mountains in background

One-stop burrhole shop: emergency kit containing Hudson brace and Dandy cannula

Papine estate in East Kingston. It is a public hospital, although patients are charged an admission fee and ultimately receive a bill for their medical care (in contrast to KPH for which there is no charge). UHWI also provides private healthcare at the Tony Thwaites Wing. Under the supervision of consultants Dr Carl Bruce, Dr Kevin Wade and Dr Peyton Lawrence, I assumed the same duties as those of the residents. This entailed a 1:4 24h on-call, twice weekly operating lists at UHWI, a weekly clinic, and general inpatient care.

Our elective lists encompassed the generality of neurosurgery including complex spinal fixation, aneurysmal clipping, intra- and extra-axial tumour resections, transsphenoidal hypophysectomies, minimally invasive spinal surgery, and CSF procedures. There were almost daily emergency operative cases of the sort one would expect in a busy general neurosurgical unit (EVDs, CSDH, trauma craniotomies — although not a single cauda equina syndrome). Some of these hyperacute cases went in a special book: 'dire emergencies'. I had several of these during my on-calls. Memorably at one point we took an elderly gentleman with complex medical comorbidities to theatre as a 'dire' in the middle of a routine ward round for burr holes for a chronic subdural haematoma after a precipitous neurological deterioration. At other times, perioperative pathways were less smooth. Owing to nursing skill mix on general wards, post-operative craniotomies have to be nursed in ITU, and often this was a barrier to theatre.



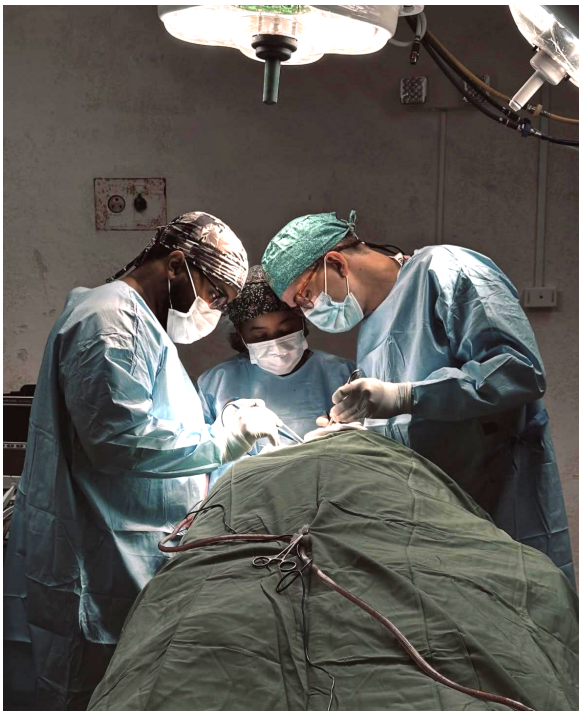
Overlooking Kingston from Skyline drive

Jamaican trainees have impeccable textbook knowledge of neurosurgery, and surgical principles in general; but perhaps have slightly less operative exposure than British trainees, so when a case is happening in theatre everyone in the firm is expected to attend, from the intern up to the consultants. I enjoyed this collaborative approach to operations, as there was always some part of the case that each trainee could attend to. They were also excellent teaching opportunities for the residents, myself included.

I learnt several operative tips and tricks from my co-residents and fellow, Dr Ronette Goodluck. These include the 'Jamaican bipolar'; how to fashion an EVD from a Dandy cannula, nasogastric tube and a saline giving set; and of course, how to use a Hudson brace! This item is considered a curio back home, but in Jamaica it is used for all simple cranial access procedures, including EVD insertion, VP shunt insertion, CSDH evacuation (it's also used with a Gigli saw at KPH for trauma craniotomies if the patient cannot afford drill rental…) This took some getting used to, as I initially noticed my burrholes taking much longer than those of my fellow residents. I wouldn't say I mastered the thing, but I was proud of myself for inserting an EVD in a comatose patient alone in the middle of the night without complication. Without doubt my surgical experiences in Jamaica have made me a more well-rounded, resourceful and resilient surgeon.

As with any new environment, I initially found the on-calls challenging. This was not so much in terms of the clinical decision-making around neurosurgical cases but more in terms of local processes, shortcuts and ways of getting things done. I was supported by a junior resident but often was called upon to perform tasks I hadn't done in some time, including basic haemodynamic observations; vascular access; taking patients to and from scans; and administering missed medications. This was a rewarding experience in taking me back to the core elements of being a doctor, not just a neurosurgeon. I reflected that I am lucky to have worked in environments which are well-staffed, and one can assume that many of these things have been done in the background. It also made me feel full of respect for how hard the residents work in Jamaica, with no working hours restrictions

Outside the surgical wards of Kingston Public Hospital



Elevation of depressed skull fracture with co-residents Dr Samuels and Dr Hamilton at KPH

or ‘zero days’ – you simply stay until the work is done.

After two months at UHWI (and a couple of breaks to the North coast), in my third month I spent time shadowing residents’ on calls at KPH under the supervision of Dr Mark Morgan. KPH is the oldest hospital in Jamaica, founded in 1776, and occupies three blocks in hectic, bustling downtown Kingston. Its high parapet walls give it a foreboding air but the attitude inside the dilapidated building is friendly and ‘can-do’. This was a valuable experience in seeing the huge volume of traumatic brain injury which is dealt with at this unit. During my time there I performed numerous operations including evacuations of subdural haematoma, elevation of depressed skull fracture, and intrinsic tumour resection (no image guidance was available so craniometrics were used to localise the lesion). I was also involved in data collection and overseeing the pilot phase of the Caribbean neurotrauma registry, a GEO-TBI study.

Neurosurgery is an expensive specialty, in terms of personnel required to deliver an optimal service, the time required from nurses and doctors to adequately care for the complexity level of the patients, and in terms of consumables (from basics such as prophylactic low-molecular weight heparin to advanced implants such as spinal fixation systems or endovascular coils). I have gained an enormous respect for the neurosurgical teams in Jamaica who tirelessly work to optimise patient outcomes in the face of financial constraints, and more broadly a deeper appreciation of the challenges of working in a resource-poor healthcare environment – to which the modern-day NHS, despite its well-publicised struggles, compares favourably.

My wife and daughter came with me to Jamaica, and as a family we were able to explore the island, eventually visiting all 14 parishes. Highlights include Portland, a magical, lushly rainforested corner of the North East, with some of the best beaches on the island, good surf and cool hotels (it’s also the home of jerk chicken). Followed in close second by the low-key beach vibe of Negril.

I would not hesitate to say that the SBNS Caribbean Training Fellowship was one of the best things I have done during my time as a neurosurgical trainee, and can

wholeheartedly recommend it to others who are ready to challenge themselves. There were times when I was taken out of my comfort zone, and I have grown as a result of this. It's very easy to stay stuck in one's own lane in a practice as specialised as neurosurgery, and only through travel and seeing other units does one gain a different perspective on how things can be done. I have made lifelong friends in Jamaica and I'm already looking forward to going back again.

From left, Dr Carl Bruce, Dr Mark Morgan; co-residents and fellows

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