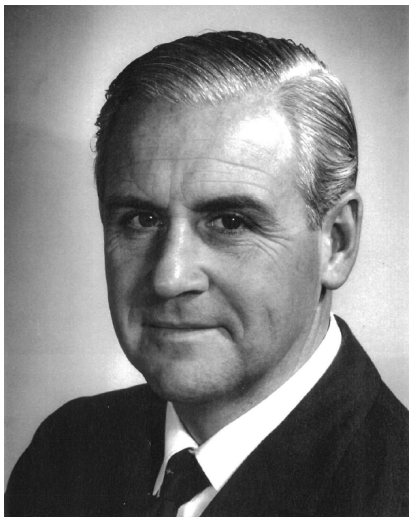
Australian Society *of* Plastic Surgeons

**John Snell**
**1924 - 2023**



I was born on 15th June 1924 in Zanzibar then part of British East Africa. Zanzibar, which had a Sultan, was then a British Protectorate. My father was working there at the cable station as an electrical engineer for the Eastern Telegraph Company.

**Education**

I attended primary school in Durban, South Africa until I was 9½ years old, where I learned to play the game that is played in Heaven. At age 9½, I was sent to England to complete my education at the Royal Masonic School Bushey Herts. The education was excellent but it was not a happy time.

My father had died in South Africa when I was 6 and my mother had remarried in 1938 to a man working for Sime Darby in Malaya. In August 1940 my brother and I were brought out from England to Malacca where my parents were living as it was thought that if the War went badly, it was better for us all to be together. I had completed my Matriculation Exams and wished to do Medicine but there was no proper course in Malaya. What to do?

By extraordinary good fortune (as far as I was concerned) in February 1941 the 8th Division came to Malaya and the 10th A.G.H. took over the Malacca General Hospital. We soon met the medical personnel, Albert Coates who was o/c Surgical, Dr Edward White was the CO, and Dr Cotter Harvey from Sydney was o/c Medical. We got to know them all well. Bert Coates one day at lunch suggested that he could arrange for me to start a medical course in Melbourne. My parents readily agreed and astonishingly, only two weeks later, I was actually in Melbourne and Ormond College and commencing the course.

As soon as I reached Australia I knew I was in Paradise and have had no reason to change my mind since. Coates went on to immortal fame on the Burma railway and was justly knighted for his efforts. Cotter of course earned distinction as probably the first medico to commence a crusade against smoking.

I graduated with honours in Surgery, and Obstetrics and Gynaecology in 1947. This was a year later than I should, as I fractured my femur playing Rugby in Final Year and spent four months in bed in hospital waiting for the leg to unite. In those days there were no intra-medullary pins and I was in extension with a Kirschner wire through the upper tibia. I was then on crutches for four months and so had to repeat the year. It was some consolation to be awarded a full Blue for Rugby. While repeating the year I got my golf handicap down from 22 to 7.

**Postgraduate Education**

- Resident Medical Officer at the Alfred Hospital Melbourne 1947-1949
- Associate surgeon to L H Ball FRCS at the Alfred Hospital 1950-1951

It was about this time that I decided that plastic surgery was what I wanted to do. No drama was involved but I had always been keen on making models and such things and the creative aspect of the discipline appealed to me. Thus, in about April 1951 after gaining my First Part, I asked advice from Bennie Rank. He and Alan Wakefield were the only Plastic Surgeons in Melbourne at that time. He had no idea who I was and was rather discouraging, telling me I would have to get my Fellowship first and start at the bottom etc. To my great good fortune firstly, I passed my Final FRACS in May 1951 and secondly, a few days later, I found myself on the boat to England with Bennie and Barbara. During the voyage we got to know each other and became firm friends. He has been the greatest of help and encouragement to me ever since, despite the fact that I set up as his first opposition in Plastic Surgery when I returned from England. I do not think I posed much of a threat!

- Primary FRACS Nov 1950
- Final FRACS May 1951
- Final FRCS (Eng.) Nov 1951
- Surgical Registrar Queen Mary's Hospital, Stratford, London 1952. A great job for unlimited cutting.
- Registrar Stoke Mandeville Hospital Plastic Surgical Unit under Prof. T. Pomfret Kilner 1952-1954

The unit used to make visits to East Grinstead to Sir Archibald MacIndoe, to Basingstoke to see Sir Harold Gillies, and to Salisbury to see John Barron. Every Friday afternoon we would go to Oxford to Kilner's clinic at the Churchill Hospital. It was great training.

Eric Peet was 2IC of the unit and he was an artist in the true sense as well as a beautifully artistic surgeon. He earned fame as a violin maker and it was said that a copy of a Guarneri he showed in Amsterdam was better than the original. While I was there as his registrar, he was persuaded to take up painting by an Australian, and he was so successful with this that within six months he was teaching painting at the London Polytechnic! His cleft lip and palate repairs were works of art.

- Plastic Registrar Surgical Unit Mount Vernon Hospital Northwood Middlesex under Rainsford Mowlem

I returned to Melbourne at the end of 1954 and became the fourth plastic surgeon, the others being Bennie, Alan Wakefield, and George Gunter. Not long afterwards, Dick Newing and John Hueston returned and set up practice

In 1955 I was appointed Hon. Plastic Surgeon to the Alfred Hospital. This was an inaugural position. It was in the days when the general surgeons thought that they were capable of doing all surgery so that I was awarded the princely number of 2 beds! However, I was permitted to use other people's beds to operate in so was able to keep two operating lists a week going. Virtually no plastic surgery had been done there before and a split skin graft was regarded as a major procedure with an expected high failure rate. It was considered that only a plastic surgeon was capable of carrying this out. I was always being asked "How many of your grafts take?". When I claimed a 90% plus success rate this was received with considerable scepticism.

At the same time in 1955 I was appointed Hon. Plastic Surgeon to the Austin Hospital. I had, to begin with, no assistant at either hospital so was responsible for all the emergency surgery at both hospitals. This proved at times very onerous and on one occasion I was called out 13 nights out of 14. John Barnett soon joined me at both Hospitals and I was pleased to hand over the Austin him in 1963.

Things of course were very different in those days. Anaesthesia had only recently advanced from open ether, though after induction with pentothal ether was commonly used to continue, often with nitrous

oxide. Coughing after removal of the endo-tracheal tube was often a source of great concern to the surgeon especially if he had just completed a large flap or free graft and one could almost watch the haematoma occur. The change today is dramatic. I last year had a G.A. for a Keller's operation and woke up as if I had just had a pleasant sleep. Not a suggestion of nausea, so that I was able to partake of a three-course dinner an hour later. Upper arm blocks were hardly known, as were local intravenous blocks.

Burns were a major problem as they are today. Resuscitation was fairly inexact, and electrolyte control was primitive. There was no really satisfactory local application or dressing. Almost all large bums became infected with Pseudomonas which was very difficult to combat despite all measures. One of the registrars at the new (as it then was) Blond Burns Unit at East Grinstead remarked to me in 1954 that Pseudomonas was the nearest thing to spontaneous generation that he knew. Intravenous alimentation was unknown. Trying to keep up the caloric intake was extremely difficult and the high protein mixtures that were fed by gastric tube generally caused diarrhea. Early excision of the deep burn was just coming in. It was a maxim that a 50% burn in a man of 50 carried a 100% mortality. It was pretty true.

If skin defects could not be closed satisfactorily with free grafts or local flaps then the tubed pedicle flap was often all we had. This took a minimum of four operations at no less than 3-week intervals and often further procedures were needed to thin and trim the flap. At each stage there was a risk of compromising the circulation in the flap so that we all breathed a sigh of relief with the successful final detachment. Various methods, some ingenious, some less so, were devised to maintain an arm in good position when transferring a tubed pedicle flap from a wrist to a lower leg or to the face, so that the pedicle did not stretch or kink and cut off the blood supply. We generally used plaster casts to hold the parts together for this. It was a most uncomfortable time for the patient. The whole exercise was a long, major, and hazardous proceeding.

Dick Newing years ago, had a patient on whom he wished to transfer a flap from his upper arm to the face. We usually used plasters for this as explained above, but it was even more difficult in this situation. His anaesthetist suggested trying hypnosis and the patient was found to be susceptible. He was instructed that at the end of the operation he would keep his arm fixed in position and not move it under any circumstances. Late that night the arm inevitably and inadvertently drifted out of position stretching the pedicle. The nurses tried to reposition the arm but the patient would not allow this. The anaesthetist was therefore called in and instructed the patient to move the arm into position, which of course he did. Next night the same thing occurred and the anaesthetist was again called in to fix things as the patient would not obey the nurses as instructed under hypnosis. When this happened on the third night the anaesthetist, now rather fed up, told the patient that he must obey the nurses and thus transferred his hypnotic powers to the nurses. The arm was thus kept in position for the necessary three weeks and all was well. I do not think that Dick ever tried it again though.

If possible, on lower leg defects, one could shorten the number of stages by using a cross leg flap. Here the legs had to be held together for three weeks while the flap picked up its new blood supply. The operation was usually a nightmare for the assistant who had to hold the legs together unmoving, the whole time while the flap was attached. This generally took at the very least an hour and the poor assistant was exhausted at the end. The operation was dreaded by one and all. Preformed plasters and bars to lock the legs together helped considerably but pressure sores under the plaster were a hazard. Though it had its place I do not think anyone mourned the passing of this procedure. I can safely say that free flap transfer has revolutionised the surgery of repair and reconstruction.

Augmentation mammaplasty was unsatisfactory, as no really inert material had been developed though many and various were the substances tried. Silicone was just coming in and injecting liquid silicone in behind the breast was attempted by a few people. This was a disaster as the silicone inevitably migrated downwards in time under the influence of gravity. I well remember seeing a woman who had had this procedure presenting with a sinus in the groin from which silicone was oozing. Reputable surgeons would have little to do with it.

Reduction mammaplasty; the commonest method was the Biesenberger procedure. This consisted in excising skin and breast with an S-shaped excision and then winding it up in a coil before suturing. Almost always one or both nipples were blue at the end and one had one's heart in the mouth for a day or two waiting to see if they would survive. It was dangerous as it comprised the circulation too much. Nipples and entire breasts were lost. The Stromberg method was an enormous advance and led to far fewer complications.

Microsurgery had not started and fine structures were perforce repaired by the naked eye. The finest suture material was 6/0 nylon. Digital vessels could not be repaired so replantation of digits was not possible. I recall one of the senior surgeons saying, when he heard, I was going to repair a digital nerve in a finger, "Oh, you won't find one of those son".

Cleft lip and palate were still a contentious problem. Various types of lip repair were in vogue and Millard's method was just being accepted. Primary alveolar bone grafting was just starting and the place of bone grafting had not been established. The results of palate repair as regards to speech were very variable, as were the methods of assessment. Bill Manchester in Auckland made great contributions to bilateral repair and his results were superb. He had a great sense of humour and at one College meeting he presented a case of palate repair in a horse. A wit in the audience asked what the speech result was like. Bill replied quick as a flash, "Excellent, I heard it straight from the horse's mouth".

One of the problems we faced in those days was damage from Radiotherapy. The dose could not be accurately controlled and burns were not uncommon. Furthermore, a number of benign lesions were treated with radiotherapy, such as plantar warts, port wine stains, skin papillomata, and dermatoses. We would not think of doing that these days. The resulting ulcers failed to heal, were often very painful, and if bone was involved the pain was intense and intractable. The damage to blood vessels extended out beyond the ulcer itself and wide excision was needed to reach healthy tissue. Flap repair was virtually obligatory and generally from a distance as it was difficult to be sure that local tissue was unaffected. They were real problems. Free flaps would have been a boon.

Split skin was cut with an open blade or Humby type knife with a roller to help in controlling the thickness of the graft. It was a bit of a shock to find that at Mount Vernon we were not allowed to use a Humby but were compelled to use open blades to develop our skill. We furthermore had to sharpen them ourselves. It stood us in good stead in the future though. The Padgett dermatome was occasionally employed if a very even graft was needed but was not easy to use if the cement did not adhere. It often caused great frustration and was probably the most commonly plastic surgical tool. To become airborn. Electric dermatomes did not exist.

The work in the public hospital was largely trauma especially from road accidents, and the introduction of seat belts dramatically changed the type of injuries we saw. Gross facial and eye damage and middle third fractures were every day affairs and they almost disappeared when seat belts came in. Further great improvement followed the anti-drink driving laws. There was much cancer surgery and for some years a good deal of paediatric work at the Alfred until at length it all went to the Royal Children's Hospital.

Public hospitals were not considered to be the right place for cosmetic surgery so none was done.

Down the years since those early days, I have seen all the modern developments that are now in vogue. Perhaps the most important have been the development of microsurgery and Ian Taylor's remarkable work on angiosomes and all that has resulted. The surgery of repair has been revolutionised.

I have kept sane (relatively), by playing golf and at one time played off a handicap of one. Later on, I took up Royal Tennis, perhaps the most fascinating ball game of all. For a while I owned an aeroplane and travelled extensively in Australia. One highlight was a round Australia trip as co-pilot with Ted Gibson in his aircraft. Trekking in the Himalaya was something that I loved, and I was lucky enough to make several trips to various areas. I have always had an interest in astronomy and have made a few telescopes including grinding the lenses which proved challenging to say the least.

I had a spell of three months during the war in Vietnam in 1966 with an Alfred Hospital Surgical Team in Bien Hoa, and later a short tour to Dacca (now Dhaka), in Bangladesh trying to train a Bengali plastic surgeon, but sadly local politics finally scuppered this scheme. Interplast sent me to Suva a few years ago which I felt was rewarding.

November 1999

Dr Snell passed away in 2023.