"No good surgeon uses his fingers when he could have used scissors, and no good surgeon uses scissors when he could have used a knife." These oft-spoken words of wisdom will be familiar to many students and associates of Dr. Robert Meredith Janes, who quoted Baird Hastings: "What I, at least, treasure most when I think of the past, is not my research or my published papers; it is my students, my medical students, my graduate students and my post-doctoral students." Dr. Janes was a man who held nothing more precious than his students at all levels. It is said that his real goal in life was to be a great teacher. In pursuing this goal, he displayed a unique genius, and has been properly described as one of the finest teachers the University of Toronto Medical School has produced.

In 1947, Dr. Janes succeeded his old teacher and friend, Dr. W. E. Gallie, as Professor of Surgery, University of Toronto, and as Surgeon-in-Chief of the Toronto General Hospital, posts which he fulfilled superbly until 1957. There were manifold problems in the postwar period: many young veterans were returning from the medical services of the Armed Forces seeking training in surgery, the research facilities and financial support of the department were in desperate need of expansion, and the Toronto General Hospital was embarking on a major building program. He seized the opportunity of developing still further the first-class training program which W. E. Gallie had instituted and which had already given Toronto an excellent reputation for surgical training. Support for research was found and facilities were provided. Generations of graduates will remember his logical, common-sense teaching and his stress upon the fundamentals of anatomy, physiology and pathology. Dr. Janes felt that the science of surgery was easier to teach than the art and that, to a large extent, the art must wait upon experience. Great advances in the sciences and their application to surgery have been made in the last few decades, but the art of surgery still plays an important role. For the maximum of success, Dr. Janes felt that there must be a happy marriage of both the sciences and the art. He believed that much could be learned from the experience of others and he acknowledged his own great debt to long association with wise teachers. In the discharging of this debt he gave his time, energy and knowledge to young men in a most unselfish fashion and with great delight. The high esteem in which he was held by his undergraduate students was demonstrated at the annual banquet of the Medical Alumni Association in June 1957, when he was guest of honour and was presented with a silver tray inscribed, in Latin, "to a great teacher and a master surgeon".

Few surgeons excelled in as many related fields as did Robert Janes. He was not only a superb technical surgeon, but also a wise clinician, the ideal consultant. While he guided the Department of Surgery at the University of Toronto with skill, wisdom and firmness, he was interested in surgery on an international scale. During this period he also served the Royal College of Physicians and Surgeons of Canada as a member of Council from 1949 to 1950, as Vice President (Surgery) from 1951 to 1953, and President from 1955 to 1957. His good judgment did much to guide and shape the policy of the College, and in particular his courageous and optimistic outlook as President was a decisive factor in the decision to construct the new College building.

He was one of the most active supporters of the exchange Professorships between the University of Toronto and the Middlesex Hospital Medical School, London, England. As the visiting Professor of Surgery at the Middlesex Hospital in the spring of 1957 he endeared himself to the staff and students at the Middlesex by entering completely into every aspect of the life of both the Hospital and the School. On that same visit he gave the Mynihen Lecture of the Royal College of Surgeons of England and represented the Canadian Royal College of Physicians and Surgeons at the opening of the Nuffield Foundation Building which adjoins the Royal College of Surgeons, London.

He was a founder member of the American Board of Thoracic Surgery in 1948. In 1953 he was elected President of the American Association for Thoracic Surgery, a signal honour for a Canadian in an Association predominantly American. During his years as Professor of Surgery, he received many honours and was appointed to many offices of high responsibility in several countries. He was made an Honorary Member of the British Association for Thoracic Surgery and an Honorary Fellow of the Royal College of Surgeons of England, the Royal Society of Medicine, the Los Angeles Surgical Society, the Chicago Surgical Society, and the British Columbia Surgical Society. Added to these distinctions was a rather more personal one which was held with equal pride—an Honorary Member of the Lambton County Medical Society (his old home county). Before he was appointed Professor of Surgery he had been made a Regent of the American College of Surgeons; he continued to fill this office until 1955.

At home he played a leading role in the extensive building program of the Toronto General Hospital and he found time to contribute no less than 24 articles to the medical literature. Although a leader in thoracic surgery, he remained an outstanding general surgeon, and his publications covered a wide variety of subjects. While 12 of these dealt with chest and pulmonary surgery, the remainder were on such subjects as the training of surgeons, thrombosis and antithrombotics, carcinoma of the breast, gallbladder surgery, postoperative complications and mastitis. His publications on surgery of the parotid gland made him a worldwide authority on this subject.

When one reads the medical publications of Dr. Janes a few features immediately become apparent. If, as Anatole France once said, "supreme talent" consists of "writing very simply about very complicated matters", then Dr. Janes demonstrated "supreme talent". He had an amazing knowledge of world literature and freely gave credit where credit was due. None of his articles represented a compilation of material by his resident staff which carried his name as a stamp of approval; his publications were precise and obviously the result of his own time, effort and vast knowledge.

While he served on the Editorial Boards of several journals, his greatest literary responsibilities came in 1956 when he was chosen first Chairman of the Editorial Board of the new Canadian Journal of Surgery. The success which the Journal has achieved to him great pleasure, and this success has been due in part to the wise guidance which he continued to offer until he retired from the office of Chairman in 1965.

Like so many of our great doctors of his generation, Robert Meredith Janes was born on a farm. The Janes farm, where he was born on September 6, 1894, is near Watford in Lambton County in western Ontario, near Sarnia. He never lost his love for the land. His primary schooling was obtained at Warwick S.S. No. 1, and at the age of 12 he registered in Watford High School for his secondary education, graduating in June 1911.

The Janes family is believed to be of Welsh origin. His grandfather Samuel Meredith Janes was born in Glestonbury, Monmouth, England. Dr. Janes’s father, William, came to Canada with his parents (Samuel and Anna) and settled in western Ontario. He was a good student at Watford and enjoyed his farm life. It is reputed that there was a Robert Janes, a surgeon in Glestonbury in 1844. Dr. Janes’s father had two brothers, Samuel and Tom, who were both doctors. His mother’s youngest brother, Jim McGillicuddy, was a doctor in Lansing, Michigan, and he had two sons who were both doctors. Dr. Janes admired and patterned his life after his favourite uncle, Jim McGillicuddy. One of Dr. Janes’s brothers was Dr. Ernest C. Janes, a well-known surgeon in Hamilton.
Ontario. He also had a sister, Evelyn, who graduated as a nurse from St. Joseph's Hospital, London, and a brother, Lorne, who was Director of Dental Services for the Canadian Army overseas in the Second World War. Two other brothers, Kenneth and Eustace, remained on the farm, and the latter was elected to the Provincial Legislature where he remained until his retirement, never being defeated in an election.

Dr. James entered the Faculty of Medicine, University of Toronto, in 1911. He was ready to enter his final year of Medicine when he enlisted as an Infantry Private hoping to get overseas rapidly during World War I. He was disappointed when medical students were forced back to school to finish their courses so that there would be enough medical officers for the Canadian Expeditionary Force. While a student at the University of Toronto he was one of four of his year to be elected to the A.O.A. Honorary Medical Fraternity, and by his final year he was elected A.O.A. President.

Upon graduation in 1916 he enlisted in the Canadian Army Medical Corps, and was shortly afterwards sent abroad where he served in England and France until 1919. Fortunately, his war service was chiefly in the laboratory and this gave him a secure foundation of bacteriology and pathology for his later training in surgery. It was in this capacity that his first contribution to medical literature appeared in a reference to wound infections. When Drs. J. G. Fitzgerald and D. E. Robertson reported that wounded men of the C.E.F. were being returned to Canada from overseas with diphtheroid wound infections their report resulted in a combined inquiry of Canadian pathologists in England who failed to find any considerable evidence of this infection. Dr. James was not satisfied with the way in which this investigation had been carried out, and he instigated another investigation of orthopedic cases at the Granville Canadian Special Hospital at Buxton, England, with Dr. Newton Thomas. They found practically the same percentage of diphtheric wounds as had been reported from Canada. His published results supported the reports of Drs. Robertson and Fitzgerald became the basis of a long-lasting friendship among them.

Following the war he undertook what for men of his time was an unusually extensive postgraduate training in surgery, because he was certain of its importance for the adequate preparation of qualified surgeons. While house surgeon and then resident surgeon in the Hospital for Sick Children, Toronto from 1919 to 1921, he was also an assistant in anatomy at the University of Toronto in 1920 at the princely yearly stipend of $500.00. He went back to England in 1922, to St. Bartholomew's Hospital, London, and finally returned as resident surgeon at the Toronto General Hospital in 1922-23 to complete his surgical training. In 1923 he was appointed to the surgical staff of the Toronto General Hospital and commenced an association with the University of Toronto that was to continue actively for 34 years.

Lister died in 1912, one year after Dr. James became a medical student, yet even then it was difficult for his generation to appreciate what surgical wards must have been like in the days before Lister. Equally, it is difficult for us to picture the type of patients young James faced as a junior demonstrator for the University and assistant surgeon at Toronto General Hospital. When the third Toronto General Hospital opened in 1913, it was regarded as one of the most modern on the North American continent. Surgical patients were, however, accommodated in three general surgical wards, and no provision was made for the specialties since none existed. Urology was just beginning to branch off because of the newer methods of investigation made possible by the development of new instruments. Many of the problems in the wards had to do with infection—ulcers (both varicose and syphilitic), cellulitis, boils, carbuncles, osteomyelitis, tenosynovitis, septic arthritis, tuberculosis and syphilis. Syphilis was the only infection for which there was specific therapy. Salvarsan (606) was just coming into use, but mercury and iodides were still standard treatment. Erysipelas was common, and in the young and the very old was often fatal. Infected wounds of various kinds were so common as to occupy the time of a dressing nurse, and during the teaching session an extra couple of hours each morning contributed by a final year student. As a house surgeon, Dr. James's weekly Sunday morning chore was to see to all dressings in order to be familiar with the progress of wounds.

While he was a junior surgeon, infections were treated by incision and drainage, and there was the never-ending quest for the ideal antiseptic which would kill the bacteria but not the tissue cells—a quest that was, of course, doomed to failure. The principles of immunity were poorly understood. It was common practice to incise a spreading subcutaneous cellulitis in the hope of limiting its progress, to open boils early and to incise an acute mastitis while it was still a cellulitis. Tuberculosis of the skin, were and joints was extremely common. Wards of the Children's Hospital were full of advanced cases, many with abscesses, and all too many of these were secondarily infected with pyogenic organisms. Many of the latter group of patients developed amyloid disease. Dr. James's chief at that time, Professor Clarence Starr, achieved international recognition by being the first to advocate surgical evacuation of tuberculous abscesses and immediate closure to avoid the dreaded secondary infection.

Thyroidectomy was an uncommon and dangerous operation. Cholecystectomy was just beginning to supplant choledochostomy, and major gastrointestinal surgery was in its infancy. Diagnosis was largely clinical, and x-ray films did not replace glass plates until around 1924 or 1925. Chest plates, although helpful for diagnosis, were not very common. Cholecystography awaited the description of the excretory test by Graham and Cole in 1924.

Thoracic empyema was extremely common but ineffectually treated. James's early days as a house physician coincided with an epidemic of pneumonia, and many of the patients developed empyema. As soon as purulent fluid was discovered in the pleural space, a patient was transferred to the surgical side as an emergency where a rib resection was done and open drainage established under general anesthesia. The mortality was appalling. Chronic bronchitis was a common diagnosis before 1922 when Forrester described the Lipiodol bronchogram. Many of these patients must have had bronchiectasis. Pulmonary embolism was rarely recognized. Wards held many cases of advanced and hopeless cancer.

Anesthesia could scarcely be called a science in those days because the principles upon which modern practice is based were not understood. Many of the patients suffered from prolonged hypoxia which accounted for the postoperative restlessness, probably for personality changes sometimes attributed to an operation, and for the occasional patient reduced to a vegetable existence. The patient who received 500 c.c. of normal saline subcutaneously or of tap-water by rectum was thought to be adequately hydrated. The use of citrated blood was first described in 1914, but the indications for its use and the amount of blood needed were not generally appreciated until the Second World War.

Thus, Dr. James began his surgical career in an era when the advancement of knowledge in physiology and surgical technique progressed at a rate difficult to imagine. To have taken part in that progress by expanding his own knowledge in many areas was an early demonstration of his outstanding ability. During the decade ending in 1930 he contributed articles to the medical literature on the subjects of blood transfusion, surgical treatment after industrial accident cases, healing of fractures, hemolytic jaundice associated with splenomegaly, tuberculous empyema and intestinal obstruction.

But his greatest contribution to the young and struggling specialty of thoracic surgery that he made was his excellence at the task. Upon joining the staff of the Toronto General Hospital in 1923, he became associated with that other great general surgeon, Norman Shenton, and the association continued for over 20 years until Dr. Shenton's retirement from the Hospital in 1946. Dr. James's name was linked with Dr. Shenton's in all their early work in the field of thoracic surgery. They were leaders in this field in Canada, and were in fact recognized as such in the whole of North America and England. At that time surgeons throughout the
world were attempting to evolve an improved technique for lung resection to alleviate the suffering of patients afflicted by bronchiectasis, chronic lung abscess and tumour. The methods then practised were crude and associated with prolonged morbidity and a mortality rate of about 50%.4

Samuel Robinson in his presidential address before the American Association for Thoracic Surgery in 1923 painted a picture which might well have discouraged all but the most venturesome. His description of the typical operation is a classic:

The patient is placed on the operating table, the posture is uncomfortable. There may be cyanosis. It induces coughing. The anaesthetist is greeted by an evacuation of a large amount of purulent, purulent sputum incident to the posture on the table. The whole bronchial tree may be filled with this material as the anaesthetist begins. If regional blocking and paravertebral procainization is carried out, the pleura is no sooner opened and traction on the diaphragm commenced, than the need of general anaesthesia is obvious. As the sections well toward the trachea, the cyanosis increases. The lower lobe obstinately resists being delivered. The pleural adhesions are strong and wide-spread. The attachments to the diaphragm are rope-like and tenacious. Finger dissection is inadequate, work with the knife and scissors is blind. Cleavages are sought in vain, the pericardium is dangerously involved in adhesions. Meanwhile the patient's condition may become distressing and perhaps alarming. If open pneumothorax is adding insult to injury, the lung cannot be used to plug the thoracic gap because the lobe is not deliverable. If differential pressure is being employed, that too may be acting badly. The mucopurulent secretions may interfere with proper intratracheal aspiration. It interferes with the respiration under positive pressure. There may be cyanosis even with the head outside a negative pressure cabinet and then the difficulties multiply. The complete liberation at one sitting may have to be abandoned. There is bleeding and leakage from the lung and bleeding from the diaphragm. Tight closure without drainage seems inadvisable under such conditions and yet necessary to avoid the ills of post-operative pneumothorax. Suddenly it is obviously time to return the patient to his bed. Not much has been accomplished.5

The progress through the remainder of the 1920's was slow and the mortality continued to remain high—for removal of a single lobe in unselected cases, 47%; for more than one lobe, 70%. In 1929, Harold Brunn published an article on “Surgical Principles Underlying One Stage Lobectomy” which represents another landmark in surgical treatment of bronchiectasis. He had operated upon six cases with one death. In 1929, Drs. Shenstone and Janes invented the lung tourniquet which, for the first time, made resection of a lobe or even a whole lung relatively simple and safe.5 A preliminary report of their experiences with the use of the specially designed lung tourniquet to control the stump while the lobe was being further amputated and the stump oversewn was published in 1932. The following year, a further report was published by Dr. Janes in the British Journal of Surgery. Perhaps only those who have a special interest in thoracic surgery can appreciate what a tremendous contribution Shenstone and Janes made and the effect which it had upon pulmonary surgery. It dispelled certain fallacies that had existed in regard to surgery of the chest, and for the first time made it possible for surgeons in many countries to perform lobectomies with what was regarded at that time as an acceptable mortality and to familiarize themselves with the anatomical and physiological problems involved. An important by-product of this advance in technique was that, for the first time, fresh tissue became available for the study of the pathology and bacteriology of lung disease.5

Dr. Janes was promoted to the rank of Senior Surgeon at the Toronto General Hospital in 1930, and was appointed Assistant Professor of Surgery at the University of Toronto in 1946. During this time he made many important contributions to the fields of general and thoracic surgery and published 20 additional papers on a wide variety of subjects—pancreatic disease, salivary gland surgery, breast cancer, rectal cancer and 13 papers related to thoracic surgery. He described one of the early series of diverticula of the lower esophagus treated by excision, and wrote a classic paper on chest wall tumours. As the first consultant in thoracic surgery to the Toronto Hospital for Tuberculosis from 1925 to 1947, he shared in the development of the various techniques of thoracoplasty and was a pioneer in advocating and practising lobectomy for certain tuberculous lesions before antituberculous drugs were available. As Consultant to the Radiotherapy Clinic at the Toronto General Hospital he became equally well known for the contributions which he made, in association with Dr. Gordon Richards, in the management of advanced breast cancer by a combination of radiotherapy and surgical extirpation.

He was elected to Resident Fellowship in the Academy of Medicine of Toronto in 1922, and over the years he gave it steady support and served it in several capacities, as a member of Council, Chairman of the section of surgery, and Chairman of the program committee.

In 1955, while he was still Professor of Surgery, a group of 20 surgeons with a common bond, together with their wives, gathered in Ottawa to hold an inaugural scientific meeting. From this nucleus grew a society of 114 members, the requirements for membership being graduation in Medicine between 1943 and 1953 and at least three years of postgraduate training in surgery under the direction of Professor Robert Meredith Janes. It was only fitting that this group elected to be known as the Janes Surgical Society and it was honoured by Dr. and Mrs. Janes's acceptance of the invitation to be their patrons. From that time on, the annual meetings of the Society were graced by the presence of Dr. Janes and his charming wife—a presence which the Society anticipated, cherished, and desired with increasing pride. Through their enthusiasm and quiet encouragement, the regular scientific and social meetings became an annual highlight. Dr. Janes's world renown and his many friends on both sides of the border and on both sides of the Atlantic gave the members the opportunity to meet many leaders in the surgical world. The tenth anniversary of the Society celebrated his 70th birthday in 1964 by meetings in Glasgow, Edinburgh, and London, culminating in a dinner at the Royal College of Surgeons, London, England (Figs. 1 and 2). The meetings
were highlighted by the gracious hospitality of his many personal friends.  

A man is indeed honoured when his former pupils think so highly of him that they form a group to bear his name. The members of the Janes Surgical Society felt it a great privilege to have had such an opportunity and to have served their apprenticeship under his guidance. While this was a particular and personal honour which gave Dr. Janes much satisfaction, each of the members benefited in some way by their association with him, first as students, later as colleagues.

Incorporated in the official emblem of the Society is the Janes lung tourniquet. At their annual meeting in May 1967, Mrs. Janes presented to the Society a beautiful hand-carved gavel designed and executed by a friend and master craftsman. She said that Dr. Janes had taken considerable pleasure and interest in the creation of this gift. The design was that of the lung tourniquet devised by Drs. Shenstone and Janes in the early days of pulmonary surgery, and the gavel was made from the wood of one of the old oaken benches of the old Toronto General Hospital (Fig. 3).

In June 1957, Dr. Janes formally ended his term as Professor of Surgery and was succeeded by Dr. F. G. Kergin, who was appointed Professor Emeritus of Surgery. On the occasion of his retirement as Professor, Dr. Sidney Smith, President of the University of Toronto, wrote, "I am directed by the Board of Governors to say that this action is taken in recognition of the splendid service that you have given to the Faculty of Medicine for the past 37 years. You have built much into the fabric of our medical school and of the University as a whole. Medicine has been enriched by your research, your colleagues have benefited from your wisdom, and generations of your students will testify to the lasting value of your teaching."

After his retirement from the Chair of Professor of Surgery, Dr. Janes did anything but withdraw from contact with medicine. He took his retirement as an opportunity to widen his interests and accept new responsibilities. He continued his writing and published eight more articles over the next seven years touching on the training of surgeons, carcinoma of the breast, postoperative complications, malignant duodenocolic fistula, and memories of 45 years in surgery. Up until his final illness he was engaged in writing a history of the Toronto General Hospital for which he had painstakingly accumulated a large amount of material.

Many honours and awards continued to be showered on him. The luxury of an unhampered private practice was short lived. The first four months of 1958 were spent as the Sims Commonwealth Travelling Professor, a fellowship established by Sir Arthur Sims of New Zealand to enable outstanding professors of medicine and surgery to visit other Commonwealth countries and to exchange views of medicine, an appointment made by the Royal College of Surgeons of England. With Mrs. Janes he visited the Medical Schools of the West Indies and of the Commonwealth countries of Africa. By their warm interest in the local problems of these developing countries they won many friends for Canada. This experience culminated in a dinner at the Royal College of Surgeons of England where he gave his report of the trip.

Upon his return to Canada, he continued his teaching interests by accepting the appointment of Chief Consultant in Surgery at the Humber Memorial Hospital in January 1959. Here he conducted weekly surgical rounds and was available for direct consultation about difficult cases. This arrangement constituted a pilot plan to see if it could be adapted to other peripheral hospitals in Toronto in an attempt to improve continuing education in hospitals outside the University sphere. He was consulted on many difficult diagnostic problems and was hesitant to operate or take over a case from another consultant even though the family, family doctor, or consultant himself might have wanted him to do so. Often when a case was mishandled he would be so subtle in his remarks that the reprimand they implied would only be recognized several days later. In spite of the fact that he no longer was chairing medical meetings, he continued his medical reading and knew as much of the recent literature as any of the other surgeons in the hospital. He enjoyed the company of younger men and enjoyed the stimulus of any discussion or argument. On many occasions he was helpful in advising the administration in the hospital, and the Administrator of the Humber Memorial Hospital remembers him as a man with a "will of iron", malleable but full of principle and immovable on points which he considered important.

He served on the Advisory Medical Committee for planning the North York General Hospital. It was Dr. Janes who told the initial Hospital Board of Directors, and meetings of local citizens anxious to encourage the building of a hospital, that the new institution should be planned to encourage the largest feasible number of doctors to become associated with and participate in the rendering of medical services within it. He maintained that there must be close association between general practitioners and the hospital to enable the former to keep up to date with rapid developments in medical practice as they occurred. With Drs. Farquharson and Low he advised the new Board that the compulsory retirement age of chiefs of departments of Toronto University Hospitals was 62, but at that age the departmental chiefs were just at their best. If the new hospital would make their retirement age 67 it would be possible to persuade chiefs of departments of Toronto University Hospitals, upon retirement, to accept appointments to these offices in the new hospital, and thus utilize their immense experience in the creation of competent medical staffs. This advice was taken.

In 1958, the international relief organization, CARE, established its service, MEDICO, and the Advisory Board of CARE of Canada believed that a Canadian organization for its support would be useful. Dr. Janes was the guiding spirit in building this organization. When he was approached, he reacted to the idea with enthusiasm, and undertook to enlist the support of the Canadian medical profession. He organized a meeting which was attended by a large and distinguished group of doctors. The first MEDICO Advisory Board was formed from representatives of each of the specialty groups and Dr. Janes provided the leadership in raising voluntary contributions to send the first Canadian MEDICO team into the field in October 1964. "You give a man a fish, and you feed him for a day. You teach a man to fish, and he feeds himself for a lifetime." With this philosophy Dr. Janes took a profound personal interest in the work of the team and, in addition, encouraged many Canadian specialists to make month-long voluntary visits, not only to Malaysia, but also to other parts of the world, to contribute their services where they were needed. Because of his leadership and inspiration Canadians have a more intense awareness of their obligation to the sick and suffering of the world. This awareness is an important part of Dr. Janes's legacy to mankind.

During this time he was further honoured by election to Senior Membership of the Ontario Medical Association and Senior Membership of the Canadian Medical Association. He was made an Honorary Member of the Southwestern Ontario Surgical Association, an Honorary Life Member of the Ontario Thoracic Society, an Honorary Fellow of the Academy of Medicine, Toronto, an Honorary Life Member of the University of Toronto Medical Alumni Association, and
was awarded a Certificate of Merit by the Canadian Cancer Society.

In 1964, at the age of 70, he retired from active surgical practice while in full possession of his surgical skill and judgment. His colleagues realized that this was a wise, courageous, and difficult decision, and many were the tributes he received from former pupils, trainees, and colleagues. As one wrote:

You will pardon me if I feel a bit sad to hear of your retirement from operative surgery. However there is given to a teacher of this stature a legacy that needs be denied to all others. Every day for many years to come you will be at work in operating rooms where you have never been, operating upon patients you have never known, through the hands and minds of pupils you have taught. You have brought to your office a dignity with compassion that none of us shall ever forget. You will leave behind a heritage of sound surgical judgment, precise operative technique, and devotion to teaching, in a whole generation of surgeons who have been your pupils.

Somehow, in the midst of his busy and productive life, he found time to cultivate other interests and hobbies. He had a great appreciation of nature and loved to work outdoors. He was happy when close to the soil, gardening, felling trees at his cottage, using rocks as paving stones and making walks around his property. He enjoyed improving his cottage on the shore of the Lake of Bays and, in his last years, the country home which he had developed at Campbellcroft. His hobby was making furniture, both at home and in his workshop at the cottage, and he also made toys for his grandchildren. He was an enthusiastic and expert photographer, and in later years turned his interests to colour photography.2

He was a devoted member of the Timothy Eaton Memorial Church, one of its esteemed Elders, and he loved and supported the opera and ballet. One of his greatest pleasures was the search for more knowledge, cultural or practical. His reading included history—of religion, of countries, of people—and archeology.

On September 10, 1923, Dr. James married Lily Erland Kelly, and they later became the parents of two daughters, Mary (Mrs. Mary Gorrie) and Ann (Mrs. G. W. Bahen). No small part of the popularity and respect which Dr. James enjoyed in his relations with his colleagues in Canada, the United States, and Great Britain, was due to the unfailing support of Mrs. James and her warm personality which turned casual acquaintance into lasting friendship.2 To all his academic activities there was a social side which Mrs. James shared most charmingly, and to friends the world over they were simply Ebo and Lil. They were inseparable. Nevertheless the "practise" was always completely separate from their family life. A principle with Dr. James was "never take your troubles home", and he never did.

To try to project Dr. James to the reader is a formidable task, and of necessity much must be left unsaid. To each man who knew him, this man was something different. To the general public he was Dr. James, a dedicated, kindly doctor, a medical man of stature. To the staff of the Toronto General Hospital he was Professor James, a man noted for his brilliant work in lung surgery, his vast knowledge in all aspects of surgery, his friendly advice available at all times, and his constant interest in the surgical training of his interns. His surgical technique was a delight to watch. It was gentle, the dissection was sharp, the moves were planned so that without the slightest appearance of hurry, the procedure was completed in a remarkably short space of time. Dr. James' accomplishments were formidable, but he was not. He was a gentle man, devoted to the welfare of his patients, absolutely selfless, loyal to his ideals. To each member of the James Surgical Society he was a friend, a revered teacher, a brilliant surgeon, and a fine gentleman.

However, no man is without idiosyncrasies. He had an abhorrence of poor English, particularly in medical writing, and had a fetish for clean shoes and a neat hairstyle. Some of his early army training remained with him throughout his life, and he had a habit of walking in step with his colleagues, residents, and students. He disliked dishonesty and laziness, mental or physical, and while he was a bit critical in his early days (and what young man isn't) this phase passed and kindness and courtesy were shown to everyone from the welfare patient to the millionaire. His reputation was built upon complete integrity, hard work, an open mind, a readiness to tread new roads, and the ability to tread them well. His family remember him as a man with a perfect disposition who was always fair and kind. His elder daughter said, "I know a completely different side of him that most people never did. Warmer, with all formality gone—but never his dignity—this is a side of the man not too many people ever saw. He was the most tolerant human being that I am sure that I will ever be privileged to know."

Dr. Robert Meredith James died in Toronto on November 23, 1966 and, while already afflicted with fatal illness, 22 days before his death he addressed the inaugural banquet of the Toronto East General and Orthopaedic Hospital Research Foundation. At the funeral service at the Timothy Eaton Memorial Church in Toronto it was a moving sight when some 40 members of the James Surgical Society entered the church together to pay their respects to the Chief. On that occasion, Dr. C. Andrew Lawson described him as one of the finest men that he had been privileged to know, standing for all that was high and noble, and a Christian gentleman in the best sense of the word.

Inscribed in the minutes of Council of the Royal College of Physicians and Surgeons of Canada is a Memorial Resolution:

WHEREAS Robert Meredith James exemplified all the highest attributes of the medical profession, and

WHEREAS he was one of the great general surgeons of his generation, a superb teacher, an able academic administrator, a wise medical statesman, a distinguished ambassador for the Canadian medical profession and,

REFERENCES

8. Office of CARE MEDICO: Personal communication.