Prof. Kerin, Prof. McAnena, distinguished guests, colleagues, ladies & gentlemen. I was delighted to be asked by the Committee to deliver this State of the Art Lecture at the Freyer Symposium this year. I have been coming to the Freyer meeting for many years since its foundation in 1976 by the late Prof. Sean O’Beirne. To be now added to the list of the State of the Art Lecturers is a tremendous honour and may I pay tribute to Dr. Les Nathanson for a terrific Freyer Lecture last night. His is a household name in my operating theatre in Beaumont Hospital and his simple retractor is a brilliant example of surgical innovation.

The Freyer Symposium holds a special place in the Irish surgical culture for the past 50 years. It has served as a wonderful medium for young trainee surgeons and young scientists to first present either their clinical or scientific research before an audience of their peers and senior colleagues. All surgeons will attest to the importance of that first step of presenting a paper in a public forum. I would like to take this opportunity to congratulate Prof. Fred Given and his colleagues who developed this meeting and to acknowledge the current organisers, Michael Kerin and Oliver McAnena, who continue to develop and expand the scope and activities of the meeting.
Many of you will be aware that Patrick Freyer, the grandson of Sir Peter who was a very regular attender at this meeting for many years, died recently after a lengthy illness. Patrick, who himself had no children, was the last living link to Sir Peter. He has very kindly donated his body to the Anatomy Department at the Royal College of Surgeons in Ireland and his GP and lifelong friend Dr. Knut Moe, himself a graduate of the RCSI, bequeathed Sir Peter’s fob-watch to the College. I understand that Patrick has also given a similar watch and a brooch to the Sir Peter Freyer Collection.

As the current President of the College and the recipient of this gift from the late Patrick Freyer I feel these recent events cement the strong links between the University here in Galway and the Freyer Symposium and the College of Surgeons. It also heightens my sense of responsibility in delivering this lecture today.

I have previously said on many occasions during the past year what a privilege it is to be the President of the Royal College of Surgeons. With privilege however comes responsibility. We are all only too painfully aware of the current state of crisis in our health service and in particular the difficulties faced by our patients and our trainees. Consultants too are faced with ensuring the delivery of high quality surgical care in the face of inadequate and ever shrinking resources whilst at the same time facing daily an ever increasing undermining of the medical and surgical profession which frequently leaves us perplexed. It is highly appropriate, in my view, and very timely that our College, the voice of surgery in Ireland, should be centrally involved in highlighting these issues. We as a community of surgeons must have our opinions heard and respected and it is my view that the College is the obvious conduit.
RCSI’s modern mission is built on its heritage and therefore to understand how to develop a vision and strategy for the future of our health service I believe history has important lessons to teach us. We should all be reminded intermittently of how we have evolved to our current existing health administration system and practice models right up to the most recent announcements in May 2013 of the formation of Hospital Networks.

You’ll all remember this map from your geography classes!

The county system dates back to Norman times and under the Local Government Act of 1898 local councils were empowered to run services in their county, including education, justice and health. For many years the local hospital or county hospital had only one permanent doctor – the surgeon - with other specialists such as an anaesthetist visiting as needed. With the foundation of the State in 1922 the new Local Government Act allowed for continuation of this system. Running of the local councils was totally political, however, and unfortunately quite corrupt. In 1932 the County & City Management Act resulted in executive function being put in the hands of a fulltime administrator appointed via the Local Appointments Commission. The County Manager therefore was responsible for local health administration – including the hospitals (on which 70% of the budget was spent).

My father was a County Manager and I grew up listening to his view of senior clinicians which at times were very amusing!

The Department of Health was created in 1947 but for 20 more years after its foundation hospital administration remained under the control of the then Department
of Local Government and Public Health. In 1968 the Government of the day commissioned Professor Patrick Fitzgerald, Professor of Surgery at UCD and St. Vincent’s Hospital to prepare a report on the future of the Irish hospital system. Remember at that time there were 169 acute medical surgical and maternity services and only three hospitals (all in Dublin) had more than 300 beds. Fitzgerald concluded that “the Irish hospital sector is outmoded and now a hindrance to good medicine” and proposed that acute hospital services should be provided in only 12 locations in the country in 16 large hospitals. Other hospitals not included in the 16 were to become community health centres.

Fitzgerald was a brave man to make these proposals and not unexpectedly his report resulted in vociferous protests from many counties. One of the strongest was from Wexford – my home town - which at the time boasted an average of 23.7 day length of stay and a 70% occupancy rate. Roscommon was not to be outdone and the old IRA organised a sit in protest in the hospital. It is no surprise that the Fitzgerald report was never enacted but it remains very relevant today to the whole issue of hospital reform.

In 1970 under a new Health Act – Health Administration was reorganised into 10 Regional Health Boards which resulted in several counties being grouped together for the purposes of health management. Political and inter county issues remained strong and delayed hospital reforms. After 30 years of that arrangement and with the objective of eliminating the influence of local and regional politics on important health reforms and issues, these Regional Health Boards were abolished in 2004 and the Health Service Executive (HSE) was established and became operational in January 2005. It was responsible for 107,000 employees (67,000 direct and 40,000 working in agencies on behalf of the HSE). As we all know there were no job losses with the
formation of the HSE and many middle managers and others in the new system
didn’t know or understand what their role was. Thus there was no responsibility or
accountability for many decisions despite endless bureaucratic activity.

The Department of Health is the strategic arm of the Health Service with the following
Mission Statement: “to improve the health and well-being of people in Ireland in
a manner that promotes better health for everyone, fair access, responsive and
appropriate care delivery, and high performance.

This by the way is the same Department that Brian Cowen, former Taoiseach,
described as Angola – clarifying by saying “just when you have cleared one land
mine – another goes off”.

It wasn’t long before the HSE whose mission we all remember was to create “a world
class health service” took over the strategic as well as the executive arm of the
Health service and the lines of Governance and accountability became very blurred.
We can all recall Minister Harney’s standard answer in Question Time in the Dail was
“ask the HSE”!

Our current Minister for Health abolished the HSE as per a Fine Gael election
promise and shortly after taking up office ceremoniously disbanded the board of the
HSE and the Chief Executive subsequently resigned. Some years later we still see
the HSE working without a clear leadership and governance structure which means
that the decision making process and delivery of action is frequently if not virtually
always a problem. Despite this lack of governance there are many people in the
HSE who are committed and hard-working and indeed dedicated to improving and
delivering high quality services in all their areas of activities. Unfortunately the other
side of the HSE and indeed the Department of Health is a relentless drive to control one and all who are involved in frontline delivery of service including of course and especially Consultants.

The history of delivery of consultant services is also extremely interesting and important to our current situation. Up to the time of the introduction of the Common Contract consultants worked on a sessional basis in voluntary hospitals whilst surgeons in county hospitals were salaried. There was no pension and no retirement age. Understandably the leadership of the consultants at the time were concerned about the lack of pension in particular. The Common Contract was negotiated in 1982 with the great support of CJ Haughey although Michael Woods was Minister for Health. That was when retirement age became 65 and consultants were entitled to a pension. Further modifications of the Contract occurred in 1991 (Gleeson), 1997 (Buckley) and the latest in 2008. Whilst you couldn’t argue about the benefits of a pension the price was loss of autonomy and inevitably increasing control by employing authorities.

Over the years unfortunately a small number of Consultants including surgeons did not fulfil their obligations under the Common Contract and left much of the public practice to their trainees, and junior hospital staff. The vast majority, however, of hospital consultants and in particular surgeons, worked many hours over their contracted number in the public hospitals treating their patients, training their junior staff, and carried on with their private practices over and above that.

There were many who were concerned about the Common Contract who saw the dangers in loss of independence in becoming a full time employee of the health boards or of the hospitals. Some never signed a Common Contract and continued to
work as proper Consultants providing services on a sessional basis to public and private hospitals. Subsequent versions of the contract have increasingly restricted Consultants to public hospital practice only and due to the ideology of the Progressive Democrats which purported to eliminate the two tier system but which as we now know instead has consolidated it.

We have as a result the anomaly of a peer appointed consultant to a public hospital unable to deliver a service to 45-50% of the population who are insured unless their diagnosis is emergent or so serious as to mandate public hospital admission. During the Celtic Tiger economy a plethora of private hospitals were developed and they understandably required specialists to work and keep the beds occupied to maintain business. The evolution of this model in my view is wrong for a country of our size and undermined the quality and consistency in previous models where well trained and peer appointed consultants delivered a service to both the public and private patients.

So here we are in September 2013 having evolved from administrative and clinical care delivery systems many of which are clearly no longer fit for purpose for modern times. This slide summarises in my view the current major problems that face us as a surgical profession and which we must tackle with vision and leadership to ensure a better system.

No-one needs reminding that we are in the midst of a serious economic downturn (20% Health Budget cut, 3 billion Euros since 2007) and ongoing major health reforms. There is no dispute that major reform in health care delivery overall and in our case in surgical care delivery is required. There have been huge technological, immunological and pharmacological advances in the past 20 years including
laparoscopic surgery and improved video systems and energy sources and the push towards minimally invasive techniques in all surgical disciplines have resulted in a significant decrease in surgical trauma, with resultant benefits to patients and reduction in hospital stay.

To those of us who worked in America we were very familiar as a concept going back for many years of Day of Surgery Admission, increasing use of day surgery, and monitoring length of stay. The surgical community in the College has shown great leadership in collaborating with the HSE to develop the Surgical Clinical Programmes including the Elective Surgery Programme and the more recently launched Acute Surgery Programme. If it was said some 10 – 15 years ago that the Royal College of Surgeons and the HSE would be collaborating in such a major way there would have been many who would have said it wouldn’t happen and wouldn’t work. However, it has happened and those of us who have seen it at work up close have no doubt about the overall benefits to both parties as a result of this collaboration. And I might single out my predecessor and past President Frank Keane and current Council Member Ken Mealy as two men who have shown terrific leadership and worked tirelessly in leading a team of medics and project managers who produced these templates for the Surgery Clinical Programmes.

However the next big, and a most important task, is the implementation and to date because of the political imperative to avoid trolley waits in A&E Hospital Managers are universally committed to implementing the Acute Medicine Programme. Unfortunately commitment to the Surgery Programme is less uniform. Where successful however e.g. in Castlebar the drive of the surgeons (Barry/Waldron/Bennett), combined with a willingness and support from management has resulted in very successful implementation with immediate benefits related to
decrease in routine waiting lists, improved opportunities for our trainees and professional fulfilment for our surgeons.

More than any other branch of the profession we have repeatedly shown our ability to adapt and reinvent ourselves. We can all still remember the palpable sense of anticipation when Barry White, the then Lead Clinician of the Clinical Care Programmes, said he wanted to bring elective surgery back into all the major hospitals. We the surgeons got on board - supported the concept in every way - but we now need to see more implementation and hospital managers understanding, or being forced to understand, that having good and constant surgical practice ongoing in their hospital is of great benefit. That message is not getting through in many institutions and with increasing financial constraints the elective surgical activity still becomes the easy target. It is not good for surgeons and their operating teams to be idle, not filling their lists or dealing exclusively with an emergency workload.

Of course there are other reasons for idle surgeons related to a fundamental lack of resource assigned to them in the first place and I will come back to that issue later.

I want to talk now about training the next generation of surgeons in Ireland.

Since they originated in 1977 it is generally recognised that our surgical training programmes in all disciplines have produced excellent quality trainees with a strong background of academic pursuits, overseas experience and a 4-5 year higher programme with exposure to a wide range of surgical and clinical conditions. Whilst recognising the outstanding quality of our trainees who have completed our programmes in recent years it has been shown that interest in surgery as a career is decreasing amongst young graduates of our Medical Schools. The numbers and
quality applying for BST were falling and the numbers dropping out after starting were increasing. Feedback indicated that the journey from basic surgical to higher surgical training was too uncertain and the gap years were almost akin to a surgical wilderness for a period of 2-3 years before successful applicants were restored to a definitive training programme.

A more recent personal experience of one of our own RCSI graduates brought home the issue to me. This young man Daniel Joyce, a Galway native, qualified from RCSI with First Place and First Class Honours in his final in 2000. He was Valedictorian and multiple prize winner. During his Internship with me he expressed an interest in a career in surgery and I reassured him that he would be a successful BST candidate. However he decided early on that he was not applying for BST because he felt that the pace of training and the gap years in particular would be unattractive and accordingly he applied abroad. He matched without the need for a preliminary year because of his outstanding results and is now a second year Resident at the Cleveland Clinic. Last year he was named outstanding First Year Resident in the programme of all the specialties at the Cleveland Clinic and currently is doing his research in Transplant Immunology. He was 22 when he graduated so he will be Board Certified with fulltime research completed and be close to finishing his Fellowship by the age of 30 – 31.

To keep the likes of Daniel at home it was clear for a number of years therefore that change was required and rather than tinkering again with BST, we have taken a bold step and revamped the training to an 8yr programme eliminating the so called “gap years”. 
So just to remind you - this slide illustrates the programme up to this year with three years in Basic Surgical Training, variable gap years followed by entry to the Higher Surgical Training programme and Fellowship years. As Oscar Traynor himself put it “the longest training programme in the world”!

This is the new programme – ST1 – ST8.

One of the key questions, of course, relates to the difficulty of specialty selection immediately post Internship. We have encouraged young trainees to identify very early their first and second choices of specialty and thereafter will try to mentor and streamline successful applicants to the programme into the specialty of their choice.

There are also understandable concerns from both current and future trainees and trainers about how surgical training can be successfully achieved in such a short time frame. One of the most crucial changes is the elimination of the gap years where, as we know, trainees to date have spent time in research to develop a bibliography and curriculum vitae to make themselves competitive for entry to Higher Surgical Training. Critics have said we are dumbing down the academic component of our programme.

I do not believe that and I wish to acknowledge the Professors in our Academic Departments of Surgery who, over many years, have provided research opportunities for our young trainees. This contrasts greatly with the situation in the 70’s and 80’s, when in addition to stepping out of clinical surgery trainees had to travel abroad for research opportunities. Despite its long duration our surgical programme has always been admired worldwide for the high quality of the trainees graduating and a significant factor in this has always been the academic and research emphasis
during the training. The support of the Academic Departments and the Professors for the new programme is critical and I am extremely grateful for that.

I have no doubt that trainees, when they progress to the later years of their programme, will identify areas of research that interest them which are of more relevance to their specialty choice. They will take time out from the training programme to do full time research and thus academic and scientific pursuit of a more focused nature will continue to be an important component of our training programmes. For those who are not of a research bent there will be bespoke MCh programmes so that all trainees in all disciplines will have the appropriate understanding of scientific method, statistics and other aspects of research.

There is still considerable work to be done in terms of clarifying selection criteria. Progression is equally important and will be competency based. The next major challenge for us, as trainers and assessors, is to establish a robust and rigorous assessment process which we can stand over. Trainers therefore will be expected to do much more assessment of the trainees in the work place and it is intended to appoint Programme Directors for each specialty and also to put in place local Hospital Programme Directors who will be very important in terms of bringing with them institutional assessment of the trainees in the various different jobs. Identification of high quality training posts will be important. Whilst there will be competitive entry for the trainees, there will also be competition between training units as they vie for the young surgeons of the future to come and work in their Department. No unit will be immune from being discontinued if they under perform.
There is a new air of excitement about this programme as evidenced by a significant surge in the numbers of applications – 179 - and the quality of the successful applicants. The programme will be extremely competitive and already we are getting feedback of candidates considering leaving the programme to move to Radiology or other specialties but we must not forget that BST has always been a developmental 2 yrs for launching into other specialties.

In July of this year 58 new trainees were appointed to the programme, 18 of whom had deferred from last year. This represents a reduction by 20 of the number of training posts compared to previous years. We are conscious of the implication for service of this reduction but we make no apology for looking after surgical training as our first priority. Over a number of years the College like many other institutions has been considering Physicians Assistants, Nurse Specialists and hospitalists as ways of service provision instead of surgical trainees. We haven’t made a lot of progress with these concepts in talks with the HSE and Department of Health. Perhaps the time is right to resurrect those discussions because understandably there are concerns from many quarters, about the impact on service, particularly from our Emergency Department colleagues.

Trainees who have commenced their programme within the last 2 years and those who are currently in the gap years are understandably unsettled by the proposed change process. However we have an expert project manager in Kieran Tangney who has been working on the programme night and day. This slide here illustrates how it is proposed over the transition years to incorporate those in current BST training as well as those currently in the gap years. Expansion of Higher Surgical Training posts to accommodate the bulge will actually result in possible enhanced opportunity in some disciplines.
In any event no matter what the reservations of some trainers may be and no matter what the concerns and worries of current trainees and those in gap years are, as they are so to speak caught in the middle, leaving things as they are was not an option. We have inherited from our forefathers a legacy of doing what is right for surgical education and training for our current and future generations and I and the rest of the leadership of the College are firmly committed to the task. I believe this new programme is an example of College leadership in so far as they reacted to feedback and changed the system.

Since my time of first involvement in the College of Surgeons in 1991 there has been a long campaign for the introduction of countrywide audit amongst surgical practitioners. Despite elongated discussions with various parties in the Department of Health there was never any commitment to funding forthcoming for such an important aspect of surgical practice. There is no doubt therefore that our collaboration over the last number of years, with the HSE in relation to Clinical Programmes has contributed to the establishment of the National Office of Clinical Audit.

In particular, direct support from Dr Philip Crowley, Director of HSE Quality and Patient Safety has allowed RCSI, with Ken Mealy a long advocate of clinical audit and patient safety, lead the way in establishing governance and framework structures through NOCA. The National Office of Clinical Audit is governed by a multi stakeholder Board chaired by myself, President of RCSI, and the Board is currently overseeing the design, delivery and governance of several audit streams, including the Irish Audit of Surgical Mortality; the Irish National Orthopaedic Register, a
National ICU Audit linked to ICNARC UK and most recently a Major Trauma Audit which will connect to TARN UK.

In relation to the audit of Surgical Mortality there has been a delay in commencement because of the issue of confidentiality of the data. Essentially we will need a new Health Information Act passed by the Government to guarantee that information provided to a database will be privileged and not subject to discovery, Freedom of Information or Data Protection or any other possibility of release under legal threat. Only then will all of the surgeons in the country hopefully commit to this audit so that we will have a true and accurate figure on surgical mortality in this country.

We are all aware of the Scottish Audit of Surgical Mortality which has been in existence now for 20 years. They have a similar system in Australia, New Zealand. Mortality audits work in those countries because the data is privileged. Nothing short of that will be acceptable in this country. This is a booklet produced by the ANZASM on National Case Reviews, which includes case studies with a summary and clinical lessons for all to read. Arising out of these cases there are overall recommendations which include communication between all staff, the need for senior clinical leadership, the special significance of the acute abdomen in the elderly and the importance of accurate recording of all data. ANZASM is now including Private Hospital Data in NSW and expanding into Queensland.

Many of you will be aware of the recent controversy over publication of individual surgeon outcomes in the UK. This, as we all know, will inevitably lead our policy makers and Government to move towards this method of demonstrating surgeon accountability and transparency in Ireland. We must as a College be centrally involved in discussions and not find ourselves foisted with a system that has us on
the back foot as we were with the National Cancer Strategy. The National Office of Clinical Audit is the ideal governance mechanism in my view through which surgeons outcome data can be managed and published in an appropriate manner. I find it ironic that we have been encouraged to work as multidisciplinary teams over the past decade and yet when it comes to outcomes it will be individual rather than unit based. We must manage that issue very actively and carefully because we have already seen how easily - not just an individual surgeons reputation - but a National reputation can be damaged.

I am referring of course to the Lancet paper on National Mortality Rates for non-cardiac surgery published in September 2012. This was the so called EUSOS Study (European Surgical Outcome Study) and marked a landmark in international comparison of mortality rates and patterns of use of critical care resources in patients undergoing non-cardiac surgery. The study provided data for 46,000 patients aged over 16 undergoing surgery across 28 countries from 498 European hospitals collected between April 4th – 11th, 2011. The investigators were intensivists and the hypothesis was that with better use of critical care resources, and more of them, mortality from routine elective surgery would be lowered. Most surgeons were unaware of the study and were in no way involved and the data collectors in Ireland, at least, were mainly SHO’s/Registrars in anaesthesia. The Authors reported a mortality rate of 4% which was higher than expected with 73% of patients who died not being admitted to critical care. The investigators reported very significant variation between countries.

In Ireland the EUSOS group had recruited surgical patients in 17 hospitals and reported a mortality rate of 6.4%, significantly higher than the UK rate which was used as a baseline.
I was sitting at a lecture by Atul Gawande (champion of surgical safety) at the ACS in late September 2012 when he showed the graph from the Lancet paper (with Ireland ranked 4th from the bottom with Poland, Latvia, Romania) whilst making the point about ensuring acceptable surgical standards in Europe & America before trying to develop and ensure a standard in the Third World. It was to say at the least embarrassing and maddening in equal measure.

This paper was discussed at our Council meeting in October 2012 and there was unanimous support that we should challenge the findings. We were already aware of anecdotal reports of data sets being destroyed and wrongly reported deaths as well as a discrepancy between the overall numbers in the study and HIPE data for the corresponding time period. In RCSI we put together a Governance Group with representatives from RCSI, the College of Anaesthetists, HSE Quality & Safety Directorate and an extern Intensivist, Dr. Gavin Lavery from Belfast. Despite numerous communications to the lead author, the local Irish co-ordinator and the Editor of the Lancet we received little response or co-operation. We therefore decided to repeat the study entitled Irish Surgical Outcomes Study (ISOS) for the same time period, April 4-11, 2011 using a cohort of clinical researchers who were trained in the exact methodology of the study, including a pilot study at Beaumont Hospital. Ethical approval was sought from RCSI Ethics Committee and was accepted by the 17 participating hospitals. All that process took some time and we have just completed the study last week.

It is worth emphasising that RCSI resolved to do all this 3 months ahead of any of the information coming into the public arena in February 2013.
I am unable to reveal the figures of our study here today in case it would compromise our dealings with the Lancet to which we will be submitting the paper. What I can tell you is that we identified significant more patients in ISOS than EUSOS, fewer admissions to critical care and most importantly a much lower death rate in ISOS than EUSOS with that of ISOS being well within acceptable international norms.

**The findings of the ISOS Study:**

- More eligible patients
- Fewer critical care admissions
- Fewer deaths

- Significant doubt on accuracy and completeness of data in EUSOS as evidence by incomplete data sheets in charts
- Patients who were admitted prior to study period included in critical care data

- Illustrates how the reputation of an entire surgical community can be so easily damaged

The final costs of this study are not to hand but were substantial.

I would like to acknowledge and thank Cathal Kelly, CEO RCSI, who immediately recognised the threat of this study and authorised the funding to repeat it. This was an excellent example of RCSI stepping up to its leadership role in Irish surgery to challenge and refute very damaging data published in a reputable journal and which turns out to be a very poor scientific study.
Quality and patient safety in our health service has become a huge issue. A Quality & Safety Directorate has been established in the HSE with Dr. Philip Crowley at its head. But do we just pay lip service to quality and safety in this country and could there be a Mid-Staffordshire scandal looming in our health service. Some years ago Dr. Aidan Halligan, a champion of patient safety in the NHS, said it was “paper safe, but not patient safe”. The NHS spent millions of pounds in technology and yet even as they installed computers and ran their patient safety and governance committees, patients were dying of dehydration and starvation in the wards of Mid-Staffordshire hospitals. Could the same happen here – we would be stupid and arrogant to think it couldn’t!

Three factors amongst many have been identified to have had a detrimental effect on surgical care in the past 10-15 years and could have contributed to the genesis of events in Mid-Staffordshire. The first relates to nurse training. Nursing became a degree course in 2000 and student nurses now spend 50% of their time or less on the wards. No-one would argue that nursing shouldn’t be a degree course because of the complexity of modern care but the gap in provision of routine patient care on the wards has been filled by health care assistants who are largely undertrained and unregulated. The starving and the dehydrated patients were not identified.

The second factor was the rapid adoption by the NHS of the European Working Time Directive to the letter of the law. Surgeons knew and predicted how deleterious to surgical training and practice the EWTD would be. The calls for flexibility were ignored but shift working, constant handovers and destruction of the surgical team structure became the norm, all of which impacted on continuity of patient care. The slavish adherence to the EWTD by the NHS has greatly undermined professionalism.
Surgeons are not by nature clock-watchers but this strict policing of working hours interferes with their sense of vocation and of being there to serve the patient’s needs.

Thirdly the overzealous pursuit of targets to the detriment of quality of care was a significant contributor. The management at Mid-Staffordshire hospitals were obsessed with obtaining Foundation Trust Status and lost sight of patient care. Managers insisting that an elective case needed to be done ahead of a clinically more urgent case, patients who require highly specialised care being removed from waiting lists without the surgeons knowledge are common scenarios.

Do we recognise similarities in our health service presently? Of course we do. Many of our senior experienced nurses here in Ireland have been highlighting current nursing problems for some time. Because of the financial imperative the EWTD is now being aggressively enforced to the detriment of patient continuity of care. The emphasis on targets and target driven medicine policed by the SDU is obvious. The duration of time spent in A &E is the surrogate marker of quality of care rather than proper assessment and accurate diagnosis before definitive treatment. Remember Networks will be competing with one another to get Trust status.

Do we as surgeons have a role in changing this culture or do we just blame it all on management? The latter are acting in response to dictates from on high primarily related to financial issues. Surgeons have a duty to speak out where patient care falls below an acceptable standard. Equally we must be prepared to police ourselves and if concerns are raised about individual surgeons or their teams it is essential the cause is established and where there is proof, remedial action is taken. One of the risk areas for us in RCSI is that being close collaborators with the HSE & DOH potentially inhibits the voicing of justified criticism of various aspects of quality of
care. It is at all times a delicate balance and there has to exist a healthy tension between the two organisations.

RCSI is and has to be the voice of surgery in Ireland on issues of education, training and practice. It is worth noting that the objective of the founders of our College as stated in the original Charter was “to establish a liberal and extensive system of surgical education that should proceed on a non-sectarian basis for the public good and the advancement of the profession”. These objectives espoused in our Charter reinforce for me the rightful role of RCSI in advocating for the highest quality of surgical care for our patients and all the conditions required for our surgeons to do so including relevant training and work conditions.

However in a recent survey of our Fellows in 2011 disappointment was expressed by them about the College’s lack of engagement and debate with Government and their agencies over surgical practice issues. We must be aware that if we take on an advocacy role we may attract unwanted attention and criticism but my firm belief is that if that is the price we have to pay so be it because we can no longer afford to sit on the fence when issues of surgical care delivery are being debated and RCSI do not have a firm view and indeed a policy. We are a professional body and as such statements and comments from us in relation to current conditions of practice for our Fellows must be on a purely professional basis. Many of our colleagues are currently disappointed with our representative associations who remain strangely silent and in the background in terms of championing our case. The representative organisations understandably devote a significant amount of their energies to supporting individual consultants who have industrial relations issues. However, it is also important that these bodies are to the forefront in tackling issues generic to all consultants.
Although it may be controversial and potentially detrimental to the overall unity of all consultants it is increasingly my view that the term Common Contract is obsolete. It may have served its time well at the outset but to my mind in terms of what we as surgeons do and what resources we require to do the work for which we are trained we are miles apart from Consultant colleagues such as Psychiatrists and Dermatologists. Presently too many young surgeons are staying abroad, or if they come home, are taking up posts in hospitals with enthusiasm, energy and expertise in the latest techniques from their overseas Fellowships and yet are not provided with the appropriate resources by their hospitals in order to exercise their technical skills and treat their patients in a timely fashion. It is common practice for these newly appointed surgeons to be offered a half days operating a week or even, in some instances, a half day a fortnight. The same employing authorities who do not provide them with theatre resource find it acceptable that these newly appointed young surgeons would have no proper secretarial help, no office and sometimes very little access to junior staff. While strictly speaking that may be contractual it is also professional because a surgeon’s wellbeing and sense of confidence would rapidly be eroded if he or she feels that they are significantly undervalued in the organisation and not being given proper opportunities to work.

Therefore we, as a College, have every right to be involved in advocacy for these surgeons so that they are given the appropriate resources to perform at the highest level. In former times, when these situations occurred at the beginning of someone’s consultant lifetime, he or she would negotiate access to the local private hospital so that at least they could maintain their skills and their confidence and develop a referral practice. In the current climate however this access is not available to them despite numerous representations to the HSE and other employers of the importance to a newly appointed surgeon of maintaining and expanding their clinical repertoire
as soon as possible after being appointed. It is well recognised that habits developed in early days of practice stay forever so a good busy work schedule is very important in the early years. At a minimum, in my view, a newly appointed surgeon should be operating two days a week and if the public system cannot offer that to young surgeons then in turn employers should ensure that they do not become deskillled. We know there is spare capacity in many of our private hospitals currently. Let's work out how to use them to treat patients.

Minister Reilly says he is going to act over the loss of trained doctors but he hasn’t been specific. My proposal to encourage trained surgeons to return to Ireland after Fellowships would be to re-establish sessional arrangements for provision of care. For possibly a lesser salary or sessional related payment, the skills and expertise of the highly trained surgeon would be available in public hospitals and in his or her own time private or insured patients could be treated in the local private hospital. Surely in a country of our size we cannot continue to have two sets of consultants – those in public hospitals which are over-regulated and those in private hospitals which are by comparison under-regulated. A radical rethink of how our surgical services are provided is needed if we are to successfully bring home our current crop of specialists who are abroad as well as give some succour/support to recently appointed surgeons who clearly do not enjoy their job as they should. It’s a potential win win for the Department of Health – to save more of the public purse through less salary and pension – and the lifting of the restriction on private practice will restore the consistency of surgical care delivery between public and private hospitals and keep surgeons operating.
The biggest obstacle in my view to this model is not necessarily the firm commitment of policy makers to consolidate clear demarcation between public and private practice but rather the desire for control of consultants by HSE/DOH.

The sessional commitment to public hospitals works extremely well in Australia where larger numbers of consultants with subspecialty expertise are available to all the hospitals. The surgeons in turn have plenty of resources available for them to do their work. There is a serious commitment to train their juniors during these public sessions but trainees can also attend/assist at private cases for educational benefit. In an era when we are trying to reduce duration of training, we should be maximising trainees’ exposure to good clinical cases irrespective of patient location.

We know the health insurance companies have recently muscled in on this scenario as well and have become self-appointed regulators of private practice. As far as I am concerned the insurance companies are third party payers on behalf of their client who has received a service from a surgeon. In my opinion they have no right to deny payment on behalf of their client to the provider of that service based on the type of contract he or she has with the State. That situation surely needs to be challenged.

More recently we are seeing the model of private hospitals recruiting young clinicians because of specific expertise and skills they in turn release them to provide services on a sessional basis to public hospitals. Perhaps this is another model that requires our consideration.

The recently announced hospital networks may allow us to look afresh at some of these issues. They offer an ideal opportunity to have the academic institutions play a central role in the development and administration of groups of hospitals and will add intelligence and strategic thinking to the decision making within these six regions.
Key in my view is the degree of autonomy permitted for the network. We are told they will be governed by a Chair and a Board of Management with a CEO answerable to the Board. Some of the Networks already have these governance arrangements in place. I understand however that the CEO will also be answerable centrally to the CEO of the HSE and the Secretary General of the Department of Health. If local autonomy is permitted services can be organised around the individual hospitals in each network and the leadership of the network can determine the specific roles for those hospitals for instance elective versus acute surgery. All surgeons within the network could be given opportunities equally to do elective and emergency work. Emergency rota’s could be organised with great effect around groups of hospitals as we have already seen in some areas of the country.

The network announcement has provided an ideal opportunity for the surgical profession to take a major leadership role and we must drive a common sense approach. For instance the ambition must be to perform high risk, low volume surgery in a Level 1 hospital with outcomes being monitored and audit provided through the National Office of Clinical Audit as well as through the National Cancer Control Programme. High volume and lower to intermediate risk surgery can be organised in Level 2,3,4 hospitals throughout the network. Surgeons and their trainees, in my view, must be prepared to travel reasonable distances – the Drogheda/Dundalk model is a shining example. These arrangements will provide an ideal opportunity for training young surgeons and developing technical skills. Why not include private hospitals in the Network in this arrangement also.

Extrapolating RCSI’s collaboration with the HSE as already outlined and the benefits accruing therefrom I would encourage all to involve themselves as much as possible in the development of the networks. Here in Galway I know there has been
tremendous enthusiasm for the re-organisation of your services regionally and hospitals of all levels are reporting improved morale and improved throughput of patients. However the *quid pro quo* for surgical buy-in to the network concept there has to be, in parallel, a realisation and understanding by the Government and the Department of Health and HSE for a fundamental rethink on how our services are provided. We the surgeons after all know better than anyone what is required to provide high quality surgical care for our patients.

Many organisations and successful businesses attribute their good performance to good leadership. The Francis Report identified leadership as a key factor in overcoming the challenge of improving quality of care in the face of ongoing financial constraint which is exactly what we are faced with here in Ireland over the next few years. There is a very unhelpful but widely held misconception that leadership is something which older people with fancy titles do. Leadership exists and needs to exist at every level and is simply about giving others the tools and support to do their job.

Dwight Eisenhower described leadership as the art of getting someone else to do something you want done, because they want to do it! Eddie O’Connor, entrepreneur and former CEO of Bord na Mona describes good leadership as being able to convince your colleagues and employees to buy into your vision.

Every surgeon is a leader by definition. He or she leads their team, leads the operating team, and leads the multi-disciplinary team. Their natural leadership and enthusiasm and dedication to hard work infects others who come in contact with them throughout their working day and is a force for positivity. Leaders should as far as possible be upbeat about their organisation and about their own job. Colin Powell
said that perpetual optimism is a force multiplier but leaders who whine and blame others engender the same behaviour in their colleagues. That is not to say that a surgeon shouldn’t be critical of what we have discussed in terms of inadequate resources and inadequate management when it is identified. We are however, like it or not, key leaders in word and deed and leading by example is very powerful.

There are, I’m sure, other and wider issues that need to be addressed in our health service but the ones I have highlighted I believe are the most important for us as surgeons. It goes without saying that retention of our surgical workforce in Ireland is vital. Modernising surgical education and training, developing surgical practice with appropriate resources and opportunities are also key to a quality workforce. Support for the National Audit System by enabling the collection and supervision of high quality data is hugely important.

The bottom line is that RCSI’s ultimate aim and mine as President is to create a well regulated, properly audited, attractive and fulfilling environment for our highly trained surgeons, to encourage them to come home, to use their skills so that our patients in Ireland can have the highest quality of surgical care.

I urge you all to join with us in the pursuit of that aim.

Professor Patrick J. Broe MCh FRCSI
President, RCSI

Sir Peter Freyer State of the Art Lecture: September 2013