

A unique surgical experience in a WWII prisoner of war camp

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ON 23 FEBRUARY 1942, our lives changed. Major Roy Stevens, AAMC, and I, with all our patients and hospital staff, sat on the ground in front of our Japanese captors in East Timor, staring at the barrels of three machine guns. We were waiting for the order to fire. I remarked, "This was the date in 1909 of my mother's marriage." Roy replied, "And this is my wife's birthday." We each thought it was an appropriate date to be shot, but those manning the machine guns were suddenly summoned by a Japanese officer. One guard returned and informed us we would not be shot as the Emperor had changed his mind. The order concerning the killing of prisoners of war (POWs) had to be changed as a result of 100 000 Allied troops surrendering to the Japanese in Singapore 8 days previously.

The Japanese officer told us how we were to behave towards the Japanese, and demonstrated how to bow properly. He warned us not to attempt to escape, and then allowed us to return our patients to the hospital. We were to go about our work and shortly we would be united with our captured comrades at Oesapa Besar.

And so began our life of captivity and fear, with the cruelty of our guards.

Oesapa Besar, Timor

It must be understood that I was not appointed a surgeon by the Australian army. When I left my general practice in Scone, New South Wales, to join the Australian Imperial Force (AIF) in April 1941, I had hoped I would further my plans to become a qualified surgeon in the future. I accepted an appointment in the 2/12th Field Ambulance, as I thought this would meet my requirements better than a navy or an air force appointment.

In December 1941, I was sent to Timor as part of "Sparrow Force", a sacrificial force of 1500, to attempt to stop the Japanese from invading Australia! My efforts as a free man ceased.

However, I was now provided with an abundance of repair surgery. This was the result of injuries sustained by our troops following the pattern bombing and the Zero strafing that had been unleashed on our undefended force for weeks before the landing. Shrapnel wounds were the most prevalent injuries; few parts of the anatomy escaped. In addition, the fighting for 5 days had produced many bullet wounds. With no x-ray facilities, I had to rely solely on clinical observations.

Although Stevens (an ear, nose and throat specialist) and two other Resident Medical Officers (Brown and Gilles) supported me, they had no surgical inclinations, so the surgical cases were my responsibility. This greatly consoled me, and it was the only time I was happy as a POW, albeit grossly overworked.

Stevens was a good anaesthetist, and I was fortunate to have two well-trained medical orderlies in Pat Bailey and Bert Adams. Within 2 months, we had established a well-appointed and organised camp on the beach at Oesapa Besar.

The Japanese had allowed a return visit to our hospital at Tjamplong to recover some instruments, dressings and a good quantity of ether. Our soldiers had built a small hut of coconut timber and leaves, which served as an operating room.

We made hospital beds of bamboo poles and hessian. These were placed in several wards, each holding about 20 to 30 beds. We called this our hospital area. Our two padres helped to build a chapel and a small cemetery. The kitchen staff did the best they could with the rice ration and the grass-like vegetables, and cooked with seawater to keep our salt balance.

At first, the soldiers were hostile towards the officers because of their surrender, but within months this had settled and camp morale improved. Even the Japanese guards settled down to slapping faces rather than their earlier tortures. They liked watching operations and came to calling me "The Potong doctor" (*potong* means to cut).



Captain Les Poidevin was educated at Sydney Grammar School and Sydney University. He completed two resident medical officer years at Royal Prince Alfred Hospital in Sydney before entering general practice in country NSW. After 18 months in Scone, he enlisted in the AIF as part of 2/12 Field Ambulance, and joined Sparrow Force (2/40 Battalion), which deployed to Timor in December 1941. In February 1942, the Japanese assault on Timor by 19 000 troops began. Following

the surrender of the Australian troops, Poidevin was selected to provide surgical support, first in Timor and later in Batavia (Java). He had a lively interest in surgery and anatomy, but had no formal surgical training. In Batavia, he was responsible for the establishment of a new surgical hospital outside the POW camp, and performed surgical procedures there, including more than 60 major operations. This surgical service was unique in Japanese POW camps. Just after the Japanese capitulation, Poidevin was summoned by Admiral Patterson to operate on a sailor aboard HMS Cumberland. He was Mentioned in Dispatches, but received little other recognition for his pioneering work. After the war, Poidevin qualified as a gynaecologist and moved to Adelaide, where he practised with distinction for many years.

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I: Crime and punishment at POW Camp No. 4, Batavia, 1943–1944

Sentence	Crime
Death (summary execution by decapitation or shooting)	<ul style="list-style-type: none"> ■ Resisting Japanese Army ■ Conspiracy to incite ■ Escape longer than 7 days ■ Aiding escape ■ Informing about Japanese troop movements
Heavy incarceration, reduced diet for up to 100 days	<ul style="list-style-type: none"> ■ Escape where surrender occurs within 7 days ■ Failure to report planned escapes ■ Disobeying orders of camp commandant or guards of working parties ■ False identities ■ Arson
Light incarceration confinement for up to 21 days, hard labour for more than 14 hours per day, reprimand	<ul style="list-style-type: none"> ■ Laziness or lack of purpose when undertaking orders of camp commandant

2: Nationality of 143 surgical patients at St Vincentius Hospital, Batavia, 1944–1945

Nationality	Number	(%)
Dutch	87	(61%)
British national	41	(29%)
Australian	11	(7%)
British Indian	2	(1%)
American	2	(1%)

Director of Medical Services Singapore. He was interested to hear of my work in Timor.

The Japanese guards were less visible, because of the size of the camp, but the British officers kept us in order. Brown, Gilles and I were given a daily sick parade, but we had few drugs to dispense.

In the second month of our imprisonment at Tandjong Priok, Warrant Officer Billett, AIF, presented at my sick parade with a large tumour on his left arm. It was pulsating, and I recognised it as a brachial artery aneurysm. He had only noticed much enlargement of the tumour since he had been going out on work parties. He remembered a through and through bullet wound on his left arm during the fighting on Timor, 9 months previously.

When I told Maisey about this, he wanted to send Billett to the Japanese hospital in Batavia. I balked at this, reminding him of two previous patients that he had sent to the Japanese hospital. These were a man with acute appendicitis and a man with a head injury sustained when he hit a rock while swimming. Neither was ever seen again, and they were presumed dead.

I told him that I did not want Billett, who was an Australian of 2/40th Battalion, to share that fate. I realised that whatever facilities existed in Batavia, they were not acceptable by Australian standards. Maisey then asked whether I was prepared to operate on Billett. I agreed, and he promised to think it over. He talked to the other British medical officers, who did not agree to my operating, but, after further discussion, I received permission. I explained where I would do it and the steps I proposed for the operation.

On the afternoon of 2 December 1942, I had Brown give Billett an ether anaesthetic, and I proceeded to ligate the aneurysm. I had looked up the anatomy, especially of the profunda brachial artery: this would provide a collateral blood supply to the arm after the main brachial artery was closed off. Some Japanese guards who had accompanied us from Timor watched the operation.

Billett recovered, saw the rest of the war in Thailand on the Burma railway, and returned home to Burnie, Tasmania,

We doubted this false utopia could last. In August 1942, about 200 POWs were taken to larger camps in Batavia, Java. A second draft was taken in September, and the remainder of the camp, including all our sick, was moved to Batavia in late September 1942.

We all embarked on the *Dai Ichi Maru* late on 23 September, and sailed for Surabaya, where we disembarked on 1 October. We had endured seven inhuman, filthy days in the hold, where hygiene was our greatest problem.

From Surabaya, we entrained to Batavia, 200 miles to the west. We then were forced to march to a large British POW camp on the docks of Tandjong Priok. We took turns to carry the sick on stretchers.

Tandjong Priok, Batavia, Java

Tandjong Priok camp was primarily for British POWs, with many senior officers and a complement of about 3000 men. It was a strictly disciplined camp (Box 1) with much saluting. The Senior Medical Officer was Lieutenant Colonel CW “Pete” Maisey, who had been Assistant

3: Spectrum of surgery performed at St Vincentius Hospital, Batavia, 1944–1945

Operation	Number	General anaesthetic	Deaths
Appendicectomy	51	22	4
Herniorrhaphy	19	1	
Genitourinary*	14	2	
Bowel tumours	9	4	1
Sequestrations	8	0	
Peptic ulcer	7	6	1
Cholecystectomy	6	6	
Ear, nose, throat operations	5	1	
Tendon operations	4	0	
Thyroid surgery	4	0	
Bowel obstruction	3	1	1
Fistula in ano	3	0	
Amputations, upper limb	3	0	
Ophthalmic (cataract, tear duct)	2	0	
Subphrenic abscess	1	1	
Vitello intestinal duct abscess	1		
Knee operations	1	1	
Amputations, lower limb	1	0	
Radical mastectomy	1	1	

*Included orchidectomy performed using chloroform.

where he died in 2002. In 1978, when I visited him, he showed me his scar. I don't think he realised the drama I had to go through to get permission to do that operation. I have never done another major vascular operation.

Perhaps the success of Billett's operation reassured the other medical officers, although, as they were English, it was not likely. None of them ever spoke to me about it.

Establishing a surgical service

Maisey now was an ally, so I decided to raise the issue of treating surgical patients. He agreed to talk to the Japanese doctor and ask permission to establish two hospitals in Batavia for treatment of Allied POWs. I suggested one for medical patients, as there were many people with tropical and diarrhoeal diseases, and one for surgical patients. There were still about 10 000 Allied POWs held in Java.

Maisey was successful, and in January 1943 the Japanese offered two old churches: Mater Dolorosa and St Vincentius. Both had extensive potential accommodation areas, which was just what we wanted. By July, the necessary alterations were completed, and we prepared to move into the hospitals in August 1943.

A team for the medical hospital (Mater Dolorosa) was established with a Dutch Doctor Smit to be commanding officer (CO), and a team for the surgical hospital (St Vincentius) with Maisey as CO. The Japanese nominated me as the surgeon, with three British medical officers as support, including Flight Lieutenant John Lillee, RAF, as the senior of the three. There were also two Dutch surgeons. Lillee and I cooperated very well and became great friends. He was from Ireland and played poker dice like a professional.

Maisey ensured that St Vincentius hospital ran very smoothly. He appointed medical orderlies and others to work in a workshop for making equipment. He selected a Dutch chemist, Dr Zaandordijk, to run the dispensary, and this man proved to be a great help to me.

St Vincentius had a large central courtyard and a large ablution block. A daily bath using ablution buckets was a luxury.

From the outset, the two Dutch surgeons and I agreed that we would treat our own nationals (I was responsible for the English-speaking patients: Australian, English, American, British Indian). This eliminated any language or cultural misunderstandings. This worked very well in practice over the next 18 months (Box 2).



Batavia, Java, 24 September 1945. Australian ex-prisoners of war on the verandah of their sleeping quarters at Bicycle Camp, so named because of the large number of bicycles found there when first occupied by the prisoners. Conditions inside the building (an ex-Dutch barracks) were even more cramped. Photo by Lieutenant R Buchanan. Australian War Memorial Negative number 123669.

I was allocated two rooms: an operating theatre with a ceiling electric light, and a smaller room with a tap and large basins. It was primitive by contemporary Australian standards, but we were able to scrub up properly, even in cold water, and keep our dress to a minimum. For all that time we operated without gloves or gowns.

Every patient admitted required surgery, so I had a wide range of conditions to treat (Box 3). I was fortunate in possessing the two volumes of Rodney Maingot's *Abdominal operations*, without which I would have been dangerous! These textbooks were extremely comprehensive and well illustrated, and formed the basis of my understanding. Because we lacked any radiological facility, clinical acumen was the mainstay of diagnosis, although there was an x-ray service of indifferent quality in Batavia.

Lillee liked assisting at surgical operations, and so we did all the procedures together.

Anaesthesia

Providing adequate anaesthesia was a problem. Luckily, the Japanese were very liberal with Novocaine crystals and, although I never found out why, my requests for more were always granted.

In my general practice in Scone, I had often resorted to using spinal anaesthetic when my partner, Walter Pye, was not available. I was relieved when our Dutch chemist was able to produce a 2% solution of Novocaine from these crystals; the usual dose for a spinal anaesthetic was 2 mL.

Spinal anaesthesia was effective for surgery from the lower limbs to the upper abdomen. Operations for ruptured gastric ulcers (a very common complaint in POWs on rice diets) could be done by letting the heavy Novocaine rise in the spinal canal, watching carefully that it did not get too high. Operations below the gall bladder were usually accomplished easily under spinal anaesthetic.

Although spinal anaesthesia suited most patients, there were occasions when general anaesthesia was necessary. One of the first cases that convinced me of this was that of an older



Les Poidevin, 1941

man who was admitted with a gastric haemorrhage. Maisey and I agreed that I would have to operate, but, as I explored the abdomen for the bleeding vessel, he complained of pain. Fortunately, I speedily found the cause of his bleeding and ligated it, and he recovered.

I repeated my request for ether, but the Japanese doctor just smiled. I never did get any ether from the Japanese.

My friend the Dutch chemist offered to manufacture ether. Earlier he had kept his promise to make soap, so I was confident he could do what he offered.

“Get me two ingredients, sulfuric acid and alcohol, and I will distil them until I have ether.”

We had a meeting to discuss how we might supply these ingredients. We knew motor-car batteries contained sulfuric acid, and this could easily be removed with a glass pipette.

This job was allocated to the work party who were assigned to the Ford factory.

It surprised most of us to know the sergeant's mess had been making *sake* wine from rice for some months. Their services were enlisted to supply their illicit product to our chemist, who declared it satisfactory. He began to distil it and 2 weeks later he visited our mess bringing with him a small bottle: “Smell it.” It was definitely ether. We all congratulated him and sent him away to make useable quantities.

A total of 8.4 litres of camp-manufactured ether was used in 42 operations. In a further four operations, the volume of ether was not specified.

Surgical challenges at St Vincentius

Most cases were straightforward and there were few surgical deaths (Box 4). But occasionally some unusual problems came along.

In early 1944, Lillee and I went to the docks to unload about 150 POWs who had been transported in cramped conditions in the hold of a leaking Japanese cargo vessel. They had been constructing an aerodrome for the Japanese at Haroekoe. We found most of them sitting in flexed positions or lying on their sides, all in filthy conditions. Some had been like this for several weeks. Indeed, we had to establish

4: Surgical deaths at St Vincentius Hospital, Batavia, 1943–1945

Condition	Surgery	Anaesthetic	Comments
Appendicitis	Appendicectomy	Ether (225 mL)	Died 5 days after surgery, peritonitis
Appendicitis	Appendicectomy	Ether (210 mL)	Died 24 hours after surgery, peritonitis
Appendix abscess	Extraperitoneal drainage	Local	Died after surgery, retroperitoneal sepsis
Gastric carcinoid	Gastroenterostomy	Ether (380 mL)	Died 10 days after surgery
Perforated appendix, peritonitis	Appendicectomy	Ether (370 mL)	Died 3 days after surgery, sepsis
Perforated duodenal ulcer	Repair/oversew duodenal ulcer	Ether (175 mL)	Died 3 days after surgery
Small bowel obstruction	Reduction of hernia in foramen of Winslow	General	

whether some were dead or alive. We carried those who were alive to waiting trucks and put them in Lillee’s ward for clean-up and assessment.

A few days later, Lillee asked me to look at a few of these men, some of whom had fixed contractures of their hamstrings and others of their tendo-Achilles. He had asked the physiotherapist to see what he could do, without much luck, and wondered whether I could help.

I had never seen anything like this before, so I consulted what books I had, only to discover that the conditions had little mention except for suggestions such as stretching exercises and the like. I found the contractures, especially of the semi-tendinosus and semi-membranosus very tenacious, and the tendo-Achilles contractures were too strong to get any stretching. I gave much thought about what to do.

I knew how to lengthen a piece of wood, but I recalled from Sydney Grammar School that Livy had pointed out that the way to disable your opponent was to cut his hamstrings! Understandably, I was a bit frightened.

I decided to go quietly using a “step” technique under spinal anaesthesia. I made my “step” incisions and allowed the tendon to lengthen, and then put in parachute silk sutures to prevent any further movement.

Post-operative care was important, as the greater the effort, the quicker the recovery.

I found the three hamstrings easy to handle, but although they could be easily lengthened, the knee joint remained reluctant to extend. I realized the internal ligaments must have suffered and would also need stretching, which I found was the answer. Therefore, I applied constant extension. I found that early ambulation helped, as the movements of walking very much assisted the recovery.

One patient, Buchan, had knee and ankle disabilities, but with several operations and much post-operative manipulation and extension measures, was almost back to normal by Christmas 1944.

After the war, he kept in touch with me for a few years and explained how he was playing soccer with some success.

Most of Lillee’s patients had been cured or greatly improved by Christmas 1944.

Closure of the hospitals

Early in 1945, Maisey hinted that there were some rumblings that the two hospitals would be closed shortly and we would all be returned to Bicycle Camp.

It seemed to us that the Japanese were resigned to defeat, and were planning to eliminate all POWs. War historians eventually confirmed this Japanese elimination plan.

By April 1945, the hospitals closed and we were moved to other camps, where we awaited our fate.

On 6 August, the first atomic bomb was dropped on Hiroshima, and this guaranteed our safe release.

Reflections

Life as a prisoner of war was very hard, physically and mentally, but it had to be endured if there were to be a future. I now consider it to have been a great educational experience.

Medically, it was extra difficult, dealing with extremely debilitated bodies.

At no stage did our captors provide us with essential medical requirements. We relied on our own inventiveness to solve our problems, to such an extent that, at the end of it all, I realised that no problem in the future could ever be too difficult.

That thought stood me in good stead for the rest of my working life.

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