FEATURE ARTICLE HISTORY OF PLASTIC AND MILITARY SURGERY

The first English textbook of plastic surgery—William (Jerry) Moore

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Abstract

The nineteenth century bore witness to a remarkable proliferation of reconstructive literature in Europe, based on procedures originally described in India and Italy. Despite the publication of a successful forehead flap in England in 1816, texts exclusively dedicated to the field of plastic surgery were relatively scarce in the English-speaking world. The authors sought to identify the first English textbook entirely devoted to plastic surgery. A comprehensive examination was undertaken, spanning various databases encompassing medical, medical humanities and historical domains (PubMed, MEDLINE, Web of Science, Anthropology, JSTOR, Encyclopedia of Ancient History), as well as an extensive perusal of materials housed in the State Library of Victoria, the University of Melbourne and the HathiTrust Digital Library. The scope of this search was confined to publications predating Harold Gillies' influential 1920 textbook. Within this vast literary landscape, an Australian surgeon named William Moore emerged as a figure of notable significance, authoring the first textbook of plastic surgery in English in 1899. Moore's legacy as a pioneering surgeon ahead of his era is undeniable. Yet, various factors conspired to obscure his rightful place in the annals of surgical history.

Introduction

Australian and New Zealand surgeons are recognised as pioneers in the development of modern plastic surgery.[1–3] New Zealand-born Harold Delf Gillies is often credited with the modern birth of our specialty. His work in World War I (1914–1918) led to the publication of his seminal book *Plastic surgery of the face based on selected cases of war injuries of the face including burns with original illustrations.*[4] Although the book in question was groundbreaking, it was not the first textbook of plastic surgery in the English language. That distinction belongs to a relatively lesser-known Australian surgeon named William (Jerry) Moore. In this article, we rediscover Moore's 1899 textbook, aptly titled *Plastic surgery: with illustrative cases.*[5] We further chronicle the author's biography and outline the circumstances that led to his name being largely forgotten.

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Plastic surgery texts in the nineteenth century

Historical documentation pertaining to what we now call plastic surgery is evident across diverse epochs. Tracing its roots back to antiquity, references can be discerned in Ancient Egypt (the *Edwin Smith Papyrus*), India (the *Sushhruta Samhita*), Imperial Rome (*De Medicina*), Early Byzantium (the *Synagôgai iatrikai)*, and Imperial China (the *Jin Shu* annals).[6] The preservation of many of these surgical techniques can be attributed to Byzantine figures such as Paul of Aegina, notably through the *Pragmateia.*[7] Subsequently, during the Middle Ages, these procedures experienced widespread dissemination, facilitated by the scholarly endeavours of the great translation movement of the Middle East and medical authors like Albucasis.[7] The dissemination of reconstructive knowledge was accelerated in 1794 by a contribution to *The Gentleman's Magazine* by English engraver Barak Longmate who provided a comprehensive account of the Indian rhinoplasty.[8] This informative letter motivated English surgeon Joseph Carpue to perform the procedure which he successfully executed in 1814 and eventually wrote about in 1816.[9]

German and French publications

The subsequent decades of the nineteenth century witnessed a prolific surge in European medical literature addressing various facets of reconstructive surgery, with prominent contributions from German and French surgeons. Nasal reconstruction stood as the predominant subject of the era. In 1818, Carl Ferdinand von Graefe (1787–1840), Professor of Surgery at Berlin University, published a groundbreaking work titled *Rhinoplastik* describing the Italian, Indian and German methods of nasal reconstruction.[10] It marked the earliest use of the term 'plastic surgery' in the medical literature.[11] Another prolific German, Johann Friedrich Dieffenbach (1792–1847), published two books: *Chirurgische erfahrungen* (Surgical experiences) in 1829[12] and *Die operative chirurgie* (Operative surgery) in 1845.[13] The former delves into the Indian and Italian methods of nasal reconstruction; restoration of the lip, velum and urethra; auricular reconstruction; lacrimal duct repair; correction of ectropion and cleft palate closure.[12,14] The latter—a two-volume general surgical textbook—contained sections on nasal reconstruction, otoplasty, cheiloplasty, cleft lip repair, genioplasty, cleft palate repair and blepharoplasty.[14,15] It was immediately followed up by an associated atlas compiled by two of Dieffenbach's students, Hermann Eduard Fritze and Otto Friedrich G Reich.[14,16] In 1838, Eduard Zeis (1807–1868) published *Handbuch der plastischen chirurgie* (Manual of plastic surgery), with an introductory note by Dieffenbach.[11] Zeis credited von Graefe for coining the term 'plastik' and chose 'plastischen chirurgie' as the most encompassing term to describe the newly emerging field. This text is recognised as the first comprehensive textbook dedicated entirely to plastic surgery.[14] The manual provided a detailed review of the existing literature, the history of plastic surgery, the techniques employed and indications for surgery. It described specific operations, including rhinoplasty, blepharoplasty, cheiloplasty, stomatoplasty, genioplasty, otoplasty and cleft palate suturing. Zeis also addressed palmar fascia contraction, a procedure attributed to both Guillaume Dupuytren and Dieffenbach.[14] A similar work to Zeis' manual was published by Friedrich August von Ammon, with the collaboration of Moritz Baumgarten (a physician and ophthalmologist working in Dresden).[17] Of immense importance to Moore's book was the technique of split-thickness skin grafting advocated by Carl Thiersch in 1874.[18]

In France, a parallel interest in plastic surgery was also developing.[14] Pierre Léon Auguste Labat, like Von Graefe, published a book entirely devoted to nasal reconstruction in 1834, again focusing on the Indian and Italian methods.[19] Alfred Armand Louis Marie Velpeau, a surgeon and anatomist, published what Wallace called 'the first systematic textbook of plastic surgery'[20] (although this can be disputed after studying Mazzola and Foss).[14] It was named *Nouveaux elements de médecine opératoire accompagnés d'un atlas* (New elements of operative surgery accompanied by an atlas)[21] and was a four-volume text related to all surgical procedures of which 100 pages discussed autoplasty, nasal reconstruction, blepharoplasty, cleft lip and cleft palate.[14] The term 'autoplasty' was introduced to the surgical lexicon in 1836 by Philippe Frédéric Blandin in his seven-part text *Autoplastie ou restauration des parties du corps qui ont été détruites à la faveur d'un emprunt fait à d'autres parties plus ou moins éloignées* (Autoplasty or reconstruction of parts of the body which have been destroyed by borrowing from other parts more or less distant).[22] It focuses on the indications for reconstructive surgery with descriptions of local flaps, rhinoplasty, blepharoplasty, otoplasty, cheiloplasty, genioplasty, cleft palate, postoperative management and complications.[14] Michel Serre published *Traité sur*

l'art de restaurer les difformités de la face, selon la méthode par déplacement, ou méthode Française (Treatise on the art of restoring facial deformities by the sliding method, or French method) in 1842[14,23] in which he summarised the techniques of rhinoplasty, including those from von Graefe and Dieffenbach, and then proceeded to describe the French method using an advancement flap.[14] 'Chirurgie plastique' was first introduced to the French literature by Antoine-Joseph Jobert de Lamballe in his two-volume *Traité de chirurgie plastique* (Treatise on plastic surgery) in 1849.[24] This was followed by an ambitious project *Quarante années de pratique chirurgicale* (Forty years of surgical practice)[14] by Philibert Joseph Roux who managed to only complete two volumes before his death in 1854. The first volume was devoted to plastic surgery and includes autoplasty, blepharoplasty, genioplasty, cheiloplasty, nasal reconstruction, cleft lip, cleft palate and repair of the female perineum.[14] Over 20 years later, reconstructive surgery reappears again as the first volume of Aristide Auguste Stanislas Verneui's *Mémoires de chirurgie.*[25]

English publications

In the English-speaking world, Thomas Spencer-Wells holds the distinction of being the first individual to attempt to amalgamate the techniques and methodologies elucidated in Europe.[26,27] His efforts date back to 1854 when he authored 'Practical essays on plastic surgery'. Published in the *Medical Times and Gazette* this was perhaps the first time the term plastic surgery was used in the English language (**Figure 1**).[27] Within the essay's pages, he earnestly sought both knowledge and the translation of pivotal works by the aforementioned figures in Europe. He also includes techniques of wound closure, suture selection, composite grafting and local flap reconstruction. Regrettably, the eruption of the Crimean War in 1853 redirected Spencer-Wells from his plastic surgery pursuits in London to the hospitals of the Dardanelles and it appears that he did not revisit the subject.[26] The resurgence of interest in this subject occurred in 1878, thanks to Francis Mason (1817–1886), who published a work titled *On the surgery of the face.*[28] The book was a dedicated exploration of facial surgery in relation to tumours, trauma, congenital malformations, nasal reconstruction, cheiloplasty and scar contractures.[14]

Of great importance to Moore's work was the publication of John Reissberg Wolfe's dependable technique for full-thickness skin grafting[29] (although some argue that George Lawson described it first in 1871).[14] It's worth noting that Wolfe practised in Melbourne between 1893 and 1901 at the same Collins Street address as Moore.[30,31] Their collaboration is evident in an 1898 letter addressed to Wolfe from Moore (**Figure 2**). Around the same time as Moore's 1899 book, Charles Stonham published *A manual of surgery* in the United States, which covered some aspects of reconstructive surgery (cleft lip, cleft palate and wounds).[32] Moore's publication however holds the distinction of being the first English-language textbook devoted entirely to the field of plastic surgery.

T. SPENCER WELLS, ESQ., ON PLASTIC SURGERY. 9

seat in the crystalline lens and vitreous humour; secondly, those confined to the essential organ of vision, the retina.

I imagine that no opacity of the lens, however slight, can escape detection by the use of this instrument. Certain it is that opacities which even materially interfered with vision, but which escaped the scrutiny of the most experienced eye, have been readily detected by a resort to the ophthalmoscope. Some very eminent oculists have reported cases of this kind. I have seen, at the clinic of M. Desmarres, beautiful opaque streaks in two lenses, which had eluded all other means of examination. When seen by the aid of this instrument, opacities of the crystalline appear as greyish-brown patches or streaks, of various sizes and shapes, upon a reddish back-ground, afforded by the illuminated retina. The importance, as to treatment and prognosis, of distinguishing the very commencement of cataract from impairment of vision produced by other more serious lesions of the vitreous or of the retina itself, is too obvious to need illustration. Who that has had even a limited experience in diseases of the eye has not seen patients with incipient cataract, tortured for months or years with leeches, cupping, blistering, and a thousand pernicious drugs, under the supposition of a commencing amaurosis? And who has not been consulted by patients sent to be operated upon for cataract, in whom the lens was perfectly transparent?

The most common alteration of the vitreous humour is the appearance in its substance of deep brown or greyish corpuscles, in greater or less abundance. These bodies are of very various sizes and shapes. Sometimes we see only two or three large, irregular flakes, either floating separately in the liquid vitreous humour, or united to each other by a number of small filaments. At other times an immense number of smaller corpuscles, some angular, others in the form of shreds, and others, again, resembling pieces of membrane with ragged edges. When agitated by the sudden movements of the globe, these floating bodies are seen bounding and darting about in the interior of the eye, and gradually subsiding towards the inferior part when the organ is at rest.

Whether these substances are inflammatory exudations from the ciliary body, retina, or choroid, that have become detached; whether they are the remains of blood effused into the cavity of the eye; or, as is more probable, attributable sometimes to one and sometimes to the other of these sources, is not yet settled. Future observations can alone decide that question. Since, in all cases where these corpuscles exist, the vitreous humour is disorganised and liquid, I have thought that some of them might be opaque and thickened portions or shreds of hyaloid membrane.

Doubtless many cases of muscæ volitantes are produced by these little bodies floating before the retina. As, however, they are not unfrequently seen in patients who are not at all troubled with muscæ, and are absent in others where this phenomenon is complained of, they cannot be considered as its sole cause. If small, and occupying the anterior segment of the vitreous body, they may throw no shade upon the retina, and hence not interfere in the slightest degree with vision. But when of large size, and situated in the posterior segment, near the retina, they must necessarily derange the sight by mechanically intercepting the rays of light.

[To be continued.]

PRACTICAL ESSAYS ON PLASTIC SURGERY.(a)

By T. SPENCER WELLS, F.R.C.S.

Surgeon to the Samaritan Hospital.

PLASTIC SURGERY IN GENERAL.

It is not a little singular that no work on Plastic Surgery has yet appeared in the English language. There is too much reason to fear that this want in our literature is connected, either as cause or effect, with a certain inadequate appreciation in this country of what Plastic Surgery can effect, and some ignorance of what it has effected in Germany, France, and Italy. Some years ago I made known to the Profession, by means of two long analyses of the Operative Surgery of Dieffenbach, published in the *British and Foreign Medical Review*, many of the more important improvements the great German Surgeon had introduced, hoping that a complete translation of his work would be brought before the British Profession by some industrious translator. But no such work has appeared, and the results of Dieffenbach's experience are still reserved for the German scholar only. The same must be said for the valuable contributions of Von Ammon and Baumgarten, Zeis, Langenbeck, and Blasius, to Plastic Surgery. Even the works of our French neighbours, Jobert and Blandin, are not generally known among English Surgeons, certainly not by translation.

I trust, therefore, that a series of essays, intended to embrace the whole domain of Plastic Surgery, and thus to make known what our continental neighbours have done and are doing in this department of our art, will not be without interest to English readers, especially to that large class of General Practitioners who are not in the habit of performing severe and dangerous operations, but who would be enabled to obtain reputation and profit by the performance of slighter operations for the restoration of some lost part, or the removal of some deformity.

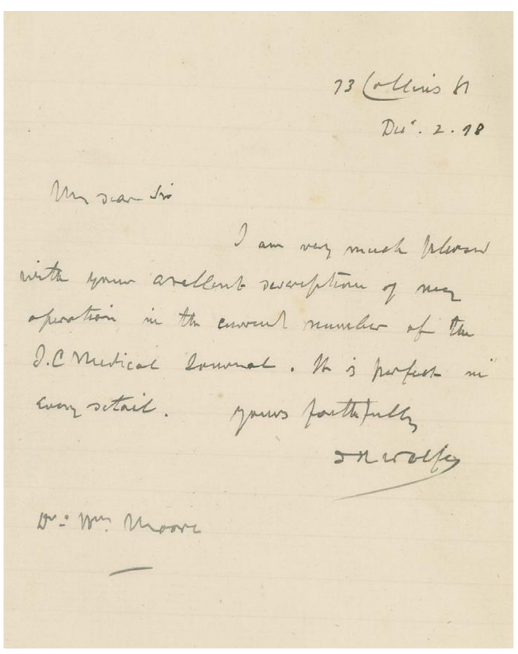
The term Plastic Surgery may be said to imply that department of operative surgery which has for its end the reparation or restoration of some lost, defective, mutilated, or deformed part of the human body. It is here that the Surgeon wins some of his greatest triumphs, not only in the achievement of restoring a lost nose, but in lesser matters. The cure of a hare-lip; the removal of an ugly cicatrix; the straightening of a crooked finger, an oblique nose, or a squinting eye; the replacement of an inverted or everted eyelid or lip; the closure of a fistulous opening or a palatine fissure; the completion of a defective urethra; the union of a ruptured perinæum; the permanent replacement of a prolapsed rectum, bladder, uterus, or vagina; the closure of unnatural communications between any of these organs; the cure of an artificial anus, and other operations of this class, relieve the patient from great bodily suffering and mental distress, and restore him to a state of comfort and bodily integrity. While no operations tend more to add to the reputation of the operator, none are attended with so little danger to life, and are therefore so likely to endanger his credit. The operator does not require that species of courage and coolness, or even the minute anatomical knowledge, which are absolutely necessary for the man who undertakes to tie the larger arteries, to excise the joints, or to dissect out tumours from the interior of the body, or from parts abounding in important vessels and nerves. He seldom or never has the fear that his patient's life may be endangered by the immediate consequences of his proceedings. He is never embarassed by profuse hæmorrhage; but he requires qualifications of another order,—extreme patience, unconquerable perseverance, confidence under temporary failure, a certain amount of artistic skill in fashioning the form and size of the organic material he employs, a thorough knowledge of the various methods which others have employed, and their results in any given class of cases, delicacy and precision in manipulation, and the necessary physiological and pathological knowledge, without which even careful attention to every detail of preparatory or after treatment may lead to misdirected measures. There are many Surgeons who remain cool and undaunted before large wounds and excessive hæmorrhage, who are quite incapable of performing plastic operations well. They have not the faculty of maintaining constant and fatiguing attention upon very tedious proceedings, or the patience to form a precise plan of operating, to prepare the patient for it, to carry it out exactly, and to give that minute attention to the dressing of the wounds and the after care of the patient which are absolutely necessary for the Surgeon who hopes to obtain all the perfection to which Plastic Surgery may be brought. Of course there are some bright examples of great Surgeons who combine all the different qualifications for making them masters of their art in all its branches; but there are many among the important class of General Practitioners, who, without the constitutional hardihood required to form a great operator, do still possess the natural capacities which, with the requisite study, could enable them to take a high rank among Plastic Surgeons. It is more particularly to them that these short practical essays will be addressed.

It will be convenient, before proceeding to describe the plastic operations performed in different regions of the body, to allude to some general principles which must guide us in all such operations.

The *preparation of the patient* must be carefully undertaken. The general condition must be considered, and very great care taken to warn the patient against mental agitation, and to make him comprehend how necessary extreme quiet and patience are to ensure success. A well-regulated diet, an airy, cheerful apartment, and sufficient exercise, must be enjoined if the general health be not sound, and these hygienic means are far more likely to lead to a favourable condition of the blood for plastic

(a) Mr. Wells will gladly receive accounts of any plastic operation performed by British Surgeons, in order that the results may be made known in these Essays. Letters to be addressed to 30, Brook Street, Grosvenor Square, London.

Fig 1. 'Practical essays on plastic surgery' in the Medical Times and Gazette.[27] *Source: HathiTrust Library. CCBY 4.0*


73 Collins St

Dec. 2. 98

My dear Sir

I am very much pleased with your excellent description of my operation in the current number of the I.C Medical Journal. It is perfect in every detail.

Yours faithfully

J R Wolfe

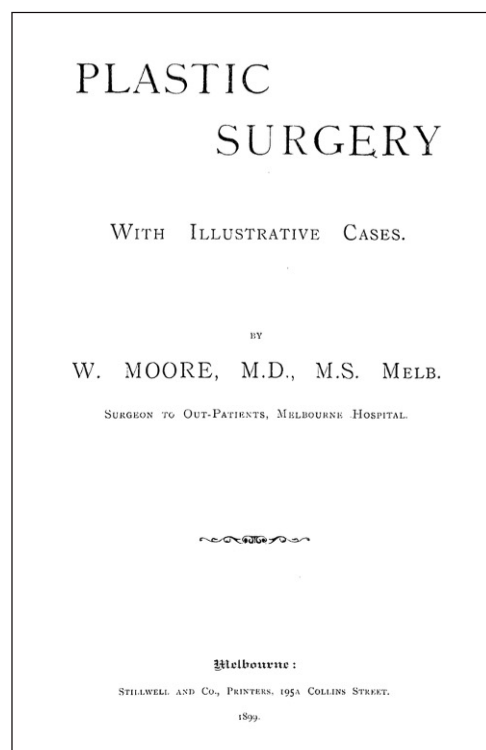
Dr. Wm. Moore

Fig 2. Letter from Dr Moore to Dr Wolfe of Wolfe graft fame, December 1898. Source: University of Melbourne, Medical History Museum. CCBY 4.0

Plastic surgery: with illustrative cases[5]

Moore's book was originally serialised as individual chapters and cases within the pages of the *Intercolonial Journal of Australasia* (1896–1899), a publication reflecting the era before the federation of Australia. It was published as a textbook in 1899 (**Figure 3**). A cursory examination of the text reveals a comprehensive approach to reconstructive surgery, encompassing both general principles and specific procedures. Moore dedicates significant effort to explaining the precise positioning of incisions and the intricacies of suture techniques within the contemporary era of aseptic practices. Three chapters are entirely devoted to the methods of skin grafting described by Wolfe and Thiersch.

The text explores various local flap techniques, including the four-flap method for closing large mastectomy wounds (**Figure 4**). The discussion also encompasses the application of V-Y flaps in addressing conditions like ectropion, lip tumours and eyebrow deformities (**Figure 5**). Moreover, an innovative approach using a type of deltoid flap is presented as an effective strategy for releasing axillary burn contractures. In chapter four, Moore laments that numerous surgical textbooks of his era neglected the Tagliacotian arm flap procedure largely due to its perceived complexity and patient discomfort concerns. He emphasises that local flaps may not be suitable for numerous defects and recommends considering distant flaps as a preferred option before resorting to healing by secondary intention. He meticulously compiles a comprehensive set of indications and contraindications for distant flaps, providing a detailed procedural roadmap that encompasses defect site preparation, flap design, flap inset, splint application, dressing techniques, flap division and donor site closure. What stands out is Moore's unflinching honesty as he candidly shares his difficulties with precision of flap design, the duration of the procedure within the constraints of chloroform anaesthesia and the occasional challenges of flap failure. He provides several case reports of his successes with the arm flap, including that of a seven-year-old girl whose right superior maxilla was eroded by cancrum oris (**Figure 6**). The text proceeds with several cases of nasal reconstruction, with Case II illustrating the use of the forehead flap to address long-standing disfigurement resulting from syphilis (**Figure 7**). Once more, Moore's candid assessment of his outcomes stands out: 'this case was a great disappointment, as I had hoped…to obtain a good nose…The final result can hardly be considered satisfactory, still it must be admitted to be an improvement on her condition prior to operation, and I believe it can be further improved.'[5]



PLASTIC
SURGERY

WITH ILLUSTRATIVE CASES.

BY

W. MOORE, M.D., M.S. MELB.

SURGEON TO OUT-PATIENTS, MELBOURNE HOSPITAL.

Melbourne:

STILLWELL AND CO., PRINTERS, 195A COLLINS STREET.

1899.

Fig 3. Title page of Plastic surgery: with illustrative cases.[5]
Source: State Library of Victoria. CCBY 4.0

Moore's expertise transcends mere illustration of reconstructive cases. His mastery as a maxillofacial surgeon shines through in his duteous accounts of performing nasopharyngeal carcinoma resections on two adolescent patients. He eloquently delineates the intricacies of maxillectomy, providing exacting descriptions of the surgical incisions, strategies for managing unexpectedly large tumours and the delicate nuances of palate closure. The successful recoveries of both patients underscore the depth of his surgical acumen. In accordance with his general surgical background, Moore delineates a novel approach to address severe hypospadias and details his surgical methodology for managing imperforate anus. In the case of the former, characterised by a penoscrotal variety with a urethral opening located at the juncture of scrotal and penile skin, his technique involves rerouting the urinary flow through a perineal incision. The procedure entailed a transverse incision to rectify penile curvature, fixation of the penile shaft to the abdominal wall, and the application of skin grafts to address the resultant raw surfaces.

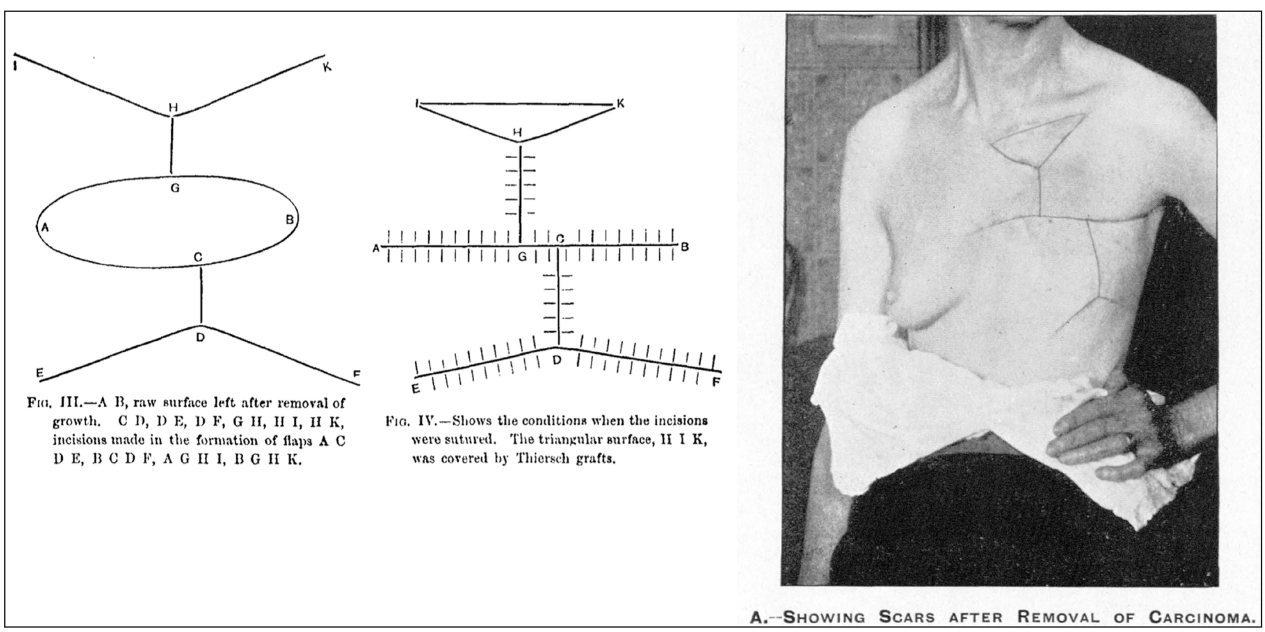


Fig 4. Four-flap method for large mastectomy wounds from Plastic surgery: with illustrative cases.[5]
Source: State Library of Victoria. CCBY 4.0

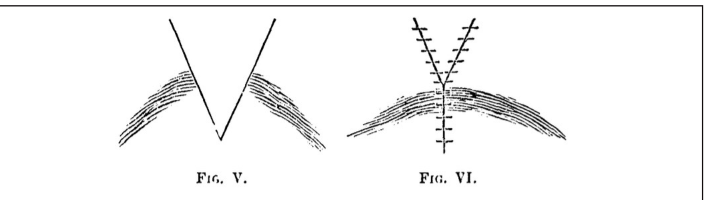


Fig. V represents the eyebrow as it was before operation ; also the incision made to remedy the deformity. Fig. VI represents the parts at the end of the operation after the sutures have been applied.

Fig 5. V-Y flap for the eyebrow from Plastic surgery: with illustrative cases.[5]
Source: State Library of Victoria. CCBY 4.0

Fig 6. The Tagliocotian arm flap for maxillary reconstruction from Plastic surgery: with illustrative cases.[5] *Source: State Library of Victoria. CCBY 4.0*

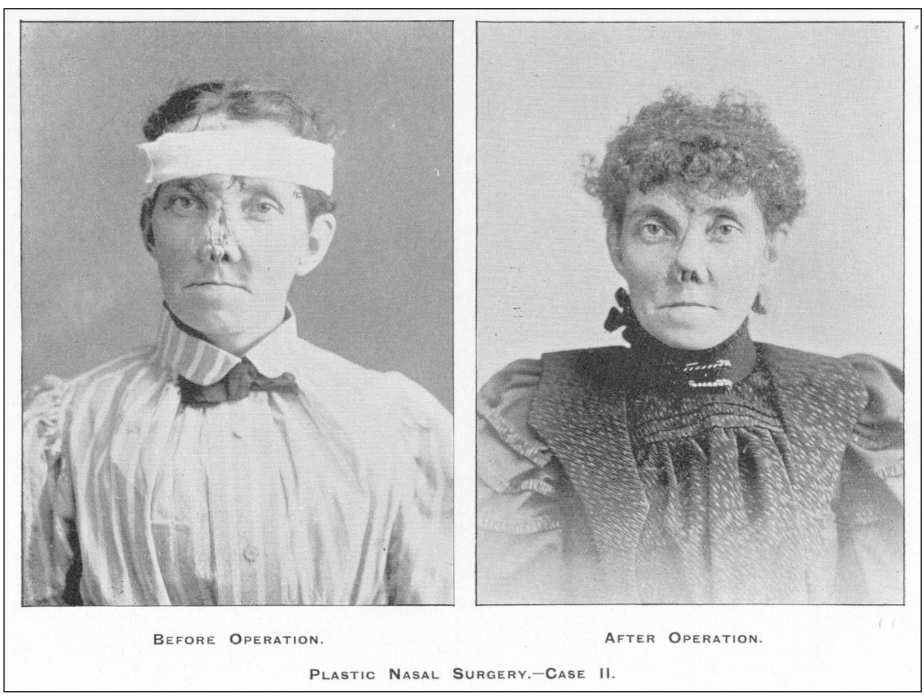


Fig 7. Nasal reconstruction using the forehead flap. Moore was not entirely satisfied with the result. From Plastic surgery: with illustrative cases.[5] *Source: State Library of Victoria. CCBY 4.0*

William (Jerry) Moore

Pioneer and reformist

Renowned Australian surgeon Sir Benjamin Rank (1911–2002), who trained under Gillies, provides the sole account of the life and era of William Moore.[30] As a 'Melbourne Hospital man', Rank was intrigued by Moore's inexplicable obscurity which was sparked by a casual comment from his anaesthetist, Leonard Lillies, in the operating theatre—'I have not seen anyone do that since Jerry Moore.' This inquisitiveness led Rank to delve into Moore's enigmatic story, gathering insights from various primary sources, including case records preserved by Moore's son, the Melbourne Hospital (now the Royal Melbourne Hospital) archives, the British Medical Association's (BMA) records, and testimonies from Moore's contemporaries.

In 1879, William Moore, an academically accomplished young man from Brisbane, left for Melbourne at the age of 18. He developed a passion for medicine during his time at Brisbane Grammar School, partly inspired by his second headmaster, Mr Crampton, who humorously nicknamed him 'Jerry' after a case of mistaken identity with a local cobbler's son, Jeremiah Moore. Despite matriculating for Sydney University, William chose the University of Melbourne for what he perceived as a superior medical education. He graduated with top honours in 1883 (**Figure 8**). His career then took off as he quickly secured a role at Melbourne Hospital, specialising in skin diseases and outpatient surgery, a mere two years after graduating. During this time, he earned the titles of Doctor of Medicine and Master of Surgery (the first ever awarded by the University of Melbourne), completed a year's residency at the hospital, and even served as a university anatomy demonstrator. Dr EM James, a respected surgeon at Melbourne Hospital, recognised Moore's skills and frequently sought his assistance. Later, when Dr James returned to England, he offered Moore his medical practice and townhouse at 2 Collins Street, known as Alcaston House. While many of Moore's colleagues initially doubted this decision, it marked a significant turning point in his career. Additionally, Moore corresponded with Dr James Beaney, another surgeon at the hospital who had frequent absences due to illness. During Beaney's periods away, Moore stepped in as an inpatient surgeon, displaying a deep commitment to his patients by personally overseeing their treatment and closely monitoring their conditions.

Moore's early career coincided with a transition from septic to antiseptic surgical practices. He advocated for Listerism and aseptic techniques, even in the face of resistance from senior colleagues. His introduction of Listerism at Melbourne Hospital led to a remarkable reduction in mortality rates for abdominal surgeries (up to 80%),[2] ultimately gaining wider acceptance. Moore's unwavering dedication to patient care, including round-the-

Fig 8. Dr William Moore by Bardwell's Instantaneous Photographs, 1882. Source: University of Melbourne, Medical History Museum. CCBY 4.0

clock postoperative visits, allowed him to promptly address issues at the source. This dedication ultimately earned him a position at St Vincent's Hospital, where he served from 1899 to 1906. Those familiar with Moore often cited his deep dedication to the Baptist Church and his love for cricket. However, they also recognised his outspoken and principled nature, which sometimes led to controversy. A contemporary, Dr George Syme, wrote: 'Both in writing and speaking he was lucid, logical, and dogmatic. He never seemed to have any doubts about anything, whether in surgery, hospital administration, cricket, politics, or religion. We often differed but one recognised the absolute sincerity of his views and actions.'[30]

Moore's profound fascination with reconstructive surgery set him apart as a pioneering figure in the English-speaking world. His dedication to this field is evident through his extensive written contributions, including the 1899 book *Plastic surgery: with illustrative cases*.[5] The exact source of Moore's knowledge in the field of reconstruction remains a mystery. Although he was in communication with Wolfe, and while it is plausible that he encountered European techniques during his travels to the United Kingdom, Moore himself recounted that he 'was eager to see old towns, old churches, country lanes and trees. Thinking what a lovely place England was kept me away from surgeons and hospitals.'[30] Despite being an early proponent of the term 'plastic surgery' in English medical literature, his work was not recognised, even by prominent figures like Gillies. By 1900, Moore had significantly advanced reconstructive techniques, showcasing a meticulous and innovative approach to patient care. Moore's meticulous approach is exemplified in his hospital records, where he left no detail unaddressed, from dressing patients personally over multiple days to designing intricate skin flaps.[30] He demonstrated a profound understanding of flap vascularity management and advocated for primary repair of surgical defects using local flaps and skin grafts.[5] While Moore excelled in many areas, he grappled with allografting due to the limited knowledge of graft rejection mechanisms at the time.

Throughout his career, Moore's surgical skills, powers of observation, and courage in tackling complex cases earned him accolades from some contemporaries. His innovative techniques, such as perineal urethrostomy for hypospadias and ligating the saphenous vein for varicose ulcers, underscored his inventive spirit. However, in 1906, a series of unfortunate events led to professional and legal challenges, ultimately resulting in his resignation from the BMA in 1911 (see below). Despite this setback, Moore dedicated the latter part of his career to hospital management reform, focusing on issues like patient payment policies and electoral systems for honorary staff appointments. After retiring from Melbourne Hospital in 1914, Moore sought to serve in World War I but was retained in Melbourne for his expertise in plastic surgery. His later years were marked by a significant role in establishing the Carey Baptist Grammar School, where he served as the inaugural chairman from 1923 to 1925. In the last year of his life, he became a founding member of the new Royal Australasian College of Surgeons. Moore passed away in 1927 and the exact circumstances of his death remain undisclosed.

The regrettable events that marred the reputation of an esteemed individual[30]

In June 1906, an English shipping agent named EL Palmer, who was visiting Melbourne and staying at the Grand Hotel, sought medical assistance for a painful swelling in his mouth. He had already received advice and treatment in various cities during his travels, including Kobe, Shanghai, Rangoon and Calcutta. In Melbourne, he was under the care of Dr William Fox, a general practitioner

who also specialised in X-ray work, electrotherapy and genitourinary medicine. After consulting Dr Fox, Palmer's condition worsened, and he was due to sail for London. At the insistence of his friend, Mr Hutchinson, Palmer sought a second opinion from Dr William Moore. Moore diagnosed Palmer's condition as malignant. Palmer eventually left for London and passed away during the voyage. Fox was incensed upon discovering that Moore had visited his patient without prior consultation, sparking a written exchange between them. Despite Moore's diligent efforts to clarify his intentions, Fox remained resolute in his scepticism. In Moore's ultimate correspondence to Fox, he lamented Fox's reluctance to accept his straightforward explanation that he had merely sought to assist someone in distress, concluding 'I regret that you do not accept my explanation in reference to Mr Palmer. It is also evident that no good purpose can be served by any further statement of mine.'[30]

The incident sparked a controversy, resulting in an extended legal battle and ongoing repercussions in the medical community. In fact, the case remained unresolved until August 1911 and overshadowed Moore's legacy. Fox filed a formal grievance against Moore's conduct with local medical associations and publications. When he found their responses unsatisfactory, he elevated the matter internationally to the head office of the BMA and its Central Ethics Committee. The escalation triggered widespread interest, resulting in an extensive exchange of letters and documents. Consequently, the involvement of the BMA and its Central Ethics Committee amplified the complexity and disagreements surrounding the case. Moore's professional standing and reputation were challenged throughout the process. Eventually, Moore decided to resign from the Australian branch of the BMA, feeling isolated from the organisation and its members. The episode had lasting implications for Moore, impacting his professional and personal life. It also exposed the intricacies and challenges of resolving professional disputes within the medical community during that era.

Why was Jerry forgotten?

Moore's remarkable contributions to the field of plastic surgery have, for the most part, lingered in relative obscurity. Rank put forth a number of factors that may shed light on the limited acknowledgment of Moore's achievements.[30]

As surgical techniques evolved, placing a growing emphasis on abdominal surgery, many surgeons increasingly focused on visceral operations. Moore's own career mirrored this shift after he visited renowned figures of the era, such as the Mayos (William and Charles), Edward Judd, George Crile, John Murphy, Howard Kelly, William Halstead, John Finney, Joseph Bloodgood and Roswell Park in the United States, as well as Berkeley Moynihan, Arbuthnot Lane and Victor Horsley in England.[30] This period was a time of significant advancement in surgical science and its auxiliary disciplines, but a less progressive era for plastic surgery itself.

Furthermore, the radical surgical approach to malignant diseases, as practiced by Moore in his early career, began to wane in popularity in the early twentieth century, with the emergence of radiotherapy as an alternative. This new cancer treatment offered few opportunities for reconstructive surgery and the traumatic injuries prevalent in the industrial age were not as common. The medical community generally accepted the hardships of secondary intention healing as a normal consequence of severe injuries, while the infectious risks associated with primary wound closure remained a significant concern.

Lastly, Moore did not have a true protégé to whom he could pass on his skills. He lived a somewhat solitary life, isolated from other members of the medical profession which was catalysed by a five-year legal battle regarding an issue of minor consequence. He was not universally well-received by his contemporaries and did not align with the mainstream. He was a reformer, and his zeal for change often put him in conflict with the establishment. Such reformers do not necessarily rise to prestige through time served and agreeable conformity; instead, their recognition often comes in retrospect.

Conclusion

Moore's extensive body of work serves as a testament to his surgical mastery, firmly establishing him as a pioneering visionary ahead of his time. His lasting legacy holds great importance in the realm of plastic surgery, notably as the author of the first English textbook dedicated to this discipline. It is deeply unfortunate that minor disagreements and the pervasive 'tall-poppy syndrome' have, to some extent, obscured his exceptional talents. Nevertheless, as we reveal the mysteries surrounding this remarkable figure, we fervently hope that William (Jerry) Moore finally receives the recognition he so rightfully deserves.

Conflict of interest

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References

1 Yousef J, Morrison W. Australian and New Zealand contribution to plastic surgery. *ANZ J Surg*. 2021;91(7–8): 1428–434. https://doi.org/10.1111/ans.16650 PMid:33656239

2 Morrison AM W. Plastic surgery origins and the Antipodean influence. *Australas J Plast Surg*. 2018;1(1):6–16. https://doi.org/10.34239/ajops.v1i1.64

3 Brown E, Klaassen MF. War, facial surgery and itinerant Kiwis: The New Zealand plastic surgery story. *Australas J Plast Surg*. 2018;1(1):66–78. https://doi.org/10.34239/ajops.v1i1.32

4 Gillies HD. *Plastic surgery of the face based on selected cases of war injuries of the face including burns with original illustrations*. London: H Frowde, 1920.

5 Moore W. *Plastic surgery: with illustrative cases*. Melbourne: Stillwell Printers, 1899.

6 Yousef J, Leow SKH, Morrison W. Plastic surgery in antiquity: an examination of ancient documents. *Eur J Plast Surg*. 2021;44(4):419–28. https://doi.org/10.1007/s00238-020-01763-4

7 Yousef J, Soliman B, Morrison W. The great translation movement—plastic surgery in the Middle Ages. *Eur J Plast Surg*. 2023;46(2):137–47. https://doi.org/10.1007/s00238-022-01991-w

8 Longmate B. A curious surgical operation. Letter to the editor. *The Gentleman's Magazine*. 1794;64:891–92.

9 Carpue JC. *An account of two successful operations for restoring a lost nose from the integuments of the forehead, in the case of two officers of His Majesty's army: to which are prefixed, historical and physiological remarks on the nasal operation; including descriptions of the Indian and Italian methods*. London: Longman, Hurst, Rees, Orme and Brown, Paternoster Row, 1816.

10 Von Graefe KF. *Rhinoplastik*. Berlin: Reimer, 1818.

11 Zeis E. *Handbuch der plastischen chirurgie*. Berlin: G Reimer, 1838. https://doi.org/10.1515/9783112635247

12 Dieffenbach JF. *Chirurgische Erfahrungen besonders über die Wiederherstellung zerstörter Theile des menschlichen Körpers nach neuen Methoden: mit 2 Lithogr*. Berlin: Enslin, 1829.

13 Dieffenbach JF. *Die operative chirurgie*. Leipzig: FA Brockhaus, 1845.

14 Mazzola RF, Foss CB. The nineteenth century: the rebirth of plastic surgery in the western world. In: Mazzola RF, Foss CB (eds). *Plastic surgery: an illustrated history*. Cham: Springer International Publishing, 2023. pp 197–278. https://doi.org/10.1007/978-3-031-12003-9_5

15 Gräfe CF von. Neue beiträge zur kunst theile des angesichts organisch zu ersetzen. *J Chir Augenheilk*. 1821;2:1–35.

16 Fritze HE, Reich OFG. *Die plastische chirurgie, in ihrem weitesten umfange dargestellt und durch abbildungen erläutert*. Berlin: Hirschwald, 1845.

17 von Ammon FA, Baumgarten M. *Die plastische chirurgie nach ihren bisherigen leistungen kritisch dargestellt.* Berlin: Reimer, 1842. https://doi.org/10.1515/9783111510408

18 Thiersch C. Ueber die feineren anatomischen verlinderungen bei auf heilung von haut auf granulationen. *Arch Klin Chir*. 1874;17:318–24.

19 Labat P. *De la rhinoplastie, art de restaurer ou de refaire complètement le nez*. Paris: Ducessois, 1834.

20 Wallace AF. *The progress of plastic surgery: an introductory history*. Oxford: WA Meeuws, 1982.

21 Velpeau A. *Nouveaux elements de médecine opératoire accompagnés d'un atlas*. Paris: J-B Baillière, 1839.

22 Blandin P. *Autoplastie ou restauration des parties du corps qui ont été détruites à la faveur d'un emprunt fait à d'autres parties plus ou moins éloignées.* Paris: G Baillière, 1836.

23 Serre M. *Traité sur l'art de restaurer les difformités de la face, selon la méthode par déplacement, ou méthode Française*. Paris: J-B Baillière, 1842.

24 Jobert AJ. *Traité de chirurgie plastique: accompagné d'un atlas in-folio de 18 planches gravées et coloriées*. Paris: J-B Baillière, 1849.

25 Verneuil AAS. Chirurgie réparatrice. In: *Mémoires de chirurgie*. Vol 1. Paris: G Masson, 1977.

26 Bennett J. Aspects of the history of plastic surgery since the 16th century. *J R Soc Med*. 1983;76(2):152–156. https://doi.org/10.1177/014107688307600214 PMid:6338233 PMCid:PMC1438692

27 Spencer-Wells T. Practical essays in plastic surgery. *The Medical Times and Gazette*. 1854;2:9, 32, 55, 109, 210, 262 and 661.

28 Mason F. *On the surgery of the face*. London: J & A Churchill, 1878.

29 Wolfe JR. A new method of performing plastic operations. *Br Med J*. 1875;2:360–361. https://doi.org/10.1136/bmj.2.768.360-a PMid:20747957 PMCid:PMC2297561

30 Rank BK. *Jerry Moore and some of his contemporaries*. Melbourne: Hawthorn Press, 1975.

31 Riddell WJB. John Reissberg Wolfe, MD, FRCSE (1823–1904). *Br J Plast Surg*. 1950;3(3):153–164. https://doi.org/10.1016/S0007-1226(50)80026-7 PMid:14783672

32 Stonham C. *A manual of surgery*. Vol 1. New York: Macmillan and Co Ltd, 1899.

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